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Evaluation of the Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries

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EXECUTIVE SUMMARY

Authorized by the Medicare Modernization Act of 2003 (MMA), the prescription drug program known as Medicare Part D administers benefits to over 26 million beneficiaries through private drug plans. These plans include standalone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs) that offer drug benefits combined with managed care coverage for standard Medicare services. MA-PDs offer prescription drug benefits only to enrollees who also receive Part A and/or Part B coverage through the same MA parent organization, while PDPs offer coverage to beneficiaries specific to a geographic region; there are 34 prescription drug regions defined by the Centers for Medicare & Medicaid Services (CMS). Medicare pays for up to 75 percent of the cost of an average plan, with beneficiaries paying the rest in premiums.

The MMA also mandated that CMS establish the Low-Income Subsidy (LIS) program, which provides subsidies that reduce or eliminate premiums and deductibles and offers zero or reduced co-payments for low-income beneficiaries. Eligible beneficiaries included Medicaid dual eligibles, Supplemental Security Income (SSI) recipients, and other low-income beneficiaries. The LIS program also established a strategy of auto- and facilitated enrollment. Under auto-enrollment, if a Medicare dual eligible who is deemed to be eligible for the full LIS subsidy does not select a plan, he or she is randomly assigned to a plan that qualifies for the full subsidy of the Part D premium. The facilitated enrollment process is similar, but applies to all other beneficiaries who are found to be eligible for LIS.

Full premium subsidies are available in plans whose bid for standard Part D coverage was at or below the average in that PDP region. The average premium associated with such bids is called the regional low-income benchmark premium amount. Beneficiaries who are eligible for the full LIS subsidy will pay zero premiums if they are enrolled in an at- or below-benchmark plan. If they enroll in above-benchmark plans, they are responsible for paying the amount of the premium above the benchmark. Because benchmarks are recalculated on an annual basis, some plans may be at or below the benchmark in one year but not in the following year. Any full subsidy beneficiary who was originally auto/facilitated enrolled into one of these plans is reassigned by CMS to another plan that will be at or below the benchmark in the following year, unless the beneficiary opts to stay in the original plan or selects a different plan.

As defined by the MMA, the regional low-income benchmark for each region is computed annually by taking an average of PDP and MA-PD plan premiums, weighted by enrollment in the previous year. Because PDP plans had no enrollment prior to 2006, CMS calculated the benchmarks by assigning equal weights to PDP plans, zero weights to new MA-

PD plans, and weights for existing MA-PD plans based on enrollment as of March 31, 2005. Given disproportionate enrollment in low cost plans in 2006, a switch to enrollment weights for 2007 would have significantly reduced the calculated benchmark, resulting in fewer below-benchmark plans. To maintain substantial availability of below-benchmark plans and minimize disruption to continuing LIS beneficiaries who would need to switch plans or otherwise face positive premiums, CMS decided to phase in the enrollment weights methodology using a demonstration program. Under the “Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries,” the 2007 benchmarks were calculated using the same “uniform weights” methodology used in 2006. For 2008, the benchmarks were a composite of 50 percent uniform weighting methodology (equal weights for PDPs and enrollment weights for MA-PDs) and 50 percent enrollment weights across all plans. In addition, the demonstration created a *de minimis* policy, where enrollees in plans with premiums that were rising above the benchmark by no more than \$2 in 2007 and no more than \$1 in 2008 were still fully covered by the LIS. However, CMS would no longer auto- or facilitate-enroll newly-eligible LIS enrollees or reassign enrollees to *de minimis* plans.

In this report, we examine the impact of the demonstration in four dimensions: the effect on availability of at- or below-benchmark plans, beneficiary response to changes in plan availability, the stability of drug utilization, and characteristics of demonstration-affected beneficiaries. Our analysis draws on administrative data from CMS, including plan information and premiums from the Health Plan Management System (HPMS), enrollment files and beneficiary information from the Common Medicare Environment (CME), and prescription drug spending from the Prescription Drug Event (PDE) files. We review the key findings below.

Availability of Below-Benchmark “Zero Premium” Plans

By design, the demonstration kept the regional benchmarks higher than what they would have been. The 2007 median regional benchmark was \$29.55, but had the enrollment weighting methodology been implemented, the benchmark for that region would have been \$5.51 less. This change in benchmarks due to the weighting methodology would have compounded a decline in the benchmarks driven by significant decreases in average plan bids between 2006 and 2007. With no change in the weighting methodology, the change in plan bids alone dropped the median benchmark from \$32.46 to \$29.55.

Higher regional benchmarks, combined with the *de minimis* policy, translated to greater numbers of zero-premium plans available in each region. By zero-premium, we mean a standard benefit plan whose premium is at or below the regional benchmark. Full-benefit dual eligible LIS beneficiaries pay zero premiums if they are enrolled in these plans. As the table below

shows, the impact of the demonstration on plan availability was significant in 2007. Under the demonstration, there were a total of 638 zero-premium plans, nearly three times as many as there would have been under the full enrollment weighting methodology. Regions 26, 28, and 29 (New Mexico, Arizona, and Nevada) would each have had only one zero-premium plan available. Under the demonstration, no region had fewer than nine such plans available in 2007.

The impact of the demonstration on 2008 plan availability was less pronounced. The total number of zero premium plans under the demonstration was 495, compared to 341 absent the demonstration. The 2008 composite weighting methodology was less different from the full enrollment methodology, but part of the lower impact resulted from a rise in the number of plans that would have been available under the full enrollment weighting methodology. For Regions 4, 8, and 34 (New Jersey, North Carolina, and Alaska), the demonstration had no effect on the number of plans. For Region 29 (Nevada) the demonstration increased its available plans to five, compared to one under the enrollment weights methodology.

**Implication of the Demonstration on the Number of Zero-Premium Plans
Overall and By Region**

	2007			2008		
	Full Enrollment Methodology	Demonstration Methodology	% Difference	Full Enrollment Methodology	Demonstration Methodology	% Difference
Total	213	638	200%	341	495	45%
Mean	6	19	335%	10	15	122%
Min	1	9	42%	1	5	0%
Max	13	26	1300%	18	20	700%

Beneficiary Response to Changes in Plan Availability

As part of the reassignment process, CMS sent letters to affected beneficiaries informing them of the plan to which they will be reassigned, as well as how to either stay in their current plan or select a new plan. These beneficiaries could respond to the letter in one of four ways:

- (a) Take no action and be enrolled in the assigned plan in January,
- (b) Select a different zero-premium plan,
- (c) Choose to stay in the same plan and start paying part of the premium, or
- (d) Select different plan with a positive premium.

Of the 2.1 million beneficiaries who received a reassignment notification in November 2007, about 1.9 million remained enrolled in Part D and eligible for reassignment by CMS into a plan effective January 2008. Of the 141,023 who were no longer eligible for reassignment by January, 41 percent lost eligibility for 100% LIS, another 30 percent were no longer enrolled in

Part D, 23 percent had died, and just under 7 percent had moved outside of their region. Nationally, the vast majority (90 percent) of the 1.9 million beneficiaries did not respond to the notification letter and hence were enrolled into their reassigned plan in January. Slightly over 6 percent decided to stay in their original plan and pay a positive premium. About 3.7 percent of notified beneficiaries switched plans and enrolled in a plan other than the one to which they were reassigned, with 2.6 percent selecting another zero-premium plan.

There are important variations across regions. In Region 1 (New Hampshire and Maine), only 74 percent of beneficiaries stayed in the plan they were originally assigned, a large share of these beneficiaries (over 22 percent) selected a different zero-premium plan. Region 18 (Missouri), Region 3 (New York) and Region 28 (Arizona) show the largest rates of beneficiaries choosing to stay in their original plans (slightly over 10 percent).

Beneficiary response to reassignment also varied by demographic characteristic and Medicare status. Compared to beneficiaries who were reassigned, beneficiaries who stayed in their original plan were more likely to be white and significantly less likely to reside in a long term institution. In contrast, beneficiaries who moved to a zero premium plan other than the one to which they were reassigned were older and more likely to be institutionalized. Compared to beneficiaries who were reassigned, beneficiaries who moved to a positive premium plan were more likely to be white and less likely to be disabled, dual eligible, or living in long term institutions.

Beneficiaries who have clinical conditions associated with higher expected drug costs were more likely than low-risk beneficiaries to either have stayed in their original plan or actively selected (or have selected on their behalf) a plan different from the one to which they were reassigned. Those with the highest prevalence rates of expected high-cost conditions selected new plans. We find a similar pattern when looking at drug utilization levels. Beneficiaries who stayed in their original plan filled more prescription drug event (PDE) claims on average than those who were reassigned. Over 11 percent of beneficiaries who were reassigned had no PDE events in 2007, but fewer than 5 percent of beneficiaries who selected a different plan had no drug usage during 2007. Over 25 percent of beneficiaries who actively selected a different plan had over 80 PDEs in 2007, compared to 18 percent of beneficiaries who were reassigned. Among those who selected plans, those who selected a different zero-premium plan had the highest monthly costs in 2007 (46 percent higher than reassigned beneficiaries).

Stability of Drug Utilization

Reassignment preserves the full LIS subsidy for beneficiaries, but it may disrupt drug utilization and may move beneficiaries into plans with more restrictive formularies. To assess the evidence around utilization, we examine the specific drugs taken by each beneficiary in 2007

and 2008. We consider the average number of PDEs per month, the monthly drug costs, formulary coverage and the degree of utilization management. In particular, we calculate the share of the drugs for that beneficiary that were in the formulary for his or her plan, the share of these drugs that were subject to prior authorization (PA), and the share subject to a quantity limit (QL) at the date of service.

Our findings suggest that beneficiaries did fill drugs under more restrictive formularies in 2008 compared to 2007. The percent of drugs in formularies dropped from 2007 to 2008 for all groups, while the percent of drugs subject to QL and PA increased for almost all groups. We find only very slight differences across groups. While beneficiaries who were not subject to reassignment had a slightly lower share of drugs under quantity limits in 2008 compared to other groups, they also showed the largest increase in this share from 2007 to 2008.

Looking at drug utilization patterns, we find that all beneficiary groups increased both the average number of PDEs per month and monthly average drug costs from 2007 to 2008. Compared to beneficiaries who accepted reassignment, beneficiaries who were not subject to reassignment and stayed in their original plan had a larger increase in the average number of monthly PDEs between 2007 and 2008. These differences remain even when comparing subpopulations of beneficiaries with similar levels of risk scores. For example, reassigned beneficiaries in the highest Part D clinical risk score bracket increased their monthly average drug costs by \$32 (6 percent), but beneficiaries in the same risk score level who were not reassigned increased their cost by \$49 (10 percent). Among all groups, beneficiaries who actively selected a plan had the highest rates of PDE usage growth in terms of the number of PDEs and drug costs. Not surprisingly, beneficiaries who actively selected a new plan chose ones that better fit their pharmacy needs.

Finally, we examine the differences in the rate at which beneficiaries refilled their 2007 prescriptions depending on their reassignment status. To identify drugs that were due for refill in 2008, we first select all drugs that were purchased at least twice during 2007. Although imprecise, this serves as an approximate measure for drugs that are expected to be continued over time. We then select the fill with the latest date of service in 2007 and calculate the “last supply date,” which is equal to date of service plus days of supply. Only those drugs with a last supply date in 2008 are included in this analysis and only those beneficiaries with at least one drug due for refill in 2008 are included in the analysis. Our results reveal that the average percent of drugs that were refilled in 2008 varies very slightly across beneficiary groups. Compared to beneficiaries who either stayed in the original plan to which they were auto/facilitated enrolled or who actively responded to reassignment, reassigned beneficiaries were less likely to refill their drugs, and when they did, they spent on average 6 more days to refill their medications.

Impact of the Demonstration on Beneficiary Reassignment

Under the demonstration, over 1.1 million LIS enrollees in 2006 and 2.1 million in 2007 were subject to reassignment and received notice of new plan assignments in the fall of the plan year. Absent the demonstration, many more beneficiaries would have been affected, as the table below shows. For 2006, a majority (78 percent) of LIS enrollees would have received reassignment notices, compared to 22 percent under the demonstration—a difference of 2.8 million enrollees. The demonstration had a lesser effect in 2007, where it kept 748,171 fewer enrollees from receiving reassignment notices.

Implication of the Demonstration on the Number of LIS Beneficiaries Subject to Reassignment Notification

Year	Total Number of LIS Auto-/Facilitated Enrollees	Subject to Reassignment Notification		
		Demonstration Methodology	Full Enrollment Methodology	Difference
October 2006	5,196,359	1,166,524	4,033,002	2,866,478
	100%	22%	78%	55%
October 2007	5,304,115	2,111,255	2,895,426	748,171
	100%	40%	55%	14%

Based on the patterns of beneficiary response to reassignment, we used regression modeling to estimate the expected responses of auto- and facilitated enrollees who did not receive reassignment notification because of the demonstration. Our model predicts that those affected by the demonstration have nearly identical responses to reassignment compared to those who received reassignment notices in 2007. This suggests that the composition of the demonstration-affected group does not differ significantly from the actual group who received reassignment notices. Thus, the demonstration decreased the overall number of beneficiaries who were reassigned, but it did not appear to have a disparate impact on different beneficiary groups.

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1 INTRODUCTION

Medicare Part D, the voluntary prescription drug program for Medicare beneficiaries, provided beneficiaries with access to drug coverage through Medicare starting in 2006. Authorized by the Medicare Modernization Act of 2003 (MMA), Part D currently covers over 26 million beneficiaries—about 60 percent of all Medicare beneficiaries. Under the program, Part D participants receive prescription drug benefits through private drug plans. These plans include both standalone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs), which provide coverage for prescription drugs in combination with HMO-style coverage of hospital and physician care. Plans compete with each other for enrollees, who make their selection based on plan features such as benefit structures, premiums, deductibles, pharmacy networks and formularies. Part D plan offerings are based on region, with 34 prescription drug plan regions defined by the Centers for Medicare & Medicaid Services (CMS).

Although the Part D program offered new coverage for most beneficiaries, it was a change in coverage for beneficiaries who were also enrolled in Medicaid. Prior to the establishment of Part D, these dual eligibles received drug coverage through state Medicaid programs. However, the MMA prohibited federal Medicaid payments for drugs eligible for coverage by the new Medicare program. In its place, the statute called for CMS to establish the Low-Income Subsidy (LIS) program. For Medicaid dual eligibles enrolled in Part D, the LIS program covers premiums and deductibles and offers zero or reduced co-pays. Supplemental Security Income (SSI) beneficiaries and other low income individuals may also qualify for full or partial premium coverage and reduced co-pays through the LIS program.

To ensure that Medicaid dual eligibles did not lose drug coverage with the switch to Medicare, the LIS program also established a strategy of auto- and facilitated enrollment. Under auto-enrollment, if a Medicare dual eligible who is deemed to be eligible for the full LIS subsidy does not select a plan, he or she is randomly assigned to a plan that qualifies for the full subsidy of the Part D premium. All enrollees receiving 100% LIS pay zero premiums if they are enrolled in an at- or below-benchmark plan. The facilitated enrollment process is similar, but applies to all other beneficiaries who are found to be eligible for LIS.

Under auto/facilitated enrollment, if a Medicare beneficiary who is deemed to be LIS eligible does not select a plan, he or she is randomly assigned to a plan that qualifies for full subsidy of the Part D premium. Full premium subsidies are available in plans whose bid for standard Part D coverage was at or below the average in that PDP region. The average premium associated with such bids is called the regional low-income benchmark premium amount. All dual eligibles pay zero premiums if they are enrolled in an at- or below-benchmark plan.

To determine the low-income benchmarks in each region, CMS calculates a weighted average of the plan bids in that region. The first year, CMS calculated the 2006 benchmarks using a “uniform weights” methodology that applied equal weights to PDP plans, enrollment weights to MA-PD plans, and zero weights to new MA-PD plans. However, the statute called for moving to weighting entirely by enrollment starting in 2007, using plan enrollment in the previous year.

Enrollment patterns in 2006 made it clear that the “enrollment weights” methodology required in the statute would create significant reductions in the regional benchmarks compared to the uniform weights methodology, given the large take up of Part D, especially in low-cost plans. Under the enrollment weighting methodology, LIS beneficiaries could face not only a reduction in zero-premium options, but also the disruption of having to switch plans to maintain full subsidy. Unless an LIS beneficiary has actively selected a plan, CMS ensures that beneficiaries stay fully subsidized by reassigning those who would face a premium increase to a new plan through the same auto-/facilitated enrollment strategy.

