Legislative Fiscal Bureau

One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

May 26, 2005 | Joint Committee on Finance | Paper #377

SeniorCare Program Options (DHFS -- MA, BadgerCare, and SeniorCare -- Eligibility, Payments and Services)

CURRENT LAW

SeniorCare, created in 2001 Wisconsin Act 16, provides prescription drug assistance to Wisconsin residents who are 65 years of age or older. Any elderly Wisconsin resident may enroll in the program, but each recipient's income determines whether he or she is required to pay a deductible or meet a spenddown requirement.

Act 16 provided $49.9 million GPR in 2002-03 to fund SeniorCare benefits. Subsequent to the enactment of Act 16, the state obtained a waiver of federal MA law, which permitted the state to receive federal MA matching funds to support costs for recipients with income up to 200% of the federal poverty level (FPL). Program revenue is available from rebates paid by pharmaceutical manufacturers whose drugs are covered under SeniorCare.

Enrollees first received benefits under the program beginning September 1, 2002. As of March, 2005, there were approximately 87,500 individuals enrolled in SeniorCare.

The attachment provides a description of the current provisions of the program.

GOVERNOR

The Governor recommends maintaining the current program with no changes with respect to recipient cost-sharing or eligibility.

AB 100 would provide approximately $142.1 million ($51.8 million GPR, $49.2 million FED, and $41.1 million PR) in 2005-06 and approximately $153.7 million ($56.8 million GPR, $51.6 million FED and $45.3 million FED) to support SeniorCare benefits in the 2005-07

biennium. These amounts reflect base funding for the program ($39.3 million GPR, $36.3 million FED and $38.1 million PR), and funding changes recommended by the Governor to reflect changes in eligibility systems and reduced reimbursement payments to pharmacies.

DISCUSSION POINTS

1. Medicare Part D, the new prescription drug benefit under Medicare, will become available to Wisconsin seniors on January 1, 2006. Attachment 1 to this memorandum compares the SeniorCare program with Medicare Part D with respect to eligibility, enrollment, cost-sharing requirements, and pharmacy participation. This comparison illustrates that, particularly with respect to eligibility, cost-sharing requirements and drug coverage, the SeniorCare program provides greater benefits to Wisconsin seniors than the Medicare Part D benefit is expected to provide.

2. The primary argument for maintaining the current SeniorCare program, as the Governor recommends, is that program benefits are funded from several non-state funding sources, so that the cost to the state of supporting a relatively generous pharmacy assistance program is significantly less than the value of the benefits SeniorCare recipients receive. For example, in 2005-06, it is estimated that SeniorCare benefits costs (excluding costs paid by recipients, such as costs recipients incur during their deductible periods and copayments), under current law, will be approximately $146.9 million (all funds) in 2005-06, of which $54.2 million (37%) will be funded with state GPR funding, while $92.7 million, or 63%, will be supported from federal MA matching funds ($52.6 million FED) and rebate revenue the state receives from pharmacy manufacturers ($40.1 million PR).

Further, it is argued that, by providing greater access to drugs to this population, SeniorCare enables Wisconsin's elderly population to remain healthy and thus, may reduce hospitalization and long-term care services that SeniorCare recipients would otherwise require.

3. However, due to concerns over rising program costs and the possibility that the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) may not renew the waiver under which SeniorCare operates when it expires on July 1, 2007, some have argued that Wisconsin's SeniorCare program should be modified, either to increase cost-sharing requirements or reduce eligibility. Others have suggested that the program was created to address a need that no longer exists, since, at the time SeniorCare was created, there was no outpatient pharmacy benefit under Medicare.

