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Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs

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Summary

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA, P.L. 108-173), enacted in December 2003, will have a significant effect on Medicaid beneficiaries who also have Medicare coverage (i.e., "dual eligibles") and on state Medicaid programs. This report highlights several provisions affecting dual eligible beneficiaries and state Medicaid programs and describes some of the areas where significant questions remain. This report will be updated.

Introduction

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA, P.L. 108-173) enacted in December 2003, made several major changes to Medicare including (1) adding a voluntary outpatient prescription drug benefit effective January 1, 2006; (2) offering Medicare beneficiaries during 2004 and 2005 discounted prescription drugs through an endorsed discount card; and (3) modifying various Medicare payment rates.[1] This report focuses on the provisions in MMA which add a prescription drug benefit under a new Medicare Part D starting in 2006. The report discusses the effect of the new benefit on beneficiaries who are dually eligible for both Medicaid and Medicare and on state Medicaid programs.

[1] For additional information, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, And Modernization Act of 2003*, by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger and Paulette Morgan and CRS Report RL32283, *Medicare Endorsed Prescription Drug Discount Card Program*, by Jennifer O'Sullivan.

Implications for Medicare/Medicaid Dual Eligibles

The term "dual eligibles" refers to individuals who qualify for both Medicare benefits and those Medicaid benefits offered in their state. Sometimes these individuals are referred to as "full benefit duals."[2] In general, Medicare is the primary payer for those services covered by both Medicare and Medicaid (e.g., hospital services). Medicaid usually covers those costs in excess of what is covered by Medicare. For those Medicaid benefits not available under Medicare (e.g., many long-term care services), Medicaid covers the entire cost unless there is another third-party payer. While these rules will still apply for most Medicare and Medicaid services, MMA will significantly change the interaction of Medicare and Medicaid for coverage of prescription drugs.[3]

Changes to Eligibility for Dual Eligibles' Prescription Drug Coverage

Currently Medicaid covers several services for dual eligibles not covered by Medicare including, at state option, prescription drugs. As of November 2002, all 50 states and the District of Columbia covered prescription drugs for at least some Medicaid beneficiaries.

Starting in 2006, dual eligible individuals will no longer be eligible for the state's prescription drug benefit provided under the Medicaid state plan.[4] To receive coverage of prescription drugs, dual eligibles must enroll in the Medicare Part D benefit. This benefit will be offered through drug plans that have received approval from the Secretary of Health and Human Services (HHS).

It is unclear if the requirement for dual eligibles to enroll in Medicare Part D will also apply to those who receive prescription drugs through a Section 1115 Medicaid waiver.[5] Several states (e.g., Arizona) provide a substantial portion of their Medicaid program under the auspices of a Section 1115 waiver. Other states have specifically developed Section 1115 waivers to expand drug coverage to low-income seniors. Policy guidance on this issue is needed prior to implementing the new Medicare benefit.

Another issue is how MMA will affect dual eligibles whose eligibility pathway for Medicaid is "medically needy." These individuals qualify for Medicaid because they incur medical expenses that "spend-down" or deplete their income to a state-specified

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[2] Some groups (including the Centers for Medicare and Medicaid Services) include in the definition of "dual eligibles" those low-income Medicare beneficiaries for whom Medicaid *only* covers some Medicare cost-sharing. For example, states are required to cover Qualified Medicare Beneficiaries (QMBs), and Specified Low Income Medicare Beneficiaries (SLMBs).

[3] See CRS Report RL32277, *How Medicaid Works: Program Basics,* by E. Herz, et al., and [http://www.cms.hhs.gov/medicare/] for more information on the Medicaid and Medicare programs.

[4] The Medicaid state plan is the document that states submit to the federal government for approval which describes the eligibility groups covered and the services provided.

[5] Section 1115 of the Social Security Act allows the federal government to waive certain sections of Medicaid law for research and/or demonstration purposes. The waiver must be budget neutral over a five-year period.

standard. Some currently medically needy dual eligibles may no longer qualify for Medicaid if their prescription drugs are paid for by Medicare and are no longer out-of-pocket medical expenses. The number of individuals who may no longer qualify for Medicaid is unknown; data about out-of-pocket expenditures for medically needy individuals are not available.

Changes to the Scope of Prescription Drug Coverage for Dual Eligibles

Medicaid currently covers a broad range of prescription drugs. States may create lists of preferred drugs or require prior approval for non-preferred drugs, but statutory requirements insure that Medicaid covers a comprehensive list of drugs.[6] Most states limit coverage of prescription drugs through the quantity of the prescription (e.g., 30-day supply), the number of refills, or the number of prescriptions within a given time period.

