

Testimony for Public Hearing of the State Pharmaceutical Assistance Transition Commission
(SPATC), July 7, 2004

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Good morning, Chairman Henneberry and Commission members. Thank you for allowing me the opportunity to speak with you this morning and to share some insights from a study of state pharmacy assistance programs that my colleagues and I have conducted over the past three years that I hope will be helpful to the Commission in fulfilling its charge.

My name is Kimberley Fox and I am a Senior Policy Analyst at the Rutgers Center for State Health Policy (CSHP). With support from The Commonwealth Fund, and under the leadership of my colleague Stephen Crystal, CSHP has undertaken a study of state pharmacy assistance programs to assess best practices and lessons that might be learned to inform the design and implementation of a Medicare prescription drug benefit. As part of this study, we have conducted three annual surveys of SPAPs, case studies of eight state subsidy programs and six discount card programs, and most recently telephone interviews with SPAP program directors on their plans to coordinate with the new Medicare drug benefit. We have already issued a number of reports, links to which I have made available to the Commission's staff. We are also soon to release two reports including a chartbook that includes detailed information on SPAP benefit structure, eligibility requirements, enrollment, utilization, and costs and a report on coordination of benefit issues, both of which we believe are very relevant to your work and that we will share with the Commission as soon as they are available. This testimony draws from the findings of this work.

To assist the Commission in its charge to ensure a smooth and seamless transition for SPAP enrollees into the new Medicare drug benefit my testimony will focus on:

- 1) Generally describing how SPAPs compare and contrast with the Medicare benefit;
- 2) Discussing different options for wrapping around the Part D Medicare benefit that states are considering and anticipated challenges;
- 3) Describing existing third party payment collection by SPAPs and current efforts to coordinate with the temporary \$600 transitional assistance available under the

interim Medicare-endorsed discount cards; and some of the key lessons learned for coordinating with the new Medicare Part D drug benefit going forward.

1) How SPAP benefits compare with Medicare?

In 2003, twenty two states offered more than 1.5 million enrollees subsidies for prescription drugs. The designs of these programs vary considerably across states. While most of these programs are funded solely by state dollars, six states (FL, IL, MD, SC, WI, VT) obtained Medicaid waivers to extend Medicaid drug coverage to low-income seniors and/or disabled who are not Medicaid eligible. Since Medicaid and Medicaid-waiver programs are treated separately in the MMA and the future of these waiver programs is still unknown, this testimony focuses on the remaining 17 states that have SPAPs supported solely by state funds that serve approximately 1.1 million enrollees¹.

With average income eligibility limits of 220% FPL, the principal challenge for SPAPs will be addressing prescription drug affordability for the near-poor and those with some assets, who are eligible only for the basic Part D benefit which is typically less generous than SPAP benefits. While benefit designs vary considerably across state programs (see Table 1), for SPAP enrollees with incomes above 150% FPL who represent as many as half the enrollees in some state programs, basic Part D coverage requires greater cost-sharing than the benefit in many SPAPs, particularly for those enrollees who spend less than \$5,100 per year on drugs. In contrast, for those who have incomes under 150% of poverty and few assets, low-income Part D subsidies generally provide cost-sharing equivalent to or better than that provided by SPAPs, but may restrict access to some drugs through PDP formularies or preferred drug lists.

Estimating low-income subsidy eligibility is a challenge for SPAPs. To develop a coordination plan with Medicare, all states will need to estimate how many of their enrollees are eligible for the standard Part D benefit, and how many are eligible for the two tiers of low-income subsidies, as each benefit level will require different wrap-around requirements by the state. As only two SPAPs currently require an asset test as a condition of program eligibility (MN and MD), the remaining states either need to collect this information from their current enrollees, which would be a difficult task, or use proxy measures to estimate the number of persons eligible for each Medicare benefit category. For example, New Jersey has used the proxy measure of interest and dividend income reported on its program applications. By this measure, NJ estimated that approximately 22% of income eligible persons in the lowest income tier (<135% FPL) and 14% of income eligible persons in the low-income tier (135-150% FPL) may not meet the asset test. Other states that do not collect similar information on their applications have used more general estimates. For example, in assessing the potential savings to the state from the new Medicare benefit and remaining gaps in coverage, Missouri assumed that 10% of income-eligible persons would not meet the Medicare asset test.

¹ Our analysis includes Illinois, which has both a Medicaid waiver and a state-only program that serves disabled persons under 135% FPL who are eligible for transitional assistance.

Medicare Drug Formularies Likely to be More Limited than SPAPs

In addition to differences in eligibility and cost-sharing, the Medicare benefit also may cover fewer drugs than are currently available through SPAPs. The Medicare drug benefit will be administered by multiple private companies that will utilize cost containment methods that most SPAPs are not currently using. For example, while Prescription Drug Plans are required to cover drugs in each of the drug categories and classes that are not explicitly excluded from Medicare drug coverage, they are allowed to use closed or restricted formularies that may limit coverage to only two drugs per class, or have higher cost-sharing for non-preferred off-formulary drugs. With the exception of a few states that limit drugs covered to certain conditions (ME, IL, NC, MD), state pharmacy assistance programs generally have open formularies, meaning that enrollees have access to most drugs that have been FDA-approved for which the state has been able to obtain a manufacturer rebate. Thus, depending on the formulary of the specific plan selected, SPAP enrollees may no longer have access to certain drugs that are currently covered under their state program². Particularly in some drug classes, such as psychiatric drugs, there is some research evidence that many patients and their physicians are hesitant to switch medications in response to formulary changes, even if the out-of-pocket impact is significant. This might lead even individuals eligible for subsidized Part D benefits to seek help from states. The issue of help with access to off-formulary drugs may become a complex one for states, given the disallowance of spending for off-formulary drugs in the calculation of “true out-of-pocket costs.”

More Limited Pharmacy Networks

Similarly, PDPs may have more limited pharmacy networks than SPAPs. While the Medicare benefit has minimum geographical standards for pharmacy coverage that the PDPs must meet, it is unlikely that the PDPs in a region will have the same pharmacy coverage that is available in most SPAPs, which generally average anywhere from 95-100% of pharmacies in the state. In fact, states have reported that many of the discount cards, which must comply with similar minimum pharmacy network requirements as those required under Part D, do not have as extensive networks as the SPAP.

