CSHP
Rutgers Center for State Health Policy

The Institute for Health, Health Care Policy and Aging Research

Coordinating Medicare Prescription Drug Benefits With Existing State Pharmacy Assistance Programs: Partnership or Crowd-Out?

Kimberley Fox, M.P.A.
Jasmine Sia, M.D., M.P.H.
Stephen Crystal, Ph.D.

March 2006

THE STATE UNIVERSITY OF NEW JERSEY
RUTGERS

Acknowledgements

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

Table of Contents

Coordinating Medicare Prescription Drug Benefits With Existing State Pharmacy Assistance Programs: Partnership or Crowd-out?

Kimberley Fox, M.D., Jasmine Sia, M.D., M.P.H., Stephen Crystal, Ph.D.

Executive Summary

As Medicare Part D implementation approaches, states face key questions about how best to maintain their role in pharmacy assistance, in order to complement available federal funds to provide the best coverage possible for beneficiaries. Based on an ongoing study of state pharmacy assistance programs (SPAPs), this report reviews the operational and policy issues facing states and lessons learned from their experience in coordinating with the Medicare discount card program.

Key findings include:

- Most states had plans to continue coverage in some form as of Spring 2004, but the - administrative cost and 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 to avoid crowd-out of the current state contributions to pharmacy assistance for the elderly and disabled.
- The key issues for states will be maintaining a visible state role, getting their enrollees to enroll in the Part D benefit and the low-income subsidies and once enrolled, ensuring smooth coordination of benefits that result in the greatest federal savings to the state.
- Autoenrollment into preferred discount cards was the most successful strategy for enrolling current SPAP beneficiaries into the discount card program. Despite recommendations of a federal commission established to address SPAP-specific transition issues, autoenrollment into preferred plans is not allowed under Part D[1].
- Establishing eligibility for the Medicare low-income subsidies (LIS) will be a major challenge for states. Unlike the discount card period, during which enrollees completed one application for the card and transitional assistance, the two-step application process for low-income subsidies under Part D is likely to deter enrollment in these low-income subsidies where the states stand to gain the greatest savings.

[1] State Pharmaceutical Assistance Transition Commission, Report to the President and Congress, December 20, 2004.

- States also have deep concerns over the impact of the asset test on enrollment in subsidized Part D coverage. Most SPAPs do not have an asset test but to ensure that all LIS eligible members apply and are determined eligible, SPAPs may need to collect asset information in the future.
- Based on the experience in third party collection and data coordination during the interim Medicare discount card program, a centralized approach for timely data-sharing would be preferred over a retail method that would require states to collect information from multiple prescription drug plans. The importance of such data-sharing is illustrated by the experience of many SPAPs during the interim Medicare discount card program that available Medicare transitional assistance benefits were often not being utilized by eligible SPAP members enrolled in the discount card program. Although such problems may exist with a preferred plan, they can be more readily identified and addressed if data-sharing is centralized or provided on a real-time basis through a preferred card sponsor than with multiple sponsors. While CMS has developed a centralized mechanism for tracking true-out-of pocket costs it is unclear what information the states will be able to access. The prohibition on SPAPs working with a preferred card sponsor is likely to increase the potential for mistaken billing to the states for benefits that should be paid by Medicare.

The final Part D regulations released in January 2005 present a fairly strict interpretation of how states must coordinate with Part D plans. In so doing, they may impact the level of supplemental coverage that states provide. Early experience in Connecticut during the discount card program indicates that partnering with multiple plans results in much lower enrollment rates and thus reduced savings to the state. For states with relatively small SPAPs, low anticipated federal savings coupled with higher administrative costs may discourage them from supplementing the Medicare drug benefit at all. States with longstanding programs are less likely to drop coverage, at least in the short term. However, the long-term ability of these programs to compete for state dollars, and the extent of coverage they provide, is likely to be affected by the extent to which they can remain visible, distinct state initiatives.

Coordinating Medicare Prescription Drug Benefits With Existing State Pharmacy Assistance Programs: Partnership or Crowd-out?

Kimberley Fox, M.D., Jasmine Sia, M.D., M.P.H., Stephen Crystal, Ph.D.

Introduction

The new Medicare Part D prescription drug coverage, available in January 2006, will offer many Medicare beneficiaries drug coverage that was previously unavailable to them. This new benefit will also affect 1.5 million Medicare beneficiaries who currently have drug coverage through state pharmacy assistance programs (SPAPs) in twenty-two states, whose future is somewhat uncertain[2]. Many of these state programs, particularly those that have been enacted in the last five years, were initiated in response to the strong public outcry for some assistance with prescription drug costs among the most vulnerable disabled and elderly populations in absence of any drug coverage through Medicare. Now that prescription drug coverage will be available through Medicare, states are reassessing their roles and whether or not they should continue these programs at all and if so, in what capacity.

The Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA) acknowledges the contributions of the SPAPs toward pharmacy coverage for low-income persons. Because the SPAPs were generally designed and operate as free-standing programs that directly enroll beneficiaries, establish formularies, purchase pharmaceuticals on beneficiaries' behalf, pay claims directly, and negotiate and receive rebates, coexistence of the existing programs and the new Part D benefits posed many challenges. During the development of the legislation, various alternatives were considered to avoid "crowding out" these programs by creating incentives to encourage states to continue to supplement the Medicare Part D benefit as a secondary payer. Those that were included in the final legislation and regulations included:

- SPAPs are allowed to either purchase supplemental insurance through Part D plans or wrap around Part D benefit plans by helping beneficiaries pay for premiums, cost-sharing, or for drugs not covered by the plans.
- Qualifying SPAPs are given the unique opportunity to count state expenditures made on behalf of a Medicare beneficiary to help pay for Part D cost-sharing to count toward the

[2] For additional information on SPAPs, see Trail T, et al. State Pharmacy Assistance Programs: A Chartbook. Rutgers Center for State Health Policy: New Brunswick, NJ; August 2004. Available at http://www.cshp.rutgers.edu/PDF/758_Trail_state_pharmacy_assist_progs_chartbook.pdf.

enrollees' true out of pocket costs (TROOP). This would allow the beneficiary to reach the more generous catastrophic coverage available under Part D sooner without having to pay the full cost-sharing out of their own pocket.

