State Solutions
An Initiative to Improve Enrollment in Medicare Savings Programs

Expanding Medicare Savings Program Eligibility: A Cost-Saving Strategy for States with State Pharmacy Assistance Programs?

Authors: Kimberley Fox, Carolyn Gray, University of Southern Maine Muskie School of Public Service

October 2007

Introduction

Under Medicare Part D rules, individuals who are enrolled in Medicare Savings Programs (MSPs) are automatically deemed eligible for Part D full Low Income Subsidies (LIS) and need not apply through the Social Security Administration (SSA).[1] This 'back door' to the Medicare Part D LIS benefits through the MSPs may offer new incentives for states -- particularly those with state pharmacy assistance programs (SPAPs)-- to reassess the cost/benefit of liberalizing MSP eligibility or reducing documentation requirements.

This issue brief discusses how states and consumers stand to benefit from MSP eligibility expansions under new Medicare Part D rules. The paper first describes the interrelationship between LIS, MSP, and SPAPs and how states may maximize the value of these subsidy programs to both consumers and the state. We then present case studies of two states – Maine and Vermont -- that have recently expanded MSP eligibility to take advantage of this 'back door' to LIS. Specifically, we discuss the impetus these states had to pursue these MSP eligibility expansions, how they were implemented and the impact on MSP and SPAP LIS enrollment as well as anticipated state costs and benefits. The brief concludes with a discussion of state-specific considerations in replicating similar MSP eligibility expansions in other states.

Background

MSPs are federally mandated but administered by state Medicaid programs. Federal rules set income and asset limits for MSPs, but states have some discretion with regard to the methods used to count income and assets and the process used to make eligibility determinations for the program.[2] Under Medicaid statute, all states must use the eligibility rules of the SSI program as the starting point for determining eligibility for MSPs. However, under the authority of

State Solutions

A national program of The Robert Wood Johnson Foundation® and The Commonwealth Fund.

Rutgers Center for State Health Policy
The Institute for Health, Health Care Policy and

National Program Office
Joel C. Cantor, *Director*
Heather Allen, *Program Administrator*

Rutgers CSHP
55 Commercial Avenue, 3rd Floor
New Brunswick, NJ 08901-1340

p) 732-932-3105
f) 732-932-0069
e) statesolutions@ifh.rutgers.edu
www.statesolutions.rutgers.edu

section 1902(r)(2) of the Social Security Act states can use less restrictive income and/or resource rules than SSI, if they are described in the state's Medicaid plan (through a state plan amendment).

Eligibility restrictions and onerous documentation requirements are often cited as barriers to enrollment into low-income programs in general and specifically in the Medicare Savings Programs (MSPs).[3] Previous State Solutions briefs have highlighted state "best practices" to expand and/or simplify MSP eligibility processes and minimize administrative burden using 1902(r)(2) authority.[4] While some states have made some progress in liberalizing MSP eligibility criteria[5], many have been reluctant to do so in the past due to budgetary concerns.

New Reasons for States to Expand MSP Eligibility since Part D

Lower than Expected LIS in State Pharmacy Assistance Programs

Twenty one states currently have pharmacy assistance programs that assist approximately 1.9 million low-income aged and/or disabled residents in purchasing prescription drugs, most of whom are also Medicare beneficiaries and enrolled in Part D.[6] Since Part D, most SPAPs have redesigned their benefits to 'wrap around' the Medicare Part D benefit to cover some portion of Medicare cost-sharing. While SPAP benefits vary by state, many SPAPs pay for premiums, deductibles, and cost-sharing in and out of the donut hole.[7]

SPAP eligibility rules vary by state, but the average SPAP income eligibility is approximately 200 percent of the federal poverty level. SPAPs generally do not have asset tests. Thus all SPAPs serve at least some individuals who are potentially eligible for MSP. Despite their overlapping populations, prior to Part D, only a few states had linked applications or coordinated enrollment between the SPAP and MSP.[8]