2) Do States Plan to Continue Coverage and If So, How?

Most SPAPs plan to continue some low-income drug coverage in 2006. Based on interviews in May/June 2004, only two states (Kansas and Wyoming³) of those contacted had definitive plans to stop providing prescription drug coverage for Medicare beneficiaries in 2006. Minnesota, Indiana, and North Carolina, which target very low-income seniors who will receive the greatest benefit from the new Medicare prescription drug law, were uncertain of their future status in 2006. However, the vast majority of states had plans to continue to provide supplemental coverage in some form.

² Note that four states (NC, IL, ME, MD) currently restrict drug coverage to certain conditions and thus enrollees in these states will have access to a larger number of drugs.

³ As Wyoming's program does not limit eligibility by age, it will continue its SPAP for non-elderly, non-Medicare beneficiaries.

Most States Still Considering Part D COB Options; Focused on Implementing Discount Card

The MMA requires Part D prescription drug plans to coordinate benefits with SPAPs that provide financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals and which offer the same benefit regardless of the part D plan in which the individual is enrolled. States can either opt to coordinate benefits with the private PDPs available in their region or pay a Prescription Drug Plan a lump sum for the private plan to provide supplemental coverage on the state's behalf. The law also allows for the use of a single card that a part D plan may issue in connection with coverage of benefits provided by a SPAP.

With one exception, states were still in the preliminary stages of defining how they would wrap-around the Medicare benefit. Since the full Medicare Part D benefit will not be available until 2006, states have focused most of their attention to date on coordinating with the interim Medicare-endorsed discount card program, which began in June of 2004. However some options being considered for Part D include paying all or a portion of the Part D premiums, wrapping around cost-sharing to the current state coverage, or providing coverage for beneficiaries affected by the "doughnut hole," all of which will require detailed, real-time information-sharing between PDPs and states to work effectively. At the time of our interviews, few states had considered the lump sum payment option, primarily due to the difficulty of developing an actuarial model for determining an appropriate level of payment.

Missouri Takes the Lead in Proposing a Doughnut Hole Plan

State pharmacy assistance programs are unique compared to other insurers or Medicaid in that the MMA explicitly allows the dollars that SPAPs contribute toward on-formulary drugs during the deductible period, and towards cost-sharing both before and during the 'doughnut hole' period to be counted as true out-of-pocket costs for the consumer. Thus, SPAPs can help consumers with high drug costs reach the generous Medicare catastrophic benefit without having to expend \$3600 on their own. The governor of Missouri has already decided to take advantage of this unique opportunity by proposing to restructure its current benefit plan in 2006 to be a 'doughnut hole' supplemental plan for Medicare low-income beneficiaries up to 200% FPL who do not qualify for low-income subsidies in 2006. It is the first state in the country to propose legislation to explicitly use state pharmacy dollars for this purpose. While the proposal did not pass in this legislative session, program officials indicated that the state will revisit the proposal in the next session once the Medicare regulations are released.

3) What Can Be Learned from Existing COB Efforts with Other Third Party Payers and with the new Medicare Discount Cards?

In the discount card program, auto-enrollment of SPAP beneficiaries into one preferred card sponsor appears to be a highly successful strategy for enrolling eligible individuals. Based on aggregation of estimates from program officials in 15 states, approximately 540,000 SPAP enrollees, about half of total current enrollment, are eligible for the \$600 transitional assistance credit on the Medicare-endorsed discount cards (see TABLE 2). Three states (CT, ME, WY) have mandated enrollment in Medicare discount cards to ensure enrollment. The majority of other states were facilitating enrollment by working with a preferred card and/or autoenrolling their members (see Table 3). Some have also provided incentives to their members to enroll (see Table 4). Approximately 435,800 (80%) of SPAP TA-eligibles are already or are in the process of being autoenrolled. SPAPs that automatically enrolled their TA-eligible members into a preferred discount card found this strategy to be very effective and relatively transparent to enrollees and recommend that a similar strategy be pursued for Part D. The Commission may want to consider ways in which this approach could be implemented in Part D.

Claims coordination in the discount card program requires duplicate billing on the part of pharmacies, using third party liability fields. While transitional assistance is available, most SPAPs are either completely blocking payment until the \$600 is spent down or are paying all or some portion of the 5-10% coinsurance. In both cases, SPAPs are using their point-of-sale systems by flagging pharmacists of other coverage. Once flagged, the pharmacist is responsible for billing the other payer (i.e., the Medicare endorsed discount card) first, and in states which are wrapping around the coinsurance, entering the copayment amount required by the consumer in the third party liability (TPL) field. This model relies heavily on pharmacists to coordinate the benefits, and requires them to bill twice, requiring them to pay two separate transaction fees. If Part D is implemented in such a way as to require a similar procedure, this may become quite burdensome to pharmacies as well as adding significant additional administrative costs to the system.

Continued success in coordinating the \$600 credit with SPAP benefits is reliant in large part on yet untested timely data-sharing with the preferred card sponsor as well as data file matches with CMS indicating what SPAP enrollees are enrolled, in what plans, and how much of the credit they have spent. This enrollment information, which has yet to be transmitted to states, is expected to be particularly critical for states that are not working with one preferred card, but also important for other states that intend to wrap around the benefit for all enrollees, whether they enroll in the preferred drug card, are enrolled in an exclusive Medicare HMO card, or opt-out and enroll in another card. Many SPAPs indicated that for Part D, where benefit designs will be even more complicated, information-sharing should be centralized as much as possible both by allowing states to work with a preferred PDP and by providing information directly to the states from CMS.