Given these issues, CMS launched a demonstration to delay the transition to the enrollment weights methodology. Under the “Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries,” the uniform weights methodology was used to calculate the 2007 low-income benchmarks, and a composite of uniform-weights averages and enrollment-weights averages comprised the 2008 benchmarks.

This report evaluates the effect of the demonstration on CMS, plans, and beneficiaries by addressing four key research questions:

- 1) What was the effect of the demonstration on the availability of plans for LIS beneficiaries?
- 2) How did beneficiaries respond to changes in plan availability?
- 3) What is the impact of plan transition on the drug utilization of LIS beneficiaries?
- 4) How would beneficiaries have responded to changes in plan availability if the demonstration had not been in effect?

To address these questions, we examine plan availability and plan changes among LIS beneficiaries during the 2006-2008 demonstration period. We rely primarily on data from CMS for our analysis; these data include the Prescription Drug Event (PDE) files, enrollment files from MARx, and beneficiary files from the Common Medicare Environment (CME).

The rest of the report is organized as follows: Section 2 reviews the LIS program and the reassignment process as background to the demonstration. In Section 3, we detail the change in plan availability in 2007 and in 2008 as a result of the demonstration, as well as the number of LIS beneficiaries subject to potential reassignment. Focusing primarily on the 2007 to 2008

transition, Sections 4 and 5 track the LIS beneficiaries who received reassignment notification. In Section 4, we examine their response to the potential reassignment and how these responses differed by beneficiary characteristics. Section 5 examines the effect of plan changes on Part D utilization. Using the findings on beneficiaries subject to reassignment under the demonstration, Section 6 considers what beneficiary responses would have been in the absence of the demonstration. Finally, we offer conclusions in Section 7.

2 BACKGROUND

As context for understanding the effects of the demonstration, this section provides a brief overview of the eligibility and benefit structure of the LIS program. We then describe the auto-/facilitated enrollment and reassignment process. Finally, we review the calculation of the regional low-income benchmark amount and the goals of the demonstration.

2.1 Low-Income Subsidy (LIS) Benefits

The LIS program provides subsidized premiums, deductibles and co-payments for low-income beneficiaries. The full LIS subsidy – meaning 100% subsidy for the premium and \$0 deductible – is available to individuals who are dual eligibles on Medicaid/Medicare or SSI/Medicare. As shown on Table 2.1, these “full benefit” LIS beneficiaries face different copays depending on income and other factors. There are no copayments for institutionalized Medicaid recipients, while Medicaid dual eligibles with income below the federal poverty level (FPL) have no more than a \$1 copay for generics and \$3 for brand name prescription drugs. Dual eligibles with a slightly higher income have \$2/\$5 copays, as do SSI beneficiaries and those who have incomes below 135% of the FPL who apply for extra help through the Social Security Administration.¹ Full benefit LIS enrollees do not face a coverage gap, nor do they have copays in the catastrophic coverage phase.

Slightly higher income individuals can also receive some assistance if they meet income thresholds as shown in Table 2.1 and have no more than \$10,000 in countable resources if single or \$20,000 if married (2006 values, indexed for inflation). Individuals with income between 135% and 150% of FPL are considered “partial benefit” LIS beneficiaries because they pay a share of the premium based on a sliding scale. At the high end of this range, partial LIS beneficiaries pay a \$50 deductible (raised to \$53 in 2007 and \$56 in 2008). These beneficiaries pay no more than 15% in co-pays, with a maximum of \$2/\$5 in the catastrophic period. Like the full benefit LIS enrollees, partial benefit LIS enrollees do not face a coverage gap.

The 100% premium subsidy listed in Table 2.1 does not guarantee that a full benefit LIS beneficiary pays zero premiums. The actual premium paid by each LIS beneficiary depends on the premium amount of the specific plan into which he or she is enrolled and the amount of the regional LIS benchmark premium. In particular, the premium subsidy for a 100% LIS beneficiary is equal to the lesser of (1) the beneficiary’s plan’s monthly premium for “basic” prescription coverage, or (2) the greater of the regional low-income benchmark amount or the

¹ For full subsidy, these beneficiaries must also have less than \$6000 in countable resources if single and less than \$9000 if married.

Table 2.1: LIS Subsidy by Eligibility Categories, 2006

	Medicare and	Income or other factors	Premium Subsidy Level	Deductible	Coverage Gap	Co-pay Level	Co-pay Catastrophic
Automatically qualify – “Deemed”	Medicaid benefits – Full	≤100% FPL	100%	\$0	No	\$1/\$3	\$0
		>100% FPL	100%	\$0	No	\$2/\$5	\$0
		Unknown	100%	\$0	No	\$2/\$5	\$0
		Institutionalized	100%	\$0	No	\$0	\$0
	Medicaid benefits – Partial	MSP, QMB, SLMB, or QI	100%	\$0	No	\$2/\$5	\$0
	SSI benefits		100%	\$0	No	\$2/\$5	\$0
Must apply – “Applicant”	Limited Income and Resources	<135% FPL	100%	\$0	No	\$2/\$5	\$0
		135%-140% FPL	75%	\$50	No	15%	\$2/\$5
		140%-145% FPL	50%	\$50	No	15%	\$2/\$5
		145%-150% FPL	25%	\$50	No	15%	\$2/\$5

Notes: Premium subsidy is relative to the greater of the low income benchmark premium amount or the lowest PDP premium for basic coverage in the region. Deductible and co-payment levels adjusted annually for inflation. MSP: Medicare Savings Program, QMB: Qualified Medicare Beneficiary, SLMB: Specified Low-Income Medicare Beneficiary, QI: Qualified Individual.

lowest monthly premium for basic prescription coverage in a PDP plan in that region. The subsidy amount for a partial LIS beneficiary is determined using the same formula, but the final amount is reduced by the appropriate percentage.

Basic prescription coverage plans offer benefits equivalent to the “standard benefit,” which is defined by the MMA and represents the minimum coverage level Part D plans are expected to provide. For plans that offer enhanced benefits—those that are actuarially greater in value than the basic coverage package defined by the MMA—only the share of the premium attributable to basic coverage is considered in the formula. So, a 100% LIS beneficiary who enrolls in an enhanced plan will have to pay a share of the monthly premium attributable to the added benefits. This is true even if the plan’s total premium is below the regional low-income benchmark amount. Otherwise, as long as a full LIS beneficiary enrolls in a basic coverage plan

with a premium at or below the regional benchmark, he or she will have no out-of-pocket premium costs. Beneficiaries enrolled in basic coverage plans above the regional benchmark will have to pay for the share of the premium that is above the subsidy amount. Regardless of plan type and premium level, partial LIS beneficiaries will always have a positive premium cost (equal to the difference between their plan’s premium and their subsidy amount).

Table 2.2 summarizes the circumstances for full and partial subsidy LIS beneficiaries if they enroll in a standard benefit plan below the regional benchmark (Example A), a standard benefit plan above the benchmark (Example B) or an enhanced plan, in this case, with the enhanced premium below the benchmark (Example C). The full subsidy LIS beneficiary pays the difference between the premium and the benchmark for Plan B and the difference between the enhanced premium and the amount attributed to basic coverage for Plan C. The 50% partial subsidy beneficiary pays these amounts plus one-half of the lower of the premium attributable to the standard benefit or the regional benchmark. Only in the case of plans like Plan A, where the plan offers standard benefits with the premium below the benchmark, does a 100% subsidy beneficiary pay zero premium. As we describe further below, we will refer to plans like Plan A as “zero-premium plans.”

Table 2.2: Monthly LIS Beneficiary Premiums for Three Example Plans

	A	B	C
Plan Type	Standard	Standard	Enhanced
LIS Regional Benchmark	\$27.40	\$27.40	\$27.40
Plan Monthly Premium	\$26.40	\$30.40	\$27.00
Premium Attributable to Basic Coverage	\$26.40	\$30.40	\$25.00
LIS Beneficiary Premium			
100% Subsidy	\$0.00	\$3.00	\$2.00
50% Subsidy	\$13.20	\$16.70	\$14.50

2.2 Plan Selection, Auto-Enrollment and Re-Assignment

The concept of “zero-premium plans” is crucial to understanding the Part D enrollment process for LIS beneficiaries. To balance between beneficiary choice – an underpinning of the Part D program – and the importance of ensuring continued drug coverage for Medicaid and SSI beneficiaries, CMS established a strategy to always offer LIS beneficiaries the choice of Part D programs, but to automatically assign them to a plan if they have not selected one. This was particularly critical at the launch of the Part D program in 2006, when Medicaid dual eligibles switched from Medicaid drug coverage on December 31, 2005 to Medicare drug coverage on January 1, 2006.

Full subsidy LIS beneficiaries may select a Part D plan at any time, as well as switch plans during the year, an option not available to non-LIS enrollees. These beneficiaries are considered to have selected a plan if they actively enroll in a PDP plan or, prior to 2006, were enrolled in Part C coverage that offered Part D coverage starting in 2006. These Part C options included Medicare Advantage (MA) and Private-Fee-For-Service (PFFS) that offered Part D coverage, as well as Programs for All-Inclusive Care for the Elderly (PACE).

How long CMS waits for beneficiaries to select a plan depends on the basis for eligibility. For 2006, full benefit Medicaid beneficiaries with Part A and B coverage were expected to select plans in the open period during 2005. As Medicaid beneficiaries become eligible for Medicare (e.g. by reaching age 65), they are expected to select a plan of their choice within the first three months of their initial enrollment period (IEP), which corresponds to three months prior to the start of their Medicare eligibility. SSI beneficiaries, partial benefit Medicaid beneficiaries and full benefit applicants were given longer to actively select a plan. In 2006, these beneficiaries were given until May 2006, with retroactive coverage for SSI beneficiaries, as nearly all eventually become dual eligibles.

Full subsidy LIS beneficiaries who do not select a plan in these time frames are automatically enrolled by CMS into a zero-premium plan.² Technically, CMS refers to the full benefit Medicaid dual eligibles as subject to auto-enrollment and other full subsidy LIS beneficiaries as subject to facilitated enrollment, as shown in Table 2.3. Auto-/facilitated enrollees have the option of switching to a different plan at any time after the auto-enrollment effective date.³ If a full-benefit dual eligible disenrolls from a Part D plan—either voluntarily or involuntarily—and does not enroll in a new plan by the time CMS runs its monthly auto-enrollment, he will be auto-enrolled into a new plan by CMS, unless he has affirmatively declined or opted-out of auto-enrollment. The effective date of auto-enrollment is retroactive to when the beneficiary disenrolled from the previous plan.

CMS auto-/facilitate-enrolls beneficiaries in PDP plans in their region that offer basic drug coverage and have a premium at or below the low income regional benchmark. These zero-premium plans are randomly selected through a two-step process. In the first step, CMS identifies all the organizations who offer these types of plans in a particular region. Beneficiaries in the region will be randomly assigned to one of the organizations. In the second step, beneficiaries assigned to an organization are then randomly assigned to one of its plans. If an organization only has one zero-premium plan, all the beneficiaries assigned to it will be assigned that plan.

² CMS does not automatically enroll beneficiaries who decline or opt out of auto-/facilitated enrollment, reside outside the 34 PDP regions, or reside in a correctional facility. Beneficiaries whose employers are claiming the retiree drug subsidy on their behalf are also excluded from facilitated enrollment

³ Facilitated enrollees may only switch once during the year while auto-enrollees have no limit.

Table 2.3: Auto- and Facilitated Enrollment by LIS Eligibility Group

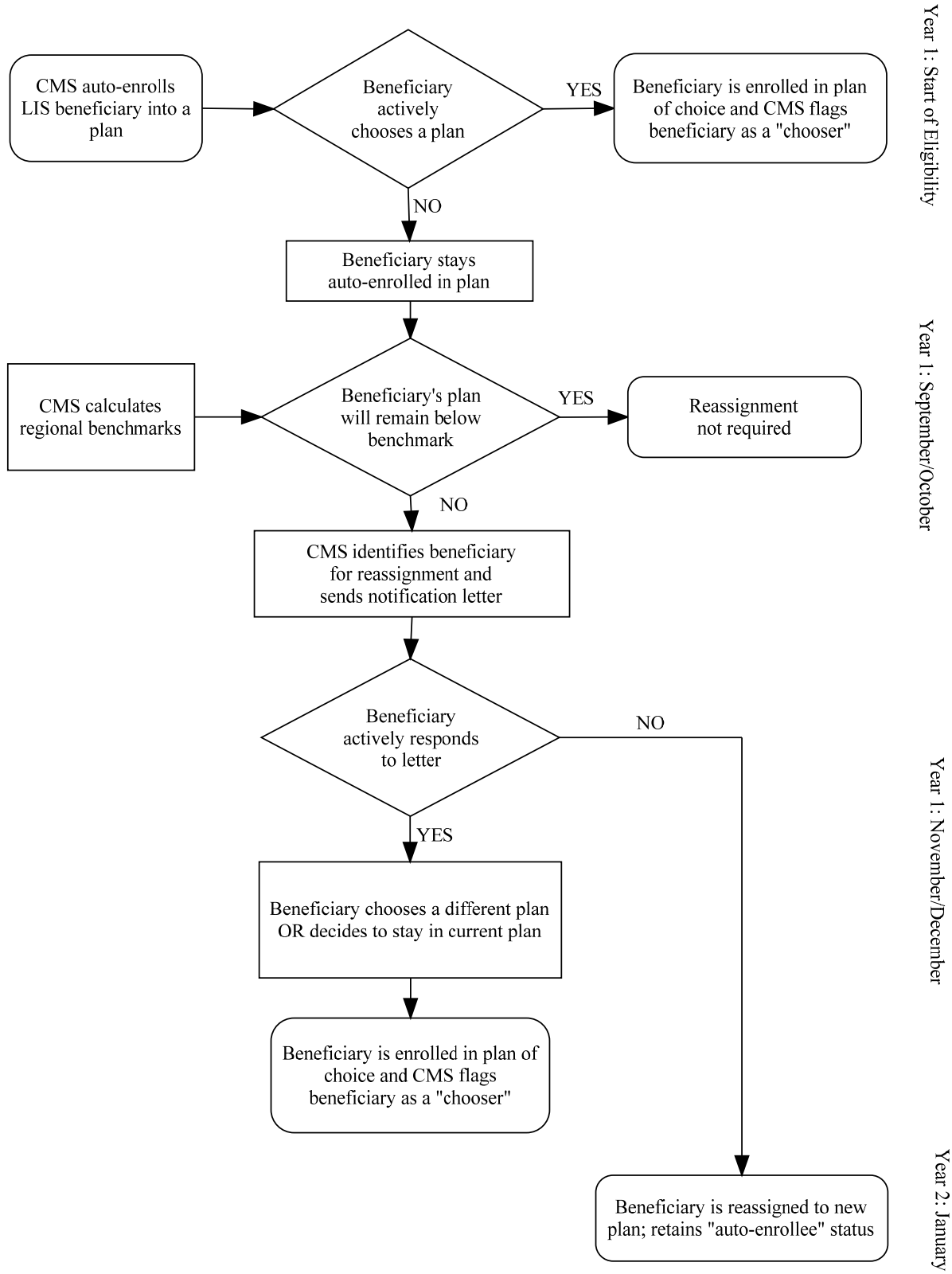
LIS Eligibility Based on	Deemed or Applicant	Auto- or Facilitated Enrollment	Effective
Medicaid benefits – Full	Deemed	Auto-enrollment	On Jan.1, 2006 or first date of dual eligibility, whichever is later.
Medicaid benefits – Partial	Deemed	Facilitated Enrollment	On May 1, 2006 or first day of second month after CMS notification of LIS eligibility, whichever is later.
SSI benefits	Deemed	Facilitated Enrollment	On May 1, 2006 or first date of dual eligibility, whichever is later.
Limited Income and Resources – Full LIS Subsidy	Applicant	Facilitated Enrollment	On May 1, 2006 or first day of second month after CMS notification of LIS eligibility, whichever is later.
Limited Income and Resources – Partial LIS Subsidy	Applicant	Facilitated Enrollment	On May 1, 2006 or first day of second month after CMS notification of LIS eligibility, whichever is later.

A plan that is zero-premium in one year may not be zero-premium the next year, either because the plan increased its premium over the benchmark or because the benchmark fell below the plan’s premium. For auto-enrolled beneficiaries in plans that move from zero-premium to a positive premium from one plan year to the next, CMS reassigns them to new plans to ensure they continue to have zero premium costs.