- Part D plans are required to coordinate benefits with SPAPs and to share necessary data for benefit coordination.
- Congress also appropriated $125 million for grant funding for FY 2005 and 2006 to states with SPAPs to assist their current enrollees in enrolling in Part D plans and the low-income subsidies[3].

To qualify as an SPAP, states must attest that they will offer the same financial assistance regardless of the plan in which someone enrolls.

Because of the substantial burden of copayments, the "doughnut hole", and other aspects of Part D designed to limit the federal cost of the benefit, the importance of maintaining state and other pharmacy coverage resources that could supplement the federal benefits has been widely acknowledged. Because qualifying SPAPs have the opportunity to provide supplementation that is not counted against the beneficiary in calculating TROOP, and because states have committed substantial budgetary resources toward pharmaceutical assistance for the elderly and disabled, SPAPs have the potential to play a crucial role in filling Part D gaps, particularly for the "near-poor" who are not quite poor enough to qualify for low-income subsidies under Part D, for low-income individuals who fail to pass the assets test for the subsidies, and for beneficiaries subject to the "doughnut hole". This role could take the form of assuring current enrollees the level of benefits that they currently receive through the SPAP – i.e, "holding their enrollees harmless." States could also reprogram dollars freed-up by Part D benefits, or new dollars, to provide new or expanded coverage to help fill Part D gaps for populations not currently covered by their SPAPs – for example, states currently covering only the elderly, by maintaining their effort, could extend SPAP coverage to disabled Medicare beneficiaries.

However, despite these important opportunities and the need for supplemental coverage, other administrative complexities in the Part D rules may discourage states with existing programs from maintaining coverage, particularly in light of significant state budget deficits and the need to cut costs. Similarly, these complexities could discourage other states from coming forward to fill Part D gaps.

As Medicare Part D implementation approaches and federal policies are defined, states are debating how best to supplement the new federal benefit within political and fiscal constraints in order to provide the best coverage possible for beneficiaries. This report discusses the options for states in coordinating with Part D plans and the challenges in transitioning to the new Medicare benefit with state

[3] 42 CFR Parts 400, 403, 411, 417, and 423. Medicare Program; Medicare Prescription Drug Benefit; Final Rule. Federal Register, Vol. 70, No. 18, January 28, 2005; p. 4327.

supplementation drawing from their experience in coordinating with the Medicare discount card program based on interviews and follow-up discussions with state pharmacy program directors in Summer 2004 and early 2005.

Background – Comparison of SPAP and Medicare Part D Benefits

As of September 2003, twenty-two states had at least one operational state pharmacy assistance program providing subsidies to low-income Medicare beneficiaries to help pay for prescription drugs.[4] As indicated in Table 1, these programs varied considerably in terms of income eligibility, benefit design and enrollees' out-of-pocket costs. Several states had more than one program, or operated sliding-scale programs with different eligibility and cost-sharing rules for persons with higher incomes. Some SPAPs offer comprehensive first-dollar coverage with minimal cost-sharing and no benefit caps. Other programs require much larger consumer cost-sharing, through high deductibles ranging from $275 to $1715, or by capping the total benefit provided, with caps that vary from $500 per year in Indiana for moderate income enrollees to $5,000 in Nevada.

States that choose to wrap around the new Medicare benefit to maintain the same level of benefits for their enrollees must interface their already complicated benefit structures with an equally complex benefit structure for Medicare Part D. As indicated in Table 2, the standard Medicare drug benefit available to all Medicare beneficiaries in 2006 includes a monthly premium, an annual deductible, an interim benefit cap, and catastrophic coverage above an out-of-pocket limit. The unique coverage gap once an individual has reached the interim benefit cap but before he/she has met the out-of-pocket limit – referred to as the "doughnut hole" – is a problem on which states are likely to focus, as consumers must pay 100% coinsurance during this period and SPAP contributions can be counted as true out-of-pocket costs, allowing beneficiaries to reach the catastrophic cap sooner. Medicare also offers generous subsidies for the lowest-income Medicare beneficiaries who also meet asset tests, which will require different and more limited wrap-around by states, to the extent that these enrollees apply.

While it is difficult to compare actuarial equivalence of such disparate plans, SPAP benefits in some of the largest programs – which account for the majority of SPAP enrollees nationally – are considerably more generous than Part D because they have no doughnut hole, lower or no up-front costs, limited cost-sharing, broader pharmacy networks, and open formularies. Few states have up-front fees of the magnitude proposed for Medicare in 2006 for the Part D basic benefit. Compared to the 25%

[4] Another 8 states had state-sponsored drug discount cards in place. These cards generally offer discounts off of the retail price of the drugs but with no subsidy paid on behalf of the state.

coinsurance up to the initial coverage limit and the 100% coinsurance up to the catastrophic cap that will be required under Part D, SPAP benefits for moderate income persons in Connecticut, Illinois, New Jersey, Pennsylvania, New York, Maine, Michigan, Massachusetts, Nevada, South Carolina, Wisconsin and Vermont generally have lower annual cost-sharing for the drugs that they cover. However, there are several exceptions. Moderate income SPAP enrollees in Delaware, Missouri, North Carolina, and Rhode Island currently must pay comparable or greater coinsurance, at least before the doughnut hole level of spending, and in some cases also face lower benefit caps or limits on drugs covered per month. Missouri also requires an annual fee and a $250-$500 deductible. For enrollees in these states, the basic Medicare benefit may be comparable or even more generous than their current coverage.

In contrast, the Medicare subsidies available for those earning less than 135% FPL who meet the asset limits are more generous in terms of cost-sharing than most SPAPs, offering first-dollar coverage with nominal copayments of $2 for generic drugs and $5 for brand name drugs. The subsidies for those earning between 135% and 150% FPL are also better in many cases than what may be provided by SPAPs.

