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Implications of the Medicare Prescription Drug Benefit for State Budgets

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Summary

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA, P.L. 108-173) made several major changes to Medicare including (1) adding a voluntary Medicare Part D outpatient prescription drug benefit effective January 1, 2006; (2) offering Medicare beneficiaries discounted prescription drugs in 2004 and 2005 through an endorsed discount card; (3) modifying various Medicare payment rates.

The new Medicare drug benefit is funded in two ways: (1) by traditional Medicare funding through enrollee payments and the Health Insurance Trust Fund; and (2) by phased-down (commonly referred to as "clawback") payments from the states to the federal government. The state payments reflect the fact that starting in 2006, Medicare Part D will replace the prescription drug benefits currently received by dual eligibles (individuals enrolled in both Medicaid and Medicare) through state Medicaid programs.

The funding mechanism for the new Medicare prescription drug benefit has the potential to reduce both Medicaid and other state health expenditures. However, two types of issues associated with the financing of Part D may affect the potential for state budget savings: (1) technical issues associated with the formula for calculating phased-down state payments to the federal government; and (2) policy issues raised by MMA that may directly or indirectly impact Medicaid and other state health programs.

This report outlines the issues associated with the financing of Part D coverage through phased-down state payments to the federal government, as well as the potential impacts of the Medicare drug benefit on Medicaid and other state health expenditures. It will not be updated.

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Overview

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA, P.L. 108-173) made several major changes to Medicare including (1) adding a voluntary Part D outpatient prescription drug benefit effective January 1, 2006; (2) offering Medicare beneficiaries discounted prescription drugs in 2004 and 2005 through an endorsed discount card; (3) modifying various Medicare payment rates.[1]

In general, Medicare is the primary payer for those services covered by both Medicare and Medicaid, and Medicaid usually covers those costs in excess of what is covered by Medicare. For Medicaid benefits that are not available under Medicare (for example, 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.

Federal Medicaid law allows states to offer a number of benefits that are not covered by Medicare, including (at state option) prescription drugs. All 50 states and the District of Columbia currently cover prescription drugs for at least some Medicaid enrollees. Starting in 2006, full-benefit dual eligibles[2] will qualify for prescription drug benefits under Medicare Part D, and states will no longer be allowed to claim federal Medicaid matching funds for state dollars spent on drug coverage for these individuals. In order to receive prescription drug coverage, full-benefit dual eligibles must enroll in the new 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).

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[1] For additional information, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O'Sullivan et al. and CRS Report RL32283, *Medicare Endorsed Prescription Drug Discount Card Program*, by Jennifer O'Sullivan.

[2] The term "dual eligible" refers to individuals who qualify for both Medicare and Medicaid. Some dual eligibles receive only a limited set of Medicaid benefits (for example, pharmacy only or assistance with Medicare Part A and Part B premiums and cost-sharing only). Those who receive the full range of Medicaid benefits offered in their state are referred to as "full-benefit" dual eligibles.

government. The state payments reflect the fact that starting in 2006, Medicare Part D will replace the prescription drug benefits currently received by full-benefit dual eligibles through state Medicaid programs.

Two types of issues associated with the financing of Part D may have an impact on state budgets: (1) technical issues associated with the formula for calculating phased-down state payments to the federal government; and (2) policy issues raised by MMA that may directly or indirectly affect Medicaid and other state health programs. This report focuses on these issues for the Part D provisions in MMA that may impact state budgets.[3] It does not address other provisions with a potential impact on states, including disproportionate share hospital (DSH) payment changes and new Medicare payments for services that previously have been covered by Medicaid for dual eligibles (for example, initial preventive physical exams).

Phased-Down State Payments

Starting in 2006, full-benefit dual eligibles will qualify for Medicare Part D coverage, and states will no longer be allowed to claim federal Medicaid matching funds for state dollars spent on prescription drug benefits for these individuals. However, states will continue to be responsible for a significant portion of their drug costs through phased-down payments to the federal government. These monthly amounts are calculated under a formula (see **Table 1**) relating past state Medicaid drug expenditures and the current number of full-benefit dual eligibles in a state.

