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

Karen Tritz
Analyst of Social Legislation
Domestic Social Policy Division

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 those MMA provisions that add a prescription drug benefit under a new Medicare Part D starting January 1, 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 services under both Medicare and those Medicaid 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., personal care), Medicaid covers the entire cost unless there is another payer. While these rules will still apply for most Medicare and Medicaid services, MMA changes the interaction of Medicare and Medicaid for coverage of prescription drugs.

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 September 2003, all 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 plan³ or a comprehensive Section 1115 Medicaid waiver.⁴ To receive coverage of prescription drugs, dual eligibles must enroll in the Medicare Part D benefit. This benefit will be offered through prescription drug plans (PDPs) that have received approval from the Secretary of Health and Human Services (HHS).

Four states (FL, IL, SC, and WI) have developed Section 1115, “Pharmacy Plus” waivers to expand drug coverage to low-income seniors. Individuals enrolled in Pharmacy Plus waivers will not be required to enroll in the Medicare Part D plan. However, HHS has indicated that the need for Pharmacy Plus waivers will decrease given the new Medicare benefit. States that continue to offer Pharmacy Plus waivers must meet a revised budget neutrality test that reflects the implementation of the Part D drug benefit.

MMA will also 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 standard. Some currently medically needy dual eligibles may no longer qualify for Medicaid if their

² Some groups (including the Centers for Medicare and Medicaid Services, CMS) include in the definition of “dual eligibles” those low-income Medicare beneficiaries for whom Medicaid *only* covers some Medicare cost-sharing.

³ 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.

⁴ Section 1115 of the Social Security Act allows the federal government to waive sections of Medicaid law for research and demonstration purposes so long as the project is budget neutral over a five-year period. Several states (e.g., Arizona) provide a substantial portion of their Medicaid program under the auspices of a Section 1115 waiver.

prescription drugs are covered by Medicare and are no longer out-of-pocket expenses.⁵

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, for example, the number of refills, or the number of prescriptions in a given time period.

Generally, drugs covered under the Part D benefit will include those drugs that states are *required* to cover under Medicaid. Except for smoking cessation drugs, the Part D drug benefit will not include those drugs that are *optional* for states to cover under Medicaid (e.g., over-the-counter drugs). Within the list of covered Part D drugs, PDPs are permitted to establish a formulary as long as it includes drugs within each therapeutic category and class. A PDP is not required to cover *all* drugs within a category or class. As requested in MMA, the United States Pharmacopeia (USP) developed and released a draft list of therapeutic categories and classes in August 2004.

PDPs that submit formularies for review can use the classification system developed by USP or can develop an alternative classification system. In either case, CMS intends to review the formularies proposed by PDPs by looking at best practices in existing drug benefits and ensuring that the drugs covered in the formulary are adequate and do not discriminate against a specific disability or condition.

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. States may, however, continue to use Medicaid funding to cover those drugs not covered by MMA.

For individuals the scope of benefits will likely change as they switch from Medicaid to Medicare. Unlike the Medicaid program, MMA does not limit the number of prescriptions an individual can receive or require prior authorization for particular drugs. However, an individual will have to determine which drugs are on the PDP formulary and, if needed, request coverage of a different drug. MMA gives individuals (or their authorized representative(s)) rights to access a particular drug not covered by the formulary through an exceptions or appeals process.⁷ Requests for exceptions to the formulary or appeals of a PDP decision must be made by the PDP within 72 hours (or 24 hours for expedited requests.) If necessary, other levels of appeal may also be available.

⁵The 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.

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.

