

Primary Care Physicians' Views of Medicare Part D

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Since January 2006, Medicare Part D has covered outpatient prescription drugs for many Medicare beneficiaries and all Medicare-Medicaid dual-eligible beneficiaries. The transition to Part D was difficult for seniors, and their preliminary opinions of Part D were mixed.¹ However, opinion polls have shown a notable increase in seniors' satisfaction with Part D over time.^{2,3} To date, most research on seniors' experiences under Part D has focused on the initial transition period from Medicaid to Medicare in early 2006 and not their experiences under the more stable period that followed. Although existing research has shown that Part D increased seniors' utilization and decreased their out-of-pocket costs on average,^{4,6} other effects of Part D and its impact in selected populations—including minorities, patients with greater clinical needs, and seniors with previous prescription drug coverage—have not been studied. For Medicare beneficiaries without prior drug coverage, Part D is expected to have improved their access to prescription drugs. For seniors with drug coverage before becoming eligible for Part D enrollment, however, access may have improved or worsened depending on the generosity of their prior coverage relative to the Part D benefit. To examine these issues, we conducted a Web-based survey of primary care physicians' opinions regarding Medicare Part D.

In this article we analyze how physicians viewed the Part D benefit and its effects on their patients' access to prescription drugs as of late 2007 and early 2008. This is important because the effects of Medicare Part D on seniors' access to prescription drugs likely depend partly on the availability and design of coverage before and after Part D's implementation. Prescription drug plans typically rely on formularies to limit expenditures, both directly by altering patients' cost-sharing arrangements⁷ and indirectly by shifting physicians' prescribing habits. Prior to Part D, most seniors who had prescription drug coverage obtained it through their employers, Medicaid, or Medicare supplemental plans. Under Part D, seniors have a wider choice of plans and associated formularies, including Part D plans, Medicare Advantage plans that cover prescription drugs, and employer-sponsored coverage. Part D plans vary across a range of dimensions, including their copayment

levels, which drugs they cover, whether any insurance is provided to cover the "donut hole," and the types of supply-side controls (eg, prior authorization requirements) that they use.^{8,9} Variety among plans may have offsetting effects on access: it may improve enrollees'

Objective: To examine physicians' attitudes about the impact of Medicare Part D and how it varied among seniors, particularly Medicare-Medicaid dual-eligible enrollees.

Study Design: Web-based survey of primary care physicians in North Carolina (generous Medicaid formulary) and Florida, Massachusetts, and Texas (restrictive Medicaid formularies).

Methods: Of 5141 eligible primary care physicians, 716 (14%) responded between November 2007 and March 2008. We examined Part D's effects on access overall and for selected populations. We used descriptive and regression analyses to assess physicians' views about Part D's effects on dual-eligible enrollees and how those views differed between North Carolina and the other states. All analyses were weighted for nonresponse.

Results: More respondents had a favorable (48%) than an unfavorable (37%) view of Part D overall, and 55% reported Part D improved access to prescription drugs in general. However, 44% reported access declined for individuals with prior drug coverage, and 64% reported Part D formularies were insufficient for their patients' needs. Nearly half (49%) reported dual-eligible enrollees' access was worse under Part D in 2007 relative to Medicaid before 2006; 63% reported higher administrative burden. Physicians reported Part D lowered dual-eligible enrollees' access and increased providers' burden more in North Carolina than in the 3 restrictive Medicaid states.

Conclusion: Primary care physicians held generally positive but widely varying views of Part D. Respondents expressed concerns about access to prescription drugs under Part D, particularly for dual-eligible enrollees. Improving the transparency and generosity of Part D formulary coverage may improve access.

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ability to find coverage that matches their needs while complicating the physician's decision to prescribe the best medication given the patient's medical needs and drug coverage.

