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## Issue Brief

# Medicare Part D: State and Local Efforts to Assist Vulnerable Beneficiaries

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**ABSTRACT:** Medicare Part D became available in 2006, offering millions of Americans the potential for improved access to medications. Certain aspects of the program have been problematic or confusing for vulnerable beneficiaries, but creative efforts across the country have helped individuals obtain and use the Part D benefit. Coalitions supply the information, training, and support that community partners need for outreach, education, and enrollment activities. Trusted local organizations provide one-on-one counseling for culturally and linguistically diverse populations. States have expanded eligibility criteria for the Medicare Savings Programs, thereby increasing the pool of beneficiaries deemed eligible for the Part D Low-Income Subsidy. In redesigning state-funded prescription programs, states fill coverage gaps for beneficiaries and extend coverage for others. Wider use of these practices has the potential to substantially improve the Medicare Part D program for the most vulnerable beneficiaries. Achieving this, however, will require continued and enhanced federal and state support.



### BACKGROUND

In 2006, prescription drug coverage became available under Medicare for the first time. Called Medicare Part D, the program marks a significant change in government health care programs, offering the potential for improved access to needed medications for millions of Americans. As of January 2008, more than 25 million Medicare beneficiaries were enrolled in Part D prescription drug plans (PDPs).<sup>1</sup> The program extends coverage to many beneficiaries who formerly had none.

The Low-Income Subsidy (LIS) is available for some beneficiaries to help with premiums and cost-sharing of Part D benefits, though a substantial proportion of them still are not receiving the subsidy. The lowest-income Medicare

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beneficiaries, who formerly had drug coverage through Medicaid, now are covered under the Part D program. The transition has been problematic for many.

A number of entities are involved in administering the program: the Centers for Medicare and Medicaid Services (CMS); state Medicaid programs; the Social Security Administration (SSA), which processes applications for LIS; as well as pharmacies and health care providers.

The difficulties associated with implementing the Part D program, particularly for low-income beneficiaries, have been well-publicized.<sup>2</sup> Creative and effective responses to the challenge of Part D implementation, however, have received less visibility. This issue brief describes practices undertaken to help low-income beneficiaries obtain and use the Part D benefit. It describes four approaches relevant to Part D implementation: building coalitions; providing assistance to culturally and linguistically diverse populations; promoting enrollment in LIS; and filling gaps in Part D coverage. The creation of a comprehensive approach to protecting low-income beneficiaries from lack of access to drugs is also described.

The activities and policies described here should be of interest to government officials, health plans, providers, and advocates across the country as they seek to improve access to and the operations of the Part D program and learn how to enhance the effectiveness of other benefit programs.

## **PART D AS A CATALYST FOR COLLABORATION**

The prospect of preparing for the implementation and ongoing operation of the Medicare Part D program spurred active collaboration among federal, state, and local agencies; advocates; and community groups. Stakeholders include state officials associated with the Medicaid program; officials associated with State Pharmaceutical Assistance Programs (SPAPs); programs for the elderly and individuals with disabilities; state retiree health insurance programs; and housing and income assistance programs.

Individuals from state health insurance and assistance programs (SHIPs), which are charged with

educating and counseling Medicare beneficiaries, are also involved, as are regional SSA offices. Representatives of state and local advocacy organizations and other community-based organizations are also important members of coalitions. In some states, well-established groups that routinely address issues affecting Medicare beneficiaries take on tasks related to Part D. In other cases, new coalitions have been formed.

## **Program Implementation**

In Maine, the Medicare Part D Stakeholders Group, mandated by the state legislature, was formed specifically to address issues related to prescription drug coverage. In addition, the Maine Medicare Work Group, sponsored by the State Office of Elder Services and SHIP, has been meeting every two months for a number of years and has established good working relationships across programs, agencies, and the state. Thus, members of the two groups reported they were ready to tackle Part D issues together. Ohio Medicare Partners brought together representatives from state agencies such as the Departments of Aging, Health, Job and Family Services, and Insurance. Representatives from CMS and SSA, as well as Medicare fiscal intermediaries and a Medicare Quality Improvement Organization, also participated in meetings to plan for Part D in Ohio.

## **Efforts to Maintain and Enhance Benefits**

In New Jersey, the Medicare Dual Eligibles Coalition worked with the legislature to implement a Part D wraparound benefit to fill certain coverage gaps for people receiving both Medicare and Medicaid benefits. Connecticut's Part D Wraparound Coalition has been instrumental in developing a plan to coordinate Connecticut's ConnPACE and Medicaid prescription drug coverage with Medicare Part D. California's Medicare Part D Working Group, comprising exclusively advocates for Medicare beneficiaries, has urged state and federal agencies to adopt policies designed to assure that the needs of low- and modest-income beneficiaries are being met by private plans and state and federal programs.

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### State Coalitions: Observations

- In addition to considering state and local circumstances, effective coalitions must make realistic assessments of what can be accomplished.
  - Coalitions have been instrumental in promoting the use of state resources to enhance benefits provided through the federal Part D program.
  - Coalitions also provide the information and support that local community partners need for outreach, education, and enrollment activities.
  - Effective coalitions include established groups undertaking activities related to the Part D program, as well as new groups convened by state officials, advocacy groups, and private foundations to meet legislative mandates.
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### Information and Resources for Community Groups and Beneficiaries

Nebraska's Medicare Prescription Drug Coalition provides guidance and technical support to local teams engaged in efforts to reach beneficiaries, help them enroll in plans, and use their benefits. Coalition members include AARP Nebraska, the Nebraska Area Agency on Aging Association, the Nebraska SHIP, the Nebraska Health and Human Services System, SSA, the University of Nebraska-Lincoln (UNL) Extension, and the UNL Center on Children, Family, and the Law. The coalition sponsored four Medicare Part D training videoconferences for at least 800 viewers, including counselors and eligibility workers. The two-hour trainings were filmed at and broadcast by the University of Nebraska-Lincoln Extension and featured panels of experts from SHIP, SSA, and Nebraska's Medicaid program. The coalition also sponsors monthly conference calls and satellite conferences and has developed tool kits, a speaker's bureau, and other resources for local organizations. Approximately 1,000 people across the state have participated in the satellite conferences and conference calls.