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-payments for the services they use. To enroll in the Medicare drug benefit, most persons will have to pay drug plans a premium for coverage 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 some 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

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.

different formularies and have different premiums or co-payments. Dual eligible beneficiaries will have to choose which PDP they want to enroll in. To decrease the likelihood that a dual eligible's drug coverage will lapse when switching from Medicaid to Medicare, starting in October 2005, CMS will randomly assign dual eligible individuals to a low-cost PDP and notify them of this assignment. Dual eligibles may choose another plan; however, if another plan is not chosen, the dual eligible individual will be enrolled in the assigned plan effective January 1, 2006. Unlike other Medicare beneficiaries, dual eligibles will be permitted to change enrollment in Part D plans at any time.¹⁰

Changes for Dual Eligibles Residing in Institutions

To access prescription drugs, dual eligibles residing in institutions will *also* be required to enroll in Medicare Part D and select a PDP. Currently, institutions (e.g., nursing facilities) must provide pharmacy services for Medicaid residents (including dual eligibles). Generally, facilities contract with a single long-term care (LTC) pharmacy that supplies prescriptions drugs for those residents. Since residents of institutions access prescription drugs somewhat differently than those in the community, MMA requires PDPs to provide "convenient access" for prescription drugs for institutional residents.¹¹

Federal regulations implementing MMA require PDPs to contract with *any* LTC pharmacy that meets certain standards (to be established by CMS) and that is willing to participate in the PDP's network. CMS will require PDPs to demonstrate that there is a sufficient network of participating LTC pharmacies to meet MMA's convenient access requirements. Institutions may select and contract with the LTC pharmacy(ies) that best meets their needs, and residents will receive information about those PDPs that provide access to LTC pharmacy benefits in their specific institution.

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 FY2003 federal and state drug rebate agreements reduced Medicaid drug expenditures by 22%.¹²

MMA's effect on overall drug prices is unknown; several areas remain unclear:

- Forty-three percent of Medicaid expenditures for outpatient prescription drugs are spent on dual eligibles. With a significant decrease in Medicaid drug expenditures, will state and federal Medicaid official's ability to negotiate rebates with pharmaceutical companies diminish?

¹⁰ Other Medicare beneficiaries are limited to changing enrollment once a year.

¹¹ Section 1860D-4(b)(1)(C)(iv) of the *Social Security Act* as added by P.L. 108-173.

¹² CRS analysis of Centers for Medicare and Medicaid Services' data, Form 64, FY2003.

- To enhance its ability to negotiate with drug manufacturers, will states increasingly join other states in pooled purchasing arrangements?
- What will be the effect of MMA provisions stipulating that prices negotiated by PDPs will not be considered in the rate Medicaid pays?

Administration of Low-Income Subsidy

Under MMA, state Medicaid agencies and the Social Security Administration (SSA) must determine eligibility for the low-income subsidy of the drug benefit for all Medicare beneficiaries not just dual eligibles. SSA has established an application and eligibility process that a state can also be use. However, to comply with MMA, upon a beneficiary's request, a state must complete applications using its own eligibility determination process starting July 2005. Developing the administrative capacity and changing the state's eligibility determination system within this timeframe will be challenging.

While screening individuals for the low-income subsidy, 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 Medicare cost-sharing assistance and receiving full Medicaid benefits.

Coordination of Services for Dual Eligibles

States have also requested gaining access to the Part D drug utilization data by dual eligibles for the purpose of managing and coordinating care. For example, a state may be implementing a care management program for individuals with chronic illness in which information about prescription drug utilization may be an important component for managing that care. Given the requirements of MMA, it is unclear whether CMS has the authority to give state Medicaid agencies utilization data or can require the PDPs to share the data with states.

Medicaid Financing: The Clawback Formula

States are also responsible for partially funding the new Part D 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 prescription drug expenditures 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 is reduced from 90% for 2006 and gradually declines to 75% for years after 2014. In its final regulation, CMS provided detailed information on the data sources to be used to calculate state clawback payments. The calculation does not address earlier state issues with the clawback formula (e.g., using FY2003 data that do not reflect more recent state efforts to reduce spending).

Finally, it is unclear how or if states will modify their state Medicaid programs in response to MMA (e.g., to lower the "clawback" payment by reducing eligibility for dual eligibles, or to cover drugs not included in the Part D benefit.) This will be addressed in future updates as information becomes available.