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

State (Program)	Enroll-ment	Income Eligibility (% FPL)	Annual Fee/ Premium	Deductible	Coinsurance / Copayment	Benefit Cap	Out of Pocket Cap
CT	50,905	226%	$30		$16.25		
DE	5,975	200%			$5 or 25%, whichever is greater	$2,500	
FL	47,843	120%			$2/$5/$15 tiered copay	$160 a month	
IL (Circuit Breaker)	60,840	236%	$5 or $25 by income		$0 or $3 by income up to $2,000, 20% coinsurance above $2000		
IL (Senior Care)	174,250	200%			< 100% FPL, no copay. Up to 200% FPL $1 Generic, $4 Brand, up to $1,750. 20% coinsurance above $1,750		
IN	14,890	135%			50%	$500, $750, or $1,000 by income	
KS	2,020	135%			30%	$1,200	
MA	77,685	None	$0 to $99 per month by income	$0 to $125 a quarter by income	$9/$23/$45 to $12/$30/$50 by income for a 30-day supply		$2,000 or 10% of income, whichever is lower
MD	47,958	116%			$5.00		
ME	35,538 (in 2002)	185%			$2 or 20%, whichever is greater		$1,000 for drugs for non-covered conditions
MI	14,672 (in 2002)	200%	$25		20%		Monthly co-payment maximums by income.
MN	7,040	120%		$35 a month	None		
MO	21,928	189%	$25 or $35 by income	$250 or $500 by income	40%	$5,000	
NC	16,206	200%			40%	$600	
NJ (PAAD)	193,210	223%			$5.00		
NJ (Senior Gold)	28,048	334%			$15 plus 50% of the remaining cost of the drug		$2,000 single, $3,000 couple
NV	7,412	245%			$10 generic, $25 preferred brand	$5,000	
NY (Fee)	245,094	223%	$8 to $300 by income		$3 to $20 by drug price		9% of annual income
NY (Deductible)	78,498	390%		$530 to $1,715 by income	$3 to $20 by drug price		9% of annual income
PA (PACE)	196,014	156%			$6.00		
PA (PACENET)	32,397	178%		$500 a year	$8 generic, $15 brand		

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

State (Program)	Enroll-ment	Income Eligibility (% FPL)	Annual Fee/ Premium	Deductible	Coinsurance / Copayment	Benefit Cap	Out of Pocket Cap
RI	37,258	420%			40%, 70%, or 85% by income		$1500 for lowest income level
SC	49,628	200%		$500 a year	10 generic, $15 brand, $21 brand name requiring prior authorization		
VT (VHAP)	9,223	150%			$3 generic, $6 brand		$50 per calendar quarter
VT (VScript)	n/a	175%			$5 generic, $10 brand		$100 per calendar quarter
VT (VScript Exp.)	3,343	225%		$275 a year	41%		$2,500 per calendar quarter
WI	91,467	240%		Income <160% FPL – no deductible; income 160%<200% FPL - $500 per person; income 200%< 240% FPL - $850 per person; income >240% FPL - $850 after spend down	$5 generic, $15 brand		
WY	1,151	100%			$10 generic, $25 brand	3 prescriptions per month	

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

Table 2: Medicare Part D Benefit and Low-Income Subsidies

	Premiums	Deductibles	Cost-sharing from Deductible to Coverage Limit ($2,250 in 2006)	Cost-sharing above Coverage Limit to OOP ($3,600 in 2006) - "Doughnut Hole"	Cost-sharing above OOP cap "Catastrophic coverage"
Standard Part D	@ $35 per month in 2006*	$250 in 2006	25%	100%	Greater of $2 generic/ $5 brand or 5%
100% - 135% FPL; Assets $6/$9k	None- Full Medicare subsidy based on weighted average of basic premiums offered by plans in that region or lowest premium whichever is greater.	None	$2 generic/$5 brand indexed to CPI to out-of-pocket threshold		None
<150% FPL; Assets $10/$20k	Premium subsidies based on sliding scale from 100% for those at or below 135% to 0% for those at 150% FPL	$50	15%		$2 generic/$5 brand

*All premiums, deductibles, cost-sharing, initial coverage limits, and out-of-pocket thresholds are estimated for 2006. Future years indexed to annual growth in average per capita Medicare Part D drug spending.

In addition to the level of consumer cost-sharing, benefit value is also measured by what drugs are covered and the number of pharmacies at which beneficiaries may purchase these drugs. In this respect, the Medicare benefit may also be more limited than what is currently available through the 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 (PDPs) 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. 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 program.[5] Similarly, PDPs will likely 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 minimum pharmacy network requirements that are similar to those required under Part D, do not have as extensive networks as the SPAP.

Issues and Challenges for SPAPs Under Part D

For those states that intend to provide additional coverage for Medicare beneficiaries, states face a number of issues and challenges in transitioning from their existing benefit to the new Medicare drug benefit with state supplementation. The following are some key issues and challenges states face.

The Challenge of Maintaining a Distinct and Visible State Role.

In many states, SPAPs have been highly visible and successful state programs that provide valuable assistance to the elderly and, in some cases, the disabled. Their visibility and popularity have made it possible for them to compete effectively for state funds, even during periods of budgetary

[5] 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 under Part D than under the existing SPAP.

stringency, and even to motivate creation of new revenue sources to support the programs. They represent tangible benefits to constituents that bring considerable political credit to their sponsors.

While the availability of federal offsets through the new Medicare drug benefit may promise some budgetary relief to SPAPs, it also will fundamentally modify the state's role from primary to secondary payer. As Part D is implemented, it remains uncertain how the form and identity of the state programs, from the beneficiary's perspective, will change. For example, will SPAPs remain in the role of a direct, claims-paying provider of benefits? Respondents, particularly from some of the larger and more mature state programs, were interested in program models under which they would interact with beneficiaries and providers in much the same way that they do today, while drawing down the federal dollars to which their beneficiaries are entitled in order to offset part of the cost. Some states expressed a reluctance to give up the visibility and independent identity of their programs. States have invested heavily in these programs to address their constituents' needs. In order to compete for limited state resources, state programs need to be "branded" in such a way that the benefits can be clearly attributed to the state.

To Wrap or Not to Wrap?

States have the option of maintaining their state-only programs in their current form, but few are likely to forgo offsetting their current state expenditures with new federal dollars. States also have the option of ending their programs. Of the seventeen states we contacted in the spring of 2004, only Kansas and Wyoming had definite plans to end their programs in 2006.[6] By Spring 2005, after the final Part D regulations were released, four more states including Minnesota, North Carolina, Florida, and Michigan indicated that they planned to terminate their programs effective January 2006[7]. Two other states – Missouri and Indiana – were terminating their current programs and replacing them with new restructured programs to supplement Medicare coverage. Other states were still considering their options.

