Filling the Holes in Part D: The Essential Role of State Pharmacy Assistance Programs

(Part 2 of 2)

Our companion piece, *The Holes in Part D: Gaps in the New Medicare Drug Benefit*, details the significant financial and coverage gaps in the new Medicare Part D drug benefit. It also discusses the Medicare program's history of limited success when it comes to getting low-income beneficiaries enrolled in programs that can help them. Any efforts that states make to fill these gaps could be helpful—even essential—to beneficiaries. Fortunately, there is a tool that states can use to help fill these gaps and improve the enrollment process—State Pharmacy Assistance Programs (SPAPs). These programs, which already provide some form of prescription drug coverage to Medicare beneficiaries (and sometimes others) in more than 25 states,[1] are a promising means of delivering this help because they are already serving the target population of Medicare beneficiaries. In several states, these programs are well established, well-liked by their beneficiaries, and have broad political support. And State Pharmacy Assistance Programs are eligible to receive special grants totaling $125 million to help with the transition to Part D. In addition, because most State Pharmacy Assistance Program beneficiaries will get their primary drug coverage through Medicare Part D starting in January 2006, these programs will see a substantial savings—totaling about $600 million per year, according to CMS[2]—which will free up state resources to fill the gaps in Part D and to meet other health care needs.

. . . advocates need to be alert to changes in their states' Pharmacy Assistance Programs and be vigilant during their state budget processes to ensure that savings that are expected to accrue to these programs are used for health care needs.

In states that already have Pharmacy Assistance Programs, advocates need to work with policy makers to start looking at how they will both preserve their programs and adapt them to respond to the confusing ins and outs of the new drug benefit. In states that don't have such programs, advocates should consider how their state can provide wraparound coverage and/or facilitate enrollment and how a Pharmacy Assistance Program could be helpful with these processes. Whether or not your state has an existing program, this piece is designed to guide you through the issues you will need to address when adapting—or creating—a Pharmacy Assistance Program so that Medicare beneficiaries don't fall through the cracks.

When working with Pharmacy Assistance Programs to provide wraparound coverage, states will need to understand how assistance from these programs intersects with the Medicare drug benefit. They will then have to make key decisions about whom to help, what they want their programs to cover, and when their programs will take effect. This piece briefly examines these key decision points and explains the special role envisioned for Pharmacy Assistance Programs under the Medicare drug law. It concludes with a discussion of the other major task in which State Pharmacy Assistance Programs can play a constructive role—enrollment.

The Special Role of State Pharmacy Assistance Programs

In addition to the grants awarded to State Pharmacy Assistance Programs, these programs have a unique advantage under the Medicare law that makes them especially suitable for assisting Medicare beneficiaries with drug costs. Unlike any other insurance program, so long as a State Pharmacy Assistance Program meets federal requirements, its contributions to beneficiaries' drug costs will count towards the beneficiaries' true out-of-pocket (TrOOP) limit. Once a beneficiary has reached this limit or threshold, her catastrophic coverage kicks in, and the Medicare drug benefit pays for most or all of her drug expenses (depending on whether she is eligible for the low-income subsidy).[3] (This only applies to drugs covered by a beneficiary's Part D plan. The cost of drugs not covered by a beneficiary's plan does not count towards his or her TrOOP.) Assistance from other insurers, such as private insurance or Medicaid, is not treated this way—any help from those programs will not count towards a beneficiary's TrOOP. This means that other assistance will not get beneficiaries any closer to the point where the catastrophic benefit begins and Medicare resumes paying for their drugs.[4]

Not only is this assistance helpful to beneficiaries, but it ends up being advantageous to State Pharmacy Assistance Programs as well. This is why: Once a beneficiary reaches his or her TrOOP and catastrophic coverage begins, Medicare pays most or all of the beneficiary's drug costs, and the State Pharmacy Assistance Program needs to pay little, if anything. For sicker or older beneficiaries whose care may require taking many expensive prescriptions, this will relieve State Pharmacy Assistance Programs of significant costs. This in turn limits the cost of providing wraparound coverage. (There may be circumstances where a state might not want to take advantage of this special treatment of Pharmacy Assistance Programs. They are discussed in the Appendix, "Non-Qualified State Pharmacy Assistance Programs: Can States Go It Alone?".)

