Legislative Fiscal Bureau

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May 24, 2011 Joint Committee on Finance Paper #344

Require SeniorCare Participants to Enroll in Medicare Part D (DHS -- Medical Assistance -- Services)

[LFB 2011-13 Budget Summary: Page 219, #7]

CURRENT LAW

SeniorCare provides prescription drug benefits to Wisconsin residents who are age 65 or older and who are not eligible for full benefits under medical assistance. The program has four benefit levels based on the enrollee's income. Level 1 is for individuals with incomes not greater than 160% of the federal poverty level (FPL). These enrollees do not have to meet a deductible. Level 2a is for individuals with incomes greater than 160% of the FPL but not greater than 200% of the FPL. These individuals must meet a $500 annual deductible. Level 2b is for individuals with incomes greater than 200% of the FPL but not greater than 240% of the FPL. These individuals must meet an $850 annual deductible. Level 3 is for individuals with incomes greater than 240% of the FPL. These enrollees must first "spend down" by incurring prescription drug costs equal to the difference between their income and 240% of the FPL. After Level 3 enrollees satisfy their spend-down requirement they must meet an $850 annual deductible. Once a SeniorCare participant meets their deductible, if any, they can obtain prescription drugs covered by the program by paying a $5 copayment for generic drugs and a $15 copayment for brand-name drugs. SeniorCare requires participants to pay a $30 annual enrollment fee. The program does not have an asset test.

SeniorCare participants in Levels 1 and 2a are part of the SeniorCare waiver program, which operates pursuant to a waiver agreement between the Department of Health Services (DHS) and the federal government. Under the waiver, the state receives federal MA matching funds to help support benefit costs for participants with incomes not greater than 200% of the FPL. The current SeniorCare waiver expires on December 31, 2012.

Under current law, SeniorCare participants are not required to enroll in a Medicare Part D plan, or in any other type of third-party prescription drug coverage.

GOVERNOR

Reduce funding for SeniorCare benefits by $18,300,000 (-$5,000,000 GPR, -$5,000,000 FED, and -$8,300,000 PR) in 2011-12 and by $36,600,000 (-$10,000,000 GPR, -$10,000,000 FED, and -$16,600,000 PR) in 2012-13 to reflect the administration's estimate of the savings that would result from requiring SeniorCare participants to apply for, and if eligible to enroll in, Medicare Part D. Under the bill, the Part D requirement would apply to new SeniorCare enrollees beginning on the bill's general effective date. Current SeniorCare enrollees would have until January 1, 2012 to comply with the requirement.

DISCUSSION POINTS

1. The SeniorCare program was created in 2001 Act 16 (the 2001-03 biennial budget), and began providing prescription drug benefits to Wisconsin seniors in September, 2002. As noted, that portion of the program that serves participants with incomes not greater than 200% of the FPL operates under the terms of a Pharmacy Plus waiver agreement between the state and the federal Centers for Medicare and Medicaid Services (CMS).

2. In January, 2006, the federal government instituted the Medicare Part D prescription drug program. The "2010 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds" (2010 Trustees' Report) describes Medicare Part D as "a voluntary Medicare prescription drug benefit that offers beneficiaries enrolled in either Part A or Part B a choice of private drug insurance plans in which to enroll. The cost of the drug coverage is substantially subsidized by Medicare. Low-income beneficiaries can receive additional assistance on the cost-sharing and premiums, depending on their resource levels."

3. Individuals enrolled in Medicare Part D receive their coverage through private insurance plans. Those plans can either be stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA-PDs). Federal law requires Part D plans to cover at least two drugs in every therapeutic category of prescription drugs. Exceptions to that requirement include barbiturates, benzodiazepines, and drugs prescribed for weight gain or weight loss, fertility, cosmetic purposes, relief of cough or cold, and prescription vitamins and mineral products.

4. According to the Henry J. Kaiser Family Foundation, 898,400 Wisconsin residents were eligible for Medicare Part D as of February, 2010. Of those individuals, 303,600 were enrolled in PDPs and 178,500 were enrolled in MA-PDs as of that date.

