Medicare Part D Frequently Asked Questions: Administrative Issues

This list of "Frequently Asked Questions" regarding administrative issues surrounding the new Medicare Part D prescription drug benefit is designed to both inform advocates and be used as a tool to educate consumers. It is one document in a series that address four different categories: Eligibility & Enrollment, Benefit Design, Exceptions & Appeals, and Administrative Issues. This document will continue to evolve as new questions arise. If you have a question that is not addressed here, please contact NMHA's Advocacy Resource Center at shcrinfo@nmha.org.

What will be the fiscal impact of Part D on states?

There is disagreement between CMS and Medicaid officials about whether or not the new Medicare benefit will save states money. CMS estimates that the Medicare drug benefit will lead to net state budgetary savings of about $7.9 billion over the period from CY 2006-2010. States are projected to get net savings of about $1 billion in 2006 and $7.9 billion in the first five years of the drug benefit. However, state Medicaid Directors and others question whether states will be able secure savings at these levels.

What is the "clawback"?

Since states will no longer pay for medications for people who are dually eligible for Medicaid and Medicare, the authors of Medicare Part D developed a way for states to finance part of this new benefit. Officially called the "phased-down state contribution," the clawback is a monthly payment made by each state to the federal government beginning in January 2006 to help fund the new program. The amount of each state's payment approximately reflects state expenditures of its own funds that the state would make if it were still paying for medications for dual eligibles. In the first year, states will pay the federal government 90 percent of their estimated savings, and this amount will gradually be reduced to 75 percent in the following 9 years. The Congressional Budget Office estimates that the states will pay $48 billion toward Part D coverage over the first five years of the benefit.

What is a SPAP?

A State Pharmaceutical Assistance Program (SPAP) is a state-financed and state-administered program providing pharmaceutical assistance to certain populations, most often seniors. SPAPs usually work one of two ways: (1) providing subsidies to qualified individuals for help with costs associated with prescription drugs; or (2) providing drugs (at a discount) directly to individuals. In 2004, 32 states had operating SPAPs.[1]

How do SPAPs work with Medicare Part D plans?

SPAPs will need to coordinate their benefits with the Part D program, so that coverage does not overlap for enrollees eligible for both. States will also have the option to amend their SPAPs in order to financially

[1] State Pharmaceutical Assistance Programs, National Conference of State Legislatures, March 1, 2005, available at http://www.ncsl.org/programs/health/drugaid.htm

assist enrollees with costs associated with the Part D program (such as payment of premiums, co-pays, etc.) or provide prescription drug coverage that "wraps around" and supplements the Part D prescription drug benefit.

What can states (or SPAPs) do to provide supplemental/wraparound coverage or assistance with cost-sharing for dual eligibles?

States have the option to fill in the gaps in Part D coverage and pay certain costs through their existing SPAP or by creating one. To fill in the coverage gap, SPAPs can decide to:

- Pay the Part D premium
- Cover cost-sharing (deductible and/or coinsurance)
- Cover prescription drug purchases in the doughnut hole
- Cover non-formulary purchases
- Cover non-network pharmacies
- Cover non-Part D covered drugs (like benzodiazepines)
- Buy plan's supplemental coverage

SPAPs can also decide what populations to cover, by basing eligibility on income levels or including specific groups, like the disabled or dual eligibles.

Do State Pharmacy Assistance Programs (SPAPs) have to work with all Medicare prescription drug plans offered in their state?

Yes. The federal statute provides that in order to meet the definition of an SPAP and have the contributions count toward the TrOOP, the SPAP must provide assistance to Medicare prescription drug benefit eligible individuals in all Medicare prescription drug plans without discriminating based upon the Medicare prescription drug plan in which an individual enrolls.

How will State Pharmacy Assistance Programs (SPAP) coordinate benefits with the various Medicare prescription drug plans?

SPAPs may make payment of Part D premiums and cost-sharing on behalf of the SPAP enrollee, and make per capita payments to a drug plan to provide supplemental coverage for the SPAP enrollee.

Will Medicaid still pay for drugs for full-benefit dual eligible enrollees that are not part of the list of "covered drugs" under the Medicare prescription drug benefit (i.e. barbiturates, benzodiazepine, or prescription vitamins)? Will this count toward an enrollee's true out-of-pocket expenditures?

States will continue to have the option to provide Medicaid coverage of the drugs listed under section 1927(d)(2) of the Act (for example, benzodiazepines), which are excluded under the Medicare prescription drug benefit (except for smoking cessation drugs which are included under the Medicare prescription drug benefit).

If Medicaid does provide coverage of drugs listed in 1927(d)(2) and other non-Part D drugs otherwise covered under Medicaid, the state can receive federal matching funds, but the costs of these drugs cannot count toward the true out-of-pocket costs since they are not covered drugs under the Medicare prescription drug benefit.