Editorial
Understanding the effects of Medicare Part D from key stakeholders’ perspectives: Important progress, but abundant research opportunities remain

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added prescription drug coverage to Medicare beginning in January 2006. The prescription drug coverage is voluntary, although beneficiaries face a significant penalty for delaying enrollment. The drug coverage is provided through private drug plans; beneficiaries have a choice of staying in the original Medicare program and receiving separate prescription drug coverage from a Medicare prescription drug plan (PDP) or receiving all their Medicare benefits through a private Medicare Advantage plan with prescription drug coverage (MA-PD). The Centers for Medicare and Medicaid Services (CMS) is responsible for administering this very complex program. Medicare Part D has dramatically reshaped the prescription drug insurance market and has had significant effects on insurers, beneficiaries, and providers. For researchers, it has provided a rich source of research questions to examine. This themed issue includes 7 articles in which researchers examine aspects of Medicare Part D from a variety of key stakeholder perspectives.

One important outcome of Medicare Part D is its effects on prescription costs, addressed in this themed issue by Mott et al and Goedken et al. By expanding access to prescription drug insurance, Medicare Part D was expected to increase prescription drug utilization and overall expenditures but decrease beneficiary out-of-pocket costs. Mott et al examined whether these effects differed by levels of pre-Part D drug spending. They concluded that Part D significantly reduced beneficiary out-of-pocket costs and increased drug use for individuals in the highest pre-Part D spending group, relative to individuals in the moderate and lowest pre-Part D spending groups. This finding suggests that Part D helped the beneficiaries who most needed help, the beneficiaries with high pre-Part D costs. Goedken et al compared prescription drug cost sharing for Part D plans and employer-based PDPs; they also examined effects of that cost sharing on prescription drug use. They found that brand name drug copayments were higher for beneficiaries in Part D plans than for beneficiaries in employer-based plans, but copayment level did not significantly predict the number of prescriptions used by beneficiaries. An important component of prescription drug cost control is use of generic drugs. Goedken et al also examined how generic drug utilization rates differed before and after Medicare Part D and across insurance type post-Medicare Part D. They found that generic utilization was lowest among beneficiaries in employer-based plans both before and after Part D. Post-Medicare Part D, generic utilization rates among Part D beneficiaries were higher than beneficiaries in employer-based plans and not significantly different from beneficiaries with no prescription drug insurance coverage.

Medicare Part D has presented both challenges and opportunities for pharmacies and pharmacists. One opportunity is that it provided prescription insurance to some previously uninsured Medicare beneficiaries, potentially increasing access to prescription drugs and the volume of prescriptions dispensed by community pharmacists. A challenge has been the increased workload for pharmacists; partially because of not only the increased prescription volume but also the time spent helping beneficiaries navigate the Part D enrollment process and manage Part D plan benefit structures.
such as tiered copayments and utilization management requirements. The article by Bono and Crawford in this issue compared similarities and differences in chain pharmacist and independent pharmacist experiences during the Medicare Part D implementation. They found that both chain and independent pharmacists strongly criticized the implementation process, but thought that Part D benefited beneficiaries who previously lacked prescription drug coverage. There were some differences between chain and independent pharmacist experiences; specifically that independent pharmacists expressed more concern about their future viability, whereas the chain pharmacists felt that their corporate support gave them a competitive advantage and a better long-term financial picture.

Another challenge for pharmacies has been the reimbursement from the Part D plans. Since the drug benefit’s implementation, pharmacies have been complaining about “low and slow” reimbursement from the Part D plans. Part D caused some cash patients and all patients who were dually eligible for Medicare and Medicaid to transition to Part D. This resulted in loss of margin because Medicare Part D prescription margins have been reported to be the lowest among the third-party payers. Another challenge for pharmacists is the length of time to receive payment from Part D plans, although this complaint theoretically has been addressed by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. This law took effect in 2010 and requires Part D plans to pay clean claims with 14 days. In this issue, Zhang et al describe independent pharmacists’ satisfaction with third-party contracts. The authors surveyed independent pharmacy owners in six Medicare regions to identify influences on satisfaction with their most and least favorable Part D contracts. Overall levels of satisfaction with Part D contracts were low; with the most common complaints being too low reimbursement rates and “take it or leave it” contracts. They found a different set of significant influences on satisfaction with the most and least favorable contracts. For the most favorable contracts, contending (use of coercive tactics) and equity (fairness) were significant. For the least favorable contracts, negotiation, equity, generic rate bonus, and payment for medication therapy management (MTM) services were significant. The authors concluded that over the long-term, this low level of satisfaction with Part D plans could result in increased contract rejections by independent pharmacists. They also concluded that Part D plans could improve satisfaction with their contracts by including a generic dispensing rate bonus or payment for MTM services.