We also examined physicians' views about the effects of Part D on Medicare-Medicaid dual-eligible enrollees. Dual-eligible enrollees have a disproportionate need for medical services and prescription drugs, lower incomes, and less education than other Medicare beneficiaries on average.¹⁰ Before 2006, dual-eligible enrollees had drug coverage through Medicaid. The transition to Part D for dual-eligible enrollees was especially challenging¹¹ because of the administrative complexity of the enrollment process,^{12,13} Medicare's policy of random auto-assignment to prescription drug plans,¹⁴ and inconsistencies in the coverage of required drug classes.¹⁵ Moreover, because the generosity of the Medicaid drug benefit varied substantially across states, dual-eligible enrollees in states with generous Medicaid coverage may have fared relatively worse than those in states with restrictive Medicaid coverage in the transition to Part D.

METHODS

Sample Selection

We surveyed primary care physicians in 4 large, racially diverse states (Florida, Massachusetts, North Carolina, and Texas) that represent distinct regions in the country and vary in the restrictiveness of their Medicaid drug formularies. As all of these states have relatively low Medicaid managed care penetration, their Medicaid formularies apply to most Medicaid enrollees. Prior to 2005, Florida, Massachusetts, and Texas adopted restrictive Medicaid formularies that do not permit pharmacists to request prior authorizations,¹⁶⁻¹⁸ whereas North Carolina continues to have a generous Medicaid formulary.¹⁹ Of the 26 on-patent drugs we identified as being used to treat 3 common clinical conditions—hypercholesterolemia, hypertension, and diabetes—prior authorization was required for 16 in Florida, 23 in Massachusetts, 14 in Texas, and none in North Carolina as of October 2007.

We used physician-level prescribing data from Wolters Kluwer Health to identify a sample frame of primary care physicians in the 4 study states. These data distinguished the source of payment among cash, Medicaid, and other insurance but did not separately identify prescriptions paid for by Medicare Part D. To ensure respondents had adequate exposure to Part D and dual-eligible enrollees in clinical practice, we limited the sample frame to physicians whose patients filled a minimum of 30 new (nonrefill) prescriptions overall and 5 new Medicaid prescriptions for hypercholesterolemia, hypertension, and diabetes in the year preceding the study (September 2006 to August 2007). Respondents who reported being enrolled in or

having completed a clinical fellowship, practicing as a hospitalist, or not treating both Medicaid and Medicare patients in the last 2 months were ineligible to take the survey.

Survey Instrument and Fielding

We collected detailed information regarding both physician-level characteristics (race, sex, medical specialty, board certification, international medical graduate status, years in practice, and time spent on clinical medicine) and practice-level characteristics (number of physicians in the practice, and the income level, race/ethnicity, and insurance status of patients in the practice). We asked physicians about their overall impressions of Part D and their perceptions of its effects on access to prescription drugs for their Medicare patients in general, among selected subgroups (their sickest, healthiest, and minority patients), and for their patients who did and did not have drug coverage prior to Part D. In addition, physicians were asked about the sufficiency of prescription drug formularies under Medicare Part D and Medicaid. Finally, physicians were asked to compare aspects of prescription drug coverage retrospectively for dual-eligible enrollees under Part D in 2007 with coverage under Medicaid prior to 2006, including their patients' satisfaction, compliance with and access to medications, and the physicians' own ability to prescribe preferred medications and administrative burden.

The self-administered online survey was pilot-tested extensively for clarity and breadth, and took an average of 22 minutes to complete. A paper version of the instrument is available on request. It was fielded from November 2007 through March 2008. Invitation letters were sent by first-class mail in 4 overlapping waves. Honoraria for participation ranged from \$50 to \$100. Up to 3 postcard reminders were sent to nonrespondents with valid addresses.

Response Rate

Of the 5901 physicians in the sample frame, 760 had invalid mailing addresses or were ineligible for the study. Of the remaining 5141 physicians, 716 completed the survey, for an overall response rate of 14%. The response rate was highest among physicians in North Carolina (19%) and lowest among physicians in Texas (11%). Compared with nonrespondents, a greater proportion of respondents were from North Carolina (31% vs 21%) and female (31% vs 27%), and a smaller proportion of respondents were from Texas (30% vs 37%); on average, respondents were less experienced and younger ($P < .05$ for all comparisons) than nonrespondents (eAppendix Table, available at www.ajmc.com). We calculated weights to balance all of these characteristics except age and experience between respondents and nonrespondents.

