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State Pharmacy Assistance Programs at a Crossroads:

How Will They Respond to the Medicare Drug Benefit?

By Claudia Williams, Sarah Goodell, Jack Hoadley, Ellen O'Brien, and Matt Kanter*

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This policy brief is one in a series presenting results from a recent study of State Pharmacy Assistance Programs (SPAPs), their implementation experience and responses to the new Medicare drug benefit. The study included site visits, in-depth interviews with state program leaders and stakeholders and a questionnaire of state program directors to explore their plans and preferences for responding to the Medicare drug benefit. The Principal Investigator for the study is Jack Hoadley. The study was funded by The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization initiative, for which AcademyHealth serves as the National Program Office.

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Introduction

This policy brief presents results of a recent study examining the implementation experience of State Pharmacy Assistance Programs (SPAPs) and their initial responses to the new Medicare drug benefit. These results should be of interest to state policymakers examining future options, to federal policymakers implementing and monitoring the new Medicare drug benefit and to beneficiary groups concerned with consumers' drug choices and coverage.

Faced with a new Medicare drug benefit that will cover many SPAP and Pharmacy Plus Waiver Program enrollees, states are rethinking their role in providing pharmacy assistance. Will they provide supplemental benefits wrapping around the new Medicare benefit, continue to operate stand-alone programs providing a full range of benefits or possibly, terminate programs?

State Pharmacy Assistance Programs: Facts at a Glance

Twenty-eight states have programs to provide pharmacy benefits to seniors and other groups. Twenty-two states have State Pharmacy Assistance Programs, which are solely funded by states. Six states have Waiver programs funded by both state and federal governments through Medicaid.

Most state programs provide direct coverage, with benefits often restricted to or more generous for seniors with low-incomes. Some states have drug discount programs available to all seniors and others have implemented a tax credit approach. Several states have pursued more than one model.

Number of states with SPAPs	22
Number of states with Waiver Programs	6
Number of states with program eligibility above 150 percent of FPL	18
Total enrollment in SPAPs and Waiver Programs	1.7-1.8 million

These questions are of particular importance to SPAPs because a substantial portion of their enrollees will receive income-based subsidies under the Medicare drug benefit. In addition, SPAPs are afforded a unique status by the Part D statute; their contributions to enrollee cost-sharing will count towards the out-of-pocket spending threshold for catastrophic benefits. The Medicare Part D benefit may also produce significant savings for SPAPs, especially for program enrollees who qualify for low-income subsidies and thus have a higher proportion of their drug utilization covered by the Medicare plan.

Several states delayed decisions about the future of their SPAPs until they had clarification from the federal government on issues such as whether states will be able to operate a Prescription Drug Plan (PDP), designate a single PDP or continue programs supported by Pharmacy Plus Waivers. The final regulations for the Medicare drug benefit provide answers to some of these questions, but others remain.

Despite this remaining uncertainty, states are proceeding with planning and several have set up commissions or advisory panels to make recommendations on future program structure. Some states have made decisions, while others have not yet chosen among the wrap, stay or fold alternatives. A range of responses is likely, reflecting the considerable diversity of states and their priorities. A state's choice among alternatives will likely be informed by:

- How many PDPs will participate in the region.
- PDPs' decisions about the composition of their formularies and pharmacy networks.
- The structure of the current state program including whether it currently coordinates or wraps

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around other coverage.

- History and politics in the state including the popularity of the program and the generosity of the SPAP relative to the new Medicare coverage.
- The cost of various wrap-around options, state budget concerns and the viability of the SPAP.
- Practical issues such as the administrative difficulty of coordinating with multiple PDPs.

The Current Context for State Decisions

As clarified by the recently released Medicare drug benefit regulations, states will not be able to direct SPAP members to preferred PDPs.

One of the main changes states wanted in the Medicare drug benefit final regulations was the ability to select preferred PDPs. They hoped to closely coordinate with these plans and auto-enroll current members into them. States that automatically enrolled members into Medicare drug discount cards say this approach simplified the process for seniors and facilitated coordination with discount card sponsors, resulting in higher enrollment, less confusion and an easier transition for beneficiaries.