According to the MMA statute, if an SPAP chooses to supplement Part D, it may either pay the PDP an added "lump sum" premium to provide a supplemental coverage package on the state's behalf, or maintain a separate program and wrap around the Part D benefit, which will require coordinating enrollment and payment across programs. The Part D rules also allow co-branding partnerships between prescription drug plans and states for which a joint card would be issued. At the time of our interviews, few states were considering the lump sum option, due to concerns about how an appropriate supplemental

[6] As WY's program does not limit eligibility by age, it will continue its SPAP for non-elderly, non-Medicare beneficiaries.

[7] Based on informal discussions with state officials in Spring 2005. States that had either passed or were proposing budgets that terminated their SPAP benefit included WY, KS, MN, NC, FL, IN, MI.

payment rate would be established across all plans. Those that were considering it were only in the preliminary stages of determining which option would be more cost-effective for the state to pursue.

The majority of states were considering various wrap-around options including:

- Paying Medicare premiums,
- Paying some portion or all of the deductibles, and cost-sharing in and out of the doughnut hole;
- Covering non-Part D and/or off-formulary drugs; and
- Covering drugs purchased outside of the pharmacy network or holding pharmacists harmless with respect to current SPAP reimbursement.

Most states were considering all options in developing proposals for their legislatures. Many were considering covering some portion of the cost-sharing but had not yet determined to what extent. Far fewer mentioned considering coverage of off-formulary drugs or out-of-network pharmacies. Some states also noted that deciding to wrap around the formulary in the SPAP raised equity issues with the dual-eligible population.

While a few states have imposed preferred drug lists in recent years, the vast majority of SPAPs have open formularies. Thus this is a potential area of concern depending on how restrictive the final Part D plan formularies are. If plans were to use the minimum two-drug per class guidance, many drugs currently covered by SPAPs may not be covered under Part D. Final Part D regulations and subsequent guidance define an extensive formulary review process by CMS to ensure that plan formularies do not discriminate against individuals in particular disease states and CMS expanded guidance in six categories to require plans to cover all drugs in these classes. There is also an incentive for plans to keep the formularies broad at least initially to encourage enrollment. But states are concerned about whether broad formularies will be maintained over time, once the market-share across plans is established.

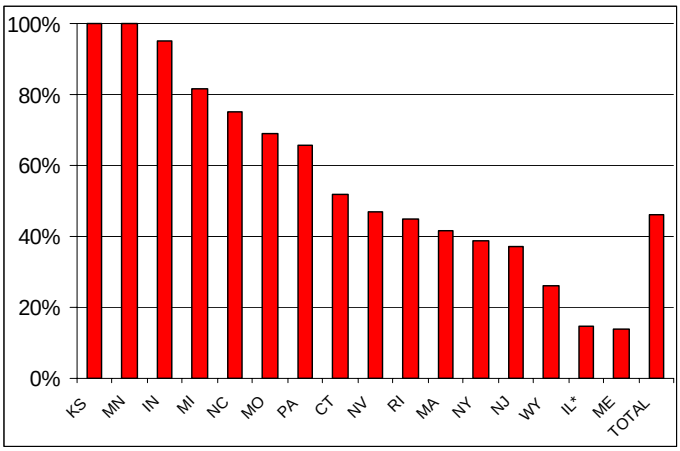
Delays in state decision-making at the time of our survey on how to wrap around Part D may be appropriate. The Part D program is still in its infancy. States may have chosen to wait until the Part D plans were approved in the fall of 2005 or even until 2006, before deciding exactly how their state can best wrap without negatively influencing market forces. For example, some states are concerned that decisions about wrapping around formularies could precipitate Part D bidders to propose more limited formularies within that region, particularly in single state regions.

Getting SPAP Enrollees Enrolled in Part D

Enrollment into Medicare Part D is voluntary. Since the basic Medicare benefit and low-income subsidies may be less generous or only slightly better than current SPAP coverage in some states, there may be little financial incentive for SPAP enrollees to enroll voluntarily in the new Medicare benefit. Even where there is some financial incentive, the complexity of choosing between Part D plans, the two-step application process and asset test requirement for the Medicare low-income subsidies which are not required for most SPAPs, and the loyalty to the state plan are all likely to discourage Medicare enrollment.

The states, on the other hand, have a clear financial incentive to get their enrollees enrolled in order to maximize federal funding before drawing on the state benefit, thereby freeing up state funds for other purposes. The SPAPs stand to reap the greatest savings from federal offsets from the Medicare low-income subsidies – with an estimated annual average federal contribution of more than $3,600 compared to $1355 for the basic Part D benefit - to the extent that their enrollees are determined eligible.[8] Based on their experience during the Medicare discount card program, SPAPs estimate that anywhere from 14 percent to 100 percent of their enrollees will be income eligible for the full subsidy and an even greater

Chart 1: Percent of SPAP Enrollees with Incomes Under 135% FPL Eligible for Transitional Assistance



Excludes SPAP enrollees in FL, IL SeniorCare, WI, MD, SC, and VT who are covered under Medicaid waivers and are therefore ineligible for transitional assistance.** IL's state-only funded Circuit Breaker program includes disabled persons below 135% of FPL.^ WY's program is available to persons of all ages below 100% of FPL.

Source: Interviews with SPAP program directors conducted by the Center for State Health Policy, May/June 2004.

[8] 42 CFR; p 4466

percentage would be eligible for at least partial subsidies. Since only two SPAPs (Minnesota and Maryland) require an asset test as a condition of program eligibility, it is unclear in most states how many income-eligible Medicare beneficiaries will fail to meet the asset test.

In mid-2005, states were determining how best to ensure that their enrollees enroll in Medicare Part D and the LIS and were considering the following options:

- Mandate enrollment in Medicare and the low-income subsidies as a condition of participation in the SPAP.
- Modify the design of the SPAP, in order to reconfigure it as a supplement to Medicare.
- Encourage enrollment through outreach and education, including possible promotion of co-branded plans, to the extent permitted by CMS under its "non-steering" requirements.
- Autoenroll SPAP beneficiaries in Part D plans, if they do not voluntarily enroll by a certain date, acting as authorized representative to assign beneficiaries to plans that meet certain standards.
- Forgo "qualified" SPAP status, and autoenroll all or LIS eligible members into a preferred plan.

