

**The Pharmacy Coverage Safety Net:
Variations in State Responses to
Supplement Medicare Part D**

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TABLE OF CONTENTS

Executive Summary	i
Introduction.....	1
Methods.....	4
Medicaid Survey Findings	5
SPAP Survey Findings.....	11
Policy Implications & Discussion.....	22
Conclusion	27
Appendix 1: Glossary of Terms.....	28

EXECUTIVE SUMMARY

The rocky transition of the poorest Medicare beneficiaries to the new Part D benefit has been the subject of considerable media attention. More than half of the states have declared public health emergencies and provided temporary emergency drug coverage until enrollment problems are fixed. But these short-term problems are only part of the story. States have also been making tough choices about their longer-term roles in wrapping around the Medicare drug benefit and maintaining a pharmacy coverage safety net for poor and near-poor Medicare beneficiaries once they are enrolled in Part D.

In the absence of a Medicare drug benefit in the past, state Medicaid programs and state pharmacy assistance programs (SPAPs)¹ have generously provided safety net pharmacy coverage to millions of poor and near-poor elderly and disabled persons. Indeed, states assisted more than eight million low-income Medicare beneficiaries in 2005. All of these individuals are now eligible for the Medicare drug benefit which, depending on the state program and the benefits provided, could be more or less generous than what they previously received.

Relative to Medicaid coverage, under Part D those dually eligible for Medicare and Medicaid may face 1) higher co-payments, 2) the loss of guaranteed access to medications when they can't pay their co-pays, 3) the loss of coverage for denied drugs during an appeal, and 4) formularies and networks that may not include the drugs they had been taking or the pharmacy they used under Medicaid. Enrollees in SPAPs that serve the near poor that do not qualify for Medicaid may face 1) challenges in applying for and getting low-income subsidies 2) paying up-front costs such as premiums and deductibles that they previously did not pay, 3) higher cost-sharing in and out of the "doughnut hole," and 4) more limited formularies and pharmacy networks.

This report summarizes the findings of two separate surveys of selected state Medicaid and SPAP directors conducted in the Fall 2005 about state plans for wrapping around these gaps in the Part D benefit. The report highlights what "D-gaps" the states intend to fill over time and discusses state policy issues and the potential impact on state program enrollees.

FINDINGS

States not filling "D-Gaps" for dual-eligibles except to cover Part D excluded drugs

The surveyed Medicaid programs will cover the limited list of excluded Part D drugs for duals to the same degree that the Medicaid program currently covers them for non-dual Medicaid enrollees.

Beyond this, most surveyed states are deferring to the Medicare Part D benefit and do not plan to fill in the Part D gaps for the duals. Exceptions include New Jersey and New York

¹ State pharmacy assistance programs (SPAPs) are state-funded programs that provide drug coverage to the near-poor that do not qualify for full Medicaid benefits. For a complete glossary of terminology used throughout the report, see Appendix I.

that will cover off-formulary drugs in special circumstances and New Jersey, Maine, Nevada and Missouri that will pay a portion or all of the copayments.

The decision by most surveyed states not to provide wrap-around benefits for the duals may be tied to the finding that the vast majority of states also estimated that under the “clawback” formula, they would pay more to support duals under Part D, at least in the short-term, than they would have if they continued to provide drug coverage themselves.

At the time of our survey, only one third of states were intending to assist duals to identify and enroll in Part D plans that best matched their existing drug needs and pharmacy use. Only the state of Maine had conducted such a match as of January 2006.

SPAP states offering “D-Gap” coverage to hold SPAP enrollees harmless

Most states have elected to maintain their SPAP programs and wrap around Part D. Only six states planned to close their programs. Most of these were states where all or most of the enrollees will be eligible for the Medicare Part D low-income subsidy (LIS) program, entitling them to more generous coverage than the SPAP provided.

In contrast to Medicaid, most SPAPs are holding their enrollees harmless for cost-sharing under Part D and will pay some or all of the Part D premiums and cost-sharing during the deductible period, initial benefit period, and gap in coverage (known as the doughnut hole) up to the current SPAP cost-sharing requirements. Five of the larger, well-established SPAPs also will cover some off-formulary drugs.

SPAPs are largely defaulting to private Part D plans’ utilization management, so SPAP enrollees may face more administrative hassles than they have been used to in the past.

Most SPAPs do not plan to expand benefits or eligibility in 2006 and may be waiting to quantify the full magnitude of Part D savings.

POLICY IMPLICATIONS/DISCUSSION

States filling D-gaps more in SPAPs than in Medicaid

Medicaid agencies and SPAP programs are taking different tacks in offering Part D gap coverage for their current or prior enrollees. These differences in Medicaid and SPAP responses may reflect Part D’s different financial impact on each program and its beneficiaries, and differences in the flexibility and incentives provided to wrap around the Part D benefit. SPAPs were given much more flexibility and were encouraged in the MMA to design wrap-around benefit programs, while Medicaid programs were largely expected to drop out of the administration of prescription drug coverage for the duals and only to pay clawback payments to fund duals’ coverage under Medicare.

Regardless, many duals are likely to face greater barriers to drug coverage under Part D. States may want to debate the need to maintain the pharmacy coverage safety net for their most vulnerable citizens and to consider adopting best practice policies such as:

Assisting in assignment of duals to Part D plans that best match each person's current drug and pharmacy use,
paying for marginal increases in co-payments for the duals under Part D, and
covering off-formulary drugs in limited circumstances and with state prior approval and demonstration of medical necessity.

States could do more to maximize SPAP Part D savings

Many states with SPAPs could be doing more to ensure that eligible enrollees benefit from the LIS and are enrolled in plans that are most cost-effective. Such efforts would, in turn result in savings for the SPAP. These include:

Mandating Medicare and LIS enrollment as a condition of eligibility in states that have not already done so,
collecting accurate asset information to enable the SPAP to submit LIS applications to the SSA on behalf of enrollees,
assigning enrollees to Part D plans that most closely match their drug and pharmacy profile,
comparing benefits in low-premium versus high premium Part D plans to reassess the cost-effectiveness of limiting SPAP premium subsidies to the lowest cost premiums, and
re-visiting the SPAP anti-discrimination provisions with the federal government to seek greater flexibility in working with specific plans, as has been allowed in several states.

Need for Monitoring the Impact of Part D and State Policy Decisions on Beneficiaries

States are not obligated to fill the gaps in the federal Medicare drug benefit. In fact, some would argue that by offering gap coverage, states are relieving the federal government and the private Part D plans of their responsibility to provide adequate and appropriate coverage for those in greatest need. Many state Medicaid officials seemed reticent at the time of the survey to step in to fix gaps in what they perceived as a federal program they neither requested nor wanted to pay for. However, as seen with the initial Part D transition problems, states are best positioned to identify and at least temporarily fix any problems that arise.

In addition, SPAPs and Medicaid agencies that plan to wrap around cost-sharing are positioned to monitor the impact of new administrative and financial barriers to access such as utilization management requirements and tiered co-pays. Information regarding the extent to which these barriers limit use of necessary drugs could be useful for reassessing state and federal policymakers' decisions in the future about wrapping around or expanding formulary requirements.

INTRODUCTION

As the new Medicare Part D prescription drug benefit is being implemented, state governments have been making some tough choices about their future role in providing drug coverage for low-income state residents. States have historically been the pharmacy coverage safety net for low-income elderly and disabled persons: All states elected to provide drug coverage through their state Medicaid programs to the poorest residents and half of the states offered drug coverage to the near-poor that did not qualify for full Medicaid benefits through state-funded state pharmacy assistance programs (SPAPs). These state Medicaid and SPAP programs provided safety net pharmacy coverage to more than eight million low-income Medicare beneficiaries in 2005. All of these individuals are now eligible for the Medicare drug benefit which, depending on the state program and the benefits provided, could be more or less generous than what they currently receive.

The states are left with a fundamental policy choice: They can transfer their enrollees to the new Medicare benefit and entrust to the federal government the responsibility of providing adequate, affordable drug coverage to individuals previously served by the state. Alternatively, they can continue to serve as a safety net to address some or all gaps in the Medicare drug program. Each state's decision is driven in part by economic circumstances and also by the magnitude of the state-specific differences between the existing state programs and the new Part D program. Some subgroups of enrollees in state programs, may be more vulnerable than others and face larger gaps in coverage to the degree that they are only eligible for the basic Part D benefit and not the low-income subsidies (LIS) - commonly referred to as the "extra help" - being offered through the Medicare program.

Much media attention has focused on the short-term transition problems to the new Medicare drug benefit and the temporary emergency coverage that states are providing. Far less attention has been paid to the role of the states in supplementing Part D over time and whether and how Medicaid and SPAP programs will wrap around the Medicare drug benefit for their enrollees. This report summarizes the states' plans for wrapping around Part D, based on a survey of state Medicaid and SPAP programs conducted in Fall 2005, and discusses state policy issues and the potential impact on state program enrollees.

Background – Potential Gaps in Coverage for Medicaid and SPAP Enrollees under Medicare Part D

To provide some context for our survey of states, this section outlines the major differences between Medicaid and SPAP programs relative to the new Medicare Part D benefit. As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) effective January 1st, 2006, the federal government no longer provides matching funds to state Medicaid programs for outpatient prescription drug coverage for those persons who are eligible for both Medicaid and Medicare benefits. These individuals, known as the "dual-eligibles" or duals, will instead receive their drug coverage through the new Medicare Part D benefit and were to be randomly auto-enrolled into newly created private Part D Prescription Drug Plans (PDPs)

by CMS in November, 2005.² The MMA also requires states to make monthly payments to the federal government - commonly referred to as “clawback payments” - to help pay for coverage of the dual-eligibles under the new Part D benefit.³ If, in addition to paying the “clawback,” states elect to wrap around the gaps in Medicare Part D coverage for the dual-eligibles, they must do so with state-only funds.

While specific cost-sharing requirements can vary by Part D plan, the standard Medicare Part D drug benefit requires the beneficiary to pay:

- Monthly premiums averaging \$25 per month,⁴
- a deductible up to \$250,
- an average of 25% of drug costs up to an initial benefit limit of \$2,500,
- 100% of drug costs during the coverage gap from \$2,500 to \$5,100, known as the “doughnut hole”, and
- 5% of drug costs after you reach the \$5,100, referred to as “catastrophic coverage”.

To help, low-income beneficiaries pay for these cost-sharing requirements, Medicare provides low-income subsidies (LIS) for those with incomes below 135% of the federal poverty level (FPL) and assets below \$6,000 for singles or \$9,000 for couples, and partial subsidies for those with incomes below 150% FPL and assets below \$10,000 and \$20,000 (Table 1). In general, those who meet the income and asset requirements for LIS:

- Pay no or sliding scale premiums,
- pay no or a \$50 deductible,
- pay maximum co-payments of \$3, \$5, or 15%,
- do not have a coverage gap or doughnut hole, and
- pay nothing if they reach the threshold for catastrophic coverage.

