

**Prescription Drug Access and Affordability
among the Vermont Medicare-Eligible Population
and Impact of Medicare Part D**

**Prepared for the
Vermont Division of Health Care Administration**

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Background and Objectives

The 2005 Vermont Household Health Insurance Survey (VHHIS) was conducted to better understand current levels of access to care and health insurance coverage in Vermont. It also serves as an update to similar information collected in the 2000 VHHIS, thus permitting analysis of trends in insurance coverage and access.

Using the findings from both surveys and other sources, this Issue Brief examines prescription drug access and affordability among the Medicare-eligible population in Vermont prior to and during the early stages of the implementation of Medicare Modernization and Prescription Drug Improvement Act (Medicare Part D). In addition, we compare eligibility estimates from the 2005 VHHIS with actual enrollment in the Medicare Part D program and the state sponsored Low Income Subsidy (LIS) program that provides financial subsidies to low-income beneficiaries.

Approximately 15% of all Vermonters reported having Medicare coverage in the 2005 VHHIS. The majority of these Medicare beneficiaries are over 65 years with approximately 17% of Medicare beneficiaries under 65 and disabled. Before Congress passed the Medicare Modernization and Prescription Drug Improvement Act in 2003, Medicare did not offer prescription drug coverage. As of January 1, 2006, all Medicare beneficiaries are eligible for prescription drug coverage under Part D, provided they enroll for this benefit. The initial period for enrollment in Medicare Part D began on November 15, 2005 and ended on May 15, 2006.

As the new Medicare Part D program is implemented, the information and trends on prescription drug access and affordability presented in this Brief will help the state of Vermont identify populations that may require additional information and assistance. This may help the state target education and outreach efforts to Medicare beneficiaries who need it the most. It should also help the state understand what populations may continue to face gaps in prescription drug coverage.

Methods

The 2005 VHHIS was a random digit-dialed telephone survey of 4,468 randomly-selected households in Vermont conducted between November 2005 and February 2006. This included a total of 4,006 surveys of households from the general population (insured and uninsured) and an additional 462 surveys of uninsured households to obtain a larger sample of the uninsured. From the general population survey we obtained information on 9,754 Vermont residents, including 1,398 Medicare beneficiaries. The margin of error for the general population survey was $\pm 1.5\%$ and the response rates to the general population was 58%.¹ The 2005 VHHIS, which was conducted during the Medicare Part D enrollment period, asked Vermont seniors about their knowledge and perceptions about the new drug benefit.

Access and affordability issues of prescription drugs in Vermont

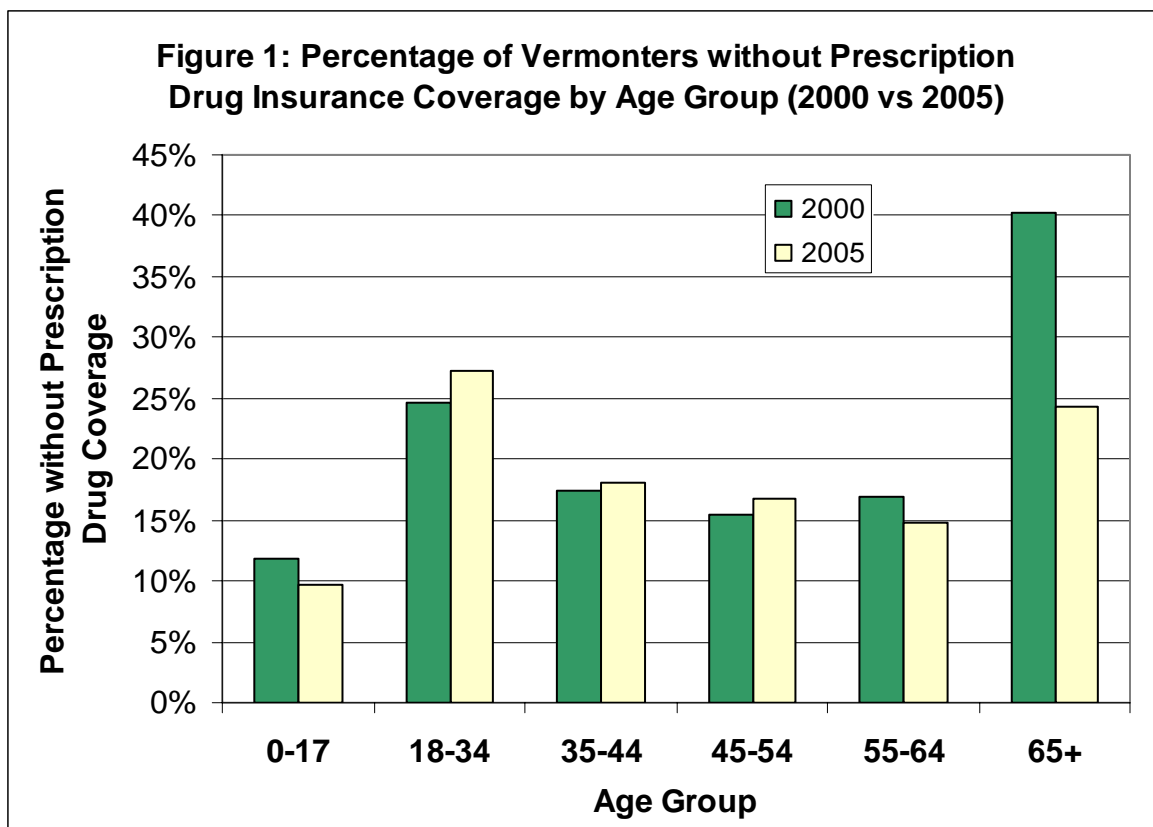
Prescription drug coverage in Vermont before Medicare Part D

Prior to the passage of Medicare Part D in 2003, Medicare did not cover prescription drugs. This resulted in nearly a quarter (23%) of all Medicare enrollees without any type of prescription drug coverage in 2005. Prescription drug coverage among Vermont Medicare beneficiaries in 2005 was up from 2000 when nearly 40% of all elderly and disabled Medicare beneficiaries were

¹ Calculated using the Council of American Survey Research Organizations (CASRO) methods.