Table 1. Calculation of Phased-Down State Payments

Formula:		
$\text{Monthly payment}_{state}$	=	[(1/12) *x* $\text{Base year per capita}_{state}$ *x* (1-FMAP_{state}) *x* Inflation adjustment] *x* $\text{Enrollment}_{state}$ *x* Annual adjustment factor
Where:		
$\text{Base year per capita}_{state}$	=	State Medicaid per capita spending on covered Part D drugs for full-benefit dual eligibles in 2003
FMAP_{state}	=	Federal matching assistance percentage (FMAP) is the federal share of Medicaid financing for a given state (determined by a formula related to state personal income); one minus FMAP is the state share of Medicaid financing
Inflation adjustment	=	For 2006, the annual increase in per capita expenditures for all prescription drugs from National Health Expenditure projections; for later years, the annual increase in actual per capita expenditures for drugs covered under Part D
$\text{Enrollment}_{state}$	=	State number of full-benefit dual eligibles in a given month
Annual adjustment factor	=	90% for 2006, declining to 75% for 2015 and later years

Source: Table prepared by the Congressional Research Service (CRS) based on Section 1935(c) of the Social Security Act.

[3] For a discussion of the impact on dual eligibles and on state Medicaid programs, see CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs*, by Karen Tritz.

The phased-down payment formula is designed to approximate what the state share of Medicaid spending on prescription drugs for dual eligibles would have been in the absence of the new Medicare Part D benefit and to provide some shifting of these costs to the federal government. The partial shifting of prescription drug costs for these individuals from the states to the federal government is done over time through the annual adjustment factor (the factor is 90% for 2006 and gradually declines to 75% for years after 2014).

Phased-Down State Payment Formula Issues

Inflation Adjustment. As with most inflation adjustments, the inflation rate used in the phased-down state payment formula is calculated on a national basis. However, the new Part D benefit provides coverage through approved plans on both a national and a regional basis. Differences between regions and plans related to drug formularies, ability to negotiate drug prices, and cost control mechanisms may lead to differences in increases in prescription drug prices. Using a national inflation adjustment assumes that there are no such differences. Another issue is that until the new Medicare Part D benefit begins, the inflation rates used for 2004, 2005, and 2006 will be based on increases for all prescription drugs, not just those covered under the Part D benefit. To the extent that the prices of Part D drugs grow at a rate that is different than the average for all drugs, phased-down state payments will not reflect the difference until 2007.

Selection of 2003 as the Base Year. One issue associated with the base year per capita expenditure amounts is the timing of the data used to calculate them. The use of 2003 locks in a base level of state funding that does not reflect recent changes made by states to control their Medicaid drug spending. To the extent that a state made changes after 2003, including the use of a drug formulary or co-pays to limit costs under Medicaid, the state will not realize these savings in their phased-down payments.[4] The use of 2003 also locks in a base level of state funding that reflects the profile of a state's full-benefit dual eligible population in one particular year. As a result, states with higher levels of drug utilization in 2003 will have higher base year per capita drug expenditures and will permanently fund the Medicare drug benefit at a higher rate than other states. Regardless of how utilization patterns may change in future years, phased-down state payments will continue to reflect the level of full-benefit dual eligible drug utilization in 2003.

Quality and Availability of Base Year Data. The first piece of information needed for the calculation of base year per capita expenditures is the number of full-benefit dual eligibles enrolled in Medicaid fee-for-service and managed care arrangements in 2003. While states are required to submit information to the Centers for Medicare & Medicaid Services (CMS) on the dual eligible status of every Medicaid enrollee through the Medicaid Statistical Information System

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[4] A recent survey of the 50 states found that 46 took some type of pharmacy cost containment action in state fiscal year (SFY) 2003; 44 took action in SFY2004. See Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in FY2003 and FY2004* (Sept. 2003), Appendices B — E.

(MSIS), some have difficulty doing so. Based on fiscal year (FY) 2001 data, nine states could not identify the Medicare status (that is, whether or not an individual was enrolled in the program) of 10% or more of Medicaid enrollees.

Even when states are able to identify dual eligibles in their MSIS data, they may not be able to identify whether or not they are entitled to full Medicaid benefits. In FY2001, 18 states could not identify the benefit status (that is, whether an individual was entitled to full benefits or limited assistance only) of 25% or more of dual eligibles.[5] CMS is currently working with the states to improve the quality of data reporting in this area, but if some states are not able to provide complete information for 2003, it is unclear how the number of full-benefit dual eligibles will be determined for purposes of calculating base year per capita expenditures and how this will affect the size of phased-down state payments.