Dual-eligibles were automatically deemed eligible for additional low-income subsidies (LIS) based on meeting the income and asset tests of the state Medicaid programs.

While more generous than the basic Part D benefit, the Medicare low-income subsidies available to the dual-eligibles differ in several ways from the drug benefit available under Medicaid. Under Medicare Part D, depending on their income, duals will be faced with higher co-payments, no protections in the event they cannot afford the co-payments, no coverage for denied drugs during an appeal, and formularies that may not include the drugs they had been taking under Medicaid. Though states are not prohibited from filling these new gaps for duals with state-funded benefits, they will receive no federal matching funds for any such coverage.

² The actual implementation of the Part D transition of the duals was fraught with problems and resulted in more than half of the states declaring a public health emergency and stepping in to provide temporary emergency coverage through their Medicaid and SPAP programs.

³ The clawback has been the subject of considerable controversy. As of Feb 2006, 5 states intend to legally challenge it. Halper, E. State to Sue U.S. Over Medicare. Los Angeles Times, Feb 2, 2006.

⁴ The anticipated average premium was originally \$35, but has been lowered to \$25 based on actual plans offered. Inside CMS, CMS: Robust drug plan competition lowers average Part D premium, Feb 9, 2006.

Table 1. Medicare Part D and Low-Income Subsidies

Program	Eligibility		Benefit			
	Income	Assets	Premium	Deductible	Cost Sharing	Cost-Sharing above Out-of-Pocket Limit
Medicare Part D	No income or asset test available to anyone eligible for or enrolled in Medicare Parts A or B		\$35*	\$250	25% up to initial coverage limit of \$2,500. 100% during from \$2,501 to \$5,100 (referred to as the doughnut hole)	Greater of 5% or \$2 Generic/ \$5 Brand name
Part D Low-Income Subsidies for Institutionalized Dual-eligibles	Non-Institutionalized	Medicaid asset test	None	None	None	None
Part D Full Low-Income Subsidies	Below 100% FPL	\$6,000 single \$9,000 couple	None	None	\$1 Generic \$3 Brand name	None
	Below 135% FPL	\$6,000 single \$9,000 couple	None	None	\$2 Generic \$5 Brand name	None
Part D Partial Low-Income Subsidies	Below 150% of FPL	\$10,000 single \$20,000 couple	Sliding scale	\$50	15% coinsurance	\$2 Generic \$5 Brand name

Source: Drawn from Federal Register 42 CFR Parts 400, 403, 411, 417, and 423: Medicare Program; Medicare Prescription Drug Benefit; Final Rule. Department of Health and Human Services. January 28, 2005. Pp. 4388-89.
*Estimated average. On 2/1/06, CMS released revised estimates based on actual Part D plan experience to be \$25.

In addition to Medicaid, half of the states also previously offered drug coverage to low-income senior and/or disabled Medicare beneficiaries who were not eligible for Medicaid through state-funded state pharmacy assistance programs (SPAPs). With no federal minimum standard for SPAPs, coverage varies considerably by state in terms of who is eligible, the breadth of drugs covered and the level of cost-sharing required.

SPAPs face similar yet different challenges as the Medicaid programs. Unlike Medicaid enrollees, SPAP enrollees will not be automatically enrolled by the federal government into Part D plans or deemed eligible for the low-income subsidies. These beneficiaries, or the SPAPs on their behalf, must apply for LIS and enroll in Part D plans. Since SPAPs do not have asset test requirements, they do not know precisely how many of their enrollees are eligible for the low-income subsidies. Based on SPAP income data they face the challenge that their enrollees fall into three different benefit categories under Part D – those eligible for the full low-income

subsidy, those eligible for the partial subsidies, and those eligible only for the basic Part D benefit.

Coordinating the SPAP benefits with the new Medicare Part D benefit and the low-income subsidies is likely to be difficult, particularly given the variations in SPAP benefit designs and the equally complex benefit that will be provided through multiple private Part D plans. Many SPAPs covered most drugs that could be purchased at most pharmacies in the state. The Part D rules allowing plans to limit covered drugs to as few as two per class, could restrict access for both SPAP enrollees and duals. Total cost sharing in many SPAPs is lower than in the basic Part D benefit but equivalent or higher than cost sharing for those receiving the LIS. The requirements that SPAPs coordinate their benefit with each distinct Part D plan in the region multiplies the complexity of the task, particularly if states elect to wrap around the Part D drug formularies and each plan's unique cost-sharing design.

METHODS

To determine how states were intending to wrap around Part D for their Medicaid and SPAP enrollees, we developed two separate surveys for Medicaid and SPAP directors. Written surveys were sent to all SPAP directors and selected Medicaid directors in August/September 2005. SPAP surveys were sent to all states that subsidized some portion of prescription drug costs for state residents, including states with Medicaid Section 1115 or Pharmacy Plus waivers that extended Medicaid drug coverage only to elderly and/or disabled persons above Medicaid income eligibility limits. States that had more than one SPAP program completed separate surveys for each program. State-sponsored discount card programs were excluded. Surveys were sent to SPAP program directors in 24 states with 28 programs. Survey findings are reported by state, rather than by program, unless otherwise indicated, even though a few states have two programs.

Medicaid programs selected for the survey included the 12 Medicaid programs with the largest drug budgets and two mid-size programs that had been recently considering creative Medicaid pharmacy program design options. These 14 Medicaid programs represented 66% of Medicaid drug expenditures in 2005. Eleven of the 14 Medicaid programs also had an SPAP in their state.

The SPAP survey included questions about program enrollment, likely eligibility of enrollees for Part D and low-income subsidies (LIS), transition planning to get SPAP enrollees enrolled in the Part D benefit and the low-income subsidies if eligible, current and proposed program budget, estimated savings from Part D, and changes in SPAP eligibility, benefits, utilization management and other program features resulting from Part D..

The Medicaid survey included questions about state plans to fill in gaps between prior Medicaid coverage and Part D coverage, state plans for providing transition assistance into Part D plans, the financial impact of the Part D phased-down state contribution or "clawback", and plans for screening low income subsidy applicants for other Medicaid-funded programs.

Reminders were sent and telephone follow-up interviews were conducted as needed to clarify state responses. Completed surveys were returned by 23 of 24 SPAP states for a 96% response rate, and 14 out of 14 Medicaid states for a response rate of 100%, although one state only partially completed the survey and did not respond to follow-up calls. We supplemented survey information with a review of state statutes and other available literature and program descriptions in six states that had passed legislation to supplement the Medicare drug benefit in 2006.⁵

It is important to note that these findings reflect what was known of states' plans at the time of our survey. Where possible, we have tried to track more current reports of state activities, but as this area of policymaking is changing on a daily basis, there may be some states that have changed their policies since the Fall 2005.

MEDICAID SURVEY FINDINGS

Finding #1: States generally not electing to provide “wrap-around benefits” for the dual-eligibles except for coverage of drugs excluded under Part D

Background: Although prescription drugs are an “optional” service under the federal Medicaid rules, every state Medicaid program provides coverage for prescription drugs. Federal matching funds are available for such coverage at the standard matching rate applicable to all medical services in each state. Federal Medicaid rules limit co-payments to no more than \$3 and prohibit providers from denying drugs based on the inability to pay a co-payment.⁶ Federal rules also allow states to exclude selected drugs from coverage including non-prescription drugs, vitamins, cosmetic drugs, drugs for weight loss, fertility, cold and cough, and barbiturates and benzodiazepines. As for all Medicaid services, states are required to provide coverage for denied prescriptions during the appeals process.

States historically varied in how their Medicaid pharmacy benefits were structured. The majority required some co-payments, but many did not. The co-payment amounts and drugs to which they applied varied by state.⁷ While all states cover at least some excludable drugs, the categories covered varied by state.⁸

Impact of Part D: Effective January 2006, dual-eligibles were to be enrolled in Part D plans. All dual-eligibles were deemed eligible for the federal low-income subsidies (LIS) and their Part D premiums are fully subsidized up to the federal low-income subsidy benchmark. This amount is the average beneficiary premium of all competing standard plans in the region. Therefore, duals will have a choice of roughly half of the plans in their area, unless they are willing to pay

⁵ National Conference of State Legislatures, State Pharmacy Assistance Programs, NCSL, 2005 edition accessed on August, 2005 at <http://www.ncsl.org/programs/health/drugaid.htm>.

⁶ CFR447.54, CFR447.15, CFR 447.53.

⁷ Pharmaceutical Benefits Under State Medical Assistance Programs, 2004, pg 4-41, National Pharmaceutical Council.

⁸ www.cms.hhs.gov/medicarereform/states/optdrugcov.asp.

the difference in cost between the low income subsidy (LIS) amount and any higher cost plan premium or unless the state elects to pay the difference on their behalf.

Duals now receive the vast majority of their drug benefits from Medicare Part D plans. States are no longer able to claim federal Medicaid matching funds for payments for drugs made on behalf of the dual-eligibles, except for the list of drugs excluded from coverage under Part D. Drugs that are denied by a Part D plan because they are not on the formulary or not in the network are still considered to be drugs that are “covered” under Part D. Therefore, if a Medicaid program covered these denied drugs, they could not claim federal matching funds on the expense. However, states may elect to provide such coverage using state-only funds.

As members of Part D plans, dual-eligibles will be subject to the rules of those plans, which differ from the rules and protections that apply under Medicaid:

Under Part D, co-pays can be as high as \$5.00 for dual-eligibles, representing a 66% increase over the previous maximum Medicaid co-pay level, pharmacies can refuse to fill a prescription for any Medicare beneficiary, including a dual-eligible, who is unable to pay his or her co-payment, and the appeals process has longer turn-around timeframes than Medicaid and there is no coverage during an appeal.

Survey Findings: To assess the degree to which states intend to bridge the gaps in coverage and protections between Medicaid and Part D, we asked a series of questions about states’ plans to pay for part D plan premiums that exceed the LIS amount, to wrap around the Part D plan co-payments, to pay for off-formulary drugs, or to cover drugs excluded from Part D (Figure 1).

