



**NASDDDS**

## **POLICY ADVISORY**

*Unravelling the Mysteries of Federal Policy...*

September 13, 2004

PA 02-2004

# **Understanding the New Medicare Drug Coverage Law**

## *A Guide to Assist State Developmental Disabilities Agencies*

**Background:** On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173; MMA). Touted as the most far-reaching re-write of Medicare law since the program's inception in 1965, the legislation provides seniors and individuals with disabilities with a prescription drug benefit, as well as making a number of other significant changes to the federal health insurance program. P.L. 108-173, was passed after nearly six years of debate and negotiation in Congress.

In the years since Medicare's creation, the role of prescription drugs in U.S. patient care has significantly increased. As new, more sophisticated and expensive drugs have come into use, patients have found prescriptions harder and harder to afford. The MMA attempts to address this problem through various drug coverage options, incentives and initiatives to create private health care plans, low-income benefits, and a drug discount card program to fill the gap until the new Medicare drug benefits goes into effect. The MMA also contains a series of "conceptual" reforms or initiatives, such as income-related premiums and benefits within Medicare, a chronic care demonstration programs, health savings accounts (HSAs), procedural cost control provisions, and the 2010 "premium support" competition demonstration.

The MMA was crafted with a very close eye on the legislation's budgetary impact. Prior to approving the legislation, Congress voted not to exceed \$400 billion in additional Medicare spending over the 10-year budget period on the new drug benefit between 2004 and 2013. As a result, the prescription drug benefit is funded

---

*in a complex manner, reflecting the diverse priorities of the lobbyists and constituencies whose support was needed to ensure its passage. The legislation provides a subsidy for large employers to discourage them from eliminating private prescription drug coverage for retired workers; it prohibits the federal government from negotiating discounts with drug companies; and it prevents the government from establishing a drug formulary, though it does not prevent private providers such as health maintenance organizations (HMOs) from doing so.*

*The most significant implication of the Medicare Part D prescription drug benefit for state MR/DD agencies lies in provisions shifting the coverage of medications for "dual eligibles" (i.e., individuals who are eligible for both Medicare and Medicaid) from Medicaid to Medicare. Given the fact that a sizeable number of individuals with developmental disabilities who receive Medicaid-funded long-term services and supports through state MR/DD agencies also are eligible for Medicare, state agencies can expect a significant operational and budgetary impact from implementation of the MMA's new Medicare drug benefit. The purpose of this **Policy Alert** bulletin is to explain the ramifications that the changes in prescription drug coverage for dual eligibles will have for state MR/DD agencies.*

---

## ***What are the basic drug coverage provisions of the Medicare Modernization Act?***

The Medicare Part D Prescription Drug benefit provides Medicare beneficiaries with prescription drug coverage that will be offered by private, risk-bearing plans. Beneficiaries who choose to remain in fee-for-service programs to receive Medicare benefits will be able to sign up for drug coverage under stand-alone, private prescription drug plans (PDPs). Other beneficiaries may elect to get all Medicare benefits, including the new prescription drug benefits, as part of an integrated health plan, furnished by preferred provider organizations (PPOs), HMOs or similar health plans. These plans are known, in Medicare parlance, as Medicare Advantage (MA) plans.

The new legislation creates a federally subsidized benefit, which may vary from plan to plan, subject to certain constraints. Beneficiaries who choose to sign up for the new drug benefit will pay a monthly premium, estimated to be \$35 per month in 2006. Beneficiaries will be responsible for the first \$250 in drug expenses, and then will pay, on average, a 25 percent coinsurance until they reach the benefit limit (\$2,250 in 2006). Once they reach the benefit limit, enrollees will face a gap in coverage and be required to pay 100 percent of the costs of drug purchases up to \$5,100 in total drug spending (equal to \$3,600 in out-of-pocket spending). Medicare then will pay 95 percent of drug costs above that amount. These benefit levels are indexed to rise annually with the growth in per capita drug expenditures for the Medicare population. Private drug plans are required to provide drugs in each therapeutic class and category but are granted the flexibility to modify cost-sharing levels (other than the out-of-pocket limit) and can also modify formularies and preferred drug lists.

