State's Rx for Medicare Gaps

Some states have made long-term commitments to help their low-income citizens pay their out-of-pocket costs for Medicare Part D. For some it was a matter of life or death.

By Richard Cauchi

In January, elderly and disabled Americans, many on medications for numerous diseases, were being overcharged or turned away without their pills while pharmacies struggled to get the information they needed to help them.

Some states took emergency action in those first weeks, making sure their citizens weren't falling through the cracks in the ambitious new federal prescription drug program that may eventually cover some 42 million people.

Connecticut, Maine, Massachusetts, New Hampshire, North Dakota and Vermont were ready in a matter of days, announcing plans to guarantee pharmacists that they would get paid for drugs that should have been provided through the Medicare plans. Within three weeks, 35 states had decided to pay for drugs or inappropriately high co-payments for low-income people who were having trouble getting the drugs they needed through Medicare as the program was launched.

"Every pharmacist knew that all the drugs were covered and that we would worry about who pays for it later," said Massachusetts Senator Mark Montigny. "Our new law is very clear."

In North Dakota, says Senator Judy Lee, lawmakers were working with pharmacists, Medicaid and Medicare to "make sure everyone gets what they need until the problems are resolved. We are doing everything we can to make sure this goes seamlessly for our seniors."

STATES WERE FIRST

Not only did states step in with emergency coverage in January, many also saw a need to help citizens with prescription medicines years earlier.

Long before Medicare provided a drug benefit, many states had established their own publicly funded prescription drug assistance programs. By the end of 2003, 28 states were providing subsidized medicines to about 1.8 million seniors, people with disabilities, and some other low-income residents. These programs didn't follow any single model, and almost always depended on state appropriations.

Many of these State Pharmaceutical Assistance Programs (SPAP) laws required direct negotiated price deals or rebates with pharmaceutical manufacturers and were run day-to-day by a single state agency within a Department of Aging or Health. In the past few years, a dozen states added discounted prescription drug programs for higher-income seniors or other adults. Five states won the right to get some federal matching funds through so-called Pharmacy Plus Medicaid waivers.

WRAPAROUND PROGRAMS

For states with a strong history of pharmaceutical assistance, one clear challenge for 2006—after the transition period is over and the Medicare benefit is running smoothly—is to design simple and seamless state benefits that will add to and complement the new Medicare Part D program.

Twenty states are trying "wraparound" support to help low-income seniors and individuals with disabilities pay for the deductibles, co-payments, coverage gaps and medicines not covered by Medicare. The wraparound approach already works in public and private health programs, including retired employee health plans and Medicaid. But the complexity of the new Medicare benefit—with its reliance on newly designed, competing commercial plans (legally called "Prescription Drug Plans" or "PDPs")—makes this task daunting. The federal benefit design encourages variations among Medicare Part D drug plans—in costs and in coverage.

"Massachusetts enacted wraparound legislation to protect Medicare recipients who have yet to enroll in the Part D plan," Senator Richard T. Moore said in January. "We will keep those enrolled in Prescription Advantage—the state funded program—eligible for the next six months. It's the only fair thing to do considering the confusion over Part D." The state will also help with deductibles, copayments and coverage gaps.

Similarly, Nevada enacted a wraparound

SENATOR
MARK MONTIGNY
MASSACHUSETTS

SENATOR
RICHARD T. MOORE
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NORTH DAKOTA

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CHARLES SCOTT
WYOMING

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plan for 2006 that makes Medicare Part D the required primary coverage. Lawmakers sought to maintain present coverage "to the extent allowed by federal law," as well as to maximize prescription drug coverage and the use of federal funds. "We want to make sure no one is worse off," says Mike Willden, Nevada's Director of Health and Human Services.

South Carolina's goal for its wraparound program is to help seniors pay for the $2,850 "donut hole" that requires them to pay for any expenses they incur after spending $2,250 and before they hit $5,100—the gap not covered by Medicare.

Legislators in Maine, Minnesota, Pennsylvania, Rhode Island, and elsewhere continue to work on state subsidized benefit plans.

OTHER APPROACHES

Some states with a history of state-only pharmaceutical assistance are following a different path. Florida, Kansas, Michigan, Minnesota and North Carolina have elected to end their state-funded senior pharmaceutical programs because the 2006 Medicare plans provide very similar benefits.