All of the states surveyed indicated that they would cover drugs for duals that are on the list of drugs excluded from Part D coverage (e.g. benzodiazepines, over-the-counter drugs, vitamins, etc) to the degree that they were currently covering them. Indeed, since CMS interpreted the law to require them to offer the same coverage to dual-eligibles for these drugs as to persons eligible only for Medicaid, this finding is not surprising.⁹

In contrast, only two of 14 states (NY, NJ) indicated that they will cover off-formulary drugs that are denied by a Part D plan, and one of them indicated it would only do so after an appeal had been made to and denied by the Part D Plan.¹⁰

New Jersey was the only state of those surveyed that will cover drugs for duals while their appeals are pending with the Part D plans, though even New Jersey will only cover a six day emergency supply.

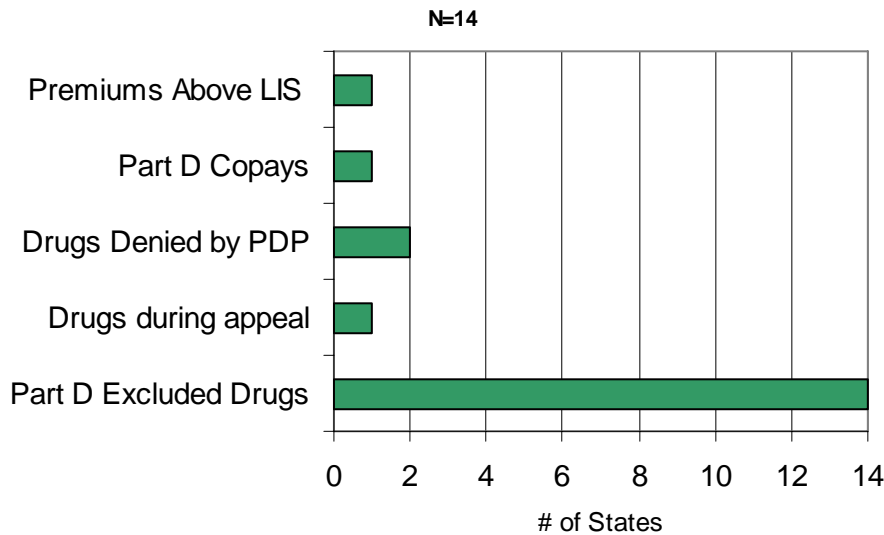
⁹ CMS letter # 05-002 to Medicaid Directors, June 3, 2005, Dennis Smith, page 1.

¹⁰ Subsequent to our survey, New York released the Governor’s proposed budget which would maintain NY Medicaid’s coverage of Part D off-formulary drug coverage for all classes through July 2006. From that point forward, NY Medicaid will offer coverage for off-formulary drugs in four drug classes after Medicare appeals have been exhausted and if deemed medically necessary. New York Fiscal Year 2006/2007 Budget. <http://publications.budget.state.ny.us/fy0607artVIIbills/HMH.HTM>.

Of the four surveyed Medicaid states that previously charged no drug co-payment under Medicaid, only New Jersey indicated that it would cover co-pays for duals, and is doing so by creating an SPAP specifically for dual eligibles. None of the states that charged some co-payments previously intended to assist the duals with any increased co-payments resulting from Part D. As noted in the SPAP section later in the report, three SPAP states (ME, MO, NV) - not included in the Medicaid survey - indicated that their SPAPs also would cover all or a portion of co-pays for duals.

Only New York indicated that it would cover premiums above the LIS amount, and only in those cases when the individual is enrolled in a Medicare Advantage managed care plan whose drug benefit premium is above the federal LIS amount.¹¹

Figure 1: Medicaid Plans for Filling Part D Gaps for Duals in Selected States, 2006



Source: Fox and Schofield, Medicaid and SPAP Part D Survey, Fall 2005.

Finding #2: Most states predicted that they would suffer losses in their Medicaid budget in 2006 as a result of Part D implementation

Background: In recent years, most states have adopted aggressive pharmaceutical cost containment strategies in their Medicaid programs, such as mandating generic substitution, limiting coverage to a preferred drug list unless a non-preferred drug is prior authorized, and negotiating supplemental rebates from drug manufacturers. These initiatives had helped to slow the cost growth in the Medicaid pharmacy benefit, which had been annually increasing by double digits in the 1990's.

¹¹ The Part D drug benefit is administered by both stand-alone Prescription Drug Plans (PDPs) and by Medicare Advantage managed care Prescription Drug plans (MA-PD) that include drugs in the array of services covered in their Medicare managed care product. Individuals enrolled in a Medicare Advantage plan with a prescription drug benefit, must enroll in the MA-PD's plan.

Impact of Part D: The MMA required that states remit to the federal government the major portion of what they would save by no longer having to cover drugs for duals. This amount is statutorily referred to as the “phased down state contribution” and colloquially known as the “clawback”. The clawback amount is based on a state’s expenditures for covered drugs for duals in 2003. The law assumed this amount would be saved by the state, since these expenditures would be replaced by Medicare. This estimated “savings” amount is then adjusted for inflation and enrollment. Each state’s contribution is 90% of estimated savings in 2006 phasing down to and remaining at 75% of savings in 2015 and thereafter, with the intention of producing greater savings for the states over time.

However, several states implemented cost containment measures after 2003., Therefore the results of their cost containment efforts will not be reflected in their clawback calculation. In addition, many states contend that basing the inflation factor on the experience of Part D drug plan expenditures will not reflect the inflation trend Medicaid programs would have had in the absence of Part D, because Medicaid’s drug inflation trend was lower than in commercial drug plans.

Survey Findings: Several questions were asked regarding financial estimates and the clawback.

Eight Medicaid programs predicted losses, two predicted savings, and four were unable to share estimates of impact.

Of the two indicating savings, one was eliminating a Medicaid waiver program covering senior drug benefits and the other did not have a preferred drug list or supplemental rebate program in its Medicaid program.

Eight states indicated that they had sought changes in the base year figures on the basis that they had initiated subsequent cost containment initiatives. However, none were successful in their efforts.

Finding #3: States vary in the degree to which they are supplementing federal efforts to assist the dual-eligibles through the transition

Background: CMS retained responsibility for transitioning duals into the Part D plans, including randomly assigning them to plans by December 31, 2005 and informing them of their assignment and options to move to plans of their choice. Individuals who are not eligible for full Medicaid benefits but who receive some assistance from Medicaid to pay for Medicare Part B premiums and cost-sharing (sometimes referred to as “partial dual-eligibles”), also are deemed eligible for LIS benefits by SSA and are to be auto-enrolled by CMS by May 15, 2006.

Unlike the SPAPs, Medicaid agencies were given no transition funds to provide the duals with any assistance beyond that planned by CMS, although any state expenditures for such purpose would be considered eligible for federal matching funds as administrative expenses. States’ primary responsibilities were to provide CMS with data on the dual population and to send letters to beneficiaries informing them that the Medicaid drug benefit was ending effective Jan 1, 2006.

Because of concerns that many duals would fall through the cracks during the transition, in May 2005, CMS notified Medicaid agencies that they could cover a three-month supply of drugs in January and claim federal matching money for the costs.¹² Doing so would not, however, reduce the clawback by a commensurate amount in the first year, thus resulting in states essentially paying twice for the extended supply.

Although the random auto-assignment process was conducted by CMS, states also had the opportunity to educate duals or reassign them into more appropriate plans based on their existing drug use and pharmacy history.

Survey Findings:

Even though the primary responsibility for transitioning the duals lay with CMS, all surveyed states described some efforts to work with other state agencies, senior advocacy agencies, and provider groups to educate them about the impact of the MMA on duals and to enable them to assist the duals through the transition. However, the degree of these efforts varied significantly, from sending out a simple bulletin to providing in-depth training and joint planning sessions.

Five of the fourteen states surveyed indicated that they would provide duals with information about which Part D plans best matched their needs, so that they could choose a better suited plan than the one to which they were randomly assigned, if there was one. This information would be based on a comparison of plan formularies and perhaps pharmacy networks to each patient's drug profile. Most were exploring use of vendor-supplied software to be applied for all duals, though one intended to do it on a more informal one-on-one basis for individuals who requested assistance. In addition, two SPAP states (ME, NV) whose Medicaid programs were not surveyed, planned to include the duals in the SPAP plan assignment based on individual members drug use profiles (see SPAP findings section). As of January, 2006, only the state of Maine had actually re-assigned its members to plans based on their drug use profiles.

Three of the fourteen surveyed states indicated they would cover a three-month supply, one of which would only do so on a case-by-case basis. A fourth state failed to answer the question, but subsequent news reports indicated that the state was intending to cover the three-month supply but had not widely publicized this decision.¹³

It is important to note that these survey responses were collected prior to actual program implementation. Once the benefit was implemented in January 2006 and dual-eligibles experienced considerable Medicare Part D enrollment problems and coverage gaps, thirty one states - including all but three of the states that we surveyed - have since elected to

¹² CMS guidance "A Strategy for Transitioning Dual Eligibles from Medicaid to Medicare Prescription Drug Coverage, May 2, 2005. Note that this 3-month supply policy preceded decisions made by CMS in January 2006 to make the states whole for temporary emergency coverage.

¹³ Alonso-Zaldivar, R. "Seniors Not Told of Drug Bridge", Los Angeles Times, Home Edition A-1, December 12, 2005.

provide temporary emergency drug coverage to the duals in lieu of or in addition to the three-month supply for those who received it.¹⁴

Finding #4: Few states intend to use SSA LIS data to identify individuals who might be eligible for the Medicare Savings Programs

Background: State Medicaid agencies also had some increased responsibilities for determining eligibility for Medicare's low income subsidies. The MMA allows eligible individuals to apply for Part D federal low income subsidies either through the Social Security Administration (SSA) or the state Medicaid agency. While most individuals are expected to apply through SSA, states are required to have the capacity to determine LIS eligibility and screen individuals who apply for LIS at the Medicaid agency, to determine if they might also be eligible for the Medicare Savings Programs (MSPs), which have been historically under enrolled. MSPs (also known by the acronyms QMB, SLMB, and QI-1) are federally mandated programs paid through Medicaid that subsidize Medicare Parts A and B premiums and co-payments for Medicare beneficiaries meeting similar, but slightly different, income and asset requirements than LIS eligibility requirements.

Unlike the state Medicaid agencies, the SSA is not required to screen for these programs but will provide some information to the states on residents found to be LIS eligible who could also be eligible for MSPs. The data provided by the SSA is limited and will not provide all of the information the states need to fully determine MSP eligibility, but only to screen them for possible eligibility. States may, but are not required to, follow up on these LIS leads from SSA to get these potential enrollees into the MSP programs.

States have publicly expressed concerns that the MMA will result in growth in their enrollment numbers for MSP programs, even if they do not reach out and screen the SSA LIS applicants. Indeed, this is a factor in their overall assessment that Part D implementation will result in a negative impact on the state Medicaid budget.