---

## ***How will the population served by state MR/DD Agencies be affected by the prescription drug provisions of the MMA?***

As of January 1, 2006, dual eligibles will be expected to obtain their prescription drug coverage through the new Medicare “Part D” of the program; Medicaid no longer will provide drug coverage for such individuals. Dual eligibles are individuals who are entitled to receive both Medicare and Medicaid benefits. While the vast majority of dual eligibles are low-income elderly persons, there are several million non-elderly individuals who qualify for Medicare on the basis of disability (i.e., they meet the OADSI/SSI disability criteria and have paid Social Security taxes for a sufficient number of quarters, given their age at disability) and also have income and resources below the state’s Medicaid financial eligibility standards. However, a portion of non-elderly dual eligibles qualify on the basis of the Social Security earnings records of a parent. These so-called Disabled Adult Children (DACs) are qualified to receive Social Security payments, and, after a 24-month waiting period, Medicare coverage, upon the death, retirement or disability of their fully insured parent. According to the Social Security Administration (SSA), in December of 2002 there were 744,532 Disabled Adult Children. Of this number, 397,810, or 53 percent, were also receiving Supplemental Security Income (SSI) benefits. SSA data establishes that of the total number of DACs (744,532), 421,660 qualify for this status through a diagnosis of mental retardation or another mental disorder such as cerebral palsy; autism, epilepsy. Although the exact number of dual eligibles receiving long-term care services due to mental retardation or a related developmental disabilities is unknown, these figures suggest that they make up a significant proportion of the population served by MR/DD agencies – probably 50 percent or more.

These dual eligibles will need to be transitioned from their current Medicaid prescription drug coverage to a new Part D plan. How this process will take place has yet to be fully resolved. It also is not clear how the coverage under the Part D plans will compare to coverage that dual eligibles currently have under state Medicaid programs, since the new Medicare law does not guarantee equivalent prescription drug coverage for dual eligibles. If dual eligibles do not enroll in a Part D plan or if they need more drug coverage than is provided by the private Medicare participating drug plan they select, states will not be able to secure federal Medicaid matching funds for the cost of providing additional prescription drug benefits.

## ***How will the Part D Prescription Drug Plans (PDP) work?***

In general, coverage for the new prescription drug benefit will be provided in two ways. First, beneficiaries who wish to receive health services through Medicare Parts A & B in addition to drug coverage can do so through Medicare Advantage (MA; formerly known as Medicare+Choice) plans that offer integrated prescription drug and health care coverage (MA–PD plans). Most dually eligible individuals receiving long-term supports through Medicaid will enroll in private prescription drug plans (PDPs) that offer drug-only coverage, which must meet basic standards enumerated in the MMA, but may also offer supplemental benefits through enhanced, alternative coverage for an additional premium. Privately managed drug benefit plans will compete for regional contracts with Medicare to offer these PDPs. Beneficiaries then will

---

select from among competing PDPs in their region. The Act requires that each Part D eligible individual have available a choice of enrollment in at least two qualifying plans, at least one of which must be a PDP.

### ***When does Medicare part D coverage begin?***

Medicare Part D coverage begins January 1, 2006, and Medicaid prescription drug coverage for dual eligibles ends on the same date, so there is no transitional grace period. Enrollment in the PDPs will open on November 15, 2005. Although the MMA does offer Medicare Part D eligible beneficiaries the opportunity to obtain drug coverage before January of 2006 through the prescription drug discount card program, individuals with Medicaid prescription drug coverage are not eligible to participate in this program.

### ***Who will be responsible for enrolling dual eligibles in Medicare Part D?***

The MMA envisions individuals eligible for Medicare Part D benefits receiving information on approved prescription drug coverage options in their area, selecting the plan that best fits their needs, and enrolling themselves. The Secretary of U.S. Department of Health and Human Services (HHS) is responsible for establishing a process for the enrollment of Medicare beneficiaries that will include broad dissemination of comparative information to beneficiaries on different Part D plans, including the premiums charged, the benefits offered, and quality and performance. The process also contemplates the use of marketing materials by Part D plans; these materials are subject to prior review by the Secretary to ensure that they are not materially inaccurate or misleading. The Secretary also is authorized, but not required, to provide information to Part D plans about eligible beneficiaries in order to facilitate marketing by the plans and enrollment of individuals into the plans. Since the new prescription drug benefit is a voluntary program, most eligible beneficiaries who do not enroll will simply be assumed to have chosen not to participate in Medicare Part D.