Coordinating payment from other third party payers where the state is deemed the payer of last resort, has required persistent efforts to gather information from insurers,

and has produced marginal return on investment. While many SPAP programs exclude persons with any other drug coverage from eligibility, seven states allow people to enroll in their programs either after their coverage has been exhausted or if that coverage is of lesser value than the benefit offered by the state. As the payer of last resort, some of these states have attempted to recover costs from the primary drug insurer. Other states have simply not elected to pursue payment from third parties to which they are entitled because states had insufficient data on the availability of other drug coverage for their enrollees and assumed that most of their enrollees did not have access to other coverage, which will not be the case in 2006. Those that have pursued third parties have found that even with strict state statutes requiring insurers and health plans to provide enrollment and benefit information, this has not been easy to enforce and has resulted in relatively minimal recoveries. As with the state Medicaid programs, SPAPs have generally needed to purchase the services of information brokers to gather information from multiple sources at an additional cost to the state.

Policy Implications for the SPAP Transition Commission's Work

Whatever the form that SPAP programs end up taking, coordinating their benefits with Part D will not be easy. It will require a significant amount of information exchange that is unlikely to go smoothly in even the best situation and even less likely to go smoothly with a large number of plans. While the number of PDP and MA-PD plans that will be available is still unknown, based on the experience of the discount card program there could be dozens of competing plans available. The administrative hassle required to coordinate benefits is likely to factor into states' decisions about how to move forward, and should be minimized as much as possible in order to encourage states to supplement the gaps in Medicare prescription drug coverage and provide the greatest coverage to Medicare beneficiaries, and to minimize crowd-out of the current state contributions to pharmacy assistance for the elderly and disabled

To minimize the burden of coordination, centralization of information-sharing appears to be the key, both through allowing states to work with a preferred PDP and through providing information directly to the states from CMS rather than from multiple plans. CMS is likely to be collecting all of the information required of SPAPs, in order for Medicare to calculate payments.

Based on the early experience coordinating with the discount cards, autoenrollment is the most efficient mode of getting people enrolled in Part D plans. However, the coordination with the discount cards is only in the early stages of implementation and many issues may still arise. For example, the success of the coordination-of-benefits model employed by states during the discount card period is tied to the degree to which pharmacies cooperate by duplicate billing. Based on previous experience with third party billing in some states, states may encounter more pharmacy resistance and may need to significantly increase both audits and interventions to ensure compliance. Continued tracking of the TA autoenrollment experience is needed to refine the process for Part D, particularly related to processing eligibility in a timely fashion, dealing with denials and

resubmitting appeals, tracking disenrollment rates, and monitoring spend-down. As of June 18th, autoenrollment of SPAP TA eligibles had only taken place for enrollees in New Jersey and Pennsylvania.

The remaining states are still in various stages of submitting their autoenrollment files or awaiting CMS approvals. Tracking states' experience with the discount cards will be critical to assessing how different approaches taken by states have yielded intended results.

This concludes my testimony. I am happy to take any questions from the Commission and offer our services in the months ahead in assisting the Commission with its work. Thank you again for giving me the opportunity to speak with you.

Table 1: SPAP Income Eligibility and Cost Sharing Requirements, 2003

State (Program)	Income Eligibility (% FPL)	Annual Fee/ Premium	Deductible	Coinsurance / Copay	Benefit Cap	Out of Pocket Cap
CT	226%	\$25		\$12.00		
DE	200%			\$5 or 25%, whichever is greater	\$2,500	
FL	120%			\$2/\$5/\$15 tiered copay	\$160 a month	
IL (Circuit Breaker)	236%	\$5 or \$25 by income		\$0 or \$3 by income up to \$2,000 in drug costs. 20% coinsurance above \$2000		
IL (Senior Care)	200%			< 100% FPL, no copay. Up to 200% FPL \$1 Generic, \$4 Brand, up to \$1,750. 20% coinsurance above \$1,750		
IN	135%			50%	\$500, \$750, or \$1,000 by income	
KS	135%			30%	\$1,200	
MA	500%	\$0 to \$99 by income	\$0 to \$125 a quarter by income	\$6/\$16/50% or \$40 to \$10/\$28/50% or \$40 by income		\$2,000 or 10% of income, whichever is lower
MD	116%			\$5.00		
ME	185%			\$2 or 20%, whichever is greater		\$1,000 for drugs for non-covered conditions
MI	200%	\$25		20%		Monthly co-payment maximums by income.
MN	120%		\$35 a month	None		
MO	189%	\$25 or \$35 by income	\$250 or \$500 by income	40%	\$5,000	
NC	200%			40%	\$600	
NJ (PAAD)	223%			\$5.00		
NJ (Senior Gold)	334%			\$15 plus 50% of the remaining cost of the drug		\$2,000 single, \$3,000 couple
NV	245%			\$10 generic, \$25 preferred brand	\$5,000	

Table 1: SPAP Income Eligibility and Cost Sharing Requirements, 2003 (cont.)						
State (Program)	Income Eligibility (% FPL)	Annual Fee/ Premium	Deductible	Coinsurance / Copay	Benefit Cap	Out of Pocket Cap
NY (Fee)	223%	\$8 to \$300 by income		\$3 to \$20 by drug price		9% of annual income
NY (Deductible)	390%		\$530 to \$1,715 by income	\$3 to \$20 by drug price		9% of annual income
PA (PACE)	156%			\$6.00		
PA (PACENET)	178%		\$500 a year	\$8 generic, \$15 brand		
RI	420%			40%, 70%, or 85% by income		\$1500 for lowest income level
SC	200%		\$500 a year	10 generic, \$15 brand, \$21 brand name requiring prior authorization		
VT (VHAP)	150%			\$3 generic, \$6 brand		\$50 per calendar quarter
VT (VScript)	175%			\$5 generic, \$10 brand		\$100 per calendar quarter
VT (VScript Exp.)	225%		\$275 a year	41%		\$2,500 per calendar quarter
WI	240%		No deductible for income <160% FPL; Income 160%<200% FPL - \$500 deductible per person; Income 200%<240% FPL - \$850 per person; Income >240% FPL - \$850 after spend down	\$5 generic, \$15 brand		
WY	100%			\$10 generic, \$25 brand	3 prescriptions per month	

Source: Rutgers Center for State Health Policy State Pharmacy Assistance Program Survey, 2003.