Figure 2.1 provides an overview of the reassignment process. In October, CMS identifies 100% LIS beneficiaries who (a) are “non-choosers,” i.e. currently in the PDP plan in which they were originally auto-enrolled, (b) face a positive premium for basic coverage if they stay in the plan in the coming year, and (c) will continue to be eligible for full LIS in the upcoming year.⁴ CMS will first attempt to reassign these beneficiaries to other at- or below-benchmark basic coverage PDPs in their region that have the same parent organization as their current PDP. If the organization has more than one plan available, beneficiaries will be randomly reassigned to one of the plans. If the organization has no qualifying plans available, then beneficiaries are randomly assigned to at- or below-benchmark plans selected using the same process that was used for auto-enrollment. CMS notifies the affected plans and beneficiaries of the reassignment in late October or early November. A beneficiary has until December 31 to actively enroll in a different plan or accept the reassigned plan. If he takes no action, then he will be enrolled into the reassigned plan with an effective date of January 1. A same process applies for full LIS beneficiaries with facilitated enrollment.

⁴ Additionally, CMS reassigns LIS beneficiaries in any PDP plan that is terminating in the upcoming year, regardless of the level of LIS or whether they chose the plan themselves.

Figure 2.1: Auto-Enrollment and Re-Assignment



2.3 Low-Income Benchmark Premium and Goals of the Demonstration

As described above, the low-income benchmark premium determines the threshold for zero-premium plans for full subsidy LIS beneficiaries and, by extension, the plans eligible for auto-enrollment and reassignment. The low-income benchmark is calculated for each of the 34 PDP regions on a yearly basis. It was defined in the MMA as the average of premiums for PDP (including fallback plans) and MA-PD plans in the region, weighted by the share of Part D beneficiaries enrolled in each plan. Specifically, the weight for each plan is a percentage with the numerator representing the number of Part D eligible beneficiaries enrolled in the plan and the denominator representing the total number of Part D eligible beneficiaries enrolled in all PDP and MA-PD plans in the region during a reference month.⁵ Enhanced benefit plans are included in the weighting, but only the portion of the monthly premium attributable to basic coverage is included in the calculation of the average. Because no PDP plans existed in 2005, CMS made an exception for the 2006 benchmark calculation by using a “uniform weights” methodology that applied equal weights to PDP plans, enrollment weights to MA-PD plans (using March 31, 2005 enrollment numbers), and zero weights to new MA-PD plans.

The “Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries,” was launched in 2007 with the goal of reducing the number of beneficiaries who would have had to switch plans or start paying a share of their premiums because their current plans moved above the regional low-income benchmark. Under the demonstration, the methodology used to calculate the 2007 and 2008 benchmarks deviated from that defined in the MMA. As Table 2.4 shows, for 2007, the demonstration called for using the same “uniform weights” methodology used for calculating the 2006 benchmarks. The 2008 benchmarks under the demonstration were a composite of uniform-weights averages and enrollment-weights averages.

Additionally, if a PDP or MA-PD plan’s premium for basic coverage exceeded the benchmark by not more than \$2 in 2007 and \$1 in 2008, the demonstration’s “*de minimis*” policy required these plans to charge full LIS beneficiaries only the amount equal to their premium subsidy, rather than the full premium amount. This means that in 2007, a 100% LIS beneficiary enrolled in a plan offering basic coverage with a premium that was less than \$2 above the regional benchmark would have no out-of-pocket premium costs. The *de minimis* policy does not affect partial subsidy LIS beneficiaries and those who enroll in plans with premiums above the benchmark by an amount greater than the *de minimis*. So, if a 100% LIS beneficiary in 2007 enrolled in a plan with a premium that was \$2.05 above the benchmark, the beneficiary would have to pay the entire \$2.05 out-of-pocket. Partial LIS beneficiaries would

⁵ Medicare Medical Savings Account (MSA) plans, private fee-for-service (PFFS) plans, Program of All-Inclusive Care for the Elderly (PACE), and 1876 cost plans are excluded from this calculation.

still pay for the difference between the plan’s full premium amount and their applicable premium subsidy amount, even if their plan’s premium was within the *de minimis* amount.

Table 2.4: Demonstration: Transitional Structure of Weighted Average for Regional Low-Income Benchmark Premium

Year	Benchmark Weighting Methodology	De Minimis Amount
2006	Equal weighting to PDP plans, zero weights to new MA-PD plans, and weights based on March 31, 2005 enrollment for MA-PD plans.	-
2007	Equal weighting to PDP plans, zero weights to new MA-PD plans, and weights based on June 2006 enrollment for MA-PD plans.	\$2
2008	50% of the LIS benchmark amount was calculated using the same methodology used in 2006 and 2007—applying equal weights to PDP plans and weighting MA-PD plans by June 2007 enrollment. The other 50% was calculated using June 2007 enrollment weights for both PDP and MA-PD plans.	\$1
2009 (Post-Demo)	100% of the benchmark amount is weighted by enrollment in PDP and MA-PD plans as of June 2008.	-

In keeping with the conception for the demonstration, Table 2.4 shows the 2009 weights as enrollment weights accounting for both PDP and MA-PD enrollment. The MMA definition of the enrollment weights was later amended such that starting in 2009 (following the end of the demonstration), the numerator and denominator would only include LIS beneficiaries rather than all Part D enrollees. We do not explore the impact of the change to LIS-only enrollment in this report.

The rest of the report explores the impact of the demonstration on plan availability and on the reassignment of beneficiaries who were auto-/facilitated enrolled into plans. For our purposes, we will refer to any automatic assignment by CMS as “auto-enrollment,” and beneficiaries who are subject to auto-/facilitated enrollment or reassignment simply as “auto-enrollees.”

3 IMPACT OF DEMONSTRATION ON PLAN AVAILABILITY AND BENEFICIARY REASSIGNMENT

By changing the weighting methodology, the demonstration changed the regional low-income benchmarks and, in doing so, increased the number of zero-premium plans available. In this section, we detail what the regional benchmarks were under the alternative weighting methodologies. We then examine how these changes affected the number of plans available as zero-premium plans for full subsidy LIS beneficiaries. Finally, we report how many beneficiaries were subject to reassignment with and without the demonstration.

3.1 How Did the Demonstration Affect the Regional Low-Income Benchmarks?

After the 2006 initial year's experience with the Part D program, average plan bids dropped significantly. Even under the demonstration maintaining the uniform weighting methodology, the benchmark dropped in every region. As shown in Table 3.1, with the uniform weighting methodology in 2006, the regional low-income benchmarks ranged from \$23.25 in Region 32 (California) to \$36.39 in Region 20 (Mississippi). In 2007, the uniform weighting methodology yielded benchmarks between \$20.56 (Region 29, Nevada) and \$33.56 (Region 34, Alaska). Region 11 (Florida) experienced the biggest percentage drop, with the benchmark falling 22 percent without a change in methodology.

The drop in benchmarks between 2006 and 2007 would have been far larger, though, without the demonstration. Not surprisingly, Part D beneficiaries disproportionately enrolled in less expensive plans. Region 28 (Arizona), for example, would have had an \$11.52 regional low-income benchmark if the enrollment weighting had been imposed in 2007. This represents more than a 50 percent drop from its 2006 benchmark of \$24.62. Under either methodology, the update in the benchmarks had the smallest effect on Region 34 (Alaska). Seventeen out of the 34 regions would have experienced a 25 percent or greater drop in the regional benchmark.

The change between 2007 and 2008 was somewhat more complex. Table 3.2 shows three alternative methodologies: the uniform weighting, the enrollment weighting and the composite weighting that actually applied in 2008 as a result of the demonstration. By definition, the composite weighting is a blend of the uniform and enrollment weights. Unlike the previous year, however, the bids did not generally fall between 2007 and 2008 in similarly weighted calculations. Only six regions would have had lower benchmarks for uniform weights in 2008 than in 2007. Only five regions would have had lower benchmarks under enrollment weighting in 2008 than under enrollment weighting in 2007.

Nevertheless, even with rising premiums, the shift toward enrollment weighting in 2008 in using the composite did lower the regional benchmarks compared to the previous year for

Table 3.1: Regional Low-Income Benchmarks for 2006 and 2007 by Methodology

PDP Region	State(s)	2006	2007	
		Uniform	Uniform - Demonstration	Enrollment
1	NH, ME	36.09	30.72	27.33
2	CT,MA,RI,VT	30.27	27.35	22.97
3	NY	29.83	24.45	19.30
4	NJ	31.37	28.12	19.23
5	DE, DC, MD	33.46	29.65	25.74
6	PA, WV	32.59	28.45	25.66
7	VA	34.42	30.52	25.82
8	NC	36.30	32.13	29.65
9	SC	34.88	31.41	27.90
10	GA	33.15	31.07	27.78
11	FL	29.07	22.63	15.18
12	AL, TN	32.33	29.60	25.00
13	MI	33.22	30.79	28.14
14	OH	30.69	28.51	23.10
15	IN, KY	35.69	32.42	28.20
16	WI	31.27	29.67	26.28
17	IL	31.60	29.66	26.57
18	MO	31.37	27.88	20.84
19	AR	35.45	30.51	26.32
20	MS	36.39	31.70	27.41
21	LA	34.14	28.45	22.63
22	TX	31.68	26.93	21.08
23	OK	35.13	30.35	24.26
24	KS	33.44	30.56	23.82
25	IA, MN, MT, ND, NE, SD, WY	33.11	29.50	20.47
26	NM	25.95	22.72	16.35
27	CO	28.92	27.37	18.70
28	AZ	24.62	21.37	11.52
29	NV	23.46	20.56	11.57
30	OR, WA	30.60	28.71	22.60
31	ID, UT	33.62	31.77	25.22
32	CA	23.25	21.03	15.00
33	HI	27.44	26.35	19.82
34	AK	34.66	33.56	31.47

Table 3.2: Regional Low-Income Benchmarks for 2008 by Methodology

PDP Region	State(s)	Composite - Demonstration	Uniform	Enrollment
1	NH, ME	30.64	30.72	30.08
2	CT,MA,RI,VT	29.17	27.35	28.00
3	NY	24.18	24.45	21.33
4	NJ	31.23	28.12	31.53
5	DE, DC, MD	30.78	29.65	30.44
6	PA, WV	26.59	28.45	24.98
7	VA	31.03	30.52	30.34
8	NC	33.43	32.13	33.22
9	SC	31.12	31.41	30.44
10	GA	30.04	31.07	28.76
11	FL	19.16	22.63	16.03
12	AL, TN	28.29	29.60	26.35
13	MI	30.49	30.79	29.82
14	OH	26.82	28.51	25.11
15	IN, KY	33.50	32.42	32.58
16	WI	31.03	29.67	29.70
17	IL	30.26	29.66	28.74
18	MO	26.71	27.88	23.84
19	AR	27.69	30.51	25.73
20	MS	31.35	31.70	30.02
21	LA	24.62	28.45	21.58
22	TX	25.01	26.93	23.17
23	OK	28.04	30.35	25.44
24	KS	30.62	30.56	28.66
25	IA, MN, MT, ND, NE, SD, WY	30.61	29.50	29.21
26	NM	19.28	22.72	15.73
27	CO	24.59	27.37	21.66
28	AZ	15.92	21.37	11.40
29	NV	16.64	20.56	12.31
30	OR, WA	30.19	28.71	28.38
31	ID, UT	33.53	31.77	32.18
32	CA	19.80	21.03	16.42
33	HI	24.32	26.35	20.72
34	AK	36.42	33.56	37.97

21 out of the 34 PDP regions. In the remaining 13 regions, the regional low-income benchmark in 2008 was higher than in 2007 even after accounting for enrollment weighting. Among these 13, two regions actually had greater proportions of individuals in higher cost plans: Regions 4 (New Jersey) and 34 (Alaska) had higher benchmarks under enrollment weighting than under uniform weighting.

3.2 How did the Demonstration Impact the Number of Zero-Premium Plans?

For all regions in 2007 and most regions in 2008, the demonstration raised the regional low-income benchmarks above what they otherwise would have been. The demonstration also increased the number of plans that would be effectively zero-premium through the inclusion of the *de minimis* policy. In 2007, the *de minimis* policy allowed enrollees in plans with premiums less than \$2 over the benchmark to pay no premiums. In 2008, the *de minimis* threshold was \$1.

The combination of the notably higher regional low-income benchmarks in 2007 and the *de minimis* policy resulted in a significantly larger number of zero-premium plans available to LIS beneficiaries than would have occurred in the absence of the demonstration. As Table 3.3 shows, three times as many plans were available at zero premium than would have been if the enrollment weights methodology been used. On average, each region would have had only 6 zero-premium plans, compared to an average of 19 under the demonstration. Beneficiaries in Regions 26, 28, and 29 (New Mexico, Arizona, and Nevada) would have had only one zero-premium plan, compared to at least 9 plan options under the demonstration.

In numbers of plans, the effect of the demonstration was somewhat more modest in 2008, as expected under the composite weighting. Compared to the full enrollment weighting, the demonstration increased the number of zero-premium plans from 341 to 495. The difference in impacts between 2006-07 and 2007-08 was partly due to the demonstration effect, with fewer plans available under the demonstration compared to the previous year (495 compared to 638) because of the composite methodology. But the difference is also partly due to more plans that would have been available under the full enrollment methodology (341 compared to 213 in 2007), reversing the trend from the previous year.

Tables 3.4 and 3.5 put the zero-premium plans into the larger context of PDP plans available in 2007 and 2008. The premiums in these tables are those faced by a full subsidy LIS beneficiary. In 2007, there were 1,865 PDP plans available with an average of 55 plans in each region. The zero-premium plans represented just over a third of the plans available, split between roughly 26 percent of plans below the benchmark and about 8 percent with premiums above the benchmark by the *de minimis* amount of \$2 or less. Regions 29, 28 and 11 (Nevada, Arizona and Florida) had the fewest share of plans available as zero-premium in 2007.

Table 3.3: Implications of the Demonstration on the Number of Zero-Premium Plans

PDP Region	2007			2008		
	Full Enrollment Methodology	Demonstration Methodology	% Difference	Full Enrollment Methodology	Demonstration Methodology	% Difference
1	12	21	75%	16	18	13%
2	7	20	186%	13	14	8%
3	5	16	220%	7	15	114%
4	4	20	400%	18	18	0%
5	9	21	133%	15	18	20%
6	13	26	100%	8	18	125%
7	6	21	250%	13	17	31%
8	10	21	110%	17	17	0%
9	11	26	136%	17	20	18%
10	9	20	122%	16	18	13%
11	2	10	400%	1	8	700%
12	6	17	183%	11	15	36%
13	12	25	108%	15	17	13%
14	5	22	340%	8	15	88%
15	10	19	90%	14	17	21%
16	10	20	100%	13	16	23%
17	11	23	109%	14	19	36%
18	3	15	400%	5	13	160%
19	10	23	130%	11	18	64%
20	8	21	163%	13	15	15%
21	4	11	175%	2	10	400%
22	5	19	280%	10	15	50%
23	4	20	400%	6	13	117%
24	4	20	400%	9	17	89%
25	4	20	400%	13	16	23%
26	1	14	1300%	4	11	175%
27	2	19	850%	3	12	300%
28	1	10	900%	1	7	600%
29	1	9	800%	1	5	400%
30	3	20	567%	12	15	25%
31	3	20	567%	13	14	8%
32	2	14	600%	2	9	350%
33	4	18	350%	5	10	100%
34	12	17	42%	15	15	0%
Total	213	638	200%	341	495	45%
Mean	6	19	335%	10	15	122%
Min	1	9	42%	1	5	0%
Max	13	26	1300%	18	20	700%

Table 3.4: PDP Plans by Premium for Full Subsidy LIS Beneficiaries, 2007

PDP Region	Number of Plans	Zero-Premium Plans		Positive Premium Plans			
		Below Benchmark	De Minimis (\$2)	Up to \$1	\$1 to \$2	\$2 to \$5	More than \$5
1	53	18	3	1	1	3	27
2	51	15	5	0	1	3	27
3	61	13	3	1	0	12	32
4	57	19	1	1	0	6	30
5	55	16	5	0	1	4	29
6	66	20	6	1	1	6	32
7	53	17	4	0	2	2	28
8	51	14	7	0	2	1	27
9	59	16	10	0	1	2	30
10	55	16	4	0	1	6	28
11	56	5	5	0	2	8	36
12	56	14	3	0	1	8	30
13	54	15	10	0	1	2	26
14	60	13	9	0	0	7	31
15	53	17	2	1	0	5	28
16	54	19	1	0	1	5	28
17	56	17	6	0	1	5	27
18	53	10	5	1	0	6	31
19	58	18	5	1	1	5	28
20	52	15	6	1	1	1	28
21	52	8	3	0	2	6	33
22	60	12	7	0	1	8	32
23	56	14	6	0	2	3	31
24	53	16	4	0	1	4	28
25	53	16	4	1	0	5	27
26	57	9	5	0	1	11	31
27	55	15	4	0	1	4	31
28	53	8	2	0	1	7	35
29	54	7	2	0	1	9	35
30	57	16	4	0	1	4	32
31	56	18	2	1	0	3	32
32	55	9	5	1	0	9	31
33	46	13	5	0	1	2	25
34	45	15	2	0	1	5	22
Total	1865	483	155	11	31	177	1008
Average	55	14	5	<1	<1	5	30

Source: 2007 PBP Extract from HPMS, OACT report

For enrollees willing to pay up to \$5 to be in a higher premium plan, they could choose from an average of 6 plans in each region; beneficiaries in Region 3 (New York) could choose from 13 plans. Because the *de minimis* policy was in effect in 2007, the few plans available in which full LIS enrollees could pay \$2 or less in premiums were all enhanced benefit plans. Approximately half of all plans in each region were those for which full LIS enrollees would have to pay more than \$5 in premiums. About 80 percent of these plans were enhanced plans.

