Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

May 21, 2015 Joint Committee on Finance Paper #346

SeniorCare -- Cost to Continue
(Health Services -- Medical Assistance -- General)

[LFB 2015-17 Budget Summary: Page 203, #2]

CURRENT LAW

Wisconsin's SeniorCare program provides assistance to help eligible seniors purchase prescription medication. State residents who are age 65 or older, who are not eligible for full Medicaid benefits, and who meet income requirements are eligible for benefits under the program. SeniorCare participants must pay a $30 annual enrollment fee, which supports costs the Department of Health Services (DHS) incurs to administer the program. Once an individual is enrolled, his or her receipt of benefits depends upon meeting deductible and copayment requirements. The deductible, if any, is based on the annual income level of the enrollee, as follows: (a) no deductible for persons with an annual income below 160% of the federal poverty level (FPL); $500 deductible for persons with an annual income between 160% of the FPL and 200% of the FPL; and (c) $850 deductible for persons with an annual income between 200% of the FPL and 240% of the FPL.

Persons with incomes above 240% of the FPL may enroll in the program, but will not be eligible for benefits unless the program's spend down rules are met. "Spend down" means that the person incurs expenses for prescription drugs within a year that equals the difference between his or her annual income and 240% of the FPL. Upon meeting that threshold, persons in the spend-down category must then meet an $850 deductible. After satisfying the applicable deductible, all enrollees make copayments of $5 for generic medications and $15 for brand name medications, while the program pays all other medication costs.

SeniorCare benefits are funded with a combination of state general purpose revenue (GPR), federal Medicaid matching funds (FED) and program revenue (PR) from rebates received from drug manufacturers that participate in the program. Base funding for program benefit expenditures is $86,519,500, ($19,316,000 GPR, $16,694,700 FED, and $50,508,800 PR).

GOVERNOR

Provide $20,069,200 ($1,644,100 GPR, $4,221,500 FED, and $14,203,600 PR) in 2015-16 and $32,247,100 ($4,313,900 GPR, $7,011,400 FED, and $20,921,800 PR) in 2016-17 to fund the difference between base funding for SeniorCare benefits and the administration's estimates of projected costs to fully fund the program, without program changes, in the 2015-17 biennium.

DISCUSSION POINTS

1. The bill would increase SeniorCare appropriations reflecting the administration's estimate of funding needed to pay benefits during the 2015-17 biennium, absent any changes to program eligibility or other parameters. A separate item in the bill would modify eligibility requirements by requiring program participants to purchase a Medicare Part D plan. The bill would reflect the impact of this requirement, but can be considered independent of the cost-to-continue item. A discussion of the Medicare Part D proposal is provided in LFB Issue Paper #347.

2. Table 1 shows the 2014-15 base funding, along with the funding that would be provided under the cost-to-continue item.

TABLE 1

		Administration's Cost to Continue Estimate		Change to Base	
	Base Funding	2015-16	2016-17	2015-16	2016-17
GPR	$19,316,000	$20,960,100	$23,629,900	$1,644,100	$4,313,900
FED	16,694,700	20,916,200	23,706,100	4,221,500	7,011,400
PR	50,508,800	64,712,400	71,430,600	14,203,600	20,921,800
Total	$86,519,500	$106,588,700	$118,766,600	$20,069,200	$32,247,100

3. The administration's cost-to-continue estimates are based on projections for the following parameters: (a) the state's federal medical assistance percentage (FMAP) during the biennium; (b) the number of participants in the program, along with the distribution of participants in the program's different income-based enrollment categories; (c) the cost of program benefits per participant, by enrollment category; and (d) the percentage of program benefit costs that can be paid with drug rebate revenue, by enrollment category. The following points discuss each of these factors that affect program costs.

Federal Matching Percentage

4. The administration's estimates were based on projections of the state's FMAP for federal fiscal year 2015-16 and 2016-17. Since the time of these estimates, the actual federal fiscal year 2015-16 FMAP and an updated projection of 2016-17 FMAP have become available. Due to a slight increase in the state's FMAP, relative to the earlier projections, the GPR share of total costs is estimated to decrease (and FED will increase) by $23,900 in 2015-16 and $76,700 in 2016-17.

Number and Distribution of SeniorCare Participants

5. The administration assumes that program enrollment will grow by 1% annually. Since the administration adopted estimates DHS prepared in the summer of 2014 (in preparation for its biennial budget request submittal), the 2015-17 enrollment projections start from a 2014-15 baseline that also assumes a 1% annual growth in that year from a starting point in June, 2014.