However, the legislation makes special provisions for dual eligibles, directing HHS to develop procedures for enrolling dual eligibles in a Part D plan for which a full premium subsidy (offered to low income beneficiaries) is available if they do not do so on their own. In areas where there is more than one Part D plan for which a full subsidy is available, the Secretary is directed to randomly assign dual eligibles among such plans. Although the legislation does not provide any timeframe by which the Secretary's procedures must provide for the enrollment of dual eligibles in Part D plans, CMS tentatively plans to randomly assign dual eligibles to plans if they have not selected one by December 1, 2005. The legislation also does not provide any mechanism to enable the Secretary to identify dual eligibles in need of such coverage, nor does it give states any direct authority to ensure that dual eligibles are enrolled in Part D plans. In proposed rules to implement Part D, CMS suggests that states might be given the responsibility of auto-enrolling dual eligibles in PDPs, CMS itself may fill this role, or, alternatively, CMS might contract with a private entity to perform this function.

---

States should be aware that, under the legislation and CMS' proposed regulations, individuals will have only a two week window within which to make a plan selection, or they will be auto-enrolled in a randomly chosen plan. Although dual eligibles could not be enrolled in a plan whose premium would not be covered by the low-income premium subsidy, the complex drug needs of much of this population make it likely that, in a region with a number of PDP options, the plans auto-selected for these individuals will not be the best suited to meet their medication needs. Considering the incidence of dementia, mental health concerns, and simple confusion within the dual eligible population, it is highly likely that a significant number will require assistance to choose a plan or will be randomly enrolled.

### ***How will dual eligibles with developmental disabilities choose a plan that meets their needs and that their residential service provider can work with?***

In its proposed regulations, CMS anticipates conducting a significant public information campaign to educate beneficiaries about the new Medicare drug benefit, placing an emphasis on ensuring that low-income individuals and “hard-to-reach populations” are aware of the additional benefits available to them and how to receive those benefits. The regulations propose that CMS provide enrollment assistance with and through “appropriate State and Federal agencies,” although, with the exception of State Health Insurance Assistance Programs, these agencies are not specified. Although the statute does not require it, the information would be made available to beneficiaries at least 30 days before their initial enrollment period under CMS' proposed rules. The information dissemination activities for Part D would be similar to, and coordinated with, the information dissemination activities that the agency currently performs for Medicare beneficiaries. The law requires that CMS include comparative information on PDPs regarding benefits and prescription drug formularies, the monthly beneficiary premium, quality and performance, cost-sharing, and the results of consumer satisfaction surveys.

However, it is difficult to imagine most dual eligibles with developmental disabilities successfully navigating this flow of information without some additional assistance. Unfortunately, no agency at the federal or state level is specifically charged with the responsibility of educating dual eligibles about the choices they face and assisting them in making those choices in an informed manner. Whether dual eligibles are effectively informed of the choices they have will depend on whether HHS, CMS, the Social Security Administration (SSA), and the individual states work to achieve this objective.

### ***Will dual eligibles be able to change plans easily?***

While most beneficiaries will only be able to make changes to their plan enrollments during specially designated periods once a year, the MMA establishes more frequent “special enrollment periods” (SEPs) for a number of sub-populations affected by the new program. SEPs allow an individual to disenroll from one PDP and enroll in another more often than once annually. CMS has proposed establishing a twelve-month annual SEP for individuals who are eligible for both Medicare and full benefits under a state's Medicaid program, which effectively

---

would allow dual eligibles to make such changes at any time. This approach would provide dual eligibles who have been automatically assigned to a plan on December 1, 2005 the opportunity to change PDPs immediately, or at any point during the year if they choose to do so.