Table 2: Estimated SPAP Enrollees Income Eligible for \$600 Credit, 2004*

	Estimated Enrollees with Incomes <135% FPL	Total Enrollment	% of Total Enrollment
CT	27,000	52,000	52%
DE	NA	NA	NA
IL**	9,000	60,840	15%
IN	17,575	18,500	95%
KS	2,500	2,500	100%
MA	34,000	82,000	41%
ME	5,800	42,000	14%
MI	12,000	14,672	82%
MN	7,500	7,500	100%
MO	12,959	18,797	69%
NC	26,250	35,000	75%
NJ	81,000	220,000	37%
NV	4,230	9000	47%
NY	126,000	324,000	39%
PA	150,000	228,000	66%
RI	17,000	38,000	45%
WY^	300	1,151	26%
TOTAL	533,114	1,153,960	46%

*Excludes SPAP enrollees in FL, IL, WI, MD, SC, VT that are covered under Medicaid waivers and are therefore ineligible for transitional assistance.

**While enrollees of IL's SeniorCare program are ineligible as they are covered under a Pharmacy Plus waiver, IL's state-only funded Circuit Breaker program includes disabled persons under 135% FPL

^Note that Wyoming's program is available to persons of all ages under 100% FPL.

Source: Fox, K, Crystal, S. *Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs*. New York, NY; The Commonwealth Fund, publication forthcoming. Based on interviews with SPAP program directors conducted by the Center for State Health Policy, May/June 2004. .

Table 3: Enrollment Methods Utilized by SPAPs to Facilitate Enrollment of Transitional Assistance Eligible Enrollees into Discount Cards

	Mandatory	Preferred Card Sponsor		No Preferred Card Sponsor	
		Autoenrollment	Facilitated Enrollment	Autoenrollment	Voluntary Enrollment
CT	X			X	
DE					X
IL*					X
IN					X
KS					X
MA		X			
ME	X	X			
MI		X			
MN					X
MO			X		
NC			X		
NJ		X			
NV			X		
NY		X			
PA		X			
RI			X		
WY	X				X
TOTAL	3	6	4	1	6

*Excludes Florida, Maryland, Illinois Senior Care, South Carolina, Wisconsin, Vermont pharmacy programs which have received Pharmacy Plus or 1115 Medicaid waivers for drug coverage making them ineligible for the transitional assistance.

Source: Fox, K, Crystal, S. *Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs*. New York, NY; The Commonwealth Fund, publication forthcoming. Based on interviews with SPAP program directors conducted by the Center for State Health Policy, May/June 2004.

Table 4: Incentives Used by SPAPs to Encourage Enrollment in Medicare Endorsed Discount Card and \$600 Credit

	<i>State pays all coinsurance</i>	<i>Wrap 5-10% up to SPAP copay</i>	<i>State fee waived</i>	<i>\$600 counts toward SPAP deductible</i>	<i>Lowered SPAP Coinsurance/ Increased Benefit Cap</i>	<i>SPAP as Primary Payer</i>
CT		X				
DE						
IL*						X
IN					X	
KS						
MA		X				
ME		X				
MI	X					
MN						
MO		X^		X		
NC		X				
NJ		X				
NV						
NY		X	X			
PA**	X					
RI		X				
WY						
TOTAL	2	8	1	1	1	1

*Excludes Florida, Maryland, Illinois Senior Care, South Carolina, Wisconsin, Vermont pharmacy programs which have received Pharmacy Plus or 1115 Medicaid waivers for drug coverage making them ineligible for the transitional assistance.

^Missouri's wrap around copayment only applies for those enrolled in the state's preferred card.

**Pennsylvania also has waived renewal applications for PACE enrollees in 2005 if they enroll in the discount card.

Source: Fox, K, Crystal, S. *Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs*. New York, NY; The Commonwealth Fund, publication forthcoming. Based on interviews with SPAP program directors conducted by the Center for State Health Policy, May/June 2004.

Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs: Key Issues and Concerns

*Presentation to the
State Pharmaceutical Assistance Transition Commission*

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Rutgers Center for State Health Policy

July 7, 2004



Study Description

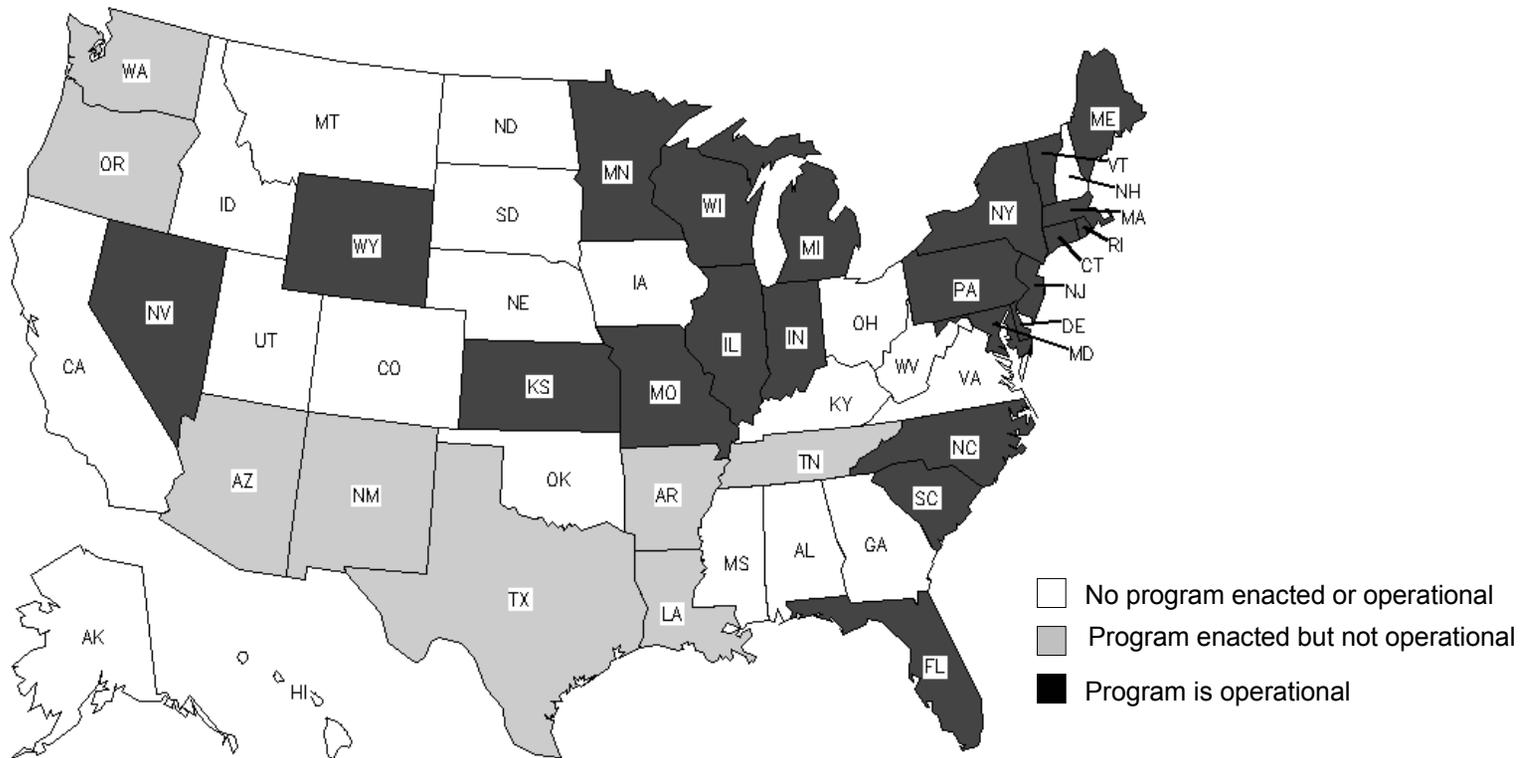
- Three year study of state pharmacy assistance programs funded by The Commonwealth Fund.
- Study design
 - Longitudinal survey of SPAPs, 2000-2003.
 - In-depth case studies of eight subsidy programs and six state discount cards in 2002/2003 on program design, enrollment and participation rates, and cost containment strategies.
 - Telephone interviews in Spring 2004 with 17 states re: Medicare coordination of benefit issues and discount card experience.
 - Published reports and forthcoming publications.