In 2008, there were a total of 1,824 PDP plans—slightly fewer than the number in 2007. Access to below benchmark plans was only slightly below where it had been in 2007, with 24 percent of plans below benchmark, compared to 26 percent the year before. In 2008, however, only 3 percent of plans were zero-premium because they were above the benchmark by the *de minimis* amount of \$1 or less. For full subsidy LIS enrollees willing to pay \$1-\$5 to be in a higher premium plan, they could choose from an average of 9 plans in each region. With only 5 zero-premium plans, Region 29 (Nevada) had the fewest low-cost plan options for LIS beneficiaries. Beneficiaries in Region 9 (South Carolina) had the most options. Because the *de minimis* policy was in effect in 2008, there were no basic plans in which enrollees would pay a positive premium of \$1 or less. Additionally, there were no enhanced plans in which full subsidy LIS enrollees had a cost share of \$1 or less. More than half of all plans in most regions were those for which full subsidy LIS enrollees would have to pay more than \$5 in premiums. Of these, 75 percent were enhanced plans.

A key focus for the demonstration is not just the number of plans available at zero-premium, but the number of plans that lose zero-premium status, triggering the reassignment process described in Section 2 to ensure that full subsidy auto-enrollees maintain a zero premium. Even with the demonstration, plans that were zero-premium in 2006, and thus eligible for auto-enrollment, lost that status in 2007. Similarly, plans that were zero-premium in 2007 lost that status in 2008. In some cases, plans became enhanced alternative plans. Because of the large number of plans that stayed as zero-premium due to the demonstration, only 91 plans lost zero-premium status between 2006 and 2007, as shown on Table 3.6. More than twice as many plans lost zero-premium status between 2007 and 2008, even with the demonstration. Overall, auto-enrolled beneficiaries in 224 plans were potentially subject to reassignment.

Table 3.5: PDP Plans by Premium for Full Subsidy LIS Beneficiaries, 2008

PDP Region	Number of Plans	Zero-Premium Plans		Positive Premium Plans			
		Below Benchmark	De Minimis (\$1)	Up to \$1	\$1 to \$2	\$2 to \$5	More than \$5
1	53	17	1	0	3	6	26
2	51	13	1	0	3	6	28
3	55	12	3	0	2	6	32
4	57	18	0	0	3	7	29
5	52	15	3	0	3	4	27
6	63	14	4	0	3	12	30
7	52	15	2	0	1	6	28
8	52	17	0	0	4	8	23
9	56	18	2	0	3	6	27
10	54	17	1	0	2	7	27
11	58	5	3	0	3	9	38
12	53	13	2	0	1	7	30
13	55	15	2	0	2	5	31
14	58	13	2	0	1	6	36
15	52	16	1	0	2	8	25
16	57	14	2	0	2	9	30
17	53	19	0	0	2	5	27
18	52	11	2	0	2	5	32
19	55	17	1	0	1	7	29
20	49	13	2	0	2	6	26
21	50	7	3	0	2	7	31
22	56	13	2	0	3	6	32
23	52	13	0	0	3	5	31
24	52	14	3	0	1	6	28
25	52	14	2	0	2	6	28
26	55	9	2	0	5	7	32
27	55	11	1	0	2	5	36
28	51	6	1	0	2	8	34
29	53	2	3	0	2	8	38
30	55	13	2	0	1	9	30
31	54	14	0	0	3	6	31
32	56	9	0	0	1	8	38
33	49	10	0	0	4	6	29
34	47	15	0	0	2	3	27
Total	1824	442	53	0	78	225	1026
Average	54	13	2	0	2	7	30

Source: 2007 PBP Extract from HPMS, OACT report

Table 3.6: Number of Plans Losing Zero-Premium Status

PDP Region	2006 to 2007	2007 to 2008
1	4	4
2	2	8
3	7	6
4	1	6
5	3	4
6	2	11
7	2	5
8	2	6
9	1	8
10	3	6
11	3	8
12	2	6
13	1	9
14	4	10
15	2	5
16	4	6
17	2	4
18	2	5
19	3	6
20	1	8
21	6	4
22	5	6
23	2	9
24	2	5
25	2	6
26	3	5
27	0	9
28	3	5
29	3	6
30	3	7
31	3	8
32	4	7
33	2	11
34	2	5
Total	91	224

3.3 What Was the Impact of the Demonstration on Beneficiary Reassignment?

The goal of the demonstration was to reduce the number of LIS beneficiaries affected by reassignment by sustaining a larger number of low-cost plans available to them. So far, we have focused largely on the effect of the demonstration on the number of plans available for zero premium. However, the demonstration itself is predicated on the fact that beneficiaries are not evenly distributed across plans. We therefore turn to the question of how many beneficiaries were reassigned under the demonstration and how this differs from what would have occurred in the absence of the demonstration.

By October 2006, there were nearly 5.2 million full subsidy LIS beneficiaries who were still enrolled in a plan that they had been assigned to through the auto-enrollment or facilitated enrollment process. Table 3.7 reports the number of the beneficiaries who received reassignment notification in 2006 because they were enrolled in one of the 91 plans from Table 3.6 that lost their zero-premium status, a total of almost 1.2 million beneficiaries or 22 percent of the October 2006 auto-enrollees. Auto-enrollees from every region except Region 27 (Colorado) were subject to reassignment notification, even under the demonstration. Four other regions had fewer than five percent of auto-enrollees subject to reassignment: Region 4 (New Jersey), Region 9 (South Carolina), Region 13 (Michigan) and Region 20 (Mississippi). Regions 11 (Florida), 21 (Louisiana), 28 (Arizona) and 29 (Nevada) all had more than 40 percent of auto-enrollees facing potential reassignment for the 2007 plan year.

As Table 3.7 also demonstrates, the number would have been far larger under the full enrollment methodology. In that case, more than three-quarters of the 2006 auto-enrollees would have been subject to reassignment. Other than Region 21, which was close to the average under the full enrollment methodology, those regions that had more than 40 percent facing reassignment with the demonstration would have had more than 90 percent facing reassignment without it. In fact, all but 1 percent of California's (Region 32) auto-enrollees as of October 2006 would have faced higher premiums without reassignment if the demonstration had not gone into effect. Even Region 27 (Colorado), which had no reassignments required under the demonstration, would have required 85 percent of its auto-enrollees to have been reassigned.

Consistent with the findings for plans, many more beneficiaries who were still in an auto-enrolled plan in October 2007 faced reassignment in 2008, even under the demonstration, as shown in Table 3.8. Overall, the demonstration saved 784,171 out of 2,895,426 full subsidy LIS beneficiaries from needing to select another plan or being reassigned. In four regions (Regions 2, 4, 8, and 34), the demonstration had no impact. Among these four are Regions 4 (New Jersey) and 34 (Alaska), which had higher benchmark values under the full enrollment methodology than under the composite methodology from the demonstration.

Table 3.7: Implications of the Demonstration on Beneficiary Reassignment, 2006-2007

PDP Region	LIS Auto-Enrollees as of October 2006	Received Reassignment Notification		
		Demonstration Methodology	Full Enrollment Methodology	Difference
1	49,782	10,210	30,106	19,896
2	272,302	42,752	178,198	135,446
3	438,414	151,690	372,744	221,054
4	134,961	6,392	99,746	93,354
5	81,283	13,560	49,744	36,184
6	186,733	18,587	142,283	123,696
7	109,286	11,832	90,152	78,320
8	198,226	26,140	113,275	87,135
9	104,722	3,735	58,560	54,825
10	132,754	19,986	89,816	69,830
11	284,692	125,863	270,076	144,213
12	270,618	49,544	228,531	178,987
13	181,660	6,574	96,049	89,475
14	168,630	67,560	121,945	54,385
15	182,881	23,515	111,402	87,887
16	100,009	27,570	47,730	20,160
17	226,259	23,210	116,660	93,450
18	126,688	22,056	108,052	85,996
19	60,752	11,177	39,025	27,848
20	110,162	4,816	66,105	61,289
21	107,668	49,380	82,534	33,154
22	276,863	71,455	228,588	157,133
23	69,002	9,586	59,234	49,648
24	34,681	4,982	27,122	22,140
25	158,835	18,440	127,270	108,830
26	36,964	13,601	31,410	17,809
27	39,956	0	34,088	34,088
28	50,795	23,290	48,520	25,230
29	23,114	10,394	21,481	11,087
30	129,336	20,813	115,170	94,357
31	35,195	5,647	30,937	25,290
32	780,061	265,358	771,987	506,629
33	22,678	4,665	19,186	14,521
34	10,397	2,144	5,276	3,132
Total	5,196,359	1,166,524	4,033,002	2,866,478

Table 3.8: Implications of the Demonstration on Beneficiary Reassignment, 2007-2008

PDP Region	LIS Auto-Enrollees as of October 2007	Received Reassignment Notification		
		Demonstration Methodology	Full Enrollment Methodology	Difference
1	51,129	7,032	12,005	4,973
2	272,068	118,950	118,950	0
3	446,637	214,374	298,308	83,934
4	135,535	55,687	55,687	0
5	84,788	10,087	20,677	10,590
6	199,525	72,948	137,860	64,912
7	111,315	25,771	31,182	5,411
8	199,041	54,101	54,101	0
9	105,937	30,015	36,932	6,917
10	137,719	26,114	36,321	10,207
11	290,875	234,418	239,968	5,550
12	261,560	63,943	104,223	40,280
13	183,285	64,416	65,330	914
14	175,868	92,519	117,106	24,587
15	190,088	43,063	53,128	10,065
16	99,696	28,848	43,430	14,582
17	225,166	42,368	75,079	32,711
18	123,074	33,136	71,299	38,163
19	62,555	16,053	31,275	15,222
20	109,688	42,814	43,166	352
21	111,624	35,573	84,278	48,705
22	295,880	93,508	123,965	30,457
23	70,949	26,184	42,692	16,508
24	34,755	6,187	19,724	13,537
25	162,460	39,778	40,880	1,102
26	37,948	13,723	24,338	10,615
27	41,558	18,775	36,713	17,938
28	55,843	10,078	46,513	36,435
29	24,348	16,160	19,009	2,849
30	132,455	43,103	45,307	2,204
31	36,716	10,062	10,337	275
32	800,436	507,934	735,283	227,349
33	22,750	9,552	16,379	6,827
34	10,844	3,981	3,981	0
Total	5,304,115	2,111,255	2,895,426	784,171

4 BENEFICIARY RESPONSE TO REASSIGNMENT NOTIFICATION IN 2007-2008

Under the demonstration, 2,112,132 LIS beneficiaries were sent a reassignment notification in November 2007. These beneficiaries were full subsidy Part D beneficiaries who had been auto-enrolled in a plan and had not switched from that plan during the year. The notifications inform beneficiaries of the plan to which they will be reassigned, as well as how to either stay in their current plan or select a new plan. These beneficiaries could respond to the letter in one of four ways:

- (a) Take no action and be enrolled in the assigned plan in January,
- (b) Select a different zero-premium plan,
- (c) Choose to stay in the same plan and start paying part of the premium, or
- (d) Select different plan with a positive premium.

In this section, we examine how LIS auto-enrollees responded to reassignment notification in 2007. First, we present regional statistics showing the percent of beneficiaries who accepted reassignment and the percent of beneficiaries making each potential choice. Then, we compare each group by their demographic characteristics, health status and Part D usage during 2007. Comparable results for the beneficiaries who received the 2006 notification are provided in Appendix B.

4.1 2007-2008 Enrollment Reassignment

Table 4.1 shows the number of beneficiaries who received a reassignment notification in each PDP region and how these beneficiaries distribute across different responses. (A listing of states by PDP region can be found in Appendix E.) Of the 2.1 million beneficiaries who received a reassignment notification, about 1.9 million remained enrolled in Part D and eligible for auto-enrollment in January 2008. Of the 141,023 who were no longer eligible for auto-enrollment by January, 22.7 percent had died, 6.9 percent moved from one region to another, 29.7 percent dropped out of Part D, and 40.7 percent lost full LIS eligibility.

Nationally, the vast majority (90 percent) of the 1.9 million beneficiaries did not respond to the notification letter and hence were enrolled into their reassigned plan in January. Slightly over 6 percent decided to stay in their original plan and pay a positive premium. About 3.7 percent of notified beneficiaries switched plans and enrolled in a different plan other than the one to which they were originally reassigned, with 2.6 percent enrolling into a zero-premium plan. There are important variations across regions. In Region 1 (New Hampshire and Maine), only 74 percent of beneficiaries stayed in the plan they were originally assigned; a large share of these beneficiaries (over 23 percent) selected a different zero-premium plan. Region 18 (Missouri),

Region 3 (New York) and Region 28 (Arizona) show the largest rates of beneficiaries choosing to stay in their original plans (slightly over 10 percent).

Table 4.1: Beneficiary Response to Reassignment Notification, 2007-2008

PDP Region	Received a Reassignment Notification	Still Eligible for Auto-Enrollment January 2008	Beneficiaries Subject to Reassignment and Eligible for Auto-Enrollment in January 2008			
			% Reassigned in January 2008	% Stayed in Same Plan	% Moved to Another Zero-Premium Plan	% Moved to Positive Premium Plan
1	7,033	6,632	74%	1.6%	23.7%	0.5%
2	118,965	112,221	91	3.7	2.1	3.1
3	214,441	199,751	84	10.5	4.3	1.3
4	55,692	52,428	92	2.4	5.0	0.2
5	10,095	9,399	97	1.9	1.3	0.3
6	72,958	67,145	93	3.4	3.4	0.2
7	25,781	24,295	97	1.3	1.4	0.2
8	54,109	50,965	98	1.1	1.2	0.1
9	30,022	27,745	90	4.1	2.2	3.4
10	26,128	24,232	97	1.3	1.7	0.2
11	234,643	212,683	88	8.1	3.1	0.8
12	63,976	60,344	88	6.3	3.0	2.4
13	64,423	60,347	93	4.6	1.8	0.5
14	92,585	84,879	84	8.4	6.4	1.3
15	43,081	40,540	96	2.4	1.9	0.2
16	28,856	26,923	91	3.8	2.4	3.0
17	42,368	38,878	90	9.4	0.6	0.1
18	33,163	30,874	82	11.7	3.9	2.6
19	16,064	14,769	90	6.1	2.7	1.5
20	42,822	40,192	97	2.0	1.3	0.1
21	35,598	33,330	87	7.9	3.9	1.0
22	93,573	87,518	91	4.8	3.2	1.1
23	26,197	24,631	90	3.3	3.1	3.4
24	6,187	5,799	96	2.2	1.7	0.2
25	39,787	37,505	97	1.7	1.6	0.2
26	13,737	12,650	90	6.7	2.2	0.7
27	18,775	17,338	89	4.5	4.0	2.7
28	10,108	8,692	86	10.1	3.2	0.7
29	16,192	14,645	94	4.0	1.4	0.8
30	43,110	40,141	96	2.1	2.0	0.2
31	10,066	9,156	89	4.2	3.4	3.5
32	508,058	481,882	90	7.8	1.2	0.8
33	9,556	8,827	95	1.9	2.6	0.3
34	3,983	3,753	93	2.6	4.4	0.5
Total	2,112,132	1,971,109	90%	6.3%	2.6%	1.1%

4.2 Beneficiary Response by Demographic Characteristics

Table 4.2 compares the beneficiaries who actively responded to the reassignment notification to other beneficiaries with similar demographic characteristics. For each group of beneficiaries defined by their response to the reassignment notice, Table 4.2 presents their distribution across age groups, gender, race, Medicare and Medicaid status, and institutional status as of January 2008.

