# THE MEDICARE PART D LOW-INCOME SUBSIDY PROGRAM
## Experience to Date and Policy Issues for Consideration

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# THE MEDICARE PART D LOW-INCOME SUBSIDY PROGRAM
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Now in its fifth year, Medicare Part D, which provides government subsidized prescription drug coverage for Medicare beneficiaries through private stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs), has been a valuable addition to Medicare for millions of beneficiaries. The Part D program also provides additional premium and cost-sharing assistance to beneficiaries with low incomes and limited resources who qualify for the program's Low-Income Subsidy (LIS).

This report uses data from the program's first five years to describe LIS enrollment and plan availability for LIS beneficiaries. It describes the potential for program improvement associated with recent legislative and regulatory developments. It also examines other strategies that can be used to improve the effectiveness of the LIS program by increasing take-up rates, promoting greater stability in plan offerings for low-income beneficiaries, minimizing coverage disruptions from year to year, and easing transitions between drug plans when they do occur (see Appendix 1 for a description of methodology).

Our review of the marketplace for low-income subsidy recipients under Part D finds a relatively low take-up rates for subsidies, with little improvement since 2006. Fewer than half of eligible low-income beneficiaries who are not automatically enrolled – 40 percent – received the low-income subsidy in 2009. Since 2006, the number of "benchmark plans" (stand-alone prescription drug plans available to low-income beneficiaries for no premium) has dropped by 25 percent, causing both disruptions in coverage and increases in premiums for LIS enrollees. Less than a fifth of the benchmark plans that were offered in 2006 are still offered to LIS enrollees for no monthly premium in 2010. As a result of these and other changes (including the fact that most enrollees do not voluntarily switch plans from year to year), the share of LIS beneficiaries enrolled in PDPs paying premiums has increased, from 6 percent in 2006 to 22 percent in 2010. The number of "choosers" – LIS enrollees who have chosen a different plan after being automatically enrolled in a PDP – who must switch plans on their own or face paying premiums has increased, from approximately 700,000 in 2007 to 2.2 million in 2010.

## ASSISTANCE FOR LOW-INCOME BENEFICIARIES IN PART D

Medicare beneficiaries who choose to sign up for the Part D drug benefit can enroll in either stand-alone prescription drug plans or Medicare Advantage prescription drug plans. Medicare beneficiaries who qualify for full Medicaid benefits (dual eligibles), those enrolled in Medicare Savings Programs (MSP), and those receiving Supplemental Security Income (SSI) are "deemed" eligible for the LIS; they automatically qualify and do not have to apply separately. Other beneficiaries must apply for the LIS through the Social Security Administration (SSA) or their state Medicaid programs and qualify for full or partial subsidies if their income and assets are below specified levels **(Exhibit 1)**.

[1] Author affiliations: Georgetown University (Summer and Hoadley); NORC at the University of Chicago (Hargrave).

The federal government pays plans for the monthly premiums, deductibles, and coverage gap expenses of LIS beneficiaries with full subsidies, while LIS beneficiaries pay modest copayments for each on-formulary prescription and the full cost of any drugs not on their plan's formulary. Eligible beneficiaries with somewhat higher incomes or assets receive partial subsidies.[1] CMS estimates that in 2011, the average value of the subsidy amount applied to the Part D benefit, premium and cost-sharing for those enrolled in the LIS program will be approximately $4,000.[2]

**Exhibit 1**
**Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2010**

| Low-Income Subsidy Level | Monthly Premium | Annual Deductible | Copayments |
|---|---|---|---|
| Individuals with Medicare and Medicaid | $0 | $0 | $1.10-$2.50/generic $3.30-$6.30/brand-name; no copays after total drug spending reaches $6,440 |
| Individuals with Medicare and Medicaid in nursing homes | $0 | $0 | No copays |
| Individuals with income <135% of poverty and resources <$8,100/individual; $12,910/couple | $0 | $0 | $2.50/generic $6.30/brand-name; no copays after total drug spending reaches $6,440 |
| Individuals with income 135%-150% of poverty and resources <$12,510/individual; $25,010/couple | sliding scale up to $31.94* | $63 | 15% of total costs up to $6,440; $2.50/generic $6.30/brand-name thereafter |

SOURCE: Kaiser Family Foundation summary of Medicare drug benefit low-income subsidies in 2010.
NOTE: 2010 poverty level is $10,830/individual and $14,570/couple. Resources include funeral or burial expenses of $1,500/individual and $3,000/couple. *$31.94 is the 2010 national average monthly Part D beneficiary premium.

LIS enrollees may choose to enroll in any Part D plan. However, the LIS program will cover their premiums only up to a "benchmark" amount, which is calculated separately for each of the 34 PDP regions based on the average premium bid for the basic benefit by stand-alone PDPs and MA-PDs. Stand-alone PDPs with monthly premiums below the benchmark amount are called "benchmark plans" and qualify for automatic enrollment of LIS beneficiaries with the full premium subsidy (see Appendix 2 for a more detailed discussion of benchmark plans). If LIS beneficiaries enroll in a non-benchmark prescription drug plan, they are responsible for paying the premium amount that is above the benchmark, but otherwise benefit from the subsidized cost sharing.

Using an automatic enrollment process, the Centers for Medicare & Medicaid Services (CMS) randomly assigns full-benefit dual eligible LIS beneficiaries to basic PDPs with premiums below the benchmark when they first qualify. (See page 9 for a discussion of basic versus enhanced PDPs.) Other LIS beneficiaries are similarly randomly assigned to a PDP if they do not enroll on their own; this is called facilitated enrollment. Each year, LIS beneficiaries who are enrolled in a plan that does not qualify as a benchmark plan for the next year are either automatically reassigned by CMS to a new plan or need to take action to switch into a benchmark plan if they want to avoid paying premiums. Whether or not they have been randomly assigned or re-assigned, any LIS beneficiary can choose a new plan at any time during the year (and are referred to thereafter by CMS as "choosers"). But once a beneficiary becomes a "chooser," CMS will no longer reassign that beneficiary if his or her plan loses benchmark status.

## LOW-INCOME SUBSIDY PROGRAM ENROLLMENT

More than one-third of the 24.7 million Part D enrollees (9.8 million, or 40 percent) receive the Low-Income Subsidy in 2010. Approximately 81 percent of them are enrolled in PDPs and the remainder are in MA-PDs (Appendix Table 1).[3] This calculation excludes the 2.5 million Part D enrollees in employer-only plans and certain types of MA plans.

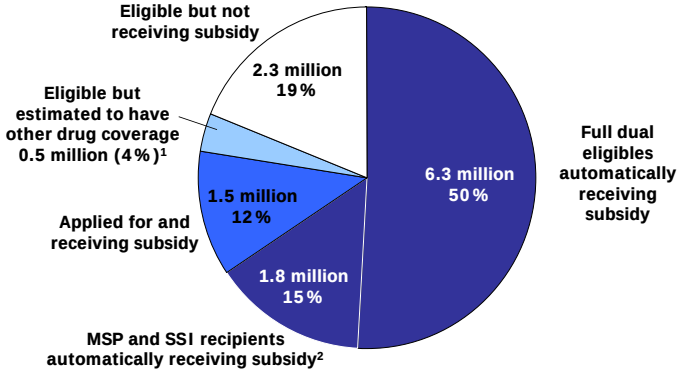
## SUBSIDY TAKE UP RATES ARE LOW

- ***Fewer than half of eligible beneficiaries not automatically enrolled receive the subsidy***

The most recent data available from CMS indicate that 12.5 million beneficiaries were eligible for the LIS in 2009 **(Exhibit 2)**. CMS reports that 8.1 million eligible beneficiaries were deemed eligible for the LIS that year, comprising 6.3 million full dual eligibles and 1.8 million MSP and SSI recipients who automatically receive subsidies. Almost half a million were eligible, but had other coverage and so did not enroll in Part D. The remaining 3.8 million other low-income beneficiaries had to apply for the LIS on their own.

Exhibit 2

**Medicare Drug Benefit Low-Income Subsidy Eligibility and Participation, 2009**



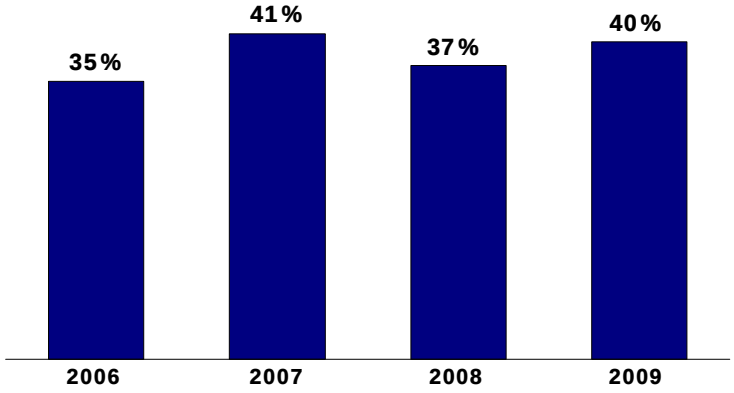

**Beneficiaries Eligible for Low-Income Subsidies = 12.5 million**

SOURCE: Centers for Medicare & Medicaid Services, 2009 Enrollment Information (as of February 1, 2009).
NOTE: [1]Includes Veterans Affairs, Indian Health Service, and Retiree Drug Subsidy (RDS) coverage. [2]MSP is Medicare Savings Program; SSI is Supplemental Security Income.

More than 2 million beneficiaries are eligible for low-income subsidies but not receiving them. Of the 3.8 million people who must apply on their own for the LIS, only 40 percent actually received the LIS in 2009 **(Exhibit 3)**. The low participation rate for this group has not changed significantly over the past five years, despite major efforts to inform beneficiaries about the availability of the subsidy and to provide assistance with applications.

Exhibit 3

**Share of Non-Deemed LIS-Eligible Medicare Beneficiaries Receiving the Low-Income Subsidy, 2006-2009**




SOURCE: Georgetown/NORC analysis of CMS enrollment data for the Kaiser Family Foundation.
NOTE: LIS is low-income subsidy.

For the first four years of the Part D program CMS released estimates of the numbers of beneficiaries eligible for the Low-Income Subsidy, but the agency did not report that number for 2010. Between 2007 and 2008, CMS reported a decrease of 700,000 in the number estimated to be eligible, but the methods used to make the estimates have not been reported. The pool of beneficiaries eligible for the subsidy has likely grown in 2010. The Social Security Administration estimates that as a result of a change that excludes the cash value of life insurance policies in evaluating assets, hundreds of thousands more beneficiaries will qualify for the LIS.[4] In addition, assistance provided by others for household expenses is no longer included in the income calculation. Increases in the resource limits for the Medicare Savings Programs, effective January 2010, also will have an effect on the number of people eligible for the MSP and LIS benefits. Economic circumstances, which have left many beneficiaries with less retirement savings and income than anticipated, may also contribute to an increase in the number of beneficiaries who qualify for the LIS.

- ***Complexity and confusion are among the reasons for low take-up rates***

A national survey of seniors indicates that lack of awareness about LIS benefits is a significant factor in low participation rates, particularly among low-income seniors of color.[5] Medicare beneficiary counselors report that the most common reasons beneficiaries do not apply for the LIS are that they do not have the information they need; they are not aware that a subsidy is available; they do not know how to apply for the subsidy; or they think they are ineligible for financial reasons.[6] Some Medicare beneficiaries are reluctant to ask for help or to share personal financial information.[7] Others are confused about the two-step process required for low-income beneficiaries to apply for the LIS and enroll in a Part D drug plan.[8] Confusion among eligibility workers has also been documented.[9] Furthermore, the asset test for the LIS is a source of complexity related to the application process. Beneficiaries may not understand what information is required; they may have difficulty obtaining the information; and the need to verify the information can be time-consuming.[10] The recent federal legislation that exempts the value of life insurance policies from asset test calculations will simplify the application process somewhat, but the process would be even simpler without an asset test.[11]

- ***LIS eligibility assessments and reassessments may affect participation rates***

Eligibility for the LIS from one year to the next is not always automatic. Three groups (CMS, state Medicaid programs, and the Social Security Administration) assess LIS eligibility on a regular basis. The agency that initially determines a beneficiary's LIS eligibility is responsible for reassessing eligibility for the following calendar year.[12]

Each year, in July, CMS works with state Medicaid agencies to determine who will continue to be automatically eligible for LIS status in the following year based on their continued eligibility for the Medicaid, MSP, or SSI programs. States redetermine individuals' financial eligibility for these programs at least annually. Beneficiaries who no longer appear to qualify for these programs receive a notice in September, which explains that they will not automatically receive LIS benefits the next year, but that they can apply for the LIS through the Social Security Administration. An application for the next year's subsidy accompanies the notice. Beneficiaries must return the application to SSA or their state Medicaid office for a new eligibility determination or, if they reapply and re-qualify for the Medicaid, MSP, or SSI programs before the end of the calendar year, they will be re-deemed for the LIS.[13]

The Social Security Administration also conducts LIS eligibility redeterminations annually for two groups of beneficiaries. "Initial redeterminations" are conducted each August for beneficiaries who qualified for the LIS during a 12-month period starting in the previous year. In addition, a group of LIS beneficiaries who applied for the LIS through SSA are selected each year for "cyclical redeterminations." Both groups include individuals who appear, based on agency data, to be likely to have a change in subsidy status because of a change in factors such as household size or finances. Beneficiaries selected for redetermination receive a letter and an "income and resources summary" sheet in September explaining that they must return the summary within 30 days or they are at risk of losing their LIS status.[14]

In the fall of 2008, CMS notified 447,000 beneficiaries, nearly 5 percent of LIS beneficiaries, that they would lose their deemed status and advised them to apply though SSA or Medicaid to retain the LIS for 2009. Approximately 45 percent regained their deemed status by the end of the calendar year. Among the almost 250,000 remaining beneficiaries, less than half (47 percent) filed applications with SSA in the first half of 2009. In the fall of 2009, almost 403,000 beneficiaries received notices about losing their deemed status.[15]

Across states, the proportions of LIS beneficiaries who were notified that they could lose deemed status for 2010 ranged from 1.5 percent to 9 percent. Factors such as the financial and health status of the population may account for some differences across states in the proportions of beneficiaries that could lose deemed status, but state policies are likely more of a factor. States with broader eligibility criteria

for their Medicaid and MSP programs and states that make an effort to ensure that eligible Medicaid and MSP beneficiaries retain coverage are likely to have fewer beneficiaries at risk of losing their deemed status for the LIS. For example, Louisiana, which had the smallest proportion of beneficiaries losing deemed status for 2010, uses an administrative renewal process for MSP enrollees. If an internal review of records initiated by the state indicates that they are still eligible for MSP benefits, beneficiaries receive a letter advising them that their benefits will continue for another 12 months unless they report a change of circumstances. In most other states, beneficiaries must be more proactive in order to maintain their eligibility.