The coalition worked with the Nebraska Educational Television Network to reach beneficiaries in more direct ways. It produced a one-hour special

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### The Illinois Make Medicare Work Coalition

The Illinois-based Make Medicare Work Coalition provides education, training, and technical support to its members in the Chicago metropolitan area. Headed by three local nonprofit organizations and funded by Illinois-based foundations and the Access to Benefits Coalition, it also assists other organizations and agencies throughout the state in helping families understand their Medicare benefits. The coalition draws on the expertise of members who are knowledgeable about the needs of beneficiaries with particular conditions, such as HIV/AIDS, and who are also familiar with related state programs such as Illinois Cares Rx.

User-friendly materials developed by the coalition are more accessible (and Illinois-specific) than some "official" materials on the same subjects. Currently, the group has an e-mail list of more than 500 organizations and individuals, and 100 to 200 people attend its quarterly trainings and summits.

The coalition also works to reach populations with limited English proficiency. Two coalition members—the Progress Center for Independent Living and Age Option—headed these efforts in partnership with community groups. Using a "train the trainer" model, the coalition provided assistance and training for staff members of local Bosnian, Cambodian, Chinese, Ethiopian, and Korean organizations. The ultimate goal was for staff to feel comfortable providing linguistically and culturally appropriate assistance with Medicare Part D to beneficiaries and their families. Many of these groups work with entire families, not just seniors, enabling younger family members to get involved and help their older relatives with the Medicare Part D enrollment process.

The coalition has been instrumental in making the disability community more visible as part of the Medicare community and has helped highlight the common interests and goals of the aging and disability networks. The closer working relationship has resulted in wide support for two state-level Part D-related initiatives: the creation of a State Pharmaceutical Assistance Program (SPAP) targeting the HIV/AIDS community,<sup>3</sup> and an effort to reform the state's existing two-level SPAP to provide the same benefits for all Medicare beneficiaries who qualify.

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called Nebraska Connects, featuring experts who provided a question and answer program on the various aspects of Medicare's Part D benefit. The program was broadcast several times on the NETV station, potentially reaching more than 25,000 people with each viewing.

### **ASSISTANCE FOR DIVERSE POPULATIONS**

Medicare beneficiaries, like other segments of the U.S. population, are extremely diverse, representing a wide spectrum of cultural backgrounds and languages. The low-income population is especially diverse. In California, for example, 53 percent of low-income dual eligibles are from racial or ethnic minority communities, and more than 32 percent have limited proficiency in English.<sup>4</sup>

Both CMS and Part D drug plans are required to provide culturally and linguistically competent outreach and services to ensure that every Part D beneficiary has access to the programs benefits, and some federal funding has been available to support beneficiaries with limited English proficiency. However, much of the Part D information provided by CMS—through the [MEDICARE.gov](http://MEDICARE.gov) Web site, the drug plan finder, for example—is available only in English and, occasionally, in Spanish. Most mailings to beneficiaries are sent in English.

Stakeholders have raised concerns about whether Part D plans are offering the type of assistance they are mandated to provide to enrollees and prospective enrollees. In a recent survey, the call centers of seven national plan sponsors provided language-appropriate services to low-income limited English proficient beneficiaries in California less than 60 percent of the time. Not one of the 417 callers in the survey was able to obtain written materials in Spanish or other non-English languages.<sup>5</sup>

### **Organizations Providing Resources and Counseling in Multiple Languages**

Organizations around the country that provide assistance for Medicare beneficiaries whose first language is not English often find it necessary to translate and develop materials about the Part D program; counsel

beneficiaries; and engage in outreach activities. A small part of this effort is federally funded through grants distributed by the Administration on Aging to community-based groups that serve particular populations. The federal funding is time-limited, however. On an ongoing basis, many local organizations, particularly those that provide one-on-one counseling, have responded to the demand from clients for assistance with Part D matters. Without additional resources, however, they have had to curtail some activities.

The National Asian Pacific Islander Center on Aging (NAPCA) has administered telephone hotlines to assist individuals with Medicare prescription drug issues since 2004. Starting with the prescription drug discount card and then with Medicare Part D in late 2005 and 2006, NAPCA staffed four telephone lines to provide direct bilingual enrollment assistance in Cantonese and Mandarin Chinese, English, Korean, and Vietnamese. Due to limited resources, NAPCA decided to offer services in these languages based on the number of seniors in each ethnic group and the percentage of those seniors with limited English skills.

The hotlines and other outreach events were publicized through culturally appropriate organizations and media outlets. NAPCA found that newspapers were effective in reaching Chinese-speaking seniors, since two national Chinese newspapers are circulated and written Chinese does not vary across dialects. Churches were found to be effective in reaching Korean seniors, since Korean-language newspapers are more regional in scope. Radio was found to be most useful in Vietnamese communities, where literacy rates among seniors tend to be lower. Through such outreach, the hotlines fielded more than 45,000 Part D calls in 2005 and 2006. Elders calling a hotline could access bilingual counselors without first reaching English voicemail or phone menus.

In most cases, clients were sent dual-language simplified versions of the Part D Plan Finder and an eligibility questionnaire for LIS, printed with side-by-side English translation. These materials allowed seniors to read about the program in their native language, and also to ask younger family members—who may

read only English—for assistance. Counselors then called clients back to provide Part D counseling and assistance completing the forms. NAPCA estimates that it counseled 25,000 individuals. In addition to the hotline, NAPCA provided materials and technical assistance to local partner organizations throughout the country. In selecting partners, NAPCA emphasized knowledge of and ability to reach a target population.

