Michigan League for Human Services

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Understanding the Medicare Prescription Drug Benefit

Overview

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was signed into law. This Act creates a voluntary prescription drug benefit program (Part D) under Medicare for individuals entitled to Medicare Part A or enrolled in Part B. The new benefit is effective January 1, 2006. Prior to full implementation of the new drug benefit, a "discount" card will be available for Medicare beneficiaries to purchase, which is expected to provide about a 15 percent discount in drug prices. The discount card will cost $30 per year for beneficiaries with incomes above 135 percent of the federal poverty level. For beneficiaries below 135 percent of the federal poverty level, the discount card will not only be free, but will also carry a $600 credit (known as transitional assistance) to be used for the purchase of Part D eligible drugs. Beneficiaries will be required to pay copayments of 5 – 10 percent. The discount card and transitional benefit will end upon full implementation of the Part D benefit.

Medicare Part A: covers hospitalizations;
Medicare Part B: covers outpatient and physicians services

The new Part D drug benefit will be administered by Medicare-contracted drug plans or managed care organizations. The contracted plans do not have to be identical, rather, they must provide an "actuarial equivalent benefit" or "basic"coverage. Plans may not have higher deductibles than the established standard or a higher threshold to qualify for catastrophic coverage. There must be at least two plans to choose from within regions and each plan must cover at least two drugs in each therapeutic class of drugs.

Costs and Benefits under the New Law

Enrollees in Medicare Part D with incomes at or above 150 percent of the federal poverty level will pay:

- monthly premiums of about $35/month ($420/year),
- an annual deductible of $250, and
- 25 percent of the covered Medicare Part D drug costs up to $2,000 (above the deductible).

For covered Medicare Part D drug costs between $2,251 and $5,100, the enrollee is responsible for 100 percent of the cost, there is no Part D benefit. For covered Part D drug costs above $5,100, an enrollee will qualify for "catastrophic coverage" and will pay the greater of 5 percent of the cost of the drugs, or copays of $2 for generic/$5 for brand name drugs. Enrollees will spend $3,600 for drug costs plus the $420 for premiums before they reach "catastrophic coverage." Any expenditure by an enrollee for a non-covered Part D drug will be in addition to the $3,600 stated above.

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The cost of covered Part D drugs will be determined by the drug plan administering the benefit, as will be the specific drugs covered (only two drugs per therapeutic class are required). There is no meaningful re-importation clause included in the law to facilitate acquisition of lower-cost drugs from Canada. Enrollees will be required to choose a plan to administer their benefits, and will be allowed to change plans only once per year. *Plans, on the other hand, will be allowed to change coverages during the year.* There is also a provision in the law that prohibits the sale of Medigap policies to supplement the Part D benefit, either in the "coverage gap" (drug costs between $2,251 and $5,100), or for drugs not covered by the Part D plan. This provision is particularly troubling for low-income individuals because out-of-pocket costs will increase each year. The premium is projected to increase to $58/ month by 2013. The deductible, cost sharing and "coverage gap" will increase each year by the actual growth in per capita Part D drug spending for enrollees. Projections for 2013 are that out-of-pocket spending will increase to $6,400 (not including the increased premiums) to reach "catastrophic coverage." *(Kaiser Foundation 12/ 10/03)*

While Part D is defined as a voluntary component of Medicare, individuals who do not enroll within the federally specified time frame will be assessed a late enrollment penalty. The penalty will be the greater of an amount determined by the Secretary of Health and Human Services, or one percent of the premium for each month that the individual did not have prescription drug coverage from another source ("creditable coverage") after the end of the individual's enrollment period.

For enrollees with incomes below 150 percent of the federal poverty level and who meet specific asset tests, there are subsidies to assist with the premiums, deductibles and cost sharing. For enrollees with incomes below 135 percent of the federal poverty level and meeting the asset requirements, the premium and deductible will be fully subsidized by the federal government. For enrollees between 135 percent and 150 percent of the federal poverty level, the premium will be based on a sliding scale, and the deductible will be $50.

Low-income enrollees will also have reduced cost sharing. For those with incomes below 135 percent of the federal poverty level, cost sharing will be copayments of $1 or $2 for generic drugs and $3 or $5 for brand name drugs. For enrollees with incomes between 135 percent and 150 percent of the federal poverty level, cost sharing will be 15 percent of the cost of covered Part D drugs after the deductible is met.

There is no gap in coverage for enrollees with incomes below 150 percent of the federal poverty level. There is no further copayment for enrollees with incomes below 135 percent of the federal poverty level once their covered Part D drug costs reach $5,100 (in 2006). Actual out-of-pocket costs will depend on the mix of generic and brand name drugs prescribed. For enrollees with incomes between 135 percent and 150 percent of the federal poverty level, the copayment changes to $2 for generic drugs and $5 for brand name drugs once their covered Part D drug costs reach $5,100 (in 2006). That will equate to out-of-pocket spending of $808.