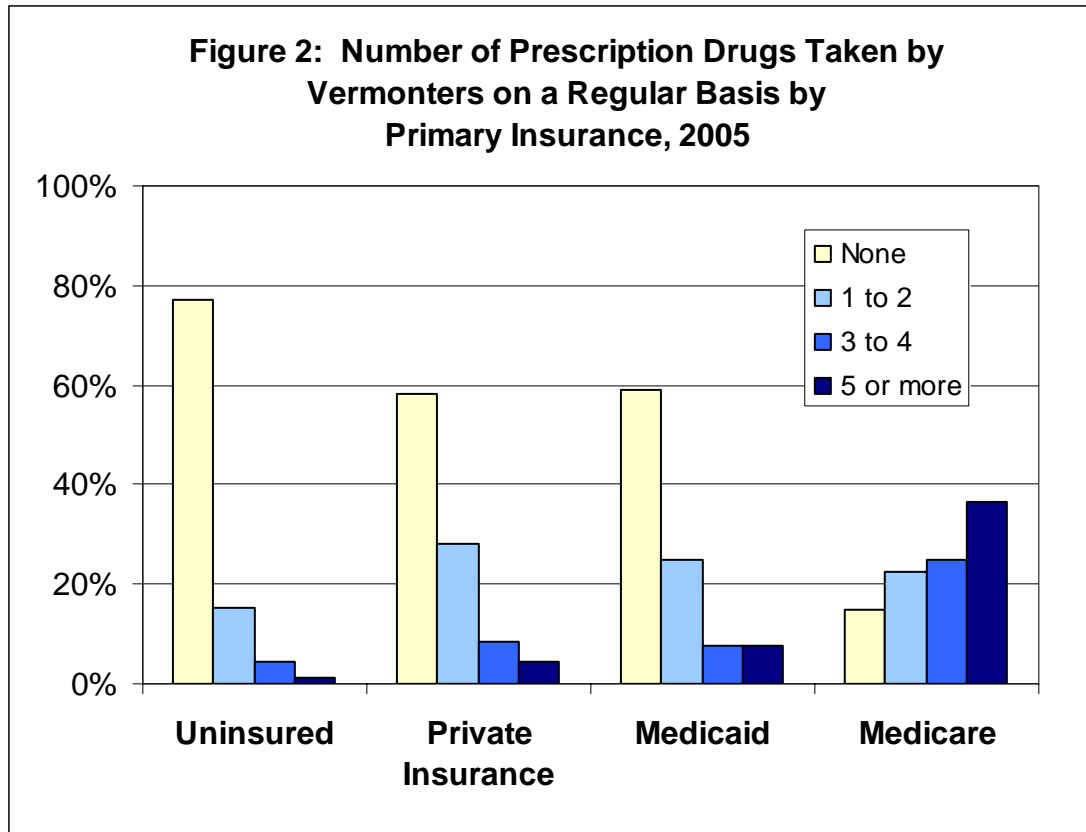
without coverage². There are several possible factors that help explain the increase in prescription drug coverage among Medicare enrollees during this time period. One factor is that the number of dually enrolled Medicare/Medicaid beneficiaries as a subset of all Medicare recipients has gone up significantly. In addition, the number of Medicare recipients who reported getting coverage through state prescription drug plans – Vscript, VHAP Pharmacy, and Health Vermonters – has increased since 2000.

The largest drop in the size of the population without prescription drug coverage between 2000 and 2005 occurred in the over 65 population, nearly all of whom (97%) are enrolled in Medicare—see Figure 1. During the same time period, the population without prescription drug coverage stayed about the same for most other age groups. This indicates that, even before Medicare Part D, Medicare beneficiaries were already gaining better access to drug coverage. However, in 2005, the percentage of Medicare recipients without drug coverage was still larger than Vermonters without coverage in all other age groups except for the 18-34 age group.



The lack of prescription drug coverage for the Medicare population is a particular concern because, as people age or become disabled, they are more likely to develop medical conditions that require them to take prescription drugs. For example, the 2005 VHIS shows that Vermont Medicare beneficiaries are far more likely to be on 3 or more drugs on a regular basis than groups with other types of insurance – see Figure 2.

² Department of Banking, Insurance, Securities and Health Care Administration, “Access to and Affordability of Prescription Drugs for Vermont Seniors”, Issue Brief Number 3, November 2001.



Prior to 2006, when the Medicare Part D drug coverage benefit began, the state of Vermont provided drug coverage to those dually eligible for Medicare and Medicaid through the state Medicaid program (dual eligibles). Vermont also was one of only a dozen or more states that offered additional drug coverage to other low-income Medicare-eligible residents. Through three state pharmacy programs created in the 1990s – the Vermont Health Access Plan (VHAP) Pharmacy, VScript, and VScript Expanded – Vermont offered prescription drug coverage to individuals whose income was higher than the Medicaid eligibility levels but lower than 225% of the federal poverty level.

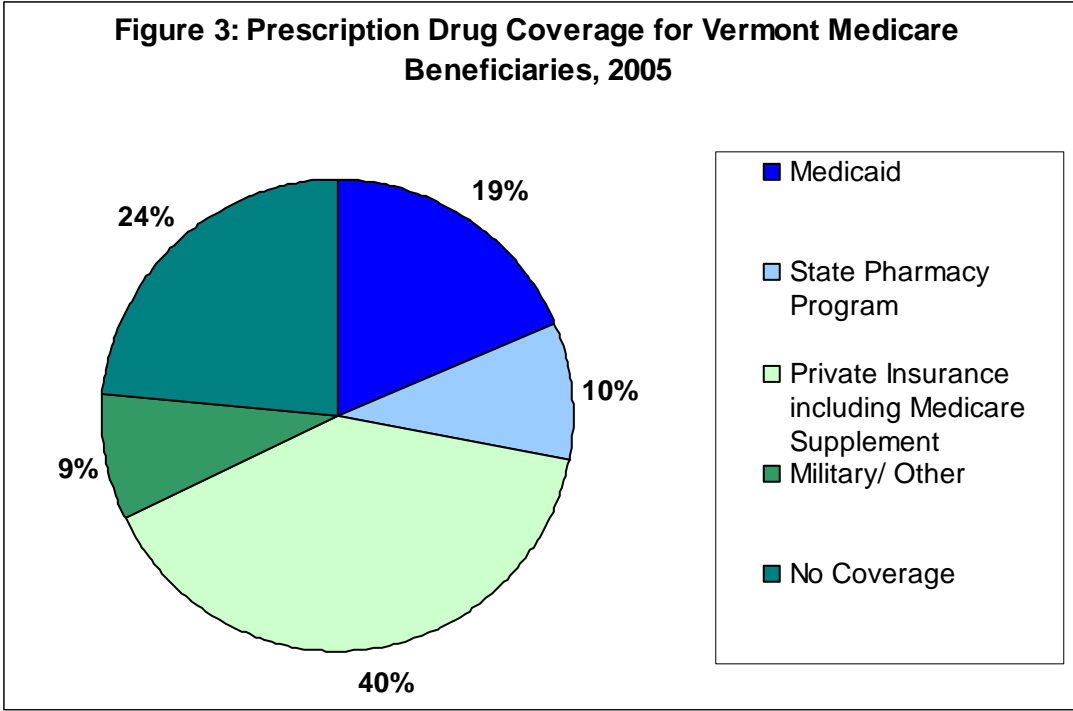
Since 2002, Vermont also has offered the Healthy Vermonters program to extend Medicaid-level discounts on most drugs to Vermonters who do not qualify for the other state pharmacy programs and who either have no drug coverage or an annual maximum prescription benefit on their commercial insurance plan. While not a substitute for insurance, Healthy Vermonters can help reduce the costs of prescription drugs by allowing recipients to purchase drugs at the Medicaid payment rate, a price lower than that paid by cash-paying customers – see Table 1 for information on the various state pharmacy programs.

