

## The Medicare Prescription Drug Benefit: Issues and Implications for States

Presentation  
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## Outline of Presentation

- Overview of provisions of new law
- The drug discount card
  - "Transitional Assistance" for low-income beneficiaries
  - State Pharmacy Assistance Programs (SPAPs)
- The Part D drug benefit
  - Overview of Part D drug benefit
  - Part D covered and non-covered drugs
  - State "clawback" payments to the federal government
- Implications of Part D for the states
  - Financial, beneficiary and administrative issues

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## Medicare Prescription Drug, Improvement, & Modernization Act (MMA) of 2003 (P.L. 108-173)

- Prescription drug discount card
- Part D prescription drug benefit
- Many other changes (not being discussed today) include:
  - Increased Medicare reimbursement for hospitals, physicians, rural health providers, managed care
  - Made important changes for durable medical equipment, lab, ambulance, dialysis; indexing of the Part B premium and deductible
  - Replaced Medicare + Choice with "Medicare Advantage" for managed care
  - Created "Health Savings Accounts"

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## Drug Discount Card

- A *voluntary* program for Medicare beneficiaries
  - Excludes dual Medicare – Medicaid eligibles
  - Excludes those with employer pharmacy coverage
- Medicare "endorsed" 73 national and regional cards sponsored by insurers, health plans, pharmacies, and PBMs
- Enrollment fee of \$30 or less
- Cards effective June 1, 2004 to January 2006

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## Drug Discount Card: Discounts and Coverage

- Brands: discounts tend to be 12% to 17% below average retail prices (with larger discounts through mail order)
- Generics: discounts may be much larger
- Coverage must include negotiated prices for at least one drug in 209 drug classes – but different sponsors include different drugs.
- CMS projected 7.4 million would enroll
- As of 7/6/04: 3.7 million enrollees
  - (66% through SPAP auto-enrollment)

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## Drug Discount Card Offers Real Benefit for Low-Income Beneficiaries: \$600 in "Transitional Assistance"

- Only for persons below 135% of poverty level (\$12,569 for individuals; \$16,862 for couples in 2004)
- No enrollment fee
- Credit of up to \$600 per year
  - Amount not used in 2004 will carry forward to 2005
- Coinsurance
  - 5% if below 100% of poverty level
  - 10% if below 135% of poverty level

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## Drug Card: Implications for States

- Administrative implications:
  - Auto-enrollment through SPAP
  - Monthly data tape of Medicaid dual enrollees
- Medicaid eligibility:
  - Once approved for Transitional Assistance, beneficiary retains \$600 credit, even if later becomes eligible for Medicaid
  - Spend-down eligibility: Beneficiary can qualify for Transitional Assistance if not yet eligible for Medicaid
  - Medicaid enrollment and costs may increase due to a "wood work" effect
- State Pharmaceutical Assistance Programs (SPAPs)
  - States may see savings in general fund costs of SPAPs
  - States may "Auto-Enroll" low-income SPAP beneficiaries, with an "Opt-Out" process
  - States pursuing auto-enrollment include: CT, MA, MI, NJ, NY, PA, and others

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## Medicare Part D Drug Benefit: The Basics

- Enrollment: Voluntary
- Initial enrollment period: November 15, 2005 for six months
- Annual enrollment periods: November 15 to December 31
- Coverage is to begin: January 1, 2006
- Premiums: estimated to be \$35 per month in 2006
  - Those who don't enroll initially, or who don't maintain continuous coverage, will pay higher premiums
- Employers: Significant subsidies to maintain retiree pharmacy coverage

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## Administration of Part D Benefit

- The Part D benefit will be administered by:
  - Prescription Drug Plans (PDPs).
  - Medicare Advantage Prescription Drug plans (MA-PDs).
  - Federal *fall-back* plans.
- The PDPs & MA-PDs will be risk-bearing private plans.
- Beneficiaries will be able to choose from at least 2 plans, if available, or a *fall-back*.
  - A *fall-back* non-risk bearing plan will be available if other plans are not offered in an area.
- HHS is prohibited from controlling or negotiating prices for PDPs & MA-PDs.