What states wanted from the Part D final regulations…	What the final regulations say…
Ability to auto-enroll SPAP enrollees into a preferred PDP.	Automatic enrollment is not allowed. *Facilitated* enrollment allowed for some groups, but people thus enrolled cannot be directed to a preferred plan.
Ability to sponsor PDPs.	SPAPs cannot sponsor PDPs.
Detailed and proactive requirements in the regulations governing PDP coordination with SPAPs.	Requirements were not specified in the regulations but guidance will be released in July 2005. The federal government will establish centralized tracking of TrOOP.
Continuation of Pharmacy Plus Waiver Programs.	Pharmacy Plus Programs can continue but will be subject to a new budget neutrality formula. Spending does not count toward enrollee TrOOP.
Mechanisms allowing SPAPs to prepay premiums for enrollees.	This authority already exists and states can use it.
Elimination or softening of requirement that states not "interfere" with PDPs' cost management tools.*	SPAPs and other supplemental payers will not be required to change their coverage rules to increase effectiveness of PDPs' cost management approaches.

* For instance by paying enrollee copayments on drugs subject to tiered cost-sharing.

The final regulations do not provide this option for Part D. While the rules allow for facilitated enrollment—essentially permitting default enrollment for dual eligibles, enrollees in Medicare Savings programs and seniors who would be eligible for the full subsidy—states are not allowed to sponsor or direct enrollees to a preferred PDP because the federal government considers this a violation of nondiscrimination clauses in the law.

This outcome will certainly make wrapping around PDP benefits more challenging for SPAPs, but the practical importance of this decision will depend on how many plans there are in a given region. Many states are likely to have more than a few. There are at least 34 Medicare drug discount card choices in all states, and while few expect that many PDPs, it is possible that a dozen or more sponsors could offer the benefit in a single state.

Working with multiple PDPs could prove taxing for SPAPs, as demonstrated by early experience with discount cards. Connecticut allowed its members to choose among several options (15 discount cards offered by 13 different sponsors) and reported challenges coordinating with multiple cards and lower than expected discount card enrollment. Choosing among 15 discount cards caused confusion for seniors and pharmacists as well as coordination problems for the SPAP. The SPAP had to train the prior authorization call center staff on the requirements of 15 different cards, each of which had quantity and dispensing limits that differed from the SPAP's. The state concluded that it would have been much easier to coordinate with one or two cards rather than 15.

Without the ability to partner closely with PDPs through a preferred plan mechanism, states' coordination of benefits will rely on the rules and requirements CMS imposes on PDPs.

States want real-time information on eligibility, enrollment, formularies, claims and expenditures and, having encountered difficulties obtaining information from discount card sponsors, prefer a centrally administered information function.

The regulations offer some clarification on these issues, but not definitive answers. CMS published further guidance on these matters in July 2005. According to the final regulations, PDPs will be required to "permit" SPAP coordination of benefit activities, a fairly weak standard according to states. CMS has also indicated it will contract with a third party to provide centralized tracking of true out-of-pocket costs (TrOOP) for enrollees, facilitating SPAP wrap-around for costs in the coverage gap (the so-called "doughnut hole") between the initial coverage limit and the catastrophic threshold.

States Predict SPAP Outcomes for 2006

Our questionnaire of state health officials explored states' likely responses to the new Medicare drug benefit. While specific choices may change for any individual state, these collective responses give us a sense of which options are favored and which are less likely to be pursued. The responses must be interpreted carefully, however, as they preceded the publication of the final program regulations and in light of continued state discussions and consideration of multiple options. A few states, for instance, indicated that they are likely to continue stand-alone programs and wrap-around Medicare benefits. Whether these are concurrent or alternative choices is not clear.

Description of Questionnaire of State Officials: In November and December 2004 our study team questioned state officials about the most likely outcomes for their programs in 2006. We requested participation from the 14 states profiled in our initial case studies and from an additional eight states with well-established SPAP or Pharmacy Waiver programs. We obtained responses from 16 of the 22 state programs and collected public information about future plans from one additional state for a total of 17 states. Given the speculative nature of the responses, we do not identify responses by state. Despite the lack of responses from a few states, we believe the aggregated responses will be helpful to state officials and other stakeholders affected by these decisions.

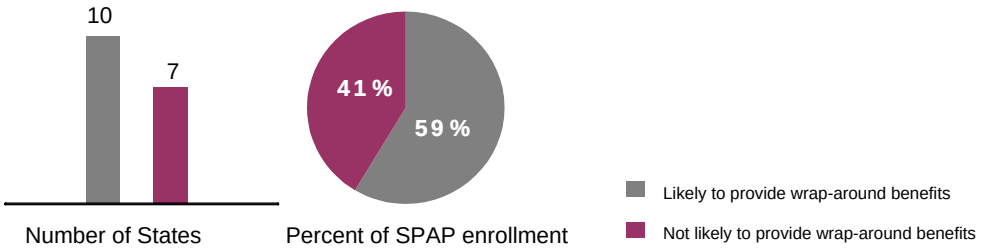
Wrap, Stay or Fold?