Survey Findings:

Half (seven out of 14) of the surveyed states said that they would not follow-up on the SSA LIS data to identify persons that could be MSP-eligible. Only four indicated that they would use the SSA data and another three states had not yet decided whether they would use the SSA data to identify possible MSP-eligible persons.

Six out of the seven states that indicated they would not use the SSA LIS leads, still had budgeted for increases in MSP enrollment. Given that the SSA is not required to screen for MSPs and since most states are guiding persons to apply through the SSA, it is not clear that MSP enrollment would increase as these states are predicting.

¹⁴ National Conference of State Legislators, State Medicare Part D Transitional and Emergency Coverage. Updated February 8, 2006. <http://www.ncsl.org/programs/health/partdpatch.htm>.

SPAP SURVEY FINDINGS

Finding #5: Most SPAPs Are Maintaining Some Coverage to Hold Enrollees Harmless

Background: Before the MMA, there were huge state variations in pharmacy coverage available for low-income elderly or disabled Medicare beneficiaries ineligible for Medicaid. Half of the states did not provide any state-subsidized drug coverage beyond what was provided through the state Medicaid program. States that provided SPAP coverage each defined their own categorical and income eligibility. Benefit design and the type and quantity of drugs covered varied significantly. The programs also varied in size, ranging from 71 enrollees in Alaska to more than a quarter million in each of the states of NY, PA, and NJ.¹⁵ These wide variations across SPAPs further supported the need for a standardized federal benefit through Medicare, rather than leaving this responsibility to the states. However, SPAP enrollees are at risk of having less comprehensive coverage or reduced access through the Medicare program, to the degree that some states had more generous or less administratively complex coverage than what will be available through Part D.

Impact of Part D: The MMA minimized the role of states in the implementation of Part D. In keeping with the conceptual framework of a privately administered drug benefit, SPAPs were neither allowed to become Part D plans nor to obtain subsidies for maintaining their programs, such as those available to employer-sponsored retiree plans.

However, the MMA does provide some incentives for SPAPs to continue to provide or expand coverage to their enrollees as a secondary payer. The availability of drug coverage through Medicare is expected to relieve the states of some financial burden as Medicare assumes the role of primary payer. In addition, in contrast to other third party insurers or group health plans, SPAP contributions toward Part D cost-sharing paid on behalf of the beneficiary will count toward “true out-of-pocket” (TrOOP) costs.¹⁶ This allows SPAP enrollees to get through the “doughnut hole,” while spending much less out-of-pocket. Once through the doughnut hole, Medicare catastrophic coverage kicks in, covering 95% of the cost of drugs, thereby relieving the SPAPs of a cost burden for these highest cost users that they would otherwise have borne in the absence of Part D. Part D plans are also required to coordinate benefits with SPAPs. States have the option of either coordinating benefits or paying plans a lump sum payment option. Finally, the MMA provided SPAPs with transitional grant funds to assist in getting their enrollees enrolled in the new Medicare Part D benefit.

To be eligible for these privileges, each SPAP must attest to being “qualified” and must state that their program “provides financial assistance for the purchase or provision of supplemental prescription drug coverage on behalf of Part D eligible individuals...and does not discriminate based upon the Part D plan in which the individual is enrolled.”¹⁷ Qualified SPAPs cannot steer beneficiaries toward a preferred plan. SPAPs also cannot interfere with the primary payer status of Medicare and cannot receive any federal funding (thereby discouraging states with Medicaid

¹⁵ Fox and Schofield, Medicaid and SPAP Director Part D Survey, Fall 2005.

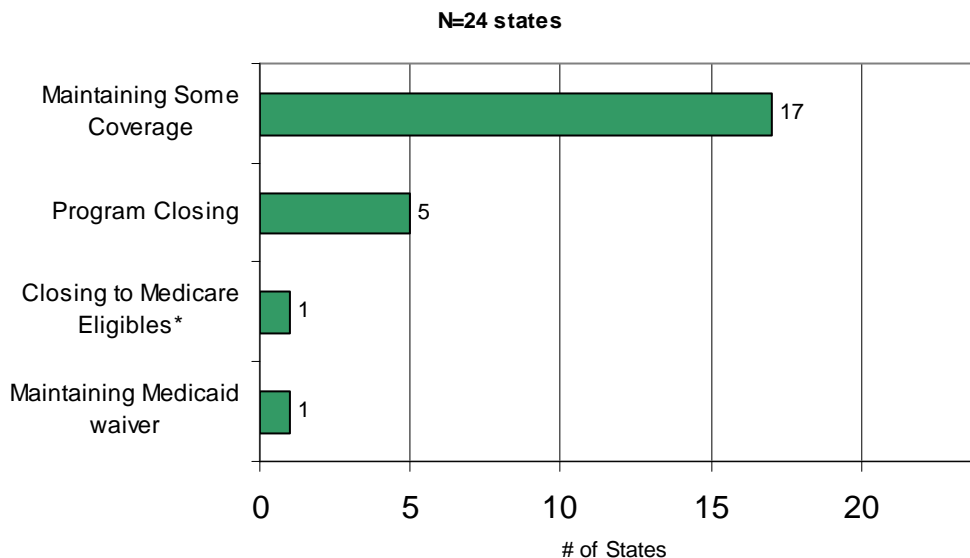
¹⁶ H.R. 1, 2003, Section 1860D-2(b)(4)C (ii). True-out-of-pocket costs are those costs incurred by the beneficiary for Part D covered drugs during the deductible period and for cost-sharing before and during the doughnut hole.

¹⁷ HR 1, 2003, Section 1860D-2(b)(1).

Pharmacy Plus or other waivers to maintain them). While discouraged by CMS, states may still elect to be “unqualified” and act as a group health plan supplementing Medicare as a secondary payer, but forego the special privileges of being an SPAP.

Survey Findings: The vast majority of states reported that they will be “qualified” in 2006 and will maintain some assistance for their enrollees.¹⁸

Figure 2: SPAP Plans Once Medicare Part D Begins in 2006



Source: Fox and Schofield, *Medicaid and SPAP Part D Survey, Fall 2005*.

*Maryland is also closing its waiver program to Medicare eligible but will continue a second state-only program to provide wrap assistance for non-LIS eligible persons.

Only five states (FL, NC, KS, MI, MN) reported that their programs were closing entirely and one state (WY) will be maintaining its program only for non-Medicare eligible persons (Figure 2).

Four of the six closing programs had income eligibility at or below 135% FPL and anticipated that most or all of their enrollees would be eligible for full or partial low-income subsidies from Medicare, which would provide more generous coverage than previously available through the SPAP.

For SPAPs that will maintain some coverage, states are either replacing existing programs for Medicare-eligible persons with new Medicare D-gap plans or modifying their existing programs to be the secondary payer. In both cases, the benefit structures

¹⁸ At the time of our survey, both Pennsylvania and Missouri were inclined to be “unqualified” in order to work with one preferred plan. Subsequently both have decided to be a “qualified” SPAP. Snowbeck, C., Pennsylvania Governor unveils “marriage” of PACE/Part D plans, *Pittsburgh Post Gazette*, Dec 1, 2005; CMS Qualified SPAP list downloaded from <http://www.cms.hhs.gov/States/Downloads/QualifiedSPAPList1108.pdf>, 2/1/05.

are designed to cover Medicare cost-sharing up to the existing state cost-sharing requirements to the extent possible to hold their current enrollees harmless.

With the exception of Wisconsin,¹⁹ all of the states that had Pharmacy Plus or Section 1115 waivers intend to either terminate their waivers entirely or maintain them only for non-Medicare-eligible enrollees.

Four waiver states (SC, IL, VT, and MD) developed new wrap-around programs for Medicare-eligible waiver enrollees supported by state-only dollars.

In addition, several other states that did not previously have an SPAP and thus were not included in our survey passed legislation in 2005 to supplement Part D in some form (HI, MT, KY, NH), or have signed qualified SPAP certifications with CMS (CA, WA).²⁰

Finding #6: SPAP “D-Gap” Plans Vary – No Clear Patterns

Background: The new standard Part D benefit, with its premiums, deductibles, cost-sharing, doughnut holes and catastrophic coverage, has a much different benefit structure than what was previously typically available through SPAPs. Few SPAPs required enrollees to pay premiums or enrollment fees, and only a third had deductibles.²¹ Those programs that had up-front costs imposed different ones than required under the standard Part D benefit. For most SPAPs, cost-sharing remained the same regardless of enrollee expenditure level, although a few states had benefit caps or lower cost-sharing once someone had spent a catastrophic amount. The level of cost-sharing in SPAPs ranged from a few dollars per prescription to 85% of the discounted price of the drug.²²

Impact of Part D: SPAPs can choose to wrap around any combination of the gaps in the standard Part D benefit or the full or partial low-income subsidies. For the basic benefit, states may pay a portion or all of the premiums on behalf of their enrollees, help with cost-sharing during the deductible period and in or out of the doughnut hole, pay for off-formulary or non-Part D covered drugs, or cover drugs purchased outside of the Part D plans pharmacy networks. Only the state’s contribution toward cost-sharing in the deductible period and in and out of the doughnut hole counts toward TrOOP.

Further complicating benefit design for states, not all their enrollees will face the same cost-sharing requirements under Medicare. Many, but not all, SPAP enrollees will be eligible for the full or partial low-income subsidies. These enrollees will have no or partial premiums, no or

¹⁹ Foley, R. “Drug plan safe until July 2007, Doyle says”, Associated Press, Oct 13, 2005.

²⁰ National Conference of State Legislatures. State Pharmacy Assistance Programs, Updated Jan 1, 2006.

<http://www.ncsl.org/programs/health/drugaid.htm>. CMS Qualified SPAP list downloaded from

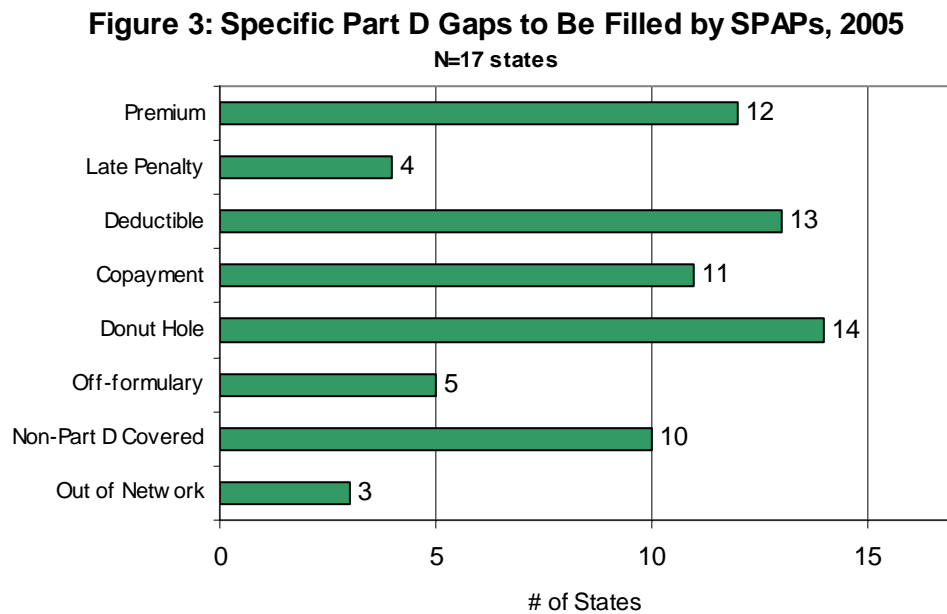
<http://www.cms.hhs.gov/States/Downloads/QualifiedSPAPList1108.pdf>, Feb 10, 2006

²¹ Trail, T., Fox, K., Silberberg, M., Cantor, J., Crystal, S. State Pharmacy Assistance Programs: A Chartbook, Commonwealth Fund, New York, NY, August 2004.