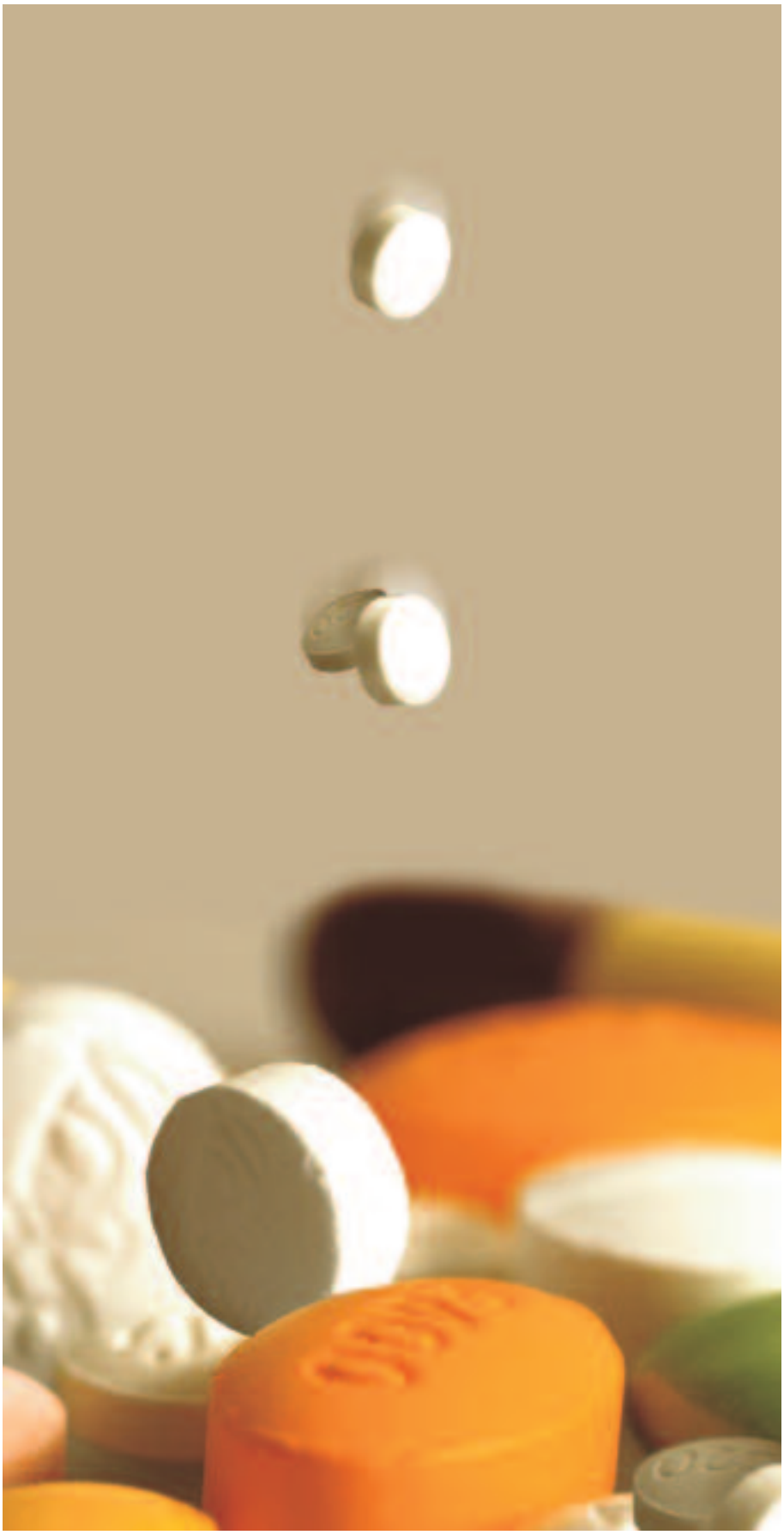
Wyoming will stop covering citizens eligible for Medicare in June, and shift state aid to those who don't qualify for any federal assistance. Senator Charles Scott says he is "guardedly optimistic," that Medicare Part D will be good for seniors who don't have drug coverage—if it survives the initial phase. "There really are some advantages to having the private sector compete to provide the highest quality coverage at the lowest cost," he says.

Hawaii has authorized both discounts and subsidies for 2006.

"Our Hawaii Rx+ program is supposed to expand coverage not only for seniors but for the general population as well," says House Health Chair Representative Dennis Arakaki. "We are hoping it will ease the transition for people who are going into the drug benefit plan. The real challenge is to get people enrolled."