SPAP states have a strong financial incentive to get their members enrolled in Medicare Part D plans in order to offset current expenditures and maximize federal dollars, particularly in light of state fiscal pressures. With a few exceptions, these programs are funded through state general funds or through other earmarked funds such as state lottery or tobacco settlement funds. States stand to gain the greatest savings from the generous Part D LIS, which will cover the vast majority of prescription drug costs for eligible SPAP enrollees. LIS offers a significantly more generous benefit than the basic Part D benefit: the average federal government contribution for the basic Part D benefit was originally estimated to be $1355 compared to $2283 for LIS enrollees.[9] For SPAP members, these additional federal subsidies may reduce the member's out-of-pocket cost and also reduce the SPAP's costs as the secondary payer. Thus, identifying and enrolling SPAP members in the LIS program is important to both the individual enrollee and to the SPAP. Both stand to see substantial cost savings through the LIS program.

In order to maximize the greatest federal savings and thereby reduce the burden on state budgets, most SPAPs have mandated that their members enroll in Medicare Part D if eligible and apply for the generous low-income subsidies as a condition of SPAP eligibility. Some states have also given the SPAPs the

authority to collect asset information on SPAP applications and to submit LIS applications to SSA on enrollees' behalf.

Nevertheless, the number of SPAP enrollees determined eligible for LIS through voluntary application to SSA has been much lower than most states initially anticipated. In a 2005 survey, SPAP directors estimated between 40% to 100% of their members were eligible for either full or partial Part D LIS. Actual LIS enrollment reported in 2006 by these same states was significantly lower, ranging from 18% to 80% (Table 1). Lower than expected LIS enrollment could be the result of a combination of over-estimations of those eligible due to insufficient information on assets, failure of members to apply, low enforcement of the LIS mandate in states that mandate, and/or incomplete data from CMS on LIS eligibility. Even states that have made extra efforts to help SPAP enrollees apply through SSA have incurred significant administrative costs with only marginally higher approval rates. Most commonly SPAP enrollees appear to be denied LIS due to assets exceeding the LIS limits.

Table 1: Percent of SPAP Members Estimated Eligible for LIS in 2005 and Percent Actually Enrolled in 2006 in Selected States

State	*Full LIS*		*Partial LIS*		*TOTAL LIS*	
	2005 Estimated Eligible	*2006 Enrolled*	*2005 Estimated Eligible*	*2006 Enrolled*	*2005 Estimated Eligible*	*2006 Enrolled*
IN	100%	40%	0%	40%	100%	80%
MA	43%	29%	34%	8%	77%	37%
NJ	29%	25%	9%	4%	38%	29%
NY	35%	25%	9%	2%	44%	27%
PA	54%	15%	14%	3%	68%	18%
TX	60%	64%	20%	5%	80%	69%
VT	60%*	46%	NA	14%	60%	60%

Source: Fox,K and Schofield,L, National Pharmaceutical Council SPAP Surveys, 2005 and 2006. Table only includes states that reported data in both years. Many states still did not have accurate LIS enrollment information from CMS in August/September 2006. Vermont 2006 estimate includes members that were 'deemed' eligible for LIS as a result of MSP eligibility expansions described in more detail below.
** VT estimate only available for both full and partial LIS eligible*

As a result of low LIS enrollment, SPAPs are paying more per member per month than they otherwise would expend as the secondary payer if their members were enrolled in LIS and getting full federal subsidies for premiums and drugs covered during the 'donut hole', and only paying modest copayments.

Link Between MSPs and LIS

Like the dual-eligibles who are enrolled in both Medicaid and Medicare, all MSP enrollees are deemed eligible for LIS and do not need to apply through SSA for the subsidy.[10] This automatic enrollment of MSPs into LIS occurs regardless of state MSP eligibility criteria. This significantly expands the value of the Medicare Savings Program benefit for the low-income member, providing them with two benefits in one. If MSP enrollees are also enrolled in a SPAP, the automatic linkage to LIS also reduces the SPAPs' cost of wrapping around the Part D benefit and the administrative burden of getting their members to voluntarily apply for LIS through SSA.