MMA defines covered drugs as the same specific types of drugs as those covered in Medicaid. Drug plans are permitted to establish a formulary as long as it includes drugs within each therapeutic category and class of covered Part D drugs. A drug plan does not have to cover *all* drugs within a category or class. MMA requests the United States Pharmacopeia to develop (in consultation with others) a list of therapeutic categories and classes that may be used by drug plans.

If a state wishes to cover other drugs in a therapeutic class or category included under MMA, the state may not use federal Medicaid funding to do so. This differs from other benefits covered by both Medicaid and Medicare in which Medicaid can supplement Medicare coverage.

From the individual's perspective, it is likely that the scope of benefits will change; the extent of this change and the process for beneficiaries are unknown. Unlike the Medicaid program, MMA does not appear to limit the number of prescriptions an individual can receive or require prior authorization for particular drugs, but an individual may have access to only those drugs on a drug plan's formulary. For example, a drug plan formulary may cover a cholesterol drug that differs from the one an individual is currently using; he or she may have to change prescriptions. MMA does give individuals limited grievance and appeal rights to access a particular drug not covered by the formulary.[7] Key factors influencing the degree of change for dual eligibles are the definition of therapeutic classes and categories and the standards for drug plan formularies.

Changes to Premiums and Cost-sharing for Prescription Drugs

Currently, most dual eligibles do not have a premium to enroll in Medicaid, but they may have nominal co-payment requirements for the services they use. To enroll in the Medicare drug benefit, most persons will have to pay drug plans a premium for coverage

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[6] For additional information see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

[7] To appeal coverage of a drug not on the formulary, the individual's prescribing physician must determine that all covered drugs on the formulary would not be as effective for the individual as the non-covered drug or would have adverse effects for the individual.

and cost-sharing amounts when they use benefits. MMA, however, establishes special rules for dual eligible individuals. All dual eligibles will qualify for low-income subsidies for premiums and co-payments. Full benefit dual eligibles are entitled to a subsidy equal to the weighted average premium of all plans in the region, or if greater, the lowest premium for a plan in the region. If a dual eligible chooses a drug plan with a higher premium than the amount of the subsidy, he or she will be required to pay the difference.

Cost-sharing requirements differ for dual eligibles depending upon whether or not the individual resides in an institution. Individuals who reside in an institution have no additional cost-sharing obligations under MMA (e.g., deductible, co-payment for drugs).[8]

For dual eligibles who do not reside in an institution, the amount that they pay for prescription drugs may change. Currently, state Medicaid programs are permitted to impose nominal cost-sharing on non-institutionalized Medicaid beneficiaries. In 2003, 38 states imposed cost-sharing charges for Medicaid beneficiaries who received prescription drugs. Generally, cost-sharing ranged from $.50 per prescription to $3.00.

Under MMA, the prescription drug benefit permits drug plans to charge non-institutionalized dual eligibles co-payments for prescription drugs. Dual eligibles whose income (as calculated by the Supplemental Security Income program) is less than 100% of the federal poverty level can be charged up to $1 for a generic drug or a preferred drug that is considered a "multiple source"[9] drug and $3 for any other drug. This co-payment amount will be adjusted annually based on the Consumer Price Index (CPI). For other dual eligibles, their co-payments will be $2 for a generic drug or a preferred drug that is considered a "multiple source" drug and $5 for any other drug. This co-payment amount will be increased annually based on the percentage increase in per capita expenditures for the Medicare Part D benefit. No co-payments apply after a beneficiary has total drug costs of $5,100 in 2006; this amount is increased in subsequent years by the increase in Medicare per capita drug spending.

It appears that non-institutionalized dual eligibles may pay more per prescription under the Medicare Part D benefit than they currently do under Medicaid. The size of that increase is unknown and will vary by person depending upon income level, the prescription drugs used, and increases in the CPI and Part D expenditures.

Enrollment of Dual Eligibles in the Medicare Part D Benefit

Currently under Medicaid, dual eligibles receive prescription drug benefits as part of a package of Medicaid services, and the same prescription drug coverage rules apply to all Medicaid beneficiaries. Under the Medicare drug benefit, drug plans may offer different formularies and have different premiums or co-payments. Dual eligible beneficiaries will have to choose the type of drug plan they want to enroll in. If a dual eligible does not choose a plan, MMA permits the Secretary of HHS to automatically enroll an individual in a drug plan in their area. The process to identify dual eligible individuals and enroll those who do not enroll themselves is still under development.

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[8] Medicaid beneficiaries residing in institutions are required to contribute most of their income to the cost of their care (referred to as "post-eligibility treatment of income"). MMA does not change this requirement.