In the past two years, nine states decided to provide discounted prescription drugs to their adult, non-Medicare population—a population not covered by the new federal benefit. New Mexico, Oklahoma and Wisconsin have no age or income limits.

REPRESENTATIVE
DENNIS ARAKAKI
HAWAII



Others have maximum income limits: Arkansas (350 percent of federal poverty guidelines), Illinois (300 percent), Maryland (150 percent), Michigan (300 percent), Montana (250 percent) and Rhode Island (200 percent).

Some states sought federal approval to make the transition from state prescription help to Medicare Part D easier for seniors. Massachusetts got the go-ahead last year to enroll automatically most state pharmaceutical participants into five (out of the 44) commercial plans available in the state under Medicare Part D. The five were selected based on their willingness to provide electronic coordination of the transfer and their lower-end monthly premiums. Pennsylvania, Illinois and South Carolina have similar arrangements.

STATE BUDGETS: WINNERS, LOSERS

While some states will save Medicaid money under Medicare Part D, others, especially those that implemented cost containment measures in 2004 and later, contend that they will be required to pay more than they would have spent.

As of mid-2005, 26 state Medicaid programs predicted that Medicare Part D would increase their costs, 15 expected to break even, and nine anticipated saving money, according to a survey by the Kaiser Commission on Medicaid and the Uninsured.

For the dozen-plus states that have offered a generous pharmaceutical program, the Medicare benefit means some real savings. New Jersey's 100 percent state-funded Pharmaceutical Assistance for the Aged and Disabled program would have paid, for example, just over $1,800 of a $2,000 annual drug cost faced by a typical senior citizen. Now Medicare will cover a projected $1,300 of that bill, and the state share, including a $380 premium it is picking up, will drop to about $870, while the beneficiary pays only a $5 copayment, usually under $200 a year.

All states, however, including New Jersey, will be subject to the Medicaid-related "phased-down state contribution" requirement which can be more costly. Widely labeled "the clawback," the phased-down contribution is the amount, based on 2003 dollars, that states will pay back in return for the feds taking over the prescription drug costs of the 6.4 million people who are enrolled in both Medicare and Medicaid—the dual eligibles. "Don't underestimate the degree of resentment that the 'clawback' has wrought. It's wide and it's deep, and I think it's going to cause widespread litigation," says Senator Scott.

Virginia is one state that knows it is going to be a more expensive, mostly because of the clawback requirement. About 136,000 of its Medicaid clients have been transferred to Medicare for pharmaceutical benefits. Patrick Finnerty, director of the state Department of Medical Services Assistance, says the budget introduced this session includes $38 million in FY 2007 to pay back the federal government for the new Part D coverage.

2006 STATE WRAPAROUND PHARMACEUTICAL ASSISTANCE

State	Maximum income for 1 person	Premium help	Deductible help	Copayment help	Coverage gap help	Under 65 with Disabilities
Alaska	$21,437	Yes	Yes		[2]	No
Connecticut	21,400	Yes	Yes[1]	Yes[1]	Yes 100%	Yes
Delaware	19,600	Yes	Yes	No	Yes	Yes
Hawaii	11,270	Yes	Yes	Yes	Yes	Yes
Illinois	21,218	Yes	Yes	Yes[1]	Yes	Yes
Indiana	14,700	Yes[2]	Yes[2]	Yes[2]	No	No
Kentucky	14,700	Yes[2]	Yes[2]	Yes[2]	Yes[2]	Yes[2]
Maine	18,130	Yes	Yes	Yes[1]	Yes	Yes
Maryland	29,400	Yes	Yes	Yes	Yes	Yes
Massachusetts	49,000	Yes	Yes	Yes	Yes	Yes
Missouri	14,700	Yes	Yes	Yes		Yes
Montana	19,600	Yes	Yes	No	No	Yes
Nevada	23,175	Yes	Yes[2]	No	Yes	Yes
New Hampshire	14,700	Yes	Yes	Yes	Yes	Yes
New Jersey	30,989	Yes	Yes	Yes	Yes	Yes
New York	35,000	No	Yes	Yes	Yes	No
Pennsylvania	23,500	Yes	Yes	Yes[1]	Yes	No
Rhode Island	38,478	[2]	[2]	Yes[1]	[2]	No
South Carolina	19,600	No	No	[2]	Yes	No
Texas	14,700	Yes	Yes		No	Yes
Vermont	22,050	Yes[1]	Yes	Yes	[2]	Yes
Washington	None	Yes	Yes	[2]		
Wisconsin	22,968	No	No	Yes	[2]	No

Note: This table does not include Medicaid program benefits. Maximum incomes based on 2006 federal poverty guidelines, Jan. 24 2006.
1. State pays the portion that is higher than the standard state copayment or premium.
2. Benefit under review or not yet determined.