Table 4.2: Demographic Characteristics of LIS Beneficiaries by Response to Reassignment Notification, 2007-2008

Beneficiary Characteristics	All LIS Auto-Enrollees as of October 2007	Received Reassignment Notification	Reassigned in January 2008	Stayed in Same Plan	Moved to Another Zero-Premium Plan	Moved to a Positive Premium Plan
Number of Beneficiaries	4,907,091	2,112,132	1,773,856	123,812	52,190	21,271
Age (%)						
0-64	48.0	44.7	45.1	43.8	36.2	41.8
65-74	24.9	26.3	26.3	28.6	23.5	28.8
75-84	18.2	19.6	19.5	20.2	23.7	20.7
85+	9.0	9.4	9.1	7.4	16.6	8.7
Gender (%)						
Male	41.4	40.9	40.9	39.1	36.0	34.7
Female	58.6	59.1	59.1	60.9	64.0	65.3
Medicare Status (%)						
Aged without ESRD	53.6	56.3	55.9	57.4	64.5	59.5
Aged with ESRD	0.5	0.5	0.5	0.6	0.7	0.4
Disabled without ESRD	44.4	41.8	42.3	40.5	33.5	38.9
Disabled with ESRD	0.8	0.8	0.8	0.9	0.8	0.7
ESRD only	0.3	0.3	0.2	0.3	0.2	0.2
Race/Ethnicity (%)						
White	62.0	60.2	59.4	63.6	71.9	68.9
Black	21.5	19.4	19.5	17.2	15.9	15.0
Asian	5.7	7.2	7.5	7.8	4.3	6.7
Hispanic	7.3	9.3	9.7	8.0	4.7	6.1
Other	3.6	3.8	3.9	3.5	3.3	3.4
Institutional Status (%)	6.9	6.9	6.8	1.9	28.3	4.7
Dual Eligible (%)	93.1	94.5	94.5	94.4	96.0	92.1

Compared to those beneficiaries who were reassigned, beneficiaries who stayed in their original plan are similar to those who were reassigned according to age, gender, race, Medicare and Medicaid status, but they are more likely to be white and significantly less likely to reside in a long term institution. In contrast, beneficiaries who moved to another zero-premium plan (other than the one to which they were reassigned) are older and more likely to be residing in a

long term institution. In fact, over 28 percent of these beneficiaries were found to be institutionalized in a long-term care facility in January 2008. Compared to beneficiaries who were reassigned, beneficiaries who moved to a positive premium plan are more likely to be white and less likely to be either disabled, dual eligible or living in a long term institutions.

4.3 Beneficiary Response by Clinical Characteristics

To assess differences in health status across group of beneficiaries defined by their response to reassignment, Table 4.3 compares the prevalence rates of the top 30 most frequent Rx_HCC conditions. The Rx_HCCs represent ICD-9-CM diagnostic groups, currently used by CMS for risk adjustment in Part D. Each Rx_HCC conditions used in the model is associated with higher expected drug costs.

The comparison of prevalence rates of Rx_HCCs across groups shows clear differences by health risk. First, beneficiaries who received a reassignment letter have slightly higher rates of prevalence in most of the conditions listed in Table 4.3, compared to all LIS enrollees who were auto-enrolled in October 2007. Second, beneficiaries who have clinical conditions associated with higher expected drug use are more likely to either have stayed in the same plan in which they were originally enrolled or actively selected a plan (or have selected on their behalf) different from the one to which they were reassigned. For example, beneficiaries who decided to stay in their original plan have higher prevalence rates in all but three of the conditions (dementia, seizure disorders and schizophrenia) listed in Table 4.3. Those who selected a new plan have the highest prevalence rates. This evidence suggests that beneficiaries who have high expected drug use are more likely to actively select a plan rather than accept reassignment.

Differences in prevalence rates by Rx_HCC condition shows that, while beneficiaries who actively stayed in their plans or chose another plan are sicker compared to reassigned beneficiaries, there are important distinctions between these three groups – (i) those who stayed in the same plan, (ii) those who selected another zero-premium plan and (iii) those who selected a positive premium plan. Both the beneficiaries who stayed in the same plan and those who chose a positive premium plan have the largest prevalence rates on disorders of the lipid metabolism, hypertensive heart disease or hypertension and spinal discs. However, beneficiaries who selected a zero-premium plan are more likely to suffer from dementia and significant psychiatric symptoms/syndromes than any other group.

Table 4.3: Prevalence Rates of Top 30 Rx_HCCs by Response to Reassignment Notification, 2007-2008

Clinical Conditions (Rx_HCC)	All LIS Auto-Enrollees as of October 2007	Received Notification	Reassigned in January 2008	Stayed in Original Plan	Moved to Another Zero-Premium Plan	Moved to a Positive Premium Plan
Hypertensive Heart Disease or Hypertension	39.2%	41.3%	41.2%	46.5%	43.5%	48.7%
Other Musculoskeletal and Connective Tissue Disorders	34.7	36.4	36.2	37.2	44.3	39.3
Disorders of Lipoid Metabolism	31.1	33.3	33.1	41.3	34.7	42.6
Significant Psychiatric Symptoms/Syndromes	22.7	23.0	22.6	24.0	32.2	28.7
Asthma and COPD	18.4	19.3	19.0	22.2	22.3	23.9
Acute Myocardial Infarction and Unstable Angina	17.9	19.4	18.8	23.9	25.4	23.8
Other Specified Endocrine/Metabolic/Nutritional Disorders	17.1	17.5	17.1	19.2	24.9	20.9
Esophageal Disease	15.8	16.3	16.0	18.7	20.2	21.7
Disorders of the Vertebrae and Spinal Discs	14.4	15.1	14.8	19.9	15.9	21.2
Diabetes without Complication	14.3	14.8	14.8	16.1	16.0	16.5
Congestive Heart Failure	12.2	12.8	12.3	14.2	18.2	14.0
Vascular Disease	12.1	13.3	12.9	14.0	22.3	15.0
Other Diseases of Upper Respiratory System	10.1	10.6	10.6	12.7	10.8	13.7
Diabetes with Specified Complications	10.0	10.8	10.6	12.2	13.5	12.9
Cerebral Hemorrhage and Effects of Stroke	9.9	10.6	10.4	11.1	17.0	11.3
Cellulitis, Local Skin Infection	9.3	9.9	9.7	10.7	13.8	10.8
Osteoporosis & Vertebral Fractures	7.5	8.5	8.3	10.6	11.3	10.9
Specified Heart Arrhythmias	7.3	7.5	7.2	8.6	11.1	8.9

Clinical Conditions (Rx_HCC)	All LIS Auto-Enrollees as of October 2007	Received Notification	Reassigned in January 2008	Stayed in Original Plan	Moved to Another Zero-Premium Plan	Moved to a Positive Premium Plan
Dementia/Cerebral Degeneration	6.9	7.0	6.7	4.5	17.0	6.1
Acute Bronchitis and Congenital Lung/Respiratory Anomaly	6.1	6.4	6.4	7.0	6.0	7.5
Seizure Disorders and Convulsions	5.8	5.9	5.9	5.0	9.6	5.6
Impaired Renal Function and Other Urinary Disorders	5.8	6.1	5.9	7.1	8.3	7.5
Schizophrenia	5.6	5.8	5.8	5.4	8.0	5.6
Peptic Ulcer and Gastrointestinal Hemorrhage	5.1	5.4	5.3	6.1	7.0	6.4
Macular Degeneration and Retinal Disorders, Except Detachment and Vascular Retinopathies	4.5	5.0	4.9	6.0	7.7	6.3
Mononeuropathy, Other Abnormal Movement Disorders	4.5	4.6	4.5	5.7	5.8	6.4
Open-angle Glaucoma	4.3	4.8	4.7	6.0	5.9	6.1
Polyneuropathy	3.4	3.7	3.6	4.9	4.4	5.2
Urinary Obstruction and Retention	3.3	3.5	3.5	4.2	4.6	4.6

4.4 Beneficiary Response by Part D Utilization

To investigate the relationship between Part D utilization and response to reassignment, Table 4.4 shows statistics on the number of Prescription Drug Events (PDEs) and total drug costs for 2007 for each beneficiary group. The top panel shows, for each group, the monthly average number of PDEs and the share of beneficiaries allocated to each level of PDE use. The bottom panel shows similar statistics for total drug costs.⁶

The evidence presented in Table 4.4 is consistent with the differences in health status across groups described in Section 4.3. Namely, beneficiaries who were subject to reassignment

⁶ Total Drug Costs= Ingredient Costs + Dispensing Fee + Sale Tax

have slightly higher Part D use compared to the rest of LIS auto-enrolled population (3.9 PDEs per month compared to 3.7). Beneficiaries who stayed in their original plan filled on average more PDEs compared to the population that was reassigned (4.4 monthly PDEs compared to 3.8). Finally, the group who moved to zero-premium plans show the highest levels of drug consumption (on average this group filled 5.6 PDEs per month in 2007). The distribution of beneficiaries across PDE utilization levels reveals the source of the observed differences. About 12 percent of beneficiaries who were reassigned had no PDE events in 2007, but less than 5 percent of beneficiaries who selected a different plan had no drug usage during 2007. Also, about 19 percent of beneficiaries who were reassigned had over 80 PDEs in 2007, while over 25 percent of beneficiaries who selected a different plan had this level of drug usage.

Differences in Part D use are more pronounced when measured by total drug cost. LIS beneficiaries who were reassigned filled on average 14 percent fewer PDEs compared to those who stayed in their original plan, but the difference in the monthly Part D costs is over 27 percent. While 19 percent of those reassigned had drug baskets that cost on average over \$425 a month, over 26 percent of those who stayed in their original plan had drug baskets at this price range. Among those beneficiaries who were not reassigned, beneficiaries who selected a zero-premium plan other than the one originally reassigned had the highest monthly costs in 2007 (46 percent higher compared to beneficiaries who were reassigned).

Table 4.4: Part D Use by Response to Reassignment Notification, 2007-2008

	All LIS Auto- Enrollees as of October 2007	Received Reassignment Notification	Reassigned in January 2008	Stayed in Original Plan	Moved to Another Zero- Premium Plan	Moved to a Positive Premium Plan
Average Monthly Number of PDEs	3.7	3.9	3.8	4.4	5.6	4.9
Number of PDEs in 2007 (%)						
0	13.6	11.9	11.7	6.4	4.9	4.9
1 to 5	7.4	6.9	7.1	5.0	3.2	3.7
6 to 10	5.6	5.3	5.4	4.7	2.9	3.9
11 to 20	10.7	10.6	10.8	10.2	7.3	9.1
21 to 30	9.9	10.1	10.3	10.6	8.0	9.6
31 to 40	8.9	9.2	9.3	10.3	8.3	10.0
41 to 50	7.9	8.2	8.2	9.2	8.2	9.8
51 to 60	6.9	7.2	7.2	8.1	8.1	8.8
61 to 70	5.9	6.2	6.1	7.0	7.7	7.4
71 to 80	4.9	5.2	5.1	6.0	7.0	6.5
81 +	18.5	19.3	18.8	22.7	34.5	26.4
Average Monthly Drug Cost	\$ 267.48	\$ 282.91	\$ 276.31	\$ 379.34	\$ 403.57	\$ 377.44
Average Monthly Drug Cost in 2007 (%)						
\$0 - \$20	24.8	22.4	22.6	13.9	10.0	10.7
>\$20 - \$188	33.7	33.9	34.4	32.0	27.9	32.2
>\$188 - \$425	23.0	24.1	23.9	27.4	30.0	29.8
\$425 +	18.5	19.7	19.1	26.8	32.1	27.3

5 IMPACT OF PLAN REASSIGNMENT ON PART D UTILIZATION

One of the biggest concerns regarding reassignment is that it preserves the full premium subsidy but moves beneficiaries into plans that are otherwise less favorable. This section evaluates whether plan reassignment had an impact on drug utilization in 2008. We first calculate metrics of 2008 formulary offerings and Part D utilization for all full subsidy beneficiaries who were auto-enrolled in a zero-premium plan in October 2007 and enrolled in Part D and eligible for auto-enrollment in January 2008. We then compare these metrics across the following groups: a) LIS auto-enrollees not subject to reassignment notification who remained in the same contract from October 2007 to January 2008, b) reassigned beneficiaries, and c) beneficiaries who were subject to reassignment and either chose to stay in their original plan or chose a different plan. To control for differences in health status, we create separate statistics for beneficiaries grouped by their Part D clinical risk score.⁷ In particular, we group beneficiaries into low risk score (from 0 to 0.9), medium risk score (from 0.9 to 1.3) and high risk score (greater than 1.3) categories.

5.1 Comparison of Formulary Offerings

To assess whether beneficiaries who were reassigned faced more restrictive formularies compared to other groups, we examine the specific drugs taken by each beneficiary. For the drugs each beneficiary filled in 2007 and 2008, we calculate the percent that were within the beneficiary's plan's formulary, percent of drugs that were subject to prior authorization (PA), and percent subject to a quantity limit (QL) at the date of service.⁸ Table 5.1 compares these percentages across beneficiary groups and years. (Beneficiaries who lost LIS eligibility, died or dis-enrolled from Part D by January 2008 were excluded from this analysis.)

Table 5.1 suggests that beneficiaries filled drugs under more restrictive formularies in 2008 compared to 2007. The percent of drugs in formularies dropped from 2007 to 2008 for all groups. Moreover, the percent of drugs subject to QL and PA increased for almost all groups. The evidence also suggests that there were very slight differences across groups. While beneficiaries who were not subject to reassignment had a slightly lower share of drugs under quantity limits in 2008 compared to other groups, they also show the largest increases in this share from 2007 to 2008.

⁷ The Part D clinical score reflects the relative expected drug costs caused by having one or more of the Rx_HCC conditions.

⁸ Formulary restrictions were obtained by mapping the Service Provider ID reported in the PDE to the reference NDC listed in the Plan Finder Formulary File for that plan and for the submission period corresponding to the date of service.

Table 5.1: Comparison of Formulary Offerings between 2007 and 2008

LIS Auto-Enrollees:	Number of Beneficiaries	2007 Formulary Offerings Share of PDEs			2008 Formulary Offerings Share of PDEs		
		Formu- lary	Subject to PA	Subject to QL	Formu- lary	Subject to PA	Subject to QL
Not Subject To Reassignment and Remained in Same Plan until January 2008	1,973,258	98%	1%	23%	97%	2%	27%
Low Risk Score	466,765	98	1	21	97	2	25
Medium Risk Score	771,190	98	1	23	97	2	27
High Risk Score	735,303	98	2	23	97	2	28
Reassigned Beneficiaries	1,436,896	98	2	21	96	2	28
Low Risk Score	332,462	98	1	20	96	2	26
Medium Risk Score	561,188	98	1	22	96	2	29
High Risk Score	543,246	98	2	21	97	2	28
Subject to Reassignment and Selected a Plan	174,808	98	2	21	96	2	28
Low Risk Score	32,450	98	1	21	96	2	26
Medium Risk Score	65,225	98	1	22	96	2	29
High Risk Score	77,133	97	2	21	96	2	28

5.2 Change in Part D Utilization

Table 5.2 shows the differences in the average number of PDEs and the average monthly total drug costs between the third quarter of 2008 and the third quarter of 2007 for groups of beneficiaries defined by their reassignment status. The population is restricted to include only beneficiaries who were enrolled in Part D and alive during both quarters.

All beneficiary groups increased both the average number of PDEs per month and monthly average drug costs from 2007 to 2008. Compared to beneficiaries who accepted reassignment, beneficiaries who were not subject to reassignment and stayed in their original plan have a larger increase in both the average number of monthly PDEs and the average drug costs between 2007 and 2008. This evidence is consistent with the observed differences in Rx_HCCs prevalence rates found between these two groups. However, these results hold when comparing subpopulations of beneficiaries with similar levels of risk scores. For example, reassigned beneficiaries in the highest Part D clinical risk score bracket increased the monthly average drug costs by \$32 (6 percent), but beneficiaries in the same risk score level who were not reassigned increased their costs by \$49 (10 percent). Among all groups, beneficiaries who actively selected a plan had the highest rates of PDE usage growth in terms of the number of PDEs and drug costs. Not surprisingly, beneficiaries who actively select a new plan choose one that better fits their pharmacy needs.

