



DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

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January 21, 2004

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Ladies and Gentlemen:

The recent enactment of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 has received a great deal of media attention examining how this benefit will provide prescription drug benefits to over 40 million Medicare enrollees nationally.

The Medicare prescription drug legislation is complex, and there are a number of unknown factors regarding the impact of this law on current State programs. However, the enclosed analysis examines the Medicare benefit compared to current Maryland programs and estimates the potential impact of this benefit on Maryland residents and the State Budget.

This report, prepared by the Office of Policy Analysis, was written by Ms. Shannon McMahon and Ms. Linda Stahr. Editorial review was performed by Dr. Simon Powell and Mr. David Romans. I trust that you will find this information helpful in your deliberations on this subject.

Sincerely,

Warren G. Deschenaux
Director

WGD/SMM/meg

Enclosure

cc: President Thomas V. Mike Miller, Jr.
Speaker Michael E. Busch

**Impact of the Medicare Prescription Drug,
Improvement, and Modernization Act of 2003 on
Current Maryland Prescription Drug Programs**

**Department of Legislative Services
Office of Policy Analysis
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Impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 on Current Maryland Prescription Drug Programs

Medicare Prescription Drug Benefit Enacted; Impact on State Programs Must Be Addressed During 2005 Session

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This legislation creates “Medicare Part D”, which includes an optional outpatient Medicare Prescription Drug Program. The program has varying levels of cost sharing and coverage levels based on an eligible individual’s income and prescription drug coverage under other health benefit programs.

Phase I – June 1, 2004: Medicare Prescription Drug Discount Card and Transitional Assistance Program

By June 2004, prescription drug discount cards approved by the Center for Medicare and Medicaid Services (CMS) will be offered for seniors to purchase. These voluntary cards will be offered temporarily until the full prescription drug benefit program is implemented. Approved Medicare discount cards will provide a discount off the full retail price of prescriptions in the range of 10-25%. An annual enrollment fee of up to \$30 may be charged to receive a card.

Medicare eligible individuals not enrolled in Medicaid, TRICARE, or the Federal Employees’/Retirees’ Health Benefit Program with incomes less than 135% of federal poverty guidelines (FPG) will qualify for a \$600 subsidy to help pay for prescription drugs through the discount card program. Federal law excludes individuals enrolled in Medicaid or Medicaid waiver programs from participating in the drug discount program or the subsidy. Therefore, individuals enrolled in the Maryland Pharmacy Assistance Program (MPAP), the Maryland Pharmacy Discount Program (MPDP), or in Medicaid are ineligible for the discount card program. However, individuals enrolled in the Senior Prescription Drug Program (SPDP) may also be eligible for the discount card and/or subsidy based on their income.

Phase II – January 1, 2006: Full Implementation of Medicare Parts C & D

The Medicare Prescription Drug, Improvement and Modernization Act calls for full implementation of the Medicare prescription drug benefit beginning on January 1, 2006.

Medicare eligible individuals will have the option of enrolling in a Medicare prescription drug program. The drug benefit will be provided through private prescription drug plans that

contract with the Medicare program. Medicare managed care plans, currently known as Medicare+Choice, will be renamed Medicare Advantage under the newly created Medicare Part C. Medicare Advantage plans are authorized by the federal government to provide a drug benefit in addition to managing benefits currently provided under Medicare Parts A & B.

Enrollee Benefits under the Medicare Prescription Drug Benefit Program

After paying a premium estimated to be \$35 a month and incurring a \$250 annual deductible, drug costs will be covered as follows:

- Enrollees will pay 25% of drug costs between the deductible and \$2,250 ($\$2000 \times 25\% = \500 out-of-pocket);
- Enrollees will pay for all drug costs between \$2,250 and \$5,100 (\$2,850 out-of-pocket); this equals a maximum of \$3,600 in total beneficiary out-of-pocket spending on the first \$5,100 of drug costs ($\$250 + \$500 + \$2,850 = \$3,600$ out-of-pocket); and
- Enrollees then will pay 5% of drug costs above \$5,100 or \$2 generic/\$5 brand name co-pay, whichever is greater.