The National Alliance for Hispanic Health led a comprehensive initiative called *La Promesa*, or The Promise, to help Hispanic seniors understand and enroll in Medicare Part D. Alliance activities were funded by a number of groups, including AARP, the Atlantic Philanthropies, CMS, the National Association of Area Agencies on Aging, the National Council on Aging, and Pharmaceutical Research and Manufacturers of America (PhRMA). The alliance helped 31 organizations in 17 states perform one-to-one outreach and benefits counseling in predominately Hispanic areas. These organizations were able to provide linguistically and culturally appropriate outreach in the communities they served. In San Antonio, Texas, for example, the local organization CommuniCare set up a booth at an annual fiesta to provide information about the Medicare benefit to seniors. CommuniCare workers were able to mingle easily with seniors and their families because they were part of the community.

The alliance worked with bilingual newspapers, radio, and television, which led to coverage on Univision, Telemundo, and CNN's *en Español*. The alliance also assisted CMS in its development of materials for Hispanics, including the Spanish-language version of the CMS helpline, 1-800-MEDICARE. To create a national focal point for benefits counseling and enrollment assistance, the alliance increased the capacity of its own bilingual helpline (1-866-SU-FAMILIA). From November 1, 2005 to June 30, 2006, the alliance helpline received more than 4,600 calls related to Medicare, 93 percent of which were conducted in Spanish.

### **Materials and Training for Local Counselors**

Recognizing that communication with and outreach to beneficiaries is an essential element of the Medicare

Part D program, a number of organizations have made important efforts to provide culturally and linguistically appropriate services, including bilingual materials, information, training, and counseling to diverse communities of Medicare Part D beneficiaries, including those who have limited English proficiency. In many states, SHIPs provide small grants to community organizations that serve specific racial and ethnic minority populations. These organizations then recruit and train volunteers who have the necessary language skills and other attributes needed to reach culturally diverse communities.

Washington's SHIP (the Statewide Health Insurance Benefits Advisors, or SHIBA) benefits from substantial state funding, which accounted for more than half its \$2.2 million annual budget in fiscal year

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### **Assistance for Culturally and Linguistically Diverse Populations: Observations**

- A sizable need exists for interpretation, translation, and outreach to culturally diverse populations in Medicare nationwide.
  - There is a lack of adequate and sustained funding for assistance to culturally and linguistically diverse populations; volunteer systems alone will not meet their needs.
  - Individuals who speak the same language are not all alike in language skills, culture, or literacy level. A variety of materials and approaches are needed to communicate effectively in different communities.
  - Trusted local organizations play an extremely important role in reaching and assisting beneficiaries from racial and ethnic minorities.
  - Local and ethnic press may be more accessible and more trusted than national newspapers.
  - Counselors must not only speak the appropriate language, but must also have a good understanding of program rules and procedures.
  - Even when appropriate information is available, the need to provide one-on-one counseling for vulnerable beneficiaries remains important.
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2006. That state funding has been crucial in allowing SHIBA to hire a dedicated person to manage the translations of key materials on Part D into five languages—Chinese, Korean, Russian, Spanish, and Vietnamese—that can be downloaded from SHIBA’s Web site.<sup>6</sup> SHIBA also works with 25 sub-grantees across the state, several of which are focused on outreach to people with limited English proficiency: Koreans and other beneficiaries in Pierce County; Chinese, Vietnamese, and Russian beneficiaries in King County; and the Latino community in eastern Washington. SHIBA recruits and trains bilingual volunteers, though retention of volunteers in the Part D context is always difficult due to the complexity and difficulty of Medicare counseling. Bilingual volunteers face the added pull of other pressing demands in their communities.

The Southeast Asian California Healthy Elders Leadership Project, a three-year project funded since

2005 by the California Endowment and the U.S. Department of Health and Human Services, provides training, support, and technical assistance to 10 nonprofit mutual assistance associations and faith-based organizations serving Southeast Asian seniors in California.<sup>7</sup>

Through the project, local Health Insurance Counseling and Assistance Programs (HICAPS), the California SHIPs, worked with leaders of the Cambodian, Laotian, and Vietnamese communities in Fresno, Oakland, Sacramento, San Joaquin, and San Jose to conduct intensive two-hour workshops on assisting dual-eligible beneficiaries with Medicare Part D. Community leaders, in turn, worked with local HICAP volunteer counselors and staff from the National Asian Pacific Islander Center on Aging to assist individual seniors with Medicare Part D plan selection and application for LIS.

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### **An Expansive Role for the New Mexico SHIP**

The Health Insurance and Benefits Assistance Corps (HIBAC), New Mexico’s state health insurance and assistance program (SHIP), has an extensive network of bilingual volunteers and considerable experience with the dual-eligible population. The organization recruits and trains volunteers fluent in Spanish and in Native American languages, including Apache, Hopi, Keres, Navaho, Tewa, Tiwa, Towa, and Zuni, to provide outreach and assistance to hard-to-reach populations statewide. The state has large Spanish-speaking and Native American populations, many of whom are monolingual.

The HIBAC program has formed a partnership with the state’s Department of Human Services and its Income Support Division, which is responsible for Medicaid eligibility determinations. HIBAC provides intensive case management services to help reinstate Medicaid benefits for low-income Medicare beneficiaries—especially those with limited English proficiency and low literacy rates—who have lost their coverage and, as a result, their eligibility for the Part D LIS. In 2006, for example, 6,000 New Mexico Medicaid beneficiaries lost their Medicaid benefits because they failed to have their eligibility re-determined. Although they may have received a notice that they needed to re-apply for benefits, many ignored or did not understand the request. Letters may be written in an appropriate language such as Spanish, but elders with low literacy may not be able to read or comprehend those letters. As a result, they lose their eligibility for Medicaid and LIS. Most do not realize that their coverage has ended until they encounter a problem at a pharmacy.