The re-deeming process is designed to help ensure that subsidies are well targeted, but some eligible beneficiaries, particularly those who may be unable to respond to requests for information or resubmission of the LIS application because they are ill or who do not understand that they are required to respond, may lose coverage during the process. This type of coverage loss is one factor that contributes to low participation rates among those eligible for the LIS.

## LOW-INCOME SUBSIDY PLAN AVAILABILITY

### PROGRAM DESIGN AFFECTS COVERAGE AND PLAN STABILITY FOR LIS BENEFICIARIES

All Medicare beneficiaries have access to multiple plans and are advised to make informed choices about their Part D coverage each year, but the process can be more complicated for Part D enrollees who receive the LIS, even though they typically have fewer plan options available to them if they want to receive the full premium subsidy. This is in part due to significant changes in the availability of benchmark plans across years.

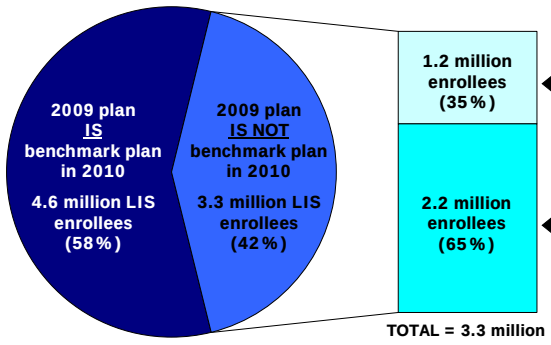
- ***The benchmark plan market is volatile***

Of the 409 benchmark plans offered in 2006, only 65 plans (16 percent) have qualified as benchmark plans each year since then.[16] Seven of the 34 regions do not have a single plan that has had benchmark status for all five years. Thus, a relatively small share of LIS beneficiaries enrolled in Part D since 2006 are likely to have had stable coverage from the same PDP over the five-year period.

At the time of open enrollment season for the 2010 plan year (November 15 to December 31, 2009), more than 3 million people – almost 4 of every 10 LIS beneficiaries – were enrolled in benchmark PDPs in 2009 that no longer qualified as benchmark plans in 2010 **(Exhibit 4)**. Of this total, CMS reassigned about one-third, or 1.2 million. This group includes beneficiaries who initially were randomly assigned to benchmark plans through auto- or facilitated enrollment and did not make any plan changes on their own. The remaining 2.2 million beneficiaries had to switch plans on their own or pay premiums if they remained in their 2009 plans. The vast majority of them are beneficiaries eligible for full subsidies who are termed "choosers" by CMS

**Exhibit 4**

**Low-Income Subsidy Enrollment in Benchmark Plans, as of 2010 Open Enrollment Period**




**Total LIS Enrollment in PDPs in 2009 = 7.9 million**

SOURCE: Georgetown/NORC analysis of CMS enrollment files for the Kaiser Family Foundation.
NOTE: Estimates may not sum to total due to rounding. Analysis includes enrollment in stand-alone prescription drug plans only. LIS is low-income subsidy. CMS is Centers for Medicare & Medicaid Services.

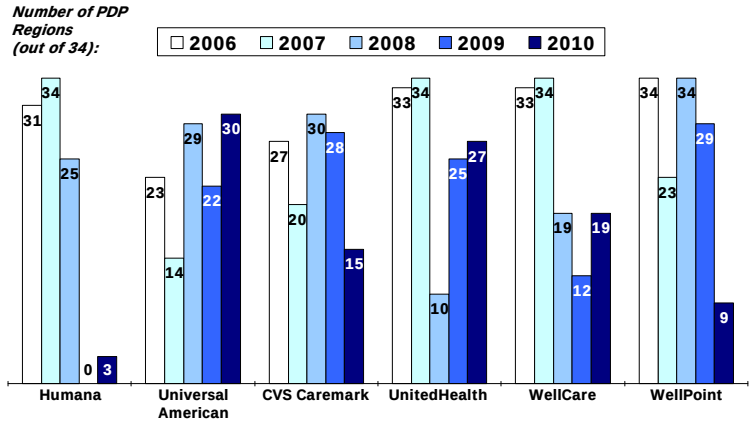
because at some point they made a decision, by themselves or with assistance, to switch out of the PDP to which they were auto-enrolled.[17]

One factor contributing to this lack of continuity has been the strategic decisions by several plan sponsors to introduce new plans with premiums lower than the premiums for their plans that qualified as benchmark plans in 2006. For example, United Healthcare's AARP MedicareRx Saver and WellCare's Signature plans were new in 2007. By 2010, the original benchmark plans offered by these sponsors in 2006 were no longer benchmark plans, although they retained some LIS enrollment – and the newer Saver and Signature plans qualify as benchmark plans in some regions.

The number of benchmark plans offered by the major Part D organizations has fluctuated substantially during the program's five years **(Exhibit 5)**. In 2006, Humana, UnitedHealth, WellCare, and WellPoint offered LIS plans in nearly all regions, but in 2010 Humana has LIS plans in only 3 regions and WellPoint has LIS plans in only 9 regions.[18] Among the six plan sponsors shown in Exhibit 5, all had benchmark plans in 23 or more of the 34 regions in 2006, but only Universal American and UnitedHealth qualify with benchmark plans in as many as 23 regions for 2010.[19]

**Exhibit 5**

**Number of Benchmark Plans Offered by Six Major Part D Organizations, 2006-2010**




SOURCE: Georgetown/NORC analysis of CMS 2006-10 PDP Landscape Source Files for the Kaiser Family Foundation.
NOTE: Counts include combined offerings of merged organizations, but do not include offerings by local subsidiaries of WellPoint.

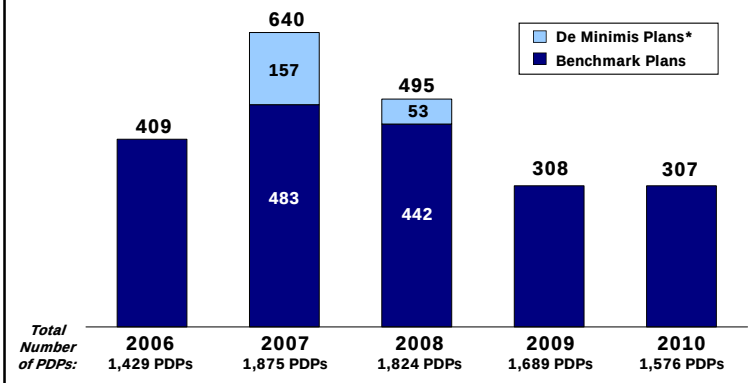
Among the 1.2 million low-income beneficiaries who were randomly assigned to new benchmark plans in 2010, most (94 percent) were reassigned because the PDP in which they were enrolled in 2009 lost benchmark status for 2010. In addition, 76,000 were enrolled in plans in 2009 that left the market in 2010 (60,000 in MA-PDs and 16,000 in PDPs). Some beneficiaries faced another round of changes in March 2010 when CMS ended its contract with one drug plan sponsor because of significant deficiencies found during an agency audit. As a result, more than 123,000 beneficiaries, about 94 percent of whom were LIS beneficiaries, had to switch plans.[20] CMS anticipates that approximately 500,000 beneficiaries will be reassigned in 2011.[21]

- ***The availability of benchmark plans has declined over time, but varies across regions***

Compared to 2006, there are 102 fewer benchmark plans available in 2010, a 25 percent decrease **(Exhibit 6)**. The proportion of plans that qualify for automatic or facilitated enrollment of LIS beneficiaries has also declined substantially over the five years that the program has been in operation, from 29 percent in 2006 to just 19 percent in 2010. CMS policy decisions regarding benchmark

**Exhibit 6**

**Number of Medicare Stand-Alone Prescription Drug Plans Available Without a Premium to Low-Income Subsidy Enrollees, 2006-2010**




SOURCE: Kaiser Family Foundation analysis of CMS PDP Landscape Source Files, 2006-2010.
NOTE: Excludes PDPs in the territories. *Under a Medicare demonstration, de minimis plans were eligible to retain LIS beneficiaries despite exceeding the benchmark premium by $2 in 2007 and $1 in 2008.

calculations as well as decisions on the part of organizations about whether to try to sponsor benchmark plans in various regions are factors that have likely affected benchmark plan availability.

The total number of benchmark plans for Part D low-income subsidy (LIS) recipients decreased by just one between 2009 and 2010, but the small change in the total number of plans masks the turnover among plans. Of the 308 benchmark plans available to LIS recipients for zero premium in 2009, 97 were no longer benchmark plans in 2010. These benchmark PDPs were either withdrawn from the Part D market entirely or their 2010 premiums exceeded the regional premium benchmark amounts. During the same period, 96 other new or existing plans gained benchmark status.

Among the 34 regions, five have two or three more benchmark plans in 2010 than in 2006 and two have the same number of plans. In the 27 regions with fewer plans, 12 saw a decrease of 5 or more plans. The largest decrease occurred in New Hampshire and Maine where just four plans are available in 2010, compared to 14 in 2006. With fewer plans available, beneficiaries not only have fewer choices related to plan design features such as formularies or utilization management requirements, but may also have fewer pharmacy choices (Appendix Table 2).

Five regions had very little volatility in the availability of benchmark plans between 2009 and 2010. In three of the five regions, no plans lost benchmark status and in the two others, beneficiaries in the plans that lost benchmark status were reassigned to other benchmark plans offered by the same organization and therefore had no significant change in coverage.[22] But nine regions had substantial volatility in benchmark plan availability, losing five or more benchmark plans between 2009 and 2010 and gaining up to three new benchmark plans (Appendix Table 3).

- ***Disruption in coverage for LIS beneficiaries is more common in some regions than others***

Nationally, about 15 percent of LIS beneficiaries were reassigned to a new plan in 2010. But reassignment was much higher in some regions than in others. The proportion of beneficiaries reassigned ranged from less than one percent in Arizona, California, Louisiana and Oregon/Washington, all of which gained plans in 2010, to more than 27 percent in Mississippi, North Carolina, Ohio, and Wisconsin, which all lost plans in 2010 (Appendix Table 4). By far, the largest proportion of LIS beneficiaries was reassigned in Nevada (55 percent) where the one benchmark plan in 2009 lost benchmark status for 2010; five others became benchmark plans in 2010. In general, larger proportions of beneficiaries were reassigned in regions with greater reductions in available benchmark plans between 2009 and 2010.

Another factor that affects the numbers reassigned is the extent to which state-based organizations or programs assist beneficiaries with plan switching. Once beneficiaries switch plans they become choosers and are no longer part of the pool of beneficiaries to be reassigned. Another group of beneficiaries, those who participate in some state pharmacy assistance programs (SPAPs), are not reassigned by CMS. In order to coordinate reassignments, SPAPs that help beneficiaries with their plan choices send CMS lists of beneficiaries who should not be included in the CMS reassignment process.

- ***Among LIS enrollees who were reassigned to a new plan, most were shifted to a plan offered by a different organization, rather than a plan offered by the same sponsor***

According to CMS estimates, 92 percent of low-income beneficiaries eligible for reassignment were reassigned to a different plan offered by a different organization in 2010 when their benchmark plan in 2009 lost benchmark status for 2010. Those beneficiaries are much more likely to see significant changes in plan formularies, utilization management requirements, or quality measures. The remaining eight percent of LIS enrollees were reassigned to a different plan offered by the same sponsoring organization in 2010.