Statistical Analysis

We computed descriptive statistics for respondents overall and also compared the responses of physicians from North Carolina (generous Medicaid formulary) with the responses of physicians from Florida, Massachusetts, and Texas (restrictive Medicaid formularies). Unadjusted analyses used *t* tests for continuous variables, Fisher exact tests for binary variables, and χ^2 tests for categorical variables. Multivariate binary and ordered logistic regressions were estimated to account for the effects of differential distributions of respondent characteristics (ie, physician specialty, board certification status, international medical graduate, race, sex, survey wave, years of experience, practice size, time devoted to clinical practice, and distributions of income level, race, and insurance status of patients in practice) between North Carolina and the 3 restrictive Medicaid states combined. We also tested the equality of responses among Florida, Massachusetts, and Texas using regression-based joint Wald tests. To account for potential nonresponse bias, we weighted our analyses using the weights that balance the respondent and nonrespondent samples as closely as possible. Only deidentified data were used in this analysis, and strict measures were undertaken to preserve participants' confidentiality. This study was approved by the Arizona State University Institutional Review Board.

RESULTS

Table 1 reports respondents' unadjusted descriptive characteristics. Respondents were predominantly white (54%), male (69%), and board certified (80%). Respondents treated substantial shares of Medicaid (22%), Medicare (33%), and uninsured (11%) patients on average. Most respondents characterized their practices as serving patients primarily of low or

medium income, and almost none reported treating primarily high-income patients.

Bivariate analyses found several differences between physicians from North Carolina and physicians from the other 3 states (data not shown). Compared with physicians practicing in the 3 restrictive Medicaid states, physicians in North

■ **Table 1.** Survey Respondent Characteristics (N = 716)

Characteristic	Percentage ^a
Race/ethnicity	
White	53.8
Black/African American	8.1
Asian	17.5
Hispanic/Latino	11.3
Other/multiracial/missing	9.4
Female	31.4
Medical specialty	
Family practice	62.3
Internal medicine	37.7
Board certified	79.6
International medical graduate	30.6
Years of experience, mean (SD)	14.1 (10.0)
Spent at least 80% of time in last 30 days on clinical medicine	86.2
Number of physicians in practice	
1	30.6
2	14.9
3 or 4	18.6
5-10	19.8
>10	16.1
Income level of patients in practice	
Low	39.7
Medium	35.3
High	0.7
Mixed	24.3
Race/ethnicity of patients in practice, mean (SD)	
White	49.4 (25.4)
Black/African American	23.5 (19.1)
Hispanic/Latino	22.4 (24.1)
Other	4.7 (9.5)
Insurance status of patients in practice, mean (SD)	
Medicaid	21.5 (14.7)
Medicare	33.2 (16.0)
Other insurance	34.4 (20.2)
No insurance	11.0 (14.4)

^aValues are percentages except where noted.

Carolina were more likely to be white (66% vs 48%) or black/African American (15% vs 5%), to be women (38% vs 29%, $P = .04$), and to specialize in family practice rather than internal medicine (74% vs 57%). By contrast, fewer physicians in North Carolina were Asian (12% vs 20%) or Hispanic/Latino (1% vs 16%), board certified (72% vs 83%; $P = .001$), or international medical graduates (19% vs 26%) ($P < .001$ for all comparisons unless noted otherwise).

Views on Part D’s Effects on Patients

On average, physicians expressed positive views of Part D overall; however, physician views were mixed and varied based on the subpopulation examined (Table 2). More respondents had a positive overall impression of Part D’s prescription drug benefit than a negative one (48% vs 37%, respectively). In total, 55% of respondents reported that Part D improved access to prescription drugs for their Medicare patients in general; far fewer said that patients’ access worsened (20%) or remained unchanged (18%).