Key Decision Points

Decision Point 1: Whom to Help

Historically, State Pharmacy Assistance Programs have served primarily low-income seniors who did not have prescription drug coverage and whose incomes or assets were too high for them to qualify for Medicaid. Several states have expanded these programs to cover people with disabilities and other groups. However, as discussed extensively in *The Holes in Part D: Gaps in the New Medicare Drug Benefit*, all Medicare beneficiaries will face gaps in their drug coverage once the Part D benefit starts. All Medicare beneficiaries—both the seniors and the people with disabilities—will need wraparound help.

As states begin to revise existing assistance programs or to design new ones, advocates and policy makers should first examine who will be worse off under the Part D program and low-income subsidy than they are currently. The place to start building a wraparound program is to make sure that those who will be losing some form of coverage are no worse off under Part D. Once that is done, states may find that they can expand coverage to other beneficiaries, possibly using savings that accrue to their Pharmacy Assistance Programs (if they have one). Those who will likely need help include the following:

- Full dual eligibles, including both the elderly and people with disabilities, will have higher copayments in many states than they do now. These beneficiaries have in the past been served by Medicaid and not by State Pharmacy Assistance Programs, so states will need to revise their program eligibility rules to include this new group in new or existing programs.
- There are other low-income beneficiaries, including partial dual eligibles, who have been receiving assistance from State Pharmacy Assistance Programs in many states. Some of these beneficiaries may face higher costs under Part D, even with help from the low-income subsidy, than they currently do under their states' programs. State Pharmacy Assistance Programs can continue assisting this group by covering beneficiaries' out-of-pocket drug costs.
- Those beneficiaries with slightly higher incomes who are not eligible for the low-income subsidy will almost certainly face higher costs than they do if they are covered under an existing State Pharmacy Assistance Program. Moreover, in general, beneficiaries with incomes or assets just above the eligibility levels for low-income assistance may find the basic Part D benefit prohibitively expensive without additional assistance. For example, a single elderly woman with a yearly income of $14,451 (151 percent of poverty in 2005) could spend 28 percent of her income ($444 in premiums and $3,600 on Part D drugs) before reaching her catastrophic benefit.

Decision Point 2: What to Cover

States also need to consider what they will cover—which gaps they will fill. The most obvious holes are financial—copayments for low-income beneficiaries, and co-insurance, premiums, and the coverage gap (a.k.a. the doughnut hole) for others. In addition, beneficiaries who have to get their prescriptions filled at pharmacies outside of their plans' networks will likely face higher costs.

Beneficiaries may also face gaps in their drug coverage, for a couple of reasons. First, the Part D benefit will not cover certain classes of drugs, such as benzodiazepines, that beneficiaries may need. Second, a beneficiary's plan may not cover all of the particular drugs he or she needs.

At this stage, it is difficult to predict how much wraparound coverage of specific drugs will be needed because Part D plans have not yet released their formularies to the public. The more comprehensive these formularies are, the less need there will be for states to provide coverage in this area. By contrast, it is easier to predict how much help beneficiaries will need with out-of-pocket costs such as copayments because current utilization data from Medicaid and State Pharmacy Assistance Programs can be used to estimate the average number of prescriptions that beneficiaries will use.

Filling these gaps and ensuring access to necessary medications will be a life-saving role for state wraparound programs.

Decision Point 3: When Coverage Should Start

Ideally, states will have their wraparound programs in place on January 1, 2006, the day the Part D benefit begins. Indeed, many states with existing Pharmacy Assistance Programs are in the process of modifying their programs to accommodate the new Medicare benefit (see the discussion on page 7). That way, beneficiaries will experience minimal disruptions in their coverage.

Advocates and policymakers should not despair, however, if their State Pharmacy Assistance Program is not ready, or does not exist, by January. In states where there is no program, this is the time to start laying the groundwork by learning about the need for wraparound programs and building coalitions to get these programs funded and up and running. Once the Part D benefit starts, hardship stories from individuals will inevitably arise, and these stories can help make a compelling case for the need for such programs. It will also be easier to estimate future costs of new state assistance programs once the main federal Part D program is underway.

The Logistical Challenges of Enrolling Beneficiaries

Some low-income beneficiaries will be automatically enrolled in either a Part D plan or the low-income subsidy, or both. Full dual eligibles, whose Medicaid drug coverage ends on December 31, 2005, will be automatically enrolled by CMS into a Medicare Part D plan and are automatically eligible for the low-income subsidy. Partial dual eligibles—those in Medicare Savings Programs (MSPs)—will be automatically eligible for the low-income subsidy as well. In addition, CMS has stated that MSP beneficiaries who do not join a Part D plan during the initial enrollment period that ends May 15, 2006 will be enrolled by CMS into a Part D plan.[5] However, when CMS automatically enrolls both full and partial dual eligibles into plans, it will choose at random from among the low-cost plans in a region *without regard for beneficiaries' specific drug needs*. Other low-income beneficiaries will have to sign up on their own with a Part D plan and enroll in the low-income subsidy.