The majority of states plan to modify their SPAP programs to wrap-around the Medicare drug benefit (figure 1).

Ten states, representing about 60 percent of enrollment in the 17 states responding to the questionnaire, say they are likely to redesign their programs to provide wrap-around benefits. As discussed below, states are still unsure what shape these wrap-around benefits will take.

Many states will need to seek changes in state laws to allow them to wrap-around the Medicare drug benefit. These changes might include allowing SPAPs to provide concurrent coverage (many programs exclude applicants with other drug coverage), expanding eligibility to Medicaid enrollees and requiring that SPAP enrollees also enroll in the Medicare drug benefit. With legislatures out of session or busy with other matters, some states say it will be difficult to make required legislative changes before the Medicare benefit goes into effect.

Figure 1. Ten of Seventeen States, Representing about 60 Percent of SPAP Enrollment, Plan to Provide Wrap-Around Benefits



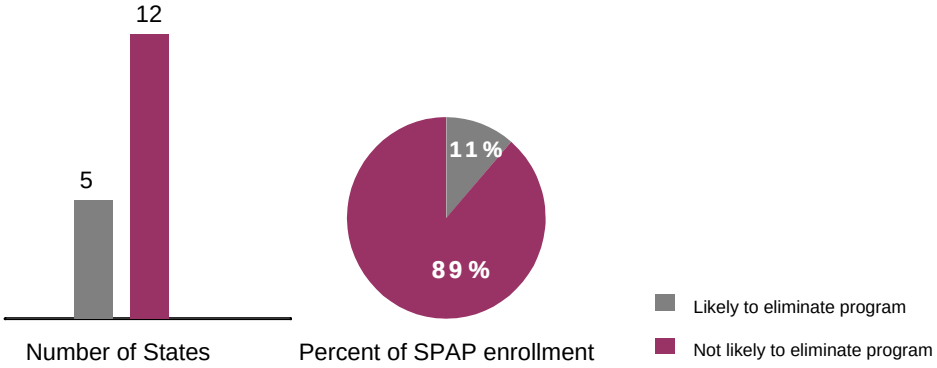
Figures based on responses and SPAP enrollment of 17 states responding to this question in the questionnaire

Most states would provide wrap-around benefits through SPAPs, but some states might consider establishing "uncertified" state programs in order to more seamlessly wrap around the Medicare benefit. An uncertified program could designate a preferred PDP (perhaps one sponsored by its own benefit administrator, as occurred for discount cards in some states) and auto-enroll clients into it. Because these activities violate the federal nondiscrimination clauses of the Part D statute, the program would not qualify as an "SPAP" and its contributions to enrollee cost sharing would not count toward enrollee TrOOP, a privilege uniquely enjoyed by SPAPs. The SPAP would then be responsible for providing coverage for high spenders who otherwise would have qualified for the Medicare catastrophic benefit. These added state costs could be substantial as some SPAPs have been attractive to people with unusually high drug costs.

Other states might eliminate their programs, especially if Part D benefits are comparable to what is currently offered (figure 2).

Five of seventeen states indicated they are somewhat or very likely to terminate their programs. They cite the overlap in benefits and ongoing budget pressures as key reasons to shut down operations. What this means will vary by state, however. Some will eliminate programs and discontinue providing benefits, redirecting current SPAP spending to other state priorities. This will perhaps result in reduced benefits for current enrollees. Other states might eliminate the SPAP but establish other subsidies—through tax credits or other means—to cover at least some drug-related cost sharing or benefit gaps for former SPAP enrollees.

Figure 2. Five of Seventeen States, Representing about 11 Percent of SPAP Enrollment, Say they Might Eliminate Programs



