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SeniorCare -- Required Medicare Part D Application and Enrollment (Health Services -- Medical Assistance -- General)

[LFB 2015-17 Budget Summary: Page 204, #3]

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).

The federal Medicare Part D program subsidizes the cost of prescription drug coverage for seniors. Benefits are provided through federally-approved insurance plans that participants purchase by paying monthly premiums. Benefits can be provided through stand-alone prescription drug plans (PDPs), or as part of a package that also includes hospital and acute care coverage (Medicare Advantage prescription drug plans, or MA-PDs). Plans vary in their benefit structure (premiums, deductibles, copayments, and coinsurance) and drug coverage, but must meet minimum federal standards.

GOVERNOR

Require SeniorCare enrollees, as a condition of program eligibility, to apply for, and if eligible, enroll in a Medicare Part D prescription drug plan, provided that the Secretary of the U.S. Department of Health and Human Services (HHS) approves this condition of eligibility for SeniorCare. Specify that a person who is already enrolled in SeniorCare on the effective date of the bill is not required to comply with this provision until January 1, 2016.

Reduce funding for the program by $32,442,700 (-$5,198,000 GPR, -$5,198,000 FED, and -$22,046,700 PR) in 2015-16 and $64,885,400 (-$10,396,000 GPR, -$10,396,000 FED, and -$44,093,400 PR) in 2016-17 to reflect this change.

DISCUSSION POINTS

1. The state's SeniorCare program was created in the 2001-03 biennial budget act and began providing benefits in September, 2002. The federal Medicare Part D program was created in 2003, with full coverage beginning in January of 2006. Both programs provide prescription drug assistance to seniors, but the target population and program structures differ.

2. SeniorCare is targeted to low-income seniors, generally those with household income below 240% of the FPL, but who are not eligible for Medicaid benefits. The program pays all benefits, net of copayments, after participants meet the annual deductible (if any) for their income-based enrollment category. Generally all medically-necessary prescription drugs (plus insulin) are covered under the program, although certain drugs require prior authorization.

3. Medicare Part D operates through Medicare-subsidized insurance plans, which participants select annually and purchase by paying monthly premiums. Within certain limits, Part D plans may vary with respect to premiums, deductibles, copayments, and coinsurance requirements, but they all must be actuarially equivalent to the program's "standard benefit" plan (excluding any optional supplemental benefits). The standard benefit structure has various "phases" corresponding to the annual amount of drug expenditures. The first is the deductible phase (up to $320 in 2015), in which the participant pays the full costs of all drugs. The second is the initial coverage phase, during which the participant pays a 25% coinsurance amount toward all prescriptions. After total drug costs have reached the limit of the initial coverage phase ($2,960 in 2015), the participant reaches the "coverage gap" phase (also known as the "donut hole") in which

the participant pays a higher share of any additional drug purchases, varying depending upon whether the prescription is for a generic or brand name drug. In 2015, the standard plan requires participants to pay 45% of the cost of brand name drugs and 65% of the cost of generic drugs in the coverage gap. [Prior to 2011, the standard plan required participants to pay the full cost of drugs in the coverage gap. Through a combination of manufacturer drug rebates and additional federal subsidies, the standard plan's coverage gap is being phased out, so that, by 2020, participants will pay 25% of all drug costs in both the initial coverage phase and the coverage gap.] Once out-of-pocket costs reach a specified threshold ($4,700 in 2015), the participant reaches the catastrophic coverage phase, in which he or she pays a copayment (in 2015, $2.65 for generic drugs and $6.60 for brand name drugs) or 5% coinsurance, whichever is greater.

4. Although Part D plans must be actuarially equivalent to the standard plan, they vary considerably in their benefit structure. Two plans offered in Wisconsin illustrate this variability. The plan with the lowest monthly premium ($15.70), has a deductible of $320, does not provide additional coverage in the coverage gap, and has copayment/coinsurance requirements during the initial coverage phase ranging from $1.00 for preferred generic drugs to 35% of the drug cost for non-preferred brand name drugs. By contrast, another plan offered in 2015 has no deductible, provides gap coverage, has low or no copayments, but has a monthly premium of $130.

5. Medicare Part D is open to all U.S. citizens age 65 and older, as well as certain people under age 65 with certain disabilities or end-stage renal disease. Although persons of all income levels are eligible, the program provides financial assistance to some enrollees under a low-income subsidy (LIS) program. The amount of assistance, commonly known as "extra help," varies depending upon type of beneficiary, income, and assets. Under the LIS program, participants are eligible for either a full subsidy or partial subsidy. With a full subsidy, which is available for those with an income below 135% of the FPL and with limited assets, participants are not required to pay premiums or deductibles, but must make copayments, at a reduced level. With a partial subsidy, available for individuals with an income between 135% of the FPL and 150% of the FPL (also meeting assets tests), participants pay deductibles and premiums, but at lower levels than the standard plan.