### ***How comprehensive is the Medicare Part D coverage?***

The array of drugs covered by a dual eligible's Part D plan will depend on the policies of the plan in which he or she happens to enroll. Although they must follow some rules if they want to establish formularies, Part D PDPs have broad flexibility under the new law to determine the array of drugs that they want to cover. They are explicitly authorized to limit to two the number of drugs covered within any given therapeutic class, and each Part D plan may define what constitutes a therapeutic class for purposes of complying with this requirement. The Medicare prescription drug law also permits prescription drug plans to deny coverage for off-label uses of medications that are currently covered by Medicaid.

The MMA specifically cites drugs, biological products, and insulin (including medical supplies associated with injections) that are covered under Medicaid and vaccines licensed under Section 351 of the Public Health Service Act as eligible for inclusion in a PDP. Drugs excluded from coverage include those for which payment is available under Medicare Parts A or B, and those in categories that may be excluded under Medicaid (i.e., weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals, non-prescription drugs, barbiturates, and benzodiazepines), except for smoking cessation agents. Drugs not meeting the Medicare definition of reasonable and necessary, or not prescribed according to plan or Part D requirements, can be excluded from coverage by plans, but such determinations are subject to appeal.

### ***For dual eligibles, how does coverage through Medicare Part D compare to the Medicaid drug coverage it will replace?***

In many circumstances, the array of drugs covered by Part D plans may fall short of those covered under existing state Medicaid plans. In all likelihood, dual eligibles will be able to afford to enroll only in PDPs with average or below-average premiums since otherwise they will not qualify for the premium subsidies offered under the legislation. While state Medicaid programs generally are required to cover all medically necessary drugs, Part D plans have far more flexibility to limit the array of drugs they cover. Although beneficiaries can appeal a decision by their Part D plan to deny coverage of a particular drug, it is not yet clear how well these appeals procedures will work, particularly for dual eligibles with limited financial resources and, in many cases, physical or cognitive impairments.

While the formulary must be set by a committee consisting mostly of professionals, and despite the existence of appeals processes, patients requiring some specific classes of medications, such as anti-seizure medications and anti-psychotics, may experience negative health effects if forced to switch to a different drug. As a result, states could see an increase in individuals needing a

---

more intensive treatment setting or a cost shift to medications purchased with state general revenues funds only.

### ***Will dual eligibles residing in institutions be able to continue to use Long Term Care Pharmacies?***

The MMA authorizes CMS to include standards regarding access to long-term care pharmacies for Part D enrollees who reside in long-term care facilities when establishing rules for convenient access to network pharmacies. CMS has interpreted "long-term care facility" to mean a skilled nursing facility or a nursing facility, but in the preamble to its proposed regulations agency officials request comments on whether intermediate care facilities for persons with mental retardation or related conditions (ICF/MRs) should explicitly be included in this definition. CMS explains that its proposal to limit the applicability of long-term care pharmacies to skilled nursing and nursing facilities is based on the agency's understanding that only those facilities are bound to Medicare conditions of participation that result in exclusive contracts between long-term care facilities and long-term care pharmacies. However, CMS goes on to suggest that, to the extent that ICF/MRs exclusively contract with long-term care pharmacies in a manner similar to skilled nursing and nursing facilities, the agency would consider modifying this definition in the final regulations to include ICFs/MR. In this discussion, CMS recognizes that individuals residing in these facilities who are dually eligible for Medicaid and Medicare will need to be assured access to covered Part D drugs.

The preamble to the August 3 regulations further expresses CMS' belief that, given the specialized mission of nursing facilities and the narrowly defined subsets of beneficiaries they serve, the inclusion of long-term care pharmacies in PDP networks would greatly enhance Part D benefits for enrollees in such long-term care facilities. The agency is concerned, however, that requiring PDPs to include long-term care pharmacies in their networks may force plans to negotiate preferential contracting terms and conditions with those pharmacies in order to meet the requirement. The preamble to the proposed regulations considers instituting such a requirement, but also suggests that the out-of-network access requirement articulated elsewhere in the rule would assure that Part D enrollees living in a long-term care facility could use long-term care pharmacies that are not part of a PDP network. The regulations require PDPs to assure that beneficiaries have adequate access to Part D drugs from out-of-network pharmacies when beneficiaries cannot reasonably access drugs at a network pharmacy. Since it is generally the case that long-term care facilities contract with a single long-term care pharmacy, CMS reasons that Part D enrollees residing in a long-term care facility could not reasonably be expected to access their covered Part D drugs at another pharmacy, and, therefore, should be able to use the long-term care pharmacy through the out-of-network access requirement.