4. This paper offers program options the Committee could consider to reduce state costs for the SeniorCare program.

5. First, the Committee could increase the copayment for brand name drugs SeniorCare recipients receive under the program, from the current level of $15, to $20. This proposal was passed by the Legislature as part of the 2003-05 budget, but was vetoed by the Governor. In 2005-06, it is estimated that the average pharmacy payment for brand name drugs under SeniorCare will be approximately $89, which includes: (a) the payment the state makes to the pharmacy ($74) and

the recipient's copayment ($15). In 2006-07, it is estimated that the average pharmacy payment for brand name drugs under SeniorCare will be approximately $96, which includes (a) the payment the state makes to the pharmacy ($81); and (b) the recipient's copayment ($15). If the Committee adopts this alternative, it could decrease funding in the bill by $7,663,400 (-$3,888,100 GPR and -$3,775,300 FED) in 2005-06 and by $8,046,600 ($4,158,900 GPR and -$3,887,700 FED) in 2006-07 to reflect this change.

6. Second, the Committee could eliminate eligibility for recipients with income that exceeds 200% of the federal poverty level (FPL), including eligibility for individuals who spend down to 200% of the FPL. The group of recipients comprises approximately 24% of total program enrollment. In 2005, 200% of the FPL is $19,940 for an individual and $25,660 for a couple. The primary rationale for this alternative is that the state does not receive federal cost-sharing for this group of SeniorCare enrollees. Further, in comparison with other SeniorCare eligibility groups, the highest income group of SeniorCare recipients has the greatest capacity to purchase drugs without the state's assistance. If the Committee adopts this alternative, it could reduce funding in the bill by $20,518,400 (-$15,799,200 GPR and -$4,719,200 PR) in 2005-06 and by $24,333,800 (-$18,737,000 GPR and -$5,596,800 PR) in 2006-07 to reflect this change.

7. Many of the current SeniorCare recipients will be eligible for prescription drug benefits under Medicare Part D on January 1, 2006. Because there will be another option for seniors to receive their drug benefits, the Committee could choose to phase out enrollment in the program, beginning January 1, 2006. Under this option, after that date, DHFS would not enroll, or re-enroll any individuals in the program, so that, by January 1, 2007, no individuals would be enrolled in the program. Under the current program, a recipient's eligibility for the program is renewed twelve months after either their date of entry into the program or their last renewal.

8. This option would allow all recipients to receive all the benefits they expect for the year in which they are enrolled. Under this option, recipients would not pay enrollment fees ($30 per year per recipient), deductibles, or satisfy a spend down requirement, only to be disenrolled from the program before they can take advantage of the benefits available to them during their enrollment year. Under this option, funding could be decreased by $7,923,100 (-$2,922,400 GPR, -$2,837,600 FED, and -$2,163,100 PR) in 2005-06 and by $119,274,500 (-$44,848,900 GPR, -$41,924,600 FED, -$32,501,100 PR) in 2006-07 to reflect the fiscal effect of phasing out SeniorCare beginning January 1, 2006.

9. Finally, the Committee could repeal the SeniorCare program, beginning January 1, 2006. At that point all seniors in the SeniorCare program will have access to prescription drug benefits through Medicare Part D. This option would lead to the most savings of all options, but also would result in enrollees not receiving all the benefits they believed they would receive at the time they enrolled or re-enrolled in the program. Recipients whose renewals come up after July 1, 2005, would have knowledge of the change and could choose not to sign up for another year in the program. Those recipients comprise approximately 75% of total program recipients, thus leaving 25% of recipients in the group of people who would not have had knowledge of the change when signing up for another year of benefits.

10. If the Committee chooses this alternative, some recipients may choose not to renew their eligibility for the program, since they would not receive program benefits for the entire year. However, the savings estimate was calculated assuming that all individuals projected to be in the program would stay in the program until it terminates. Consequently, additional savings may occur if some recipients choose not to re-enroll due to this change. If the Committee adopts this alternative, it could reduce funding in the bill by $73,446,600 (-$27,090,500 GPR, -$26,304,000 FED, and -$20,052,100 PR) in 2005-06 and by $162,009,700 (-$60,917,900 GPR, -$56,945,800 FED, and -$44,146,000 PR) in 2006-07.