Table 1: Eligibility and Benefits in Vermont State Pharmacy Programs, 2005

<i>Office of Vermont Health Access Plan</i>	<i>Eligibility</i>	<i>Benefit</i>
Vermont Health Access Plan (VHAP) Pharmacy	Up to 150% of poverty level	Covers most drugs \$13 monthly premium No co-payments or deductibles
VScript	151% - 175% of poverty level	Covers maintenance drugs \$17 monthly premium No co-payments or deductibles
VScript Expanded	176% - 225% of poverty level	Covers maintenance drugs \$35 monthly premium No co-payments or deductibles
Healthy Vermonters	Medicare beneficiaries up to 400% of poverty level; All others up to 300% of poverty level.	Obtain most drugs at the Medicaid payment rate

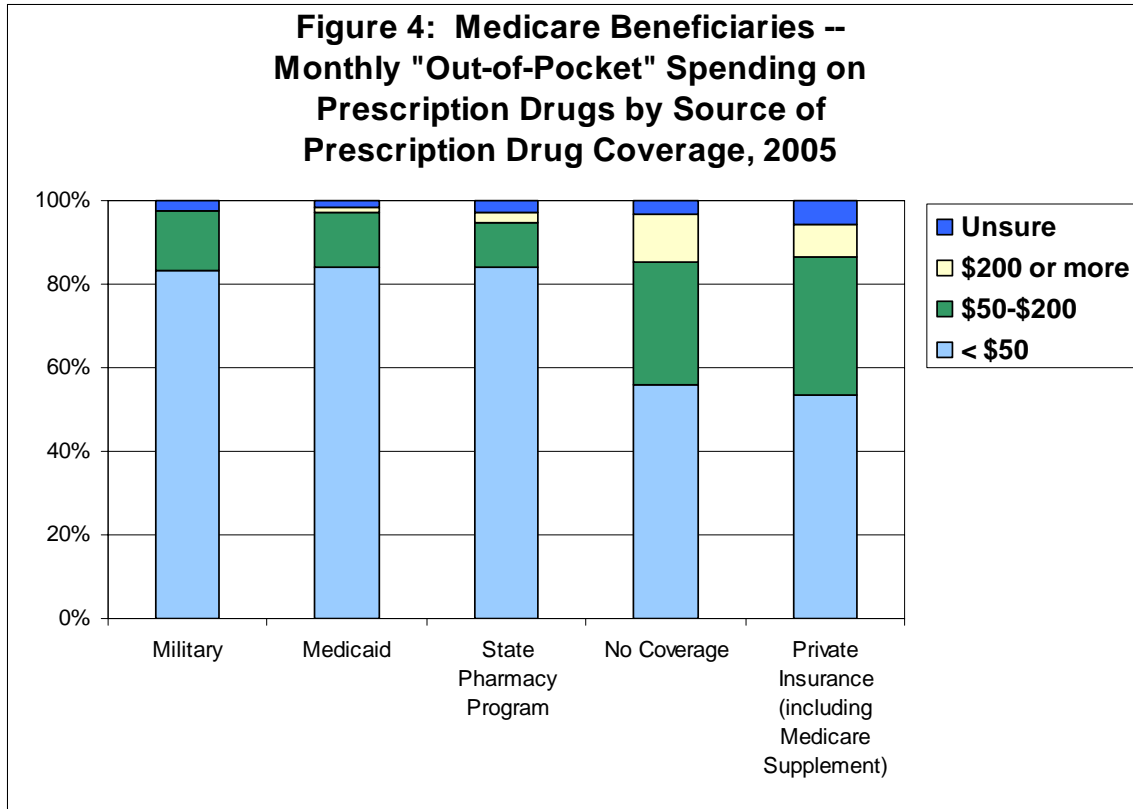
Medicaid and state pharmacy programs helped provide drug coverage to nearly 30% of the Medicare beneficiaries in the state in 2005 – see Figure 3. Most elderly and disabled Medicare-eligible Vermonters who had some prescription drug coverage obtained it through Medicare Supplemental plans (26%), Medicaid (19%), private insurance (14%), or the State Pharmacy Programs (VHAP, VScript, or VScript Expanded) (10%).

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Less than 1% of Vermont Medicare beneficiaries used the Healthy Vermonters program as their *primary* prescription drug coverage program. Most Healthy Vermonters beneficiaries had incomes above 225% FPL and were not eligible for other programs.

“Out-of-pocket” expenditures for prescription drug purchases by Medicare beneficiaries ranged by drug coverage plan and tended to be lowest for those persons with military coverage—see Figure 4. The next lowest expenses were for those enrolled in Medicaid or State Pharmacy prescription drug programs. These beneficiaries meet low-income eligibility requirements and, thus, receive significant subsidies through these programs to help them afford the cost of the drugs. Medicare beneficiaries who had no prescription drug coverage or private insurance with prescription drug coverage (including a Medicare supplement) had the highest “out of pocket” expenses.