In considering subpopulations, 42% of respondents indicated that Part D improved access to drugs for the sickest patients and only 29% said it decreased access. This held true for minority patients as well, with 42% of respondents reporting that Part D improved minority patients’ access and only 14% saying it worsened their access. Most respondents (72%) believed that Part D had no effect on access to drugs for their healthiest patients, whereas 80% reported that Part D improved access to drugs for their Medicare patients who had no drug coverage prior to enrolling in Part D. Respon-

dents were split as to whether Part D worsened access or had no effect for patients with drug coverage prior to Part D (44% vs 46%, respectively).

Concerns About Formularies

Physicians expressed concerns about Medicare Part D formularies (Table 3). Nearly two-thirds of respondents (64%) reported that Part D formularies were probably or definitely not sufficient for their patients’ needs. In Florida, Massachusetts, and Texas, 62% of respondents reported that their Part D formularies were insufficient, significantly more than the 47% of respondents in the same states who reported that the Medicaid formularies were insufficient ($P < .001$ for the 538 respondents who answered both questions). Because North Carolina uses a virtually open Medicaid formulary, we did not ask this question of physicians in that state.

Access for Dual-Eligible Enrollees

Table 4 summarizes respondents’ attitudes about prescription drug access for dual-eligible enrollees under Part D in 2007 versus Medicaid prior to 2006, both overall and by the level of Medicaid formulary generosity. Collectively, 49% of respondents reported worse prescription drug access for dual-eligible enrollees as a consequence of switching from Medicaid to Medicare Part D, whereas only 27% reported better access.

Those in the restrictive Medicaid states had less negative views than respondents in North Carolina. Compared with respondents in North Carolina, fewer physicians in the restrictive Medicaid states reported that Part D had lowered

■ **Table 2.** Physicians’ Views of Part D Overall and by Patient Characteristics^a

Survey Question	Percentage			
	Unfavorable	Neither Unfavorable or Favorable	Favorable	No Opinion
Overall, what is your impression of the Medicare Part D prescription drug benefit?	36.6	13.0	47.5	2.9
	Worsened	Remained Unchanged	Improved	No Opinion
Thinking just about your Medicare patients in 2007, compared with the time prior to the introduction of Part D in January 2006, how has access to prescription drugs changed for...?				
Your Medicare patients in general (N = 676)	20.1	17.9	55.4	6.6
Your sickest patients	28.5	29.9	41.6	0.0
Your healthiest patients	8.5	71.8	19.8	0.0
Your minority patients	14.0	44.3	41.7	0.0
Your patients who had prescription drug coverage prior to Part D	43.8	45.7	10.5	0.0
Your patients who did not have prescription drug coverage prior to Part D	5.2	15.0	79.7	0.0

^aAnalyses are weighted to adjust for nonresponse. N = 716 unless otherwise noted.

■ **Table 3.** Physicians' Views of Formulary Sufficiency^a

Survey Question ^b	Percentage				
	Definitely Not Sufficient	Probably Not Sufficient	Probably Sufficient	Definitely Sufficient	No Opinion
Do you think the Part D drug plan formularies are sufficient for your Medicare patients' needs?					
Overall (N = 697)	19.1	44.6	29.5	4.5	2.4
Florida, Massachusetts, and Texas (N = 542)	18.0	43.9	29.7	5.3	3.1
Do you think the Medicaid formularies are sufficient for your Medicaid patients' needs?					
Florida, Massachusetts, and Texas (N = 552)	13.6	33.1	43.1	9.4	8.8

^aAnalyses are weighted to adjust for nonresponse.
^bRespondents in North Carolina were not asked about the sufficiency of their Medicaid formulary.

dual-eligible enrollees' access to medications (42% vs 72%), satisfaction (49% vs 73%), and compliance (23% vs 41%). Respondents in the restrictive Medicaid states also were less likely to report that their ability to prescribe their preferred drugs for dual-eligible patients was worse under Part D than Medicaid (49% vs 78%). Moreover, respondents in the restrictive Medicaid states were less likely to report that their own administrative burden and the administrative burden on their staff associated with prescribing drugs for dual-eligible enrollees were higher under Part D than under Medicaid.