- ***Despite disruptions, few beneficiaries switch plans after reassignment***

Beneficiaries do have the option of switching from the plan to which they were reassigned, but switching after reassignment is not common. Findings from an evaluation of the transition process between 2007 and 2008 indicate that among the 1.9 million LIS beneficiaries who received letters from CMS indicating that they would be reassigned if they did not choose a new plan, only 10 percent acted on the letter and made a choice. The other 90 percent were randomly reassigned to new plans for 2008.[23]

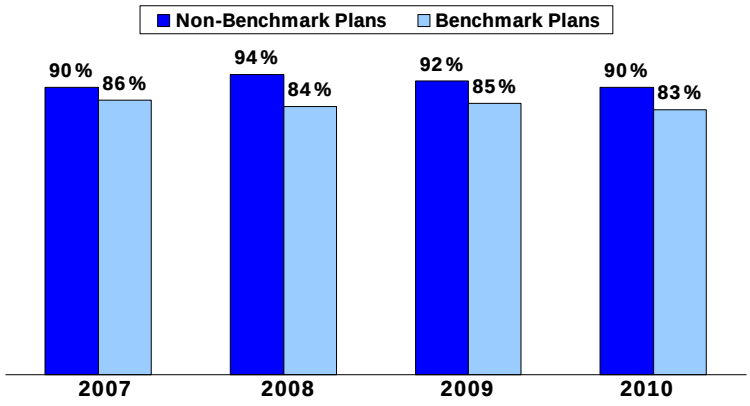
- ***Benchmark plans tend to have smaller formularies than other stand-alone plans***

On average, benchmark plans have smaller formularies than other PDPs (83 percent of drugs covered vs. 90 percent, respectively).[24] The gap between the two types of plans in the size of formularies has grown somewhat since 2007 **(Exhibit 7)**.

Regardless of whether they are enrolled in benchmark plans, LIS beneficiaries tend to be in PDPs with fewer drugs on formulary than other Part D enrollees. The share of LIS enrollees in plans with formularies covering less than the average number of drugs on all formularies is 63 percent compared to only 40 percent of non-LIS enrollees. A smaller formulary is not necessarily an inferior formulary. Plans may leave drugs off their formularies for clinical reasons or as part of negotiations for lower prices. But a smaller formulary does create the potential for more disruption when changing plans.

Exhibit 7

**Formulary Size for Benchmark and Non-Benchmark Plans, 2007-2010**




SOURCE: Georgetown/NORC analysis of CMS Formulary Files, 2007-2010, for MedPAC.
NOTE: Excludes plans that qualified to keep LIS enrollees based on the waiver for 2007 and 2008. Calculations are share of chemical entities, weighted by enrollments.

## IMPLICATIONS OF PLAN AVAILABILITY FOR LIS ENROLLEES

### PLAN INSTABILITY MAY LEAD TO DISRUPTIONS IN DRUG REGIMENS FOR LOW-INCOME BENEFICIARIES

- ***Differences in formularies, plan design, and cost management procedures may pose challenges for LIS beneficiaries when they are reassigned to new plans***

LIS beneficiaries who are assigned to new benchmark plans may face disruptions in their medication regimens if they are switched or switch on their own to a plan that does not cover their medications or imposes utilization management restrictions that their previous plan did not. CMS does not make an attempt to match an individual's prescription drug use with the list of drugs covered by benchmark plans.

LIS beneficiaries are protected from paying more than modest cost-sharing amounts for any drugs that are on a plan's formulary. But when a drug is off formulary, the beneficiary has several choices: switch to a similar on-formulary drug, request an exception, pay out of pocket, find another source for the drug (such as samples from physicians), or stop filling the prescription. The new plan may also have different utilization management requirements such as prior authorization or step therapy. For example, a beneficiary who successfully completed the prior authorization process for a particular medication in 2009

may have to obtain prior authorization again in 2010 from the new plan, and the process may or may not be the same.

Part D program rules require that if beneficiaries are assigned to new plans that do not have their current medications on formulary or that have utilization management requirements for the medications, the new plan must provide at least a 31-day temporary fill of the medication. This requirement is in effect for the first 93 days of a beneficiary's enrollment in a new plan. These rules help ensure that beneficiaries will have access to their current medications after a plan switch, but then they must still take steps to conform to the new plan's formulary or utilization management requirements.

A reassigned beneficiary who takes several drugs could face several different changes in plan coverage or requirements for their specific drugs when they are switched from one plan to another. In New York, for example, beneficiaries in the one plan that lost benchmark status for 2010 could have been reassigned to any of 11 other plans. Lexapro, an antidepressant that plans are not required to cover, was on the formulary (with no utilization management requirements) of the plan that lost benchmark status.[25] Beneficiaries assigned to six of the 11 benchmark plans could continue to obtain Lexapro as they had the previous year because it is also on the new plans' formularies with no utilization management requirements. Three of the other 11 plans also have Lexapro on their formularies, but beneficiaries switched to those plans would have had to get prior authorization from the new plan to continue coverage for the drug. The other two plans to which beneficiaries were randomly assigned did not include Lexapro on their formularies. Beneficiaries in those plans would have had to request and receive an exception for coverage in order to get coverage for Lexapro or they would have had to switch to another antidepressant on the new plans' formularies. Clinicians suggest that substitution among antidepressants is riskier than substitution among other drug classes.

Beneficiary counselors note that it is very time-consuming to advise beneficiaries because each has a particular drug regimen and each of the benchmark plans to which they are assigned has different drug-specific requirements.[26] The demand for assistance was particularly great in a state like Nevada in 2010. As noted above, the one plan that had benchmark status for 2009 lost it for 2010, and five other plans gained benchmark status. Thus, more than half of the state's LIS beneficiaries were reassigned among five different plans and most others had to choose a new plan on their own to avoid paying premiums.

## INCREASING NUMBERS OF LIS ENROLLEES ARE PAYING PREMIUMS

- ***Substantial and growing proportions of LIS beneficiaries are not enrolled in basic benchmark plans***

Part D plan sponsors are required to offer a basic benefit, either the standard Part D benefit defined by law or an actuarially equivalent benefit design. They may also offer enhanced plans, which must have a greater actuarial value than the basic plans. Enhanced plans may reduce or eliminate the deductible, charge less than the standard 25 percent coinsurance, and cover drugs in the coverage gap.

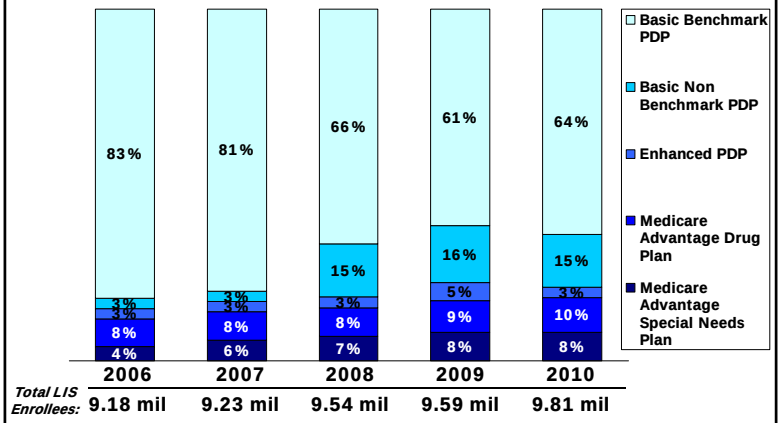
LIS beneficiaries enrolled in basic benchmark plans receive the full premium subsidy to which they are entitled. If LIS beneficiaries enroll in a basic non-benchmark prescription drug plan, they are responsible for paying the premium amount that is above the benchmark. LIS beneficiaries enrolled in enhanced benefit plans pay premiums even if the plans' premiums are below the benchmark because they are liable for the premium amount defined by the plan as having enhanced value. They pay these additional premiums even though most plan enhancements are not necessary for LIS enrollees because full-subsidy LIS beneficiaries already are protected from the deductible, the coverage gap, and pay only modest copayments, regardless of their plan type.

In 2010 the majority of LIS beneficiaries are enrolled in basic benchmark PDPs (64 percent) **(Exhibit 8)**. An additional 15 percent are in basic non-benchmark plans; 3 percent are in plans offering enhanced

benefits and 18 percent are in MA-PD plans. Nearly half of the LIS enrollees in MA-PDs are in Special Needs Plans (SNPs), a type of Medicare Advantage Plan that limits membership to beneficiaries with specific diseases or characteristics. The proportion of LIS beneficiaries enrolled in basic non-benchmark plans increased from 3 percent in 2006 to 15 percent in 2010. This means that higher proportions of LIS beneficiaries are subject to Part D premiums, translating into higher proportions of LIS beneficiaries paying premiums for Part D coverage that they would not have to pay if they were enrolled in benchmark plans.

**Exhibit 8**

**Low-Income Subsidy Enrollment by Type of Medicare Part D Plan, 2006-2010**




SOURCE: Georgetown/NORC analysis of CMS 2006-10 PDP and MA Landscape and Enrollment files for the Kaiser Family Foundation.
NOTE: Special Needs Plans are a type of Medicare Advantage plan, but shown separately here.

LIS enrollment in MA-PDs, including SNPs, has also increased over the same period (from 8 percent to 10 percent for MA-PDs and from 4 percent to 8 percent for SNPs). Most LIS beneficiaries enrolled in SNPs – 87 percent – are in plans designed to serve dual eligibles. An additional 8 percent are in SNPs for individuals with chronic and disabling conditions and the remaining 5 percent are in institutional SNPs. The growth in MA and SNP enrollment among LIS beneficiaries parallels growth in the numbers of all beneficiaries participating in MA and SNP plans during the same period.

The proportion of LIS beneficiaries enrolled in basic benchmark plans, after decreasing substantially from 2006 to 2009, rose modestly in 2010. This may have occurred in part because the number of benchmark plans was essentially unchanged from 2009 to 2010 compared to substantial decreases in the prior two years. CMS policy changes likely contributed to the relative stability between 2009 and 2010.

Some LIS beneficiaries may choose to enroll in a plan other than a basic benchmark plan because it provides particular benefits. Others may choose to stay in their current plan when they enroll in LIS or when a plan loses benchmark status if they are satisfied, particularly if they face very small premium payments for the following year. Given the substantial decrease in the proportion of LIS beneficiaries enrolled in benchmark plans over the program's five years to date, however, it seems likely that many have remained in their plans because they are not aware of the change in their coverage.

The proportion of LIS beneficiaries enrolled in basic benchmark plans in 2010 varies by region from 38 percent in Arizona to 84 percent in New Hampshire and Maine (see Appendix Table 5). The availability of MA-PD plans may affect enrollment patterns, with lower portions of LIS beneficiaries enrolled in basic benchmark plans in regions such as Arizona where MA-PD plans are more commonly available and may attract low-income beneficiaries.[27] The high rate of basic benchmark plan enrollment for LIS beneficiaries in the New Hampshire/Maine region likely reflects policies in Maine, which has established procedures through the state pharmacy assistance program to evaluate each LIS beneficiary's plan each year and assign beneficiaries to the most appropriate plan.

- ***The number of "choosers" who must switch plans on their own has increased substantially***

Under CMS policy, beneficiaries who switch plans at any point after auto- or facilitated enrollment are considered to be choosers for the duration of their participation in the LIS program. Thus, the total number of LIS beneficiaries counted as choosers will generally increase over time.

Each year, some choosers are enrolled in plans that lose benchmark status for the following year. The number of choosers who must switch plans or face paying premiums has increased from about 700,000 for 2007 to 2.2 million for 2010, or from 8 percent to 23 percent of all LIS enrollees. The number of choosers who must switch plans to avoid paying premiums is affected each year by CMS policies and plan decisions that influence the number of plans and the particular plans that retain benchmark status.

Each fall, CMS sends notices to choosers who are enrolled in benchmark plans that will lose benchmark status the next year. Notices were sent to 443,000 choosers for 2008 and to 620,000 choosers for 2009. In the fall of 2009, CMS sent notices to 1.7 million choosers informing them of their 2010 premium liability and of LIS benchmark plans available in their region. This group is larger than previous years because of a CMS policy change, whereby the agency sent notices not only to choosers enrolled in benchmark plans in 2009 that were losing benchmark status in 2010 (the group that received notices in prior years), but also to any chooser who faced having to pay premiums in 2010 by remaining in their chosen plan.[28] These choosers may have stayed in non-benchmark plans in prior years – and paid premiums – either because they were unaware that the plans' status had changed or because they decided, when the plan lost benchmark status, to remain enrolled and pay a small premium because they did not want to have to change plans. CMS also sent a mid-year notice in 2010 to approximately 1.6 million LIS beneficiaries who pay premiums to remind them that they have the option to switch to a zero-premium plan.

- ***Some LIS beneficiaries are paying significant amounts for drug coverage***

For 2010, approximately 22 percent of LIS beneficiaries enrolled in PDPs are paying premiums because they are enrolled in non-benchmark plans, including enhanced plans. This share has increased substantially from 2006, when just six percent of LIS beneficiaries enrolled in PDPs paid premiums. Among MA-PD enrollees, 18 percent of LIS beneficiaries enrolled in non-SNP MA-PDs and 2 percent of LIS beneficiaries enrolled in SNPs pay premiums in 2010.

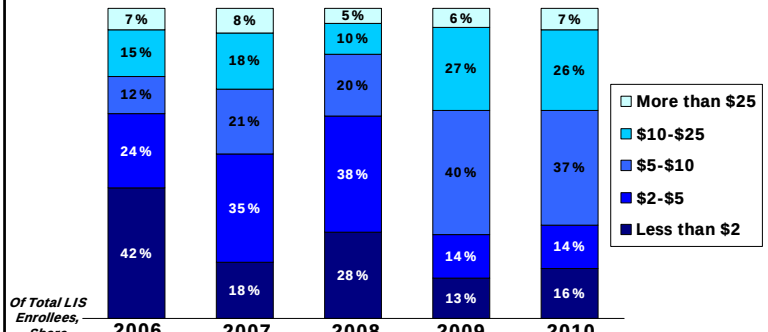
The number of LIS beneficiaries in PDPs paying premiums has increased substantially over time from almost 490,000 in 2006 to 1.7 million in 2010, an increase of more than three-fold. This has likely occurred because of market disruption and changes in benchmark plan availability. As a result, these beneficiaries are not benefitting to the fullest extent from the LIS program.