5. Approximately 91,000 individuals were enrolled in SeniorCare as of March, 2011. Of those SeniorCare participants, approximately 12,000 were also enrolled in a Medicare Part D plan.

6. Each year, the federal government establishes the standard benefit structure for Medicare Part D. In 2011, that standard benefit structure consists of the following. First, the enrollee must satisfy a $310 annual deductible. Second, after meeting the deductible the enrollee has a 25% coinsurance obligation for the prescription drugs they purchase up to the "initial coverage limit" of $2,840. Third, after reaching the initial coverage limit the enrollee enters the Part D

"doughnut hole" which continues until their purchases of covered prescription drugs total $6,447.50. Prior to the federal Patient Protection and Affordable Care Act (PPACA), enrollees were responsible for 100% of their prescription drug costs in the doughnut hole. The PPACA gradually phases out the doughnut hole during the upcoming decade. In 2011, enrollees are responsible for 50% of their brand name drug costs and 93% of their generic drug costs while they are in the doughnut hole. After exiting the Part D doughnut hole, enrollees have catastrophic coverage that pays for their prescription drug costs, subject to copayments equal to the greater of 5% or $2.50 for generics, and the greater of 5% or $6.30 for brand name drugs.

7. Companies that sponsor Part D plans are required to offer a basic benefit plan, one that is modeled either on the standard benefit structure described above or an actuarially equivalent benefit design. The range of available Part D plans varies greatly, as the plans offer different drug formularies, different deductibles, different coinsurance and copayments, and different levels of coverage in the doughnut hole. This variation is reflected in the monthly premiums. According to information on the DHS website, the premiums for PDPs offered in Wisconsin in 2011 range from approximately $15 per month to over $100 per month.

8. Medicare Part D also has a low-income subsidy (LIS) program. Under the LIS program, individuals with low income and limited resources can qualify for "extra help" with their Part D premiums, deductibles, coinsurance, and doughnut hole expenditures. To qualify for the full subsidy under the LIS program in 2011, enrollees must have income less than 135% of the FPL ($14,700 for an individual and $19,860 for a couple) and resources not greater $6,680 (individuals) or $10,020 (couples). If they meet these income and asset tests, their Part D costs are limited to copayments of $6.30 for brand name drugs and $2.50 for generic drugs, assuming they enroll in a Part D plan that does not charge a monthly premium greater than the regional benchmark amount (the benchmark amount for Wisconsin in 2011 is $36.96). Partial subsidies are available for enrollees with slightly greater resources, provided their income does not exceed 150% of the FPL.

9. Prior to Medicare Part D, a number of states maintained state pharmacy assistance programs (SPAPs) that directly subsidized prescription drug costs for the elderly and other groups. According to a May 1, 2010, report by the National Conference of State Legislatures (NCSL), after Medicare Part D was established, "Most states that had been paying for nearly 100 percent of drug subsidies chose to shift some or all of their programs to provide a supplemental or 'wrap around' benefit, so that Medicare-eligible enrollees would receive 'primary' coverage through a Part D Prescription Drug Plan, regulated and funded under federal law." According to the NCSL report, many of these states converted their assistance plans to secondary, wrap-around coverage that most often pays some or all of the enrollee's share of the Part D plan's monthly premium, annual deductible, coinsurance or payments, or doughnut hole expenses.

10. Several examples illustrate existing SPAPs identified in the NCSL report. Under Indiana's Hoosier Rx program, the state helps eligible individuals with up to $70 per month toward their Part D premiums if they are an Indiana resident age 65 or older, have income less than 150% of the FPL, are enrolled in a participating Medicare Part D plan, and have applied for "extra help" under the Part D LIS program. Under Maryland's Senior Prescription Drug Assistance Program, Maryland residents age 65 or older with income less than 300% of the FPL can receive up to $35 a month in Part D premium assistance and additional assistance for their prescription drug costs in the

Part D doughnut hole if they are enrolled in a Part D plan and have been determined to not be eligible for the full subsidy under the Part D LIS program. Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE) program covers prescription drug costs (subject to $6 copayments for generics and $9 copayments for single source brand name drugs) for Pennsylvania residents over age 65 with annual income less than $14,500 (individuals) or $17,700 (couples). PACE enrollees are not required to enroll in a Part D plan, but if they do enroll in a participating Part D plan, the PACE program will pay up to the regional benchmark monthly premium of $34.07 in 2011. Pennsylvania also operates a PACENET program for individuals with slightly higher income. In 2011, PACENET members are not required to enroll in a Part D plan, but if they do not they must meet a $34.07 deductible each month, in addition to $8 copayments for generics and $15 copayments for single source brand name drugs.