It is important to note that after an enrollee reaches the \$2,250 level of drug expenses in a year, their coverage stops, and enrollees must pay for the next \$2,850 in drug expenses out-of-pocket. This is called the “doughnut hole.” When individuals are in the doughnut hole, only out-of-pocket expenditures for drugs that are on the Medicare formulary count toward the out-of-pocket expenditure requirement. However, federal law allows state pharmacy assistance programs’ expenditures to count toward spending to get out of the “doughnut hole.” Third party payment, such as payment from private insurance companies does not count toward out-of-pocket expenditures to get out of the “doughnut hole.” In addition, CMS has indicated that it is considering starting a demonstration project that would allow private health plans to reduce or eliminate the “doughnut hole” gap in drug coverage.

Low Income Subsidy and Treatment of Individuals Dually Eligible for Medicare and Medicaid

The Medicare prescription drug benefit provides additional assistance for people with low incomes and limited assets. Individuals with Medicare who are also fully eligible for Medicaid benefits (in Maryland, this includes individuals with household incomes below 74% of poverty level) or Medicare enrollees who have household incomes at or below 100% of poverty level will no longer receive prescription drug benefits from the State Medicaid program and instead will be entitled to Medicare prescription drug benefits that include:

- full premium subsidy;
- full subsidy of deductibles; and
- co-pays of \$1 for generic drugs; \$3 for brand name drugs – According to the Department of Health and Mental Hygiene (DHMH), approximately 75,000 individuals in Maryland are full dual eligibles, including institutionalized Medicaid enrollees.

Other beneficiaries with low income and limited assets will receive premium and deductible assistance and have limited cost sharing. Medicare beneficiaries with household incomes between 100-135% of FPG are entitled to limited subsidies including:

- full premium subsidy;
- full subsidy of deductibles; and
- co-payments of \$2 for generic drugs, \$5 for brand name drugs up to the \$5,100 catastrophic limit, and no cost sharing after reaching this threshold.

Medicare beneficiaries with household incomes between 135-150% of FPG are entitled to limited subsidies including:

- premium subsidies on a sliding scale basis;
- \$50 annual deductible; and
- 15% coinsurance up to the \$5,100 catastrophic limit; greater of 5% coinsurance or co-payments of \$2 for generic drugs, \$5 for brand name drugs after reaching the catastrophic limit.

Impact of Medicare Modernization Legislation on Current Maryland Pharmacy Programs

Maryland has five programs designed to respond to the lack of a Medicare prescription drug benefit. Eligibility for these programs varies according to income and assets as well as whether or not the enrollee has other prescription drug coverage. **Exhibit 1** details current Maryland programs and how benefits provided under these programs correspond to the new Medicare pharmacy benefit.

Exhibit 1
Maryland Pharmacy Programs Compared to Medicare Drug Benefit

STATE PHARMACY ASSISTANCE PROGRAM			NEW MEDICARE PART D DRUG PROGRAM		
Income Eligibility Level	State Program	Cost-sharing	Income Eligibility Level	Federal Program	Cost-sharing
Medicaid/Medicare dual eligibles (roughly 74% FPG)	Maryland Medical Assistance Program	No premium No deductible Co-pays: \$2 brand \$0 generic	<100% FPG (includes dual eligibles)	Medicare Part D benefit – no coverage gap	No premium No deductible Co-pays: \$3 brand \$1 generic
<116% FPG	Maryland Pharmacy Assistance Program (under federal 1115 waiver)	No premium No deductible Co-pays: \$7.50 brand \$2.50 generic			
<175% FPG	Maryland Pharmacy Discount Program (under federal 1115 waiver)	No premium No deductible Enrollee pays \$1 processing fee per scrip plus 65% of retail cost after Medicaid discount	<135% FPG	Medicare Part D benefit – no coverage gap	No premium No deductible Co-pays: \$5 brand \$2 generic
			<150% FPG	Medicare D benefit – no coverage gap	Sliding scale premium; \$50 deductible; 15% cost sharing up to \$5,100; After \$5,100 co-pays: greater of : \$5 brand/ \$2 generic or 5%
Roughly < 200% FPG Exact income limits vary by manufacturer	Medbank	None	150% and above FPG	Medicare Part D benefit	Approx. \$35 monthly premium; \$250 deductible; 25% cost sharing up to \$2,250; 100% cost sharing between \$2,250 - \$5,100; 5% cost sharing after that
<300% FPG	Senior Prescription Drug Program	\$10 monthly premium Co-pays: \$35 non-preferred \$20 preferred \$10 generic Benefits may be capped at \$1000			