In 2010, 30 percent of LIS beneficiaries who are paying a premium for their PDPs have monthly premiums of $5.00 or less **(Exhibit 9)**. For others, however, the premiums are more substantial. One third (33 percent) pay $10.00 or more per month. Among them, almost 30,000 LIS beneficiaries are in plans that have premiums of more than $50 per month. The highest premium for LIS enrollees in PDPs in 2010 is $86.50 per month for a plan that has 168 LIS enrollees.[29]

The average premium amount for which LIS beneficiaries are responsible has increased over time from $6.41 to $9.95 per month. In

**Exhibit 9**

**Distribution of Monthly Part D Premiums for Low-Income Subsidy PDP Enrollees Paying Premiums, 2006-2010**




| Of Total LIS Enrollees, Share Paying Premiums: | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| | 6% | 7% | 21% | 26% | 22% |
| Number Paying Premiums: | 488,000 | 566,000 | 1,719,000 | 2,042,000 | 1,731,000 |
| Average Premiums: | $6.41 | $9.12 | $6.39 | $9.81 | $9.95 |

SOURCE: Georgetown/NORC analysis of CMS 2006-10 PDP Landscape files for the Kaiser Family Foundation.

2010, among LIS beneficiaries paying premiums, 70 percent paid $10 or more per month compared to 34 percent in 2006.

Among choosers who pay premiums, those whose plans have recently lost benchmark status pay lower premiums, on average, than choosers who have remained in benchmark plans for several years. In 2010, these groups of choosers paid estimated average premiums of $2.39 and $11.36, respectively.[30] The higher premiums for the second group likely occur because beneficiaries remained in the plans over the years despite annual premium increases.

The 294,000 LIS beneficiaries enrolled in enhanced plans in 2010 are all paying premiums. Among them, almost 48,000 LIS beneficiaries are enrolled in enhanced plans with premiums below the benchmark. Despite this, they are paying for the "extra" part of the premium attributed to the enhanced value of the benefit. Among the group in enhanced plans with premiums below the benchmark, 68 percent pay premiums of $5.00 or less and 30 percent pay $5.00 to $10.00 per month, with the remaining 2 percent paying more than $10.00 per month. Among the 795 enhanced plans in 2010, 93 have premiums below the benchmark amount.

An examination of 2010 enrollment for the ten PDPs with the largest share of LIS beneficiaries (two-thirds of LIS beneficiaries) suggests that many beneficiaries enrolled in non-benchmark plans are likely holdovers from when those plans had benchmark status in prior years **(Exhibit 10)**. It is unknown whether beneficiaries made an affirmative decision to remain enrolled and whether they were aware that they would have to pay a premium. In 2010, one of the top ten plans is not a benchmark plan in any region, though it has more than 420,000 LIS enrollees. In 2006, this plan (AARP MedicareRx Preferred) had benchmark status in 33 of the 34 regions.

**Exhibit 10**

**Medicare Stand-Alone Prescription Drug Plans with the Most Low-Income Subsidy Enrollees in 2010**

| Prescription Drug Plan | Regions Where PDP is Benchmark Plan | Total LIS Enrollment | Share of All LIS Enrollment |
|---|---|---|---|
| AARP MedicareRx Saver | 24 | 1,133,494 | 14.2% |
| Community CCRx Basic | 25 | 982,920 | 12.3% |
| SilverScript Value | 12 | 482,405 | 6.1% |
| First Health Part D-Premier | 20 | 452,950 | 5.7% |
| WellCare Classic Total | 19 | 445,681 | 5.6% |
| AARP MedicareRx Preferred | 0 | 420,922 | 5.3% |
| PrescribaRx Bronze | 27 | 411,442 | 5.2% |
| Advantage Star Plan by RxAmerica | 10 | 382,944 | 4.8% |
| Health Net Orange Option 1 | 17 | 361,309 | 4.5% |
| HealthSpring Prescription Drug Plan | 24 | 359,162 | 4.5% |
| **TOTAL FOR TOP 10 PDPs** | | **5,433,229** | **68.2%** |

**SOURCE: Georgetown/NORC analysis of CMS PDP Landscape and Enrollment Files, 2010, for the Kaiser Family Foundation.**
**NOTE: LIS is low-income subsidy.**

## STRATEGIES TO IMPROVE THE EFFECTIVENESS OF THE PART D PROGRAM FOR LOW-INCOME BENEFICIARIES

Part D and the Low-Income Subsidy are valuable programs for Medicare beneficiaries, particularly for those who did not have prescription drug coverage previously. Over the past five years, substantial resources have been devoted to helping Medicare beneficiaries enroll in the Part D program, understand it, and use it effectively. Even as the program has become better established, however, LIS enrollment lags and confusion persists for some beneficiaries. The plan changes that occur annually for low-income beneficiaries can be cumbersome. Several strategies to simplify the program are discussed below.

### INCREASING TAKE-UP RATES

Additional data sharing and enrollment facilitation on the part of the agencies that administer the program and the plans that deliver the benefit could help more beneficiaries obtain and retain the LIS.

Estimates indicate that at the beginning of 2010, fewer than 4 in 10 of the beneficiaries who must apply on their own received the Low-Income Subsidy. Possible reasons for the low participation rates are that despite the publicity, beneficiaries may not be aware of the benefit or they may not realize that they qualify. If they do not routinely take prescription drugs or if they are confused about their coverage or do not understand that they must submit a subsidy application separate from their enrollment in a Part D plan, they may not apply for the benefit.[31] Thus, efforts to inform people about the benefit may not be sufficient to increase enrollment. An effort to describe or develop a method to make accurate national and state-level estimates of potentially eligible beneficiaries would be helpful in gauging progress and in targeting outreach and enrollment activities.

- ***Default enrollment for LIS beneficiaries***

Data sources such as SSA records, tax records, and enrollment rolls from programs targeted to low-income individuals could be used to identify beneficiaries eligible for the Low-Income Subsidy and enroll them in the program with an opt-out provision. This approach would ensure that beneficiaries who do not apply for the LIS because they are not aware of the availability of the subsidy or who do not think they qualify would have the opportunity to receive the benefit. This approach is used already for Medicare beneficiaries who have Medicaid coverage. It has also been used successfully to provide subsidies for CommonwealthCare health insurance in Massachusetts.[32]

- ***Greater assistance for beneficiaries who lose deemed status***

Currently, CMS works with state Medicaid agencies to identify individuals who no longer appear to qualify for the Medicaid, MSP, or SSI programs and therefore will not continue to be automatically eligible (deemed eligible) for LIS benefits. These beneficiaries receive a notice and an LIS application to submit to the Social Security Administration. An alternate approach would be to require that when state Medicaid agencies identify these individuals, they simply use the information they have on hand about individuals' financial circumstances to determine immediately whether they meet the eligibility requirement for the LIS. State Medicaid agencies are designated application sites for the Low-Income Subsidy and therefore already have the authority to enroll beneficiaries, although currently the vast majority of individuals apply for the LIS through the Social Security Administration. Medicaid agencies can also take a more active role in helping beneficiaries who are about to lose deemed status for the LIS take necessary steps, such as completing the redetermination process for Medicaid or MSP in order to retain those benefits and as a result, continue to be automatically eligible for the Low-Income Subsidy.

The Social Security Administration could also provide assistance by keeping LIS applications submitted by beneficiaries on file and "potentially active" for a period of time, such as two years. This would help beneficiaries who apply for the LIS but are then deemed eligible because they gain eligibility for another program such as Medicaid. Currently, if they lose deemed status, for example because they no longer qualify through Medicaid's Medically Needy program, they must submit a new application to SSA. If SSA kept their original application in reserve, however, the agency could review it and make an LIS eligibility determination immediately when they are informed that a beneficiary no longer qualifies for deemed status.

- ***Improve coordination with the Medicare Savings Programs***

As of January 2010, MSP resource limits increased to match the resource limits for the LIS benefit: $12,510 for an individual and $25,000 for a couple. This change means that more beneficiaries will qualify for MSP benefits and be deemed eligible for the LIS. Also effective January 1, 2010, SSA is required, with beneficiaries' permission, to transmit data from LIS applications to states to initiate an MSP application on a beneficiary's behalf.[33] This change has the potential not only to increase MSP enrollment, but also, in states that have taken steps to expand MSP eligibility (for example by excluding

resources from the eligibility calculation), to increase the number of MSP beneficiaries who can then be deemed eligible for the LIS.

Income limits for the programs still differ, as do some of the methods used to calculate income and resources. A legislative change to fully align eligibility requirements for the MSP and LIS programs could simplify program administration considerably and decrease the confusion that some beneficiaries express about how to apply for and retain the various benefits.[34]

- ***Eliminate the asset test***

Eliminating the asset test for the MSP and LIS programs would not only promote program coordination, but also ease the application process for each program and have administrative advantages. Eight states have already used their authority under Medicaid to eliminate asset tests for the Medicare Savings Programs.[35] Data from national surveys show that beneficiaries with limited incomes tend not to have fluctuations in their financial circumstances and that the value of their assets is closely tied to income. Beneficiaries who qualify for low-income benefits based on income, but fail asset tests tend to have modest assets.[36] The Affordable Care Act of 2010 bases financial eligibility for premium and cost-sharing assistance for non-elderly individuals solely on income, a possible model for the LIS program.

## PROMOTING STABILITY IN BENCHMARK PLAN AVAILABILITY

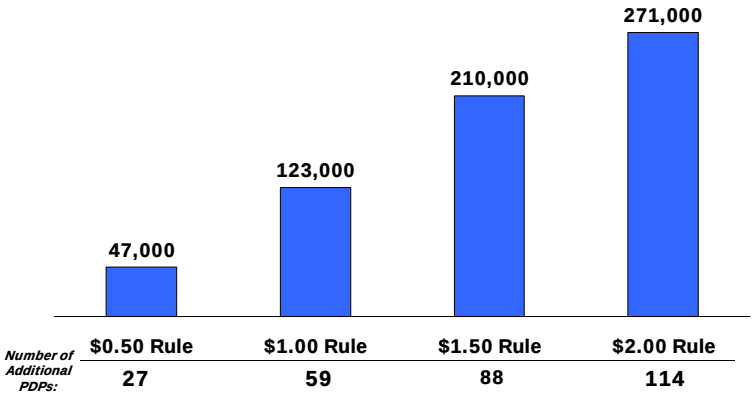
When greater numbers of plans maintain benchmark status from one year to the next, fewer LIS beneficiaries must be reassigned or in the case of choosers, pay higher premium unless they change plans. Each year policies developed by CMS regarding methods to calculate the benchmark have had an impact on plan availability and stability.

- ***The "de minimis" option for plans***

The Patient Protection and Affordable Care Act permits PDPs or MA-PDs that offer the basic benefit to waive the monthly premium charge for beneficiaries if the amount is "de minimis," which could have a significant impact on the stability of the benchmark plan market if plans take up the option. For example, with a specified de minimis amount of $1.00, 59 more PDPs would have had benchmark status in 2010; at $2.00, there would have been 114 additional benchmark PDPs and 271,000 more LIS enrollees in PDPs with benchmark status if all eligible PDPs had taken the option **(Exhibit 11)**. CMS has established a de minimis amount of $2.00 for 2011.[37] It will be important to monitor the extent to which plans use the de minimis option as well as the impact it has on the number of benchmark plans available and the number of beneficiaries who remain in plans with benchmark status as a result.

**Exhibit 11**

**Number of Low-Income Subsidy Enrollees Avoiding Disruption in Coverage in 2010, Based on Different "De Minimis" Rules**




SOURCE: Georgetown/NORC analysis of CMS PDP Landscape Source Files, 2010, for the Kaiser Family Foundation.
NOTE: Assumes all applicable plans adopted the "de minimis" option.

## MINIMIZING COVERAGE DISRUPTION

The practice of assigning and re-assigning low-income beneficiaries to PDPs on a random basis is intended to ensure a roughly even distribution of beneficiaries among plans and to minimize selection bias for plans. However, it can also cause confusion for beneficiaries. The change in formularies or utilization management procedures that occurs when beneficiaries switch from one plan to another can be particularly challenging for LIS beneficiaries who tend to have multiple chronic conditions which are controlled by adherence to many medications. They must understand which drugs are on formularies, whether the plan has requirements for prior authorization, step therapy, or quantity limits, how to request an exception, file and appeal or grievance, how to contact the plan, and which pharmacies are preferred. Pharmacists spend time counseling beneficiaries and contending with formulary changes at the point of sale. Plans must be equipped to handle inquiries about new formularies and utilization management policies and to handle to paperwork associated with requests for exceptions or appeals. Physicians may have to help patients take the necessary steps to obtain their current medications or to make a substitution and may have to counsel and monitor patients if medication changes occur.

An important concern related to coverage disruptions is whether they have an impact on health outcomes for beneficiaries. One research study found little difference in hospital or emergency room admission rates or in death rates among LIS beneficiaries who were and were not reassigned to plans.[38] These may not have been the appropriate measures to use, however, since they are affected by a variety of factors besides access to prescription drugs. More study is needed to examine the impact of the reassignment process on measures such as adherence to drug regimens and impact on health status over a longer period of time. At the same time, certain policy changes could limit disruption.