**Table 5.2: Change in Part D Use of Beneficiaries by Reassignment Status
Q3 2008 vs. Q3 2007**

Beneficiary Group	Number of Beneficiaries	Average Monthly PDEs in Q3 2007	Average Change in Monthly PDEs	Average Monthly Drug Cost in Q3 2007	Average Change in Monthly Drug Cost
LIS Auto-Enrollees Not Subject To Reassignment	2,277,208	3.84	0.28	\$ 275.93	\$ 33.19
Low Risk Score	753,002	1.58	0.25	109.32	20.17
Medium Risk Score	813,895	3.71	0.31	243.55	31.56
High Risk Score	710,311	6.38	0.29	489.67	48.83
Reassigned Beneficiaries	1,671,834	3.87	0.21	281.97	20.84
Low Risk Score	543,207	1.59	0.21	110.24	14.67
Medium Risk Score	598,251	3.72	0.22	245.96	16.69
High Risk Score	530,376	6.39	0.18	498.49	31.81
Subject to Reassignment and Selected a Plan	183,858	4.90	0.26	397.39	43.19
Low Risk Score	42,346	2.30	0.27	185.48	24.63
Medium Risk Score	66,849	4.24	0.27	314.01	39.20
High Risk Score	74,663	6.96	0.24	592.24	57.30

To assess the impact of reassignment on overall Part D utilization controlling for demographic characteristics and health status, we estimate a regression model to predict total drug costs during the first three quarters of 2008. Among the population of LIS enrollees who were auto-enrolled in October 2007 and January 2008, our analysis distinguishes two populations: 1) auto-enrolled beneficiaries who were not subject to reassignment and continue to be enrolled in the same plan by January 2008, and 2) reassigned beneficiaries. The model includes race, institutional status, Medicaid and Medicare status code and Rx_HCC values. To isolate the impact of reassignment on total drug costs, our analysis computes values of this measure not allowing for differences in the composition of the reassigned and non-reassigned populations to influence values, a factor that would not be controlled for using simple statistics. We do this by using our estimated models to simulate total drug costs under the following scenarios: (i) everyone in the population is not reassigned; (ii) everyone is reassigned. The results of the regression are presented in Appendix D.

Since these computations are done over the same group of beneficiaries, no differences exist due to variation in population composition. The only difference between these scenarios arises due to the coefficients in the statistical models associated with reassignment. In this sense, the differentials reported below capture the "pure" effect of reassignment. Table 5.3 below

shows the results. The average total drug costs from Q1-Q3 2008 for reassigned beneficiaries is about \$14 (4.8 percent) lower compared to beneficiaries who remained in the same plan.

Table 5.3: Impact of Reassignment on Part D Utilization, 2008

Group	Average Q1-Q3 2008 Total Drug Costs
LIS Auto-Enrollees Not Subject To Reassignment	\$295.15
Reassigned Beneficiaries	\$281.00

5.3 Time to Refill by Reassignment Status

Next, we take a closer look at the differences in the rate at which beneficiaries refill their 2007 prescriptions depending on their reassignment status. To identify drugs that are due for refill in 2008, we first select all drugs (defined by brand name, active ingredient, administration route, dosage form and strength) that were purchased at least twice during 2007. Although imprecise, this serves as an approximate measure for drugs that are expected to be continued over time. We then select the fill with the latest date of service in 2007 and calculate the “last supply date,” which is equal to date of service plus days of supply. Only those drugs with a last supply date in 2008 are included in this analysis and only those beneficiaries with at least one drug due for refill in 2008 are included in the analysis. For each beneficiary, we calculate the percent of the drugs that were refilled and, for those drugs that were refilled, we calculate the average number of days between the last supply date and the date of service of the earliest PDE fill in 2008.

According to Table 5.4, the average percent of drugs that were refilled in 2008 varies very slightly across beneficiary groups. Compared to beneficiaries who were not subject to reassignment and remained auto-enrolled in their original plan and those who actively responded to reassignment, reassigned beneficiaries were less likely to refill their drugs, and when they did, they spent on average 6 more days to refill their medications. These suggestive findings warrant further investigation to evaluate to what extent these differences would disappear once we control for potential differences in health needs not captured by the level of the Part D clinical risk score.

**Table 5.4: Time to Refill Previously Used Drugs, by Reassignment Status
2007 Drugs to be Refilled in 2008**

Beneficiary Group	Total Beneficiaries	Average Share of Drugs that Were Refilled in 2008	Average Number of Days to First Refill
LIS Auto-Enrollees Not Subject To Reassignment	1,697,288	91%	44
Low Risk Score	350,489	92	41
Medium Risk Score	678,869	92	42
High Risk Score	667,930	90	47
Reassigned Beneficiaries	1,219,253	90	50
Low Risk Score	245,367	90	49
Medium Risk Score	482,930	90	49
High Risk Score	490,956	89	52
Subject to Reassignment and Selected a Plan	158,734	90	47
Low Risk Score	26,851	92	43
Medium Risk Score	59,699	91	45
High Risk Score	72,184	90	50

To take a first step in controlling for differences in health status and drug treatments, we conduct a subgroup analysis for those beneficiaries who had diabetes or hypertension diagnoses linked to at least one medical service in 2007 (i.e. have diabetes if either Rx_HCC17 or Rx_HCC18 is turned on and have hypertension if Rx_HCC98 is on). For each subgroup of beneficiaries, we restrict the set of drugs used in the first analysis to include only those drugs that are used to treat a particular condition. Results for these subpopulations are shown in Tables 5.5 and 5.6. In both subgroups, the average number of drugs that were not refilled in 2008, along with the average number of days to first refill is the largest among reassigned beneficiaries; but differences are modest.

The preliminary analysis presented in this section, although suggestive, necessitates further examination to control for differences in drug treatments and health needs in the population. Such controls can be implemented using multivariate regressions models to control for every clinical condition found in 2007 and for variations in treatment intensity before reassignment.

**Table 5.5: Time to Refill Previously Used Diabetes Drugs, by Reassignment Status
2007 Drugs to be Refilled in 2008
Beneficiaries with RxHCC17 or RxHCC18**

Beneficiary Group	Total Beneficiaries	Percent of Drugs that Were Refilled in 2008	Average Number of Days to First Refill
LIS Auto-Enrollees Not Subject To Reassignment	321,253	94%	33
Low Risk Score	19,915	95	31
Medium Risk Score	116,821	95	30
High Risk Score	184,517	93	36
Reassigned Beneficiaries	238,033	93	39
Low Risk Score	14,512	93	38
Medium Risk Score	85,638	94	36
High Risk Score	137,883	92	41
Subject to Reassignment and Selected a Plan	31,691	93	36
Low Risk Score	1,502	94	31
Medium Risk Score	9,987	94	32
High Risk Score	20,202	93	39

**Table 5.6: Time to Refill Previously Used Hypertension Drugs, by Reassignment Status
2007 Drugs to be Refilled in 2008
Beneficiaries with RxHCC98**

Beneficiary Group	Total Beneficiaries	Percent of Drugs that Were Refilled in 2008	Average Number of Days to First Refill
LIS Auto-Enrollees Not Subject To Reassignment	572,986	94%	32
Low Risk Score	75,038	94	31
Medium Risk Score	265,065	94	30
High Risk Score	232,883	93	33
Reassigned Beneficiaries	425,073	92	37
Low Risk Score	54,656	92	39
Medium Risk Score	197,283	92	37
High Risk Score	173,134	92	36
Subject to Reassignment and Selected a Plan	56,665	93	35
Low Risk Score	6,068	93	33
Medium Risk Score	24,324	93	34
High Risk Score	26,273	92	37

6 CHARACTERISTICS OF BENEFICIARIES AFFECTED BY THE DEMONSTRATION

To evaluate the effect of the demonstration on reassignment, we must understand how beneficiary characteristics affect response to reassignment. Previous sections showed that beneficiaries who did not accept reassignment differ from those who did. Using estimates from how beneficiaries responded to reassignment notifications, this section shows the effect of the demonstration by predicting the responses of auto-enrollees who would have also received reassignment notification were it not for the demonstration. Section 6.1 shows estimated response to reassignment notification using regression methods, and the following sub-sections use these results to show the demographic and clinical characteristics of those affected by the demonstration.

6.1 Simulating Beneficiary Response to Reassignment Notification

To estimate the effect of beneficiaries' demographic and clinical characteristics on response to reassignment, we use the response patterns of those who received reassignment notifications in October 2007. Choosing to remain in the 2007 plan in response to a reassignment notification necessarily meant that the beneficiary had to pay the amount of the premium above the regional benchmark. Choosing another plan did not necessarily mean that the beneficiary incurred a premium liability, as a beneficiary could have chosen another plan that qualified for full subsidy. Thus, a beneficiary had four distinct choices in response to receiving a reassignment notification: (1) accept reassignment, (2) choose another plan that qualifies for full subsidy, (3) choose to stay in the 2007 plan and pay the unsubsidized portion of the plan premium, or (4) choose another non-LIS qualifying plan and pay the unsubsidized portion of the plan premium. Because of the categorical nature of these responses, we use multinomial logit regression to predict beneficiary choice, which takes the following form:

$$(6.1) \quad P_{im}(y_i = m | \mathbf{x}_i) = \frac{\exp(\mathbf{x}_i \boldsymbol{\beta}_m)}{\sum_{j=1}^J \exp(\mathbf{x}_i \boldsymbol{\beta}_j)}$$

where y_i is the reassignment outcome for beneficiary i for outcomes $1 \dots 4$, and $\mathbf{x} \boldsymbol{\beta}_m$ is the linear combination of independent variables \mathbf{x} and coefficients $\boldsymbol{\beta}_m = (\beta_{0m} \dots \beta_{km} \dots \beta_{km})$ specific to outcome m . P_{im} then denotes the probability that a beneficiary with attributes “ X_i ” will chose option “ m ”.

The independent variables \mathbf{x} capture the effect of demographics and health status. Measures for gender, age, an interaction between age and gender, and race comprise the demographic effects. Medicare enrollment status, institutional status, and dual eligibility

variables capture both health and program effects. Clinical characteristics are captured using a clinical risk score and Part D utilization measures. In particular, we create the clinical risk score by summing the relative risk factors for all the HCCs identified in 2007 for a beneficiary. This differs from the RxHCC risk measure as it excludes demographic variables, which we include independently in the regression. The measures for utilization are the annual PDE costs and the number of PDE claims filed in 2007 for a beneficiary. Finally, PDP region dummy variables are used to capture regional effects (see Appendix C for regression output).

With Equation (6.1), we can predict outcome m for any combination of \mathbf{x} . Additionally, manipulating the value of x_k , while holding all other variables constant, allows us to assess the effect of x_k on outcome m . If the values of interest for x_k are r (reference) and c (comparison), then the effect for individual i equals:

$$(6.2) \quad \frac{\exp(r \times \beta_{km} + \mathbf{x}_i \boldsymbol{\beta}_m)}{\sum_{j=1}^J \exp(r \times \beta_{kj} + \mathbf{x}_i \boldsymbol{\beta}_j)} - \frac{\exp(c \times \beta_{km} + \mathbf{x}_i \boldsymbol{\beta}_m)}{\sum_{j=1}^J \exp(c \times \beta_{kj} + \mathbf{x}_i \boldsymbol{\beta}_j)}$$

For the purpose of the simulation, however, we are not interested in change for an individual, but instead changes for a population. To do this, we calculate the average predicted probability for all beneficiaries subject to reassignment under different values of x_k . The average predicted probability of outcome m for the population when $x_k = r$ is calculated by:

$$(6.3) \quad \frac{\sum_{i=1}^N P_{im}(y_i = m | x_k = r, \mathbf{x}_i)}{N}$$

To assess the effect of x_k on the population, we take the average probability of outcome m under both r and c for x_k , calculating the difference in average probabilities using the following formula:

$$(6.4) \quad \frac{\sum_{i=1}^N P_{im}(y_i = m | x_k = r, \mathbf{x}_i)}{N} - \frac{\sum_{i=1}^N P_{im}(y_i = m | x_k = c, \mathbf{x}_i)}{N}$$

Table 6.1 presents the results of the regression by showing the predicted response for different reference categories in groups and listing the differences in responses for other categories within the groups. The figures in the reference rows predicted share in each outcome setting the value for x_k to r , calculated using Equation (6.3). The values in the comparison rows are then computed using Equation (6.4). So, the first group listed in the table is by age and gender, with women aged 65 serving as the reference category. Setting all other values constant, the model predicts that 90.7 percent of women aged 65 accepted reassignment, 2.3 percent chose

another zero-premium plan, 5.7 percent stayed with their 2007 plan, and 1.3 percent elected to enroll in another plan that required partial premium payment by the beneficiary. Men of the same age are slightly more likely to accept reassignment or another zero-premium option, but less likely to choose an option that required a partial premium payment. For both men and women, older beneficiaries are also less likely to accept reassignment and choose one of the three alternatives. The interaction of age and gender indicates that the effect of age on choosing to stay in the same plan is stronger for women, but the age effect is mitigated for women when it comes to choosing another zero-premium or positive-cost plan.

Analysis by race shows that 89 percent of whites are predicted to accept reassignment. All other racial categories were more likely than whites to allow CMS to decide their 2008 plan. Differences in the probability of accepting reassignment range from nearly 1 percent higher for Native Americans to over 4 percent for Hispanics. With the exception of Native Americans being the most likely to choose a zero-premium option, whites show the highest probability of choosing one of the three alternatives to reassignment.

The next set of predictions show that disabled beneficiaries were least likely to accept reassignment, with acceptance rates of 89.8 and 89.1 for disabled and disabled with ESRD beneficiaries respectively. The patterns show that these two groups were more likely to choose another zero-premium plan or stay in the same plan, but less likely to choose a positive premium plan compared to the reference category.

Whereas institutional beneficiaries were only slightly more likely to choose reassignment compared to community beneficiaries, they were much more likely to choose a zero-premium option, at a rate 5.6 points above community members. On the other hand, they were much less likely to stay in the plan, with 6.7 percent of community beneficiaries predicted to stay in the same plan compared to 1.4 percent for institutional beneficiaries. Institutional beneficiaries were also less likely to choose another positive-premium option.

Moving to clinical characteristics, it is clear that the health status of a beneficiary affected a beneficiary's willingness to accept reassignment. High risk beneficiaries (those with scores at the 75th percentile) were predicted to accept reassignment at a rate 1.2 percent below low risk beneficiaries (those with scores at the 25th percentile). Both Part D utilization measures also positively predict each of the three alternatives to reassignment. A beneficiary who files about 6 claims a month is 1.1 percent less likely to accept reassignment compared to one who files 1 a month, and a beneficiaries who have annual costs placing them in the coverage gap threshold are 0.4 percent less likely to allow CMS to redirect them to another plan. High risk and utilization beneficiaries are all more likely to choose one of the three alternatives compared to low risk and

Table 6.1: Predictor of Beneficiary Response, 2007-2008

Beneficiary Characteristics	Response to Reassignment Notification			
	Reassigned	Choose Zero-Premium	Stay in Same Plan	Choose Positive-Premium
<u>Gender/Age</u>				
Female 65	90.7%	2.3%	5.7%	1.3%
Compared to				
Female 85	-0.8	0.4	0.3	0.1
Male 65	0.2	0.1	-0.2	-0.2
Male 85	-0.7	0.5	0.2	0.0
<u>Race</u>				
White	89.0%	2.9%	6.9%	1.1%
Compared to				
Black	1.7	-0.6	-0.9	-0.3
Hispanic	4.1	-1.3	-2.5	-0.4
Asian	1.8	-0.5	-1.3	0.0
Native American	0.9	1.4	-2.0	-0.3
Other Race	2.2	-0.7	-1.4	-0.1
<u>Medicare Status</u>				
Aged	90.0%	2.6%	6.3%	1.1%
Compared to				
Aged with ESRD	0.3	0.1	-0.1	-0.4
Disabled	-0.2	0.2	0.1	-0.1
Disabled with ESRD	-0.9	0.4	0.7	-0.2
ESRD	0.5	-0.1	-0.3	-0.2
<u>Setting</u>				
Community	90.0%	2.1%	6.7%	1.1%
Compared to				
Institutional	0.3	5.6	-5.3	-0.6
<u>LIS Eligibility</u>				
Deemed	90.0%	2.7%	6.3	1.1%
Compared to				
Non-Deemed	-2.6	0.1	2.0	0.5
<u>Risk Scores</u>				
Low Clinical Risk	90.7%	2.4%	6.0%	0.9%
Compared to				
High Clinical Risk	-1.2	0.4	0.5	0.2
<u>PDE Claims</u>				
12 Claims	90.8%	2.4%	5.9%	0.9%
Compared to				
70 Claims	-1.1	0.3	0.6	0.2
<u>Out of Pocket Costs</u>				
\$240	90.7%	2.5%	5.8%	1.0%
Compared to				
\$2,600	-0.4	0.1	0.3	0.0

utilization beneficiaries. This pattern is consistent with the notion that beneficiaries with more severe health conditions will be more sensitive to a plan's ability to meet their pharmaceutical needs.