Physicians in North Carolina continued to hold more negative views of Medicare Part D's impact on dual-eligible enrollees than physicians in states with restrictive Medicaid coverage after multivariable adjustment for patient- and physician-level characteristics (Table 5). Although the differences were attenuated modestly after multivariable adjustment, respondents in North Carolina were more likely to report that Part D diminished dual-eligible patients' access to medications, satisfaction, and compliance; reduced physicians' ability to prescribe their preferred drugs; and increased providers' prescribing burden. Responses among physicians in Florida, Massachusetts, and Texas were not significantly different at $P < .05$ for 15 of the 18 comparisons in Table 5.

DISCUSSION

In this 4-state survey of primary care physicians who treat Medicaid and Medicare patients, we found that as of late 2007 and early 2008 respondents perceived that Medicare Part D had improved seniors' access to prescription drugs overall, but these improvements were concentrated among selected patient subgroups. Specifically, most physicians reported improved access for seniors who lacked prescription drug coverage prior to Part D, while fewer believed Part D enhanced access for the sickest patients and those with prior prescription coverage. In

contrast to these positive views about how Part D's implementation improved access in 2007 relative to before Part D, 64% of respondents indicated that the Part D formularies in 2007 were insufficient for their patients' needs. Even in states with restrictive Medicaid formularies this was less favorable than their views of Medicaid formulary sufficiency.

Another principal finding is that physicians have concerns regarding prescription drug coverage under Medicare Part D for dual-eligible enrollees, who had previously been covered under Medicaid. Among dual-eligible enrollees, physicians reported lower patient satisfaction, compliance, and access to prescription drugs; more difficulty prescribing their preferred drugs under Part D; and higher administrative burden for themselves and their staff in 2007 than under Medicaid drug coverage before 2006. Not surprisingly, these differences were largest in North Carolina, a state that continues to have generous Medicaid prescription drug coverage.

One reason for this may be that Part D uses multiple competing formularies in place of a single, statewide Medicaid formulary. A prior study documented psychiatrists' large administrative burdens from Part D.²⁰ Notably, we found that physicians reported that their administrative burdens from Part D were significantly larger than those from Medicaid despite previous evidence that restrictive Medicaid formularies like those in Florida, Massachusetts, and Texas themselves create large administrative costs for physicians.^{21,22} These extra costs arising from multiple formularies may have diminished physicians' views of Part D more broadly.

The effects of multiple, competing Medicare Part D plans and their associated formularies for patients are less clear. Competition among multiple drug plans may promote economic efficiency and spur innovation. Furthermore, the considerable variation in existing state Medicaid formulary designs suggests government-derived formularies may not reflect value-based coverage.²³ Given heterogeneity in seniors' preferences and

■ **Table 4.** Physicians' Views of Prescription Drug Coverage for Dual-Eligible Enrollees by State (North Carolina versus Florida, Massachusetts, and Texas)^a

Survey Question	Percentage			P ^b
	Overall	North Carolina	Florida, Massachusetts, and Texas	
Compared with your experience with dual eligibles covered by Medicaid prior to their transition to Part D, what is your impression of the following aspects of care for dual eligibles during 2007...?				
Patients' satisfaction (N = 601)				
Worse with Part D	55.0	73.4	49.3	<.001
Not different	25.6	18.3	27.9	
Better with Part D	19.4	8.3	22.8	
Patients' compliance (N = 612)				
Worse with Part D	26.7	41.0	22.5	<.001
Not different	58.9	51.7	61.1	
Better with Part D	14.3	7.3	16.5	
Patients' access to medications (N = 636)				
Worse with Part D	48.6	71.7	41.8	<.001
Not different	23.9	19.6	25.2	
Better with Part D	27.4	8.8	33.0	
Respondent's ability to prescribe preferred medications (N = 647)				
Worse with Part D	55.9	78.0	49.4	<.001
Not different	29.5	19.3	32.6	
Better with Part D	14.6	2.7	18.1	
Respondent's administrative burden (N = 659)				
Worse with Part D	63.3	73.8	60.3	.01
Not different	30.8	22.9	33.2	
Better with Part D	5.8	3.3	6.5	
Respondent's staff's administrative burden (N = 660)				
Worse with Part D	66.8	77.8	63.7	.004
Not different	28.2	20.3	30.4	
Better with Part D	5.0	1.9	5.9	

