

Task Force *for a Healthier North Carolina*

Executive Summary of Final Recommendations on Medicare Part D and Access to Prescription Drug Coverage for North Carolina's Seniors

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Chair, Health and Wellness Trust Fund Commission

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THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

Task Force *for a Healthier North Carolina*

On November 16, 2006, Lieutenant Governor Beverly Perdue, Chair of the Health and Wellness Trust Fund Commission, announced the formation of the Task Force *for a Healthier North Carolina*. The Task Force was given a specific charge to hold public forums and make recommendations on strategies to improve access to health care in North Carolina for vulnerable and underserved populations, including: access to prescription drug coverage for seniors; access to public-sponsored health insurance for children; and access to health benefits for employees in small businesses. The Task Force *for a Healthier North Carolina* was created by a grant from the NC Health and Wellness Trust Fund Commission (HWTF). The Lewin Group was commissioned to prepare background policy briefings and to provide analytical support to the Task Force.

The Task Force *for a Healthier North Carolina* sponsored two public meetings to explore strategies to improve access to prescription drug coverage for North Carolina seniors. An initial public forum was held on November 16, 2006 in Chapel Hill, and an official Task Force meeting was held on December 13, 2006 in Raleigh.

The Task Force respectfully submits the following recommendations on strategies to improve access to prescription drug coverage for North Carolina seniors.

Co-Chairs

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Members

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Dr. Olson Huff, HWTF Commissioner
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RECOMMENDATIONS

Recommendation 1: Improving Outreach and Enrollment for Federal “Extra Help” Low Income Subsidy (LIS) Premium Subsidies and NCRx

The Lewin Group reports that approximately 102,000 Medicare beneficiaries in North Carolina either do not have prescription drug coverage or do not have coverage that is as good as the standard Medicare benefit. In addition, as of July 2006, about 91,000 North Carolina seniors eligible for federal “Extra Help” have not enrolled in the program. Finally, there are over 11,000 North Carolinians eligible for both Medicaid and Medicare who are expected to lose their automatic qualification for “Extra Help” for 2007.

In October 2006, Governor Easley announced NCRx, a premium assistance program to help lower-income seniors participate in the Medicare Part D prescription drug program. NCRx offers an \$18-per-month premium subsidy for eligible seniors. The Health and Wellness Trust Fund Commission (HWTF) approved \$24 million in funding over the next three years (2007-09) to support the new program. North Carolina seniors began applying for NCRx during the Medicare Part D open enrollment period (November 15-December 31, 2006) and the premium assistance became available in January 2007.

As of March 2007 and still very early in the enrollment process, NCRx had approved 3,849 applications. An additional 932 applications are being processed or are waiting for additional information. The enrollment period for NCRx was originally scheduled to coincide with the federal Part D enrollment period (November 15-December 31, 2006) but it has been extended without a formal deadline.

Enrolling in NCRx also allows individuals to take advantage of a “special enrollment period” for Part D prescription drug plans. Ordinarily, once an individual enrolls in a Part D plan they are locked into that plan for a year, until the next enrollment/plan switching period (November 15-December 31). Enrolling in NCRx, however, allows individuals to enroll in or switch their Part D plan at the time of NCRx enrollment. This may be particularly beneficial for individuals who are eligible but not enrolled in a prescription drug plan or for individuals in a plan that does not offer the best coverage for them (eg. a plan in which the formulary has changed and no longer includes some or all of their medications).

The Seniors Health Insurance Information Program (SHIIP) is North Carolina’s lead agency for answering questions and counseling Medicare beneficiaries and their caregivers about Medicare, Medicare Part D, and other health insurance concerns. SHIIP is a division of the Department of Insurance and has coordinators (paid staff and volunteers) located in all 100 counties. These coordinators help Medicare beneficiaries enroll in Part D plans, apply for the federal low-income subsidy (Extra Help), and respond to related questions and concerns. Funding for SHIIP—both state and federal dollars—helps pay for the coordinators and helpline staff to assist with Medicare Part D and NCRx enrollment.