While states have little control over the federal LIS eligibility rules or application process, as indicated above they have considerable discretion over MSP eligibility procedures. If a state expands MSP eligibility rules to be less restrictive than the rules used to determine eligibility for LIS, more people can be deemed eligible for LIS than if they were to apply through SSA. This 'back-door' to LIS provides a unique opportunity to states with SPAPs, allowing them to reduce even more of their low-income members' out-of-pocket costs for both Medicare Part B and Part D, while further reducing state SPAP expenses. As a result, there is potential to have the same or lower state costs, lower consumer out-of-pocket costs and potential greater access to prescription drugs.

While federal eligibility requirements for MSP are slightly lower than eligibility for LIS (Table 2), some states have expanded MSP eligibility beyond LIS levels. Prior to the MMA, four states (AL,AZ,DE,MS) had eliminated the asset test in all three Medicare Savings Programs and two states (NY, CT) had eliminated it in the QI-1 program only.[11] Since Part D, the two states that are the subject of the following case studies – Maine and Vermont -- as well as the District of Columbia[12] have also significantly expanded MSP eligibility by eliminating the asset test, raising income limits or both. All of these enrollees, even those that have income or assets above the SSA LIS limits have been deemed LIS eligible.

Table 2: Minimum Federal Eligibility Criteria for Medicare Savings Program* and Eligibility Criteria for Part D Low Income Subsidy

Program	Income Limit	Asset Limit	Benefit
Qualified Medicare Beneficiary (QMB)	Less than or equal to 100 percent of federal poverty level (FPL)	$4,000 for an individual $6,000 for a couple	Pays all Part B premiums and cost-sharing obligations
Specified Low-Income Medicare Beneficiary (SLMB)	Between 100 and 120% FPL	$4,000 for an individual $6,000 for a couple	Pays Part B premiums
Qualified Individual 1 (QI-1)	Between 120 and 135% FPL	$4,000 for an individual $6,000 for a couple	Pays Part B premiums
Part D Full Low Income Subsidy	Below 135% FPL	$6,000 single $9,000 couple	Pays Part D premium, deductible, donut hole and all but $2/$5 copayments.
Part D Partial Low Income Subsidy	Below 150% of FPL	$10,000 single $20,000 couple	Pays for sliding scale Part D premium, $50 deductible, 15% coinsurance, and all but $2/$5 in donut hole.

*Federal minimum standards. States have the option of modifying federal income and asset eligibility criteria by increasing income and asset disregards under Section 1902(r)(2) of the Social Security Act.
Source: Federal Register 42 CFR Parts 403, 411, 417, and 423: Medicare Program; Medicare Prescription Drug Benefit; Final Rule. Department of Health and Human Services. January 2005.

Considerations in Expanding MSP

While expanding Medicare Savings Program eligibility may enable more SPAP enrollees to be deemed LIS eligible, states are still reluctant to commit to eligibility expansions without clearly determining

whether the savings incurred in the SPAP offset the additional state Medicaid costs for Part B premiums and cost-sharing under MSP.

In fact, the level of SPAP cost-savings can vary significantly by state, depending on the comprehensiveness of the SPAP wrap benefit that could be cost-avoided and the estimated additional costs the state will incur for Part B premiums and cost-sharing for Qualified Medicare Beneficiary (QMB), as well as if full Medicaid benefits are extended to QMB/ Specified Low-Income Medicare Beneficiary (SLMB).

While targeted toward existing enrollees in SPAPs, states are also concerned about potential 'woodworking' or identification of new MSP eligible but not enrolled persons who are not currently in the SPAP. The following case studies provide some insight into how two states made these eligibility changes, and their experience and impact to date.

State Case Studies

Elimination of MSP Asset Test in Vermont

The state of Vermont's decision to eliminate the asset test in all three MSP programs in December 2005, was part of a broader consolidation of its state pharmacy benefit programs. For over a decade prior to Medicare Part D, Vermont offered pharmacy benefits for low income senior and disabled individuals who did not qualify for Medicaid. Vermont had three pharmacy programs that had been established incrementally over time, each of which had slightly different eligibility and benefits (See Table 3).