^aAnalyses are weighted to adjust for nonresponse.
^bP values are from χ^2 tests of the joint equality of the responses in North Carolina vs those in Florida, Massachusetts, and Texas.

prescription drug utilization, a shift toward a single, large Part D plan may reduce coverage for some drugs, and thus make some enrollees worse off.

On the other hand, there is substantial variation across Part D formularies in which drugs are covered and at what copayment levels,⁸ and Medicare beneficiaries are not well informed about the cost-sharing details of their Part D drug coverage.^{24,25} As a result, physicians have difficulty knowing an individual patient's formulary coverage and out-of-pocket costs.^{26,27} In fact, existing research has found that physicians facing mul-

iple formularies are less likely to customize their prescribing decisions.^{28,29} This suggests that choice of plans alone might not enhance matching patients with the prescriptions best for them individually. Efforts to improve the transparency of formulary coverage, which may be facilitated by electronic prescribing, can benefit patients by making it easier for physicians to customize their prescribing for individual patients and so improve access to drugs.^{30,31}

Our findings contribute to the small body of evidence regarding physicians' views of the effects of Part D on pre-

Physicians' Views of Medicare Part D

Table 5. Unadjusted and Adjusted Differences in Physicians' Views of Prescription Drug Coverage for Dual-Eligible Enrollees (North Carolina versus Florida, Massachusetts, and Texas)^a

Survey Question	Odds Ratio (95% Confidence Interval) ^b	
	Unadjusted	Adjusted ^c
Compared with your experience with dual eligibles covered by Medicaid prior to their transition to Part D, what is your impression of the following aspects of care for dual eligibles during 2007...?		
Patients' satisfaction	0.35 (0.23, 0.52)	0.38 (0.24, 0.61)
Patients' compliance	0.41 (0.28, 0.60)	0.46 (0.29, 0.72)
Patients' access to medications	0.27 (0.18, 0.40)	0.27 (0.17, 0.43)
Respondent's ability to prescribe preferred medications	0.26 (0.17, 0.40)	0.30 (0.18, 0.49)
Respondent's administrative burden	0.54 (0.36, 0.81)	0.64 (0.40, 1.03)
Respondent's staff's administrative burden	0.49 (0.32, 0.75)	0.58 (0.36, 0.96)
Based on your own experience in 2007, what is your impression of the administrative burden of writing prescriptions under Part D compared with the administrative burden under...?		
A typical commercial insurance plan	0.75 (0.52, 1.07)	0.80 (0.52, 1.21)
Your state's Medicaid program	0.22 (0.15, 0.33)	0.25 (0.16, 0.40)
How has your knowledge of dual-eligible patients' formularies changed since the transition to Part D?	0.60 (0.43, 0.84)	0.59 (0.40, 0.88)

^aAnalyses are weighted to adjust for nonresponse. Odds ratios significant at the 5% level are boldfaced.

^bOdds ratios represent the relative difference between physicians in North Carolina and those in Florida, Massachusetts, or Texas in the likelihood of seeing Medicare Part D positively. Odds ratios less than 1 indicate that North Carolina physicians had a less positive view of Part D.

^cBinary and ordered logistic regression models controlled for physician specialty, board certification status, international medical graduate, race, sex, survey wave, years of experience, practice size, time devoted to clinical practice, and distributions of income level, race, and insurance status of patients in practice.

scription drug access. These findings are important because physicians are a key stakeholder group regarding Part D, and play an integral role in prescribing medications. Physicians are uniquely knowledgeable about the medications they would recommend for their patients and the influence of insurance programs on their own prescription choices, which is an important aspect of access. While physicians are not able to observe all aspects of patients' access to prescription drugs, information from physician surveys complements information collected from patient surveys, administrative claims, and other sources.