Many state officials were concerned about the voluntary nature of the benefit and were considering mandating enrollment in Part D and LIS as a requirement of SPAP eligibility in order to ensure that the state program is the payer of last resort. Only three states had mandated enrollment during the Medicare discount card program, but this was largely because states were granted the authority to autoenroll their members into a preferred plan.

During the interim Medicare discount card program, many states passed legislation to deem the SPAP the authorized representatives for enrollees to autoenroll their members who were eligible for the $600 transitional assistance (TA) credit into a preferred Medicare discount card, unless they opted out. The vast majority of SPAPs enrolled individuals through this mechanism (see Table 3).[9] Only six SPAPs left enrollment in the discount card and TA voluntary. These states sent letters to their members informing them of the new benefit and encouraging them to enroll, highlighting the additional benefits of enrolling in a Medicare discount card.

[9] While the discounts available from the Medicare discount cards were much less generous than the SPAP benefits, the $600 transitional assistance credit available to beneficiaries with incomes below 135% FPL represented.a significant potential savings to the state programs.

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

		Preferred Card Sponsor		No Preferred Card Sponsor	
	Mandatory	***Autoenroll-ment***	***Facilitated Enrollment***	***Autoenroll-ment***	***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**	**9**	**1**	**1**	**6**

* Excludes SPAP enrollees in FL, IL SeniorCare, WI, MD, SC, and VT who are covered under Medicaid waivers and are therefore ineligible for transitional assistance.
** IL' s state-only funded Circuit Breaker program includes disabled persons below 135% of FPL
^ IN moved from voluntary enrollment to facilitated enrollment in multiple cards effective January 2005.
+ NV initially left enrollment voluntary, but moved to autoenroll into a preferred card in December 2004.

Source: Interviews with SPAP program directors conducted by the Center for State Health Policy, Spring 2004 and follow-up in December 2004.

Based on data provided by SPAP directors, autoenrollment into a preferred card proved to be the most successful model for ensuring that eligible SPAP members enrolled in transitional assistance. States that autoenrolled their SPAP enrollees into a preferred discount card reported enrollment rates of 85-90 percent of their estimated eligible enrollees within two months of implementation. Among states that elected to leave enrollment voluntary, enrollment rates reached only 25-50 percent of estimated eligible beneficiaries. The individual experience of states was confirmed by CMS Administrator Mark McClellan, in remarks to Congress, when he indicated that the vast majority of the 1 million persons who had enrolled in TA were enrolled through autoenrollment by Medicare+Choice (M+C) plans or SPAPs.[10]

[10] Statement by Dr. Mark B. McClellan, MD, PhD, Administrator, Centers for Medicare and Medicaid Services before the Committee on Senate Finance, September 14, 2004.

While autoenrollment has the potential to limit consumer choice, states that offered their enrollees the choice of opting out during the discount card period found that very few took this option and coordination was relatively seamless and transparent to the consumer. Opt-outs were more common in states that elected to include a return form to their enrollees; however, in follow-up confirmation phone calls states discovered that many enrollees were confused as to what they were being asked to do, and subsequently opted to stay within the preferred card plan. For most SPAP enrollees, choice is less of an issue than for uninsured Medicare beneficiaries because they already have generous coverage through their state program, often with open formularies and extensive pharmacy networks. In fact, enrollees have less "choice" because the options available to them are often more limited than their current benefit. In the case of the SPAPs, in which the state acts as the payer on behalf of the consumer, the state's interest in maximizing federal funds is generally aligned with the consumer's interest that the plan cover their drugs and includes their pharmacy.

States working with preferred cards during the discount card program had an additional advantage of being able to track enrollment in real-time by requiring their contractor to provide them with daily updates of approved TA enrollment by CMS, so states could follow-up on denied cases. States that left enrollment voluntary or autoenrolled into multiple plans did not receive TA matched SPAP and TA enrollment files from CMS until the Winter of 2004, shortly before the final open enrollment period, leaving little time to do outreach and education to their potentially eligible members who had not yet applied for the $600 credit.

Despite recommendations of the SPAP Transition Commission and comments by many individual SPAPs that states be allowed to follow the same model that had been so successful during the discount card period, the final Part D rules interpret the statute's 'non-discrimination' clause to mean that SPAPs must offer the same supplemental coverage to all plans in their region. SPAPs are not allowed to work with a preferred plan if they want to be considered a "qualified SPAP," which is necessary in order to have expenses incurred by the state count toward enrollees' true out of pocket costs (TrOOP).[11] Based on their experience during the interim Medicare discount card program, this federal policy decision could significantly affect the enrollment rates, and thereby the level of savings, that states will achieve under Part D. While SPAPs do have the option of being a "non-conforming" state program, they would not be eligible to count the state's contributions toward the beneficiaries out-of-pocket limit and they would be ineligible for transitional grant funds.[12]

As an alternative to selecting a 'preferred plan' under Part D, SPAPs are allowed to co-brand with certain plans based on criteria established by the state and approved by CMS. SPAPs are also allowed to

[11] 42 CFR; p. 4222.
[12] 42 CFR; p. 4321.

randomly autoenroll into Part D plans that meet certain criteria set by the state and approved by CMS.[13] Guidance issued by CMS to SPAPs after the Part D regulations were released gives SPAPs the ability to perform "Intelligent Random Assignment" for their members who do not voluntarily enroll in a Part D plan by a certain date allowing SPAPs to determine suitable plans for an individual member based on formulary and pharmacy networks, and then assign the member into one of the suitable plans on a random basis. States confronted a limited timeframe to plan for such efforts, since as of May 2005, CMS had not yet released its official operational guidance on this assignment process.

"Intelligent random assignment" is likely to be complicated for states to implement and to require data from the PDPs on their formularies and pharmacy networks with which to compare with the members' current use. While better than no autoenrollment, autoenrolling in multiple plans either randomly or through 'intelligent assignment' is likely to increase administrative costs, and delay enrollment, based on Connecticut's experience during the Medicare interim discount card program. Connecticut was the only state to attempt to autoenroll its TA-eligible members randomly into all Medicare discount cards that agreed to share data with the state. In total, the state randomly enrolled its members into 13 Medicare-endorsed discount cards. Connecticut's enrollment in TA lagged behind that of other states that elected to work with one preferred card. While other states reported autoenrolling 80-90% of TA-eligible enrollees within the first month after autoenrollment began, Connecticut achieved these enrollment rates only after six months from initiation of autoenrollment. Delayed enrollment in TA reduced the total savings to the state, as people had a shorter period of time to utilize the benefit. Among other issues, the state attributed some of the delays to the complexities of arranging for information-sharing across multiple plans that each used unique data systems.