6. The 1% annual enrollment growth would be a reversal of recent trends. Table 2 shows actual average monthly SeniorCare enrollment since 2006-07 (the year the program reached maximum participation) through 2013-14, and the administration's projections upon which the budget estimate was based. [For 2014-15, the administration assumed 1% growth from June of 2014 to June of 2015, which amounts to a 0.5% increase between the two fiscal years when using the monthly average.]

TABLE 2

Average Monthly SeniorCare Enrollment

Fiscal Year	Average Monthly Enrollment	Percent Change
2006-07	104,420	
2007-08	93,337	-10.6%
2008-09	87,823	-5.9
2009-10	87,693	-0.1
2010-11	89,401	1.9
2011-12	87,693	-1.9
2012-13	85,276	-2.8
2013-14	84,420	-1.0
2014-15*	84,877	0.5
2015-16*	85,726	1.0
2016-17*	86,583	1.0

* Administration's budget projections.

7. Since 2006-07, SeniorCare enrollment has generally decreased, a trend that is likely attributable to the availability of prescription drug coverage through Medicare Part D. The administration assumes that SeniorCare enrollment will increase slightly in the future because it is believed that the gradual migration to Part D plans has ended. This assumption is consistent with recent enrollment trends. Through March, 2015, the actual average monthly enrollment in 2014-15 was 85,432, which is somewhat higher than the administration's budget projections.

8. Although overall enrollment has increased in 2014-15, the distribution among SeniorCare's four income-based tiers has changed. Enrollment is decreasing steadily in the lowest two income tiers (under 160% of the FPL and between 160% of FPL and 200% of FPL), and is increasing steadily in the "spend-down" category (over 240% of the FPL). To illustrate these trends, Table 3 shows enrollment in March of the past three years, along with the change over that

24-month period.

TABLE 3

SeniorCare Enrollment by Income Tier

Enrollment Category	March 2013	March 2014	March 2015	Two-Year Change
Less than 160% of FPL	34,198	33,759	32,585	-1,613
160% of FPL to 200% of FPL	17,962	17,040	16,790	-1,172
200% of FPL to 240% of FPL	9,951	9,760	9,934	-17
More than 240% of FPL	22,219	24,630	27,599	5,380
Total	84,330	85,189	86,908	2,578

9. The change in the distribution among enrollment categories has implications for program costs. Since the cost of providing benefits is higher for the lower-income tiers, a reduction in the number of SeniorCare participants in this category reduces program costs. Program costs are much lower in the highest income tier, since most participants in this category do not meet the spend-down and deductible requirements. Consequently, increases in the number of participants in this category do not significantly affect costs. To illustrate the cost differences, Table 4 shows the weekly average program costs per participant in 2013-14, by enrollment category.

TABLE 4

Average Per Capita Weekly Program Cost by Enrollment Category, 2013-14

Enrollment Category	Average Weekly Cost
Less than 160% of FPL	$30.07
160% of FPL to 200% of FPL	25.95
200% of FPL to 240% of FPL	17.52
More than 240% of FPL	1.49

10. Since the administration's cost-to-continue estimates assume a stable distribution of SeniorCare participants among the enrollment categories, the estimate does not take into account recent enrollment trends within each of the enrollment categories. Staff at the Board on Aging and Long-Term Care indicate that participation in the lowest income tier appears to be falling as persons in that income category choose to participate in Medicare Part D instead of SeniorCare. Many, although not all, seniors who meet the income qualifications for participation in SeniorCare's lowest income tier also qualify for Part D's low-income subsidy (LIS) program (commonly referred to as "extra help"), and for most of those the subsidy results in lower total costs under Part D than under SeniorCare. Migration to Part D to take advantage of the LIS program cannot explain the reduction in SeniorCare's second lowest income tier, however, since persons in this category do not qualify for

LIS.

11. Although the availability of LIS may be driving the enrollment trend in the lowest SeniorCare income tier, it is possible that eventually the balance between Part D and SeniorCare will reach an equilibrium in which all seniors have chosen the program that is most advantageous for their own personal situation. Consequently, the decreases seen over the past two years may not continue over the longer term.

12. Participation in SeniorCare's highest income tier (the spend down category) appears to be driven by the enrollment of seniors with generally very low drug costs who use SeniorCare to satisfy Medicare Part D's "creditable coverage" requirement. Under Part D, a person who attains the age of 65 years old and who does not either enroll in a Part D prescription drug plan or have other creditable coverage for prescription drugs, incurs a premium penalty (a monthly add-on to the baseline premium) if he or she later purchases a Part D plan. Since SeniorCare is considered creditable coverage for the purpose of Medicare Part D, a senior with income above 240% of the FPL who expects to incur low drug expenses may choose to enroll in SeniorCare instead of Part D. Although he or she may pay the full cost of his or her drug costs (unless changed circumstances result in very high costs, in which case the spend-down requirements would be met), these out-of-pocket costs may be less than Part D premiums. As the number of seniors who reach 65 increases (an increase in relatively healthy seniors with lower drug costs) the trend toward increasing participation in the spend-down category can be expected to continue.