Analyses of claims data may provide a comprehensive view of changes in utilization and out-of-pocket costs, but they overlook other important aspects of prescribing. Existing claims-based analyses measure only the overall effects of Part D for all seniors together. They have not distinguished seniors covered by Part D from those covered by employers or other sources, and they have not considered how Part D's effects have varied across populations, particularly dual-eligible enrollees. Because claims data include only prescriptions filled, for example, they omit changes in prescribing decisions that occur for those written but never filled. Surveying physicians addresses some of these limitations and provides insight into the ways in which

Part D coverage has influenced the quantities and types of medications seniors receive.

To our knowledge, ours is the first survey of physicians to explore access to prescription drugs for dual-eligible enrollees generally. Previous surveys examined access for dual-eligible patients with psychiatric conditions¹⁵ and disabilities,¹¹ while others have used focus groups to study access to drugs for dual-eligible enrollees.^{32,33} Our survey also extends earlier work on cross-state variation in access to drugs under Part D.³²

Primary care physicians obviously play an important role in prescribing medications and are in a position to observe multiple patients over time with Medicaid, Part D, and other sources of drug coverage. Their ability to assess the effects of Part D, particularly on patient satisfaction, may be limited, however, and possibly unreliable.

There are several other features to keep in mind when interpreting the results of this survey. The 4 states included in this study—North Carolina, Florida, Massachusetts, and Texas—were selected because they represented extremes in Medicaid formulary generosity; therefore, our findings may not be applicable to other states. Additionally, physicians in North Carolina may be different from their peers in the other 3 states

Take-away Points

Physicians in this 4-state survey had heterogeneous views of Medicare Part D.

- A plurality of respondents viewed Part D and its effects on access to prescription drugs positively overall.
- Respondents were concerned about the sufficiency of Part D formularies for their patients' needs and Part D's impact on prescription drug access for patients who had coverage previously.
- For dual-eligible enrollees, Part D in 2007 was viewed as less generous and more cumbersome than Medicaid before 2006.
- Views of Part D's impact on dual-eligible enrollees were more negative in North Carolina, a state with generous Medicaid drug coverage.

ing the impact of Medicare Part D on their patients.

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in important ways that influence their opinions of Part D and Medicaid. We accounted for this by adjusting for differences in observable physician characteristics, but remaining differences in physicians across states could cause us to misattribute the cross-state differences in physicians' views to the relative generosity of state Medicaid formularies. However, we did find that physicians' views in the 3 less generous Medicaid states were largely consistent from state to state.

Another concern is the survey's low response rate,³⁴ which may be in part due to its length, content, and Web-based administration. Although low response rates do not necessarily introduce bias,³⁵ we took several steps to minimize the introduction of potential bias from nonrespondents. Given limitations in our data, however, we cannot verify that physicians who did not respond held views similar to those of the respondents. Finally, because the survey was fielded in late 2007 and early 2008, physicians' responses should reflect their experiences with Part D after the initial open-enrollment period.

CONCLUSION

Evaluations as to how Part D affects beneficiaries' access to prescription drugs are ongoing. We fielded our survey from late 2007 to early 2008, approximately 2 years after Part D's implementation. As a result, physicians' responses regarding Part D likely reflect their experiences with the plan after the initial open-enrollment period.

We found that physicians' overall impressions of Part D are favorable, and most view it as having improved access to drugs for Medicare patients in general. Nevertheless, many physicians who responded expressed concerns about the sufficiency of Part D formularies and their effects in particular on dual-eligible enrollees' access to prescription drugs. Physicians also reported greater administrative burdens in complying with Medicare Part D for dual-eligible enrollees, likely the result of having to track many Part D formularies. Directing efforts toward reducing these burdens and enhancing the scope of Part D formularies may improve physicians' opinions regard-

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