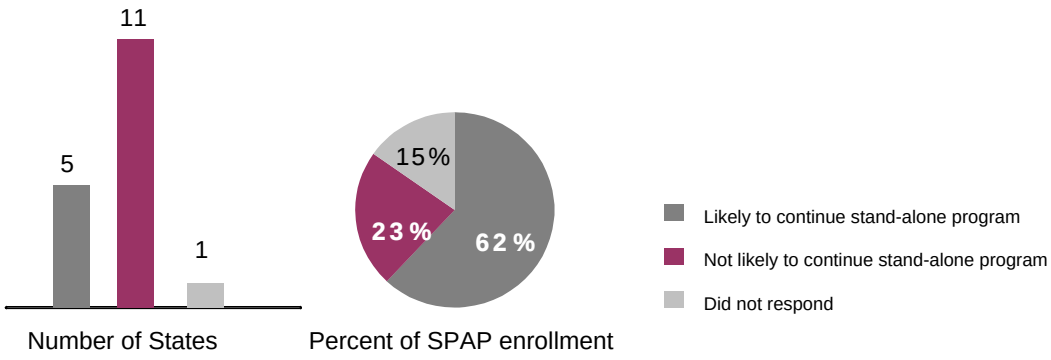
Figures based on responses and SPAP enrollment of 17 states responding to this question in the questionnaire

Somewhat predictably, states with less established programs, smaller enrollment and less generous benefits seem most likely to consider eliminating programs after January 2006. The five states considering closing programs represent only 11 percent of total SPAP enrollment in the seventeen responding states.

Only a few of the largest programs are giving strong consideration to continuing as stand-alone programs providing an alternative to Part D coverage (figure 3), but they represent a substantial share of SPAP enrollment.

Although only five states say they are likely to continue current operations, their enrollment represents a sizable share—62 percent—of SPAP enrollees in survey states. Maintaining existing benefits for this large group of beneficiaries through an administratively simple structure is a primary motivation for these states, although three of the five are also considering providing wrap-around benefits. Any state (other than those with Pharmacy Plus Waivers) that decides to continue operating a program will leave considerable savings on the table, as it will not be able to shift any drug costs to Medicare. The waiver states can continue to draw on federal matching funds.

Figure 3. Five of Seventeen States, Representing about 60 Percent of SPAP Enrollment, Plan to Continue Stand-Alone Programs



Figures based on responses and SPAP enrollment of 17 survey states

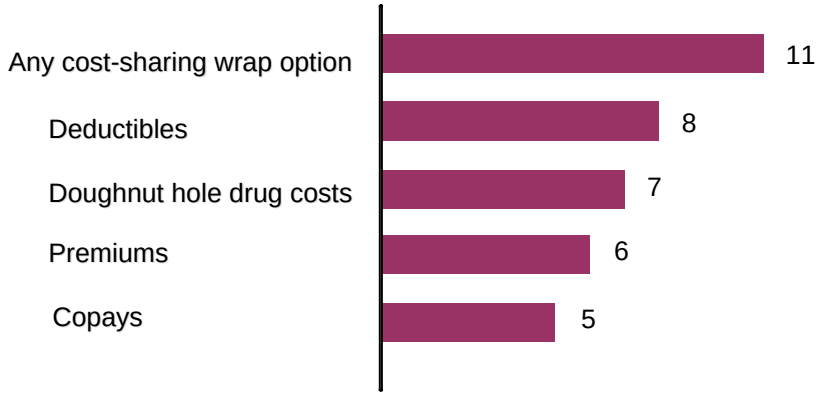
While not precluding the option of providing wrap-around coverage, officials from two of the nation's largest programs have publicly indicated they are likely to continue their programs after January 2006. One of these states will continue operating its federally funded Pharmacy Plus Waiver Program and will be guided by recent state legislation assuring that current program enrollees will be "no worse off" after the new Medicare drug plan is implemented.

States want to minimize the administrative burden of any wrap-around benefit they provide.

Regardless of their own strategy choices, states will face several initial challenges providing wrap-around benefits or cost sharing. States will likely need to wrap-around several different PDPs—as the regulations preclude designating a single plan—and may also need to establish distinct options for enrollees at different subsidy levels. Given this "baseline complexity," states say they will prioritize wrap strategies that are least expensive and present the least complexity and administrative burden. The level of complexity will be determined largely by how much coordination with PDPs is required and the predictability of wrap-around costs.

Eleven of fourteen states responding say they may pursue at least one of the options to fill enrollee cost-sharing gaps.

Figure 4. Number of States Considering Various Cost-Sharing Wrap-Around Options Out of 14 States Responding



Eleven states say they are likely to fill enrollee cost-sharing gaps and, as with other choices, states are leaning toward the options that are the least burdensome to manage (figure 4). Most of these states—eight of eleven—say they are likely to pay enrollee deductibles. Paying deductibles is relatively easy to administer: the costs are fairly predictable and uniform and paying them requires little coordination with plans. Covering doughnut hole drug costs is somewhat more complex, demanding more coordination and presenting less predictable expenses in addition to raising questions about which formulary—the SPAP's or the PDP's—to use and whether to match the cost sharing policies of the enrollee's plan. Seven states say they may pursue this option. While paying premiums is among the easier options, only six states say they might opt for this approach – perhaps because it will cost an average of at least $420 per year per enrollee. The regulation's clarification that states can use mechanisms to pay premiums automatically and prospectively may increase state interest in doing so. The least popular and most complex wrap-around option is paying for enrollee copays, an option under consideration by five states. Paying the copays would require that each transaction is processed through both the PDP's and the SPAP's claims systems.