Overview of Presentation

- Describe how State Pharmacy Assistance Programs (SPAPs) compare and contrast with Medicare Part D benefit and low-income subsidies.
- Discuss supplemental Part D options being considered and anticipated challenges.
- Describe lessons learned from existing third party payment collection and coordination with Medicare discount cards and some preliminary recommendations for Part D.

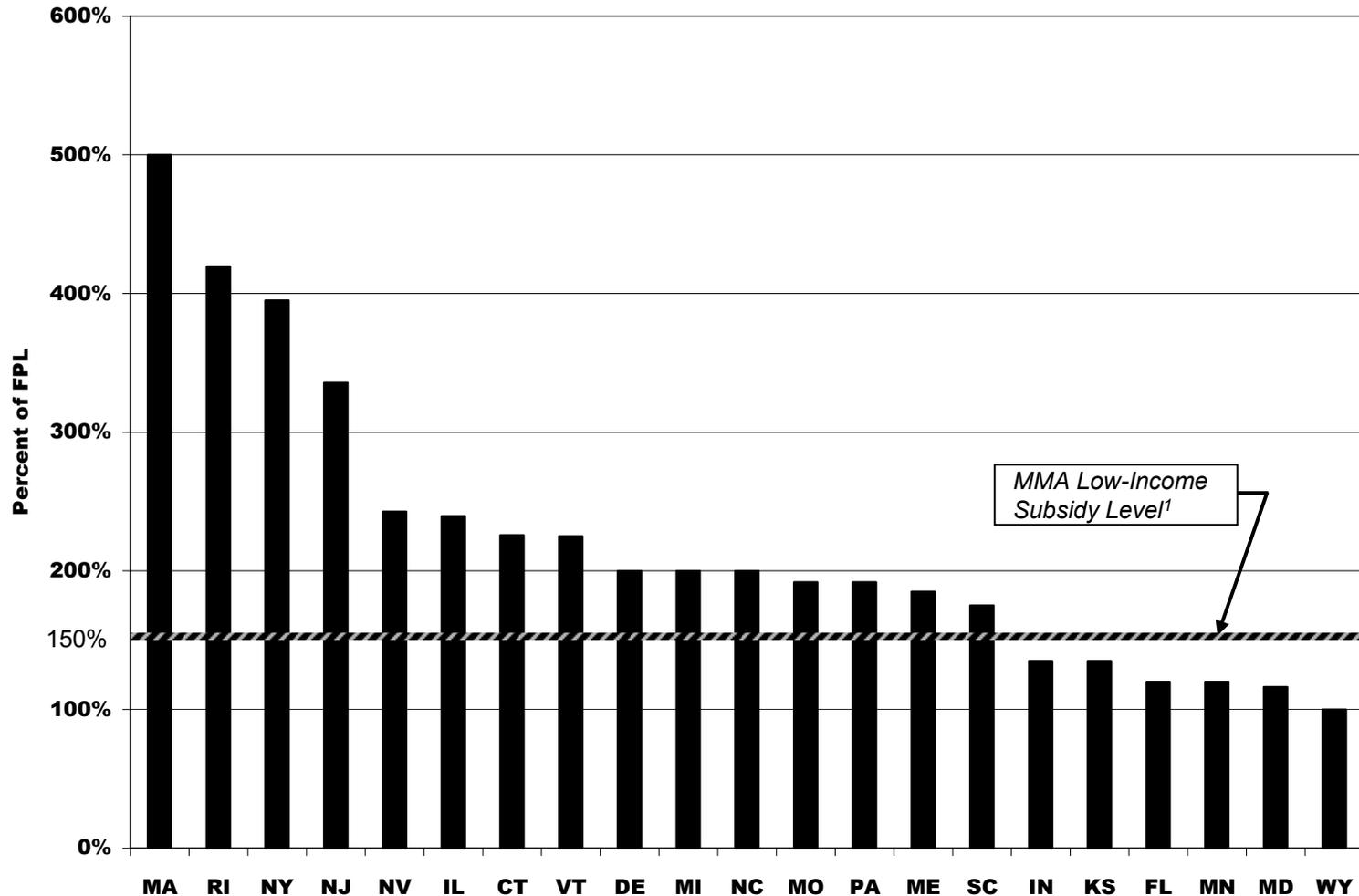
How Many States Have SPAPs?