Table 3: Vermont State Pharmacy Assistance Program Eligibility and Benefits

Program Name Pre/Post Part D	***Eligibility***	***Benefits***
VHAP/ VPharm 1	<=150% FPL	Covers both acute and maintenance drugs
VScript/ VPharm 2	>150% FPL and <=175% FPL	Maintenance only drugs
VScript Expanded/VPharm 3	>175% FPL and <=225% FPL	Maintenance drugs only

After the passage of Medicare Part D, the state elected to combine the existing three pharmacy programs under the new name VPharm.[13] Under VPharm, eligible enrollees without Medicare continue to receive the same level of prescription drug coverage as before Part D. Those with Medicare (99% of enrollees) must be enrolled in a Part D plan (PDP) or a Part C Medicare Advantage plan with a drug component (MA-PD) and the state provides wrap-around coverage to their Medicare Part D and/or Part C benefits up to their prior benefit levels. Income eligibility for VPharm was comparable to eligibility under the previous programs (<225% FPL), and those with incomes under 150% FPL were required to apply to SSA and secure LIS, if eligible.

Simultaneously, the state considered an MSP eligibility expansion to get more VPharm enrollees 'deemed' eligible for full LIS. VT MSP eligibility had been comparable to the federal minimum standard, with income eligibility at or below 135% FPL.

The enacting legislation for the VPharm program required that the Department of Vermont Health Access conduct a cost/benefit analysis of the impact of eliminating the asset test in all three MSPs and also raising income eligibility in all three programs. While the advocacy community in the state had supported MSP eligibility expansions for some time, it was only with the roll-out of Part D and the potential fiscal benefits to the state as a secondary payer to the Part D benefit, that the state was able to financially consider such an expansion.

Vermont conducted a cost/benefit analysis of the elimination of the MSP asset test. State Medicaid costs for covering the additional Part A and Part B premiums and cost-sharing for new MSP enrollees were compared with the savings to the state pharmacy program as a result of VPharm members being 'deemed' eligible for LIS. The state concluded that elimination of the MSP asset test at minimum would be budget neutral and, depending on enrollees' drug utilization could yield a savings to the state of more than $630,000. Their cost-benefit analysis of MSP income eligibility expansions was inconclusive.

Once elimination of the MSP asset test was determined to be, at minimum, cost neutral, the state submitted a State Plan Amendment, which CMS approved. The state also modified its three information systems for eligibility, claims processing, and pharmacy benefit management. Members in the existing pharmacy programs who were eligible for the MSP were automatically enrolled into the MSP. Members received notifications of their new MSP benefit from both the state in December 2005 and by Social Security in January 2006. The state has also developed a large network of advocates to help provide outreach and education regarding the MSP eligibility change. The state meets with this network regularly to provide information and updates about state activities. Vermont has also sent out information directly to beneficiaries and potential beneficiaries.

As shown in Table 4, after eliminating the MSP asset test, Vermont's MSP enrollment grew from less than 700 members to more than 6,300. While enrollment increased in all programs, the increase was most pronounced in the QI1 program, which is fully federally funded, and had historically had very low participation. In anticipation of increases in QI-1, the state had put in a request and was granted a QI-1 allotment increase.[14]

Table 4: Vermont Medicare Savings Program Enrollment Before and After Elimination of MSP Asset Test

	December 2005	January 2006	% Change
QMB	167	1445	765%
SLMB	524	2425	363%
QI1	7	2493	35514%
TOTAL	698	6363	812%
Net Increase		5695	

Source: Office of Vermont Health Access, Vermont Agency of Human Services.

Despite some early concerns voiced by the state legislature, Vermont did not experience a 'woodworking' effect from the elimination of the MSP asset test. Nearly all new MSPs were existing enrollees in VPharm, who were auto-enrolled into the MSPs. As a result of this policy change an additional 30% of SPAP members became eligible for LIS, who otherwise would not have been eligible if they had applied through SSA.

The state has not been able to fully assess the cost savings from this policy change due to additional one-time costs incurred for Part D emergency coverage in 2006. However, for the QI-1 program alone, which experienced the largest increase in enrollment and is fully federally funded, the state estimated a savings of $2.5 million in FY 2007.

MSP Eligibility Expansions in Maine

Maine's state pharmacy assistance program – the Drugs for the Elderly program -- has offered coverage for prescription drugs for low-income elderly since 1975 and for younger residents with disabilities since 1997. The state's expansion of MSP eligibility occurred in two phases and, like Vermont's, was a part of broader set of changes to the state's pharmacy benefit.