The Task Force offers the following immediate recommendations to improve outreach and enrollment for Medicare Part D Extra Help and NCRx:

- 1.1 In order to meet the on-going demand for enrollment, outreach and Medicare Part D counseling, the SHIIP program will need consistent future funding. The Task Force supports reliable and sustainable federal as well as state funding to allow SHIIP to engage in strategic and long-term planning to meet the growing needs of the North Carolina Medicare population now and in the future. Through federal grants directed to state health insurance programs and with additional state funding to make up for any federal shortfall, SHIIP must have the resources to continue to provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities.
- 1.2 The Task Force recommends committing resources (potentially from within the existing NCRx administrative or program budget) toward additional community-based outreach and enrollment efforts. For example, small mini-grants (\$2500 to \$5000) could be made available to community-based organizations that serve seniors in an effort to assist with both the NCRx and Medicare Part D open enrollment period. Currently, there are more than 20 organizations comprising the Medicare Partners State Level Coordinating Committee, a group of public and private entities that have an interest in ensuring that as many North Carolinians as possible enroll in a Part D plan and that low-income persons sign up for the subsidy program. A subcommittee of the Medicare Partners State Level Coordinating Committee, which would include the Seniors Health Insurance Information Program (SHIIP) Director, the NCRx Director, a HWTF senior staff member and two members of the senior community-based organizations community, could serve to solicit, award, and monitor innovative community-based NCRx outreach and enrollment grants.
- 1.3 The Task Force recommends targeting additional resources from the existing NCRx (administrative) budget to those counties with the greatest under-enrollment in “Extra Help” as well as those counties that operate with volunteer rather than paid SHIIP staff coordinators.
- 1.4 The Task Force recommends that SHIIP outreach coordinators collaborate with local retail and independent pharmacies to provide outreach and enrollment assistance and activities within dispensing pharmacies. Many Medicare Part D beneficiaries request information directly from their pharmacist, which makes the pharmacy an appropriate setting for targeted enrollment and outreach efforts. For example, Kerr Drug, a retail pharmacy chain in the Carolinas, operates “Health Care Centers” in several of their store locations, offering some clinical services and basic counseling on insurance-related issues. By placing SHIIP volunteers in these and other existing in-house settings, the pharmacy can become a one-stop location for many seniors who are in need of additional assistance. For example, SHIIP staff or volunteers could make use of the Benefits Checkup, a Web-based decision support tool that helps beneficiaries and those who serve them, understand and assess their current situation before enrolling in an appropriate Medicare Prescription Drug plan. At the pharmacy counter, Benefits Checkup can be

used to help determine if seniors qualify for Medicare's Extra Help or other prescription savings programs and allow them to apply for many of these programs on line.

1.5 The Task Force recommends that NCRx pilot an online application process during the next federal Medicare Part D (2008) open enrollment period and evaluate its impact on program enrollment. In other states, electronic applications have been shown to increase program enrollment. SHIP coordinators and volunteers as well as some community-based organizations currently provide Web-based assistance for seniors who are enrolling directly in Medicare Part D (see Medicare Drug Plan Finder, <http://www.medicare.gov>). Evaluations of electronic application procedures conclude:

- that applying online is quicker (the time between application submission and eligibility determination is reduced compared to paper applications);
- there is increased consumer satisfaction;
- that there is a reduced number of application errors by requiring applicants to complete all necessary information before proceeding to the next screen or by prompting applicants when data is missing;
- that because information is collected electronically, the process may improve an agency's ability to efficiently access data.

Some online application systems have "application assistors" who can work with beneficiaries to input data. This could be a particularly useful feature for seniors who may not be familiar with Web-based applications.

Recommendation 2: Strengthening NCRx

The Task Force encourages state policymakers to monitor enrollment trends during the first year of NCRx program operation. The following recommendations for the second year of the program are contingent upon availability of funds on January 1, 2008:

Strengthening NCRx Benefit Design

2.1 For new Medicare Part D enrollees, the current \$18 monthly premium assistance available through NCRx provides financial support to cover the full premium cost (\$17.80) for only the least expensive Prescription Drug Plan (PDP) in North Carolina, which carries a \$265 annual deductible. If funding is available, the Task Force recommends consideration of an increase in premium assistance (\$7.30-per-member-per-month increase in 2007) to cover the full premium cost of the least expensive plan that does not carry a \$265 deductible (\$25.30 per month in 2007).