For beneficiaries who do not qualify for the low-income subsidy, enrollment in the Part D drug benefit is entirely voluntary, meaning that those who want to join must affirmatively opt into the benefit. The fact that enrollment into the basic benefit will be voluntary for such a large group of beneficiaries will likely make it harder to achieve high enrollment

States building wraparound programs through their Pharmacy Assistance Programs will need to figure out how beneficiaries are to be properly enrolled in both a Part D plan and the low-income subsidy. Moreover, states that want to use Pharmacy Assistance Programs to create a wrap-

around program will find that making the enrollment process automatic will increase enrollment in both the Part D benefit and the low-income subsidy in their states. Automatic enrollment is the best way to ensure that low-income beneficiaries do enroll in a Part D plan and the low-income subsidy. However, federal rules limit states' options in this area. States will therefore need to pay careful attention to enrollment processes as they design their wraparound programs. We discuss the major considerations about the enrollment process below.

Enrolling Beneficiaries in the Low-Income Subsidy

Ensuring that beneficiaries are enrolled in the low-income subsidy presents several challenges. Full and partial dual eligibles are automatically eligible for the subsidy, so no further action is needed on their behalf (other than perhaps to verify the accuracy of their enrollment). For other beneficiaries, State Pharmacy Assistance Programs can apply for the subsidy on behalf of their beneficiaries if the program is acting as a "personal representative" of the beneficiaries.[6] Unfortunately, the low-income subsidy's asset test will present some additional difficulties for State Pharmacy Assistance Programs that are trying to assist with enrollment. This is because most existing programs do not consider assets as part of the eligibility process,[7] so they do not have information about their beneficiaries' assets readily available. States that want to enroll beneficiaries automatically in the low-income subsidy will therefore have to gather asset information, which will be a new burden on both state agencies and beneficiaries.

Several State Pharmacy Assistance Programs had hoped to be able to perform eligibility determinations for the low-income subsidy themselves, as they already have good information about beneficiaries' incomes. However, the MMA and CMS guidance state that only the Social Security Administration and state Medicaid agencies are authorized under the law to make eligibility determinations.[8] The best State Pharmacy Assistance Programs can do in these cases is to forward applications on behalf of their beneficiaries to the appropriate agency, but they cannot make eligibility decisions themselves.[9]

Enrolling Beneficiaries into a Part D Plan

- **States' Ability to Automatically Enroll Beneficiaries Is Limited**

CMS will automatically enroll full dual eligibles into a Part D plan, but State Pharmacy Assistance Programs will still have a role to play when it comes to assisting this population. If a state wishes to provide wraparound coverage for a dual eligible—helping cover copayments or noncovered drugs, for example—it will likely need to know what plan the dual eligible is enrolled in and perhaps take steps to ensure that the beneficiary is in a plan that best meets his or her drug needs. To do this in a way that complies with the rules of Part D enrollment, states may want to consider becoming an authorized representative for dual eligibles in order to select an appropriate Part D plan for them.

For all other beneficiaries, federal rules will complicate State Pharmacy Assistance Program efforts to automatically enroll beneficiaries into Part D plans. Initially, several states with existing State Pharmacy Assistance Programs had hoped to be able to designate a preferred Part D plan for their beneficiaries and then automatically enroll them in that plan. Designating a preferred plan would simplify the task of communicating

with enrollees, as enrollees could understand that their familiar program was now partnering with a new plan. This approach worked well in 2004 during the temporary Medicare drug discount card transitional assistance program. In that case, several State Pharmacy Assistance Programs automatically enrolled their beneficiaries in a designated preferred card. In fact, a large proportion of all low-income beneficiaries who participated in the Medicare drug discount card Transitional Assistance program were automatically enrolled by their State Pharmacy Assistance Program,[10] thus demonstrating the importance and effectiveness of automatic enrollment. Designating a preferred plan is also generally simpler for state agencies, as they only need to coordinate benefits and formularies with one plan.

