Order Code RS21837
Updated January 19, 2006

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), added a new Medicare prescription drug benefit, which was implemented in January 2006. This benefit has a significant effect on Medicaid beneficiaries who also have Medicare coverage (i.e., "dual eligibles") and on state Medicaid programs, as discussed in this report. In fact, this group is the focus of recent implementation concerns regarding the new benefit. The report does not include changes to Medicaid that may be made if the Deficit Reduction Act of 2005 (S. 1932) is enacted. 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, changed the Medicare program in several areas. This report focuses on those MMA provisions that added a voluntary prescription drug benefit under a new Medicare Part D, and the effect of this new benefit both on individuals who are dually eligible for Medicaid and Medicare, and on state Medicaid programs.

Implications for Medicare/Medicaid Dual Eligibles

The term "dual eligibles" refers to individuals who qualify for services under both Medicare and Medicaid. Most of these individuals are considered "full benefit duals."[1] 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

[1] 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.

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 still apply for most Medicare and Medicaid services, MMA changed the interaction of Medicare and Medicaid for coverage of prescription drugs.

Changes to Eligibility for Dual Eligibles' Prescription Drug Coverage

As of March 2005, all states and the District of Columbia covered prescription drugs for at least some Medicaid beneficiaries. Starting in 2006, dual eligible individuals were no longer eligible for the state's prescription drug benefit provided under the Medicaid state plan[2] or a comprehensive Section 1115 waiver.[3] To receive coverage of prescription drugs, dual eligibles were required to enroll in the Medicare Part D benefit. The benefit is offered through prescription drug plans (PDPs) that have received approval from the Secretary of Health and Human Services (HHS).

MMA also affects 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 prescription drugs are covered by Medicare and are no longer out-of-pocket expenses.[4]

Changes to the Scope of Prescription Drug Coverage for Dual Eligibles

Medicaid generally 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.[5] 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 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 (though not necessarily *all* drugs) within each therapeutic category and class. As requested in MMA, the United

---

[2] 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.

[3] Section 1115 of the Social Security Act allows the federal government to waive sections of Medicaid law as long as the demonstration project is budget neutral over five years. Several states provide a substantial portion of their Medicaid program under a Section 1115 waiver.

[4] The number of individuals who may no longer qualify for Medicaid is unknown; data about out-of-pocket expenditures for medically needy individuals are not available.

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

States Pharmacopeia (USP) has released a draft list of therapeutic categories and classes — one for 2006 formularies, and a revised version for 2007 formularies.

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

States covering *other* drugs in a class or category included under MMA may not use federal Medicaid dollars to do so. This differs from other benefits covered by both Medicaid and Medicare in which Medicaid supplements Medicare coverage. States may continue to use Medicaid funding to cover those drugs *not covered* by MMA.

For dual eligibles, the scope of benefits has likely changed. Unlike Medicaid, MMA does not limit the number of prescriptions one can receive or require prior authorization for particular drugs. However, individuals must determine whether the drugs they take 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.[6] 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 are also available.

Changes to Premiums and Cost-sharing for Prescription Drugs

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 have to pay the PDP a premium for coverage, and cost-sharing amounts when they use benefits. MMA, however, established special rules for dual eligible individuals. All dual eligibles 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. In 2006, the monthly premium subsidy varied from $23.25 in California to $36.39 in Mississippi.[7] If a dual eligible chooses a drug plan with a higher premium than the amount of the subsidy, he or she is 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]

---

[6] 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.

[7] The Goldman Sachs Group, Inc. *Health Care Services, United States: Medicare drug benefit,* Oct. 10, 2005.

[8] Medicaid beneficiaries residing in institutions are required to contribute most of their income (continued...)

For dual eligibles who do not reside in an institution, the amount that they pay for prescription drugs has likely changed. State Medicaid programs are permitted to impose nominal cost-sharing on non-institutionalized Medicaid beneficiaries. Generally, the cost-sharing imposed for prescription drugs has ranged from $.50 per prescription to $3.00.