2.2 Currently, the NCRx program pays premium assistance directly to the Part D plan on behalf of the beneficiary. For those seniors already enrolled in a Part D plan, participation in NCRx requires a senior to stop automatic deduction of their Part D premium from their social security checks. The Part D plan charges those who have selected a higher-premium plan for the difference between the monthly plan premium and the state's \$18 premium contribution. The Task Force recommends consideration of

additional benefit designs, including the offering of a “debit card,” in addition to the direct premium payment options. The state would contribute a fixed annual amount to a senior’s prescription drug spending account, equal to the current premium assistance amount (i.e., \$18 per month x 12). This benefit would operate similar to the current “flexible health spending account” debit cards that are available to state employees through a contract with AON consulting. Seniors could use the card to pay coinsurance, co-pays, or other costs at the pharmacy counter.

Expanding NCRx Eligibility

If funding is available in year 2, the Task Force recommends the following:

- 2.3 Consider eliminating the asset test, (currently set at \$20,000 for individuals and \$30,000 for married couples) which could boost enrollment and reduce overall administrative costs.
- 2.4 Consider expanding the eligibility threshold from 175% FPL (federal poverty line) to 200% FPL (\$19,600 for individuals and \$26,400 for married couples).
- 2.5 Consider expanding NCRx to cover all Medicare Part D beneficiaries under 200% FPL, including eligible Social Security Disability Income (SSDI) beneficiaries under age 65.

Recommendation 3: Navigating the Gaps in Part D Coverage

The doughnut hole is the gap in Medicare Part D coverage during which the beneficiary is responsible for 100% of their prescription drug costs. Once the beneficiary reaches the initial coverage limit of \$2,400, coverage stops completely and they must spend \$3,850 in true out-of-pocket expenses (TrOOP) before Medicare Part D catastrophic coverage begins.

Over the last four years, the Health and Wellness Trust Fund has taken several significant steps to provide a safety net for seniors and other low income populations. Recognizing that Senior Care, HWTF's former statewide prescription drug program for low-income seniors, was not a complete solution to the problems that North Carolina seniors and low-income individuals under 65 were facing, HWTF created a network of Medication Assistance Programs (MAP) to serve the underserved populations without access to prescription drugs. Since 2003, HWTF has provided over \$17 million in funding to MAP grantees to help seniors and other low-income individuals identify and apply for the lowest-cost prescription drugs available through public and private programs, including Patient Assistance Programs and discount card programs offered by pharmaceutical companies. In order to simplify the application process, HWTF equipped each grantee with computers and custom-design software (MARF) that had been developed by the NC Office of Research, Demonstrations and Rural Health Development (ORDRHD).

In addition to helping beneficiaries locate free or low-cost prescriptions, many MAP grantees also contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. MAP grantee sites provided over \$68.8

million worth of free medications to nearly 40,000 patients since January 2003 to December 2005, representing a 6:1 return on HWTF's grant investment. More than 8,000 of these patients also received medication management (MM) services during this period. Because of their leadership in the medication access field, MAP grantees have also stepped in to provide critical assistance to seniors facing the doughnut hole.

The Task Force offers the following strategies to continue helping seniors navigate the gaps in Medicare Part D coverage:

- 3.1 The Task Force recommends that SHIP and other community-based outreach organizations continue to encourage seniors with significant prescription drug needs to enroll in a Part D plan that offers some doughnut hole coverage. Currently, the least expensive Part D plan premium for coverage during the gap is \$42.90. Although the coverage only applies to generic prescriptions, this would ensure that seniors receive some financial assistance for approved medications.
- 3.2 If the NCRx premium assistance is increased to \$25.30 (or to the cost of the least expensive Part D plan with no deductible in 2007), the state, in promoting the expanded benefit, would contribute more than 50% of the cost of the least expensive plan that offers doughnut hole coverage (\$42.90 in 2007).
- 3.3 The HWTF MAP grantees should continue outreach efforts to assist those seniors affected by the doughnut hole. Additionally, the pharmacists providing medication therapy management (MTM) services available through the new NCRx Care initiative (described further in recommendation 4) should coordinate with MAP grantee organizations and refer those seniors facing the doughnut hole to available assistance in locating free or low-cost medications.
- 3.4 GlaxoSmithKline, AstraZeneca, and Pfizer, leaders in offering Patient Assistance Programs (PAPs), are all members of the Pharmaceutical Research and Manufacturers of America (PhRMA). The Task Force encourages GlaxoSmithKline, as a North Carolina-based company, to work with state leaders to showcase the important role of the private sector in providing prescription drug assistance for low-income Medicare Part D beneficiaries facing the doughnut hole.