- ***Replace random assignment with beneficiary-centered assignment***

Beneficiary-centered assignment, an alternative to random assignment, seeks to minimize disruptions by taking beneficiaries' current prescription drug regimens and pharmacies into account in assigning them to new benchmark plans. This is the same logical process that CMS recommends each year for Medicare beneficiaries when it urges them to use the web-based Plan Finder to determine whether the plan in which they are currently enrolled or an alternate is the optimal plan for them.

The 2011 draft Call Letter indicated that CMS was examining the feasibility for considering past medication use in making reassignments. The agency reported in the final Call Letter that it would not do this for the 2011 contract year, but would continue to consider modifying the reassignment process to take drug use into account. The agency has also noted that it has the discretion to implement that type of procedural change.[39]

Some state pharmacy assistance programs used a beneficiary-centered process to help beneficiaries pick plans at the start of the Part D program. States reported that it was not costly and did not have a disruptive effect on the markets in their states.[40] Some states continue to assist beneficiaries in this way. In Maine, for example, the state pharmacy program conducts evaluations each year to ensure that LIS beneficiaries are enrolled in benchmark plans with the most "usable formulary," one that not only includes the medications they need, but also has helpful utilization management policies, such as accepting prior authorization or step therapy requirements that beneficiaries fulfilled previously with another plan.[41]

The Patient Protection and Affordable Care Act requires that beginning in 2011, CMS must inform LIS beneficiaries of formulary differences between their current plans and new benchmark plans to which they are reassigned, with respect to the beneficiary's drug regimen. Thus the agency will have to take steps to compare individuals' drug regimens with plan formulary data, which can be accomplished using Part D claims data and information in the Plan Finder. A next step could be to conduct beneficiary-centered assignment for all LIS beneficiaries who would otherwise be randomly reassigned or to advise

choosers about – and perhaps enroll them in – the best alternate plans. One concern about this approach is its potential to create adverse selection or to load a large share of LIS beneficiaries into a single plan. Risk adjustors should be able to inhibit adverse selection, and methods could also be used to assure some balance in assignments. Since Medicare pays most of the cost-sharing obligation for LIS beneficiaries, beneficiary-centered assignment could be designed to reduce government spending, for example by restricting assignment to less expensive plans. Under this approach, some LIS beneficiaries might end up in plans that are not an optimal match for their current drug needs, although a better match than under random assignment. Policymakers will need to balance the goals of minimizing disruptions for LIS beneficiaries with federal costs.[42]

- ***Improve plan performance and quality ratings and consider them in making assignments and reassignments***

Beneficiaries are advised to consider plan quality when they make plan choices. Yet the random assignment and reassignment processes do not take performance or quality measures into account. Consequently, some LIS beneficiaries may find themselves in plans that are poor performers. Although they have the option of changing plans, it can be more difficult to make a change from a plan that is not always responsive or does not always provide correct information.

Currently, CMS collects and reports quality data for sponsoring organizations rather than for individual drug plans. Thus, they do not reflect plan-level operations. Some activities conducted at the organization level, such as the operation of call centers, cannot be measured at the plan level, but the development of other plan-level measures would allow beneficiaries to make more meaningful comparisons among plans. Although not as precise as plan-level measures, the wide ranges among sponsoring organizations for measures currently available do suggest that LIS beneficiaries may have very different experiences depending on the plan to which they are randomly assigned. For example, CMS reports that callers receive accurate information from Part D sponsoring organizations 79 percent of the time, on average, but organizations' performance ranges on this measure from 17 percent to 93 percent.

One example of the way in which plan quality can affect stability is the action taken by CMS in March 2010 to end its contract with one drug plan sponsor because of significant deficiencies found during an agency audit. All of the beneficiaries in the plan (most of whom were LIS beneficiaries) were immediately enrolled in LI-NET, a temporary Part D plan that helps with transitions, and informed that they would have to change plans. LIS beneficiaries who did not switch on their own were randomly reassigned.[43] Thus, some LIS beneficiaries had three different types of Part D coverage in the first three months of 2010.

Further work is needed to develop accurate and useful performance measures. The use of appropriate measures in making LIS assignments or reassignments could help promote coverage stability if plans with poor records (based on current performance measures, new plan-level measures, and internal agency information) were not eligible for assignments. Such a policy change might also be an added inducement for plans to improve performance. If beneficiary-centered assignment is used, quality is one of the factors that should be considered in making the assignments.

Customer service performance measures are particularly relevant for LIS beneficiaries; they are more likely to need assistance understanding and using plans, both because they may be reassigned to new plans frequently and because as a group, they are more likely than other Medicare beneficiaries to have multiple chronic conditions, including cognitive impairments, and to have limited English proficiency.

- ***Consider reassigning LIS beneficiaries to enhanced plans***

Enhanced plans, which are supposed to have a greater actuarial value than basic plans, have never been included among the group of plans to which LIS beneficiaries can be reassigned. But for some

beneficiaries they may be a logical alternative. Distinctions between basic and enhanced plans have become less clear as the Part D program has evolved. In 2010, for example, 136 basic plans had higher monthly premiums than the enhanced plans offered by the same sponsor in the same region.[44] LIS beneficiaries enrolled in enhanced plans, even in the 93 enhanced plans with premiums below the benchmark in 2010, must pay premiums to cover the enhanced portion of the plan. Yet, the total premium for a low-premium enhanced plan may be below benchmark. The government would save money on premiums if LIS beneficiaries were assigned to those plans even if it paid the enhanced portion of the premium. The Maine SPAP, for example, reassigns certain beneficiaries who need particular high-cost medications to an enhanced plan if that will reduce the beneficiaries' total costs. The SPAP gets referrals from counselors at SHIP and legal services agencies when the agencies encounter beneficiaries who they think would be well served by an enhanced plan.

In the preamble to the April 2010 regulations, in response to comments suggesting that the group of PDPs to which beneficiaries are assigned or reassigned be expanded to include enhanced plans, CMS indicates that by statute, the LIS does not cover the portion of the premium attributable to the enhanced benefit and that the statute clearly limits initial auto-enrollments to plans where an individual has zero premium liability; the agency has adopted the same policy for reassignment purposes.[45] Thus, a change in the law would be required before CMS could implement this policy.

## ENSURING THAT LIS ENROLLEES PAY PREMIUMS BY CHOICE RATHER THAN BY DEFAULT

- ***Reassign choosers who will face premiums the next year***

Substantial numbers of LIS beneficiaries – 1.7 million – received letters in 2009 indicating that if they did not switch plans they would pay premiums in 2010 because they would not be enrolled in basic benchmark PDPs. The data suggest that many of the beneficiaries who receive "chooser" letters from CMS do not select a new plan. The number of choosers is increasing. Also, the amount of the premiums choosers pay tends to increase over time as they remain in non-benchmark plans for more than one year. In the 2011 draft Call Letter, CMS noted that that the agency is concerned that choosers may not fully understand that they have less expensive alternatives if their current plan loses benchmark status and that there is a subsequent risk that they will not be able to pay their premiums, which could result in disenrollment. The agency considered expanding reassignment to choosers based on their 2011 premium liability, for example, if their 2011 premium would have been $10 or greater.[46] Subsequently, CMS stated, in the preamble to the April 2010 regulations, that they would continue to assess choosers' experience and noted that they do have authority to change the process for choosers. However, CMS noted in the final Call Letter that they would not implement this policy for 2011, but would consider the change in future years.

An expanded reassignment process would likely lead to a decrease in the number of low-income beneficiaries who pay premiums. Such a policy change would be most effective if CMS differentiates between choosers who chose their plan when it had premiums below benchmark and choosers who chose an above-benchmark plan, presumably for reasons other than the premium amount. With this distinction, reassignment could be limited to those who appear to have chosen a plan because of premium differences.

## EASING PLAN TRANSITIONS

- ***Ensure more consistency in policies and procedures***

The Affordable Care Act requires the use of a single, uniform exceptions and appeals process for Part D plans beginning January 1, 2012.[47] CMS has developed a standard transition notice for plans to send

beneficiaries and the agency is considering whether to require that plans use it.[48] A rule to require that the new plan accept approvals from the previous plan if beneficiaries have already met prior authorization, step therapy, or other utilization management requirements would also be helpful. Plans already are required to provide temporary fills of medications to new enrollees, but beneficiaries must meet formulary and utilization management requirements for the remainder of the year. Requiring more standard rather than plan-specific procedures would ease the transition process for beneficiaries and those who assist them and would make it easier to measure plan performance. It would be useful to have more information available about the extent to which plans have developed policies that exceed minimum temporary fill requirements and about the numbers of beneficiaries, especially LIS beneficiaries, who request and receive temporary fills.

- ***Provide more information for beneficiaries who must switch plans***

Provisions in the Patient Protection and Affordable Care Act require that beginning in 2011, CMS must inform LIS beneficiaries of formulary differences between their current plans and new benchmark plans to which they are reassigned, with respect to the beneficiary's drug regimen. CMS will also be required to inform individuals of their rights to request a coverage determination, exception, or to file and appeal or grievance.[49] This requirement will help ensure that beneficiaries understand what changes will occur in their coverage. To be most effective – unless there is a change to make procedures more uniform – beneficiaries should also be alerted about any differences in utilization management and other procedures between the plans and informed about how to proceed.

More specific quality and plan performance measures could also help beneficiaries determine whether they want to stay with the plan to which they are reassigned or make a switch. Currently, performance measures pertain to the organizations that sponsor drug plans, but beneficiaries could use more plan-specific information.

- ***Evaluate the effectiveness of outreach activities and beneficiary counseling***

Despite tremendous effort and considerable investment to find, enroll, and counsel beneficiaries, the need for assistance with the Part D program persists, particularly during the annual enrollment and reassignment period. After five years of program experience, it would be useful to better understand what types of activities should be continued or enhanced and whether different approaches could be more helpful. Program simplification would obviate the need for some of the assistance that is currently provided, but some Medicare beneficiaries will continue to need assistance.

CMS reports that in fiscal year 2009, State Health Insurance Assistance Programs (SHIPs) reached nearly 5.4 million people to provide information, counseling, and enrollment assistance for all aspects of the Medicare program. The total represents almost 12 percent of all Medicare beneficiaries and includes both beneficiaries who received one-to-one counseling and those who attended group information sessions.[50] SHIPs are required to report not only on the numbers of beneficiaries they see, but also on how many are low-income beneficiaries, on the type of assistance that is provided and on the aspect of the program that counselors cover. CMS does not routinely release this information to the public, however. More detailed information on activities at SHIPs as well as at Area Agencies on Aging and Aging and Disability Resource Centers, all of which have received funding increases to help increase LIS enrollment and help Part D beneficiaries, would be helpful to have in planning for future assistance. There is also a need for more outcome-based research to help distinguish between community-based practices that are perceived to be effective and those for which there is quantitative evidence of effectiveness.

## CONCLUSION

The Medicare Part D drug benefit and the Low-Income Subsidy program have helped to make prescription drugs affordable for millions of low-income beneficiaries. However, the LIS application and renewal process and market instability have posed problems in terms of participation rates, plan churning, and transitions between plans for LIS enrollees. Provisions included in the Patient Protection and Affordable Care Act and various regulatory changes are intended to address some of these issues, and CMS has indicated a willingness to continue to study issues that affect low-income beneficiaries. The five years of program data and experience provide a solid foundation upon which to build improvements in the LIS program. Knowledge gained through the operation of the LIS program could also be helpful for policymakers as they face the task of designing systems to ensure that eligible consumers apply for, receive, retain, and use government-subsidized coverage in a reformed health care system.

# APPENDIX 1: METHODS

### *Counting plans*

In general, our counts of drug plans exclude all plans located in the territories, all employer-only plans (both PDPs and MA-PDs that are only open to people attached to a particular employer or former employer), and Medicare Advantage plans that are section 1876 cost contract plans; national PACE plans; or demonstration plans (e.g., plans offered in the end stage renal disease demonstration and plans for residents of continuing care retirement communities). In the analysis, we separate drug plans offered by Special Needs Plans (SNPs) (a type of Medicare Advantage plan) from other MA-PDs; thus, unless otherwise specified, counts of MA-PDs exclude drug plans offered by SNPs.

We define our plan lists based on each plan's availability at the time of the annual open enrollment season and on the existence of a count of its enrollment when CMS releases the first complete plan-level enrollment numbers for the year (in February, in recent years). Plans sometimes leave the program or are terminated from the program after that date; such plans will be included in our analysis. For example, CMS terminated its contract with one plan sponsor (Fox Insurance Company) in March 2010. Because the termination came after our list was finalized, plans offered by this sponsor are included in plans counts, including total benchmark plans for 2010.

For purposes such as tracking plan offerings across years and estimating the number of benchmark plans that have been continuously offered in the program's five years, plans are matched across years based on contract and plan ID numbers even when plan names change. In late 2009, prior to the 2010 open enrollment season, CMS released for the first time a "crosswalk" that matches 2009 plans to 2010 plans for enrollment purposes. We used this crosswalk to track plan offerings between 2009 and 2010. In the absence of a crosswalk for prior years, we have matched plans based on plan names (even though the ID numbers had changed) in a few cases; doing so allowed us to create a match for one national PDP that changed ID numbers.

Designation of LIS benchmark plans are taken from the annual CMS landscape files at the time of the annual open enrollment season. As described in Appendix 2, CMS used a premium waiver in 2007 and 2008 to qualify some additional plans as benchmark plans. We have indicated in each exhibit whether these additional waiver plans are included.

### *Counting enrollees*

For privacy protection reasons, CMS enrollment files suppress plan enrollment counts of ten or under. In all enrollment counts based on plan-level files, we impute a count of five enrollees for these plans. As a result, total national enrollment counts may be somewhat different than other national totals that do not use this imputation method. In most cases, we report numbers rounded to the nearest 1,000.