Getting Enrollees to Apply and To Be Determined Eligible for Part D Low-Income Subsidies

Another difference between states' experience during the Medicare discount card program and Part D is that to get the low-income subsidies for Part D, enrollees must separately apply to either the SSA or Medicaid agencies, rather than just applying to the PDP or MA-PD. The two-step process and the asset test requirement for the Part D subsidies, which was not required to be eligible for the $600 transitional assistance credit during the discount card program, represent additional barriers to enrollment.

---

[13] For full duals, CMS will be performing autoenrollment in the fall of 2005, and for all other LIS eligibles (including enrollees in Medicare Savings Programs, SSI recipients, and others), CMS will facilitate their enrollment in the spring of 2006. CMS. Auto-Enrollment and Facilitated Enrollment of Low-Income Populations. April 5, 2005.

To reap the greatest savings from the new federal benefits, SPAPs will need to identify which of their enrollees are eligible for the low-income subsidies and get them to separately apply for these subsidies in addition to enrolling in a Part D plan. What will be complicated for states, both in assessing how benefit programs might be restructured to supplement the Medicare benefit and in coordinating wrap-around benefits, is determining how many of their current enrollees fall into the two subsidy categories or into the basic Part D benefit, each of which will require different wrap-around benefits.[14] As only two SPAPs currently require an asset test as a condition of program eligibility, the remaining states will need to collect this information from their current enrollees. The imposition of an asset test has the potential to be a deterrent for people to voluntarily enroll in Medicare.[15]

In the interim, some states have developed proxy measures to estimate the potential impact of the federal asset tests, but these proxy measures are not currently allowed for actual eligibility determination for the low-income subsidies. For example, New Jersey has used the proxy measure of interest and dividend income reported on its program applications. New Jersey, whose income eligibility for its Pharmaceutical Assistance for the Aged and Disabled (PAAD) program approximates the average income eligibility for all SPAP programs, found 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 based on interest and dividend income. In total, NJ estimates one third of PAAD enrollees will qualify for the lowest income subsidy program and 10 percent will qualify for the partial subsidy program. The remaining 57% of PAAD enrollees and all enrollees in the state's moderate income Senior Gold program will qualify only for the standard benefit.

In the final Part D regulations and against the recommendation of the SPAP Transition Commission, SPAPs were denied their request that they be allowed to determine LIS eligibility for their current enrollees, either directly or in a sub-contractual capacity to SSA or State Medicaid agencies. In lieu of this, some SPAPs advocated that SSA accept their application and recertification forms, which would be modified to include all required data elements of LIS applications, rather than requiring their enrollees to fill out a separate SSA application. These SPAPs then hoped to be able to submit this information, on behalf of their enrollees, electronically to SSA for LIS eligibility determination. In addition, SPAPs advocated for ongoing data sharing with SSA so that the state can track which of its enrollees have been determined eligible for the LIS, in order to ensure appropriate payment. As of

---

[14] For states such as New York and Massachusetts that have sliding scale cost-sharing, this process may be even more complex because there will be as many different benefits as there are combinations of state sliding scale and federal subsidy categories.

[15] Proposals to require much higher asset tests as a condition of eligibility in the NJ and CT SPAPs were overturned or repealed in response to strong public opposition.

Summer 2005, many of these issues remained under discussion with CMS and SSA, leaving states facing a compressed time period for implementation.

Coordination of Benefit Issues

Once the SPAP enrollee is enrolled in a Part D plan and the low-income subsidies, coordinating payment between Medicare and a state supplemental program will also require considerable information sharing and communication between the Part D plans. States are particularly concerned about the number of Part D plans that they may have to work with, each of which is encouraged to have its own unique formulary, pharmacy network, tiered cost-sharing, and appeals process. If the state opts to hold their enrollees harmless with respect to the current SPAP benefit levels, it would need to develop unique wrap-around models for every Part D plan available in the state, which would increase administrative costs. States with experience wrapping around retirement drug benefits in particular indicated that gathering the necessary data and getting the pharmacists to bill two payers can be complicated.

To avoid the complications of coordinating with multiple plans, SPAPs do have the option of being 'unqualified' and working with only one plan. However, the state would then forego SPAP transitional assistance grant funds and the ability to count state Medicare cost-sharing contributions toward TROOP. States were still in the process of evaluating how much state costs are incurred above the catastrophic cap to determine if the benefits of being a conforming SPAP outweighed the potential administrative costs of working with multiple plans.

While many SPAP programs currently exclude persons with any other drug coverage from eligibility, ten states allow people to enroll even if they have other drug coverage and thus have some experience coordinating benefits with other payers.[16] As the payer of last resort, these states have attempted to recover costs or prospectively deny coverage for drugs that should be covered by the primary drug insurer for a limited number of SPAP enrollees. According to officials in states that have reported the greatest success in these cost recoveries (New Jersey, Pennsylvania, and Illinois), it has required concerted effort including stronger statutory language to force insurers to provide necessary enrollment and coverage information and has nevertheless resulted in relatively minimal recoveries. Other states have not even pursued third parties due to anticipated marginal return on investment given insufficient data on the availability of other drug coverage for their enrollees. Self-report on applications was universally found to be unreliable, both because many people were not necessarily aware that they had coverage and

[16] 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, two states have no restrictions other than assigning benefits to the state, and one state does not exclude other drug coverage.

because coverage may have changed since they applied or recertified. Unlike in these situations, where a small number of enrollees have other coverage, under Part D all SPAP enrollees will be eligible for Medicare Part D and many will be eligible for the low-income subsidies. Having information on who is enrolled in which Part D plan and in which low-income subsidy program will be critical to ensure that the state does not pay for drugs that should be covered by Medicare and to prevent fraud and abuse by pharmacists who attempt to bill Medicare and the SPAP for the same prescription. While the MMA requires PDPs to coordinate benefits and share information with SPAPs, details regarding the frequency and content of what must be shared had not been defined by the Fall of 2005. Similarly, while CMS intends to provide Part D and LIS enrollment data to states and pharmacists through software to be developed, it is unclear when and how frequently this data will be made available or updated.