13. Over the course of the last two years, the trend lines (best-fit slope of the monthly data) show a monthly decrease of 64 participants and 46 participants in the lowest two income tiers, respectively, and a monthly increase of three and 224 in the highest tiers, respectively. For the purposes of the reestimate presented in this paper, it is assumed that enrollment in the lowest two tiers will continue to decline at the same rate through the first six months of 2015-16, will decline at one-half that rate for the next twelve months, and then will increase at a 1% annualized rate for the remainder of the biennium. For the spend-down category, it is assumed that enrollment will increase at the same rate as over the past 24 months through 2015-16, then will increase at one-half of that rate through the end of 2016-17. It is assumed that enrollment in the third category will remain the same over the biennium. Table 5 shows the average monthly enrollment for each fiscal year by category under these assumptions, compared to current enrollment.

TABLE 5

Comparison of Average Monthly Enrollment Estimates

		Bill		Reestimate	
Enrollment Category	March, 2015	2015-16	2016-17	2015-16	2016-17
Less than 160% of FPL	32,585	34,077	34,417	32,033	31,711
160% of FPL to 200% of FPL	16,790	17,412	17,586	16,393	16,152
200% of FPL to 240% of FPL	9,934	9,858	9,957	9,934	9,934
More than 240% of FPL	27,599	24,380	24,623	29,727	31,687
Total	86,908	85,727	86,583	88,087	89,484

14. Although total SeniorCare enrollment is estimated to be higher than assumed under the bill, the distribution would differ, reflecting recent trends within each category. As a result of decreases in the lowest income tiers (highest cost), relative to the bill, these assumptions result in lower estimated benefit costs. In combination with the revision to the FFY 2015-16 and FFY 2016-17 FMAP estimates, these assumptions would reduce estimated program costs by $5,097,900 (-$1,028,500 GPR, -$1,660,800 FED, and -$2,408,600 PR) in 2015-16 and by $7,820,600 (-$1,578,400 GPR, -$2,170,500 FED, and -$4,071,700 PR) in 2016-17, compared to the funding in the bill.

Program Costs Per Participant

15. In developing its estimate, the administration assumed that the average weekly cost per participant would increase by 11% annually for the lowest two income tiers and by 5% in the highest two income tiers. Although this rate of growth is higher than the average rate of growth over the past several years, it is in line with cost growth in 2013-14, and thus far in 2014-15. Nationally, drug costs have increased rapidly over this period as the result of the emergence of several costly single-source specialty drugs as well as price increases for some common generic drugs. Since these trends are expected to continue, the administration's estimate appears reasonable.

Rebate Revenue

16. The administration's estimate assumes that rebate revenue will account for 63% of benefit expenditures for the lowest two income tiers and 65% of the highest two tiers. These percentages are consistent with the share of program costs currently paid with rebate revenue, and so appear to be reasonable assumptions.

Discussion of Reestimate

17. The combination of the change to the FMAPs and to the enrollment assumptions outlined in this paper result in a decrease in estimated SeniorCare benefits costs, as described in Point 14. The GPR share of SeniorCare benefit costs is funded with a sum certain biennial appropriation. In the event that GPR-funded benefit costs exceed the amount appropriated, the Department is required, by statute, to suspend benefit payments. The reestimate presented in this paper makes reasoned modifications to the budget estimates, resulting in a lower GPR appropriation for the program. As with any estimate, it is possible that costs or enrollment could change in a way that results in benefit costs exceeding this budget. If this occurs, the Department could choose, rather than suspending payments, to submit a request under s. 13.10 of the statutes for a GPR appropriation supplement or an appropriation transfer from another program to maintain benefit expenditures.

MODIFICATION

Reduce funding in the bill by $5,097,900 (-$1,028,500 GPR, -$1,660,800 FED, and -$2,408,600 PR) in 2015-16 and by $7,820,600 (-$1,578,400 GPR, -$2,170,500 FED,

and -$4,071,700 PR) in 2016-17 to reflect revised FMAP and enrollment reestimates.

	Change to Bill
GPR	- $2,606,900
FED	- 3,831,300
PR	- 6,480,300
Total	- $12,918,500

Prepared by: Jon Dyck