Beyond simply providing prescription drugs, institutional pharmacies offer a number of services, including maintaining Medication Administration Records (MARS), specialized packaging, 90 day client medication profile reviews, and emergency deliveries to a range of homes and facilities. The State currently pays these pharmacies at an enhanced rate for medications, and is able to claim federal financial participation for these costs through Medicaid. Neither the statute nor the regulations address whether Medicare Part D will fund these services, or whether

---

Medicaid could continue to fund them as an expense separate from the provision of prescription drugs (e.g., as an administrative expense under the state's Medicaid plan).

### ***What are Medication Therapy Management Plans?***

It is possible, however, that some of these drug administration services would be covered, for targeted beneficiaries, by the Medication Therapy Management Plan (MTMP) benefit included in Medicare Part D. Prescription drug plans that choose to offer a Part D benefit will be required to incorporate MTMPs into their benefit structures, and are required to develop the services in consultation with practicing pharmacists and physicians. These services will be targeted to Medicare patients with "multiple chronic diseases" who are taking multiple prescription medications and whose drug spending exceeds threshold levels that will be established by the Secretary of HHS. The proposed rule invites comments on how HHS should provide guidance to drug plans in defining "multiple chronic diseases" and "multiple covered Part D drugs," or whether such determinations are best left to the plans as part of their benefit design. CMS also states its preference for delegating the responsibility for setting the level of annual costs that must be incurred by a beneficiary to qualify for the receipt of MTMP services to the private drug plans, arguing that they would be better able to evaluate their patients.

CMS expects the bulk of medication therapy management services to be provided by pharmacists but will allow drug plan sponsors to use "other qualified health care professionals" to offer such services. CMS considers MTMPs to be administrative activities intrinsic to the drug plan, so that the services would not involve direct beneficiary cost-sharing and Part D enrollees would not be required to pay separate fees for these services. Instead, the cost of a MTMP would be considered an administrative cost incidental to the provision of appropriate drug therapy and, therefore, not an additional benefit. While the statute requires HHS to establish guidelines for the coordination of any MTMP with a beneficiary's care management plan required by Medicare under a chronic care improvement program, neither the statute nor the proposed rule addresses the question of coordination with a dual eligible beneficiary's Medicaid-required Individual Services Plan (ISP).

The MMA describes a MTMP broadly, allowing PDPs to establish a broad range of additional services meant to optimize therapeutic outcomes for targeted beneficiaries. The proposed rule defines the goals of MTMPs as:

- Enhanced enrollee understanding — through beneficiary education counseling and other means — that promotes the appropriate use of medications and reduces the risk of potentially adverse events associated with the use of medications.
- Increased enrollee adherence to prescription medication regimens (for example, through medication refill reminders, special packaging, and other compliance programs and other appropriate means).
- Detection of adverse drug events and patterns of overuse and underuse of prescription drugs.

---

CMS envisions MTMPs including such services as performing patient health status assessments, formulating prescription drug treatment plans, managing high cost “specialty” medications, evaluating and monitoring patient response to drug therapy, providing education and training, coordinating medication therapy with other care management services, and participating in state-approved collaborative drug therapy management. The agency also anticipates that targeted beneficiaries will demonstrate a need for different levels of service, ranging from a fifteen-minute phone consultation to a one-hour, in-person visit with a pharmacist.

### ***Will beneficiaries have the right to appeal a decision not to cover a drug?***

All Part D plan enrollees, including dual eligibles, will have the right to ask their Part D plans to reconsider a decision to deny a prescription drug that is on the plan’s formulary. In the case of “tiered” formularies, where a Part D plan charges lower cost-sharing for preferred drugs and higher cost-sharing for non-preferred drugs, plan enrollees may request an exception in certain circumstances. Plan enrollees also will be able to appeal the denial of payment for a drug that is not on the plan’s formulary if the prescribing physician determines that none of the drugs on the formulary would be as effective for the individual as the non-formulary drug or the formulary drug would have adverse side effects.