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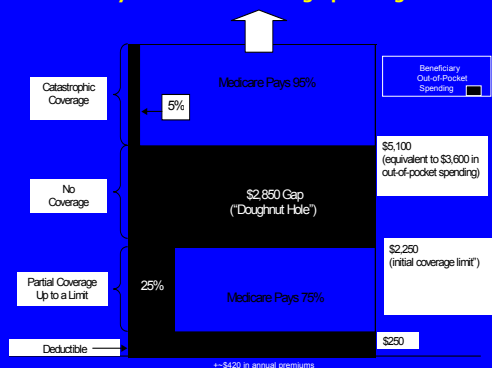
## Everyone Agrees: It's Hard to Understand All the Details

"You choose a prescription drug plan and pay a monthly \$35 premium. Okay, now it gets a little complex..."

- Reader's Digest April 2004 ...

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## Part D Standard Benefit: Beneficiary Out-of-Pocket Drug Spending in 2006



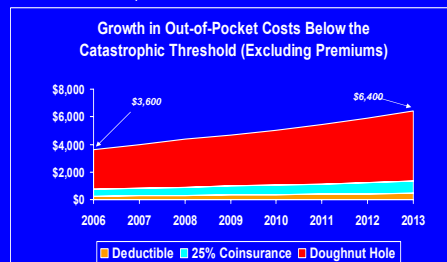
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SOURCE: Adapted from The Henry J. Kaiser Family Foundation, "Medicare Fact Sheet: The Medicare Prescription Drug Law," March 2004.

## Part D Beneficiary Out-Of-Pocket Costs Are Indexed

Projected Increases from 2006 to 2013:

- Deductible: from \$250 to \$445
- Doughnut hole: from \$2,850 to 5,066
- Catastrophic threshold: from \$5,100 to \$9,600.



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SOURCE: Congressional Budget Office letter to the Honorable Don Nickles, November 20, 2003.

**2004 Federal Poverty Levels**

HHS Poverty Guidelines for 2004			
Family Size	100% of FPL	135% of FPL	150% of FPL
1	\$ 9,310	\$12,568	\$13,965
2	12,490	16,862	18,735
3	15,670	21,155	23,505

SOURCE: Federal Register, Vol. 69, No.30, February 13, 2004, pp. 7336-7338.

**Part D  
Low-Income Subsidies  
Beneficiaries Not on Medicaid**

- Individuals with Incomes Up to 150% FPL in 2006\*

Asset Test: \$10,000 (individual) & \$20,000 (couple)  
 Premium: Sliding Scale, based on income  
 Deductible: \$50  
 Coinsurance: 15% before catastrophic threshold  
 Doughnut Hole: None  
 Catastrophic: \$2 for generics and \$5 for brands

\*150% FPL = \$13,965 (individual) or \$18,735 (couple)

**Part D  
Low-Income Subsidies  
Beneficiaries Not on Medicaid**

- Individuals with Incomes Below 135% FPL in 2006\*

Asset Test: \$9,000 (individual) & \$12,500 (couple)  
 Premium: \$0  
 Deductible: \$0  
 Copayment: \$2 for generics and \$5 for brands before catastrophic threshold  
 Doughnut Hole: None  
 Catastrophic: No co-payments

\*135% FPL = \$12,568 (individual) or \$16,862 (couple)

**Part D  
Low-Income Subsidies  
Beneficiaries on Medicaid (Dual Eligibles)**

- Premium: \$0
- Deductible: \$0
- Copayments: \$1 for generics & \$3 for brands up to 100% FPL\*  
 \$2 for generics and \$5 for brands between 100% & 135% FPL\*\*  
 \$0 copay if institutionalized
- Doughnut Hole: None
- Catastrophic: No co-payments

Beyond 2006, copays

\* For persons below 100% FPL, copays indexed to growth in CPI.

\*\* For persons above 100% FPL, copays indexed to Part D growth.

**Part D Benefit: Covered Drugs**

- Part D coverages include:
  - drugs and biologicals required to be covered by Medicaid
  - Insulin & supplies for its administration
  - Smoking cessation products
- Plans can create closed formularies (i.e., exclude specific drugs within classes)
- Formularies must include at least two drugs in each therapeutic category

**Part D Benefit: Non-Covered Drugs**

- Weight loss/gain
- Fertility
- Cosmetic or hair growth
- Cough or cold relief
- Vitamins and minerals
- Over-the-counter (OTC) drugs, normally available without a prescription
- Barbiturates
- Benzodiazepines
- Drugs covered under Medicare Parts A or B