With the implementation of Part D, Maine was one of the few states in the country that elected to not only wrap-around Part D for its existing DEL members but also to auto-enroll those dually eligible for Medicare and Medicaid into the DEL program in order to cover their Part D copayments.[15]

Legislation was passed which gave the Department of Health and Human Services (DHHS) the authority to:

- enroll Medicaid enrollees eligible for Medicare Part D into the DEL program and deem them eligible without application,
- serve as the "authorized representative" for enrollment into a Part D plan,
- apply for Medicare Part D benefits on behalf of enrollees,
- identify objective criteria for assisting or enrolling DEL and dual members into Part D plans that best matched their needs,
- establish rules by which enrollees may opt-out of this process,

- file exceptions and appeals related to Part D eligibility or benefits on behalf of enrollees,
- provide assistance with cost-sharing and premiums for DELs[16] and provide coverage of drugs for dual-eligibles to the same extent that coverage is available for Medicaid enrollees not eligible for Part D,
- provide education and outreach materials to increase access to Part D,
- have emergency rule-making authority,
- convene a Stakeholders Group.[17]

Legislation also mandated that DEL members enroll in Part D if eligible, but did not require them to apply for LIS. While all of the dual-eligible DELs and those already enrolled in MSPs were 'deemed' eligible for LIS, the remaining DEL members had to voluntarily apply through SSA. The DEL program had 42,000 individuals enrolled, approximately 85% of whom were Medicare eligible. With income eligibility at 185% FPL, many DEL enrollees could potentially be eligible for both MSP and LIS.

Prior to expanding MSP eligibility, Maine initially attempted to help their DEL members apply for LIS through SSA. They received funding from Maine Health Access Foundation to support a specialized help desk that made outgoing calls to members to help them complete the applications and also offered face-to-face counseling with staff at the local Area Agency on Aging when requested. The project promoted collaboration across agencies and helped develop a cross-agency call tracking system to connect eligible members with the subsidy. However, the program was not particularly successful in getting people enrolled in LIS. SPAP members were unwilling to provide necessary information (particularly assets) over the phone in order to complete LIS or MSP applications. Other difficulties were encountered with gathering information on other family members' income, with the SSA on-line application system, and with confirmation of LIS enrollment by CMS. By mid December '05, after 4,500 calls to members, only 300 LIS applications had been completed.

Due to low return rates, the state elected to change its focus and strategy toward getting members enrolled in Medicare Savings Programs, which would deem them eligible for LIS. Financial eligibility for MSP was at the federal income limits and there was an asset test at the federally determined level. Prior to Maine's MSP eligibility changes, enrollment in the MSPs was just under 9,000, with most enrolled in SLMB or QI-1. To help get eligible DEL enrollees into MSPs, the Medicaid agency agreed to use a short application form for MSP, which was less intrusive, as well as offering members the additional benefit of the State paying the member's Part B premium.

At the same time, the state moved to expand MSP eligibility, first eliminating the asset test in the MSP program in March, 2006 and then expanding MSP income eligibility guidelines to be comparable to income eligibility for DEL in April, 2007. Current CMS rules require that income eligibility expansions be uniformly applied across the MSP program, so Maine's income eligibility was raised by 50% FPL in each category (Table 5). The state submitted two separate State Plan Amendments, both of which were approved by CMS.

Table 5: Maine Medicare Savings Program Income Eligibility Changes

Medicare Savings Program	*2006*	*April 2007*
QMB	100% FPL	150%
SLMB	120% FPL	170%
QI-1	135% FPL	185%

The state took a number of steps to inform its DEL members and others of the MSP eligibility change. Unlike Vermont, Maine was not able to autoenroll DEL members in MSP after eliminating the asset test due to lack of information on their applications. Many enrollees' eligibility had been established under the Department of Revenue, which previously administered the program. Maine conducted extensive outreach efforts to inform members and the public about MSP eligibility changes. Letters were mailed to SPAP members who were not enrolled in MSP, to encourage them to apply if eligible. Members were also sent information about how to get reimbursed for overpayments to Part D plans. The state also designed new DEL applications to include information to verify if someone is MSP eligible. The Stakeholders group convened by the state was also very active in getting the word out about the MSP eligibility changes.