CMS releases separate plan-level files for the total number of enrollees and the total number of LIS enrollees. We combine these counts, but some technical issues remain. First, LIS enrollment is released for one month each year (most often February), whereas total enrollment is now being released on a monthly basis (but was released for only one month in 2006 and 2007). We have used the closest possible match of months for these two enrollment files, but an exact match of months is not available for each year. Second, even when using data for the same month, there are some plans for which the matched files show more LIS enrollees than total enrollees. In any such cases, we have reduced the number of LIS enrollees to match the total number of enrollees.

In these CMS plan-level enrollment files, Medicare Advantage enrollment cannot be attributed to states or regions. Some MA contracts (including regional PPOs in multistate regions, most private fee-for-service plans, and a smaller number of local HMOs or PPOs) have service areas that cross state boundaries. CMS also releases contract-level, county-level files. The county-level enrollment in these files can be aggregated to states or regions. But contracts include multiple plans and thus may include both SNPs and non-SNPs, both employer-only plans and open-enrollment plans, and both basic-benefit and enhanced plans.

The region-level tabulations reported in Appendix Table 1 for both PDPs and MA-PDs are based on the contract-level, county-level enrollment files (instead of the plan-level files used elsewhere). We used the contract-level data because it is the only available source of MA-PD data that can be aggregated to states or regions (and used the same source for PDP enrollment to maintain consistency). Enrollment in Appendix Table 1 differs somewhat from those in other tables for several reasons. First, where county-level files are used, we impute a count of one beneficiary per county per contract (instead of five enrollees in the plan-level imputation) where cells of ten or under are suppressed. Second, counts include employer-only plans and the excluded types of MA plans. This may increase total counts by as many as 43,000 LIS enrollees in employer-only plans and 28,000 enrollees in the types of MA plans excluded from plan counts (as described in the first section of this appendix). Third, we cannot separate SNPs from other MA-PDs in these region-level enrollment counts. Fourth, the county-level files use the enrollee's county of residence. Situations where beneficiaries may be enrolled in a plan that does not officially serve their county of residence include beneficiaries who have recently moved, those with multiple addresses (e.g., "snowbirds"), and those using a family member's address. Aggregating regional enrollment from the county of residence may lead to different totals than data based on plan service areas.

In Appendix Table 5, we report enrollment totals from the same contract-level, county-level files used for Appendix Table 1. Shares for different types of PDPs, however, are based on plan-level files since a single contract often includes a mix of basic and enhanced PDPs and of benchmark and non-benchmark PDPs.

### *Estimating LIS premiums*

CMS released LIS premiums in a special landscape file for the first time in 2010. Because that information is unavailable for plans in 2006 to 2009, we estimate LIS premiums for those years as the lesser of zero or the difference between the total premium and the benchmark premium for the region in which the plan is offered. This calculation is precisely accurate for basic-benefit plans, but not for enhanced plans. In enhanced plans, the LIS beneficiary must pay the entire premium attributed to the plan's enhanced value (an amount that is not reported in the files released by CMS before 2010). As a result, our method underestimates the premium paid by LIS beneficiaries in enhanced plans from 2006 to 2009. For example, in cases where an enhanced plan's premium is below the benchmark, our method reports a zero premium even though LIS enrollees in these plans will pay a premium. We include these enrollees in total counts of those paying a premium and in counts of those paying premiums of up to $2.00. For other LIS enrollees, their premium will be higher than that reported by our estimation method. As a result of our approach to estimating LIS premiums, the average premiums reported in Exhibit 9 and in the accompanying text are smaller than actual average premiums and the distributions reported by dollar ranges underestimate the share in the higher premium ranges.

### *Estimating the number of reassignments and choosers*

For each open enrollment season, we estimate the number of LIS beneficiaries who would pay a premium the next year based on the new benchmark status of the plans in which LIS beneficiaries are enrolled. Our process for matching plans across years is described in the first section of this appendix. We then subtract the number of beneficiaries that CMS reports each year as being reassigned to a new plan. We designate the remainder as "choosers." Available data on LIS enrollment by plan are for a particular month (as described in the second section of this appendix). Thus, our numbers will differ modestly from the actual numbers of choosers at the time of the annual open enrollment season since enrollment levels change each month.

### *Estimating formulary size*

The analysis of formulary size, as reported in Exhibit 7, is based on analysis conducted for the Medicare Payment Advisory Commission (MedPAC).[51] In reporting the share of drugs listed on plan formularies from 2007 through 2010, we define "drug" as a unique chemical entity. Each chemical entity includes all forms and strengths of the drug and all trade names by which drug is marketed. The universe of drugs is based on the set of chemical entities which appear in each year's formulary reference file released by CMS and includes all chemical entities that appear on at least one plan's formulary. The CMS formulary reference file includes a set of reference (proxy) NDCs intended as a list of all Part D-covered drugs that may be included on Part D formularies.

## APPENDIX 2: BENCHMARK PLAN POLICIES

The methods used to calculate the benchmark have an impact on the number of plans gaining or losing benchmark status. Over the years, CMS has implemented a number of policies related to the benchmark calculation that are designed to stabilize the marketplace and ensure that a sufficient number and variety of benchmark plans are available.

For the 2007 and 2008 plan years, CMS used its demonstration authority to phase in enrollment weighting in calculating regional benchmarks and also used demonstration authority to implement a "de minimis" policy. Under this policy, LIS beneficiaries who were enrolled in a plan losing benchmark status were allowed to stay in that plan and retain the full premium subsidy as long as the new monthly premium did not exceed the regional benchmark by more than a small amount (one or two dollars). The demonstration was discontinued in 2009, but that year CMS invoked a provision in the law to increase the benchmark in one region (Nevada) to the lowest monthly premium for a basic plan offered because no plan had a premium below the benchmark for that region that year.

A provision in the Patient Protection and Affordable Care Act permits PDPs or MA-PDs to waive the monthly premium charge for beneficiaries if the amount is "de minimis," as defined by CMS.[52] Thus, beginning in January 2011, LIS beneficiaries can remain in plans with premiums just over the benchmark for that year (if those plans accept the de minimis option). CMS will therefore not have to reassign these beneficiaries to new benchmark plans. This policy differs from the de minimis policies instituted by CMS under demonstration authority for the 2007 and 2008 plan years because CMS paid the premium differences in 2007 and 2008. Under the new policy, plans will forgo the de minimis amount in order to retain benchmark status; the policy will not increase government spending.

The agency also issued a regulation specifying that for 2009 and future years, enrollment weighting will only factor in the number of LIS enrollees in a plan, as opposed to total enrollment. Regional variation in the benchmarks had been affected by the use of enrollment-weighted average premiums in calculating the benchmark amounts, which are lower than the non-weighted averages. Plans with lower premiums tend to have higher enrollment, which gave them greater weight in the benchmark calculation, thereby reducing the regional benchmark amounts. The overall result was a smaller number of plans available to LIS recipients, causing even more concentrated enrollment in low-premium plans.

For 2010, CMS used demonstration authority to calculate the weighted average premium using Part D premiums for MA-PD plans before they have been reduced by any applicable rebates (savings from other health services).[53] Beginning January 1, 2011 CMS is required by law to use this method each year.[54] In prior years, the determinations of low-income benchmark premium amounts were based on MA-PD premiums after reduction by MA rebates. On average, MA-PD plan premiums are lower than stand-alone PDP premiums, in part because Medicare Advantage plans can use rebates to reduce their drug benefit premiums. Because MA-PD plan premiums were included in the calculation of the benchmark, lower regional benchmarks were observed in regions with a higher penetration of MA-PD plans.

## APPENDIX TABLE 1:
## Number of LIS Beneficiaries, by Region and Plan Type, 2010

| | | LIS Enrollment | | | | |
|---|---|---|---|---|---|---|
| Region | States | TOTAL | Total in PDPs | % of total in PDPs | Total in MA-PDs | % of total in MA-PDs |
| 1 | NH, ME | 122,557 | 117,163 | 95.6% | 5,394 | 4.4% |
| 2 | CT, MA, RI, VT | 429,945 | 374,104 | 87.0% | 55,841 | 13.0% |
| 3 | NY | 757,486 | 552,144 | 72.9% | 205,342 | 27.1% |
| 4 | NJ | 225,934 | 204,242 | 90.4% | 21,692 | 9.6% |
| 5 | DE, DC, MD | 176,577 | 159,955 | 90.6% | 16,622 | 9.4% |
| 6 | PA, WV | 506,701 | 354,270 | 69.9% | 152,431 | 30.1% |
| 7 | VA | 204,440 | 183,450 | 89.7% | 20,990 | 10.3% |
| 8 | NC | 348,507 | 302,096 | 86.7% | 46,411 | 13.3% |
| 9 | SC | 173,691 | 146,136 | 84.1% | 27,555 | 15.9% |
| 10 | GA | 298,355 | 253,761 | 85.1% | 44,594 | 14.9% |
| 11 | FL | 643,157 | 427,355 | 66.4% | 215,802 | 33.6% |
| 12 | AL, TN | 513,544 | 385,208 | 75.0% | 128,336 | 25.0% |
| 13 | MI | 279,042 | 258,555 | 92.7% | 20,487 | 7.3% |
| 14 | OH | 334,451 | 280,981 | 84.0% | 53,470 | 16.0% |
| 15 | IN, KY | 373,971 | 339,271 | 90.7% | 34,700 | 9.3% |
| 16 | WI | 143,541 | 122,643 | 85.4% | 20,898 | 14.6% |
| 17 | IL | 355,014 | 330,294 | 93.0% | 24,720 | 7.0% |
| 18 | MO | 198,827 | 174,888 | 88.0% | 23,939 | 12.0% |
| 19 | AR | 135,325 | 116,791 | 86.3% | 18,534 | 13.7% |
| 20 | MS | 162,877 | 150,841 | 92.6% | 12,036 | 7.4% |
| 21 | LA | 195,325 | 165,209 | 84.6% | 30,116 | 15.4% |
| 22 | TX | 713,056 | 562,459 | 78.9% | 150,597 | 21.1% |
| 23 | OK | 124,443 | 110,591 | 88.9% | 13,852 | 11.1% |
| 24 | KS | 68,572 | 63,649 | 92.8% | 4,923 | 7.2% |
| 25 | IA, MN, MT, ND, NE, SD, WY | 324,509 | 264,830 | 81.6% | 59,679 | 18.4% |
| 26 | NM | 69,957 | 56,285 | 80.5% | 13,672 | 19.5% |
| 27 | CO | 95,819 | 70,263 | 73.3% | 25,556 | 26.7% |
| 28 | AZ | 163,635 | 76,729 | 46.9% | 86,906 | 53.1% |
| 29 | NV | 49,663 | 37,282 | 75.1% | 12,381 | 24.9% |
| 30 | OR, WA | 263,500 | 202,505 | 76.9% | 60,995 | 23.1% |
| 31 | ID, UT | 71,192 | 55,592 | 78.1% | 15,600 | 21.9% |
| 32 | CA | 1,215,218 | 980,604 | 80.7% | 234,614 | 19.3% |
| 33 | HI | 37,142 | 22,651 | 61.0% | 14,491 | 39.0% |
| 34 | AK | 14,056 | 14,027 | 99.8% | 29 | 0.2% |
| | **U.S. TOTAL** | **9,790,029** | **7,916,824** | **80.9%** | **1,873,205** | **19.1%** |

SOURCE: Georgetown/NORC analysis of CMS 2010 county-level LIS enrollment files for the Kaiser Family Foundation.

NOTE: MA-PD enrollment includes SNPs. Enrollment numbers based on contract-level enrollment counts. See Appendix 1 for a description of differences between data presented in this appendix and elsewhere.