Recommendation 4: The Design of NCRx Care and Managing Out-of-Pocket Drug Costs

In October 2006, the Health and Wellness Trust Fund Commission announced NCRx Care, a medication therapy management (MTM) program. HWTF has contracted with the North Carolina Office of Research, Demonstrations and Rural Health Development (ORDRHD) to administer the program and contract with retail and community pharmacists to provide MTM services. These services include counseling Medicare enrollees on the most appropriate and cost-effective use of their federal drug coverage benefit, helping monitor health status, and identifying potentially harmful drug-to-drug interactions. HWTF has approved \$2 million over

three years to compensate pharmacists who counsel eligible seniors. ORDRHD is currently soliciting public bids for the administration of NCRx Care.

The Task Force views NCRx Care and appropriate brown-bag counseling by dispensing and non-dispensing clinical pharmacists as an important additional benefit offered as a companion program to NCRx.

The Task Force offers the following recommendations to aid in the design of NCRx Care and to help seniors manage out-of-pocket drug costs:

- 4.1 As one of the first steps in designing the new assistance program, NCRx Care will need to establish “eligibility” criteria for its beneficiaries. The program should use the NCRx criteria as a base and build in additional eligibility requirements specific to those most in need of MTM services. NCRx Care would become an added benefit to the NCRx \$18 monthly premium assistance. In addition to those who are eligible for NCRx, NCRx Care should consider offering the benefit to all Medicare beneficiaries who receive the federal low-income subsidy (also known as “Extra Help”).
- 4.2 The Task Force recommends that NCRx Care use the definition and standards of MTM provided by the APhA (American Pharmacists Association) as a guide for designing the services to be provided. This would ensure that beneficiaries receive comprehensive medication management services that include monitoring health status, providing one-on-one counseling, collaborating with physicians, and documenting action and health outcomes. At a minimum, NCRx Care should use the eligibility guidelines provided by Centers for Medicare and Medicaid Services (CMS) for MTM.
- 4.3 The Task Force recommends that NCRx Care make dispensing and non-dispensing (for example, community based pharmacists) pharmacists eligible for reimbursement.
- 4.4 The Task Force recommends that NCRx Care take active and immediate outreach and enrollment steps to begin educating beneficiaries as well as pharmacists about the available services and how they might participate in the program.

Recommendation 5: Improving the Coordination of Health Care Delivery for Seniors

Several Task Force members and advocates for seniors expressed concern that low- to moderate-income Medicare beneficiaries must navigate a confusing network of prescription drug plans, health care and other service providers, as well as other public programs. With such complexity, there is a growing need for community-based organizations that can meet a variety of needs and challenges for seniors.

There are organizations currently providing this kind of coordination. For example, Senior PHARMAssist, a nonprofit organization in Durham, NC promotes healthier living for Durham seniors by helping them obtain and better manage needed medications and by providing health education, community referral, and advocacy. In most cases, Senior PHARMAssist provides

tailored, hands-on assistance for seniors and younger Medicare beneficiaries (people with disabilities) including help finding a Medicare prescription drug plan that works best for them, applying for the low-income subsidy, medication management services, and help locating other resources such as transportation assistance and home-delivered meal services. Through their prescription drug card program, Senior PHARMAssist also acts as a secondary payer. This helps participants meet their deductibles and cost-sharing related to Medicare drug plans.

In addition to these types of organizations, North Carolina has a rich history of developing community-based health care systems. The Task Force expressed particular interest in initiatives that create community care networks for seniors, similar to the infrastructure of the Community Care of North Carolina Program (CCNC). In 2005, the North Carolina General Assembly passed legislation to expand the scope of the CCNC managed care network to include aged, blind and disabled populations. This new initiative has recently begun implementation. North Carolina has also applied for a Medicare Redesign Demonstration Waiver that would allow for a joint agreement between CMS and the North Carolina Community Care Network (a nonprofit organization that represents all the CCNC networks) to help manage recipients dually eligible for both Medicare and Medicaid.