Also required for the calculation of base year per capita expenditures is total Medicaid spending on covered Part D drugs for full-benefit dual eligibles in 2003. This may come from some combination of MSIS and Medicaid financial management (Form CMS-64) information submitted by the states. However, there are a number of data issues that will need to be addressed. One such issue is the fact that CMS-64 reports do not include a separate accounting for the cost of outpatient prescription drugs provided under capitated plans. A second issue is that expenditures for drugs purchased directly from physicians or included in claims for other services (such as institutional and home and community-based care) may also not be identified separately in these reports. While MMA addresses managed care by specifying that an estimated actuarial value of drug benefits provided under capitated plans be used in base year per capita expenditure calculations, it does not address how the other types of non-itemized drug spending mentioned above will be included in the calculations.

A third issue with Medicaid spending data and the calculation of base year per capita expenditures is the identification of expenditures attributable to drugs not covered under Part D. MMA specifies that these are to be excluded from the base year calculations, but it is unclear how non-covered drugs will be defined and how the non-covered drug expenditures will be separated out from available data.[6]

State Medicaid Expenditures

Starting in 2006, full-benefit dual eligibles will qualify for prescription drug benefits under Medicare Part D, and states will no longer be allowed to claim federal Medicaid matching funds for state dollars spent on drug coverage for these individuals. However, as discussed below, state Medicaid savings that result from

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[5] CRS analysis of MSIS state summary data provided by CMS.

[6] For example, if a state covered a broad range of brand-name drugs in 2003 that are not available or not widely available through Part D prescription drug plans (presumably because the plan formularies include less expensive substitutes), it is not clear whether the full cost of providing the brand-name drugs will be included in the calculation of base year per capita expenditures.

this shift may be offset if the screening process for the Part D low-income subsidy program leads to a greater proportion of Medicare beneficiaries being identified as eligible for Medicaid benefits. Depending on whether or not dual eligibles enrolled in Medicaid waiver programs are included in the base year per capita expenditures used to calculate phased-down payments to the federal government, some states may be able to realize savings by allowing the cost of drug coverage for these enrollees to fall solely on the Medicare program.

According to Congressional Budget Office (CBO) estimates, the elimination of Medicaid prescription drug coverage for full-benefit dual eligibles will reduce state Medicaid spending by $114.6 billion between FY2004 and FY2013. However, all but $17.2 billion of this amount will be offset by phased-down state payments ($88.5 billion), spending on new dual eligibles[7] ($5.8 billion), and administrative and other costs ($3.1 billion).[8]

Low-Income Subsidies

Under MMA, certain low-income Medicare beneficiaries are entitled to subsidies that provide assistance with Part D premiums and cost-sharing (deductibles, co-insurance, and co-payments). State Medicaid agencies are responsible for determining eligibility for these subsidies and are likely to incur both administrative and new enrollee costs as a result of the subsidy screening process.

Administrative Costs. As a condition of receiving federal financial participation for their Medicaid programs, states are required under MMA to determine eligibility for Medicare Part D's low-income subsidy program for all Medicare beneficiaries, not just those who are dual eligibles. Social Security offices will also share in this responsibility. CBO estimates that more than 14 million individuals will be eligible for low-income subsidies in 2006, although not all of them are expected to participate in the program. State Medicaid programs will receive federal reimbursement for 50% of costs associated with administering the subsidy, such as hiring new staff and modifying eligibility determination systems.

New Enrollee Costs. Starting in 2006, full-benefit dual eligibles will qualify for Medicare Part D and will no longer be eligible for Medicaid prescription drug benefits. Despite the fact that this will lead to a decrease in Medicaid prescription drug expenditures, total state Medicaid expenditures may still increase if the Part D subsidy screening process leads to a greater proportion of Medicare beneficiaries being identified as eligible for Medicaid benefits.

When screening Medicare beneficiaries for Part D subsidy eligibility, states must determine their eligibility for Medicaid-funded subsidies that provide assistance

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[7] This includes both full-benefit dual eligibles and those who receive limited assistance (for example, Medicare Part A and Part B premium and cost-sharing subsidies only).