²² Sia, J, Fox, K., Trail, T., Crystal, S. State Pharmacy Assistance Programs 2004, Commonwealth Fund, New York, NY, publication forthcoming.

limited deductibles, nominal cost-sharing requirements and no gap in coverage but could still require help in paying these costs or assistance with non-formulary or non-Part D covered drugs.

Survey Findings: The variation in SPAP benefit design pre-MMA will continue in 2006. SPAP “D-Gap” plans vary significantly in terms of how much states will help with Medicare premiums, deductibles, cost-sharing in and out of the doughnut hole and coverage of off-formulary drugs (Figure 3).



Source: Fox and Schofield, *Medicaid and SPAP Part D Survey, Fall 2005*.

Nearly all the states providing gap coverage intend to provide some coverage during the doughnut hole and the deductible period and for co-payments, all of which will count toward TrOOP.

Twelve states (71%) also plan to pay premiums in at least one of their state pharmacy assistance programs.²³ Eight of these states will only cover up to the LIS benchmark, thereby limiting the plan options available to enrollees unless the enrollee elects to pay the additional premium for higher cost plans.

Only four states plan to pay for late penalties, although many states had still not made this decision at the time of our survey.

Five states (30%) plan to cover off-formulary drugs. Most will only do so after the Medicare appeals process has been exhausted and with prior authorization by the state.

Decisions to cover off-formulary drugs were not consistent across SPAPs and Medicaid in states where both agencies were surveyed. While New York and New Jersey indicated that it would be covering off-formulary drugs in both their Medicaid and SPAP programs,

²³ The state of New Jersey will be covering premiums in its Pharmaceutical Assistance for the Aged and Disabled program for lower-income beneficiaries, but will not cover premiums for its Senior Gold program targeted to higher income enrollees.

Pennsylvania will be covering off-formulary drugs for its SPAP enrollees but not for the duals.

Many more states (10) indicated that they would continue to cover non-Part D drugs that they had previously covered.

Only a few states indicated that they would pay for drugs purchased at pharmacies out of their Medicare Part D plan's network.

In general, states are not extending benefits, but are holding their enrollees harmless. This means they have structured their benefits to assure that the combination of Medicare and SPAP benefits is no less than their previous SPAP-only benefits. Programs in Rhode Island, Texas, Illinois and Vermont, which previously covered drugs only for certain diseases or chronic conditions, plan to wrap around cost-sharing for the drugs they previously covered, not for all drugs in the Part D plan's formulary. However, enrollees that enroll in Part D will have expanded coverage because Medicare Part D plans must cover at least two drugs per class.

Three states – Illinois, Pennsylvania and South Carolina - also are testing the limits of the anti-discrimination rule by only providing wrap benefits for Part D plans that agreed to work with the state and comply with their requirements.

Finding #7: SPAP Savings Expected, but Level of Savings Still Unclear

Background: Prior to the MMA, most SPAPs were funded by state-only dollars from general funds, which were subject to threat of annual budget cuts, or from earmarked sources such as tobacco settlement, lottery, or casino revenue funds. Generally more protected from budget cuts than Medicaid programs, SPAPs had experienced double-digit increases in program budgets over the past several years as a result of increasing enrollment, utilization and per unit drug costs.^{24, 25}

Impact of Part D: To the degree that their enrollees enroll in Part D, SPAPs could see considerable savings through cost avoidance for benefits which will be assumed by the federal Medicare program. CMS projected that SPAPs would accrue as much as \$600 million per year in savings from the low-income subsidies alone,²⁶ presuming that all SPAP enrollees who are potentially eligible for LIS apply and are found eligible.

Survey Findings: While most SPAPs reported that they anticipated savings from Medicare Part D, state officials were cautious in quantifying the exact level of savings due to considerable uncertainty around enrollment in Part D and the low-income subsidies.

Programs that were ending effective January 2006, expected that a large portion of the existing program budgets would be freed up to fill other budget needs. But even these programs anticipated some delay in obtaining these savings. For example, Wyoming will exclude

²⁴ Fox, K, Silberberg, M, Trail, T., Belloff, D., Crystal, S. Impact of Budget Pressures on State Pharmacy Assistance Programs, FY 2003–2004, Rutgers Center for State Health Policy, New Brunswick, NJ, January 2004.

²⁵ Fox, K., Trail, T., Reinhard, S., Crystal, S., Managing Program Costs in State Pharmacy Assistance Programs, The Commonwealth Fund, New York, NY, February 2004.

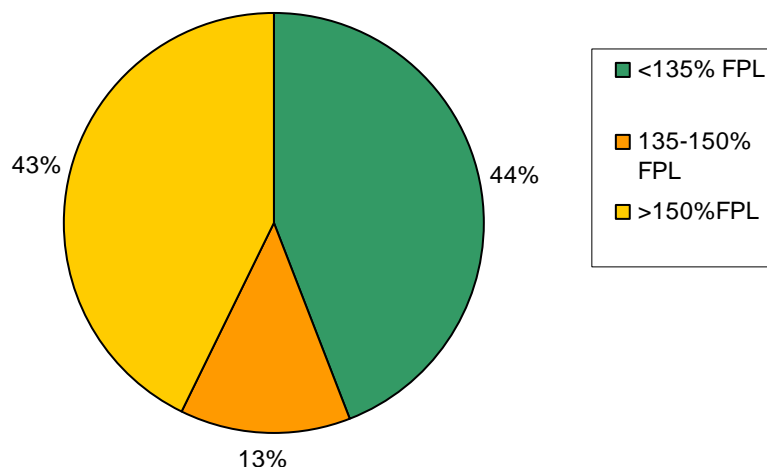
²⁶ CFR 423 V.(H)(4).

Medicare beneficiaries from receiving benefits under the state's Prescription Drug Assistance Program, but they elected to maintain drug coverage until the end of Medicare's open enrollment in May 2006 to ensure that all their beneficiaries have ample opportunity to get enrolled in the Part D plans. As a result they do not anticipate any savings until FY 2007.

States that were mandating that SPAP enrollees be enrolled in Part D and the low-income subsidies by January, 2006 were reluctant to assume that savings will be realized immediately, recognizing that there could be delays in enrollment or LIS eligibility determinations and that enforcement of the mandate might be difficult.

SPAPs reported that, on average, close to half of their enrollees are income-eligible for either the full low-income subsidies or the partial low-income subsidies (Figure 4). Since most SPAPs do not have asset tests, these estimates are based on income alone or in some cases reported interest and dividend income as a proxy for assets. LIS-enrollment rates released by SSA in November, 2005 suggest that using income eligibility may significantly overestimate the number of LIS eligibles. The vast majority of applications received by SSA were rejected due to failure to meet the asset requirements.²⁷

Figure 4: SPAP Enrollment by Income Eligibility for Part D Low-Income Subsidies, 2005
N= 1.5 m enrollees in 17 states



Source: Fox and Schofield, *Medicaid and SPAP Part D Survey, Fall 2005*.

Many SPAPs also were concerned about the cost impact of the anti-discrimination rule for qualified SPAPs. This rule requires SPAPs to offer equal assistance to members enrolled in all Part D plans and not to steer beneficiaries to one plan or another through benefit design or

²⁷ Alonso-Zaldivar, R. Few apply for low-income Medicare aid – Many seniors ignorant of or confused by new prescription benefit. *Los Angeles Times*, December 3, 2005. Kaiser Family Foundation, Medicare Prescription Drug Coverage Enrollment Update, January 2006.

otherwise.²⁸ The anti-discrimination requirement also bars SPAPs from recommending Part D plans based on “the SPAP’s financial interest in minimizing the costs of providing benefits that supplement the Part D coverage.”²⁹ States had no data to quantify the additional administrative and program costs resulting from this requirement, which are expected to be high. Indeed, in some states there are more than forty plans with which SPAPs must coordinate benefits, most of which offer an actuarially equivalent benefit structure rather than the standard Part D plan.

Finding #8: SPAP Interventions to Ensure LIS Enrollment More Limited than Expected and Only a Few States Electing to Assign Members by Drug Needs to Part D Plans

Background: SPAPs face tighter enrollment restrictions under Part D than what was allowed during the interim Medicare discount card program. Many SPAPs had achieved extremely high enrollment rates for transitional assistance during the discount card program, because they were allowed to auto-enroll their members into a preferred card and transitional assistance using existing SPAP income eligibility information.³⁰ Despite the recommendations of the MMA-mandated SPAP Transition Commission to maintain these allowances in Part D, the final regulations explicitly prohibit states from steering beneficiaries toward one plan or determining LIS eligibility.

SPAPs can act as an authorized representative on behalf of their enrollees, if they have or establish legal authority to do so. SPAPs are also allowed to co-brand with Part D plans by putting their state emblem or logo on the Part D plan enrollment card. Co-branded plans must meet criteria set by the state, and the state must extend the opportunity to co-brand to all Part D plans meeting the criteria.³¹ SPAPs were also allowed to either mirror the dual random assignment process to ensure their members were enrolled in Part D plans or to facilitate enrollment for certain groups of individuals into plans best suited to them in terms of pharmacy networks or specific drug needs. Through what has been referred to as “intelligent random assignment,” SPAPs can use objective criteria, set by the state and approved by CMS, to narrow the range of Part D plans into which enrollees will be randomly assigned. This process compares drug plan networks and formularies to individual enrollee’s pharmacy claims profiles in order to assign enrollees to the best matches. The MMA also set aside \$125 million in transitional grant funding over a two-year period, pro-rated based on SPAP enrollment, to assist states in getting their SPAP enrollees into Part D plans.