## APPENDIX TABLE 2:
## Number of PDPs and Benchmark PDPs, by Region, 2006-2010

| | Number of PDPs | | | | | | Number of Benchmark PDPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Region | 2006 | 2007 | 2008 | 2009 | 2010 | Change, 2006-10 | 2006 | 2007 | 2008 | 2009 | 2010 | Change, 2006-10 |
| 1 | 41 | 53 | 53 | 46 | 43 | 2 | 14 | 21 | 18 | 5 | 4 | -10 |
| 2 | 44 | 51 | 51 | 47 | 48 | 4 | 11 | 20 | 14 | 12 | 13 | 2 |
| 3 | 46 | 61 | 55 | 51 | 50 | 4 | 15 | 16 | 15 | 9 | 11 | -4 |
| 4 | 44 | 57 | 57 | 52 | 47 | 3 | 14 | 20 | 18 | 7 | 6 | -8 |
| 5 | 47 | 55 | 52 | 48 | 45 | -2 | 15 | 21 | 18 | 11 | 11 | -4 |
| 6 | 52 | 66 | 63 | 57 | 55 | 3 | 15 | 26 | 18 | 9 | 11 | -4 |
| 7 | 41 | 53 | 52 | 48 | 44 | 3 | 16 | 21 | 17 | 13 | 11 | -5 |
| 8 | 38 | 51 | 52 | 49 | 47 | 9 | 13 | 21 | 17 | 11 | 8 | -5 |
| 9 | 45 | 59 | 56 | 53 | 47 | 2 | 16 | 26 | 20 | 15 | 13 | -3 |
| 10 | 42 | 55 | 54 | 50 | 45 | 3 | 14 | 20 | 18 | 11 | 8 | -6 |
| 11 | 43 | 57 | 58 | 54 | 49 | 6 | 6 | 10 | 8 | 5 | 5 | -1 |
| 12 | 41 | 56 | 53 | 49 | 46 | 5 | 9 | 18 | 15 | 12 | 9 | 0 |
| 13 | 40 | 54 | 55 | 51 | 46 | 6 | 14 | 25 | 17 | 11 | 9 | -5 |
| 14 | 43 | 60 | 58 | 49 | 46 | 3 | 10 | 22 | 15 | 6 | 5 | -5 |
| 15 | 42 | 53 | 52 | 48 | 44 | 2 | 13 | 20 | 17 | 12 | 9 | -4 |
| 16 | 45 | 54 | 57 | 53 | 48 | 3 | 14 | 20 | 16 | 16 | 10 | -4 |
| 17 | 42 | 56 | 53 | 49 | 46 | 4 | 15 | 23 | 19 | 12 | 10 | -5 |
| 18 | 41 | 53 | 52 | 48 | 45 | 4 | 10 | 15 | 13 | 6 | 13 | 3 |
| 19 | 40 | 58 | 55 | 52 | 49 | 9 | 13 | 23 | 18 | 12 | 15 | 2 |
| 20 | 38 | 52 | 49 | 47 | 45 | 7 | 12 | 21 | 15 | 13 | 10 | -2 |
| 21 | 39 | 52 | 50 | 47 | 45 | 6 | 11 | 11 | 10 | 7 | 13 | 2 |
| 22 | 47 | 60 | 56 | 53 | 50 | 3 | 16 | 19 | 15 | 14 | 11 | -5 |
| 23 | 42 | 56 | 52 | 49 | 46 | 4 | 12 | 20 | 13 | 8 | 10 | -2 |
| 24 | 40 | 53 | 52 | 48 | 46 | 6 | 11 | 20 | 17 | 10 | 9 | -2 |
| 25 | 41 | 53 | 52 | 48 | 46 | 5 | 14 | 20 | 16 | 9 | 8 | -6 |
| 26 | 43 | 57 | 55 | 50 | 47 | 4 | 8 | 14 | 11 | 7 | 8 | 0 |
| 27 | 43 | 55 | 55 | 53 | 48 | 5 | 10 | 19 | 12 | 8 | 6 | -4 |
| 28 | 43 | 53 | 51 | 49 | 46 | 3 | 6 | 10 | 7 | 2 | 8 | 2 |
| 29 | 44 | 54 | 53 | 49 | 46 | 2 | 7 | 9 | 5 | 1 | 5 | -2 |
| 30 | 45 | 57 | 55 | 48 | 44 | -1 | 15 | 20 | 15 | 7 | 9 | -6 |
| 31 | 44 | 56 | 54 | 51 | 48 | 4 | 14 | 20 | 14 | 9 | 9 | -5 |
| 32 | 47 | 55 | 56 | 51 | 47 | 0 | 10 | 14 | 9 | 6 | 7 | -3 |
| 33 | 29 | 46 | 49 | 47 | 41 | 12 | 8 | 18 | 10 | 5 | 7 | -1 |
| 34 | 27 | 45 | 47 | 45 | 41 | 14 | 8 | 17 | 15 | 7 | 6 | -2 |
| **TOTAL** | **1429** | **1866** | **1824** | **1689** | **1576** | **147** | **409** | **640** | **495** | **308** | **307** | **-102** |

SOURCE: Georgetown/NORC analysis of CMS 2006-2010 PDP Landscape Source Files for the Kaiser Family Foundation.

NOTE: Predates exclusion of Fox plans from Part D in early 2010. See Appendix Table 1 for states in each region.

## APPENDIX TABLE 3:
## Gains and Losses in PDP Benchmark Status, by Region, 2009-2010

| | Number of Benchmark PDPs | | | Number of Benchmark PDPs Changing Benchmark Status | | |
|---|---|---|---|---|---|---|
| Region | 2009 | 2010 | Change, 2009-10 | Losses | Gains | No Change |
| 1 | 5 | 4 | -1 | 3 | 2 | 2 |
| 2 | 12 | 13 | 1 | 2 | 3 | 10 |
| 3 | 9 | 11 | 2 | 1 | 3 | 8 |
| 4 | 7 | 6 | -1 | 3 | 2 | 4 |
| 5 | 11 | 11 | 0 | 3 | 3 | 8 |
| 6 | 9 | 11 | 2 | 2 | 4 | 7 |
| 7 | 13 | 11 | -2 | 5 | 3 | 8 |
| 8 | 11 | 8 | -3 | 5 | 2 | 6 |
| 9 | 15 | 13 | -2 | 5 | 3 | 10 |
| 10 | 11 | 8 | -3 | 5 | 2 | 6 |
| 11 | 5 | 5 | 0 | 2 | 2 | 3 |
| 12 | 12 | 9 | -3 | 5 | 2 | 7 |
| 13 | 11 | 9 | -2 | 3 | 1 | 8 |
| 14 | 6 | 5 | -1 | 4 | 3 | 2 |
| 15 | 12 | 9 | -3 | 5 | 2 | 7 |
| 16 | 16 | 10 | -6 | 7 | 1 | 9 |
| 17 | 12 | 10 | -2 | 5 | 3 | 7 |
| 18 | 6 | 13 | 7 | 2 | 9 | 4 |
| 19 | 12 | 15 | 3 | 2 | 5 | 10 |
| 20 | 13 | 10 | -3 | 6 | 3 | 7 |
| 21 | 7 | 13 | 6 | 0 | 6 | 7 |
| 22 | 14 | 11 | -3 | 4 | 1 | 10 |
| 23 | 8 | 10 | 2 | 2 | 4 | 6 |
| 24 | 10 | 9 | -1 | 2 | 1 | 8 |
| 25 | 9 | 8 | -1 | 2 | 1 | 7 |
| 26 | 7 | 8 | 1 | 1 | 2 | 6 |
| 27 | 8 | 6 | -2 | 2 | 0 | 6 |
| 28 | 2 | 8 | 6 | 0 | 6 | 2 |
| 29 | 1 | 5 | 4 | 1 | 5 | 0 |
| 30 | 7 | 9 | 2 | 0 | 2 | 7 |
| 31 | 9 | 9 | 0 | 3 | 3 | 6 |
| 32 | 6 | 7 | 1 | 1 | 2 | 5 |
| 33 | 5 | 7 | 2 | 2 | 4 | 3 |
| 34 | 7 | 6 | -1 | 2 | 1 | 5 |
| **TOTAL** | **308** | **307** | **-1** | **97** | **96** | **211** |

SOURCE: Georgetown/NORC analysis of CMS 2006-2010 PDP Landscape Source Files for the Kaiser Family Foundation.

NOTE: Predates exclusion of Fox plans from Part D in early 2010. See Appendix Table 1 for states in each region

## APPENDIX TABLE 4:
## LIS Beneficiaries in PDPs Reassigned to New Plans in 2010, by Region

| Region | Total LIS Beneficiaries in PDPs 2009 | Total LIS Beneficiaries in PDPs reassigned for 2010 | Percent LIS Beneficiaries in PDPs reassigned for 2010 |
|---|---|---|---|
| 1 | 115,536 | 16,339 | 14.1% |
| 2 | 367,177 | 51,771 | 14.1% |
| 3 | 553,798 | 60,138 | 10.9% |
| 4 | 205,879 | 39,583 | 19.2% |
| 5 | 155,556 | 23,708 | 15.2% |
| 6 | 338,646 | 26,316 | 7.8% |
| 7 | 185,126 | 49,199 | 26.6% |
| 8 | 301,738 | 87,378 | 29.0% |
| 9 | 149,631 | 35,872 | 24.0% |
| 10 | 259,649 | 35,756 | 13.8% |
| 11 | 415,302 | 73,523 | 17.7% |
| 12 | 405,011 | 74,731 | 18.5% |
| 13 | 259,060 | 62,959 | 24.3% |
| 14 | 280,920 | 101,927 | 36.3% |
| 15 | 339,616 | 55,527 | 16.3% |
| 16 | 122,895 | 33,512 | 27.3% |
| 17 | 324,327 | 83,408 | 25.7% |
| 18 | 177,604 | 20,078 | 11.3% |
| 19 | 119,295 | 8,511 | 7.1% |
| 20 | 152,371 | 44,206 | 29.0% |
| 21 | 165,301 | 763 | 0.5% |
| 22 | 563,665 | 74,132 | 13.2% |
| 23 | 111,176 | 18,804 | 16.9% |
| 24 | 65,284 | 9,062 | 13.9% |
| 25 | 274,355 | 33,665 | 12.3% |
| 26 | 57,235 | 1,910 | 3.3% |
| 27 | 70,150 | 12,148 | 17.3% |
| 28 | 72,510 | 568 | 0.8% |
| 29 | 34,878 | 19,229 | 55.1% |
| 30 | 197,256 | 541 | 0.3% |
| 31 | 58,179 | 7,941 | 13.6% |
| 32 | 982,727 | 1,746 | 0.2% |
| 33 | 26,804 | 4,486 | 16.7% |
| 34 | 14,294 | 3,214 | 22.5% |
| **TOTAL** | **7,922,951** | **1,172,651** | **14.8%** |

SOURCE: Georgetown/NORC analysis of CMS State Counts of Blue Re-Assignment Notices for the Kaiser Family Foundation.
NOTE: Reassignments include those due to both higher premiums and plan terminations. See Appendix Table 1 for states in each region.

## APPENDIX TABLE 5:
## Distribution of LIS Beneficiaries by Type of Plan, by Region, 2010

| Region | Total LIS Beneficiaries | % LIS Beneficiaries in Benchmark PDPs | % LIS Beneficiaries in Non-Benchmark Basic PDPs | % LIS Beneficiaries in Non-Benchmark Enhanced PDPs | % LIS Beneficiaries in Other Plans |
|---|---|---|---|---|---|
| 1 | 122,557 | 84.1% | 9.3% | 2.6% | 4.0% |
| 2 | 429,945 | 74.8% | 9.6% | 3.1% | 12.4% |
| 3 | 757,486 | 61.2% | 10.6% | 1.6% | 26.6% |
| 4 | 225,934 | 77.4% | 11.5% | 2.0% | 9.1% |
| 5 | 176,577 | 65.1% | 22.3% | 3.8% | 8.8% |
| 6 | 506,701 | 57.6% | 10.1% | 2.5% | 29.8% |
| 7 | 204,440 | 66.9% | 17.7% | 5.6% | 9.8% |
| 8 | 348,507 | 63.1% | 18.6% | 5.0% | 13.4% |
| 9 | 173,691 | 65.9% | 14.8% | 3.3% | 16.1% |
| 10 | 298,355 | 68.1% | 13.9% | 3.7% | 14.4% |
| 11 | 643,157 | 41.8% | 22.7% | 1.9% | 33.7% |
| 12 | 513,544 | 56.9% | 15.9% | 2.7% | 24.5% |
| 13 | 279,042 | 72.1% | 16.6% | 4.7% | 6.6% |
| 14 | 334,451 | 62.2% | 17.7% | 4.1% | 16.1% |
| 15 | 373,971 | 67.1% | 18.5% | 5.7% | 8.8% |
| 16 | 143,541 | 74.4% | 8.3% | 3.3% | 13.9% |
| 17 | 355,014 | 78.2% | 13.3% | 2.3% | 6.3% |
| 18 | 198,827 | 74.7% | 10.9% | 3.6% | 10.8% |
| 19 | 135,325 | 69.5% | 12.4% | 5.2% | 12.9% |
| 20 | 162,877 | 75.5% | 13.6% | 4.2% | 6.7% |
| 21 | 195,325 | 71.2% | 11.1% | 2.7% | 14.9% |
| 22 | 713,056 | 60.4% | 16.4% | 2.6% | 20.6% |
| 23 | 124,443 | 68.9% | 17.4% | 3.2% | 10.5% |
| 24 | 68,572 | 70.4% | 20.7% | 5.9% | 3.0% |
| 25 | 324,509 | 65.5% | 14.2% | 5.6% | 14.7% |
| 26 | 69,957 | 62.2% | 15.9% | 2.8% | 19.1% |
| 27 | 95,819 | 50.0% | 20.6% | 3.5% | 26.0% |
| 28 | 163,635 | 38.2% | 6.5% | 1.7% | 53.6% |
| 29 | 49,663 | 44.0% | 23.8% | 4.7% | 27.6% |
| 30 | 263,500 | 61.6% | 13.3% | 2.2% | 22.9% |
| 31 | 71,192 | 56.7% | 19.8% | 4.0% | 19.6% |
| 32 | 1,215,218 | 65.8% | 13.9% | 1.4% | 18.9% |
| 33 | 37,142 | 52.2% | 6.4% | 1.4% | 40.0% |
| 34 | 14,056 | 78.7% | 22.4% | 1.9% | 0.0% |
| **TOTAL** | **9,790,029** | **63.7%** | **14.7%** | **3.0%** | **18.6%** |

SOURCE: Georgetown/NORC analysis of CMS 2010 county-level and plan-level LIS enrollment files for the Kaiser Family Foundation.

NOTE: "Other Plans" include MA-PDs and employer-only PDPs. Shares for PDPs based on plan-level enrollment counts; total enrollment and share for "Other Plans" based on contract-level enrollment counts. See Appendix 1 for a description of differences between data used in this appendix and elsewhere.