Beneficiary experiences with Medicare Part D are another important aspect to consider. Medicare Part D improved access to prescription medications for beneficiaries who were previously uninsured, and it gave some beneficiaries access to MTM services. However, beneficiaries face critical and potentially challenging decisions related to Part D. Because Part D is a voluntary benefit, the first decision beneficiaries face is whether to enroll in Part D. If they decide to enroll, they must decide whether they want a PDP or an MA-PD and choose from the large number of both types of plans that are available. In this issue, Cline et al examined factors associated with Medicare beneficiaries’ decision to enroll in any Part D plan and factors associated with the choice of an MA-PD plan given a choice to enroll in Part D. They surveyed adults age 65 and older residing in the CMS region 25; the 7-state region that includes Minnesota, Iowa, North Dakota, South Dakota, Nebraska, Montana, and Wyoming. Factors affecting the decision to enroll in Part D were rurality, plan price, perceived future need for medications, and preferences. They found that respondents were more than 3 times as likely to choose PDPs compared with MA-PDs; selection of MA-PD plan was related to rurality, state of residence, and number of diagnosed medical conditions.

The MTM services mandated for targeted beneficiaries as part of Medicare Part D has been a new benefit for many Part D enrollees and an opportunity for pharmacists. Targeted beneficiaries are those beneficiaries who are expected to incur high drug costs. Determination of targeted beneficiaries is made by the individual plans but is subject to rules published by CMS. Sometimes the MTM services are provided by pharmacists or other health care providers employed by the Part D plans, while other times they are provided by community pharmacists. The method for MTM delivery also has varied considerably, from educational mailings, to telephone consultations, to face-to-face consultations. MTM services typically are new to beneficiaries, so it is important to measure their satisfaction with the different MTM programs. In this issue, Mocz-ygemma et al describes patient satisfaction with a pharmacist-provided MTM program. The authors surveyed enrollees in one Part D plan who had received MTM services from pharmacists via the telephone. They found that beneficiaries were generally satisfied with their MTM services,
especially with their access to a pharmacist through the MTM program.

It is useful to study Medicare Part D from a variety of perspectives, including CMS, Part D plans, providers, and beneficiaries. This themed issue adds to our understanding of issues facing these stakeholders, but more research is needed. One important aspect of Part D from many perspectives is cost. Although Part D has cost less than projected, premiums costs have been rising each year with an average increase of 50% since 2006.12 The release of Part D with detailed information on benefit design should allow researchers to examine more closely what aspects of plan benefit design are most effective at controlling costs and improving patient outcomes. Medicare Part D has a standard benefit structure, but plans are allowed to deviate from this structure as long as the value of their plan is actuarily equivalent to standard benefit. Only about 10% of plans use the standard benefit structure so there is wide variation in the amount of patient cost sharing.13 Formularies and use of utilization management strategies like prior authorization, step, therapy, and quantity limitations also vary widely across plans.14 This variation lends itself to research on the effect of benefit structure on cost and patient outcomes, such as adherence and clinical outcomes. The variation also has the potential to cause adverse selection across plans, where beneficiaries who have higher (or lower) drug costs than average disproportionately enroll in certain types of plans. This adverse selection is of concern to plans, who fear attracting large numbers of high-cost beneficiaries. Although risk adjustment and risk sharing by CMS may mitigate the costs of adverse selection to the plans, it still is of concern and needs further study.