Paying for non-formulary drugs is also a strategy states are contemplating, but some consider the required claim-by-claim coordination too burdensome.

Half of the responding states—seven out of 14—say they will consider paying for some non-formulary drugs with five of these seven saying they will only consider paying for these drugs if they are on the SPAP formulary. This is likely to be a time-consuming task, requiring states to track multiple PDP formularies and determine on a claim-by-claim basis if the drug is covered by the PDP and if this PDP coverage carries restrictions or extra cost sharing.

Regardless of the wrap-around options pursued, states' learning curves will be steep.

At least four of the states in our larger study do not currently coordinate benefits. Other states coordinate benefits but without the mechanisms—file sharing with insurance carriers, established mechanisms to identify shared enrollees, concurrent claims review—to simplify and expedite the process. This lack of experience will make coordination of benefits more difficult for states, especially as they may need to coordinate with multiple plans.

Some states have amassed considerable experience—and dollars saved—coordinating benefits. One state operating a Pharmacy Plus Waiver Program reports having recovered $162 million

from primary insurers over the two and a half years it has been coordinating benefits. To identify enrollees with drug insurance coverage, states match enrollment files with Medicaid, Medicare Savings programs, private insurers or PBMs. States then use point-of-sale edits to direct pharmacies to bill primary insurance first. When other coverage is indicated on the enrollee's application in one state, the pharmacist is directed to ask the beneficiary about other coverage and bill it first. Even with this infrastructure in place, however, states say that coordinating benefits requires substantial work and is not always easy to administer. Insurers who have signed data sharing agreements with states, for instance, do not always send the requested data files.

In addition to wrapping around Medicare drug coverage, some states are considering expanding SPAP eligibility to Medicaid beneficiaries, disabled nonelderly Medicare enrollees and seniors who are not eligible for Medicare.

Many of the states in the study already cover at least some of these groups and would likely continue doing so after the Medicare drug benefit is in place. States also have the option of spending some of the savings they accrue on expanding programs to populations they previously have not covered. Seven states that responded to our questionnaire are considering expanding eligibility to at least some of these uncovered groups—most commonly to Medicaid beneficiaries. This will allow states to provide wrap-around benefits to this group. Additionally, three states are considering expansions of income eligibility, one is considering enrolling non-elderly disabled Medicare beneficiaries and three states are considering covering elderly or disabled individuals not eligible for Medicare. One possibility is that states will defer these decisions until gaining at least some experience with the new benefit.

Few states plan to purchase supplemental benefits or cover drugs purchased from out-of-network pharmacies.

Only three states are considering purchasing supplemental coverage from PDPs and only one says it is considering covering drugs purchased from out-of-network pharmacies. States are worried that covering drugs at out-of-network pharmacies will expose them to unpredictable costs and extensive and complicated negotiations with pharmacies. By the same token, states feel supplemental arrangements will reduce state control over benefits and spending; a worrisome prospect for states still facing substantial budget pressures. In addition, there is no certainty that participating Part D plans will offer supplemental benefits.

Conclusions

Not surprisingly, given the substantial federal benefits now available to low-income enrollees, many SPAPs are planning to reconfigure their programs to wrap around Part D benefits. They will do this largely by paying enrollee cost sharing. States' prior experience suggests this approach is feasible but potentially complex and time-consuming. Concerns about complexity have increased since the release of the federal Part D rules, which frustrated state hopes for a simple and streamlined process.

A diversity of state responses to the final regulations is likely, reflecting the range in state perspectives and programs. Some may respond by backing away from providing wrap-around benefits perhaps in favor of purchasing supplemental packages (if plans decide to offer them). Others may develop "uncertified" programs, preferring the flexibility and potential seamlessness of this option. But that choice leaves potential savings on the table, which may be unpalatable to legislatures. Still others—and perhaps more than initially predicted—will terminate their programs, although without necessarily ending subsidies for drug coverage. In any case, as states consider their choices they will be looking for strategies that are administratively simple and preserve current benefits at a low cost and risk.