Under MMA, PDPs may 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 is adjusted annually based on the Consumer Price Index (CPI). For other dual eligibles, their co-payments are $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 is 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 also increased in subsequent years by the increase in Medicare per capita drug spending.

It appears that some non-institutionalized dual eligibles will be paying more per prescription under the Medicare Part D benefit than they had been paying 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

Under Medicaid, dual eligibles received prescription drug benefits as part of a package of Medicaid services, with the same prescription drug coverage rules applying to all Medicaid beneficiaries. Under the Medicare drug benefit, drug plans offer different formularies and have different premiums or co-payments, and may have multiple options within a drug plan. Dual eligible beneficiaries are having to decide which PDP plan they want to enroll in. For 2006, the average number of PDP options within a region is 42 — ranging from 27 in Alaska to 52 in Pennsylvania and West Virginia.[10] In October 2005, CMS randomly assigned dual eligible individuals to a low-cost PDP and notified them of this assignment to decrease the likelihood that a dual eligible's drug coverage will lapse when switching from Medicaid to Medicare. As a backup plan, CMS contracted with Wellpoint, a national PDP, to provide access for dual eligibles who arrive at a pharmacy and are not enrolled in a PDP. As of January 2006, there have been significant challenges in operationalizing the transition of dual eligibles from Medicaid to Medicare. As a result, several states are paying for prescription drugs for dual eligibles with the expectation that they will be reimbursed. Several Senators have expressed interest in sponsoring legislation to reimburse these states for their costs. HHS has also taken steps to address the confusion and operational challenges by, for example, adding resources to

---

[8] (...continued)
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.

[10] The Goldman Sachs Group, Inc. *Health Care Services, United States: Medicare drug benefit*, Oct. 10, 2005.

handle calls from beneficiaries and pharmacists, and directing PDPs to provide a 30-day transitional supply of prescription drugs.[11]

Changes for Dual Eligibles Residing in Institutions

To access prescription drugs, dual eligibles residing in institutions are *also* required to enroll in Medicare Part D and select a PDP. Under Medicaid, institutions (e.g., nursing facilities) were required to provide pharmacy services for Medicaid residents (including dual eligibles). Generally, facilities contracted with a single long-term care (LTC) pharmacy that supplies prescription 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.[12]

Federal regulations implementing MMA require PDPs to contract with *any* LTC pharmacy that meets certain standards and that is willing to participate in the PDP's network. CMS have required 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 FY2004, federal and state drug rebate agreements reduced Medicaid drug expenditures by 24%.[13]

MMA's effect on overall drug prices is unknown. Previously, Medicaid was spending a significant share of its prescription drug expenditures for dual eligibles. With the decrease in Medicaid drug expenditures, will state and federal Medicaid officials' ability to negotiate rebates with pharmaceutical companies also diminish? In addition, to enhance its negotiating ability, will states increasingly join other states in pooled purchasing arrangements?

---

[11] K. Freking, *Senators Seek to Reimburse States for Unplanned Drug Expenses*, Associated Press Writer, Jan. 18, 2006. S. Lueck, *Medicare Drug Plan Sign-Up Surges*, The Wall Street Journal, Jan. 17, 2006. R. Pear, *Rolls Growing for Drug Plan as Problems Continue*, The New York Times, Jan. 18, 2006. C. Connelly, *HHS Works to Fix Drug Plan Woes; Widespread Difficulties with New Medicare Benefit Reported*, Jan. 18, 2006.

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

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

Administration of Low-Income Subsidy

Under MMA, state Medicaid agencies and the Social Security Administration (SSA) are determining 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 most states are also using. States were also required by MMA to develop their own application.

While screening individuals for the low-income subsidy, states must also screen individuals for assistance with Medicare Part A and Part B cost-sharing. As a result, more people may become eligible for this Medicare cost-sharing assistance 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. States continue to have concerns about the clawback formula (e.g., FY2003 data does 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.