Another example of coordinated care efforts is the Program of All-Inclusive Care for the Elderly (PACE); a unique, capitated managed-care benefit for the frail elderly that seeks to provide better care and cost savings by integrating preventive, acute, and long-term care into one package. This coordinated care model began as a federally supported demonstration project; as part of the Balanced Budget Act of 1997 (BBA), PACE was made a permanent provider under Medicare and a state option under Medicaid. There are nearly 40 PACE programs in 19 states serving approximately 17,000 Medicare and Medicaid beneficiaries.

In 2004, the North Carolina General Assembly passed legislation to develop two pilot PACE programs. One of the programs is being developed by Elderhaus, a daytime care facility for seniors based in Wilmington. The second program is being developed by Piedmont Health Services, which operates six community health centers throughout the state. This second pilot program has received some startup funding through CMS as part of a new initiative to develop PACE programs in rural areas. The pilot programs are tentatively scheduled to be operational by fall 2007 (Elderhaus) and summer 2008 (Piedmont Health Services).

5.1 The Task Force encourages continued exploration of whether the PACE program is an effective model for coordinated care for seniors. The Task Force believes that the results of a pending federal evaluation as well as further monitoring of the two pilot sites in North Carolina could provide policy makers with valuable information on models to coordinate care for the state's most vulnerable seniors. For example, policy makers might want to support a future evaluation of how the community-based physician model operates in the current pilot PACE sites and at a non-PACE site that serves a similar population.

Other Strategies to Access Prescription Drug Assistance in NC

While beyond the scope of the Task Force's formal charge, the Task Force acknowledges two important additional programs for accessing prescription drugs. These federally funded programs—340B pricing and the Aids Drug Assistance Program (ADAP)—provide assistance for low-income seniors as well as low-income non-elderly individuals.

The 340B pricing refers to a federal designation given to facilities that serve very low income individuals. States offer discounts through the 340B drug pricing programs, which requires pharmaceutical manufacturers participating in Medicaid to offer drug discounts to federal and state-supported facilities that serve the most vulnerable populations. The Task Force acknowledges that some low-income seniors in North Carolina continue to use the 340B option rather than enrolling in a Part D plan. Receiving lower cost medications through one of North Carolina's qualified facilities can be more affordable for those with very low-incomes, compared to the costs of purchasing a Medicare Part D prescription drug plan.

The North Carolina AIDS Drug Assistance Program (ADAP), also known as the HIV Medications Program, uses a combination of state and federal funds to provide low-income residents with assistance in obtaining essential, life-sustaining medications to fight HIV/AIDS and the infections that often accompany the disease. Individuals living with HIV/AIDS typically have extremely high prescription drug costs and many of the necessary medications do not have a generic equivalent.

For those with HIV/AIDS who have prescription drug coverage through Medicare Part D as SSDI recipients, NC ADAP has paid the cost of the drugs while in the doughnut; however, those costs do not count towards TrOOP. There is some exploration of whether to develop an ADAP SPAP, which would allow ADAP's contribution toward the doughnut hole to count toward TrOOP spending for those SSDI beneficiaries with Medicare Part D Coverage.

Further exploration of a range of community-based outreach and enrollment strategies as well as additional state assistance to address some of the gaps in the Medicare Part D benefit remain critically important to ensure access to affordable prescription drug coverage for all of North Carolina's seniors.

Conclusion

Many of the problems Medicare beneficiaries face stem from larger, systemic issues that no single authority can fully address. The Task Force would like to recognize the impact that programmatic complexity has on individual beneficiaries, and urges leaders at the state and federal level to push for a more user-friendly version of the Part D program and the health care system for seniors in general. We believe that less complexity and more coordination will lead to better health care and therefore, better health outcomes for all Medicare beneficiaries. Further, we hope that the recommendations put forth by this document will help to make North Carolinians' experience with Medicare better, and contribute to the overall discussion of reform.