11. The bill would require individuals to apply for, and if eligible to enroll in, a Medicare Part D plan in order to participate in SeniorCare. For new SeniorCare participants, the Part D requirement would go into effect immediately. Current SeniorCare participants would have until January 1, 2012 to satisfy the requirement.

12. Under the proposal, the SeniorCare participant's Medicare Part D plan would be the primary payer for their prescription drug costs. SeniorCare would wrap around that Part D coverage, paying costs not covered by the Part D plan. Examples of the costs SeniorCare would continue to pay under the proposal include the following: (a) drugs not covered by the Part D plan (assuming SeniorCare covers the drug); (b) drug costs incurred while the participant is satisfying their annual Part D deductible; and (c) the participant's share of drug costs incurred in the Part D doughnut hole. Note that participants would still be subject to existing SeniorCare cost-sharing obligations where applicable, including SeniorCare deductibles, spend down requirements, and copayment obligations. For instance, if a participant purchases a brand name drug that is not covered by Part D but is covered by SeniorCare, they would be required to pay the $15 SeniorCare copayment. SeniorCare would pay the balance. If the participant purchased that same brand name drug (with no Part D coverage) while they were satisfying a SeniorCare deductible, they would be responsible for the entire cost of the drug, as they are today.

13. The administration estimates that requiring SeniorCare participants to enroll in Medicare Part D will save the program $36,600,000 (-$10,000,000 GPR, -$10,000,000 FED, and -$16,600,000 PR) in 2012-13, the first full year of implementation. The projected savings for 2011-12 are one-half of those amounts, reflecting anticipated implementation delays. To develop these estimates, DHS modeled the expected savings based on assumptions of how SeniorCare and Part D would coordinate benefits. Those assumptions were based on the program's experience with the 12,000 participants already enrolled in Part D plans. Using that model, DHS estimated that requiring all SeniorCare participants to enroll in Part D would reduce total SeniorCare benefit expenditures by approximately 68%. Applying that percentage to the program's total projected benefit expenditures (prior to the Part D requirement) generated estimated GPR savings of approximately $20 million per year. As a check, DHS compared actual expenditures in calendar year 2010 for SeniorCare participants not enrolled in Part D to the expenditures for participants who were enrolled in Part D and arrived at comparable percentages.

14. DHS then discounted the projected GPR savings by 50% to reflect the possibility

that drug manufacturers will reduce the rebates they provide to SeniorCare if they would now be required to pay rebates both to the Part D plans and to SeniorCare for all of the program's participants. The effect of that 50% discount is to reduce the estimated full-year GPR savings from the Part D proposal from $20 million to $10 million. DHS has characterized this 50% discount as a conservative adjustment to the modeled savings to reflect some of the uncertainties that might arise with implementation. While the Department has not identified any empirical or legal basis for this 50% adjustment, the Committee could agree that a reasonable adjustment of some type is warranted from the standpoint of conservative budgeting principles.

15. Under the PPACA, states risk losing their federal MA matching funds if they have in effect eligibility standards, methodologies, or procedures under their state MA plan, or under any waiver of such plan, that are more restrictive than the eligibility standards, methodologies, or procedures that were in effect on March 23, 2010. For adults, this maintenance of effort (MOE) requirement is in effect until the state has a fully operational health benefit exchange in place (presumed date of January 1, 2014). During the period January 1, 2011 through December 31, 2013, there is a limited exception to this MOE requirement for non-pregnant, non-disabled adults who are covered at the option of the state and who have incomes greater than 133% of the FPL. To invoke that MOE exception, a state must certify that it has a budget deficit in the state fiscal year in which the certification is made or is projected to have a budget deficit in the succeeding state fiscal year.