²⁸ Sec 423.464 (e)(1)(ii).

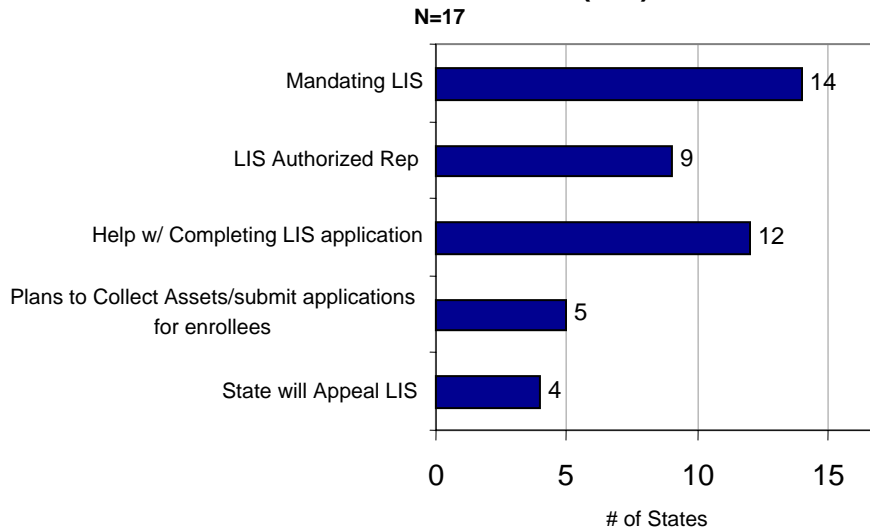
²⁹ Federal Register, Volume 70, No. 18, Friday, January 28, 2005, Preamble to rules and regulations. P 4321.

³⁰ Fox, K., Sia, J, Coordinating Medicare Prescription Drug Benefits with Existing State Pharmacy Assistance Programs: Partnership or Crowd-out? Rutgers Center for State Health Policy, New Brunswick, NJ, November 2005.

³¹ CMS, Qualified SPAP Guidelines, <http://www.cms.hhs.gov/States/Downloads/QualifiedSPAPGuidelines.pdf>.

Survey Findings: Despite the opportunity to realize much greater savings from the LIS, few SPAPs have taken every possible measure to ensure that all eligible enrollees applied and were determined eligible for the LIS (Figure 5).

Figure 5: State Efforts to Enroll SPAP Enrollees in Low Income Subsidies (LIS)



Source: Fox and Schofield, *Medicaid and SPAP Part D Survey, Fall 2005*.

The vast majority of states are relying on a mandate for eligible SPAP enrollees to apply for LIS. States were planning to verify the SSA application through CMS data matches or to require enrollees to show denials from the SSA.

While most states had also passed legislation or otherwise established themselves as the authorized representatives to apply for LIS, only five states said they had plans to collect asset information to submit applications on their enrollees' behalf. Without this asset information, states are unable to apply for LIS on their enrollee's behalf.

Of the five collecting asset information, only New Jersey was actually submitting LIS applications on behalf of their enrollees at the time of our survey. New Jersey had accelerated the SPAP recertification timeframe for enrollees that were likely to be LIS eligible and modified the SPAP recertification application to include LIS asset information. Prior to submitting applications to the SSA, New Jersey was also reviewing the applications and calling individuals to confirm or clarify inconsistent information to avert potential denials. Of the 70,000 persons sent renewal applications that the state estimated might be eligible for LIS, 63,644 returned the applications. Of these, the state has sent 42,116 to SSA that they expect will all be determined eligible and is still working to collect additional data for the remainder.³² If all of these are determined

³² Data provided by the NJ Department of Health and Senior Services, Feb 2006.

eligible, this enrollment rate of more than two thirds of estimated eligibles is much higher than that achieved by the SSA through its national campaign.³³

Most states (see Figure 6) mandated that Medicare-eligible SPAP beneficiaries enroll in Part D plans in order to continue to be eligible for SPAP benefits. Two notable exceptions were Pennsylvania and New York, neither of which required that their enrollees enroll in Part D or apply for the LIS. Neither state intended to pay Part D premiums either.

Six states were also co-branding with one or more plans to help their enrollees select among plans and three others were undecided about co-branding.

Ten states were assisting their beneficiaries to enroll in Part D plans – five through random assignment to all plans, and five through assignment to plans that best match beneficiary drug profiles.

At the time of our survey only one state had received official CMS approval for their intelligent random assignment plan, but four others were in the process of submitting criteria or were awaiting CMS approval.

Officials in Pennsylvania originally intended to assign LIS members into a preferred plan and be “unqualified”. They have since reached agreement with CMS to be qualified, but they still plan to limit the number of plans into which enrollees will be assigned.³⁴ Similarly, Illinois, which has a qualified SPAP, is only auto-assigning to two prescription drug plans and three Medicare Advantage plans, with which the state is contracting to provide wrap-around benefits. This contrasts with states such as New Jersey and Maine which included six to ten plans that agreed to provide data, suggesting that some states have successfully re-interpreted CMS’s rules against steering enrollees to preferred plans or tying benefits to plan choice by narrowly defining criteria for inclusion in the state’s assignment process.

Finding #9: Few States Expanding SPAP Eligibility

Background: Prior to the MMA, SPAP programs varied considerably in terms of income and categorical eligibility. While all the programs provided some coverage to the elderly, only half provided coverage to the disabled, and only two provided coverage regardless of age. In contrast to income-eligibility for the Medicare low-income subsidies that is capped at 150% of the federal poverty level, income eligibility caps for SPAP subsidy programs ranged from 100 to 500% of the federal poverty level.

Impact of Part D: With the availability of Medicare Part D drug coverage and the potential savings to the states, policymakers have the opportunity not only to supplement the Medicare

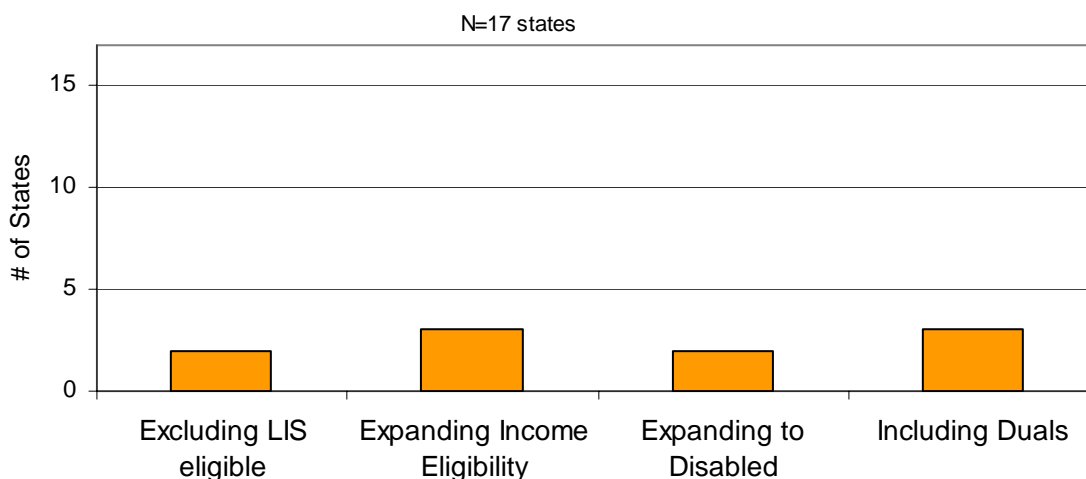
³³ Kaiser Family Foundation, Medicare Prescription Drug Coverage Enrollment Update, January 2006.

³⁴ Snowbeck, C., Pennsylvania Governor unveils ‘marriage’ of PACE/Part D plans, Pittsburgh Post Gazette, Dec 1, 2005.

benefit for existing eligible persons, but to expand to new groups that the states could not previously afford to cover.

Survey Findings: States are generally exercising caution in spending Medicare Part D savings before they are realized. Beyond mandating Part D/LIS enrollment or application as a condition of participation in the SPAP, as shown in Figure 6, only a few states are expanding income eligibility, or extending coverage to the disabled.

Figure 7: SPAP Eligibility Changes Beyond Mandating Part D/LIS, 2005



Source: Fox and Schofield, *Medicaid and SPAP Part D Survey, Fall 2005*.

Three states (ME, MO, NV) had changed eligibility rules to allow duals to receive coverage of all or a portion of their co-payments through the SPAP. In addition, as noted above, the state of New Jersey created a new SPAP specifically for its duals to cover co-payments and some off-formulary drugs.

Three states (AK, IN, MO) that previously limited income eligibility to levels below what is now the LIS maximum (i.e. 150% of FPL), were expanding income eligibility to provide premium assistance to persons with partial LIS that must still pay a sliding scale premium or those above the LIS level. Alaska, the only continuing SPAP that already had an asset test, also significantly increased its allowable asset levels.

Nevada and Missouri indicated plans to expand to the disabled. Nevada also will offer additional vision and dental benefits to all of its enrollees.

Two states (SC, MD) were excluding LIS eligibles from SPAP eligibility, since the SPAP benefits do not go beyond those already available through the LIS program.

While not shown here, Maryland's waiver program, which closed benefits to Medicare enrollees, was seeking approval from CMS to change eligibility for the discount program

to non-Medicare beneficiaries up to 200% FPL. Similarly, Wyoming's program for non-Medicare beneficiaries is likely to expand. The state plans to lift its current enrollment freeze, allowing more non-Medicare beneficiaries to enroll.

Finding #10: SPAPs Defaulting to Part D Benefit Management Strategies

Background: With a few exceptions, most SPAPs have not traditionally had aggressive utilization management strategies to contain costs. In FY 2003, nine states were using a preferred drug list with prior authorization.³⁵ The vast majority of programs, particularly the three largest in NJ, NY, and PA, had open formularies with prior authorization only on a limited list of drugs or drugs that were determined to be medically unsafe or inappropriate. States varied in how strictly they required mandatory generic substitution.

Impact of Part D: Part D plans are encouraged to contain costs through competitive free market practices that will steer utilization toward lower cost alternatives or to drugs for which deeper discounts are provided. Part D plans are allowed to use any variety of tiered formularies, prior authorization, step therapy, preferred pharmacy networks, and mail order pharmacies. Generic substitution is required and pharmacists must inform beneficiaries of a generic alternative, if one exists.