[8] Congressional Budget Office, letter to Senator Don Nickles (Nov. 20, 2003), Table 3.

with Medicare Part A and Part B premiums and cost-sharing.[9] They may also determine eligibility for full Medicaid benefits.[10] Although states will not be allowed to claim federal Medicaid matching funds for state dollars spent on drug coverage for full-benefit dual eligibles, they will continue to receive federal reimbursement for a portion of the other Medicaid costs associated with serving dual eligibles (including both full-benefit dual eligibles and those who receive limited assistance only).

Pharmacy Plus and Other Section 1115 Waivers

Under MMA, it is unclear which, if any, Medicare beneficiaries who receive prescription drugs through a Section 1115 Medicaid waiver[11] will be considered full-benefit dual eligibles for purposes of calculating phased-down state payments. Section 1115 waivers vary in their scope and comprehensiveness, and CMS has yet to release official guidance on the treatment of dual eligibles covered under these programs. Pharmacy Plus waivers, which are Section 1115 waivers that give states the option to extend Medicaid drug coverage to certain low-income elderly and disabled individuals who otherwise are not eligible for Medicaid benefits and who have limited or no access to prescription drug coverage, may have a particular impact on some state budgets.

The majority of current Pharmacy Plus enrollees are Medicare beneficiaries who will qualify for Part D in 2006. However, since they do not receive full Medicaid benefits, Medicaid drug expenditures made on their behalf in 2003 will likely not be included in the base year per capita expenditures used to calculate phased-down state payments. States, therefore, will not be required to share in the financing of Part D benefits for these individuals, and they may choose to abandon or revise their waivers to allow the cost of drug coverage for dual eligible Pharmacy Plus enrollees to fall solely on the Medicare program. In three of the four states with programs in FY2003, state spending on Pharmacy Plus benefits was approximately $945 million.[12]

Although states may opt to allow the cost of drug coverage for some dual eligible waiver enrollees to fall on the Medicare program, the impact this will have on beneficiaries may be a consideration. Currently, state Medicaid programs are permitted to impose nominal co-payments for prescription drugs (with most falling between $0.50 and $3.00 per prescription) on non-institutionalized Medicaid beneficiaries, and they are prohibited from imposing co-payments on institutionalized

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[9] These Part A and Part B subsidies are also known as the Medicare Savings Programs.

[10] For individuals eligible for both Medicare and full Medicaid benefits, Medicare is the primary payer. Medicaid covers the cost of services above the Medicare payment, as well as the cost of state-offered Medicaid services that are not covered by Medicare (such as long-term care).

[11] Section 1115 of the Social Security Act allows the federal government to waive certain sections of Medicaid law for research and demonstration purposes.

[12] Estimate based on CRS analysis of waiver data provided by CMS.

beneficiaries. There are no premiums charged and there is no additional cost-sharing required for Medicaid prescription drug coverage.[13]

Under Part D, individuals who reside in an institution will have no cost-sharing obligations, and those who are full-benefit dual eligibles will qualify for a premium subsidy equal to the weighted average Part D plan premium for their region or the actual premium amount for basic coverage under the plan they enroll in (whichever is less). As a result, the amount that institutionalized dual eligibles pay for prescription drugs under Part D may not differ substantially from what they would have paid under Medicaid. However, for dual eligibles who do not reside in an institution, they amount they pay for prescription drugs may increase under Part D. The size of that increase is unknown and will vary by person depending on income level, the prescription drugs used, increases in the Consumer Price Index (CPI), and increases in Part D expenditures.[14]

Future Drug Expenditures

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 on behalf of Medicaid beneficiaries. The "best price" formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price offered by the manufacturer for the drugs. In exchange, states are required to cover all drugs marketed by the manufacturers. A few states have negotiated supplemental rebates in addition to the federal agreements.

The potential impacts of MMA on drug prices paid by state Medicaid programs are unclear. Since more than half of Medicaid expenditures for outpatient prescription drugs are for dual eligibles,[15] it remains to be seen whether the reduction in purchasing volume created by the shifting of these individuals to Part D in 2006 will affect the ability of state and federal Medicaid officials to negotiate rebates with drug manufacturers. A separate issue is the effect of an MMA provision that exempts prices negotiated for drugs under Medicare-endorsed discount drug card plans, Part D plans, and certain other qualified entities from the best price formulas used by manufacturers in calculating rebates to the states. If the prices negotiated by these exempt purchasers are lower than those negotiated by non-exempt purchasers, states will not be allowed to benefit from these lower prices through increased rebates on their Medicaid drug expenditures.