Direct Benefit Programs, 2003



Source: Trail T, Fox, K, Cantor, J, Silberberg, M, Crystal, S. State Pharmacy Assistance Programs: A Chartbook. Commonwealth Fund, New York, NY, publication forthcoming. Data from National Conference of State Legislatures' web site: *State Pharmaceutical Assistance Programs, 2003 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. August 27, 2003.

How SPAPs Compare with Medicare Part D and Low-Income Subsidies



Source: Trail, T., Fox, K., Cantor, J., Silberberg, M., Crystal, S. State Pharmacy Assistance Programs: A Chartbook. The Commonwealth Fund, New York, NY, Publication forthcoming.

How SPAPs Compare with Part D and Low-Income Subsidies

- Cost-sharing varies by state (see Table 1 in handouts)
- Basic Part D coverage generally requires more cost-sharing than many SPAPs (i.e. enrollees who spend less than \$5100/yr on drugs)
- Medicare Part D low-income subsidies generally provide coverage equivalent or better than that provided by SPAPs.
- With no asset test in most states, estimating low-income subsidy eligibility will be a challenge for states.

How SPAPs Compare with Part D and Low-Income Subsidies (cont.)

- Medicare drug formularies likely to be more limited than most SPAPs, with the exception of a few states that limit coverage to drugs for certain conditions.
- SPAPs have extensive pharmacy networks, Medicare private plans may be more limited (e.g. discount card experience).

SPAP Future Plans Coordinating with Medicare Rx Benefit

- Most SPAPs plan to continue some low-income drug coverage in 2006.
- Still considering Part D options; most states focusing on coordinating with Medicare discount cards in 2004.
- Few states had considered lump sum payment option.
- Options for 2006 being considered include:
 - Paying all or portion of premiums.
 - Wrapping around cost-sharing to current state cost-sharing.
 - Providing coverage during the ‘donut-hole’ (e.g. Missouri).
 - Wrapping around formularies.

Anticipated Challenges for SPAPs in Coordinating with Part D

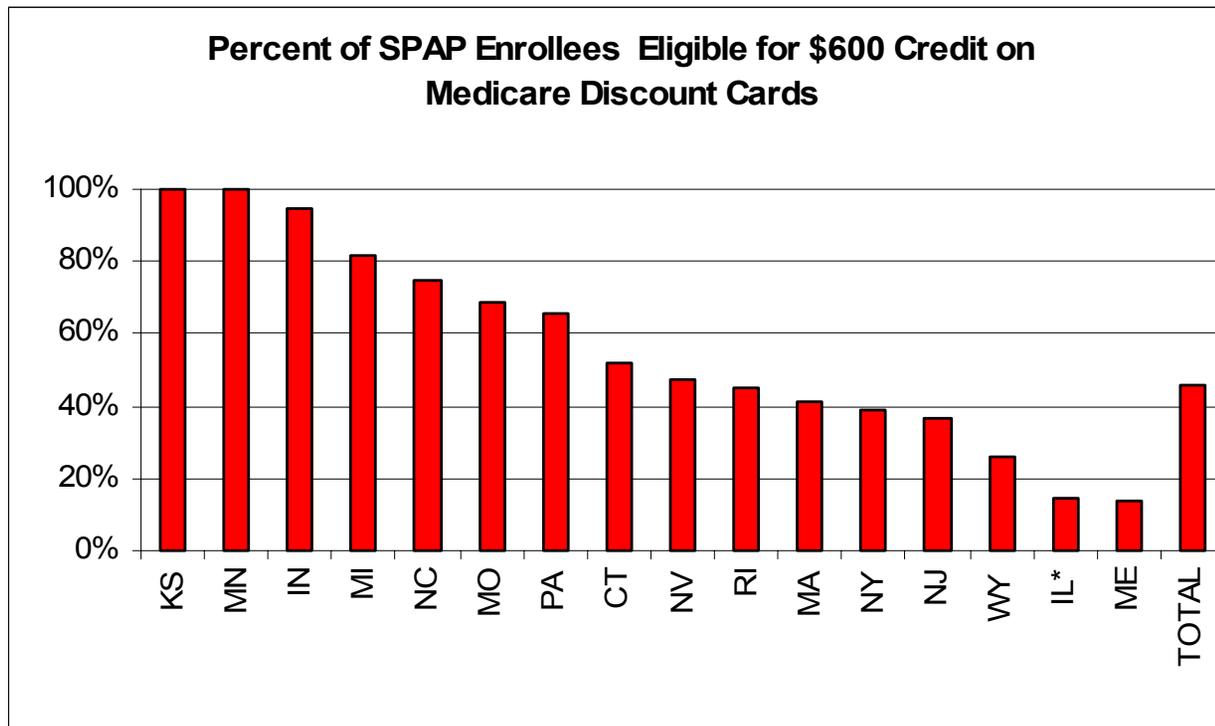
Enrollment Challenges

- Getting SPAP enrollees to voluntarily enroll.
- Gathering asset information to determine eligibility for low-income subsidies.
- For SPAPs that are managed by departments other than the Medicaid agency, conducting eligibility determination through Medicaid may be further deterrent for SPAP enrollees.