Survey Findings: We asked states about their plans to coordinate with the utilization management (UM) tools of the plans and whether states intended to keep their own utilization management systems in addition to the Part D plans for Medicare beneficiaries. The vast majority of states are electing to default to the Part D plans' formularies and utilization management, rather than attempting to coordinate benefits by maintaining their existing program rules for the wrap-around benefits. States stand to benefit financially from the Part D plans' utilization management to the degree that they monitor drug use more aggressively. However, SPAP enrollees are likely to be facing many more administrative hassles than they have been accustomed to in the past, which could reduce or delay access to medically necessary drugs. Furthermore, this creates the potential for a perceived inequity within an SPAP program, since those who are enrolled only in the SPAP may have access to an array of drugs without utilization management hurdles, which are not available to individuals enrolled in both the SPAP and a Part D plan.

³⁵ Sia, J., Fox, K., Trail, T., Crystal, S., State Pharmacy Assistance Programs, A Chartbook, Commonwealth Fund, publication forthcoming.

POLICY IMPLICATIONS & DISCUSSION

Our survey results reveal that states are moving cautiously in supplementing the new Medicare drug benefit.

Differences in State “D-Gap” Plans for Duals and SPAP Enrollees

Medicaid agencies and SPAP programs appear to be taking different tacks in offering Part D gap coverage for their current or prior enrollees. Most of the surveyed Medicaid agencies had no plans to supplement Part D formularies for duals or to assist with Part D co-payments, even in those states which previously charged no co-payments under Medicaid. Most Medicaid agencies were deferring to the Medicare benefit and not electing to pay for premiums above the LIS benchmark. Most states only intended to cover drugs excluded from Part D for which they were already paying and, to the degree that this coverage is maintained for the non-duals, for which they are legally obligated.

In contrast, the trend among SPAPs is to hold their current enrollees harmless, such that the combination of Medicare and SPAP benefits is no less than their previous SPAP-only benefits. In states where the federal low income subsidy program fully or largely replaces the benefits and serves the populations that were previously served by the SPAP, most are terminating their programs. But in states where SPAP eligibility extends well above the low income subsidy level, states are more uniformly continuing some type of SPAP benefit to complement the MMA. The vast majority of remaining SPAP states intend to help their non-LIS enrollees pay for Part D premiums and deductibles, which most SPAP enrollees were not subject to previously. In addition, most states also intend to provide wrap-around benefits for the cost-sharing in and out of the doughnut hole up to the current SPAP co-payments. Five of the larger, well-established SPAPs also will cover some off-formulary drugs.

In the states where we surveyed both the SPAP and the Medicaid agency, some showed considerable consistency across agencies in their approach to Part D gap filling, while others did not. Four of the states where the Medicaid agency indicated that it would not provide any wrap-around benefits other than Part D excluded drugs, also had SPAPs that were ending in 2006. Some states, such as New Jersey, that intend to cover co-payments and off-formulary drugs for duals, also will pay for medically necessary off-formulary drugs in their SPAP and wrap around the Medicare cost-share up to the current SPAP requirements. Other states showed less consistency across programs, with the SPAP covering co-payments up to its prior coverage level, but the Medicaid program not covering any new Medicare co-payments.

Previous research has shown that, historically, SPAPs have been more protected from budget cuts and cost containment initiatives than Medicaid programs, due to a variety of factors including their smaller size and budgetary impact as well as their stronger political constituency.³⁶ This trend appears to hold true under Part D as well. The differences in Medicaid and SPAP responses may also reflect fewer opportunities for creative design in the

³⁶ Fox, K, et al, January 2005.

Medicaid arena than in the SPAP arena. SPAPs were given much more flexibility and were encouraged in the MMA to design wrap programs, while Medicaid programs were largely expected to drop out of the administration of prescription drug coverage for the duals and only to pay clawback payments to fund duals' coverage under Medicare.

In fact the “clawback” requirement may result in many Medicaid programs paying more for Part D in the short term than they would have if they had maintained the duals under the Medicaid drug benefit. This not only reduced potential state savings to cover Part D gaps for the duals, but also undoubtedly contributed to the states' reluctance to fill holes in the Medicare benefit for which they were already forced to pay.

In addition, the low-income subsidies (LIS) that the dual-eligibles will receive cover many of the largest perceived gaps in the Medicare benefit (i.e. premiums, deductibles and the doughnut hole). In contrast, many of the SPAP enrollees will only be eligible for Part D and thus face nominally (but not necessarily relatively) larger differences in cost-sharing under Part D relative to their prior coverage. SPAP enrollees that are not found to be eligible for low-income subsidies could be facing a coinsurance of 25% of the Part D drug costs during the initial benefit and 100% of their drug costs during the doughnut hole, compared to some state programs that only required \$5 to \$15 per drug regardless of the level of the individual's drug expenditures. In contrast the duals will face modest cost-sharing increases of up to \$5 per prescription.

However, only considering the nominal differences in costs and not the relative impact may be misleading. As indicated earlier, some states had no co-pays previously, and even those that did had maximum co-pays of \$3.00. Thus, an increase to \$5.00 is at least a 66% increase, which may be equally or even more of a barrier for the duals, with incomes far below the federal poverty level, than much larger cost-sharing increases for SPAP enrollees, with incomes over 200% FPL.

SPAPs Holding Enrollees Harmless, Not Expanding Eligibility or Benefits

Even though SPAP states will eventually see some savings as a result of both cost avoidance with Medicare Part D as the primary payer and the generous low-income subsidies for the portion of their enrollees that qualify and enroll, very few SPAPs have elected to expand either SPAP eligibility or benefits to extend this Part D-gap coverage beyond what they currently provide. States are exercising some caution and waiting to capture some federal savings before expanding their programs. This “wait and see” approach may be warranted. The problems experienced in the early weeks of Part D implementation have demonstrated that states could, in fact, lose more money than they are likely to save at least until the program is fully and effectively up and running.

Even if the states do realize some savings, it is not unreasonable for a state to feel released from obligation when a federal program steps in to take over, especially after a prolonged period of state budget shortfalls, ever-growing budget demands in other areas, and years of the state generously funding pharmacy coverage due to the absence of Medicare drug coverage. Saved SPAP funds can just as easily be deployed to close budget gaps, pay down state debt, or provide drug benefits or broader health insurance coverage to other low- income, uninsured populations

with no access to Medicare benefits. Furthermore, some state policymakers and program directors seemed not to relish the administratively burdensome role of being a secondary payer to private sector plans with complex benefit structures, over whom the SPAPs have little leverage.

On the other hand, SPAPs that have had relatively modest benefits or eligibility, have the opportunity to invest relatively little in the form of Part D premium assistance to assure access to fairly comprehensive drug benefits for previously excluded “near-poor” elderly and disabled populations. Because the Part D premiums represent only about a quarter of the cost of the actual Part D plans costs, every dollar spent on premiums will assure access to benefits worth nearly three dollars on average. This is a good return on investment for a state concerned about its citizens’ welfare. Furthermore, it may even result in future savings to the Medicaid program in the long run. Individuals with subsidized access to prescription medications may be slower to spend down their assets to the level of Medicaid eligibility both because their health is better maintained and because their assets are not depleted to pay for medications. Indeed, this was the rationale behind Medicaid Pharmacy Plus waivers in recent years.

Once savings are realized, states may want to have a policy debate regarding the best use of the savings. A key question to be considered in that debate is whether it is better to use limited state funds to fill in all of the gaps in Medicare coverage for a smaller group of enrollees, or to assist a larger number of program beneficiaries with premium assistance only, thereby assuring that they have at least some coverage for drugs. Indeed, the answer to such a question may appropriately vary depending upon the level of resources of the enrollee group. It may make the most sense to phase down wrap-around benefits as income rises. This would assure that low-income persons who don’t qualify for federal low income subsidies due to assets, for example, would receive extensive gap coverage as well as premium subsidies. However, higher income persons would qualify for premium assistance only.

Formularies: To Wrap or Not to Wrap

The decision to provide coverage for off-formulary drugs is a difficult one for state Medicaid and SPAP agencies. A recent OIG study showed that only 18% of dual eligibles were randomly assigned to plans covering the 178 drugs most commonly used by duals in 2005.³⁷ This gap in access could mean a considerable bill if Medicaid programs were willing to pay, but could also spell major problems in health care quality if they don’t.

States are concerned that, by covering off-formulary drugs, they may encourage Part D plans to limit their formularies to the narrowest possible legal standard, putting them in the awkward position of assuming costs that should otherwise be assumed by the Part D plans. Furthermore, states themselves have been advocates of moving their recipients to lower cost drugs in the same therapeutic class, as many states have already done through preferred drug lists. They feel that, in many cases, moving individuals from one drug to another in the same class may have no or minimal therapeutic consequence. Therefore, many states are supportive of, or at least in no position to criticize, Part D plan efforts to contain costs through formulary restrictions and utilization management techniques. Indeed, since the inflation factor for states’ clawback

³⁷ Office of Inspector General, Department of Health and Human Services, Dual Eligibles’ Transition: Part D Formularies’ Inclusion of Commonly Used Drugs, OEI-05-06-00090. January 2006.

payments are a function of inflation rates in the Part D plans, states have a vested interest in the cost containment successes of these plans through mechanisms such as formulary restrictions.

At the same time, adverse effects from lack of coverage of specific drugs could have an impact on states in other ways. Individuals who fail to get the drugs they need may wind up utilizing other, more expensive medical services. Thus, states may wish to reserve the right to cover off-formulary drugs in limited cases or for certain categories of drugs where the likelihood of adverse outcomes is higher. At minimum they could help duals to appeal for coverage of medically necessary drugs.

The federal government could also reconsider its decision about federal matching funds for these costs. Given early experience showing a lack of plan compliance with providing transitional coverage for the duals, the federal government may want to allow the states as a safety net in these limited instances. Oversight of plan compliance with the appeals process or the anti-discrimination requirement on formulary design is likely to be difficult for CMS, given the large number of plans. Allowing states to serve as a safety net to ensure additional protections from discrimination against the sickest patients could be relatively inexpensive but good public policy. States, who will be paying half of the costs of these drugs, would still have an incentive to be conservative in which off-formulary drugs they approved, but as the protector of the public safety might find some drugs medically necessary in cases where the plans may not.

States Can Do More to Maximize SPAP Savings

In order to maximize the greatest federal cost offsets and thereby savings to the state, states should consider all the options for ensuring that all their enrollees are benefiting as best they can from the federal Medicare drug benefit. Many states could be taking much more aggressive actions to ensure that eligible enrollees benefit from the LIS and are enrolled in plans that are most cost-effective. These include mandating Medicare and LIS enrollment as a condition of eligibility in states that have not already done so, giving the SPAP authorized representative status, collecting accurate asset information to submit LIS applications to the SSA on behalf of enrollees, and assigning enrollees to Part D plans that most closely match their pharmacy claim profile.