16. The Part D enrollment requirement in the bill arguably would establish more restrictive SeniorCare eligibility requirements than were in place on March 23, 2010. Recognizing that, the Department believes the state would have to obtain a waiver of the PPACA's MOE provision before it could implement the new Part D requirement, at least with respect to individuals with incomes less than 133% of the FPL. At this time, it cannot be said whether CMS would grant such a waiver.

17. The proposal would directly impact the 79,000 current SeniorCare participants who are not enrolled in a Part D plan, as well as new enrollees who would be subject to the requirement. The most direct financial impact stems from the fact that Part D plans generally require enrollees to pay monthly premiums to obtain coverage. According to information on the DHS website, the thirty-two PDPs that offer Part D coverage in Wisconsin in 2011 charge monthly premiums ranging from approximately $15 to more than $100. While individual circumstances vary, it appears reasonable to assume that most of the 79,000 participants who do not currently have Part D coverage would choose to enroll in one of the less expensive plans in order to satisfy the bill's Part D requirement. Assuming premiums of $15 per month, the participant's additional Part D premiums would total $180 per year.

18. Some of those 79,000 SeniorCare participants would qualify for the Medicare Part D LIS program. Specifically, individuals with income less than 135% of the FPL and with limited resources are eligible for the full subsidy, which means they would not be responsible for a Part D premium (assuming they enroll in a Part D plan that does not charge more than the regional benchmark rate of $36.96 per month), nor would they be subject to the annual Part D deductible, coinsurance, or doughnut hole coverage gaps. They would be responsible for Part D copayments of $2.50 (generics) and $6.30 (brand name drugs).

19. DHS has indicated that approximately 21,300 current SeniorCare participants have income equal to or less than 135% of the FPL, making them potentially eligible for a full subsidy under the LIS program. An additional 11,100 participants have incomes between 135% and 150% of the FPL, making them potentially eligible for partial subsidies under that program. It is not possible to estimate precisely how many of these individuals would actually qualify for the Part D LIS program, however, because DHS does not maintain information on participants' assets.

20. According to the 2010 Trustees' Report, approximately 30% of all Part D enrollees nationwide qualified for the LIS program in 2009. The majority of those individuals, however, were full-benefit dual eligibles who, by definition, are not eligible for SeniorCare. Approximately 10% of Part D enrollees nationwide in 2009 qualified for the full subsidy and were not full-benefit dual eligibles. An additional 1% qualified for the LIS program's partial subsidy. These national percentages suggest that perhaps as many as 7,900 of the current SeniorCare participants not enrolled in Part D might qualify for the full LIS program subsidy. That figure is similar to those cited in a 2004 DHS document in which the Department estimated that 5,704 of the 90,000 SeniorCare participants as of that date would qualify for a full subsidy under the LIS program. Based on these two sources, it appears reasonable to assume that approximately 6,000 of the 79,000 current SeniorCare participants not enrolled in Part D would qualify for the full subsidy.

21. If all 79,000 SeniorCare participants not currently enrolled in Part D enrolled in plans with monthly premiums of $15, the additional Part D premiums paid by those individuals as a result of the proposal would total $14.2 million per year. If 6,000 of those 79,000 individuals qualified for the LIS program's full subsidy, their additional Part D premiums would total $13.1 million per year.

22. In addition to the direct financial impact on SeniorCare participants, concerns have been expressed about the burdens a Part D enrollment requirement would place on seniors with respect to selecting and applying for an appropriate Part D plan, and on the individuals who in all likelihood would be called upon to assist them with those decisions, including public workers such as elderly benefit specialists and other economic support workers. It is difficult to place a fiscal estimate on these types of costs.