As a result of the elimination of the asset test, MSP enrollment nearly doubled from 9,000 to over 16,000. After raising income eligibility, the state autoenrolled another 14,000 SPAP members in MSPs, bringing total LIS enrollment to over 30,000 (Table 6).

The percentage of SPAP members enrolled in LIS has also increased dramatically. While under SSA LIS eligibility criteria the state estimated that approximately 36% of their non-dual members would be eligible for LIS[18], after expanding MSP eligibility beyond LIS standards, the state estimates that 97% of their SPAP members have been deemed eligible for LIS. The remaining 3% are likely to be deemed eligible once data issues have been resolved.

Table 6: Maine Medicare Savings Program Enrollment Before and After Asset Test Elimination and Expansion of Income Eligibility, 2005-2007

Program	*Dec 2005*	*February 2006 - Asset Elimination*	*% Change*	*April 2007- Income Eligibility Increases*	*% Increase*
QMB	567	2,321	309%	24,471	954%
SLMB	5,809	8,391	44%	4,473	-47%
QI-1	2,555	5,447	113%	1,415	-74%
MSP TOTAL	8,931	16,159	81%	30,359	88%
Net Increase		7,228		14,200	

Source: Maine Governor's Office of Health Policy and Finance

All of the net increase in MSP enrollment was the result of 'inreach' to DEL members. As in Vermont, Maine did not see many newly identified persons enrolling in the MSP. Similarly, the state saw no increase in the number of DEL enrollees, beyond the 50,000 dual-eligibles who were auto-enrolled.

The state has not yet estimated the exact cost savings of these changes, but they are confident that they are indeed saving state funds. Like Vermont, assessing net DEL savings in 2006 is difficult due to emergency "safety net" coverage that the state provided to cover drugs for DEL members until Part D enrollment and cost-sharing problems were resolved. However, since nearly all of their DELs are now eligible for LIS, the state no longer pays Part D premiums or the donut hole for these enrollees. In anticipation of this policy change, the program booked a savings of $800,000 from averted donut hole costs incurred the prior year and returned these funds in the state supplemental budget. The elimination of premium payments for the vast majority of DELs also reduced administrative burden and costs as premium payment to plans had been difficult. The state also estimated that they paid approximately $2.6 million in Part D wrap claims for DELs in 2006 --$1.3 million of which was for deductibles and gap coverage.[19] More than half of these wrap costs are likely to be avoided in 2007 when all members are deemed eligible for LIS. Maine is using savings from the MSP expansion to provide support for the SHIPs and Legal Services for the Elderly, the organization under contract with the state that handles Part D appeals and exceptions.

Implications for other states

Both Maine and Vermont have demonstrated that MSP eligibility expansions coupled with enrollment of SPAP members significantly increased SPAP LIS enrollment. These policy changes have not only provided greater coverage of medications and financial assistance for low income state residents with Medicare, but have also been accomplished at no cost – indeed at potential savings – to the state.

Several factors contributed to the success of these initiatives. In both Maine and Vermont, the SPAP and MSP programs are administered by the Medicaid agency. This undoubtedly facilitated the discussion of this policy change because the costs and savings were assumed by the same agency. Other states where the SPAP is housed in a different department may face greater difficulties in getting the Medicaid agency's support, because the initiative will have a negative budgetary impact in their agency. In these states, involvement of the Governor's Office or the Office of Management and Budget may be required in order to assess the impact on the overall state budget rather than separate departments.

Another important factor in assessing potential state savings is the state's distribution of enrollees across MSP programs. Vermont had very low enrollment in its QI1 program so the elimination of asset tests in all three programs resulted in a much larger increase in this federally funded program. Similarly, when Maine eliminated its asset test, it saw increases in all three programs. However, once Maine raised the income limits, the vast majority of their MSP enrollees became eligible for QMB which offers a more extensive benefit covering both Part B premiums and cost-sharing, while enrollment in SLMB and QI-1 declined. Even with this enrollment shift to the QMB program, Maine still estimates that the eligibility changes have been budget neutral.