While most states have elected to only subsidize premiums for their SPAP enrollees up to the LIS benchmark, states may also want to reassess this decision once they have more time to compare benefits in non-LIS plans. They may determine that it is in a state's interest to pay the higher premium of at least some non-LIS plans because those plans offer broader formularies or lower cost-sharing across tiers, thus generating lower costs for wrap-around benefits by the SPAP. For example, a recent Lewin report found in New Mexico that Part D plans that have no deductible and "cover the first \$250 of expenses, cost \$11.50 per month more in premiums (\$138 per year) than those with a \$250 deductible."³⁸ If most SPAP enrollees use at least \$250 in drugs annually, it would be worth it for the SPAP to pay the higher premium to enroll them in no-deductible plans.

³⁸ The Lewin Group Medicare Rx Fact Sheet: New Mexico, December, 2005.

Limiting SPAP Part D premium subsidies to the LIS benchmark may also inadvertently reduce or discourage enrollment in Medicare Advantage plans by SPAP enrollees to the extent that the MA-PDs offer broader drug coverage to contain or prevent costs for other health services and thereby have higher premiums. This may not only actually cost the state more in the long run for the reasons noted above (i.e. paying more for wrap-around than they might otherwise pay if the enrollee were in an MA-PD), but also could increase state payments for cost-sharing for other traditional Medicare health services to the extent that SPAP enrollees may also qualify for Medicare Savings Programs.

Federal Government has Supported Inconsistent Interpretation of Anti-Discrimination Rule across States

One of the greatest hurdles for SPAPs, in deciding how to wrap around the Medicare benefit and in assessing how much they will actually save, has been the restriction on their ability to work with preferred plans. Federal policymaking and implementation on this topic has also been less than consistent. The regulations seem to require that wrap-around benefits be the same, regardless of which PDP a person chooses, however more recent CMS guidance on coordination of benefits allows states not to provide wrap-around benefits to plans that choose not to enter into a contractual arrangement with the SPAP.³⁹ For example, Illinois has approval from CMS to have special contractual arrangements with two prescription drug plans and three Medicare Advantage plans, to administer wrap-around benefits for the SPAP. Illinois is assigning all SPAP enrollees into these plans. Anyone who opts out of these plans to a different plan of their choice will lose coverage for wrap-around benefits. Two other states had similar arrangements pending approval at the time of the survey. This is arguably a reasonable policy decision by the state of Illinois and the other states, as it may be the most cost-effective approach for both the state and its enrollees. However, it leaves other states that have followed the regulations, rather than CMS guidance at a distinct disadvantage, since they complied with a seemingly different interpretation of the anti-discrimination requirement and were therefore compelled to coordinate benefits with as many as a dozen plans.

One potential benefit of this inconsistent interpretation of the rules is that it offers a natural experiment for states and researchers to assess the benefits and costs of the anti-discrimination requirement and the resulting broader choice of Part D plans among SPAP enrollees in most states. Metrics, such as enrollee satisfaction, administrative overhead costs and average percentages of PDP business and profits represented by SPAP enrollees, should be compared between states that followed the regulations versus those states that followed the CMS guidance. Such research could provide empirical data to support or change the anti-discrimination requirement.

Monitor Impact of State Coverage Decisions on Duals and SPAP Enrollees

The impact of state Part D wrap-around decisions on beneficiaries are worthy of continued study. Since states are doing little to hold dual eligibles harmless beyond short term emergency

³⁹ CMS, Part D Coordination of Benefits Guidance, 7/1/05, downloaded from http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CobGuidance_07.01.05.pdf

measures, all of the duals will lose some protections and/or benefits with the transition to Part D. The degree will vary depending upon previous state co-pay levels, prior authorization requirements, and use of limited preferred drug lists, as well as on individual enrollee drug use profiles. Since full duals are all automatically deemed eligible for full low-income subsidies, their maximum co-pay will be \$5.00. Since this is perceived as a relatively small incremental increase, few states were taking steps at the time of our survey to maintain benefits at previous levels. And, as noted in the findings section, there are even fewer states acting to maintain other protections at their previous Medicaid levels.

States should monitor the transition and the impact on this extremely vulnerable population very closely and be prepared to step in to fill gaps where needed. States are often the “safety net” for frail seniors and disabled persons, so the repercussions of compromised access to medications will most immediately be felt by other state programs. The impact could include potentially increased use of state mental health programs and facilities, as well as increased use of long-term care services in both the community and in nursing facilities.

Many state Medicaid officials seemed reticent at the time of the survey to step in to fix gaps in what they perceived as a federal program they neither requested nor wanted to fund. They are, nevertheless, best positioned to identify and at least temporarily fix any problems that arise. Their role is essential for protecting beneficiaries through the initial transition and beyond. Indeed, in the days before publication of this report, numerous states had taken emergency action to fill in gaps in access that became immediately apparent upon program implementation.

Similarly the SPAP enrollees, although largely held harmless in terms of cost-sharing in most states, will also face changes in their benefit, particularly being subject to greater administrative barriers to utilizing higher-cost drugs. The extent to which these administrative barriers limit use of necessary drugs should be monitored in order to reassess state and federal policymakers’ decisions in the future about wrapping around or expanding formulary requirements.

CONCLUSION

The implementation of Part D has presented many challenges to the states, and they have addressed them each in their own unique ways. Over time, states should look to each other for best practices and converge somewhat in their approaches to providing benefits to duals, SPAP enrollees, and other seniors and disabled persons. To assist them in identifying and evaluating best practices, comparative studies should be performed related to many of the policy decisions that states have had to make and will want to reconsider.

The survey findings presented in this paper help to identify the range of creative ideas adopted by states to date. With implementation underway, there will soon be the opportunity to collect information on the actual outcomes of state decisions.

APPENDIX: GLOSSARY OF TERMS

The following glossary is intended to assist the reader by providing definitions of technical terminology utilized in this report:

Authorized Representative: An individual who is designated in writing by a Medicare beneficiary or authorized under state law to act on behalf of the Medicare beneficiary to assist in enrollment, LIS application or appeals.

Auto-assignment: The process of a state or federal program enrolling a Medicare eligible person into a Part D plan in the absence of that person selecting a plan and enrolling themselves.

Categorical eligibility: Eligibility based on characteristics such as age or disability, as opposed to income eligibility.

Clawback: A colloquial term, also called the “phased-down state contribution” in federal law, which is the amount of money each State is required to remit to the federal government to cover their share of the Medicare drug benefit. It is calculated based upon an estimate of what the State’s Medicaid program would have paid for drug benefits in the absence of the Medicare benefit.

CMS (The Centers for Medicare and Medicaid Services): The federal agency responsible for administering the Medicare and Medicaid programs.

Co-branding: SPAPs may endorse certain drug plans, by putting their state emblem or logo on the ID cards and materials of those drugs plans that meet state criteria.

“D-gap” plans: State coverage of gaps in the Part D benefit through SPAPs or Medicaid.

Doughnut hole: Also called the coverage gap is the period of the Part D benefit in which beneficiaries pay 100% of the discounted Part D drug price. The coverage gap begins when total spending for drugs reaches \$2,250, exclusive of the beneficiary's monthly premium, and it ends when total spending for drugs reaches \$5,100 (generally equal to \$3,600 in total out-of pocket spending for drugs).

Dual-eligible: An individual enrolled in benefits through both Medicaid and Medicare.

FPL (Federal Poverty Level): The government's definition of poverty that is used to determine benefit levels for many low-income assistance programs, such as Medicaid, along with eligibility for certain Medicare Part D subsidies for low-income beneficiaries. The Census Bureau updates FPL each year. FPL in calendar year 2005 is \$9,570 for a single person and \$12,830 for a family of two in the contiguous United States.

Formulary: The list of drugs covered by a prescription drug plan, state pharmacy assistance program, or other insurer who covers prescription drugs. For Part D plans, formularies must include at least two drugs from each therapeutic category and class of covered outpatient drugs.

Intelligent Random Assignment: A process of assigning individuals to a drug plan based on the best match between their individual pharmacy claims profile and the formulary and network of the drug plans.

LIS (Low Income Subsidy): Extra financial help provided by the federal government to assist low income persons with Part D premiums and out-of-pocket costs.

LIS benchmark or LIS amount: The amount of the subsidy offered to LIS eligible person for premiums is capped at the LIS Benchmark amount. This amount is equivalent to the average of the premiums of standard Part D plans in the region. In other words, low income persons can be fully subsidized for premiums if they select a plan with average or lower premiums. Otherwise, they must pay the balance of the premium themselves.

MA plan (Medicare Advantage plan): A Medicare managed care plan.

MA-PDP (Medicare Advantage Prescription Drug Plan): A Part D plan offered by a Medicare Advantage plan to its enrollees.

MMA (Medicare Modernization Act): The Medicare Prescription Drug, Improvement and Modernization Act, which was signed into federal law in 2003 and has come to be known as the Medicare Modernization Act or MMA. The MMA established the Medicare drug benefit and made numerous other changes to Medicare.

Off-formulary drug: Prescription drugs that are not on the formulary and therefore are not covered routinely as a benefit, unless an exception is made through the appeal process.

Part D: The section of the Medicare Modernization Act that established the voluntary Medicare outpatient prescription drug benefit in federal law.

Part D Plan: A drug benefit plan under Medicare, including both PDPs and MA-PDPs.

PDP (Prescription Drug Plan): A stand-alone Part D plan, that is available to Medicare beneficiaries who are enrolled in the traditional Medicare fee-for-service benefits.

PDL (Preferred drug list): The list of drugs covered by a Medicaid program that do not require prior authorization.

SPAP (State Pharmaceutical Assistance Program): A state sponsored program offering drug benefits to near-poor persons not eligible for full Medicaid benefits.

SSA (The Social Security Administration): The federal agency responsible for determining eligibility for low income subsidies under Part D, among many other responsibilities.

Supplemental rebate program: A state Medicaid arrangement whereby the Medicaid program obtains rebates from pharmaceutical manufacturers in exchange for including their drugs on the preferred drug list.

MSP (Medicare Savings Programs): Benefits offered by Medicaid programs to subsidize premiums or premiums plus co-pays for low income Medicare beneficiaries who meet state-specific eligibility criteria.

TrOOP (True Out-of-pocket costs): That portion of expenses for covered drugs under a Part D Plan that are paid for by a beneficiary or an SPAP on behalf of the beneficiary. These count towards the \$3,600 out-of-pocket limit, which marks the commencement of catastrophic benefits.

Utilization Management: A variety of program rules and clinical oversight by a health or drug insurance plan to assure appropriate use of services at the least cost. These include such things as prior authorization, step therapy, and generic substitution.

Wrap-around benefits: Benefits that complement coverage already offered through the Medicare program, in order to fill in gaps in the Medicare coverage.