23. Concerns have also been raised about how the Part D requirement might impact federal expenditures under the Medicare Part D program. According to the 2010 Trustees' Report, the Medicare program provided an average of $1,086 per enrollee to Part D plans in 2009 in the form of direct subsidies ($700) and reinsurance ($386). For individuals enrolled in the LIS program, Medicare Part D paid the plans an additional $1,960 per enrollee. Based on these figures, it appears that requiring an additional 79,000 SeniorCare participants to enroll in Part D could increase costs to the federal Medicare program by approximately $85.8 million per year, assuming none of those individuals qualified for the LIS program. If some of those new Part D enrollees were eligible for low-income subsidies, the federal costs would increase.

24. An alternative to the Governor's proposal has been advanced by the Coalition of Wisconsin Aging Groups (CWAG). Rather than requiring SeniorCare participants to enroll in Part D, the CWAG proposal would replace the current SeniorCare deductibles ($500 for Level 2a; $850 for Levels 2b and 3) with a 50% coinsurance requirement. Specifically, SeniorCare participants

who currently have a $500 annual deductible would instead have a 50% coinsurance requirement that applies to the first $1,000 of their SeniorCare-covered prescription drug costs. SeniorCare participants who currently have an $850 annual deductible would instead have a 50% coinsurance requirement that applies to the first $1,700 of their SeniorCare-covered prescription drug costs. Once these coinsurance requirements were satisfied, current SeniorCare copayments would apply. The CWAG proposal would not directly impact participants with incomes less than 160% of the FPL, as those individuals do not have a deductible under the program.

25. The CWAG proposal is premised on the fact that when SeniorCare pays for any portion of a prescription drug's costs, it can claim the entire amount of the associated manufacturer rebate. For example, if a prescription drug costs $100 and there is a 50% coinsurance requirement where the participant pays $50 and SeniorCare pays $50, the program could claim the entire rebate associated with that purchase. If the expenditure was made on behalf of an individual participating in the federal waiver program, the state's share of the rebate would be approximately 40% and the federal share would be approximately 60%. If the expenditure was made on behalf of a participant in the state-only portion of the program, the state would retain the entire rebate. In contrast, if that same $100 purchase was made by a SeniorCare participant while they were satisfying a SeniorCare deductible, the program would not claim any portion of the rebate because the program would not have contributed any portion of the cost.

26. DHS has estimated that the CWAG proposal would generate approximately $6,340,000 in additional drug manufacturer rebates for the program in its first full year of implementation. Those additional rebates would be used to reduce GPR expenditures (-$1,880,000), FED expenditures (-$1,140,000), and to offset the anticipated reduction in participant cost-sharing that would occur under the proposal (-$3,320,000). DHS has indicated that if the Committee selects this option, it would take several months to obtain CMS approval for the required state plan amendment, and to implement the necessary system changes. Accordingly, if the Committee adopts the CWAG proposal, it should make the new coinsurance requirements apply to 12-month annual benefit periods that begin on or after the later of January 1, 2012 or 90 days after receipt of any necessary federal approval. Due to this phased-in implementation, and the time lags typically associated with the collection of drug rebates, it may be prudent to assume that no savings would occur in 2011-12.

27. Another option the Committee could consider as an alternative to the Governor's proposal would be to require SeniorCare participants to enroll in Medicare Part D if they are determined to be eligible for the full subsidy under the Medicare Part D LIS program. The rationale behind such a requirement would be that if a SeniorCare participant is eligible for the full subsidy, they can enroll in a benchmark Part D plan without additional personal expense, while at the same time generating savings for the SeniorCare program. If the Committee selected this alternative, it could delegate to DHS responsibility for developing procedures best suited to carry out the requirement. For instance, DHS could require SeniorCare participants with reported income of less than 135% of the FPL to report their countable assets when applying for and/or renewing their SeniorCare eligibility. The Department could then submit that information to the federal Social Security Administration for a determination of whether the individual qualifies for the LIS program.