Lastly, both states saw the political value of expanding a benefit to seniors and people with disabilities at little or no cost to the state. In addition to a potential financial benefit to the state, state residents receive two benefits in one – eliminating their Medicare Part B premiums (and sometimes copays/deductibles) as well as Part D premiums, deductibles, and donut hole, with nominal copayments. To the extent that states are able to autoenroll SPAP members, as was the case in Vermont, the process for accessing expanded coverage could be relatively seamless to low-income residents. Vermont simply autoenrolled their SPAP members and sent them a letter informing them that their Social Security checks would be higher and drug copayments would be lower because they were deemed eligible for the Medicare LIS.

While both of these case studies involved states with state pharmacy assistance programs, states that do not have an SPAP but are considering developing one to wrap around the gaps in the Part D benefit may want to consider this alternative approach. The District of Columbia, which does not have an SPAP, expanded QMB income eligibility to 300% FPL as an alternative to legislative proposals to create an SPAP to address gaps in the Medicare Part D benefit.[20] With relatively small additional investment by the state, they were able to buy a much more generous drug benefit for their enrollees, without incurring the administrative costs of creating a whole new wrap benefit program. In addition, some states have found that expanded drug coverage provided to low-income individuals through LIS has reduced the number of individuals spending down into Medicaid, suggesting that expanding MSP and thereby getting LIS could reduce Medicaid expenditures.[21]

Conclusion

The policy decision to "deem" MSP enrollees eligible for LIS creates new incentives for states to investigate the cost/benefit of expanding MSP eligibility under Part D. The experience of Maine and Vermont, both of which offer comprehensive Medicare Part D wrap coverage through a state pharmacy assistance program, confirm that such expansions can be budget neutral or even yield a net savings for the state, while significantly expanding benefits for low-income Medicare state residents. This policy change is worthy of further exploration by states with state pharmacy assistance programs as a mechanism for maximizing LIS enrollment and thereby reducing SPAP costs as the secondary payer to Medicare Part D. Further investigation of MSP eligibility expansions beyond LIS levels may also be warranted in non SPAP states as a relatively low-cost approach for states to expand drug coverage for Medicare beneficiaries.

Endnotes

1. The Medicare Savings Programs include the Qualified Medicare Beneficiary (QMB) program created under the Medicare Catastrophic Coverage Act of 1988 and the Specified Low-Income Medicare Beneficiary program (SLMB) created under the Omnibus Reconciliation Act of 1990 both funded by state Medicaid programs with federal matching funds; and the Qualified Individuals (QI-1) program that was created under the Balanced Budget Act of 1997, which is reauthorized annually and is fully federally funded. MSPs help qualifying low-income Medicare beneficiaries pay for the Medicare Part B premium ($93.50 in 2007) and Medicare Part B cost-sharing (for QMB-only).
2. Social Security Act, Section 1902(r)(2). Federal rules specify that MSP benefits be available to people with incomes less than 135 percent of the federal poverty level and with countable assets valued at less than $4,000 for an individual and $6,000 for a couple. Under section 1902(r) (2) of the Social Security Act, however, states have the ability to use less restrictive methods (through disregards) for calculating the value of income and assets than those specified in federal law.
3. Perry MJ, Kannel S, Dulio A. *Barriers to Medicaid Enrollment for Low-Income Seniors: Focus Group Findings*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2002.