However, the MMA prohibits states from "discriminating" against any Part D plan,[11] and CMS has unfortunately interpreted this provision as forbidding any State Pharmacy Assistance Program from automatically enrolling beneficiaries in a preferred Part D plan. If a state does designate a preferred plan, its Pharmacy Assistance Program will lose its status as a "qualified" State Pharmacy Assistance Program. This means that any assistance it provided in helping enrollees pay for drugs would not count towards beneficiaries' true out-of-pocket expenses, and the state program would not be eligible for additional federal funding for the transition process.[12] However, a state may still decide to go ahead and operate its program as a "non-qualified" program. For more on the pros and cons of pursuing this policy, see the Appendix discussion: "Non-Qualified State Pharmacy Assistance Programs: Can States Go It Alone?".

Even without being able to select one preferred drug plan, both existing and new State Pharmacy Assistance Programs can do a good deal to make sure that beneficiaries enroll in a Part D plan. CMS guidance says that State Pharmacy Assistance Programs can automatically enroll beneficiaries at random among all Part D plans—and they can take the personal needs of beneficiaries into account when making such assignments. For example, the state can consider whether a plan's pharmacy network or formulary is appropriate for a particular beneficiary.[13] The initial guidance does not explain how a State Pharmacy Assistance Program might actually implement such an enrollment process, but it encourages states to consult with CMS about the issue. State officials and advocates should explore this option as a way to provide good and efficient wraparound coverage to beneficiaries.

States may also "co-brand" with Part D plans—allowing the name of the State Pharmacy Assistance Program to appear on the card of a Part D plan. States can set standards (in consultation with CMS) for which plans they will co-brand with, but if they do so, they must co-brand with all plans that meet the states' standards.[14]

In summary, ensuring automatic enrollment into Part D may be a significant challenge for states. Existing State Pharmacy Assistance Programs will want to make sure that their beneficiaries transition seamlessly to Part D and a wraparound benefit. New programs will need to design efficient enrollment procedures. Having to coordinate with multiple plans and multiple formularies will create administrative difficulties, although this situation may improve in the future. And the federal government has taken several steps that may make the transition process go more smoothly. CMS has provided financial grants to existing State Pharmacy Assistance Programs for transition costs. It will also be creating an electronic system for tracking individual true out-of-pocket (TrOOP) costs for beneficiaries in all plans in order to facilitate coordination of benefits.[15] So, the technical capacities of states, CMS, and the Part D plans may improve in future years.

Education and Outreach

In addition to facilitating enrollment, states can and should conduct extensive beneficiary outreach and education efforts. It appears that these efforts can provide a great deal of specific consumer-oriented advice without violating federal non-discrimination rules. For example, states can advise beneficiaries about the following:

- which plans have lower premiums;
- which plans formularies' cover the drugs a beneficiary uses;
- which plan offers the beneficiary the most favorable combination of out-of-pocket costs (deductibles, copayments, and co-insurance) and prices for the beneficiaries' current drugs; and
- which plans' pharmacies include the same pharmacies that are in an existing State Pharmacy Assistance Program (for states that have a program).[16]

Of course, providing such detailed advice will require intensive, and sometimes costly, individual assistance and counseling. Nevertheless, it presents a potential opportunity for states to ensure that there is a workable connection between the new Part D plans and their wraparound programs.

Filing Appeals for Beneficiaries

CMS also allows State Pharmacy Assistance Programs to act as authorized representatives of beneficiaries and appeal on their behalf when a plan denies coverage for a drug.[17] States should take advantage of this provision, especially if they will be covering drugs that a Part D plan does not cover (such as benzodiazepines). In those instances, states can cover a beneficiary's drugs and then pursue an appeal to be reimbursed by the Part D plan.

Taking Action: What Will States Do?

As we go to press, many states are considering whether they will create wraparound programs and, if so, what these programs will look like. In most states that already have Pharmacy Assistance Programs, the programs are likely to be modified to serve as wraparound programs for current program beneficiaries who will be transitioning to Part D for their drug coverage. The extent of these wraparound benefits will depend in large part on the fiscal circumstances of the state. Therefore, advocates need to be alert to changes in their states' Pharmacy Assistance Programs and be vigilant during their state budget processes to ensure that savings that are expected to accrue to these programs are used for health care needs. State governments may otherwise be tempted to siphon off the savings and use those dollars for other purposes.