HIBAC counselors conduct home visits and follow up to assure that the necessary steps are taken for an eligible beneficiary to be re-enrolled in Medicaid, or they help beneficiaries fill out applications for LIS. In 2007, HIBAC played a larger role in helping to assure that benefits continue. A process was established so that HIBAC would be informed by the Medicaid agency when dual eligibles are not reinstated after an eligibility re-determination notice is sent by Medicaid. Nearly 400 volunteers statewide are trained to provide assistance, and all sign agreements that note their responsibility to maintain beneficiary privacy. SHIP managers will be able to log in to the Medicaid data system to get information on a beneficiary’s current enrollment. This time-intensive, “outdoor,” face-to-face case management is a hallmark of New Mexico SHIP’s outreach to hard-to-reach Medicare beneficiaries.

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In late 2005, the Asian Pacific American Legal Center, based in Los Angeles, worked with community-based organizations, legal organizations, a health clinic, the local SHIP program, and the Los Angeles County government to reach dual-eligible Asian/Pacific Islanders with limited English proficiency. The organization put together a “Community Advocates’ Tips and Updates” sheet and a Los Angeles resource list, “Medicare Part D Agencies Serving Clients Speaking Asian Pacific Islander Languages,” targeted to consumers. It listed the nine local agencies offering language-accessible services, with the name and contact information for each organization, types of services offered, and languages served. Once this list was compiled, the group distributed translated press releases in various languages to ethnic media, attaching the resource. A press event was held in April 2006.

These efforts played a significant role in raising awareness of services for beneficiaries and demonstrating the need for additional services to policymakers. Participants believe the effort succeeded because it involved a broad group of organizations, but had one convener, which served as a clearinghouse for information and provided leadership and direction.

The project also had a clear, direct focus with a well-defined target population.

**PROMOTING ENROLLMENT IN THE LOW-INCOME SUBSIDY**

The Part D LIS is available to help with Part D premiums and copayments for Medicare beneficiaries with incomes below 150 percent of the federal poverty line and limited resources (Table 1).

Over 60 percent of those eligible for LIS receive it automatically through receipt of full or partial Medicaid or SSI benefits; others must apply for the subsidy.<sup>8</sup> CMS estimates indicate that, as of January 2008, of the 12.5 million beneficiaries eligible for LIS, an estimated 32.6 million were not receiving it.<sup>9</sup> Individuals who counsel or advise Medicare beneficiaries regularly report that the most common reasons eligible beneficiaries are not enrolled in LIS are they do not know how to apply for a subsidy or they do not know that a subsidy is available. In addition, many say that the application process is too complicated.<sup>10</sup>

Medicare beneficiaries have the option of applying for LIS through either SSA or the state Medicaid office. SSA, CMS, and the states, through all their outreach and guidance materials on the subsidy,

**Table 1. Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2008**

Low-Income Subsidy Eligibility Criteria	Benefits		
	Monthly Premium	Annual Deductible	Beneficiary Cost-Sharing
Individuals with Medicare and Medicaid (full-benefit “dual eligibles”)	\$0	\$0	\$1.05–\$2.25/generic; \$3.10–\$5.60/brand-name; no copays after total drug spending reaches \$5,726.25
All other “dual eligibles,” SSI-only and individuals with income <135% of poverty and resources <\$7,620/individual; \$12,190/couple (includes Medicare Savings Program participants other than “dual eligibles”)	\$0	\$0	\$2.25/generic; \$5.60/brand-name; no copays after total drug spending reaches \$5,726.25
Individuals with income <135%–150% of poverty and resources <\$11,990/individual; \$23,970/couple	Sliding scale	\$56	15% of total costs up to \$5,726.25; \$2.25/generic; \$5.60/brand-name thereafter

Note: The 2008 poverty level is \$10,400/individual and \$14,000/couple. Resources include \$1,500/individual and \$3,000/couple for funeral or burial expenses.

promote SSA as the place to apply for the benefit. As a result, nearly all applications to date have been processed through SSA. States and localities are using several strategies to reach beneficiaries eligible for LIS and help them enroll.

### **Medicare Savings Program “Back Door” Eligibility**

Individuals who qualify for the Medicare Savings Programs (MSP), which pay for Medicare Part B premiums and in some cases other cost-sharing, are deemed eligible for LIS.<sup>11</sup> Eligibility rules and methods used to determine eligibility for LIS are uniform nationwide, but the rules and methods applied to the MSPs, which are administered through Medicaid, differ among states. Each state has the option to use methods to determine income and resource eligibility that are less restrictive than those that would otherwise apply. Thus, in states that have broadened MSP eligibility criteria, some individuals who would not qualify for LIS if they applied through SSA are eligible for MSP and deemed eligible for LIS.

Prior to the Part D program, several states had modified resource tests.<sup>12</sup> Since the implementation of the Part D program, three states have broadened MSP eligibility rules. As of 2006, Vermont made a policy change to disregard all resources, effectively eliminating the resource test for its MSP. Maine also disregards all resources and has raised the income limit. The new limits are at or below 150, 170, and 185 percent of the federal poverty level for the Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individual (QI) programs, respectively. Current federal limits are at or below the 100, 120, and 135 percent of the federal poverty level for the QMB, SLMB, and QI programs, respectively.