Source: Department of Legislative Services, Department of Health and Mental Hygiene, and Maryland Insurance Administration.

Note: FPG = Federal Poverty Guidelines

The following Maryland-specific programs will be impacted by the Medicare prescription drug law:

- **Medicaid** – For Medicare beneficiaries currently receiving drugs through Medicaid, the federal government will now be responsible for those expenditures. However, Maryland will be asked to pay the federal government an amount equal to a percent of what the federal government estimates the State would have paid if Medicaid were still responsible for providing the prescription drug benefit. This is known in the federal legislation as “clawback”, and is a maintenance of effort provision for states. Beginning in 2006, the State will be required to pay back to the federal government 90% of the cost of providing drug coverage to individuals who are dually eligible for Medicare and Medicaid, using fiscal 2003 expenditures as the base year and trending forward. State contribution phases down by 1.66% per year over a ten-year period until it reaches 75%, where it will remain indefinitely.

There are currently 569,000 individuals enrolled in Medicaid, and of these, 75,000 are dually eligible for Medicare and Medicaid.

- **Waiver Programs** – Medicare eligible individuals will no longer receive drug coverage under Maryland’s pharmacy waiver programs, including MPAP and MPDP. It is likely MPAP will lose its federal waiver that grants the State a 50% match on pharmacy costs. Therefore, if the program is continued for those who are not Medicare eligible, the State may bear the full cost of operating this program. In accordance with HB 762 of 2003, DHMH has submitted a waiver application to the U.S. Department of Health and Human Services that would provide federal matching funds for primary care services, including pharmacy, to low income individuals not eligible for Medicaid.

There are currently 49,000 individuals enrolled in MPAP, and of these, 14,000 are also eligible for Medicare, and 2,500 receive Medicare premium assistance.

There are currently 3,200 Medicare eligible individuals enrolled in MPDP and of these, approximately 500 receive Medicare premium assistance.

- **Retiree Drug Coverage** – Under the federal legislation, qualified retiree plans with drug coverage that are actuarially equivalent to the Medicare Part D benefit will receive a 28% subsidy for spending above \$250 and up to \$5,000 per Medicare eligible enrollee per year. Enrollees receiving Medicare drug subsidies through their retiree plan may not enroll directly in Medicare Part D.

DLS estimates that there are 30,562 Medicare-eligible retirees and dependents enrolled in Maryland’s retiree drug benefit.

- **The Senior Prescription Drug Program (SPDP)** – Administered by the Maryland Health Insurance Plan, the SPDP could be restructured since Medicare Part D provides more comprehensive drug coverage. In addition, legislation establishing the SPDP provided for the termination of the program once a “comparable” program was offered for Medicare enrollees or at the end of 2005.

There are 33,000 individuals enrolled in SPDP.

Fiscal Impact of Medicare Drug Benefit on Current Maryland Programs

As shown in **Exhibit 2**, the fiscal impact on the State is indeterminate but could be considerable.