Based on projected expenditures for Level 1 SeniorCare participants in 2011-12, and

assuming that 6,000 current SeniorCare participants would qualify for the LIS program's full subsidy, the projected savings to the SeniorCare program in the proposal's first full year of implementation would be approximately $6,731,200 (-$1,448,700 GPR, -$2,213,200 FED, and -$3,069,300 PR). That projection assumes that the SeniorCare program would incur approximately 25% of the costs for individuals enrolled in a Part D plan under the LIS program's full subsidy compared to what the program spends for Level 1 participants not enrolled in Part D. As with the Governor's Part D proposal, this alternative would require a waiver of the PPACA's MOE requirements. Therefore, if the Committee adopts this alternative it should make the new requirements apply to 12-month annual benefit periods that begin on or after the later of January 1, 2012 or 90 days after receipt of any necessary federal approval. Due to possible implementation delays, the Committee may not wish to assume that any savings would result from this alternative in 2011-12.

ALTERNATIVES

1. Adopt the Governor's proposal to require SeniorCare participants to apply for and if eligible to enroll in Medicare Part D, as specified in the bill.

2. Delete the Governor's proposal. Revise current statutory provisions relating to SeniorCare to delete the program's deductible requirements, and create new provisions that establish the following 50% coinsurance obligations: (a) for participants with income greater than 160% of the FPL but not greater than 200% of the FPL, establish a 50% coinsurance obligation for the participant's first $1,000 in purchases of SeniorCare-covered prescription drugs during the 12-month benefit period; (b) for participants with income greater than 200% of the FPL but not greater than 240% of the FPL, establish a 50% coinsurance requirement for the individual's first $1,700 in purchases of SeniorCare-covered prescription drugs during the 12-month benefit period; and (c) for participants with income greater than 240% of the FPL, establish a 50% coinsurance requirement for the individual's first $1,700 in purchases of SeniorCare-covered prescription drugs during the 12-month benefit period and specify that this coinsurance requirement would be in addition to any spend down requirement that currently applies to these participants. Further, specify that the program's existing copayment requirements would apply after the participant satisfies their coinsurance requirement. Make the new coinsurance requirements apply to 12-month annual benefit periods beginning on or after the later of January 1, 2012 or 90 days after receipt of any necessary federal approval. Provide $18,300,000 ($5,000,000 GPR, $5,000,000 FED, and $8,300,000 PR) in 2011-12 and $39,920,000 ($8,120,000 GPR, $8,860,000 FED and $22,940,000 PR) in 2012-13 to reflect the combined fiscal effect of deleting the Governor's proposal and implementing the CWAG 50% coinsurance proposal.

ALT 2	**Change to Bill** Funding
GPR	$13,120,000
FED	13,860,000
PR	31,240,000
Total	$58,220,000

3. Delete the Governor's proposal. Require SeniorCare participants who are determined to be eligible for the full subsidy under the Medicare Part D LIS program to enroll in Medicare Part D in order to participate in SeniorCare. Require DHS to request SeniorCare applicants with income less than 135% of the FPL to provide information regarding assets for the purpose of determining eligibility for the Medicare Part D LIS program. Make this new requirement apply to 12-month annual benefit periods beginning on or after the later of January 1, 2012 or 90 days after receipt of any necessary federal approval. Provide $18,300,000 ($5,000,000 GPR, $5,000,000 FED, and $8,300,000 PR) in 2011-12 and $29,868,800 ($8,551,300 GPR, $7,786,800 FED and $13,530,700 PR) in 2012-13 to reflect the combined fiscal effect of deleting the Governor's proposal and implementing the new requirements under this alternative.

ALT 3	**Change to Bill** Funding
GPR	$13,551,300
FED	12,786,800
PR	21,830,700
Total	$48,168,800

4. Delete the Governor's proposal. Adopt both Alternative 2 and Alternative 3. Provide $18,300,000 ($5,000,000 GPR, $5,000,000 FED, and $8,300,000 PR) in 2011-12 and $33,188,800 ($6,671,300, $6,646,800, and $19,870,700 PR) in 2012-13 to reflect the combined fiscal effect of deleting the Governor's proposal and implementing Alternatives 2 and 3.

ALT 4	**Change to Bill** Funding
GPR	$11,671,300
FED	11,646,800
PR	28,170,700
Total	$51,488,800

5. Delete the provision.

ALT 5	**Change to Bill** Funding
GPR	$15,000,000
FED	15,000,000
PR	24,900,000
Total	$54,900,000

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