A unique feature of Medicare Part D is the coverage gap, or “doughnut hole,” where beneficiaries who do not qualify for low-income assistance must pay the full cost of their medications after they exceed the initial coverage limit. Part D plans are allowed to offer enhanced plans with coverage of drugs in the gap, but the cost of these extra benefits is not subsidized except for beneficiaries who qualify for low-income assistance. The coverage gap has had documented effects on patient adherence and costs,15-17 but more research is needed to understand fully the impact of the coverage gap on patient outcomes. Adverse selection has been a significant problem for these enhanced plans. Coverage of brand name drugs during the coverage gap has almost disappeared,18 likely because of adverse selection. The health care reform laws passed in 2010 phase in coverage of drugs during the coverage gap and will close the gap by 2020. Beginning in 2011, pharmaceutical manufacturers will pay 50% of brand name drug costs. It will be interesting to examine whether this subsidy encourages Part D plans to offer additional gap coverage until the full gap coverage is phased in. Researchers also can examine the point at which the phased-in benefits are successful at eliminating the identified adherence and access problems associated with the coverage gap.

Low-income beneficiaries are an important population to study. Drug coverage for beneficiaries who are dually eligible for Medicare and Medicaid was transitioned from Medicaid to Medicare Part D when Medicare Part D was implemented. Dually eligible beneficiaries and some other low-income beneficiaries have generous subsidies and much lower cost sharing than other beneficiaries, but they still have faced some challenges with the benefit. Dual eligibles pay no premiums as long as they choose one of the “benchmark” plans with $0 premiums for low-income beneficiaries. However, the number of benchmarks plans has been decreasing.6 Also, dual eligibles who do not choose a plan are randomly assigned to one of the benchmark plans in their region. This may result in their being in a less than optimal plan. Another issue with low-income beneficiaries is that some beneficiaries who are not dual eligible, but who qualify for other low-income subsidies, have not enrolled in Part D. Because the low-income subsidies are quite generous, it is important to better understand why they are not enrolled.

To date, there have been large numbers of Part D available in all regions, typically 40-55 different plans per region.12 A benefit of the large numbers of plans is that beneficiaries have the opportunity to choose the plan that best meets their needs. However, a significant challenge is that it makes the process of choosing a plan confusing and labor intensive. There is some evidence that beneficiaries have been reluctant to change plans.19 The decision to have Part D benefits provided by private plans that compete in the market was made in part to harness the power of a competitive market to lower prices. If beneficiaries choose to stay in plans with large premium increases when they could switch to a less expensive plan, the ability of the competitive market to control costs may be compromised. It is critically important to better understand how beneficiaries choose a plan,
to design strategies to help beneficiaries select the plan the best meets their needs and not fear switching. This would help the beneficiaries and make the market perform better. The Cline et al.\textsuperscript{10} article in this issue helps understand choices between PDP and MA-PD plans; the next step is to determine how beneficiaries choose among different PDPs or MA-PDs. As part of this process, researchers must determine the level of beneficiary understanding of different aspects of plan benefit design and their preferences for type of plan. More research on how older adults process information related to plan choice also is essential.

Pharmacies and pharmacists have been significantly affected by Medicare Part D. The Bono and Crawford\textsuperscript{3} and Zhang et al.\textsuperscript{9} articles in this issue help illustrate the effects of Part D on pharmacies, but it is necessary to continue to monitor the effects of Part D on pharmacy profitability to ensure sufficient pharmacy access for beneficiaries. An important feature of Medicare Part D is the MTM requirement for targeted beneficiaries. From 2006 to 2009, Part D plans were allowed a substantial amount of flexibility in how targeted beneficiaries were defined and what types of MTM were provided. In 2010, new requirements for MTM went into effect. Under the new requirements, the number of targeted beneficiaries will increase and the MTM must include an interactive comprehensive medication review.\textsuperscript{20} However, a great deal of variation in the plans’ MTM programs remains. An important area for future research is to examine the effects of different Part D MTM programs on drug costs, other health care costs, and patient outcomes. With the desired growth in capacity to deliver MTM services and the important role of pharmacists, it also is critical to examine factors associated with pharmacist willingness to participate in MTM programs. In this issue, Martin et al.\textsuperscript{21} describe the development and assessment of a tool to measure community pharmacist’s self-efficacy for providing MTM services. Such tools facilitate continued study of evolving Medicare Part D MTM programs.

Medicare Part D has been a rich source of research opportunities since its implementation in 2006. Although researchers have made strides in understanding its impact on various constituencies, the complexity and continually evolving nature of Part D will yield many future research prospects. We hope that the articles in this theme issue of \textit{RSAP} contribute a usable baseline for such future research and we look forward to seeing an abundance of future research in this area.

\textbf{References}