In some circumstances, enrollees may be able to appeal the plan’s decision to the Secretary of HHS and, ultimately, to the federal courts. The law directs HHS to develop appeal procedures that operate in a manner similar to the Medicare + Choice appeals procedures. Under those procedures, the right to a hearing before the Secretary is available only to Part D plan enrollees with disputed claims of \$100 or more, while the right to judicial review is limited to claims involving \$1,000 or more. The Medicare + Choice appeals process also includes provisions for expedited appeal decisions in cases of emergency that generally call for emergency appeals to be decided within 72 hours. However, the legislation leaves unclear the question of whether individuals who appeal a denial of a drug that is not on the Part D plan’s formulary have a right to an expedited decision, no matter how urgent the situation. Furthermore, although allowed in the current Medicare + Choice procedures, the new legislation specifically bars doctors from pursuing appeals before the Secretary or the courts on behalf of their patients. Given their limited financial resources and physical and cognitive impairments, dual eligibles in the DD service system may find it particularly difficult to navigate the appeals process by themselves.

### ***Can states use Medicaid matching funds to fill gaps in the prescription drug coverage of dual eligibles under Part D?***

As of January 1, 2006, states no longer will be able to claim federal Medicaid matching funds for the prescription drug expenses of Medicaid-eligible individuals who are also eligible for Medicare Part D prescription drug coverage. The bar on using federal matching funds to provide Medicaid prescription drug coverage extends to all “full benefit” dual eligibles, whether they are covered because of federal Medicaid requirements or at state option. For example, Medicaid

---

beneficiaries no longer will qualify for Medicaid-financed prescription drug coverage if they are SSI recipients, covered under the state option to expand coverage for people with disabilities to 100 percent of the poverty line, covered under the state option to extend Medicaid eligibility for institutionalized individuals up to 300 percent of the SSI payment standard, or receiving home and community based services at state option. The one exception is that states can use Medicaid matching funds to provide classes of drugs that Part D plans are not allowed to cover. These classes of drugs are now covered under Medicaid at state option.

It is important to note that all dual eligibles who could enroll in a Medicare Part D plan, even if they have not yet done so, will lose their Medicaid prescription drug coverage as of January 1, 2006. Although the statute, and CMS' proposed regulations, call for automatically enrolling any dual eligible who has not chosen a PDP by December 1 of 2005, if auto-enrollment does not take place in a timely manner, it is possible that some dual eligibles could end up with no prescription drug coverage at all for a period of time after losing their Medicaid-financed prescription drug coverage.

### ***Will individuals currently receiving services from a state DD agency be required to pay co-pays or premiums?***

The MMA offers substantial assistance with the cost-sharing obligations of dual eligibles by establishing a low-income subsidy program that will make cost-sharing assistance available. Medicare will pay the Part D deductible on behalf of all dual eligibles, as well as the premiums of such beneficiaries if they enroll in an average or low-cost Part D plan. However, given the often-complex prescription drug needs of dual eligibles, many average or low-cost PDPs may not provide adequate coverage. If a dual eligible enrolls in a Part D plan that charges a premium in excess of the average for a region, the affected person will be responsible for the difference in premium costs. States that elect to pay the non-Medicare covered prescription drug costs of dual eligibles will need to compare the savings in premiums and deductibles associated with these low-cost plans to the expenses incurred paying for drugs not included in their formularies. The deductible and premium subsidy are available to all “full-benefit” dual eligibles, not just those who otherwise would be eligible for the new law’s low-income subsidy program due to their income or assets.