## Implications of Part D for Medicaid

- Medicaid pharmacy coverage ends for duals on January 1, 2006
  - No FMAP available to states for Part D drugs
- Part D drugs are only from Medicare Plans (PDPs or Medicare Advantage-drug plans or federal Fall-Back plans)
- States will continue to pay deductible & coinsurance amounts for Part B drugs

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## Part D Has Significant Issues for States

- Financial Impacts
- Beneficiary Impacts
- Administrative Impacts

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## Part D Financial Impacts for States

- Clawback
  - Setting the base year amount
  - Annual cost adjusters
- Rebate impacts
- Woodwork effect
- Overall financial impact

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## The Clawback Formula

- The federal Medicare Part D benefit is funded in part by states through a “phased-down state contribution”
- Clawback is based on 2003 actual state per-capita Medicaid pharmacy costs for dual eligibles, trended forward.

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## Clawback

- The Clawback base-year calculation is complex
  - “We are calculating the clawback. It is proving to be more difficult than anticipated due to the spend downs – they are in and out of Medicaid.”
  - “I don’t think anyone’s base year will reflect the way things will be in 2006.”

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured. Report forthcoming, October 2004.

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### Clawback Formula

Multiply:

- 1 Per Capita Monthly Amount
- 2 Full-Benefit Duals Enrolled in Month
- 3 Monthly Factor Adjustment

**Clawback Total Amount**

### Clawback Basics

A 1/12th CY 03 Rx Payments Full-Benefit Duals	X	B State Match Rate For Clawback Month	X	C Mfg. Rebate %	X	D Growth Factor
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For a month in:	Factor
2006	90%
2007	88.33%
2008	86.67%
2009	85%
2010	83.33%
2011	81.67%
2012	80%
2013	78.33%
2014	76.67%
2015 & After	75%

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## State Financial Issues: Clawback

- Clawback base does not adjust for Third Party “pay & chase” recoveries, post-payment audits, or state actions to control drug spending
- The “Clawback” offsets hoped-for state savings
  - “The legislature thinks we are going to get 10% savings. We don’t see any savings there.”

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured, Forthcoming, October 2004. <sup>25</sup>

## Other Financial Issue for States

- Rebates: The Clawback erodes States’ ability to negotiate manufacturer supplemental rebates
- Enrollment: A “Woodwork Effect” is expected as low-income Medicare beneficiaries find they are eligible for Medicaid.

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured, Forthcoming, October 2004.

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## Part D: Beneficiary Impacts that Concern States

- Covered drugs
- Medical management
- Nursing home patients

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## Beneficiary Issues for States: Part D Covered Drugs & Wrap-around

- Dual eligibles will almost certainly have less coverage under Part D plans
- States cannot receive FMAP if they “wrap-around” to fill the gaps or subsidize co-payments.
  - “If we cover four anti-psychotics, and Part D covers one, what do we do?”

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured, Forthcoming October 2004.

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## Beneficiary Issues for States: Copayments and Nursing Homes

- Part D co-payments are set nationally
  - “Dual eligibles [in our state] currently have no cost sharing for pharmacy. Under Part D, cost sharing will be required.”
- Nursing home patients present a difficult challenge

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured, Forthcoming October 2004. <sup>29</sup>

## Beneficiary Issues for States: Medical Management

- Medicaid has invested much effort into Drug Utilization Review and Disease Management
  - “The biggest issue is loss of data. We have duals in disease management programs, and in nursing homes.”

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured, Forthcoming October 2004. <sup>30</sup>

### Part D: Administrative Impacts that Concern States

- Determination of eligibility for benefits for low-income beneficiaries
- System change requirements and timeframes
- Availability of staff and resources
- Other administrative implications

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### Administrative Issues for States: Eligibility Determinations

- States must determine eligibility for low-income subsidies
  - “Eligibility will be an enormous problem for us. There won’t be enough time to implement.”

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured, Forthcoming October 2004.

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### Administrative Issues for States: System Changes

- States must make major eligibility system changes to prepare to implement Part D.
  - “We are going to have to request more funds to do this.”

Source: Health Management Associates interviews of State Medicaid Directors, for Kaiser Commission on Medicaid and the Uninsured, Forthcoming October 2004.

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### Summary

- States must be ready for significant new responsibilities and costs.
- All States must prepare for Part D benefit.
  - Analyze & budget for Clawback.
  - Prepare for eligibility determinations for low-income subsidies.
  - Prepare for enrollment of duals into Part D.
- States should monitor ongoing guidance & interpretation of MMA.

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