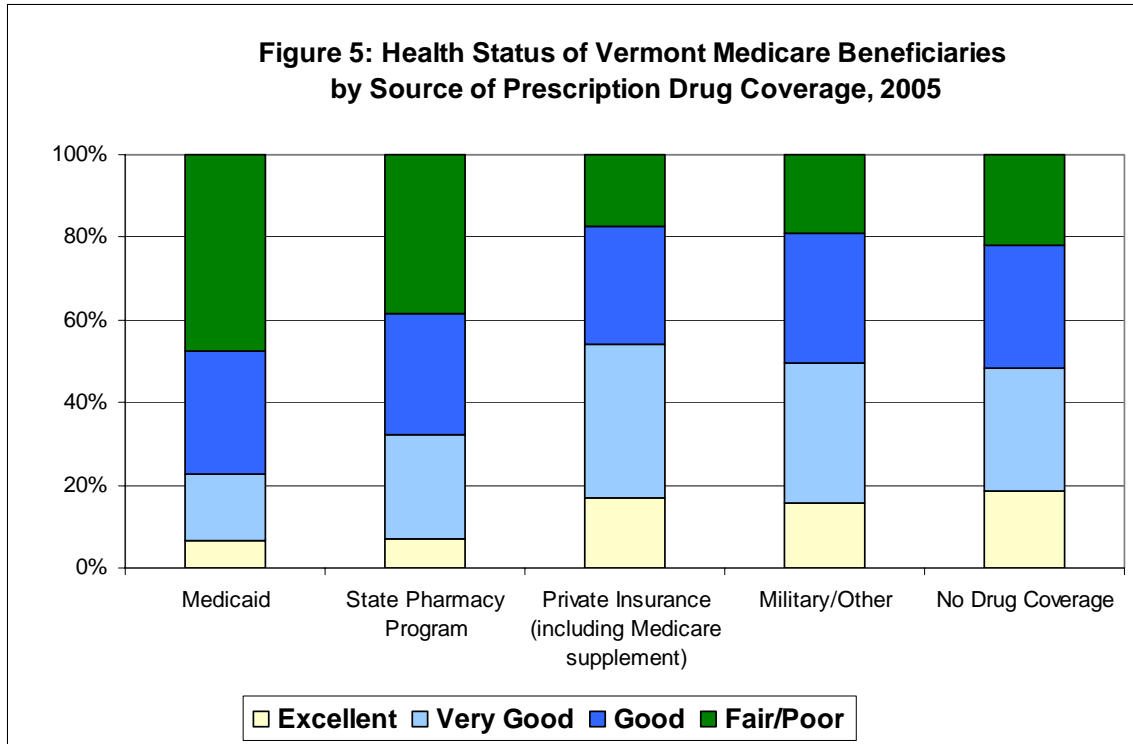


Characteristics of Medicare Vermonters without Drug Coverage

Many Vermonters without prescription drug coverage earn above 225% FPL and, thus, were ineligible for the State Pharmacy Assistance Programs (SPAP). However, more than half of Vermont Medicare-eligibles without drug coverage were earning below 225% FPL and were potentially eligible for but not enrolled in existing state and federal prescription drug coverage programs prior to Medicare Part D.

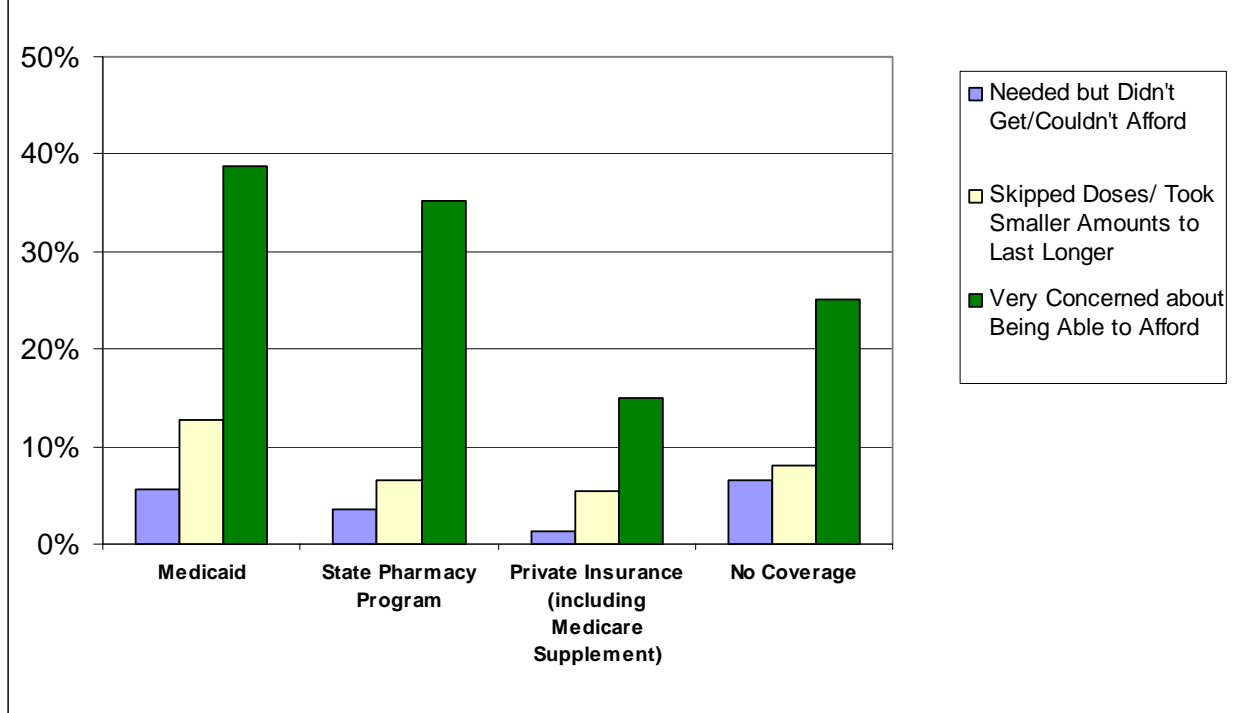
We do not know why so many people were not enrolled, for this group includes many people who have prescription drug needs. Approximately 70% regularly take at least one prescription medication, and, among those that take prescription drugs, drug costs average about \$125 per month. Non-participation could be due to lack of program awareness, a ‘welfare’ stigma of joining state-subsidized programs, or an inability to afford the premiums or cost-sharing. The high percentage of uninsured that are potentially eligible for existing programs suggests that more outreach may be needed to inform them about both the state benefit programs, the new Medicare Part D benefit and the low-income subsidies for which many of these people may also qualify.

Self-reported health status of Vermonters with Medicare varied by prescription drug coverage plan—see Figure 5. Medicare beneficiaries also enrolled in Medicaid or in a SPAP were in poorer health than those enrolled in other programs or without drug coverage.



Perhaps because their health status tends to be better, Vermont Medicare beneficiaries without drug coverage were less likely to forego needed drugs due to costs or to skip doses than Medicaid or state pharmacy program enrollees, but were slightly more likely compared to those receiving private prescription drug coverage—see Figure 6.

Figure 6: Barriers to Prescription Drugs for Vermont Medicare Beneficiaries by Source of Coverage, 2005



New Medicare Part D prescription drug coverage and impact on Vermont beneficiaries

The Medicare Part D drug assistance program that became effective January 1, 2006 offers coverage to the previously uninsured if they voluntarily elect to enroll and pay the required premiums and cost-sharing. Additionally Medicare Part D represents a change in coverage for persons previously covered under Medicare supplements, Medicaid and state pharmacy programs. Effective January 1, 2006, Medicaid no longer offers drug coverage for individuals dually eligible for Medicare and Medicaid. Instead, dual-eligibles receive their drug coverage through Medicare Part D plans. These enrollees are at risk of more limited coverage to the extent that they must pay higher co-payments or face more limited formularies in private Part D plans than what was previously available through Medicaid. In November 2005, the state of Vermont randomly assigned all dual-eligibles and Medicare-eligible individuals enrolled in VHAP-Pharmacy, VScript, or VScript Expanded that had not voluntarily selected a plan to be automatically enrolled into Part D low-premium plans. Medicare-eligible persons who were in the Healthy Vermonters plan must voluntarily sign up for a Medicare Part D plan and can keep Healthy Vermonters for drugs not covered under Part D.