4. Tiedemann, A. Fox, K. Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements. State Solutions Issue Brief, Rutgers Center for State Health Policy, New Brunswick, NJ. December 2004.
5. Nemore, P.B., Bender, J.A., Kwok, W. Toward Making Medicare Work for Low-Income Beneficiaries:A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules. Kaiser Family Foundation, May 2006. Accessed at http://www.kff.org/medicare/upload/7519.pdf on September 26, 2007.
6. National Conference of State Legislators, State Pharmacy Assistance Programs, 2007 downloaded at http://www.ncsl.org/programs/health/drugaid.htm#SC on 9/27/07 and Fox, K. and Schofield, L. results of National Pharmaceutical Council survey of State Pharmacy Assistance Programs, Fall 2006
7. Fox, K. Schofield, L. The pharmacy coverage safety net: Variations in state responses to supplement Medicare Part D. University of Southern Maine, Muskie School of Public Service, Portland, ME, Feb 2006.
8. Blume, R. Linking State Prescription Programs with Medicare Savings Programs: Examples from New Jersey and Minnesota. State Solutions Issue Brief, Rutgers Center for State Health Policy, New Brunswick, NJ. March 2004.
9. US DHHS, 42 CFR, Federal Register, Volume 70, No. 18, Medicare Program, Medicare Prescription Drug Benefit, Final Rule.Friday January 28, 2005, p 4466.
10. Ibid, p 4386.
11. Tiedeman, A., Fox, K., *Promising Strategies for Medicare Savings Program Enrollment:Modifying Eligibility Criteria and Documentation Requirements.* State Solutions Issue Brief. Rutgers Center for State Health Policy, New Brunswick, NJ. While NY and CT were approved for removing the asset test in the QI-1 program only, CMS's current rules require that if eligibility rules are changed for higher income persons, the rules must also be changed for lower income persons. Proposals to liberalize criteria in the QI-1 program need to extend the same criteria to SLMB and QMB.
12. The District of Columbia increased income disregards for its QMB program by raising the QMB income limit from 150% FPL to 300% SSI (225% FPL) in 2006. In February 2007, the District further increased the QMB limit from 300% SSI to 300% FPL through income disregards. The District had previously folded all of its MSPs (QMB, SLMB, and QI-1) into the QMB program.
13. Act 71 of the 2005 Vermont legislature.
14. Federal Register, Volume 71 No. 199, *Medicaid Program State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals Federal Fiscal Year 2006 and 2007*, pp 60663-60670. October 16, 2007.
15. Maine pays 100% of the copayment for dual-eligibles living in non-medical institutions and 50% of the cost of brand name drugs with a cap of $10 per drug, up to $2 per generic for all other duals.
16. The wrap benefit for DEL enrollees that are eligible for Part D is 100% of premiums, 50% of the deductible, 50% of the cost of brand name drugs with a cap of $10 per drug, up to $2 per generic in the initial benefit period and 20% plus $2 during the gap or donut hole. For DEL enrollees in MSP/LIS, the state pays 50% of the cost of brand name drugs with a cap of $10 per drug, up to $2 per generic.
17. Maine Public Law Chapter 401. HP 924/ LD 1325, State of Maine Legislature, An Act to Ensure Continuity of Care Related to Implementation of the Federal Medicare Drug Benefit accessed at: http://janus.state.me.us/legis/LawMakerWeb/search.asp.
18. Fox, K and Schofield, L., National Pharmaceutical Council SPAP Maine Survey, Fall 2006.
19. Presentation by Jude Walsh, Special Assistant, Governor's Office of Health Policy & Finance. *Medicare Part D Implementation Maine's Approach.* State Solutions Summit, Washington, DC, March 2007.
20. Interview with John McCarthy, District of Columbia Department of Health., January 2007.
21. Presentation by Grace Chandler, Oversight Manager Medicaid Eligibility Programs, Indiana Medicaid, Indiana Medicare Savings Programs. State Solutions Summit, Washington, D.C. March 2007.

State Solutions

The Medicare Savings Programs are publicly financed programs that help people pay for costs associated with Medicare, such as premiums, co-payments, and deductibles. It is estimated that 5 million people are eligible to receive financial help through the Medicare Savings Programs, but only half are enrolled. Eligibility is generally granted to Medicare enrollees with low incomes, including people with disabilities and seniors.

State Solutions is a national program working to increase enrollment in and access to the Medicare Savings Programs. Funding for State Solutions is provided by the Robert Wood Johnson Foundation and The Commonwealth Fund.

NCOA
NATIONAL COUNCIL ON AGING

The National Council on Aging's mission is to improve the lives of older Americans. NCOA programs help older people remain healthy and independent, find jobs and training, increase access to benefits programs, and discover meaningful ways to continue contributing to society. A non-profit organization with a national network of more than 14,000 organizations and leaders, NCOA was founded in 1950 and is based in Washington, DC. For more information about NCOA, please visit www.NCOA.org.