ALTERNATIVES

1. Increase the current $15 copayment for brand name drugs to $20 and decrease funding by $7,663,400 (-$3,888,100 GPR and -$3,775,300 FED) in 2005-06 and by $8,046,600 (-$4,158,900 GPR and -$3,887,700 FED) in 2006-07 to reflect this change.

Alternative 1	GPR	FED	TOTAL
2005-07 FUNDING (Change to Bill)	- $8,047,000	- $7,663,000	- $15,710,000

2 Eliminate eligibility for the group of recipients that has income above 200 percent of the federal poverty level, and eliminate any spenddown options. Decrease funding by $20,518,400 (-$15,799,200 GPR and -$4,719,200 PR) in 2005-06 and by $24,333,800 (-$18,737,000 GPR and -$5,596,800 PR) in 2006-07 to reflect this change.

Alternative 2	GPR	PR	TOTAL
2005-07 FUNDING (Change to Bill)	- $34,536,200	- $10,316,000	- $44,852,200

3. Phase out the SeniorCare program by not allowing any recipient renewals or new recipients beginning January 1, 2006, thus terminating the program entirely by December 31, 2006. Reduce funding by $7,923,100 (-$2,922,400 GPR, -$2,837,600 FED, and -$2,163,100 PR) in 2005-06 and by $119,274,500 (-$44,848,900 GPR, -$41,924,600 FED, -$32,501,100 PR) in 2006-07 to reflect this change.

Alternative 3	GPR	FED	PR	TOTAL
2005-07 FUNDING (Change to Bill)	- $47,771,300	- $44,762,100	- $34,664,200	- $127,197,700

4. Eliminate the SeniorCare program effective January 1, 2006. Decrease funding by $73,446,600 (-$27,090,500 GPR, -$26,304,000 FED, and -$20,052,100 PR) in 2005-06 and by $162,009,700 (-$60,917,900 GPR, -$56,945,800 FED, and -44,146,000 PR) in 2006-07 to reflect this change.

Alternative 4	GPR	FED	PR	TOTAL
2005-07 FUNDING (Change to Bill)	- $88,008,400	- $83,249,800	- $64,198,100	- $235,456,300

5. Take no action.

Prepared by: Marlia Moore
Attachment

ATTACHMENT

A Comparison of SeniorCare with Medicare Part D Prescription Drug Benefits

This attachment compares the primary features of SeniorCare (Wisconsin's prescription assistance program for eligible Wisconsin residents 65 years of age or older), and the new outpatient drug benefit created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173). This benefit, which is authorized under Title XVIII, Part D of the Social Security Act, is commonly referred to as Medicare Part D. The Medicare benefit will first become available on January 1, 2006.

Many elderly Wisconsin residents will need to decide whether to enroll, or remain enrolled, in SeniorCare, or to enroll in a prescription drug plan offered under Medicare Part D. If they choose to participate in Medicare Part D, they will have the choice of either: (a) remaining in the traditional Medicare program and joining a stand-alone prescription drug plan (PDP); or (b) joining a Medicare Advantage plan to receive their entire medical and drug benefits from one source.

Eligibility

SeniorCare: Any Wisconsin resident who is 65 years of age or older and pays a $30 annual enrollment fee is eligible, except for: (a) individuals with prescription drug coverage under medical assistance (MA); (b) individuals who are not U.S. citizens and whose immigration status would make them ineligible for MA; and (c) inmates of public institutions. Annual income, not assets, determines the level of coverage the individual receives. Annual income is defined as a prospective estimate of annual income for all persons in the household whose income and need is included in determining eligibility for SeniorCare.

Medicare Part D: People age 65 or older, some people under age 65 with disabilities, and people with end-stage renal disease are eligible for Medicare. Anyone who is entitled to Medicare Part A or enrolled in Part B is eligible to enroll in Medicare Part D. The beneficiary also must live in the service area of the PDP or Medicare Advantage prescription drug (MA-PD) plan to enroll. Income and asset tests will determine the level of coverage the individual receives. In determining an applicant's assets, only liquid assets and real estate holdings other than a beneficiary's home or residential farm will be counted.