Exhibit 2 Fiscal Impact of Medicare Drug Bill (State Funds Only; \$ in Millions)

<u>Provision or program</u>	<u>Savings</u>	<u>Cost</u>	<u>Net Impact</u>
Medicare/Medicaid dual eligibles	\$109 ¹	(\$98) ²	\$11
Maryland Pharmacy Assistance Program	\$32 ³	(\$17) ⁴	\$15
Medbank ⁵	\$0	\$0 additional	\$0
Maryland Pharmacy Discount Program ⁶	\$8	\$0	\$8
Senior Prescription Drug Program ⁷	\$20	\$0	\$20
State Employee Retirees ⁸	Indeterminate	\$0	Indeterminate
DHMH administrative costs ⁹	Indeterminate	Indeterminate	Indeterminate

Source: Department of Legislative Services, Department of Health and Mental Hygiene, Department of Budget and Management, and Maryland Insurance Administration.

¹ Savings for dual eligibles are based on fiscal 2003 spending as reported by DHMH and trended forward, using national inflationary estimates, to fiscal 2006. Figure represents annualized savings, although Medicare Part D benefit begins January 1, 2006. Because the State has already initiated measures to contain rising drug costs, the inflationary estimates may be too high, in which case, savings would be less.

² Cost of dual eligibles represents the “clawback” of State savings to the federal government. For fiscal 2006, the clawback is 90% of savings. The clawback declines each year until reaching 75% in 2015. Figure represents annualized cost, although fiscal 2006 clawback is for only half the State fiscal year.

³ Savings for the Maryland Pharmacy Assistance Program (MPAP) are for Medicare recipients, who represent 14,000 of MPAP enrollees. Figure is based on fiscal 2003 spending, trended forward, using national inflationary estimates, to fiscal 2006.

⁴ Cost for MPAP is based on the assumed loss of the Medicaid Section 1115 waiver for the program, and subsequent shift of the federal share of program costs for non-Medicare eligible enrollees to the State. There were 34,000 enrollees in MPAP who were not eligible for Medicare in fiscal 2003. Figure is based on fiscal 2003 spending, trended forward to fiscal 2006. Since MPAP enrollees are not eligible for the full range of Medicaid benefits, it is assumed that the “clawback” provisions do not apply.

- ⁵ The 2003 BRFA provides \$.5 M for Medbank in fiscal 2006. Although approximately half of Medbank participants are senior citizens who would be eligible for a full subsidy of prescription costs under the new Medicare Part D, it is assumed that the State will continue to provide a grant to Medbank in fiscal 2006. The program sunsets on June 30, 2006.
- ⁶ The Maryland Pharmacy Discount Program (MPDP) is funded through the Medicaid budget. Although \$8 million of State funds are budgeted for the MPDP in fiscal 2004, enrollment is far less than the 40,000 anticipated. It is assumed that the State will lose the Medicaid waiver that allows the State to pass on reduced Medicaid drug prices to program enrollees.
- ⁷ The Senior Prescription Drug Program sunsets on the earlier of June 30, 2005, or the availability of comparable prescription drug benefits provided by Medicare. Since the Medicare Part D program does not begin until January 1, 2006, it is assumed that the General Assembly will reauthorize the program until that date, providing 6 months of savings in fiscal 2006 and a full year of savings beginning in fiscal 2007. By law, CareFirst Inc. is required to subsidize the program up to the value of its insurance premium tax exemption. Figure represents the 2003 subsidy. Future years' subsidy will depend on CareFirst membership but is assumed to remain stable. The General Assembly may want to designate some other use for those funds.
- ⁸ The Medicare prescription drug legislation provides a subsidy to employers, including states, for 28% of drug costs between \$250 and \$5,000. DBM has no estimates at this time of potential savings. DLS estimates 30,562 Medicare-eligible retirees and dependents. For illustrative purposes only, if the State spends \$2,250 on drugs for the average Medicare-eligible retiree, the State could receive \$17 million from the federal subsidy.
- ⁹ DHMH is required to provide HHS with Medicaid eligibility information, make eligibility determinations for low income premium and cost-sharing subsidies, and engage in outreach. Regular federal matching applies to these activities. DHMH may reap savings from administrative activities no longer performed for MPDP and MPAP. DHMH may also benefit from the \$62.5 million in mandatory spending the Medicare bill provides to state pharmaceutical assistance programs for education, technical assistance, and other program coordination activities.