[9] Section 1927(k)(7)(A)(i) of the *Social Security Act*.

Changes for Dual Eligibles Residing in Institutions

Nursing facilities and intermediate care facilities for individuals with mental retardation are required to provide Medicaid residents including dual eligibles pharmaceutical services to meet the needs of each resident. In doing so, facilities generally contract with a pharmacy that supplies prescriptions drugs for those residents. Dual eligible individuals who reside in institutions will also be required to enroll in the Medicare Part D benefits. MMA requires drug plans to provide "convenient access" to prescription drugs for individuals residing in institutions.[10] It is unclear at this time how this will be implemented: Will there be requirements for drug plans to contract with the pharmacies that have existing contracts with institutions in their area? What flexibility will drug plans have to meet the "convenient access" requirement? And, how will dual eligible individuals residing in institutions experience this change in coverage?

Implications for State Medicaid Programs

Ability to Negotiate Drug Prices

Medicaid law requires drug manufacturers that wish to have their drugs available for Medicaid enrollees to enter into rebate agreements with the Secretary of HHS, on behalf of the states. Under these agreements, manufacturers must provide state Medicaid programs with rebates on drugs paid for Medicaid beneficiaries. In exchange, states are required to cover all drugs offered by those manufacturers. A few states have also negotiated supplemental rebates in addition to the federal agreements. In FY2001 federal and state drug rebate agreements reduced Medicaid drug expenditures by 19%.[11]

The effect of MMA on overall drug prices is unknown. Several areas remain unclear:

- Fifty-four percent of Medicaid expenditures for outpatient prescription drugs are spent on dual eligibles. With the majority of Medicaid drug expenditures moving to the Medicare program, will the ability of the federal and state Medicaid officials to negotiate rebates with pharmaceutical companies diminish?
- What degree of success will drug plans have in negotiating low drug prices with pharmaceutical manufacturers?
- What will be the effect of MMA confidentiality provisions stipulating that prices negotiated by drug plans cannot be considered in the rate Medicaid pays?

Revision of Payment Rates

Some states bundle prescription drug costs with other Medicaid payments, such as payments to managed care organizations and nursing facilities. States will need to adjust these rates to take into consideration the removal of prescription drug expenditures. This

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[10] Section 1860D-4(b)(1)(C)(iv) of the *Social Security Act* as added by P.L. 108-173.

[11] CRS analysis of Centers for Medicare and Medicaid Services' data, Form 64, FY2001.

bundled payment also has implications for calculating the amount of money states return to the federal government as discussed below.

Administration of Low-Income Subsidy

Under MMA, the state Medicaid agency is required to administer some components of the new drug benefit. States are required to determine eligibility for the low-income subsidy of the new drug benefit for all Medicare beneficiaries not just dual eligibles. This will require both administrative capacity and changes to the state's eligibility determination system. The federal government will fund 50% of the cost of administering the low-income subsidy. The state is required to fund the remaining 50% of the cost.

While screening individuals for Part D cost-sharing assistance, states must also at the same time screen individuals for assistance with Medicare Part A and Part B cost-sharing. More people may become eligible for cost sharing assistance for Medicare Part A and Part B because they want to take advantage of the drug benefit assistance. States may also screen the individual for Medicaid eligibility. These efforts may increase Medicaid expenditures by increasing the number of enrollees receiving assistance with other Medicare cost-sharing and receiving full Medicaid benefits.

Medicaid Financing: The Clawback Formula

States are responsible for partially funding the new Medicare drug benefit under a provision called the "clawback." The funding level for each state is a function of the number of persons eligible for both Medicaid and the Medicare drug benefit (the "dual eligibles"); state spending on prescription drugs for dual eligibles in FY2003; the state share of Medicaid funding; inflation (for prescription drugs); and a statutorily determined annual factor. Over time the annual factor will shift some of the spending on prescription drugs for dual eligibles from the states to the federal government as the factor is 90% for 2006 and gradually declines to 75% for years after 2014.

There are three key issues with the clawback formula: (1) FY2003 expenditures adjusted for inflation may not accurately reflect a state's spending for FY2005 because of changes to the Medicaid drug benefit that some states have made to address budget shortfalls. (2) If Medicaid prescription drug expenditures are bundled with other types of services, as is often the case with managed care, policymakers may have difficulty separating out prescription drug expenditures from other service expenditures. This will be important for establishing the state's FY2003 baseline expenditures. (3) Federal data on dual eligibles have some substantial limitations and are not always consistently reported by states. The clawback amount relies on an accurate count of dual eligibles by state. The federal government may have to work with states over the next two years to improve the accuracy of the data.