Enrollment

SeniorCare: Each applicant becomes eligible for SeniorCare on the first day of the month after the date the Department of Heath and Family Services (DHFS) receives a completed

application and determines that the person is eligible. Once the individual is enrolled in the program, SeniorCare recipients must re-enroll and pay the enrollment fee every 12 months to remain eligible for program benefits.

Medicare Part D: The new Medicare drug benefit is voluntary. This program has an "opt-in" rule, which means that, with limited exceptions, beneficiaries will need to sign up for the benefit by filling out an enrollment form for an approved plan (either a PDP or MA-PD plan). Initial open enrollment for Medicare Part D will begin November 15, 2005, and will run for six months, ending on May 15, 2006. If an individual enrolls by December 31, 2005, then coverage will begin with the start of the program on January 1, 2006. Enrollment during the rest of the open enrollment period will be effective the first day of the month following enrollment. After beneficiaries choose a PDP, they will generally remain enrolled for the year.

In years following the initial program enrollment, open enrollment will run from November 15 to December 31, with enrollment effective January 1 of the following year. During each open enrollment period, the beneficiary may choose to change plans for the following year. Beneficiaries who choose not to sign up at the first opportunity may pay more for their coverage if they wait to enter the program after the open enrollment period that ends in May, 2006.

Cost-Sharing Requirements

SeniorCare: Under SeniorCare, recipients are required to pay:

- A $30 annual enrollment fee;
- A copayment of $5 for a generic drug and $15 for a brand-name drug; and
- An annual deductible of between $0 and $850, depending on the enrollee's participation level (see below). Recipients receive a discount on drugs they purchase during the deductible period.

Individuals and married couples with income above 240% of the federal poverty level (FPL) are required to meet a spend-down requirement equal to the amount that the individual's or couple's household income exceeds 240% of the FPL.

Each SeniorCare recipient is assigned to one of four participation levels, which determines, in part, the amount of cost-sharing required of the enrollee. These participation levels are listed below.

Level 1 -- $0 Deductible. Individuals with income at or below 160% of the FPL are enrolled at this level. There is no deductible or spend-down requirement for these individuals. These individuals pay copayments for each drug they purchase under the program.

Level 2a -- $500 Deductible. Individuals with income above 160% of the FPL but no more than 200% of the FPL are enrolled at this level. These individuals pay a $500 annual deductible before SeniorCare pays for drugs on their behalf. Once the individual has met the deductible requirement, they pay only the copayments for the drugs they purchase.

Level 2b -- $850 Deductible. Individuals with income above 200% of the FPL but no more than 240% of the FPL are enrolled at this level. These individuals pay the $850 annual deductible before SeniorCare pays for drugs on their behalf. Once the individual has met the deductible requirement they pay only the copayments for the drugs they purchase.

Level 3 -- Spend-Down plus $850 Deductible. Individuals with income above 240% of the FPL are enrolled at this level. These individuals are first responsible for the spend-down requirement and then the $850 annual deductible requirement. Once both of these requirements have been met, they pay only the copayments for the drugs they purchase.

Medicare Part D: Similar to SeniorCare, there will be several groups of Medicare Part D beneficiaries, which will be assigned to groups, based on their income. Different cost-sharing requirements will apply to each group.

Dual Eligibles. People on Medicare who also have full MA benefits are referred to as "dual eligibles." These individuals will be automatically enrolled in Medicare Part D, and state MA programs will no longer cover their prescription drug benefits. These individuals will pay:

- No premiums;
- No deductibles;
- Copayments as follows:

a. Nursing home residents -- no copayments.

b. Individuals at or below 100% of the FPL -- $1 per generic drug or preferred multi-source drug and $3 per brand-name drug.

c. Individuals between 100% and 135% of the FPL -- $2 per generic drug or $5 per brand-name drug.