The District of Columbia also expanded income eligibility substantially. Individuals with incomes below 300 percent of the federal poverty level now qualify for QMB benefits in the District, which has also applied to CMS to disregard all resources in determining MSP eligibility. Broadening

the MSP eligibility rules can increase LIS enrollment, but historically, MSP participation rates have been low. Thus, this strategy is more likely to be effective if it is accompanied by aggressive outreach.

### **Application and Enrollment Assistance from SPAPs**

SPAPs are eager to have their members enroll in the Part D program, and a number require it. When eligible beneficiaries have their drug costs covered by the Part D program, SPAP funds that formerly had been used to pay for prescriptions can be redirected to serve a broader population or help pay for costs not covered by Part D. To promote enrollment in Part D, many states screen their SPAP enrollees for LIS eligibility. They may also facilitate enrollment in LIS by collecting necessary information from applicants and applying for the benefit on behalf of their members.

The Connecticut SPAP, ConnPACE, used extensive outreach efforts to educate enrollees about LIS and encourage eligible members to apply for the benefit. Although ConnPACE itself neither counts nor requires disclosure of assets by an applicant, its application now asks whether applicants' assets are above a certain level to determine whether they are likely to be eligible for LIS. In New Jersey's SPAP, the Pharmaceutical Assistance for the Aged and Disabled, every enrollee is screened for LIS eligibility. Applicants also are screened for the MSP and sent to their local Medicaid office if they appear to be eligible.

### **Applications at State Medicaid Programs**

State Medicaid programs have not been eager to assume the administrative responsibilities and costs for processing LIS applications. Kansas is one of the few states that have directed Medicaid offices to accept and process these applications. Kansas developed a joint application for MSPs and LIS to facilitate enrollment in both programs. The form, which is available in English and Spanish, was produced in a paper format and can be printed from the agency Web site, but it is not widely used. Introduction of the new form was not accompanied by training or promotion efforts. As

of early 2007, the state estimated that about 500 applications had been processed through Medicaid, the highest number of any state.

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**Promoting Enrollment in the  
Low-Income Subsidy: Observations**

- In states that have expanded eligibility criteria for MSPs, more beneficiaries may qualify for LIS. Outreach efforts can promote enrollment for both types of benefits.
  - More opportunities to apply for LIS at Medicaid offices could help increase enrollment.
  - The LIS application process would be eased considerably if resource tests were not required.
  - Information from other means-tested programs could be used to help identify Medicare beneficiaries who may be eligible for LIS.
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**FILLING GAPS IN PRESCRIPTION  
DRUG COVERAGE**

The implementation of the Part D program was accompanied by changes in the type of state assistance with drug costs provided for low-income Medicare beneficiaries. All states were confronted with changes for dual-eligible Medicaid beneficiaries. Under the Part D program, dual eligibles encountered new and potentially more restrictive formularies and utilization management practices. Certain drugs that had been covered under Medicaid in most states are excluded from coverage under Part D.<sup>13</sup> In addition, all low-income beneficiaries, including dual eligibles, are required to make copayments for drugs; when they cannot make copayments, access to medications is not guaranteed as it is under Medicaid.<sup>14</sup> Nearly all Medicaid programs still cover certain drugs not covered by Part D, and some help beneficiaries with Part D copayments.

Low-income beneficiaries participating in SPAPs also were affected.<sup>15</sup> Of the 24 states with SPAPs, six elected to discontinue their SPAPs for Medicare beneficiaries.<sup>16</sup> For the most part, the remaining SPAPs have been converted from beneficiaries’

primary source of coverage to a source of wraparound benefits for Medicare Part D. Generally, states started from the premise that Medicare beneficiaries who already had received some assistance with prescription drug coverage prior to Part D should be “held harmless”—that is, they should have the same access to prescription drugs as before and should not incur substantially higher out-of-pocket costs. To differing degrees, SPAPs pay some or all of Medicare Part D premiums and cost-sharing during the deductible period, initial benefit period, and gaps in coverage, also known as the “doughnut hole.” Some of the larger SPAPs also provide coverage for drugs not included in beneficiaries’ drug plan formularies.<sup>17</sup>

**New State Benefits**

Vermont’s legislature passed a budget bill in mid-2005 that instructed a transitional working group to plan for the implementation of Part D and identify “sources of funding for holding beneficiaries harmless from pharmacy cuts once Part D is implemented.” A SPAP, VPharm, was created to provide wraparound coverage for Medicare beneficiaries. Vermont residents with incomes up to 225 percent of the federal poverty level are eligible for the program and must apply for LIS. Similarly, Illinois’ No Senior Left Behind law restructured the state’s pharmacy assistance to wrap around Part D and maintain existing benefits. The state is

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**Filling the Gaps in Prescription  
Drug Coverage: Observations**

- In redesigning state-funded prescription programs, states are striving to fill gaps in prescription drug coverage for Medicare beneficiaries and, in some cases, to extend state-funded coverage for others. Program changes are financed in part through savings that accrue when the federal Part D program and LIS are available.
  - Beneficiary-centered assignment can be used by states to help ensure that dual eligible and other low-income beneficiaries who do not choose their own Part D plans are assigned to plans that are most appropriate for their needs.
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covering dual eligibles' Part D copayments and providing coverage for certain nonformulary drugs.

The New Jersey Medicaid program covers excluded drugs and Part D copayments for dual eligibles. In addition, the state now covers many needed non-formulary drugs if beneficiaries are not successful in obtaining them from their Part D plan through the prior authorization and appeals processes. Plus, Medicaid will pay for a six-day supply of a non-formulary medication to assure access while the beneficiary pursues an exception from a Part D plan. In addition to attempting to hold dual-eligible beneficiaries harmless, the state also reconfigured its SPAP. Through New Jersey's Pharmaceutical Assistance to the Aged and Disabled (PAAD) program, the state provides wraparound coverage to elderly and disabled Medicare beneficiaries who are enrolled in Part D.<sup>18</sup> PAAD beneficiaries are required to enroll in a Part D plan, but they do not have to pay premiums, deductibles, or any out-of-pocket costs beyond the regular PAAD \$5.00 copayment. The PAAD benefit, as is the case for benefits in most SPAPs that subsidize Part D cost-sharing, is available only to cover beneficiary cost-sharing in the Part D plan's network pharmacies. Wraparound coverage during the coverage gap or doughnut hole is available only to Medicare beneficiaries with incomes above the eligibility level for LIS who are enrolled in another SPAP called Senior Gold, a state program for elderly individuals with higher incomes.