Source: NCSL, January 2006.

THE NEED TO STREAMLINE

For the states with complicated wraparound payments, a key question for 2006 will be how to coordinate the payments with the Medicare processing system and how to budget for the help they are offering thousands of citizens. Premium payments are predictable (averaging $380 annually). And the Medicare coverage gap may be easy enough to figure. But it will be difficult to predict the state's cost of the required copayments (that can range from $5 to $50) and the coinsurance (commonly 25 percent) for thousands of individuals who have chosen among the 30 to 50 separately designed commercial plans.

Another unknown is how many eligible people will not sign up for any Part D or other approved plan by the May 15, 2006 open enrollment deadline and may look for state help instead.

Other decisions loom. Many state Medicaid programs will grapple with how to bargain for lower prices with pharmaceutical manufacturers now that they have reduced power. So expanded use of multi-state purchasing pools may be on more 2006 agendas. The private insurance companies involved in Part D can drop certain drugs or change their premiums, which might make people change their plans. Some of these companies may go out of business if they do not have enough enrollees to remain profitable. Health care industry mergers are common. No one knows yet what happens when a plan buys or absorbs another.

Tougher, larger tests may come later this year. For those who face the coverage gaps, the SPAPs may be the lifeline that makes the difference. And states will continue to ask, "Do the combined state and Medicare drug programs provide older people and people with disabilities with the access they need to drugs?"

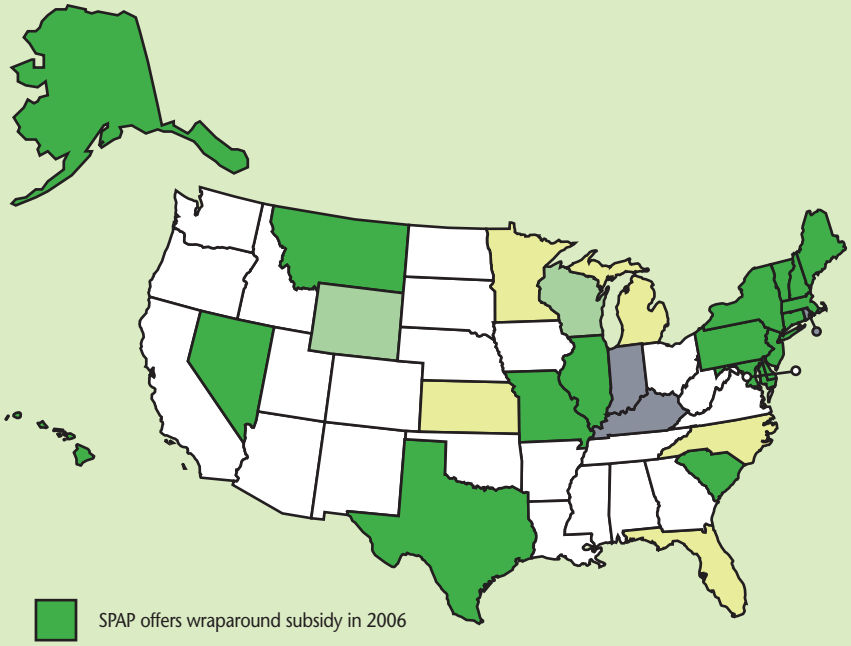
WHAT MEDICARE WILL NOT BUY
(EXAMPLE: INDIVIDUAL WITH INCOME OF $16,000)

Plan premiums (typical total = $384 a year).
Annual deductible ($0 to $250).
25 percent of drug price, purchases between $250-$2,250 annually = up to $500.
Per prescription copayments, varying from $5 to $50 or higher.
Purchases during the annual "coverage gap" between $2,250 and $5,100.

WHAT A STATE PHARMACEUTICAL ASSISTANCE PROGRAM MAY BUY
(EXAMPLE: ILLINOIS PROGRAM)

100 percent of premium (up to $397).
100 percent of annual deductible.
All of 25 percent coinsurance, except $5 brand name and $2 generic products.
80 percent of purchase price over $1,750, up to the high end of the coverage gap.
Selected pharmaceuticals not covered at all by Medicare.

STATES PHARMACEUTICAL ASSISTANCE PROGRAMS



Source: NCSL, December 2005