Impact of Medicare Drug Benefit on Maryland Residents

According to U.S. Census data, there are approximately 573,000 individuals in Maryland over the age of 65 who are eligible for Medicare benefits. The impact of the Medicare prescription drug legislation on this population will vary based on an individual's drug expenditures, household income, assets, and enrollment in a public or private retiree health benefit program that includes prescription drug coverage. **Exhibit 3** provides hypothetical examples of the impact of the Medicare drug benefit on seniors enrolled in current Maryland programs.

Exhibit 3
Examples of Impact of the Medicare Pharmacy Law on Seniors in Maryland

<u>Medicare Enrollee</u>	<u>Annual Income</u>	<u>Drug Needs & Retail Cost of Rx</u>	<u>State Program Enrollment Out-of-Pocket Cost</u>	<u>Out-of-Pocket Cost Under Medicare Pharmacy Benefit</u>	<u>Better Off Under Medicare or Current Maryland Programs?</u>
Mr. X	\$12,000 (135% of FPG)	\$1,200 for one cholesterol drug	Under the MPDP, he would pay \$663 per year. ¹ Under the SPDP, he would pay \$440. ²	He will pay only a modest co-pay of \$2 or \$5 each month for his medication. ³	Medicare
Mrs. Y	\$13,000 (150% of FPG)	\$1,080 for one diabetes drug	Under the MPDP she would pay approximately \$597 per year. ¹ Under the SPDP, she would pay \$360. ²	Annual out-of-pocket expense of \$665 or \$565 if Medicare drug plan can negotiate a 15% discount. ⁴	Indeterminate
Mr. and Mrs. Z	\$36,000 (300% of FPG) ⁵	\$4,728 for high blood pressure, ulcer, depression and anticoagulant drugs.	Under the SPDP, they would pay \$3,455. ²	Annual out-of-pocket expenses of \$2,568 or \$2,219 if Medicare their drug plan can negotiate a 15% discount.	Medicare

Source: Department of Legislative Services; retail drug costs from cvs.com

¹ All MPDP calculations assume a 15% Medicaid discount as well as the 35% State subsidy in statute.

² Assumes \$10 monthly premium per person, \$20 co-pay for each 30-day supply of a prescription, 10% discount on price negotiated by the program administrator, and \$1,000 per person cap on program benefits.

³ Because his income is below 135% of FPG, under the new Medicare Part D program, he will qualify for a full premium subsidy, no deductible, and no "doughnut hole" cost sharing.

⁴ Because her income is below 150% of FPG, under the new Medicare Part D program, she will qualify for a sliding scale premium subsidy and reduced deductible and coinsurance.

⁵ Since their income is over 175% of FPG, they do not qualify for MPDP benefits.

Conclusions and Next Steps

There remain a number of unknown factors regarding the impact of the Medicare prescription drug legislation on current State programs, particularly with regard to the fiscal impact. Regulations detailing the federal government's implementation plans for the Medicare pharmacy benefit have not been released.

If the General Assembly is interested in maintaining programs to provide prescription drug coverage for seniors or low income individuals, current programs could be restructured to address the need for gaps in coverage. One such option could include reducing out-of-pocket costs for Medicare enrollees whose drug expenditures are high enough that they are in the Medicare "doughnut hole." In addition, the State needs to begin evaluating the options for the State Employee's and Retiree's Health Benefit Program, which could include fashioning a Medi-Gap benefit for prescription drugs.

Clearly, the General Assembly will need to consider during the 2005 session how current programs could be best structured to meet the needs of seniors in the State without compromising the federal match for existing programs. New Jersey has formalized the process of working through the integration of its existing programs into the Medicare benefit by establishing an interagency task force on prescription drugs. The General Assembly may wish to consider formalizing such a task force.