### **Beneficiary-Centered Assignment**

Another way states can help fill in gaps in Part D for dual eligibles and other low-income beneficiaries is to ensure that they are enrolled in a prescription drug plan that covers as many of their drugs as possible. Since plan formularies vary—and since CMS makes random assignments to plans for dual-eligible individuals or individuals with LIS who do not choose their own drug plans—states may be able to find plans that better meet beneficiaries' needs. Medicaid agencies and SPAPs have facilitated the enrollment of their members in prescription drug plans, using “bene-

ficiary-centered” assignment. In this process, the information on enrollees' prior drug use is reviewed and compared to formularies from available plans to help beneficiaries enroll in the most appropriate plan. Other factors, such as preferred pharmacies or spouses' plans, are sometimes taken into consideration in helping beneficiaries match their needs with plans. Six states used beneficiary-centered assignment for SPAP enrollees or Medicaid beneficiaries for initial 2006 assignments.<sup>19</sup>

### **TAKING A COMPREHENSIVE APPROACH**

In Maine, Part D was approached as a program that presented challenges but also provided opportunities to coordinate and enhance benefits. Prior to Part D, Maine residents with low incomes had received prescription drug coverage either through MaineCare, the state's Medicaid program, or through Maine's SPAP, called the Low Cost Drugs for the Elderly and Disabled Program (DEL). In anticipation of the Part D program, a strategy was developed to provide optimal prescription drug coverage to low-income Maine residents. Activities were coordinated through the Governor's office. State legislation passed in the state gave the Maine Department of Health and Human Services emergency rulemaking authority to implement program changes. Key elements of the effort in Maine are: 1) collaboration, 2) wrap-around coverage, 3) beneficiary-centered assignment, 4) broadened MSP eligibility criteria, 5) fostering community-based assistance, and 6) assistance with appeals.

A Medicare work group sponsored by the state Office of Elder Services and SHIP has been meeting every two months for a number of years and has established good working relationships across programs, agencies, and the state. Thus, its members report they were ready to tackle issues together. SSA, for example, has always been well-represented at the Maine Medicare Work Group meetings. In 2005, SSA staff from the regional office in Boston and other Maine offices conducted a training session for about 50 people from Maine Area Agencies on Aging and SHIPs.

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### Connecticut's Part D Wraparound Coalition

A popular state pharmaceutical assistance program (SPAP), a strong and well-organized elder rights community, and recent experience in Medicaid drug copays all led to the creation of a Part D wraparound benefit in Connecticut. The benefit covers dual eligibles as well as those with slightly higher incomes who participate in the SPAP, ConnPACE.

Prior to Medicare Part D, ConnPACE had, for 20 years, provided prescription drug coverage to non-dual-eligible Medicare beneficiaries with low incomes.<sup>20</sup> ConnPACE covers virtually all medically necessary drugs, allows a 30-day supply or 120 pills, whichever is greater, to be dispensed at one time, and requires the use of generics unless brands are medically necessary. ConnPACE requires an annual enrollment fee of \$30 and a copay by the beneficiary of \$16.25 per prescription.

In 2005, the Center for Medicare Advocacy convened a group from Connecticut's elder rights network to plan for the challenges facing the state's low-income beneficiaries when Medicare Part D began covering their medications in 2006. The group formed the Connecticut Part D Wraparound Coalition and continues to work to ensure that Connecticut's low-income beneficiaries enrolled in Part D are covered to the same extent as Medicaid enrollees who do not have Part D coverage.

The Connecticut Part D Wraparound Coalition worked with the legislature to craft wraparound legislation that includes: 1) an entitlement to state payment of dual eligibles' copays and of ConnPACE members' copays above the copay per prescription they were already required to pay; 2) state payment of all Part D premiums for ConnPACE beneficiaries, including premiums above the benchmark for those eligible for LIS; and 3) creation of a Medicare Supplemental Needs Fund, currently funded at \$5 million per year to pay for drugs not on a dual eligible's or ConnPACE participant's Part D plan's formulary.

To maximize federal dollars paying for prescription drugs, ConnPACE not only requires its beneficiaries who have Medicare to participate in Part D but also engages in extensive outreach to encourage those members to apply for the federal Part D LIS. Although ConnPACE itself neither counts nor requires disclosure of assets by an applicant, its application now asks whether applicants' assets are above a certain level to determine whether they are likely to be eligible for LIS. This question does not appear to deter ConnPACE applicants, although in the experience of at least one advocate, applicants may need to be educated as to the reason for the question.

The state also enlisted the services of the University of Connecticut Pharmacy Department and CHOICES, the SHIP, to help ConnPACE enrollees and dual eligibles choose the best plan. And, to recover money paid out for non-formulary drugs, the Department of Social Services (DSS) engages in the Part D exceptions process on behalf of individuals for non-formulary drugs; this is handled by the pharmacy, DSS, and the physician, without a need for beneficiary participation.

One problematic aspect of the Part D wraparound was that pharmacies were not aware they should bill the state for copays and for non-formulary drugs. Chain drug stores have been slower than independents to catch on, since they appear to get their directions from a corporate central office that is unaware of state variations in operations. DSS has been committed to making the wraparound work, however, and its pharmacy unit is very helpful in resolving problems brought to its attention. More than 100,000 low-income Connecticut residents (42,000 ConnPACE enrollees and 68,000 dual eligibles) are directly helped by the wraparound program.