The patterns reflected in these results show that need is positively associated with choosing one of the three alternatives to reassignment. While none of the effects alone are large, we must consider that many of these effects are cumulative. Thus, a beneficiary who is older, high risk, and has high utilization (all three of which are likely positively related) will be much more likely to choose an alternative to reassignment compared to a younger, low-risk, low-utilization beneficiary.

6.2 Demographic Characteristics of Beneficiaries Affected by the Demonstration

Using the regression results, we can predict the response to a reassignment notification for those beneficiaries who were in plans that would have lost auto-enrollment status had the regional benchmark been calculated using full enrollment weights and the \$1 *de minimis* rule not been applied. This simulation entails using the predicted probabilities for the demonstration-affected beneficiaries. We exclude from this group those who moved to another PDP region, lost LIS status, or died during the time between receipt of reassignment notification and January 2008.

Table 6.2 compares the share of beneficiaries who accepted reassignment to the predicted shares for those affected by the demonstration. The share accepting reassignment is of those who did not move to another PDP region, lose LIS status, or die in the period between reassignment notification and January 2008. The first column shows the number of beneficiaries in each group who received a reassignment notification and the second shows the number who additionally would have received a notification were it not for the demonstration.

The last two columns list the shares, by group, who accepted reassignment and those who are predicted to accept reassignment. The final column uses predicted probabilities for the beneficiaries affected by the demonstration. These numbers should not differ substantially from the shares of those who were actually reassigned, as the groups are defined by variables used to predict reassignment. However, dissimilarities in the composition of the groups affect the probabilities, thus differences between actual reassignment and predictions indicate that members in each category differ on other characteristics that affect the response to receiving a reassignment notification. Looking at the age and gender groups, we see that the demonstration-affected groups are predicted to accept reassignment at rates similar to—though in some cases slightly lower than—that of the comparable groups who did accept reassignment. Women under the age of 65 who received a reassignment notification accepted the assigned plan at a rate of 90

percent, whereas the demonstration-affected women in the same age bracket show a predicted acceptance rate of 89 percent. The actual and predicted acceptance rates each drop by 1 percent for women 85 and older. Aged and disabled beneficiaries with ESRD show the lowest acceptance rate, at 88 percent, among the five Medicare status groups, with disabled-only and ESRD-only beneficiaries accepting reassignment at a rate of 90 percent. Among the different racial categories, whites were the most likely to choose another plan, at a rate of 12 percent, and Hispanics were least likely to choose another plan with only 7 percent opting to choose a plan other than the one assigned. Institutional beneficiaries affected by the demonstration are predicted to have the lowest acceptance rate, at 87 percent. Finally, of the 734,098 dual eligible beneficiaries affected by the demonstration, 89 percent are predicted to have accepted reassignment.

Table 6.2: Characteristics of Beneficiaries Affected by Demonstration, 2007-2008

Characteristics	Received Reassignment Notification		Share Accepting Reassignment	
	Under Demo	Affected by Demo	Under Demo	Affected by Demo
Female Age				
0-64	461,473	175,008	90%	89%
65-74	339,088	122,390	89	89
75-84	286,555	99,602	89	88
85+	160,917	55,442	89	88
Male Age				
0-64	482,625	187,538	91	90
65-74	215,890	83,035	91	90
75-84	127,595	46,980	90	89
85+	37,769	14,154	90	88
Medicare Status				
Aged without ESRD	1,189,544	440,350	89	89
Aged with ESRD	11,012	3,992	88	88
Disabled without ESRD	882,998	328,079	91	90
Disabled with ESRD	16,399	5,787	89	88
ESRD only	5,231	2,069	91	90
Race/Ethnicity				
White	1,272,066	470,496	89	88
Black	410,101	147,201	91	90
Hispanic	197,168	70,285	93	93
Asian	151,904	60,779	91	91
Native American	19,766	12,362	92	89
Other	5,286	1,932	91	90
Institutional Status	146,387	50,692	87	87
Dual Eligible	1,995,243	734,098	90	89

6.3 Part D Utilization and Clinical Characteristics of Beneficiaries Affected in Absence of the Demonstration

Next we move to reassignment by health characteristics. Table 6.3 presents statistics calculated in the same manner as those presented in Table 6.2 but for categories by health characteristics. The first set of rows shows by PDE count the numbers within each range that received a reassignment notice in 2007 and the numbers for those who would have received a notice without the demonstration. The last two columns show the share of the notified and demonstration-affected groups that either accepted reassignment or are predicted to accept reassignment. We see that the reassignment rate differs little between those who were subject to reassignment and those who would have been, with shares for the predicted either equal or within 2 percent below the actual accepted figures. Those with 0 to 5 claims in 2007 were most likely to accept reassignment, at a rate of 92 percent; the acceptance rate drops to 85 percent for those filing more than 80 claims in 2007. As expected, a similar pattern exists for monthly costs, where 92 percent of those affected by the demonstration that incurred less than an average of \$20 per month in drug costs were predicted to accept reassignment, but only 85 percent of those with more than \$425 per month in costs accepted the plan assigned by CMS.

Table 6.3: Clinical Characteristics of Beneficiaries Affected by Demonstration, 2007-2008

Characteristics	Received Reassignment Notification		Share Accepting Reassignment	
	Under Demo	Affected by Demo	Under Demo	Affected by Demo
Number of 2007 PDEs				
0 to 5	396,746	187,528	94%	92%
6 to 10	112,177	47,430	92	91
11 to 20	223,987	87,560	91	91
21 to 30	213,501	78,240	90	90
31 to 40	195,017	68,633	90	90
41 to 50	173,653	58,926	89	89
51 to 60	151,772	50,714	89	89
61 to 70	129,935	42,134	88	88
71 to 80	108,843	35,123	88	87
81 +	406,501	127,953	87	85
Monthly PDE Costs				
\$0 to \$20	460,141	213,269	94	92
\$20 to \$188	693,103	260,661	91	90
\$188 to \$425	503,311	170,133	88	88
\$425 +	455,577	140,178	86	85
RxHCC Score				
Low RxHCC	664,234	258,264	93	91
Medium RxHCC	757,475	299,143	90	90
High RxHCC	690,423	226,834	88	87

The last set of rows shows the effect of the demonstration on beneficiaries with different levels of risk. The low risk category are those with RxHCC scores below 0.9, the medium risk score beneficiaries show scores between 0.9 and 1.3, and high risk beneficiaries are classified as those with scores above 1.3. Those with low risk scores are more likely accept reassignment, with 91 percent of the affected beneficiaries in this group predicted to take the plan assigned to them. Medium risk beneficiaries show a reassignment rate 1 percent below the low risk group, and 87 percent of high risk beneficiaries are predicted to accept reassignment.

7 CONCLUSION

To minimize the effects of the 2007 enrollment weight methodology on the availability of plans serving the LIS population, CMS launched the “Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries.” Under this demonstration, CMS calculated the 2007 low-income regional benchmarks using the same methodology as in 2006. This demonstration was later amended in two ways. First, it extended the transition period to 2008. In 2008, 50 percent of the regional low-income benchmark amount was based on the 2006 weighting methodology, and 50 percent was based on the enrollment-weight methodology. Second, with the *de minimis* policy, CMS would require plans to charge full-subsidy eligible beneficiaries the applicable premium subsidy amount as long as the premium was within the *de minimis* amount of the LIS subsidy amount, which was \$2 in 2007 and \$1 in 2008.

This report evaluates the impact of the demonstration in four core areas:

- 1) Availability of zero-premium plans, which have a monthly premium equal to or below the low-income benchmark
- 2) Response of beneficiaries to changes in plan availability
- 3) Stability of drug utilization
- 4) Characteristics of beneficiaries affected by the demonstration

A summary of our findings are described below.

7.1 Availability of Zero-Premium Plans

We examine how changes in regional benchmarks affected the number of plans available as zero-premium plans for full subsidy LIS beneficiaries. Our main findings are:

- The demonstration increased the number of zero-premium plans from 213 to 638 in 2007 and from 341 to 495 in 2008.
- The increase was seen across all regions. The regional average of zero-premium plans increased from 6 to 19 in 2007 and from 10 to 15 in 2008. Under the demonstration, all regions had at least 5 zero-premium plans. Without demonstration, there would have been 6 regions with 2 or fewer plans to choose from.

7.2 Beneficiary Response to Changes in Plan Availability

Next, we present the patterns of responses of beneficiaries who received reassignment notification. Our results reveal the following:

- Of the 1.9 million beneficiaries who received a reassignment notice in 2007 and remained eligible for reassignment in 2008, about 90 percent of them did not respond and were reassigned to another plan by CMS in January 2008. A little more than 6 percent chose pay a positive premium to stay in their plan in 2008. Another 3.7 percent actively switched to a different plan. However, these patterns varied widely across regions.
- Demographic characteristics and Medicare status also affected responses. Women, whites and older beneficiaries are less likely to accept reassignment. Disabled beneficiaries are less likely to accept reassignment and more likely to either choose to stay in the same plan or choose another zero-premium option. Institutional beneficiaries are also more likely to choose another zero-premium plan, compared to community beneficiaries, but less likely to choose to stay in the same plan.
- The health characteristics of beneficiaries consistently predicted whether they chose one of the three alternatives to reassignment. High-risk, high-utilization beneficiaries were more likely to choose each of the three alternatives compared to low-risk, low-utilization beneficiaries.

7.3 Stability of Drug Utilization

Our main findings regarding the impact of plan reassignment on drug offerings and utilization are:

- On average, LIS beneficiaries who were reassigned filled their prescriptions under slightly more restrictive formularies in Q3 2008 compared to Q3 2007. The percent of drugs under formularies dropped from 98 percent to 96 percent and the percent of drugs subject to quantity limits increased from 21 percent to 28 percent. However, this group of beneficiaries had comparable restrictions to the group of beneficiaries who were subject to reassignment but chose a different plan.
- Preliminary evidence shows that reassigned beneficiaries increased their Part D consumption at a slightly lower rate compared to beneficiaries who were able to remain in the same plan until the beginning of 2008. Multivariate regression should be applied to confirm these findings.

- Preliminary evidence shows that reassigned beneficiaries took slightly longer to continue their 2007 treatments compared to beneficiaries who were not reassigned. The average rate of refill in 2008 was 90 percent for this group and 91 percent for the non reassigned group. On average, reassigned beneficiaries took 50 days to refill their 2007 drugs while non reassigned beneficiaries refilled their prescriptions every 44 days on average. These results are similar when we restrict the sample to include only beneficiaries with specific chronic conditions and when we restrict the set of drugs to include only those drugs relevant for these conditions. A multivariate regression model should be applied to confirm these findings. Moreover, sensitivity analysis on further restrictions of drugs is warranted.

7.4 Characteristics of Beneficiaries Affected by the Demonstration

In Chapter 3, we estimated the number of beneficiaries who would have been reassigned had the demonstration not been in effect. In Chapter 6, we identified patterns of responses to reassignment notifications based on beneficiary characteristics, and applied these patterns to beneficiaries affected by the demonstration (those who would have received reassignment notifications were it not for the demonstration). The results can be summarized as follows:

- Under the demonstration, the number of LIS beneficiaries who would have been reassigned dropped from over 4 million to 1,166,524 in 2007 and from 2,895,426 to 2,111,255 in 2008.
- Without the demonstration, 78 percent of LIS auto-enrolled beneficiaries would have been reassigned in 2007 and about 55 percent in 2008.
- Those affected by the demonstration are predicted to have nearly identical responses to reassignment compared to those who received reassignment letters in 2007. While not surprising, it shows that the composition of the demonstration-affected beneficiaries is similar to the composition of those who found themselves in plans that no longer qualified for full subsidy reimbursement in the following year. Thus, while the demonstration decreased the numbers of those reassigned, it does not appear to have a disparate impact on different beneficiary groups.

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APPENDIX A: DATA SOURCES AND METHODS

In this appendix, we briefly review the data sources and key definitions used in the report.

Table A.1: Data Sources

Variable	Data Source	Extraction Date
LIS Eligibility	CME LIS	July 2008
Part D Enrollment	CME PBP Elect	July 2008
Plan Premium	HPMS PBP Extract Plan Information File	2006, 2007 and 2008
Auto/Facilitated Status	CME PBP Elect	July 2008
PBP Region	HPMS Plan Service Area	2006, 2007 and 2008
LIS Benchmarks	CMS Office of the Actuary	
PDE Use	2006-2007 PDE SAF	
Formulary Restrictions	HMPS Formulary File	2006, 2007, and 2008
Rx_HCCs and Risk Scores	Part A&B SAFs	
Institutional Status	MMDF	January 2007 and 2008
Medicaid Eligibility	EDB	January 2008

Identifying Beneficiaries who Received Annual Reassignment Notification

Beneficiaries who received a reassignment notification for CY2007 were identified using the enrollment type code on the Common Medicare Environment (CME) PBP Elect table and the PBP Extract by looking at Beneficiaries who met the following criteria:

- a) Enrolled in October in 2006 in a plan that would no longer meet the LIS regional benchmark for CY2007
- b) 100% LIS eligible in October 2006
- c) Had a code of 'C' or 'A' in the enrollment type code

Identifying Reassigned Beneficiaries

Among beneficiaries who received a notification, to identify beneficiaries who were reassigned in 2007, we use the following rules:

Group 1: Beneficiaries who are 100% LIS eligible, who are enrolled in a LIS qualifying plan in January 1, 2007 with a code of 'C' or 'A' the in enrollment type code.

Group 2: Beneficiaries with a code of ‘B’, an application date of November 14, 2006, and a contract-plan start date of January 1, 2007. These beneficiaries must have been auto-enrolled into their previous contract-plan (as indicated by a ‘C’ or ‘A’ code on the CME).

Group 3: Beneficiaries with a code of ‘B’ who were enrolled in 2006 in one of five contracts that were given permission to reassign their beneficiaries on behalf of CMS. The beneficiary must have been auto-enrolled into this contract-plan (as indicated by a ‘C’ or ‘A’ on the CME) and must have been switched to a specific corresponding contract-plan on January 1, 2007. This information was provided by CMS.

To identify beneficiaries who were reassigned in 2008 we use the following rule:

Group 1: Beneficiaries who are 100% LIS eligible, who are enrolled in a LIS qualifying plan in January 1, 2008 with a code of ‘H’ in the in enrollment type code.

APPENDIX B: TRANSITIONS FROM 2006 TO 2007

Under the demonstration, 1,166,524 LIS beneficiaries were sent a reassignment notification in November 2006. These beneficiaries were full subsidy Part D beneficiaries who had been auto-enrolled in a plan and had not switched from that plan during the year. The notifications inform beneficiaries of the plan to which they will be reassigned, as well as how to either stay in their current plan or select a new plan. These beneficiaries could respond to the letter in one of four ways:

- (a) Take no action and be enrolled in the assigned plan in January,
- (b) Select a different zero-premium plan,
- (c) Choose to stay in the same plan and start paying part of the premium, or
- (d) Select different plan with a positive premium.

In section 4 we examined how LIS auto-enrollees responded to reassignment notification in 2007. Below, we show the results for 2006. Table B.1 presents regional statistics showing the percent of beneficiaries who accepted reassignment and the percent of beneficiaries making each potential choice. Table B.2 compares each group by their demographic characteristics and health status, while Table B.3 presents a comparison by Part D usage during 2006.