The low-income subsidy program also will provide extensive assistance with all of the dual eligibles’ prescription drug costs, but only as long as they use drugs covered by their particular Part D plan. While most Part D beneficiaries will face a benefit cap of \$2,250, after which they will pay 100 percent of their drug costs up to \$5,100 in total drug spending, dual eligibles will have no benefit limit. In other words, dual eligibles do not face the “doughnut hole.” Dual eligibles residing in nursing homes or other institutions are fully exempt from Part D cost-sharing obligations. Dual eligibles not living in institutions, with income at or below 100 percent of the federal poverty level, will have co-payments of no more than \$1 per generic drug and \$3 per brand name drug in 2006, although these co-payment obligations will increase over time with inflation, as measured by the Consumer Price Index. Dual eligibles with income above 100 percent of the poverty level not residing in institutions will pay up to \$2 per generic drug and \$5 per brand name drug in 2006, indexed over time to the growth in per capita Part D drug costs.

---

However, the current Medicaid rule that prohibits providers from denying prescriptions to individuals who cannot meet a co-payment requirement will not apply to dual eligibles enrolled in Part D plans. Thus, if a dual eligible is unable to meet a Part D co-payment, he or she can be denied the prescription until the co-payment requirement is met.

### ***What will be the impact of MMA on state budgets?***

The question of the impact of the prescription drug provisions of the MMA on state budgets has been a subject of some controversy. While the federal government has predicted long-term savings for states, others have predicted increases in state spending on prescription drugs for dual eligibles. In a November 20, 2003 letter to Senator Don Nickles, the Congressional Budget Office (CBO) provided estimates of the effect the MMA provisions will have on state Medicaid expenditures. According to CBO, the elimination of Medicaid-financed prescription drug coverage for dual eligibles will reduce state Medicaid spending by some \$115 billion between federal fiscal years 2004 and 2013. Over the next ten years, however, CBO estimates suggest that states will see 85 percent of this savings disappear due to \$5.8 billion in higher enrollment in Medicaid as people apply for the Part D low-income subsidy program through the Medicaid programs, \$3.1 billion in new administrative responsibilities for state Medicaid programs, and mandatory clawback payments estimated at \$88.5 billion. CBO, therefore, predicts that net fiscal relief to state Medicaid programs over the next ten years will total \$17.2 billion, with nearly 80 percent of this fiscal relief occurring in the last four years (2010 – 2013) of the 10-year period evaluated by the agency. In the short-term, in fact, CBO's estimates suggest that the new law will actually lead to increased state Medicaid spending. Between fiscal years 2004 and 2006, new state Medicaid costs due to the Medicare bill are expected to exceed Medicaid fiscal relief by \$1.2 billion. The primary reason for this cost shift to state Medicaid budgets in the short-term appears to be that states' clawback payments to the federal government in 2006 are expected to exceed the amount of fiscal relief states will secure as a result of no longer providing Medicaid-financed prescription drug coverage to dual eligibles.

The law requires state Medicaid agencies and local Social Security offices to accept and evaluate the applications of Medicare beneficiaries seeking assistance with premium, deductible, and cost sharing obligations under Medicare's Part D low-income subsidy program. Over 14 million seniors are expected to be eligible for the new subsidy program in 2006, although not all of them are expected to participate. Although a significant share of those who do participate may apply for coverage through Social Security offices, even a small portion of eligible Medicare beneficiaries applying for assistance at state Medicaid offices will lead to new state administrative expenses as states hire staff and modify their computer systems to accommodate these applicants. Moreover, the statute requires states to screen Medicare beneficiaries seeking low-income subsidies to determine their eligibility for selected categories of Medicaid benefits that provide assistance with Medicare premium and/or cost-sharing obligations and offer eligible individuals the chance to enroll in Medicaid. As a result, the new Part D low-income subsidy program is expected to have a "woodwork" effect that increases state Medicaid expenditures.

The impact of the prescription drug law on state Medicaid budgets also will depend on the extent to which a state elects to use its own general funds to address coverage gaps for dual eligibles. As discussed above, dual eligibles will not be responsible for paying deductibles or premiums if they enroll in an average or low-cost Part D plan. However, low-cost plans are less likely to