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A Medicare Part D Stakeholders Group, mandated by the state legislature, was formed specifically to address issues related to prescription drug coverage. One state official said that working with the group was important in considering how to resolve issues and implement change. It was also key to gaining the trust of benefi-

aries and called "The best group I have worked with in many years in government."

The Maine legislature specified that DEL provide coverage of drugs for dual eligibles to the same extent that coverage is available for Medicaid enrollees who are not eligible for Part D, and that DEL members

eligible for Part D receive help from DEL with premiums, copayments, deductibles, and coverage gaps. Maine's SPAP became a wraparound program. Legislation gave the department authority to deem MaineCare and Part D enrollees eligible for DEL. Thus, they become eligible for the wraparound benefits DEL provides.

Officials in Maine were concerned that the random auto-enrollment process used to assign dual-eligible beneficiaries to Part D plans would not assure access to needed drugs. They also worried that the process could be more costly than necessary if the state had to pay wraparound benefits for individuals assigned to plans that did not cover the drugs they take. State legislators determined that the Department of Health and Human Services could serve as an authorized representative for the purposes of applying for Medicare Part D benefits and enrolling in a Part D plan on behalf of enrollees. Consequently, after CMS randomly assigned Maine's dual eligibles to drug plans in late 2005, Maine reassigned certain noninstitutionalized dual eligibles to different plans. Enrollees can choose to opt out of the process. For the most part, beneficiaries are assigned to plans with premiums below the benchmark, but in a limited number of cases, the state pays the difference for plans with higher premiums if the overall costs for particular drugs will be lower and thus less costly for the state.

Prior to the 2006 start of the Part D benefit, the state matched drug utilization data from MaineCare for all dual eligibles (except those in nursing homes) with formularies and pharmacy networks for certain plans in the state. In addition, potential out-of-pocket costs associated with the plans were examined for each beneficiary. The state reassigned beneficiaries to a different PDP if they had been auto-assigned to a plan that covered less than 85 percent of the drugs they took. A similar process was used for DEL enrollees. The process was repeated in 2007 for a smaller group of enrollees and is conducted on an ongoing basis as individuals with MaineCare or DEL coverage become eligible for Medicare.

Maine has broadened its MSP eligibility criteria, which effectively expands LIS eligibility criteria

for its residents. Noting that the MSP resource test had been a major stumbling block for enrollment, Maine began on January 1, 2007 to disregard all resources for MSP applicants. Higher income eligibility limits for the MSP became effective in April 2007. The new limits are at or above 150, 170, and 185 percent of the federal poverty level for the QMB, SLMB, and QI programs, respectively.

The new MSP eligibility criteria align with the DEL eligibility criteria. Therefore, most DEL enrollees (with the exception of those who are not Medicare-eligible) will qualify for either full or partial Medicaid benefits and for the Part D LIS as well. Program outreach will be simpler and likely more effective, since individuals can be recruited for three types of benefits at the same time, and they will not have to provide documents to verify the value of assets. The state should also achieve significant savings as benefits formerly financed through the state DEL program will now be provided through Part D. State funds can then be used to pay for wraparound benefits.

With a grant from the Maine SPAP doubling its funding, the Maine SHIP worked closely with other state offices to develop state-specific resources on Part D and LIS, with the goal of creating a simple, consistent, and recognizable message for beneficiaries about how to get assistance with the cost of prescription medicines in the state of Maine. At the community level, SHIP grants fund a full-time Part D specialist at each of the state's five Area Agencies on Aging. The Part D specialists provide one-on-one counseling and enrollment assistance for LIS, MSP, and DEL. They use a "benefits check-up" approach to refer people for other benefits such as MaineCare or Food Stamps if they think individuals may qualify. The state continues to fund the positions, which were established and funded originally with SPAP grants from CMS. Also, although some offices are more active than others, each SSA office in the state designated a Part D point person so that the offices could be responsive when contacted for assistance. Some SSA offices in Maine do screen applicants informally, provide information about the programs, and advise individuals to apply for MSP.

State funding is used to support a Part D Appeals Unit for low-income beneficiaries, which helps beneficiaries with exceptions and appeals when coverage for drugs is denied by their plans. The unit, comprising a supervising attorney and five specialists, is operated by Legal Services for the Elderly. In addition, the state posts plans' criteria for exceptions and appeals on its Web site so the information is readily available.

## **CONCLUSION**

State and local government agencies and other organizations across the country have made significant efforts to help ensure that Medicare Part D and LIS work effectively for low-income Medicare beneficiaries. Wider use of the helpful practices that have been developed in some states and communities has the potential to substantially improve the experience of the most vulnerable beneficiaries in Medicare. Recent experience indicates, for example, that state coalitions have been powerful forces in improving benefits for older and disabled state residents. In states that do not have active coalitions, the Part D program remains an important reason around which to build a coalition that can act on behalf of Medicare beneficiaries. Experience to date also indicates that states and localities can be very effective in helping the substantial numbers of beneficiaries who still must apply for LIS or who must re-apply or respond to changes in coverage related to their subsidy status.

The federal government has an important role to play in providing support for state and local efforts to help vulnerable beneficiaries contend with the complexities of the Part D program. The federal government, for example, could translate model forms and notices into numerous languages to make those tools available nationwide and could more closely monitor plans' ability to provide culturally and linguistically appropriate assistance to enrollees and prospective enrollees. Federal funds dedicated to outreach and counseling for Medicare beneficiaries were essential in the implementation of the Part D program.