Coverage for Medicaid Dual Eligibles

For persons also eligible for Medicaid, known as "dual eligibles," the new law includes significant changes. Under the current law, if a benefit is covered by both Medicare and Medicaid, Medicare pays first and Medicaid pays second, picking up cost sharing and filling any gaps. In addition, Medicaid currently pays the drug benefit for dual eligibles, which includes broad pharmacy coverage and minimal cost sharing.

The new law, however, prohibits Medicaid (federal matching funds) cost sharing and from supplementing the drugs covered under the Part D benefit. Because covered Part D drugs, depending on drug plan selected, may be more restrictive than Medicaid coverage, dual eligibles may lose specific drug coverage and have higher copayments for covered Part D drugs than they are currently paying under Medicaid. States will be

allowed to continue receiving federal Medicaid matching funds for coverage of drugs for dual eligibles that are *excluded* from coverage under Part D. Further, under the Medicaid statute, providers are not allowed to deny services to Medicaid recipients if they cannot pay the co-payment. It is not clear how this issue will be handled under Part D, as that protection is not included in the law. It is also not clear how benefits will be coordinated for Medicaid spend-down clients as they are not specifically addressed in the law as are dual eligibles. The regulations, which will likely address the above issues, are not expected to be issued until early in 2005.

While Part D is considered "optional," as indicated previously, dual eligibles will not have the option of maintaining their Medicaid pharmacy benefit for covered Part D drugs. The Secretary of Health and Human Services is required to develop procedures to enroll dual eligibles, with full premium subsidies, if they do not enroll on their own. In addition, since the law eliminates Medicaid-financed prescription drug coverage for covered Part D drugs effective January 1, 2006, any state supplementation of the Part D benefit will require 100 percent state funds.

Maintenance of Effort Provision and Implications for the State

State supplementation of drug benefits might have been a very affordable option for states except the federal legislation creates a state "maintenance of effort." The maintenance of effort provision requires states to pay the federal government a substantial portion of the calculated savings that the state is expected to realize for no longer providing a pharmacy benefit under Medicaid to those who qualify for the Medicare Part D benefit. This maintenance of effort is also known as the "claw back" provision, and is the first time states will be required to help finance a Medicare benefit.

For 2006, the maintenance of effort calculation will be based on per capita state expenditures for covered Part D drugs for dual eligibles for 2003, trended forward to 2006, multiplied by the state share computed from the Federal Medical Assistance Percentage, multiplied by the number of dual eligibles for the specific month, multiplied by the "claw back" percentage for 2006 (90 percent). Theoretically, states are paying the federal government 90 percent of what they otherwise would have spent for covered Part D drugs for this population. In 2007 and future years, the growth factor will be based on the actual percentage increase in per capita spending under Part D. The "claw back" percentage declines by 1.667 percent each year until it reaches 75 percent in 2015. There are no further scheduled reductions in the "claw back" percentage. The projected impact on Michigan will be included in future updates once the base information and calculations are more clearly defined.

Any projected savings to the Medicaid program will be partially offset by increased administrative costs associated with the Part D benefit implementation and ongoing coordination. Administrative activities are expected to include enrollment of beneficiaries, administration of the low-income subsidy program, and coordination of benefits for spend-down clients. Enhanced federal match for state-required activities is not included in the law; rather, the standard 50 percent administrative match is specified. As part of the Medicare Part D enrollment process, states are required to complete a Medicaid eligibility determination. In addition, significant systems changes will likely be required to accommodate the mandated Medicaid changes.

While states are projected to save nearly $115 billion over the next 10 years, nearly 85 percent of the "state savings" will be offset by the federally mandated maintenance of effort ("claw back") payments, the cost of new Medicaid clients identified during the Part D enrollment process, and the new administrative costs associated with the implementation of Part D. The Congressional Budget Office projects that nearly 80 percent of the net fiscal relief, $17.2 billion, is expected to be realized in the 7th through 10th years of the program. States are projected to experience increased costs for the first couple of years. Individual state impacts will be determined, in

large measure, by the national growth in per capita spending (the basis for the maintenance of effort calculation) compared to the actual growth experience by the state, and enrollment increases in dual eligibles that likely would not have occurred absent the legislation. For states with aggressive pharmacy cost controls, which are prohibited in the Act, the growth in per capita state spending may have been lower than the national trend, which further diminishes the state's "savings."

Other Program Benefit Impacts

There are many questions, but as yet no answers on the impact of the Part D legislation on Michigan's Elder Prescription Insurance Coverage (EPIC) program. The FY2005 Executive Budget includes $25.5 million for the EPIC program. While this represents a significant funding reduction, negative program consequences are not expected due to the newly enacted Medicare prescription discount card, to be available during FY2004.

While the law does include a subsidy provision to encourage private and public employers to maintain their current retiree pharmacy coverage, the Congressional Budget Office projects that 2.7 million retirees will lose their private drug coverage because their former employers will eliminate it when the new Part D benefit becomes available.

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