In recognition that many Medicare beneficiaries would be unable to afford prescription drugs even under the new Medicare Part D benefit, the Medicare Modernization and Prescription Drug Improvement Act also included provisions for financial subsidies for low-income beneficiaries, the Low Income Subsidy (LIS). The following chart summarizes the features of Part D and the low-income subsidies available to those that qualify.

Table 2: Medicare Part D and Low-Income Subsidy (LIS) Eligibility and Benefits.^a

<i>Eligibility Level^b</i>	<i>Premium</i>	<i>Deductible</i>	<i>Copay</i>	<i>Copay After Catastrophic Limit^e</i>	<i>Coverage Gap</i>	<i>Enrollment</i>
Dual-eligible individuals regardless of assets ^c	None	None	\$1/\$3 ^d (generic/brand)	None	None	Auto-enrolled
Income below \$12,920 (\$17,321 for couples) meeting asset test	None	None	\$2/\$5 (generic/brand)	None	None	Facilitated by CMS
Income between \$12,920 (\$17,321) and \$14,355 (\$19,245) meeting asset test	25 to 75% of full premium, depending on income	\$50	15% of drug cost	\$2/\$5 (generic/brand)	None	Facilitated by CMS
Income above \$14,355 (\$19,245)	Approximately \$32 per month average	\$250	25% of drug cost	5% of drug cost	\$2,250 to \$5,100	Up to individual

^a Chart adapted from Fineman et al. (2005) Implementing Medicare Part D in California: A Scan of the Landscape.

<http://calendow.org/reference/publications/pdf/npolicy/Medicare%20D%20Scan%20Report.pdf>

^b Income limits are tied to the federal poverty guidelines, which are updated annually. Values shown reflect guidelines published in February 2005.

^c Institutionalized dual-eligibles will have no cost-sharing responsibilities. However, beneficiaries receiving home and community-based waiver services or living in assisted living facilities will be responsible for co-payments

^d Dual-eligible beneficiaries with incomes above \$9,570 (\$12,830 couple) will have co-pays of \$2 (generic) and \$5 (brand)

^e Set at \$5,100 in total drug spending for 2006.

Medicare Part D also eliminated drug coverage under Medicare Supplemental insurance plans in 2006. Those with Medicare Supplemental insurance plans may retain their MediGap plans covering drugs until the policy period ends but then must sign up for a Part D plan if they want to continue coverage. Survey estimates suggest that the majority of Vermont residents with a Medicare Supplement purchased their plan directly or paid the premium out of pocket. All of these individuals need to enroll in a Part D plan or risk losing drug coverage once their policy period ends. Those who received their Medicare Supplement through their current or former employer's health or retirement benefits and may or may not have to enroll in Part D plans if their employer received a subsidy from the federal government to maintain drug coverage.

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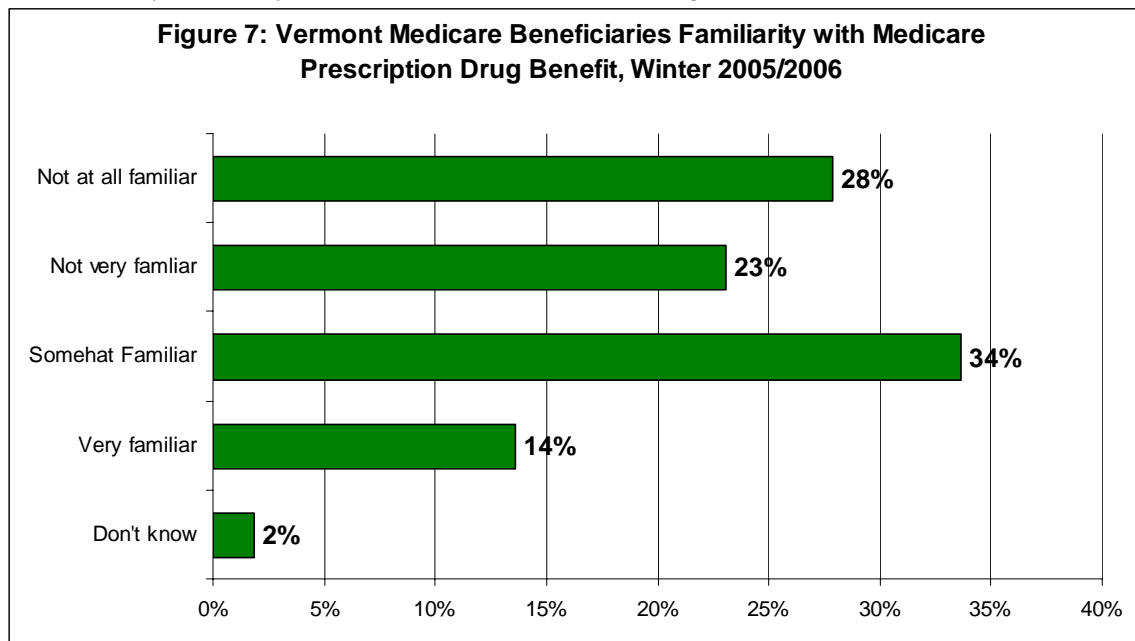
Those with private insurance provided through an employer that elected to receive a subsidy to maintain its coverage could either remain in their existing plan or sign up under Part D, but could not keep both forms of coverage. Persons with employer sponsored coverage are at risk of losing their entire health coverage if they mistakenly signed up for a Part D plan.

All of those without drug coverage could potentially benefit from Part D, but those most likely to benefit are persons eligible for the low-income subsidies. About 30 percent of Vermont beneficiaries who currently lack drug coverage meet the income eligibility requirements for Part D low-income subsidies.

Vermont Seniors: Knowledge of and Interest in Medicare Part D

The new Medicare Part D benefit has the potential to provide some relief for Vermont Medicare beneficiaries not currently covered by state programs and even to enhance coverage for those in state programs³, but only if people are familiar with the benefit, understand how it works, and elect to voluntarily enroll.

