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## **MEDICARE PART D-EXPLANATION OF STATE AND FEDERAL ASSISTANCE FOR PROGRAM BENEFICIARIES**

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The following is an explanation of the relationship between the federal Medicare Part D drug benefit, the Part D Low-Income Subsidy program, the ConnPACE program, and the Medicare Savings Program in light of changes the legislature has made in the latter two programs in the last few years.

### **SUMMARY**

Medicare Part D provides prescription drug assistance to seniors and certain individuals with disabilities who are enrolled in the Medicare program. Although many drug costs are now covered, unless enrollees have very low incomes and take advantage of federal or state assistance, they generally have to meet an annual Part D deductible and are responsible for temporarily paying 100% of their drug costs once they fill prescriptions totaling about \$3,000 (the “donut hole” phase).

Until the Part D program was enacted, Connecticut’s lower income seniors and individuals with disabilities received help with their drug costs from the state-funded ConnPACE program or, for very low-income individuals, Medicaid. For over 25 years, the ConnPACE program has limited enrollees prescription drug expenditures by essentially paying most of their drug costs provided they meet the program’s income requirements and have no other drug insurance coverage. (There is no asset test.)

When Congress passed the Part D program, the state continued this commitment by essentially making ConnPACE a “wrap around” benefit for Medicare enrollees, paying for things that the Part D benefit did not cover. This included paying a Part D prescription drug plan’s premiums, paying for coverage during the donut hole, limiting enrollee co-payments and paying for drugs a plan’s formulary did not cover.

Since enactment of the Part D program, extra federal help with paying Medicare cost sharing and the donut hole has been available to those Medicare enrollees with very low incomes through the federal Social Security Administration’s Low-Income Subsidy (LIS) program. Some lower income ConnPACE recipients may have availed themselves of this benefit since the co-payments are lower in the LIS program.

In fact, several pathways to this extra help are available, one of which is the Medicaid-funded (50% federal, 50% state) Medicare Savings Program (MSP), which provides help with Medicare Part A and Part B cost sharing. MSP recipients are automatically eligible for the LIS program.

In 2009, the legislature made ConnPACE enrollees eligible for the MSP by equalizing the two programs’ financial eligibility criteria. In addition to offering the help with Medicare cost sharing, this allowed the state to dramatically reduce its ConnPACE expenditures by moving most enrollees into MSP and hence the LIS. The legislature did not require ConnPACE enrollees to move into MSP.

That same year, the legislature also made budgetary reductions in the ConnPACE program, rendering it much less attractive to current and potential enrollees. The 2011 legislature essentially mandated that ConnPACE recipients eligible for Medicare move into MSP by eliminating their eligibility for ConnPACE coverage.

### **MEDICARE PART D—THE INTERPLAY WITH THE FEDERAL LOW-INCOME SUBSIDY, MEDICARE SAVINGS PROGRAM, AND CONNPACE**

Congress passed the Medicare Part D program in 2003. Up until that point, Medicare generally did not offer outpatient prescription drug coverage. Medicare beneficiaries could get help with prescriptions only by purchasing Medicare supplement plans from private insurers or enrolling in a Medicare Advantage plan (managed care) that offered drug coverage.

## **Coverage Under Part D—Prescription Drug Plans (PDP)**

Anyone enrolled in the Medicare program can enroll in a Part D prescription drug plan (PDP). Enrollees must have Medicare Part A (primarily hospitalization) or Part B (outpatient) coverage. Individuals who wish to enroll in a Medicare Advantage plan must have both Part A and B coverage to receive the Part D benefit.

Medicare pays for many drugs but not all that program beneficiaries need. And not every PDP may include a particular drug that an enrollee needs. Before choosing a plan, enrollees can meet with counselors to choose the plan that has a formulary (drugs that it pays for) that best meets their needs.

All PDPs must include categories and classes of drugs that cover all disease states and the federal government monitors the sufficiency of a plan's formulary. People who need a drug that is not on their PDP's formulary can request an exception to have the drug covered. If a plan approves the exception, it can charge more for it.

**Benchmark Plans.** Dozens of PDPs are available to Part D enrollees. In Connecticut, 34 plans are available in 2011, twelve of which are called "benchmark" plans. These latter, lower cost plans offer basic Part D coverage with premiums equal to or lower than the regional low-income premium subsidy amount that the federal government calculates annually. The benchmark monthly premiums start at \$14.80, but most are in the \$30 to \$35 range in 2011.

**Excluded Drugs.** Part D does not cover the following drugs:

1. barbiturates and benzodiazepenes (but starting in 2013, benzodiazepenes will be covered; barbiturates used to treat epilepsy, cancer, or chronic medical disorders will also be covered then and starting in 2014, they will no longer be excluded);
2. over-the-counter drugs (including those that physicians prescribe);
3. most weight loss or gain drugs;
4. cough and cold preparations;
5. fertility drugs;
6. erectile dysfunction drugs;

7. cosmetic and hair growth drugs;
8. most vitamins and mineral products; and
9. drugs that Medicare Parts A or B might cover.