## ENDNOTES

[1] Low-income beneficiaries residing in U.S. territories are not eligible for the LIS. Instead, the territories receive federal Medicaid funds to provide additional "wrap-around" drug benefits to dually eligible beneficiaries through the Medicaid program. Other low-income individuals who would qualify for LIS benefits if they resided on the U.S. mainland do not qualify for extra help.
[2] Centers for Medicare and Medicaid Services, "Premiums for Medicare prescription drug plans to remain low in 2011," Press release, August 18, 2010.
[3] LIS beneficiaries comprise 48 percent of beneficiaries enrolled in PDPs and 23 percent of beneficiaries enrolled in MA-PDs in 2010.
[4] Social Security Administration, "Chubby Checker and Social Security Commissioner Astrue announce a new "Twist" in the Law: Changes make it easier to qualify for Extra Help with Medicare prescription drug plan costs. Press release. January 8, 2010. Available at: http://www.socialsecurity.gov/pressoffice/pr/chubby-checker-pr.htm.
[5] Neuman, P, Strollo, M, Guterman, S, et al., "Medicare Prescription Drug Benefit Progress Report: Findings from a 2006 National Survey of Seniors, " Health Affairs, August 21, 2007 25(5). http://content.healthaffairs.org/cgi/reprint/hlthaff.26.5.w630v1?ijkey=wpOorB7zwSX6c&keytype=ref&siteid=healthaff.
[6] Summer, L, Nemore, P, Finberg, J, "Medicare Part D: How Do Vulnerable Beneficiaries Fare?" The Commonwealth Fund, April 2008. http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2008/May/Medicare-Part-D--How-Do-Vulnerable-Beneficiaries-Fare.aspx
[7] UIS. Government Accountability Office, "Medicare Part D Low-Income Subsidy. Additional Efforts Would Help Social Security Improve Outreach and Measure Program Effects" Washington, D.C., May 2007. http://www.gao.gov/new.items/d07555.pdf.
[8] Lipson, D, Barrett, A., Merrill, A. and Denny-Brown, N, "Doors to Extra Help: Boosting Enrollment in the Medicare Part D Low-Income Subsidy," AARP Public Policy Institute, September 2007. http://assets.aarp.org/rgcenter/health/2007_15_medicare.pdf; U.S. Government Accountability Office, Statement of Barbara Bovbjerg, Testimony before the Senate Committee on Finance, "Medicare Part D Low-Income Subsidy: Progress Made in Approving Applications, but Ability to Identify Remaining Individuals Is Limited," May 8, 2007. http://www.gao.gov/new.items/d07858t.pdf.
[9] Lamphere, J. and Rosenbach, M. "Promises Unfulfilled: Implementation of Expanded Coverage for the Elderly Poor," *Health Services Research,* April 2000; Rosenbach,M. and Lamphere, J. "Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs," American Association of Retired Persons Public Policy Institute, January,1999 http://www.aarp.org/health/medicare-insurance/info-1999/aresearch-import-603-9902.html ; Crystal, S., Trail, T., Fox, K. et al., "Enrolling Eligible Persons in Pharmacy Assistance Programs: How States Do It," The Commonwealth Fund, Sept. 2003, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2003/Sep/Enrolling-Eligible-Persons-in-Pharmacy-Assistance-Programs--How-States-Do-It.aspx; Glaun, K, Davenport, K., and Cohen, A, "The Medicare Low Income Drug Subsidy: Strategies to Maximize Participation, "Medicare Rights Center, January, 2005, http://www.medicarerights.org/pdf/Medicare%20LIS_Strategies_to_Maximize_Participation.pdf.
[10] Summer, L., "Increasing Participation in Benefit Programs for Low-Income Seniors," The Commonwealth Fund, May 2009. Available at: http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/May/Increasing-Participation-in-Benefit-Programs-for-Low-Income-Seniors.aspx.
[11] PL 110-275, The Medicare Improvements for Patients and Providers Act of 2008, enacted July 15, 2008.
[12] Currently, very few beneficiaries apply for the LIS through state Medicaid programs.
[13] Among the beneficiaries who re-qualified, some had continued to be eligible, but had not completed the redetermination process for the Medicaid, MSP, or SSI programs and therefore had had a coverage lapse in those programs that affected their LIS eligibility. They re-qualified for LIS when they reapplied for the other programs. Others, who "spend down" to qualify for Medicaid by deducting medical expenses from income over a specified period of time, may not have been eligible for Medicaid when states reported on their current Medicaid enrollees, but may have qualified later in the year.
[14] The criteria used to select beneficiaries for 2010 cyclical redetermination differ from past years because of a change in the law. Effective January 1, 2010, subsidy applicants are not required to provide information about the cash value of life insurance policies or in-kind support and maintenance and SSA does not consider this information in making financial eligibility determinations. For 2010, cases selected for redetermination comprised all partial subsidy determinations that had used the value of life insurance or in-kind support and maintenance in the eligibility calculation. Social Security Administration Program Operations Manual System, HI 03050.011 Redetermination of Eligibility. https://secure.ssa.gov/apps10/poms.nsf/lnx/0603050011!opendocument
[15] In the fall of 2007, the first time notices were sent, 442,000 beneficiaries received notices about their status in 2008.
[16] The total (65 plans) includes 16 plans considered benchmark plans because of de minimis rules.
[17] The group of 2.2 million beneficiaries who had to switch plans on their own or pay premiums if they remained in their 2009 plans includes the 1.7 million LIS "choosers" who received notices from CMS advising them of the need to change plans as well as other LIS beneficiaries who did not receive notices because they live in states with state pharmacy assistance programs (SPAPs) that informed CMS that they will assist beneficiaries. LIS beneficiaries who receive partial subsidies also do not get notices from CMS.
[18] In 2010, Wellpoint also has benchmark plans in two other regions (California and Indiana/Kentucky) operating under a local subsidiary's trade name.
[19] In 2006, United Healthcare and Humana were the only firms with over 10 percent of all LIS enrollment (18 percent and 13 percent, respectively). By 2010, United Healthcare remained the leading plan sponsor with 20 percent of all LIS enrollment. But because Humana no longer has benchmark plans in most regions, its share of this population has dropped to under 4 percent of all LIS enrollment. The firms that now rank just behind United are Universal American (sponsor of CCRx and Prescriba Rx plans) and CVS Caremark (sponsor of SilverScript and Advantage Star plans), with about 18 percent and 13 percent, respectively. Both have gained in the LIS population through a combination of mergers and qualifying as benchmark plans in more markets.

[20] CMS, "Medicare Ends Contract with Fox Insurance Company Drug Plan'" Press Release, March 9, 2010. http://www.cms.gov/apps/media/press/release.asp?Counter=3634&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=medicare&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date

[21] Centers for Medicare and Medicaid Services, "Premiums for Medicare prescription drug plans to remain low in 2011," Press release, August 18, 2010.

[22] No plans lost benchmark status in Arizona, Louisiana, or the Oregon/Washington regions. Regions in which plans lost benchmark status, but LIS beneficiaries were reassigned to plans in the same organization include California and New Mexico.

[23] Marrufo, G, O-Brien-Strain M, Theobald N, Lau T, Verhulst E, Moin N, "Evaluation of the Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries," Acumen, LLC, June 2009, http://www.cms.gov/reports/downloads/Marrufo_PartD_LIS_2009.pdf.

[24] Some non-benchmark plans are designed to provide enhanced benefits such as larger formularies to attract beneficiaries, but this does not appear to be a major factor that influences this comparison. In fact, a comparison of formularies for basic non-benchmark and basic benchmark plans shows a slightly wider gap with the two types of plans covering 92 and 83 percent of drugs on their formularies, respectively.

[25] Although antidepressants are one of the protected classes of drugs that all plans must cover, CMS has made exceptions for certain drugs, including Lexapro. Therefore, plans are not required to cover Lexapro.

[26] Medicare Payment Advisory Commission, *Report to Congress. Increasing the Value of Medicare.* Chapter 8, "How beneficiaries learned about the drug benefit and made plan choices." June 2006.

[27] Although relatively few MA-PD plans are benchmark plans, LIS beneficiaries enrolled in the non-benchmark MA plans may not have to pay premiums because, with rebates, some of the plans offer zero-premium Part D coverage.

[28] In addition to the 1.7 million LIS "choosers" who received notices from CMS advising them of the need to change plans, other LIS beneficiaries were at risk of having to pay premiums, but they did not receive notices because they live in states that have asked CMS not to send notices to beneficiaries participating in the state's pharmacy assistance programs (SPAPs). LIS beneficiaries who receive partial subsidies also do not get notices from CMS.

[29] LIS beneficiaries must pay the amount of the basic premium that exceeds the benchmark premium plus the value of any enhanced benefits. The premiums charged to LIS beneficiaries appear on a supplemental landscape file posted on the CMS website.

[30] The first estimate for new choosers is the weighted average premium paid by LIS enrollees in plans that lost benchmark status between 2009 and 2010. The second estimate is for plans that were without benchmark status in both years. Enrollment totals necessarily include beneficiaries first enrolling in either type of plan for 2010, as well as those who were in the plans in 2009.

[31] Stahlman, ME, "The Medicare Drug Benefit: Update on the Low-Income Subsidy," National Health Policy Forum, Issue Brief No. 833, July 31, 2009. http://www.nhpf.org/library/details.cfm/2752 Summer L, Nemore P, Finberg J, "Medicare Part D: How Do Vulnerable Beneficiaries Fare?," The Commonwealth Fund, April 2008. http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2008/May/Medicare-Part-D--How-Do-Vulnerable-Beneficiaries-Fare.aspx

[32] Dorn S, "Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform," Urban Institute, December 2009. http://www.urban.org/publications/411985.html

[33] The Medicare Improvements for Patients and Providers Act of 2008 MIPPA (PL 110-275).

[34] States already have the authority, under section 1902(r)(2) of the Social Security Act, to amend MSP eligibility rules and therefore have the ability to make MSP and LIS eligibility rules and methods conform.

[35] Medicare Payment Advisory Commission. Report to the Congress Medicare Payment Policy, March 2008.

[36] Rice, T, Desmond, K, "Who Will Be Denied Medicare Prescription Drug Subsidies Because of the Asset Test?" The American Journal of Managed Care, January 2006 12(1): 46-54; Summer, L, Thompson, L, "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits, The Commonwealth Fund, May 2004.

[37] Centers for Medicare and Medicaid Services, "Annual Release of Part D National Average Bid Amount and other Part C & D Bid Related Information," Memorandum, August 18, 2010.

[38] CMS, "Impact of Reassignment in the Part D Program on Health Outcomes," June 11, 2009. http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/ReassignmentOutcomes.pdf

[39] 42 CFR Parts 417, 422, 423, and 480, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, Federal Register, Volume 75, Number 72, April 15, 2010.

[40] Hoadley J, Summer L, Thompson J, Hargrave E, Merrell K, "The Role of Beneficiary-Centered Assignment for Medicare Part D." Contractor report for MedPAC, June 2007. http://www.medpac.gov/documents/june07_bene_centered_assignment_contractor.pdf

[41] Initially, the Maine SPAP also looked at potential out-of-pocket costs associated with each of the plans because it was in the interest of the SPAP, which provided wraparound coverage for low-income beneficiaries, to minimize these costs. As the result of a policy change in Maine to expand MSP eligibility limits, almost all SPAP members now qualify for MSP and are deemed eligible for the LIS so there are fewer instances when low-income beneficiaries have significant out-of-pocket costs that the state covers.

[42] Hoadley J, Hargrave E, Merrell K, and Summer L, "Beneficiary-Centered Assignment and Medicare Part D." Presentation to MedPAC, September 4, 2008. www.medpac.gov/.../Hoadley%20MedPAC%20presentation%2009%2004%2008.pdf

[43] CMS, "Medicare Ends Contract with Fox Insurance Company Drug Plan'" Press Release, March 9, 2010.

[44] Hoadley J, Summer L, Hargrave E, Cubanski J, Neuman T, "A Comparison of PDPs Offering Basic and Enhanced Benefits," Kaiser Family Foundation, December 2009. http://www.kff.org/medicare/upload/8034.pdf

[45] 42 CFR Parts 417, 422, 423, and 480, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, Federal Register, Volume 75, Number 72, April 15, 2010.

[46] 2011 Combined Call Letter, Center for Medicare and Medicaid Services, available at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/2011CombinedCallLetter.pdf
[47] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).
[48] 42 CFR Parts 417, 422, 423, and 480, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, Federal Register, Volume 75, Number 72, April 15, 2010.
[49] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).
[50] CMS, "Medicare Announces Solicitation of Fiscal Year FY 2010 State Health Insurance Assistance Program Grants," Press Release, December 16, 2009. http://www.cms.gov/apps/media/press/release.asp?Counter=3560&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=medicare&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=1&pYear=&year=0&desc=false&cboOrder=date
[51] More information on our analysis of formularies is available in presentations to MedPAC (January 15, 2010) http://www.medpac.gov/transcripts/2010%20Formulary%20Analysis%20for%20MedPAC%20-%20Hoadley.pdf and to the CMS Part D Data Symposium (March 18, 2010) http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp and a forthcoming contractor report to MedPAC, to be available at http://www.medpac.gov.
[52] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).
[53] In accordance with the "Medicare Demonstration to Revise the Part D Low-Income Benchmark Calculation," as approved on August 11, 2009. From CMS Office of the Actuary, "Release of the 2010 Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, the Part D Regional Low-Income Premium Subsidy Amounts, and the Medicare Advantage Regional PPO Benchmarks," Note to Medicare Advantage Organizations, Medicare Prescription Drug Plan Sponsors, and Other Interested Parties, August 13, 2009.
[54] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).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