During the discount card program, non-preferred discount cards were not obligated to provide SPAPs with any information on enrollment. Thus, CMS agreed to do a file match between their transitional assistance database and SPAP enrollment files submitted by the states. This centralized information-sharing was developed prior to the decision to autoenroll, to help states in identifying which of their enrollees were enrolled in which plans. States planned to rely heavily on this information to track enrollment and disenrollment of their members in transitional assistance, particularly those that were not working with a preferred card. Even states working with the preferred card indicated that information from CMS was helpful to gather information on spend-down in M+C exclusive cards and other cards that have no contractual obligation to share information with the state. As payers of last resort, SPAPs also planned to use TA enrollment data from CMS for their point of sale systems to flag the pharmacist to bill the discount card first.

However, one problem experienced during the discount card program was the frequency and timeliness of receiving this information. Due to competing priorities in implementing the discount card program, CMS has only been able to guarantee these file matches on a monthly basis. Although CMS indicated that these files would be sent starting in August 2004, most states had still not received them six months after the program began in November. Since states were relying on this information for cost avoiding claims at point of sale, they would have preferred to get this information prior to the start of the program and also to receive it in real-time or at least on a weekly basis. States were hoping that pilot testing this approach in the discount cards could lead to improvements for Part D implementation.

One important component of states' cost recovery efforts has been the use of private information-broker agencies to collect enrollment and other information from private plans, so that this information can be matched with state enrollment files to identify individuals who are eligible for other coverage that the state should bill for drug payments. Officials from the Illinois Circuit Breaker program, which recovered more third party recoveries than any other SPAP at approximately 1.8% of total claims

expenditures in 2001, indicated that having a private independent entity collecting enrollment and benefit design information was much more efficient than the state attempting to collect the required information on a real-time basis. This service came at a cost to the state (12 cents per claim in Illinois), but they determined that outsourcing was less expensive than building capacity internally. Similarly, CMS contracted with a facilitation contractor to receive enrollment and claims payment information from all plans primary and secondary to Medicare as a single point of contact for gathering information for tracking TrOOP (commonly referred to as the TROOP facilitator).[17] While this automated system is intended to coordinate the adjudication of claims and provide real-time claims processing across multiple insurers, most states were doubtful that such a complex system will be fully operational in 2006.

Retrospective cost recovery, informally referred to as the "pay and chase" method where the state pays first and then retrospectively bills the other insurer for claims they should have paid, has yielded limited returns, according to states that have attempted it. This approach should be avoided under Part D but may be necessary in those cases where the state elects to pay for off-formulary drugs during the appeals process.

Information brokers and states both reported the limitations of gathering information from insurance companies that are not necessarily interested in sharing their information. In fact, all states doing third party recoveries acknowledged that current, accurate enrollment information from plans is difficult to acquire. States have been resistant to blocking payment on the basis of potentially inaccurate information. Thus, some states create an edit to signal the pharmacist that they should attempt to bill the other party first, but allow the pharmacist to override the edit in the event that the beneficiary is no longer covered by that plan. Since pharmacists pay a transaction fee for every claim submitted, it is not in their interest to bill both plans and they may choose to override edits even when other coverage is available. Thus, states conduct regular audits of the overrides to ensure that pharmacists are not abusing the system.

Several states have on-line third party liability systems which allow them to cost avoid claims that should be paid by another payer. Most of these systems simply block payment for the entire claim where other insurance coverage is available. However, some states, such as New Jersey, have systems that allow the pharmacist to bill the balance of the claim to the PAAD program up to its copayment. States that have these systems in place are better positioned to coordinate with Medicare prescription drug plans (PDP or MA plans) than those states that have not, because they have already built the systems infrastructure for notifying pharmacies to bill another payer prior to billing the state. Even the few states that have sophisticated on-line systems may need to modify or refine these systems to accommodate a

[17] 42 CFR; pp. 4494-5

greater number of plans and greater subtleties in plan design such as variable cost-sharing before and after the doughnut hole period.

However, most of these systems are relatively new and have faced considerable opposition or resistance by pharmacists. During the discount card program, many states elected to wrap around the 5-10% coinsurance for transitional assistance either in full as in Pennsylvania and Michigan or up to the existing SPAP copayment to encourage enrollment (see Table 5). Most of these incentives had been proposed by states prior to learning from CMS that they could autoenroll their members, but were maintained even after autoenrollment in order to discourage persons from opting-out.

Most states implemented the wrap-around of the 5-10% coinsurance through use of the third party liability field. Pharmacists were left with the responsibility and cost of submitting two separate claims. The success of the coordination-of-benefits model employed by states during the discount card period was tied to the degree to which pharmacies cooperate by duplicate billing. States encountered some pharmacy resistance and found they needed to increase both audits and interventions to ensure compliance. While a burden in the short-term, the impact on pharmacies will be even greater under the much more complex Part D benefit, if they are expected to bear the brunt of coordination of benefits at the point of sale for all SPAP enrollees not just those that are TA-eligible. Under Part D, pharmacists could find themselves needing to double bill on nearly every claim.

Table 4: SPAP Wrap-Around Provided During Medicare Endorsed Discount Card and $600 Credit to Encourage Enrollment Requiring Coordination of Benefits

	State Pays All coinsurance	*Wrap 5-10% up to SPAP copay*	*State Fee Waived*	*$600 Counts Toward SPAP Deductible*	*Lowered SPAP Coinsurance/ Increased Benefit Cap*	*SPAP as Primary Payer*
CT		X				
DE						
IL*						X
IN					X	
KS						
MA		X				
ME		X				
MI	X					
MN						
MO				X		
NC		X				
NJ		X				
NV						
NY		X	X			
PA**	X					
RI		X				
WY						
TOTAL	**2**	**7**	**1**	**1**	**1**	**1**

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

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

Source: Based on interviews with SPAP program directors conducted by the Center for State Health Policy, May/June 2004.