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[13] See CRS Report RL3076, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne and April Grady.

[14] For more information, see CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs*, by Karen Tritz.

[15] See CRS Report RL31987, *Dual Eligibles: Medicaid Expenditures for Prescription Drugs and Other Services*, by Karen Tritz and Megan Lindley.

Other State Health Expenditures

State Pharmacy Assistance Programs

State Pharmacy Assistance Programs (SPAPs) are state-sponsored programs that provide prescription drug subsidies and discounts, most often for low-income aged and disabled individuals who do not qualify for Medicaid. Twenty-nine states currently have SPAPs in operation, and nine have enacted laws to create programs but have not yet implemented them. States appropriated an estimated $1.5 billion for SPAPs in 2001.[16]

Starting in June 2004, Medicare beneficiaries (with the exception of those who have Medicaid drug coverage) will have access to Medicare-endorsed discount cards that provide some assistance with drug costs until Part D is implemented in 2006. States may use SPAP dollars to cover discount card enrollment fees for beneficiaries. They may also continue to assist individuals with their drug costs. Beneficiaries may be enrolled in both a Medicare discount card program and an SPAP, and states may encourage them to utilize their Medicare benefits before turning to the SPAP for assistance.

Starting in 2006, many Medicare beneficiaries who currently qualify for SPAPs will be eligible for the Part D low-income subsidy program. Regardless of beneficiaries' low-income subsidy eligibility, states may choose to use SPAP dollars to supplement beneficiaries' Part D coverage by (1) purchasing additional benefits from a qualifying Medicare prescription drug plan; (2) by providing their own state programs; or (3) by helping beneficiaries meet their Part D premium and cost-sharing obligations.

In June 2004, the Secretary of HHS announced the appointment of a 24-member State Pharmaceutical Assistance Transition Commission. The commission was mandated by MMA and is charged with developing a detailed proposal to address issues faced by SPAPs and SPAP beneficiaries as a result of the new Medicare drug benefit. A report from the group is due to the President and Congress in January 2005.

State Retiree Health Plans

MMA provides financial incentives for employers, including the states, to continue offering prescription drug coverage for retirees. Starting in 2006, employers that elect to provide drug plan benefits that are at least as generous as Part D will receive direct subsidies from Medicare equal to 28% of drug costs incurred between $250 and $5,000 per retiree who is eligible for Part D but chooses not to enroll. Employers that instead provide wrap-around or supplemental benefits for retirees with Part D coverage will not qualify for the subsidy. Further, their contributions will not count toward retirees' Part D cost-sharing for purposes of calculating whether an individual has reached the catastrophic out-of-pocket limit for Part D.

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[16] National Health Policy Forum, *State Pharmacy Assistance Programs* (Apr. 26, 2004).

Based on a recent survey, an estimated 1.7 million Medicare-eligible individuals were enrolled in state-based retiree health plans (all of which offered prescription drug benefits) in 2002. When asked in the survey to speculate on what would happen if a Medicare prescription drug benefit were to be enacted by Congress, more than three-fourths of responding states anticipated retaining their drug coverage as a wrap-around supplement to whatever Medicare offered. A small number anticipated either dropping coverage altogether or retaining their current coverage in exchange for a federal subsidy.[17] In light of the budgetary pressures faced by states, those that wish to retain some type of prescription drug benefit for retirees have a strong incentive to choose the least expensive option, whether it be comprehensive coverage with a federal subsidy or limited wrap-around coverage with no subsidy.

However, as with the decision over whether to allow prescription drug costs for dual eligible Medicaid waiver enrollees to fall solely on the Medicare program, the impact on beneficiaries may be a factor in a state's decision over whether to provide comprehensive drug coverage for retirees. Individuals who do not qualify for low-income subsidies under Part D may be subject to significantly higher out-of-pocket prescription drug costs than they would be under a state-based retiree health plan. As a result, budget costs may be only one consideration when states determine the level of prescription drug benefits that will be offered to retirees.

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[17] Jack Hoadley, *How States Are Responding to the Challenge of Financing Health Care for Retirees* (Henry J. Kaiser Family Foundation, Sept. 2003).