Coordination of Benefit Challenges

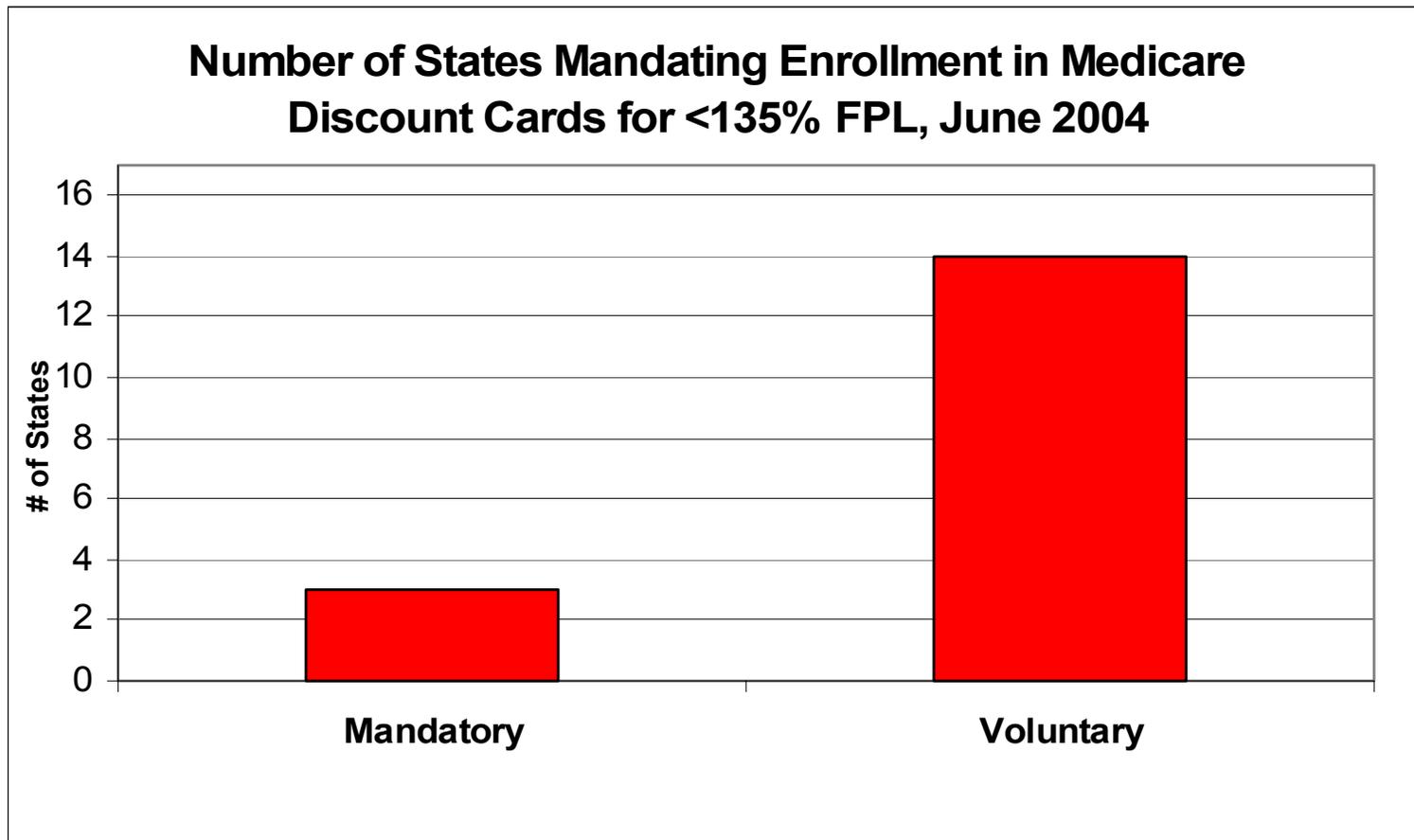
- Real-time information sharing with multiple plans.
- Point-of-sale duplicate billing and enforcement.
- Coordinating sliding scale premium payments with CMS.

SPAP Experience Coordinating with Medicare Drug Discount Cards



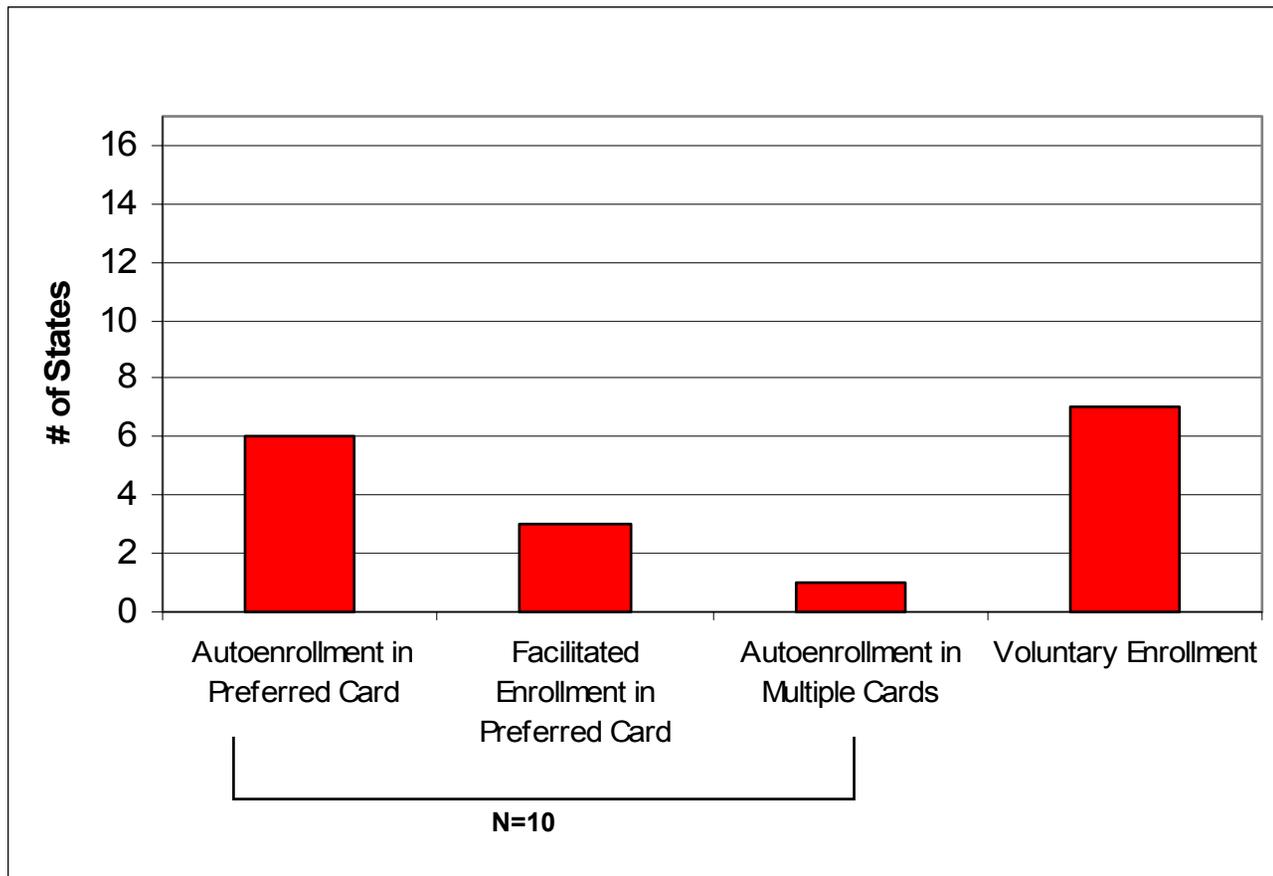
Source: Fox, K, Crystal, S. Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs. New York, NY; The Commonwealth Fund, publication forthcoming.