A couple of states have taken early, positive steps toward providing good wraparound coverage:

- **Connecticut**: A bill in the Connecticut legislature[18] would provide wraparound coverage for all Part D copayments, co-insurance, deductibles, and premiums for all State Pharmacy Assistance Program beneficiaries. These beneficiaries would pay the lesser of the Part D or the current Pharmacy Assistance Program copayment. Dual eligibles are also included and would not have to pay any new copayments or other cost-sharing associated with the drug benefit. The state would make enrollment in a Part D plan a condition of enrollment in the Pharmacy Assistance Program, but it would not designate a preferred plan. It would automatically enroll

beneficiaries in the low-income subsidy. If enacted, the program would create comprehensive wraparound coverage for its beneficiaries. The bill is pending in the legislature and has received a favorable report from a House committee.

- **Maryland**: Maryland has enacted a law[19] that would create two wraparound programs. For dual eligibles and other Medicare beneficiaries who qualify for the low-income subsidy, the scope of the assistance is left up to the state's Department of Health and Mental Hygiene. The Department would have the authority to automatically enroll these beneficiaries into a preferred drug plan, making the program a "non-qualified" SPAP. (See the Appendix discussion: "Non-Qualified State Pharmacy Assistance Programs: Can States Go It Alone?"). Higher-income individuals would receive partial premium assistance and help with deductibles and co-insurance. Although many important details of the plan have yet to be determined, it could potentially create very valuable wraparound assistance.

Not all states are moving in a positive direction, however. Michigan will end its State Pharmacy Assistance Program effective December 31, 2005. The state has not decided if it will offer any other form of supplemental wraparound coverage to any beneficiaries.

Conclusion: Building for January 2006 and Beyond

Advocates and state officials need to start planning now if they intend to help Medicare beneficiaries by providing wraparound programs for the Part D drug benefit. Existing State Pharmacy Assistance Programs are the most promising tool they can use to accomplish this goal, and advocates need to be involved in making sure that these programs continue past December 2005 and reflect the varying needs of Medicare beneficiaries.

As the Part D benefit evolves, it will become increasingly clear where the biggest gaps in the benefit lie: Are financial burdens such as copayments, premiums, or co-insurance significant barriers to obtaining drugs? Will the limitations on formularies be significant problems, especially for sicker beneficiaries? Experience will guide how states should respond, and advocates need to be alert to the needs of beneficiaries. In states where Pharmacy Assistance Programs do not exist, it is a good time to begin the process of creating one.

Over the next year, states will also face sizable logistical challenges when working to ensure that beneficiaries enroll in the appropriate Part D plan and the low-income subsidy. State officials and advocates should consider ways to work within the rules set up by CMS. Changing the CMS rules regarding steering beneficiaries to a particular Part D plan, or even the Medicare legislation itself, may be worthwhile long-term strategy options. In the meantime, however, there is much work for state policy makers and advocates to do in making sure that the holes in the Part D drug benefit get filled.

Endnotes

[1] Thomas Trail, Kimberly Fox, Joel Cantor, Mina Silberberg, and Stephen Crystal, *State Pharmacy Assistance Programs: A Chartbook* (New York: The Commonwealth Fund, August 2004), pp. 6-7. More than 20 of these states offer benefit programs; the remainder provide discounts on drugs.

[2] Memorandum from Leslie Norwalk, Deputy Administrator, Centers for Medicare & Medicaid Services, to Potential Part D Sponsors, State Medicaid Directors, and State Pharmacy Assistance Programs (SPAPs), March 29, 2005.

[3] See definition of "Incurred Costs" under 42 C.F.R. § 423.100.

[4] Financial help from individuals like family members, or from charities, can count toward a beneficiary's TrOOP so long as it does not meet the CMS definition of "insurance."

[5] This process is called "facilitated enrollment," as it will take place after the initial enrollment period is over. CMS is expected to issue details of this policy at a later date. Preamble to the final regulations, 70 *Federal Register*, p. 4,209 (January 28, 2005).

[6] Whether a State Pharmacy Assistance Program is actually a personal representative is a matter of state law, and programs can adjust their application forms to meet their state's requirements. Preamble to the final regulations, 70 *Federal Register*, p. 4,373 (January 28, 2005); 42 C.F.R. § 423.772

[7] Thomas Trail, Kimberly Fox, Joel Cantor, Mina Silberberg, and Stephen Crystal, *State Pharmacy Assistance Programs: A Chartbook*, op. cit., p. 14.

[8] Centers for Medicare & Medicaid Services, "CMS Responses to Recommendations made by the State Pharmaceutical Assistance Transition Commission," p. 1, available online at http://www.cms.hhs.gov/faca/spatc/respspatcrec.pdf.