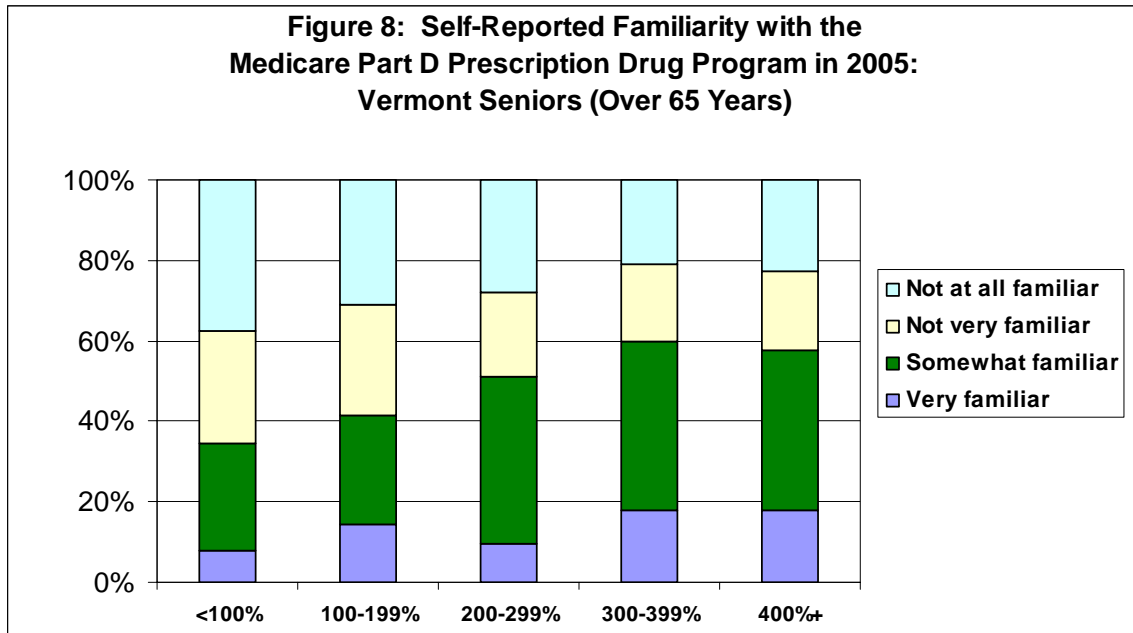
In the 2005 VHHIS, more than half (51%) of Vermont seniors (65 and older) reported that they were not at all or not very familiar with the new Medicare prescription drug benefit.⁴ Only 14% indicated they were very familiar with the benefit— see Figure 7.



³ Since VScript Expanded coverage is limited to maintenance drugs only, enrollees are likely to have broader access under Part D for non-maintenance drugs.

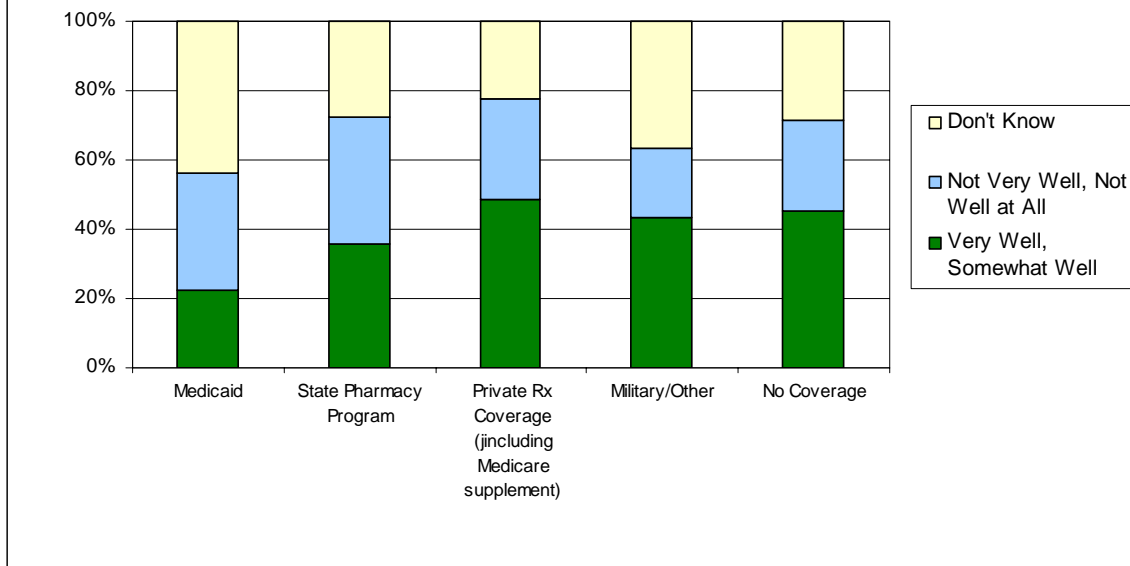
⁴ The survey questions on knowledge of and interest in the Medicare Part D prescription drug benefit were asked only of respondents age 65 and older. These questions were asked in late 2005 during the early phase of enrollment.

There were no differences in familiarity with the drug benefit by age of the senior. However, there were some income-related differences. Vermont seniors with incomes at or greater than 200% of the Federal Poverty Level were more familiar with the new drug benefit than those making less than 200% of the Federal Poverty Level, who stand to gain the most from the low-income subsidies – see Figure 8.



Even fewer Vermont seniors reported understanding the benefit. Two-thirds indicated that they had received information about the Medicare prescription drug benefit, but more than half of seniors (58 %) say they do not understand the Part D benefit well or are unsure whether they understand it. Only 12.5% said they understand it very well. Understanding of Medicare Part D varied significantly by source of existing drug coverage, with more than three quarters of the dual-eligibles indicating they did not understand well or are unsure compared to nearly half of those with private coverage, including Medicare supplements – see Figure 9.