Beginning in 2007, the copayment amounts will be increased by the percentage increase in the consumer price index.

Low-Income Recipients (Non-MA) with Income Below 135% of the FPL. Individuals who are not dual eligibles that have income below 135% of the FPL and that meet an asset test ($6,000 for singles and $9,000 for couples) will pay:

- No premium;

- No deductible; and

- Copayments of $2 per generic drug and $5 per brand-name drug. However, these individuals will not be required to pay any copayments once they spend $3,600 out-of-pocket on their prescription drugs.

Beginning in 2007, the copayment amounts will be increased by the annual percentage increase in the per capita beneficiary expenditures for Medicare Part D covered drugs.

Low-Income Recipients (Non-MA) with Income Between 135% and 150% of the FPL. Individuals with income between 135% and 150% of the FPL and that meet an asset test ($10,000 for singles and $20,000 for couples) will pay:

- Premiums based on a sliding scale -- the full premium is paid for individuals with income at 135% of the FPL, which is phased down to no premium subsidy for individuals with income at 150% of the FPL;

- A $50 deductible;

- 15% coinsurance up to $5,100 in total drug spending ($3,600 in out-of-pocket drug spending); and

- Copayments of $2 per generic and $5 per brand-name drug after the individual spends $3,600 out -of -pocket on their prescription drugs.

Beginning in 2007, the copayment amounts will be increased by the annual percentage increase in the per capita beneficiary expenditures for Medicare Part D covered drugs.

Standard Benefit (Enrollees with Income that Exceeds 150% of the FPL). Individuals with income above 150% of the FPL, regardless of their assets, will be eligible for the standard Part D benefit. These individuals will pay:

- An estimated annual premium of $35 per month ($420 per year);

- A $250 deductible;

- 25% coinsurance after the deductible is met (25% of total drug costs between $250 and $2,250); and

- 100% coinsurance for drug costs between $2,250 and $5,100. This $2,850 gap in coverage is commonly referred to as the "donut hole".

- After the $3,600 out-of-pocket limit is reached (the $250 deductible amount, $500 in coinsurance for drug costs between $250 and $2,250 and $2,850 in coinsurance for drug costs between $2,250 and $5,100), recipients pay $2 for generic drugs and $5 for brand-name drugs, or a coinsurance of 5%, whichever is greater.

Beginning in 2007, the deductible and cost-sharing amounts will be increased by the annual percentage increase in the per capita beneficiary expenditures for Medicare Part D covered drugs.

Pharmacy Participation and Drug Coverage

SeniorCare: As a condition for participating in MA, pharmacies must participate in SeniorCare. As a result, most pharmacies in the state participate in SeniorCare.

Drugs covered under SeniorCare include prescription drugs that are covered under MA that are produced by manufacturers that have entered into rebate agreements with DHFS, and thus comprise the MA preferred drug list. The only over-the-counter medication covered under SeniorCare is insulin. SeniorCare does not have a formulary, but DHFS applies the same cost control techniques under SeniorCare that it applies under the MA program. For example, prior authorization is required for certain drugs. Generic substitution is automatically done at the pharmacy whenever a generic equivalent is available. In addition, pharmacies may only fill prescriptions in the quantity prescribed, not to exceed a 34-day supply, including refills.

Medicare Part D: Each plan will employ a network of pharmacies from which plan participants may purchase drugs.

Each plan will have a formulary, which must include at least two or more drugs within each therapeutic category and class of covered Part D drugs. The United States Pharmacopeia (USP) entered into an agreement with the Center for Medicare and Medicaid Services to recommend a list of drug categories and classes to be covered under Medicare Part D. However, it is not mandated that these recommendations be followed. In addition to this required coverage, PDPs and Medicare Advantage plans may separately offer enhanced coverage for an additional premium. Medicare drug plans are allowed to change formularies at any time, but they are required to notify participants of formulary changes in a timely manner.