Continued and enhanced support is needed now. State practices have shown that the availability of

funds to support dedicated Part D counselors at Area Agencies on Aging and similar locally based organizations has been very helpful, as has support for trained professionals who help beneficiaries with exceptions, appeals, or other procedures related to using the Part D program effectively. Federal support could help guarantee that such services are available to all beneficiaries regardless of where they live.

## NOTES

- <sup>1</sup> Centers for Medicare and Medicaid Services, “Medicare Prescription Benefit’s Projected Costs Continue to Drop,” Jan. 31, 2008, press release.
- <sup>2</sup> L. Summer, P. Nemore, and J. Finberg, *Improving the Medicare Part D Program for the Most Vulnerable Beneficiaries* (New York: The Commonwealth Fund, May 2007).
- <sup>3</sup> Payments made by qualified SPAPs on behalf of beneficiaries count toward the total out-of-pocket costs (referred to as TrOOP, or true out-of-pocket costs) that establish when beneficiaries are eligible for catastrophic coverage under the Part D benefit. In many other cases, costs paid by other entities on behalf of the beneficiary do not count toward the TrOOP limit, and thus delay the onset of catastrophic coverage.
- <sup>4</sup> California Department of Health Services, Medi-Cal Statistics Section. “Medi-Cal Beneficiaries by Age/ Demographics,” Oct. 2007, available at <http://www.dhs.ca.gov/mcss/RequestedData/AgexDemo/agexdemo.htm>.
- <sup>5</sup> K. N. Scalia, *Medicare Prescription Drug Plans Fail Limited English Proficient Beneficiaries* (Oakland, Calif.: National Senior Citizens Law Center, Feb. 2007), available at [http://www.nslc.org/areas/medicare-part-d/area\\_folder.2006-09-28.5758698482/area\\_folder.2006-10-18.4955802464/article.2007-02-27.2718724527/at\\_download/attachment](http://www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-18.4955802464/article.2007-02-27.2718724527/at_download/attachment).
- <sup>6</sup> Multilingual publications on Medicare are available at the SHIBA Web site: [http://www.insurance.wa.gov/consumers/SHIBA\\_HelpLine/publications\\_otherlanguage.asp](http://www.insurance.wa.gov/consumers/SHIBA_HelpLine/publications_otherlanguage.asp).
- <sup>7</sup> The project is a program of the Southeast Asia Resource Action Center.
- <sup>8</sup> Of those receiving the subsidy, 75 percent were enrolled automatically through the deeming process.
- <sup>9</sup> CMS, “Medicare Prescription Benefit’s,” 2008.
- <sup>10</sup> L. Summer, P. Nemore, and J. Finberg, *Medicare Part D: How Do Vulnerable Beneficiaries Fare?* (New York: The Commonwealth Fund, Apr. 2008).
- <sup>11</sup> The Medicare Savings Programs (MSPs) are comprised of the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individuals (QI) programs.
- <sup>12</sup> For a number of years, all resources have been disregarded in Alabama, Arizona, Delaware, and Mississippi. Connecticut and New York disregard resources for the Qualified Individual programs. Minnesota has resource limits significantly higher than the federal standards of \$4,000 for an individual and \$6,000 for a couple. States also use more liberal methods to calculate the value of resources. For example, exclusions for burial funds are higher than the federal standard in Florida, Georgia, Hawaii, Louisiana, Maryland, Massachusetts, North Carolina, South Carolina, Vermont, and Virginia. Source: P. Nemore, J. Bender, and W.-W. Kwok, *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* (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2006), available at <http://www.kff.org/medicare/7519.cfm>.
- <sup>13</sup> Drugs not covered under Part D include benzodiazepines; barbiturates; drugs used for weight loss or gain; drugs used for cosmetic purposes or hair growth; drugs used for erectile dysfunction or fertility; prescription vitamins or supplements; over-the-counter drugs; and cough and cold medicines.
- <sup>14</sup> One exception is that individuals with Medicaid coverage who are in institutions are not required to make copayments.
- <sup>15</sup> Coverage through SPAPs ranges from more than 22 percent of Medicare beneficiaries in Rhode Island to less than 1 percent of Medicare beneficiaries in North Carolina, Nevada, Kansas, Michigan, and Minnesota. Programs in five states—New York, New Jersey, Pennsylvania, Illinois, and Massachusetts—accounted for nearly three-fourths of all enrollment nationwide in 2002. See T. Trail, K. Fox, J. Cantor et al., *State Pharmacy Assistance Programs: A Chartbook* (New York: The Commonwealth Fund, Aug. 2004).
- <sup>16</sup> K. Fox and L. Schofield, *The Pharmacy Coverage Safety Net: Variations in State Responses to Supplement Medicare Part D* (Portland, Maine: University of Southern Maine, Muskie School of Public Service, Feb. 2006).
- <sup>17</sup> The Medicare Modernization Act provided special status to qualified SPAPs by counting the payments they made on behalf of beneficiaries toward total out-of-pocket costs (referred to as TrOOP or true out-of-pocket costs). These costs establish when beneficiaries are eligible for catastrophic coverage under the Part D benefit. In many other cases, costs paid by other entities on behalf of the beneficiary do not count toward the TrOOP limit, and thus delay the onset of catastrophic coverage.
- <sup>18</sup> Eligibility is limited to individuals with incomes below \$21,850 and to couples with incomes up to \$26,791 (somewhat more than 200% of the federal poverty level). The program does not have an asset test.
- <sup>19</sup> J. Hoadley, L. Summer, J. Thompson et al, *The Role of Beneficiary-Centered Assignment for Medicare Part D* (Washington, D.C.: Medicare Payment Advisory Commission, June 2007).
- <sup>20</sup> Individuals with incomes below 226 percent of the federal income poverty guidelines, or \$23,100 for an individual and \$31,000 for a couple in 2007, are eligible for ConnPACE.

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