Although these drugs are not covered by Medicare, a Part D PDP may include them in their formulary. This means that Part D enrollees could obtain them once they pay the required co-payment.

### ***The Part D Benefit—Coverage Phases***

Part D PDPs must offer a “standard benefit” package. This includes an annual deductible and a “gap” in coverage (called the donut hole). Some “enhanced” PDPs offer coverage during the donut hole.

In 2011, the standard plan includes a \$310 deductible (the maximum allowed by federal law). Once the enrollee has paid the deductible, he or she pays no more than 25% of the next \$2,530 (\$632.50) in formulary drugs, with the plan covering the other 75%. When the beneficiary and the plan combined have paid \$2,840 (\$310 plus \$2,530), the donut hole phase begins. During the donut hole, the beneficiary pays 100% of the next \$3,607.50 in formulary drug costs.

If a beneficiary’s drug needs surpass the combined donut hole and previous formulary expenditures, he or she pays only 5% of any drugs required from that point on, or \$2.50 for generics and \$6.30 for brand name drugs, whichever is greater. This is called the “catastrophic coverage” phase.

This process begins again during the next calendar year.

***Donut Hole Phase-Out.*** The Patient Protection and Affordable Care Act of 2010 (P.L. 113-114) includes several Part D-related provisions. One requires the donut hole to gradually phase out. The first phase was in 2010 when beneficiaries received a one-time \$250 rebate.

Beginning in 2011, coverage during the donut hole phase has increased. Individuals purchasing formulary drugs during the donut hole now get a 50% discount on brand name drugs and a 7% discount on generics. These discounts will continue to increase annually until 2020, when everyone pays a flat 25% of any drugs purchased during the donut hole. (The discounts are given at the pharmacy, with no additional paperwork for enrollees.) Beneficiaries must continue to pay a small

dispensing fee for these drugs. Only drugs for which their manufacturer has signed an agreement to participate in the Discount Program can be purchased at the discounted rate (see OLR report [2010-R-0404](#) for additional information about the Part D changes in the federal legislation).

***True Out of Pocket Costs and Tracking.*** Only certain drug-related expenditures count towards the out-of-pocket limits that allow someone to move into the catastrophic coverage phase. Formulary drugs purchased by PDP enrollees, their family members, a charity, a state pharmacy assistance program or AIDS drugs assistance program, the Indian Health Service, or the Part D LIS (see below) count. Premium payments, payments for non-formulary drugs (unless approved by exception or appeal), drugs purchased outside the U.S., and drugs paid for by other insurance do not count. The Part D plan keeps track of these expenditures for plan enrollees.

### ***Low-Income Subsidy (“Extra Help”)***

The Social Security Administration helps low-income Part D beneficiaries with their drug costs by helping pay their deductibles and premiums and limiting their co-payments.

Individuals can qualify for the LIS in several ways. Some are automatically eligible by virtue of qualifying for other assistance programs and do not have to apply separately for the LIS. For example, people who are eligible for full Medicaid benefits along with Medicare (called “full duals”) can get this help. Likewise, people who are eligible for the Medicare Savings Program (MSP), which provides Medicaid-funded help with Medicare Part A and Part B cost sharing, automatically qualify for LIS.

Those people who automatically qualify for the LIS pay no Part D deductible provided they enroll in a benchmark plan. If they are full duals not living in an institution or have income up to 100% of the federal poverty level (FPL, \$10,890 annually for one person in 2011), they pay no deductible, a \$1.10 co-payment for generics and \$3.30 for brand-name drugs, and nothing during the catastrophic coverage phase. Other full duals and people who automatically qualify (including someone enrolled in the MSP) pay no deductible and \$2.50 for generics and \$6.30 through the donut hole phase. They pay nothing once in the catastrophic coverage phase.

Individuals who are not automatically eligible whose income is less than 150% of the FPL (150% is \$16,335 annually) can qualify for the LIS benefit as well, as shown in Table 1.

**Table 1: LIS for Individuals Not Automatically Eligible**

<b>Income</b>	<b>Assets</b>	<b>Deductible</b>	<b>Co-Payments</b>
Up to 135% of FPL (\$14,702 for one person in 2011)	\$8,180	None	\$2.50 (generics) and \$6.30 (brand name) through the donut hole; no co-pays during catastrophic coverage
135%-150% of FPL (Up to \$16,335 for one person in 2011)	12,640	\$63	15% through donut hole; \$2.50 (generic) and \$6.30 (brand name) during catastrophic phrase

For a more detailed explanation of the LIS, please go to [www.medicareadvocacy.org/medicare-info/medicare-part-d/](http://www.medicareadvocacy.org/medicare-info/medicare-part-d/)

### **CONNPACE—BEFORE AND AFTER PART D**

The legislature passed the ConnPACE law in 1985, providing elders and certain individuals with disabilities help paying their prescription drug costs. Until Medicare Part D passed, the ConnPACE program changed very little. The legislature built into the ConnPACE law an indexing provision to ensure that when enrollees' Social Security income rose, they would not lose their ConnPACE coverage.