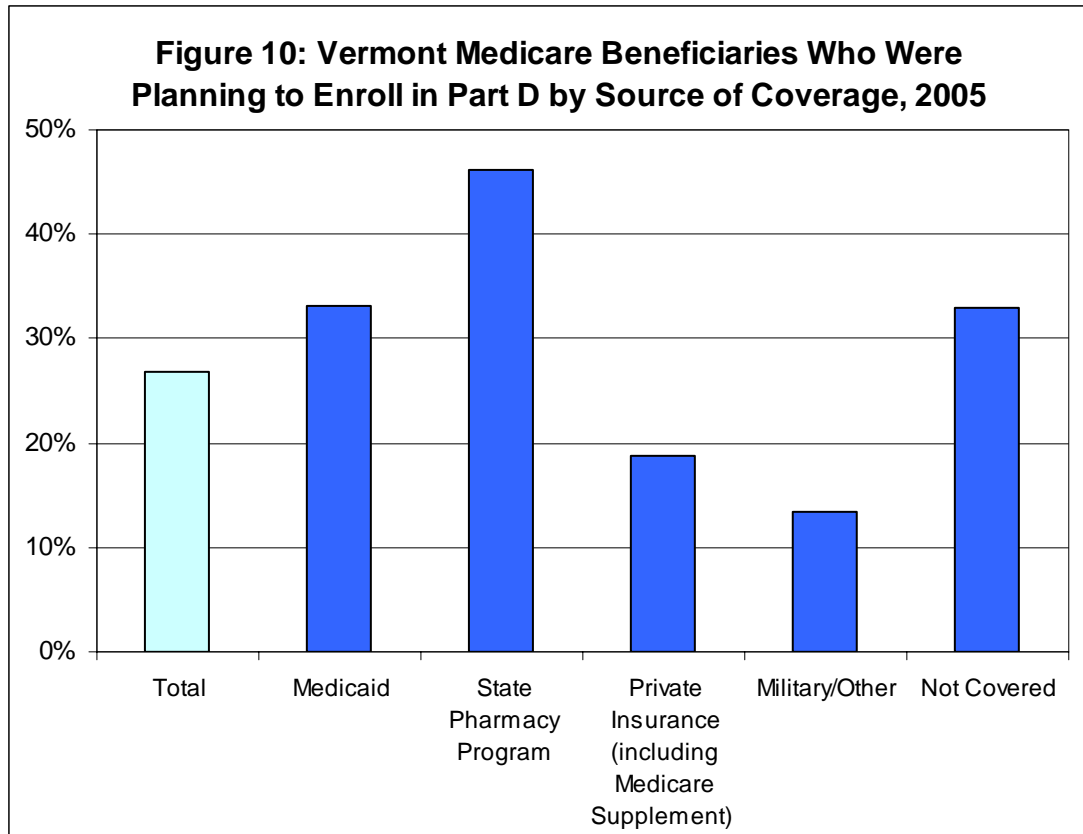
**Figure 9: Understanding of Medicare Drug Benefit
by Primary Source of Rx Coverage: Vermont Seniors, 2005**



Most seniors said they did not intend to enroll in Medicare Part D; only 27% said they intended to enroll. This may reflect their lack of understanding of the benefit at the time of the survey. More than half of Vermont Medicare beneficiaries would need to enroll just to maintain drug coverage they already have and another quarter currently have no coverage and could potentially benefit from it.⁵ Of those who said they were not planning to enroll, 42% said the reason for their decision is that they already had a plan while another 28% simply said they were not interested and 7% said they could not afford it.

There were no significant differences based on age or income in whether people were planning to enroll, but enrollment plans did vary somewhat by source of current drug coverage – see Figure 10. Those with private insurance coverage and military/other coverage were least likely to have plans to enroll, possibly because their current coverage would still be available. Less than a half of VHAP enrollees and a third of Medicaid enrollees said they had plans to enroll, despite the fact that the state auto-enrolled Medicaid and VHAP/VScript enrollees into Part D plans. This indicates that many VHAP and Medicaid enrollees were not aware that the transition was occurring. In addition, only a quarter of people with Medicare supplements that included drug coverage said they had plans to enroll in Part D plans. This could signal a potential loss of coverage resulting from these individuals not being fully aware that their existing drug coverage in their Medicare supplement will no longer be available or it could reflect that they are delaying making plans to enroll until their current policy expires.

⁵ Includes Medicaid and state pharmacy program enrollees that are mandated to enroll in Part D plans, and all persons with Medicare supplemental coverage with Rx that will no longer be available once their policies expire.



Of Medicare recipients without prescription drug coverage, a greater percentage of those with higher incomes reported that they were planning to enroll in Medicare Part D compared to those with lower incomes, although the differences were not significant. Vermont Medicare beneficiaries without drug coverage just above the federal low-income subsidy level, were the least likely to have plans to enroll.

What Vermont is doing to help with the transition to Medicare Part D

In addition to assisting the dual-eligibles and VHAP-Pharmacy, VScript, or VScript Expanded enrollees by auto-enrolling them into plans, Vermont was one of the first states to provide emergency coverage to address initial Part D enrollment and systems problems. In January, Medicare Part D data systems were not recognizing many persons that had been auto enrolled as being enrolled in a Part D plan or were incorrectly charging co-payments. The state provided emergency coverage to both the dual-eligible population and state pharmacy program enrollees until most Part D enrollment and LIS eligibility problems were resolved.

The state also has elected to provide Part D wrap-around benefits for both the dual-eligibles and state pharmacy program enrollees to maintain comparable coverage to what they had previously. For the dual-eligibles, the state will pay Part D co-payments that were previously not required under the state Medicaid program. For enrollees in the state pharmacy programs, Vermont created a new VPharm program which will help pay the cost not covered by Part D or the low-income subsidies, including premiums, deductibles, co-payments, coinsurance, and the coverage gap. It will also help cover certain drug classes that are excluded from Part D and may cover some off-

formulary drugs if medically necessary. All VPharm enrollees must enroll in Part D plans and apply for Medicare low-income subsidies if eligible.

As the state continues to coordinate with the new Medicare benefit, it is focusing primarily on maximizing enrollment in the Part D plans and in the low-income subsidies in order to maximize federal funds and minimize state contributions as the secondary payer. For example, the state has already eliminated the asset test for its Medicare Savings Programs,⁶ in order to get more individuals deemed eligible for the low-income subsidies⁷. The number of applications approved as LIS eligible through the SSA LIS application process has been much lower than expected, averaging 43% of those applied nationally and 40% in Vermont. Eliminating the asset test in the Medicare Savings Programs, may help to get more people deemed eligible without going through the SSA application process.

Other states are pursuing similar actions as Vermont. Most states with State Pharmacy Assistance Programs (SPAPs) are attempting to hold their enrollees harmless by providing supplemental coverage to the Part D benefit up to their current cost-sharing. Very few SPAPs are considering further eligibility or benefit expansions at this point, with most waiting to see the impact of Medicare Part D on state program budgets. Those that have expanded eligibility either expanded to disabled persons (NV, MO), that are already covered by the state of Vermont or expanded income eligibility to levels at or below Vermont's current income eligibility levels (AK, IN, MO). Maine has elected to expand the number of drugs it covers during the doughnut hole to all Part D covered drugs rather than limiting to the 14 conditions previously covered by their state program. For the duals, states are generally much less likely to wrap around Part D. Vermont is one of only a few states that are covering the Part D co-payments for the duals or offering to cover off-formulary drugs in cases of medical necessity.⁸

The Future outlook of prescription drug access in VT

The 2005 VHHIS indicates that only a quarter of Medicare-eligible Vermonters planned to enroll in Part D. However, this may underestimate the actual numbers that enroll. For example, all dual-eligible persons and those in state pharmacy enrollees were enrolled automatically even though only a third was aware that this occurred.