Estimating Federal Savings and Impact on SPAP Coverage Expansions

Most states had no specific estimate of the level of savings likely to be accrued as a result of Part D. However, in anticipation of the new federal dollars offsetting state costs, two states modified the SPAP's benefit structure to expand enrollees' benefits during the discount period. In Indiana, where nearly 90% of enrollees are eligible for transitional assistance, the state has lowered its existing coinsurance requirement from 50% to 25% and increased its benefit cap from a variable rate of $500-$1000 depending on income to a flat $1200 for the next eighteen months. North Carolina also expanded eligibility, doubled its benefit cap, and expanded coverage to all drugs rather than drugs for only a few conditions. As a result of these expansions in North Carolina, SPAP program enrollment doubled.

Estimated savings from the interim discount card ranged from $1.3 million in Rhode Island to $150 million in Pennsylvania. In many states, these estimates were premised on all or most of income-eligible SPAP enrollees enrolling in the discount cards and fully spending down the $600 credit. Only a few states also factored in administrative costs into this estimate. For example, Connecticut anticipated a total of $17.5 million in savings, assuming $500,000 in administrative costs.

Similarly, with the exception of Rhode Island, most states did not factor in the loss of rebates into these estimates, which could be considerable. Most state pharmacy assistance programs require that manufacturers offer rebates comparable to Medicaid, which by law are the "best price" offered to any other payer,[18] which is likely to be better than prices negotiated on the discount cards. In addition, drug discount card sponsors are required to pass on only some portion, not all, of the negotiated manufacturer rebates to the consumer. Depending on the size of the rebates that are passed on to consumers in the discount card through reduced prices, the $600 credit could buy far fewer drugs than it would have under the state program. Some states were still planning to collect rebates on any claims for which the state paid a portion of the cost (i.e. if the state covers some portion of the 5-10% copayment). This strategy may be challenged in Part D. Potential loss of rebates, which constituted approximately 17% of total SPAP expenditures in 2003, and additional administrative costs in coordinating benefits, will be important considerations for states in estimating the net savings to states under Part D, but very difficult to estimate accurately.

While states have achieved considerable savings through the discount cards, many have not achieved the level of savings they had originally estimated. Lower than expected savings were due to a variety of factors including delays in determining eligibility for some portion of their anticipated income-eligible enrollees and, for some portion of those that were enrolled, failure to spend any of the $600 credit

[18] The MMA excludes rebates negotiated for the interim Medicare-endorsed discount cards and those negotiated by future Part D prescription drug and qualifying retirement drug coverage from the Medicaid "best-price" calculation.

on the discount cards. For example, Missouri discovered after receiving enrollment data from CMS that 35 percent of their enrollees that were also enrolled in transitional assistance had not spent any of the $600 even though the state program had paid claims on their behalf.

This failure to spend-down occurred both in states that left enrollment voluntary -- where individuals would need to show the card to their pharmacist to draw down the credit -- and in states that had autoenrolled and had on-line notification systems in place to inform pharmacies when a client had a discount card that should be billed first. For individuals who enrolled on their own, they may have enrolled in a card that did not include their pharmacy in its network or failed to show the card to the pharmacist. For states that autoenrolled into a preferred card with a comparable pharmacy network, the issue may be one of enforcement. States that autoenrolled were still investigating why some pharmacies were overriding the notices to bill the discount card, but were concerned that it was due to the resistance on the part of pharmacists to coordinate the two benefits. Although technically prohibited, pharmacies may be opting to just bill the state rather than go through the process of double-billing. This does not bode well for Part D, where the coordination of benefits will be even more complicated, particularly if states are required to wrap around all Part D plans. Whether the explanation lies in pharmacy networks that are more limited than those of the states, or pharmacists refusing to bill Medicare first, both reduce the savings to the state and could have significant implications for Part D.

Conclusion and Policy Implications

As Part D is implemented, the key question for policymakers at both the state and federal levels will be how best to maintain the states' role in prescription drug coverage, in order to extend the best coverage possible for Medicare beneficiaries. The most efficient method of accomplishing this with the least administrative costs would have been to allow states to access federal subsidies directly, as proposed in the Senate version of the bill. However, short of allowing states to act as the Medicare prescription drug plan for their enrollees, coordination between private Medicare prescription drug plans and state programs should be as simple and inexpensive as possible to avoid crowd-out of the current state contributions to pharmacy assistance for the elderly and disabled.

Evidence from the interim Medicare discount card reveals that Part D coordination could be enhanced by allowing SPAPs to work with one preferred plan 1) to autoenroll their members, 2) to maximize state supplemental funding by selecting a plan that most closely mirrored the existing SPAP benefit, and 3) to simplify coordination of benefits for both the state and pharmacists

However, despite this evidence during the discount card period, the final Part D regulations prohibited SPAPs from autoenrolling their members or selecting preferred plans. In so doing, they may impact the level of supplemental coverage that states provide. Early experience in Connecticut during the discount card program indicates that partnering with multiple plans results in much lower enrollment rates and thus reduced savings to the state. For states with relatively small SPAPs, low anticipated federal savings coupled with higher administrative costs may discourage them from supplementing the Medicare drug benefit at all. States with longstanding programs are less likely to drop coverage, at least in the short term. However, the long-term ability of these programs to compete for state dollars, and the extent of coverage they provide, is likely to be affected by the extent to which they can remain visible, distinct state initiatives.

Establishing eligibility for the Medicare low-income subsidies and getting them enrolled in Part D plans will be a major challenge for states. States will need to decide whether to mandate enrollment and LIS application as a condition of participation in the state pharmacy program, which they largely did not elect to do during the discount card program. This is likely to be a politically contentious decision, since for the vast majority of SPAP enrollees the Medicare drug benefit is more limited than what the state programs currently offer. While states can also attempt to redirect some of the anticipated savings into financial or other incentives to get people to enroll, there is little evidence as to the level of incentives that would be needed to achieve significant enrollment rates.

Savings to SPAPs from Part D will depend heavily on the extent to which they are able to establish eligibility for the Medicare low-income subsidies and the ability to get sufficient, timely and accurate information to coordinate benefits. The level of savings to the state may also affect the number of additional persons eligible for state wrap-around benefits, to the degree that states opt to extend coverage to the disabled or higher income groups.