In 2005, when the full Part D benefit kicked in, the legislature redesigned ConnPACE as a wrap-around program. For Part D recipients this meant ConnPACE paid for (1) the Part D deductible, (2) co-payments for Part D drugs costing more than \$16.25, (3) Part D plan's premiums, and (4) coverage during the donut hole. It also paid for drugs not on an enrollee's formulary and drugs excluded from Part D coverage (see above). ConnPACE continued to pay for drugs (minus the co-pays) for individuals not enrolled in Medicare.

### **MEDICARE SAVINGS PROGRAM AS PATHWAY TO LIS**

The Medicaid program includes a mandatory coverage group that essentially allows Medicare recipients who would not otherwise qualify for Medicaid to receive limited help with their Medicare Part A and B cost sharing. The MSP consists of three main sub-groups:

1. Qualified Medicare Beneficiaries;
2. Specified Low-Income Medicare Beneficiaries; and
3. Qualified Individuals.

A fourth subgroup offers assistance to disabled workers who lose their Medicare Part A coverage because they return to work. (See Attachment 1 for a more detailed explanation of the MSP benefits.)

Federal law sets the MSP financial eligibility limits, but states can use more liberal eligibility methodologies by allowing deductions of income and assets. Connecticut has done this to enable ConnPACE recipients to move into the MSP.

***How MSP Became An LIS Pathway for ConnPACE Recipients***

The 2009 legislature saw a way to save money in the 100% state-funded ConnPACE program by tying the MSP eligibility limits to those for ConnPACE, which would then make ConnPACE enrollees eligible for the LIS. To do this, the state had to equalize the programs’ income and asset eligibility limits. It essentially increased the amount of income and assets it disregarded when determining someone’s MSP eligibility. Table 2 illustrates the effect of the change in MSP income limits.

**Table 2: MSP Income Limits (Single Applicants)  
Before and After PA 09-2**

<b><i>MSP Program</i></b>	<b><i>Prior Income Limit</i></b>	<b><i>Limit Under PA 09-2</i></b>
Qualified Medicare Beneficiary (QMB)	100% of FPL	207% of FPL
Specialized Low-Income Beneficiary (SLMB)	100%-120% of FPL	207% - 227% of FPL
Qualified Individual (QI)	120%-135% of FPL	227% - 242% of FPL

PA 09-5, June Special Session, directed the Department of Social Services (DSS) to eliminate the asset test altogether and the federal government approved both changes. (ConnPACE has no asset limit.)

## **RECENT CHANGES IN CONNPACE AND IMPACT ON PART D ENROLLEES**

### ***PA 09-5, September Special Session***

While moving out of ConnPACE and into the MSP was optional, other changes the legislature made in 2009 made it more likely that a ConnPACE enrollee would elect to do so.

PA 09-5, September Special Session, made the following changes to the ConnPACE program. It:

1. increased from \$30 to \$45 the annual registration fee;
2. froze the program's income limits until January 1, 2012 (hence, not allowing for any income increases related to increases in Social Security benefits);
3. created a limited open enrollment period;
4. required enrollment in one of 13 (now 12) "benchmark" plans; and
5. eliminated coverage (effective January 1, 2010) for drugs not in a Part D plan's formulary and as a corollary eliminated the state-funded Supplemental Needs Fund, which paid for these drugs.

### ***PA 11-44***

The 2011 legislature essentially mandates that ConnPACE recipients move into the MSP by eliminating ConnPACE for anyone eligible for Medicare. PA 11-44, §§ 88-90, made this change, which took effect July 1, 2011. (The legislature also repealed the statute that required DSS, under the ConnPACE program, to pay for Medicare Part D excluded drugs.)

People who are ineligible for Medicare (mostly younger individuals with permanent disabilities who have not yet qualified for Medicare and some seniors) continue to get drug assistance from the program.

### Attachment 1: MSP Program—Eligibility and Benefits (Single Person)

<b>Programs</b>	<b>Financial Eligibility in 2011 [1] (for Single Person)</b>	<b>Cost Sharing Paid by DSS</b>	<b>Value of Cost Sharing in 2011</b>
Qualified Medicare Beneficiary (QMB)	Income: 100% of federal poverty level (FPL) (\$10,890 per year); Assets: less than \$4,000	Medicare Part A (hospital and limited skilled nursing facility) premiums, deductibles, and coinsurance;  Part B (physician and other outpatient services) premiums, coinsurance and deductibles	Part A premium: \$248 per month Part A deductible: various, including \$1,132 for first 60 days of inpatient hospitalization  Part B premium: Various, depending on income; \$96.40 per month for income up to \$85,000  Part B deductible: \$162
Specified Low-Income Beneficiaries (SLMB)	Income: 100-120% of FPL (\$10,890 to \$13,068 yearly)  Assets: less than \$4,000	Medicare Part B premiums	See above
Qualified Individual (QI)[2]	Income: 120-135% of FPL (\$13,068 to \$14,702 yearly)  Assets: No test	Medicare Part B premium	See above

[1] The FPL rises each year.

[2] States receive a limited amount of federal money from which they pay on a first-come, first-served basis.

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