Actual Part D enrollment data currently available suggest that a much higher percentage of Vermonters have enrolled. Of the approximately 60,000 Vermont Medicare eligible persons that were found on the VHHIS to either have no drug coverage or were enrolled in a drug plan that may be ending and may need to enroll in a Part D plan, 41,000 or approximately 70% were enrolled in Part D plans as of April 2006⁹. However, another 30% of these individuals had not enrolled, suggesting that many were not enrolled by the end of the open enrollment period.

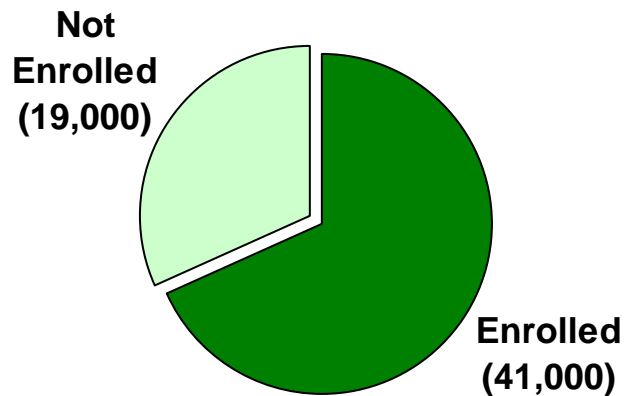
⁶ Medicare Savings Programs help pay for Medicare Part B premiums and cost-sharing for low-income individuals that meet certain income and asset criteria.

⁷ All dual-eligible persons and persons enrolled in Medicare Savings Programs are deemed eligible for the low-income subsidies. Everyone else must apply for the LIS through the Social Security Administration (SSA) or the state Medicaid agency.

⁸ Fox, K, Schofield, L. The Pharmacy Coverage Safety Net: Variations in State Responses to Supplement Medicare Part D. Muskie School of Public Service, University of Southern Maine, February 2006

⁹ CMS Part D Plan Enrollment Data as of 4/27/06 accessed at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp

**Figure 11: Enrollment in Medicare Part D
as of April, 2006:
Eligible Vermonters**



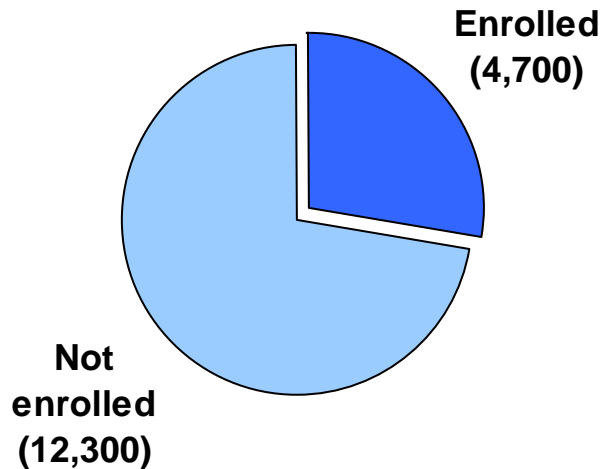
Some states (CT, DE, NJ, TX) plan to pay the Part D penalties that will be charged to beneficiaries not enrolling by May 15th¹⁰. Vermont may want to consider this strategy in the likely event that many will not be enrolled at that time. Near the end of the enrollment period, the federal government waived these late enrollment penalties for those who meet the requirements for the LIS to ensure that those who need Part D coverage the most but would have difficulty paying the penalty would receive coverage. Those not eligible for the LIS program will still face the late enrollment penalties, however.

The VHHIS did not collect asset information to determine the total number of Medicare Vermonters that are LIS-eligible. Based on income alone and excluding those already enrolled in Medicaid that were deemed eligible for LIS, an estimated 17,000 Vermont Medicare beneficiaries could be potentially eligible for the LIS and should apply. Based on SSA data, more than three quarters of these individuals (13,424) had applied for the LIS by March 2006, but only 4,715 (28% of estimated income-eligible) were determined eligible. SSA has not provided state-specific reasons for the eligibility denials, but has indicated that nationally 57% have been denied due to assets exceeding the resource limits¹¹.

¹⁰ Supplemental State Pharmacy Assistance Program Part D survey data provided by Kimberley Fox, Muskie School of Public Service, University of Southern Maine based on a survey conducted in Fall 2005.

¹¹ Accessed at Kaiser State Health Facts on May 25, 2006 at:
<http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicare&subcategory=Medicare+Drug+Benefit&topic=Low%2dIncome+Subsidy+Applications>

Figure 12: Vermonters Determined Eligible for the Low-Income Subsidies as of May 2006 as a Percent of Income-Eligible Vermont Medicare Beneficiaries



This gap in LIS approvals is important and will have ramifications for the state programs to the extent that many individuals that are denied LIS eligibility will be relying more heavily on the state pharmacy programs to supplement the basic Part D benefit. This will leave less state funds for other purposes. The actions already taken by Vermont to reduce the resource requirements for the Medicare Buy-in programs will help to avert LIS asset barriers but only to the extent that these eligibility changes are publicized. Raising income eligibility for these programs to be in-line with LIS income eligibility could also help to get more individuals automatically LIS eligible.

Once the state assesses its initial experience and level of savings coordinating with Part D plans using different cost-sharing approaches, the state may want to reassess its mechanism for paying plans or the number of plans with which it elects to coordinate benefits. Illinois and Pennsylvania are currently limiting the number of plans into which their enrollees may enroll. Illinois is also paying the plans on a capitated-basis with a reconciliation process, which limits the administrative burden of coordinating benefits. Some states are also investigating whether it is more cost-effective to pay higher premiums for enhanced plans than limiting coverage to those with low-income premiums only. Maine allows persons with high drug needs that are unable to find a benchmark plan that covers most of their drugs to enroll in an enhanced plan with which the state has a special contract. These are models that Vermont may wish to investigate in the future.

The VHHIS survey data also indicate that many people are currently eligible but not enrolled in state pharmacy programs and Medicaid. To ensure the best drug coverage for these individuals, the state may consider investing in greater outreach and education of the VPharm program to get people enrolled. The most effective method for getting people enrolled is to identify persons already enrolled in other state and federal low-income programs and automatically enroll them. The state of New Jersey has developed one application for its State Pharmacy Assistance Program, its property tax rebate program, reduced heating bill program, lifeline services, and most recently the Part D low-income subsidies. They have very high participation rates as a

result. Once initial Part D enrollment and payment issues are resolved, Vermont could also work with CMS to identify person's enrolled in Part D plans that could be automatically enrolled into the state programs. This would ensure that Vermont Medicare beneficiaries would get the best coverage available to them.