Table B.1: Beneficiary Response to Reassignment Notification, 2006-2007

PDP Region	Received a Reassignment Notification	Still Eligible for Auto-Enrollment January 2007	Beneficiaries Subject to Reassignment and Eligible for Auto-Enrollment in January 2007			
			% Reassigned in January 2007	% Moved to a Zero-Premium Plan Other Than Reassignment	% Stayed in Same Plan	% Moved to a Positive Premium Plan
1	10,210	9,394	88%	7.5%	4.7%	0.2%
2	42,752	39,512	96	2.6	1.8	0.1
3	151,690	137,028	86	3.4	10.0	0.6
4	6,392	6,040	99	0.6	0.2	0.1
5	13,560	12,502	94	1.9	4.2	0.4
6	18,587	17,081	91	2.4	6.0	0.2
7	11,832	11,077	91	1.5	7.5	0.2
8	26,140	24,607	93	1.5	5.3	0.2
9	3,735	3,476	99	0.5	0.1	0.1
10	19,986	18,245	98	1.3	0.9	0.2
11	125,863	114,586	98	0.8	0.2	0.5
12	49,544	44,022	93	1.8	5.0	0.3
13	6,574	6,156	99	0.6	0.2	0.1
14	67,560	62,439	95	2.3	2.7	0.2
15	23,515	21,882	87	2.5	9.8	0.3
16	27,570	25,158	91	2.3	6.3	0.2
17	23,210	21,432	91	1.1	7.8	0.2
18	22,056	20,049	99	0.8	0.2	0.2
19	11,177	10,426	90	1.3	8.2	0.2
20	4,816	4,558	99	0.6	0.2	0.3
21	49,380	46,713	89	2.8	7.5	0.5
22	71,455	66,871	86	2.5	11.5	0.3
23	9,586	8,965	91	1.6	7.4	0.2
24	4,982	4,595	88	2.4	9.7	0.3
25	18,440	17,099	90	2.7	6.8	0.2
26	13,601	12,281	93	0.9	5.9	0.4
27	0	-	-	-	-	-
28	23,290	20,315	92	1.3	6.8	0.3
29	10,394	9,318	94	0.9	4.5	0.4
30	20,813	18,839	92	1.9	6.0	0.1
31	5,647	5,213	89	3.3	7.1	0.3
32	265,358	249,883	98	0.3	1.2	0.3
33	4,665	4,274	92	1.4	6.3	0.1
34	2,144	2,010	91	2.0	6.4	0.3
Total	1,166,524	1,076,046	93%	1.7%	4.7%	0.3%

Table B.2: Demographic Characteristics of LIS Beneficiaries by Response to Reassignment Notification, 2006-2007

Beneficiary Characteristics	All LIS Auto-Enrollees as of October 2006	Received Reassignment Notification	Reassigned in January 2007	Moved to Another Zero-Premium Plan	Stayed in Original Plan	Moved to a Positive Premium Plan
Number of Beneficiaries	5,196,388	1,166,524	1,004,190	18,324	50,075	3,457
Age (%)						
0-64	46.0	43.2	43.1	36.7	45.9	34.9
65-74	25.5	27.1	27.1	26.9	30.2	31.4
75-84	19.1	20.2	20.5	23.1	17.1	22.8
85+	9.4	9.5	9.3	13.3	6.9	10.9
Gender (%)						
Male	40.8	40.8	40.1	34.9	45.0	35.8
Female	59.2	59.2	59.9	65.1	55.0	64.2
Medicare Status (%)						
Aged without ESRD	55.7	58.2	58.2	65.0	57.2	68.6
Aged with ESRD	0.5	0.6	0.5	0.7	0.5	0.7
Disabled without ESRD	42.5	40.0	40.0	33.0	41.1	29.6
Disabled with ESRD	0.8	0.7	0.7	0.7	0.7	0.7
ESRD only	0.3	0.3	0.3	0.3	0.4	0.3
Race/Ethnicity (%)						
White	62.6	60.3	59.6	71.9	65.5	59.7
Black	21.5	19.6	19.6	15.5	20.2	19.4
Asian	5.4	6.8	7.3	4.0	3.6	8.1
Hispanic	7.0	9.3	9.7	4.6	7.3	8.6
Other	3.4	3.9	3.9	4.1	3.5	4.3
Institutional Status (%)	7.3	6.9	7.2	17.9	2.3	11.9
Dual Eligible (%)	94.4	95.2	96.8	93.5	60.9	93.3

Table B.3: Part D Use Among LIS Beneficiaries by Response to Reassignment Notification, 2006-2007

	All LIS Auto-Enrollees as of October 2006	Received Reassignment Notification	Reassigned in January 2007	Moved to Another Zero-Premium Plan	Stayed in Original Plan	Moved to a Positive Premium Plan
Number of PDEs in 2006 (%)						
0	13.6	11.9	11.7	4.9	6.4	4.9
1 to 5	7.4	6.9	7.1	3.2	5.0	3.7
6 to 10	5.6	5.3	5.4	2.9	4.7	3.9
11 to 20	10.7	10.6	10.8	7.3	10.2	9.1
21 to 30	9.9	10.1	10.3	8.0	10.6	9.6
31 to 40	8.9	9.2	9.3	8.3	10.3	10.0
41 to 50	7.9	8.2	8.2	8.2	9.2	9.8
51 to 60	6.9	7.2	7.2	8.1	8.1	8.8
61 to 70	5.9	6.2	6.1	7.7	7.0	7.4
71 to 80	4.9	5.2	5.1	7.0	6.0	6.5
81 +	18.5	19.3	18.8	34.5	22.7	26.4
Average Monthly Drug Cost (2006) (%)						
\$0 - \$20	24.8	22.4	22.6	10.0	13.9	10.7
\$20 - \$188	33.7	33.9	34.4	27.9	32.0	32.2
\$188 - \$425	23.0	24.1	23.9	30.0	27.4	29.8
\$425 +	18.5	19.7	19.1	32.1	26.8	27.3
Average Month						
Number of PDEs	3.7	3.9	3.8	5.6	4.4	4.9
Drug Cost	267.52	282.91	276.31	403.57	379.34	377.44

APPENDIX C: REGRESSION RESULTS: BENEFICIARY RESPONSE

Table C.1 presents the results for the multinomial logit regression, omitting regional effect variables. The first column presents coefficients showing the effect of the explanatory variables on choosing between accepting reassignment or choosing another zero-premium plan. The second column lists the effects of beneficiary characteristics on choosing between accepting reassignment and staying in the same plan. The final column shows the logit coefficients predicting choice between accepting reassignment or choosing another positive-premium plan.

Table C.1: Predictor of Beneficiary Response, 2007-2008

Variable	Choose Zero-Premium over Reassignment		Choose Same Plan over Reassignment		Choose Another Positive Premium Plan over Reassignment	
	Coefficient	Standard Error	Coefficient	Standard Error	Coefficient	Standard Error
Demographics						
Female	0.05643	0.03851	0.03250	0.02413	0.40907	0.05896
Age	0.00905	0.00064	0.00343	0.00040	0.00727	0.00100
Female*Age	-0.00140	0.00057	-0.00001	0.00038	-0.00420	0.00091
White	--	--				
Black	-0.25840	0.01318	-0.15498	0.00851	-0.27571	0.02123
Hispanic	-0.63585	0.02208	-0.49778	0.01152	-0.45350	0.03081
Asian	-0.22943	0.02374	-0.22828	0.01209	0.01849	0.03046
Native American	0.41050	0.04504	-0.36384	0.03979	-0.31270	0.08086
Other Race	-0.29999	0.03280	-0.26114	0.01846	-0.16185	0.04602
Medicare Characteristics						
Aged	--	--				
Aged with ESRD	0.03092	0.05638	-0.01405	0.04100	-0.39422	0.11275
Disabled	0.07804	0.01778	0.01167	0.01133	-0.09174	0.02671
Disabled with ESRD	0.15478	0.05388	0.11452	0.03297	-0.18615	0.08892
ESRD	-0.02747	0.10719	-0.05607	0.06146	-0.21057	0.16354
Institutional	1.31845	0.01241	-1.54432	0.02182	-0.77512	0.03426
Dual Eligible	-0.07532	0.04483	-0.31881	0.02481	-0.42530	0.05483
Health Characteristics						
Clinical Risk Score	0.24435	0.01068	0.13620	0.00715	0.25968	0.01660
Total Part D Spending	0.00001	0.00000	0.00002	0.00000	0.00002	0.00000
Number Claims Filed	0.00238	0.00012	0.00192	0.00009	0.00325	0.00018
N = 1,887,267						

APPENDIX D: REGRESSION RESULTS: MONTHLY DRUG COSTS

Table D.1 presents the results for the ordinary least squares regression, omitting regional effect variables on 2008 Q1-Q3 monthly drug costs. In particular, we are looking at the effect of reassignment on monthly drug costs.

Table D.1: Predictor of Monthly Drug Costs, 2008 Q1-Q3

Monthly Cost 2008 Q1Q3	Coef.	Std. Err.	t	P>t	[95% Conf.	Interval]
Reassigned	-14.121	0.235	-60.1	0	-14.581	-13.660
Race						
Black	-10.444	0.302	-34.61	0	-11.035	-9.852
Hispanic	-8.379	0.455	-18.4	0	-9.271	-7.486
Asian	-0.741	0.512	-1.45	0.147	-1.744	0.262
Other	-4.797	0.620	-7.74	0	-6.011	-3.582
Age						
0 to 64	17.113	0.292	58.7	0	16.542	17.684
80+	-4.897	0.377	-12.98	0	-5.636	-4.158
Other Characteristics						
Female	-0.079	0.254	-0.31	0.756	-0.577	0.419
ESRD	27.949	1.254	22.28	0	25.490	30.407
Institutional	-13.070	0.579	-22.58	0	-14.205	-11.936
Monthly Cost 2007	0.913	0.000	2665.86	0	0.913	0.914
rxhcc1_07	217.948	1.253	173.98	0	215.492	220.403
rxhcc2_07	15.839	2.252	7.03	0	11.425	20.253
rxhcc3_07	1.714	1.055	1.62	0.104	-0.354	3.782
rxhcc8_07	35.868	6.093	5.89	0	23.927	47.809
rxhcc9_07	75.934	1.256	60.43	0	73.472	78.397
rxhcc10_07	11.578	0.691	16.76	0	10.224	12.931
rxhcc17_07	19.524	0.419	46.55	0	18.702	20.346
rxhcc18_07	12.004	0.341	35.25	0	11.336	12.671
rxhcc19_07	1.602	0.278	5.75	0	1.056	2.148
rxhcc20_07	9.240	0.719	12.85	0	7.830	10.650
rxhcc21_07	2.831	0.313	9.04	0	2.217	3.445
rxhcc24_07	2.670	1.109	2.41	0.016	0.497	4.843
rxhcc31_07	3.039	1.310	2.32	0.02	0.471	5.607
rxhcc33_07	21.447	1.472	14.57	0	18.561	24.333
rxhcc34_07	-0.580	0.537	-1.08	0.28	-1.632	0.473
rxhcc37_07	4.349	0.326	13.34	0	3.710	4.988
rxhcc39_07	-8.101	1.151	-7.04	0	-10.357	-5.846

Monthly Cost 2008 Q1Q3	Coef.	Std. Err.	t	P>t	[95% Conf.	Interval]
rxhcc40_07	10.411	1.187	8.77	0	8.085	12.737
rxhcc41_07	15.045	0.791	19.02	0	13.495	16.596
rxhcc42_07	11.884	1.364	8.71	0	9.211	14.557
rxhcc43_07	6.866	2.493	2.75	0.006	1.980	11.752
rxhcc44_07	37.303	3.571	10.45	0	30.305	44.301
rxhcc45_07	6.097	0.372	16.37	0	5.367	6.827
rxhcc47_07	0.212	0.445	0.48	0.634	-0.660	1.084
rxhcc48_07	2.005	0.275	7.28	0	1.465	2.545
rxhcc51_07	-1.972	1.724	-1.14	0.253	-5.351	1.407
rxhcc52_07	3.921	2.568	1.53	0.127	-1.112	8.953
rxhcc54_07	2.526	3.003	0.84	0.4	-3.361	8.412
rxhcc55_07	3.184	0.760	4.19	0	1.695	4.673
rxhcc57_07	14.218	1.700	8.36	0	10.886	17.551
rxhcc59_07	40.910	0.980	41.75	0	38.989	42.830
rxhcc60_07	22.261	0.514	43.27	0	21.252	23.269
rxhcc65_07	44.365	0.507	87.45	0	43.371	45.359
rxhcc66_07	17.010	0.295	57.57	0	16.431	17.589
rxhcc67_07	12.568	1.810	6.94	0	9.020	16.116
rxhcc75_07	5.377	1.626	3.31	0.001	2.190	8.563
rxhcc76_07	19.951	4.569	4.37	0	10.995	28.906
rxhcc77_07	-0.181	0.951	-0.19	0.849	-2.044	1.683
rxhcc78_07	-19.536	3.495	-5.59	0	-26.385	-12.687
rxhcc79_07	8.881	0.633	14.02	0	7.640	10.122
rxhcc80_07	104.710	1.390	75.32	0	101.985	107.434
rxhcc81_07	11.538	1.032	11.18	0	9.516	13.560
rxhcc82_07	11.470	3.764	3.05	0.002	4.092	18.847
rxhcc83_07	23.008	0.489	47.05	0	22.050	23.967
rxhcc85_07	7.524	0.773	9.73	0	6.008	9.039
rxhcc86_07	6.880	0.569	12.09	0	5.765	7.995
rxhcc87_07	2.377	0.700	3.4	0.001	1.005	3.749
rxhcc91_07	3.996	0.474	8.43	0	3.067	4.925
rxhcc92_07	2.005	0.350	5.72	0	1.318	2.692
rxhcc98_07	1.611	0.295	5.45	0	1.032	2.190
rxhcc99_07	-0.919	0.480	-1.91	0.056	-1.860	0.023
rxhcc102_07	4.022	0.405	9.93	0	3.228	4.816
rxhcc105_07	3.985	0.819	4.87	0	2.380	5.590
rxhcc106_07	5.478	0.388	14.1	0	4.716	6.239
rxhcc108_07	110.749	6.510	17.01	0	97.990	123.508
rxhcc109_07	11.745	0.316	37.19	0	11.126	12.364
rxhcc110_07	9.792	1.588	6.16	0	6.679	12.905
rxhcc111_07	10.813	1.171	9.24	0	8.518	13.108

Monthly Cost 2008 Q1Q3	Coef.	Std. Err.	t	P>t	[95% Conf.	Interval]
rxhcc112_07	-3.759	3.707	-1.01	0.311	-11.024	3.506
rxhcc113_07	-1.231	0.478	-2.58	0.01	-2.167	-0.295
rxhcc120_07	1.713	0.735	2.33	0.02	0.272	3.155
rxhcc121_07	0.993	0.557	1.78	0.075	-0.099	2.084
rxhcc122_07	5.671	0.565	10.03	0	4.563	6.779
rxhcc123_07	4.917	1.245	3.95	0	2.476	7.357
rxhcc126_07	-4.388	2.916	-1.5	0.132	-10.104	1.329
rxhcc129_07	-2.362	0.381	-6.2	0	-3.109	-1.615
rxhcc130_07	-4.040	1.989	-2.03	0.042	-7.938	-0.141
rxhcc132_07	-34.243	1.740	-19.68	0	-37.653	-30.832
rxhcc134_07	30.341	0.865	35.07	0	28.645	32.037
rxhcc135_07	9.669	1.675	5.77	0	6.386	12.952
rxhcc137_07	1.742	0.642	2.71	0.007	0.484	3.000
rxhcc138_07	-0.422	2.425	-0.17	0.862	-5.175	4.331
rxhcc139_07	8.901	0.655	13.59	0	7.617	10.186
rxhcc140_07	4.120	0.439	9.39	0	3.260	4.980
rxhcc144_07	-1.688	0.704	-2.4	0.016	-3.068	-0.308
rxhcc145_07	0.098	1.375	0.07	0.943	-2.596	2.793
rxhcc157_07	-0.426	0.689	-0.62	0.537	-1.777	0.926
rxhcc158_07	14.558	1.372	10.61	0	11.868	17.247
rxhcc159_07	-1.720	0.410	-4.19	0	-2.525	-0.916
rxhcc160_07	0.638	0.726	0.88	0.38	-0.785	2.061
rxhcc165_07	11.918	1.471	8.1	0	9.035	14.802
rxhcc166_07	10.528	2.485	4.24	0	5.657	15.399
rxhcc186_07	1.893	2.527	0.75	0.454	-3.059	6.846
rxhcc187_07	2.389	2.590	0.92	0.356	-2.686	7.465
Constant	17.855	0.344	51.9	0	17.181	18.529

APPENDIX E: STATES BY PDP REGION

Table E.1: States by PDP Region

PDP Region	State(s)
1	NH, ME
2	CT, MA, RI, VT
3	NY
4	NJ
5	DE, DC, MD
6	PA, WV
7	VA
8	NC
9	SC
10	GA
11	FL
12	AL, TN
13	MI
14	OH
15	IN, KY
16	WI
17	IL
18	MO
19	AR
20	MS
21	LA
22	TX
23	OK
24	KS
25	IA, MN, MT, ND, NE, SD, WY
26	NM
27	CO
28	AZ
29	NV
30	OR, WA
31	ID, UT
32	CA
33	HI
34	AK