[9] Because some states have more generous income and asset standards for their MSP programs, and because states must screen applicants for MSP eligibility, it can be advantageous to have a state Medicaid agency process the application rather than SSA.

[10] Kimberly Fox, *Lessons from Implementation of Medicare Rx Discount Cards in State Pharmacy Assistance Programs and Implications for Part D* (Washington: Rutgers Center for State Health Policy, February 4, 2004).

[11] Section 1860D-22(b)(2) of the Social Security Act, as added by the MMA (Pub. L. No. 108-173).

[12] Memorandum from Leslie Norwalk, Deputy Administrator, Centers for Medicare & Medicaid Services, op.cit.

[13] Centers for Medicare & Medicaid Services, "Qualified SPAP Guidelines," p. 4.

[14] Ibid., p. 3.

[15] Centers for Medicare & Medicaid Services, "Coordination and Collaboration between Part D Plans and State Pharmaceutical Assistance Programs," p. 2.

[16] Preamble to the final regulations, 70 *Federal Register*, p. 4,321 (January 28, 2005).

[17] Centers for Medicare & Medicaid Services, "CMS Responses to Recommendations made by the State Pharmaceutical Assistance Transition Commission," op. cit., p. 6.

[18] Connecticut H.B. 6846.

[19] Maryland H.B. 324, signed by the Governor on May 10, 2005.

Appendix

Non-Qualified State Pharmacy Assistance Programs: Can States Go It Alone?

As noted on page 6, the MMA prohibits states from "discriminating" against any Part D plan, and CMS has interpreted this provision as forbidding any State Pharmacy Assistance Program (SPAP) from automatically enrolling beneficiaries in a preferred Part D plan. If a state does designate a preferred drug plan, its program will lose its status as a "qualified" SPAP and become a "non-qualified" SPAP. This means that contributions towards beneficiaries' drug costs will not count towards their true out-of-pocket limit (TrOOP), thus defeating one of the major advantages SPAPs have over other kinds of supplemental drug coverage. In addition, CMS has stated that any non-qualified SPAP will lose access to the transitional grants CMS has provided to SPAPs.[a] However, CMS has not said that a non-qualified SPAP is impermissible, and it appears that, under the text of the law, SPAPs can operate without being "qualified."

Why would a state want to take such a risk—What would happen if a state went ahead and designated a preferred drug plan and automatically enrolled its SPAP beneficiaries into that plan? Doing this would carry several benefits. It could make delivery of a wraparound benefit considerably easier—the state could select a plan with an appropriately comprehensive formulary and pharmacy network, as well as the lowest prices for the drugs most often used by program beneficiaries. And coordinating with only one drug plan would make administering a wraparound benefit much simpler.

There may be circumstances in which operating as a non-qualified SPAP could be a good decision for a state. The fact that SPAP contributions count toward a beneficiary's TrOOP is most advantageous when beneficiaries have very high drug costs—in excess of the catastrophic limit of $5,100 a year. For these beneficiaries, Part D's catastrophic benefit acts as a stop-loss for both the beneficiary and the SPAP. However, if most beneficiaries' costs do not exceed the catastrophic limit, then it may make no difference to a state whether or not its contributions count toward reaching the TrOOP limit for the year. States will have to examine their beneficiaries' drug expenses to determine if becoming a non-qualified SPAP is worthwhile.

In addition, it may make little financial difference to an SPAP whether its contributions count toward beneficiaries' TrOOP when it comes to full dual eligibles and other low-income beneficiaries. When these beneficiaries reach their catastrophic limit, they no longer have to make any copayments. If a state had a qualified SPAP, the SPAP would be relieved of these costs as well, whereas a non-qualified SPAP would have to keep making these copayments for a while longer. However, the savings a qualified SPAP might accrue from not having to make these copayments may be relatively small, and they may not offset the administrative costs of setting up a qualified SPAP for this population. At this stage of Part D implementation, however, there are no definitive answers as to which path would be best for a state to follow.[b]

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[a] Memorandum from Leslie Norwalk, Deputy Administrator, Centers for Medicare & Medicaid Services, to Potential Part D Sponsors, State Medicaid Directors, and State Pharmaceutical Assistance Programs (SPAPs), March 29, 2005.

[b] States considering establishing non-qualified SPAPs should note that recent guidance from CMS explicitly criticize proposals where states would share a portion of a preferred plan's rebate. Ibid.

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