Few States Mandating Enrollment in Discount Cards



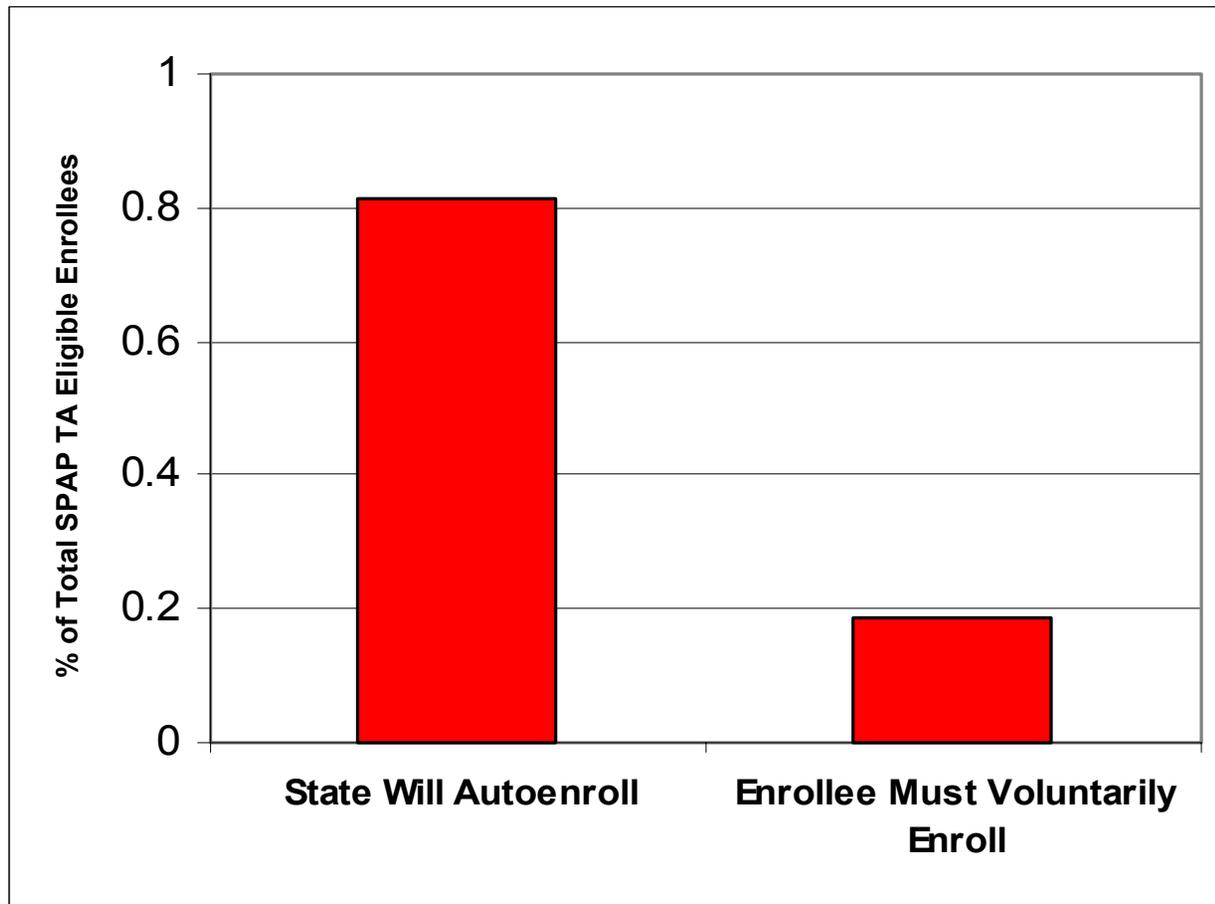
Source: Fox, K, Crystal, S. Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs. New York, NY; The Commonwealth Fund, publication forthcoming.

More than Half of SPAPs Working with a Preferred Discount Card and/or Autoenrolling



Source: Fox, K, Crystal, S. Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs. New York, NY; The Commonwealth Fund, publication forthcoming.

Vast Majority of TA Eligible SPAP Enrollees Will be Autoenrolled



Source: Fox, K, Crystal, S. Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs. New York, NY; The Commonwealth Fund, publication forthcoming.

Coordination Lessons from Discount Card and 3rd Party Collection Experience

- Autoenrollment very successful and transparent to enrollees. Commission may want to consider encouraging a similar approach for Part D.
- Both in the Medicare discount card and in pursuing 3rd party liabilities from other payers, claims coordination requires duplicate billing by pharmacies.
 - Relies on pharmacies to comply and have not always been cooperative.
 - May require additional audits/oversight by states to enforce.
 - Need to identify alternative approaches.
- Success of discount cards reliant on accurate, timely information sharing with CMS. May want to consider similar centralized information sharing/verification for Part D.
- States that pursue third party recoveries have found that even with strict statutes, not easy to get information from private insurers and have had to pay brokers to collect information.

Policy Implications for SPAP Transition Commission's Work

- The more plans, the more difficult to coordinate benefits.
- Administrative hassles could deter states from providing gap-filling coverage. Coordination of benefits should be designed to minimize crowd-out of current state contributions.
- Centralized information sharing through CMS.
- Autoenrollment efficient mode for getting people enrolled.
- Need for continued monitoring of discount card implementation particularly related to processing eligibility, duplicate billing, tracking disenrollment and monitoring spend-down.