---

cover the wide array of prescription drugs required by many dual eligibles, who often have complex medical needs. In some cases, states may feel compelled to use state funds to address some of the gaps in coverage, paying for prescription drugs not included in the formularies of low-cost PDPs available in the region. Alternatively, dual eligibles may need to enroll in more expensive plans in order to be assured access to the prescription drugs they need. In such cases, especially among the population served by state MR/DD agencies, dual eligibles may not possess the means to meet their premium, deductible, and cost-sharing responsibilities. In this situation, states may choose to use general funds to cover these increased costs for dual eligibles. This pressure may be especially strong in states with relatively comprehensive Medicaid prescription drug benefits, due to the increased expectations of dual eligibles. At the same time, these states will face particularly large clawback payments to the federal government due to their relatively high per capita expenditures on prescription drugs for dual eligibles in 2003. CBO's estimates also do not take into account states' savings on the cost of drug coverage for retired state employees or State Pharmacy Assistance Programs, or new Medicaid costs for dual eligibles that states are expected to incur due to the increase in Part B deductibles.

### ***What are the so-called “clawback” provisions of the Act?***

The “clawback” is a mechanism through which the states will help finance the new Medicare Part D drug benefit. Referred to in the statute as a “phased-down State contribution,” the “clawback” is a monthly payment made by each state to the federal Medicare program beginning in January 2006, based roughly on the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through its Medicaid program on behalf of dual eligibles. Rather than allowing states to keep their entire share of these costs and apply them to other purposes, the clawback provision stipulate that states must pay 90 percent of their estimated savings in calendar year 2006 to the federal government. Over the following nine years, the state's pay back proportion would gradually decline to 75 percent.

### ***How will a state's clawback obligations be calculated?***

The amount of each state's clawback payments will be recalculated each month by multiplying the state's 2003 share of per capita Medicaid expenditures on prescription drugs now covered under Part D for dual eligibles, trended forward by the number of dual eligibles enrolled in a Medicare Part D plan in the month in which the payment is made. That number will be multiplied by the phase-down percentage, specified in the statute, for the year in which the payment is being calculated (e.g., 90% in 2006; 75% in 2015). The resulting figure, divided by twelve, will represent the state's clawback payment for that month.

The per capita expenditure (PCE) is the amount the state spends as its share of Medicaid per capita spending for dual eligibles in calendar year 2003 for drugs that will be covered under Part D beginning in 2006, increased by the average annual percentage increase in per capita prescription drug spending nationally, for all populations, since 2003. The state share is based on the state's federal Medicaid matching rate for the month in which the payment is due. In calculating the state Medicaid per capita expenditures for prescription drugs for dual eligibles in

---

calendar year 2003, the statute requires HHS to include pharmacist dispensing fees, adjust for manufacturer rebates, and exclude any expenditures for drugs not covered under Part D. In the case of states that enrolled dual eligibles in Medicaid managed care plans, HHS must estimate the actuarial value of prescription drug benefits provided to dual eligibles under such capitated arrangements. The number of dual eligibles for the month is the number of Medicare beneficiaries who are actually enrolled in a PDP or MA-PD and have been determined by the state to be eligible for full Medicaid benefits, not just subsidies for Medicare premiums and cost-sharing.

To help states estimate their monthly payment amounts, HHS must notify each state of its yearly PCE amount no later than the preceding October 15. States then can apply their own estimates of monthly enrollment of dual eligibles, and the phase-down percentage for the year as dictated in the statute, in order to estimate their monthly obligation. The statute requires that states pay interest on any unpaid amount, to be offset “immediately” against the federal Medicaid matching funds the state otherwise would receive in the quarter in which the payment is due. CMS reports that it has begun the process of collecting the enrollment and expenditure data necessary to calculate the 2003 PCE for each state and to revise current reporting systems to generate the monthly dual eligible data needed starting in 2006.

***Where can I obtain more information concerning the impact of the MMA prescription drug coverage on dually eligible individuals?***

CMS’ proposed implementing regulations, as well as other background information prepared by the federal agency, is available on the CMS Web site at <http://www.cms.hhs.gov/medicarereform/>. The Kaiser Commission on Medicaid and the Uninsured maintains a site on dual eligibles that includes many useful reports on the new Medicare Part D prescription drug benefit at <http://www.kff.org/medicaid/duals.cfm>. Many of the most useful reports have been collected at <http://www.kff.org/medicaid/kcmu121503pkg.cfm>.

NASDDDS Contact: Dan Berland ([dberland@nasddds.org](mailto:dberland@nasddds.org))