6. Federal law requires Part D plans to cover at least two drugs in every therapeutic category of prescription drugs, as well as all or substantially all drugs in certain categories, such as anticonvulsants, antiretrovirals, and immunosuppressants. Nevertheless, Part D plans generally have a more limited formulary than SeniorCare, and copayment and coinsurance requirements vary depending upon the type of drug.

7. Prior to the creation of the federal Medicare Part D program, many states, like Wisconsin, had established pharmaceutical assistance programs for the elderly, with a wide range of program structures. With the passage of the Part D law, several of these state programs ceased operations. For instance, Florida, Kansas, Michigan, Minnesota and North Carolina shut down programs on January 1, 2006, the date that Part D program began general coverage. Other assistance programs were modified to provide "wrap-around" coverage to Part D plans. These programs provide assistance toward Part D premiums or out-of-pocket costs. Unlike Wisconsin's SeniorCare program, most remaining programs require participants to enroll in a Part D plan if

eligible.

8. A few states have retained pharmaceutical assistance programs that do not require Part D coverage, like Wisconsin's SeniorCare, but they have other cost-sharing requirements. Maine's program, for instance, does not require Part D coverage, but participants must pay 20% of prescription drug costs in addition to a $2.00 copayment. Vermont has an assistance program that also does not require Part D coverage, but charges a monthly premium, ranging from $15 to $50, depending upon the participant's income. Although participation in Vermont's program requires a monthly premium, copayments under the program are just $1 for generic drugs and $2 for brand name drugs, which is considerably lower than SeniorCare copayments.

9. Pennsylvania's pharmaceutical assistance program is the program that is perhaps most similar to Wisconsin's SeniorCare. Persons with an annual income below $14,500 for a single person or $17,700 if married (approximately 125% of the current FPL), are eligible for prescription drug benefits without a deductible or premium, and no Part D coverage is required. Copayments are $9 for generic drugs and $15 for brand name drugs. Pennsylvania residents who have slightly higher income are also eligible for coverage, but must pay a monthly premium of $33.91 if they are not enrolled in a Part D plan.

10. By establishing a requirement that SeniorCare participants enroll in a Part D plan, the bill would transition the program toward a model that is used in most other states. Under this model, Part D plans provide the primary coverage, including Medicare low-income subsidies, while the state program provides supplemental assistance, typically for out-of-pocket drug costs or for drugs not covered by the Part D plan.

11. Medicare provides subsidies to Part D plans that cover approximately 75% of the cost for non-LIS participants (on average) and nearly the whole cost for LIS participants. Through its SeniorCare program, Wisconsin lowers prescription drug costs for participants in the program, but also incurs costs that, in other states, are paid through Medicare. By requiring Part D participation, the bill would, in effect, shift some costs from the state to the federal government, resulting in GPR savings.

12. The administration's fiscal estimate for the Part D requirement is based on the difference between the average SeniorCare costs for participants who also currently have a Part D plan and the average cost of those that do not. Using this method, the proposed Part D requirement is estimated to reduce state costs by just over 50%, relative to the 2014-15 base.

13. Although not required, Wisconsin SeniorCare participants can currently also be enrolled a Part D plan. In this case, the Part D plan has primary responsibility for drug coverage, but SeniorCare pays for out-of-pocket costs not covered by the plan. Approximately 15% of SeniorCare recipients also currently have a Part D plan, and thus would meet the proposed eligibility requirements under the bill. The remaining recipients would have to purchase a Part D plan to retain eligibility for SeniorCare.

14. In general, the bill's proposed Part D requirement would increase SeniorCare participants' costs. The precise financial impact on SeniorCare participants, however, will vary

depending upon a complex set of factors, including whether the person is eligible for the Part D low-income subsidy, the type of Part D plan chosen, the amount and type of drugs purchased, and the participant's SeniorCare enrollment tier.

15. Although it may be difficult to estimate the precise impact on SeniorCare participants, one scenario may be relatively common and therefore provides a general sense of the impact. Since SeniorCare pays for out-of-pocket costs (after meeting the applicable SeniorCare deductible) but does not pay monthly premiums, it can be expected that many SeniorCare participants would respond to the proposed Part D requirement by selecting a plan with a low premium and higher out-of-pocket costs. If the Part D requirement had been in place during 2015, SeniorCare participants who enrolled in the lowest-premium plan (and who were not eligible for low-income subsidy) would have paid premiums of $188.40 for the year. Although this would be an additional cost borne by SeniorCare participants, the enrollee may have lower copayments/coinsurance with this plan in comparison with SeniorCare. That is, instead of paying $5 for generic prescriptions under SeniorCare, enrollees in the lowest-premium Part D plan would pay just $1 for at least some generic drugs (others would be $4 or might not be covered). Coinsurance for brand name drugs may be more or less than the SeniorCare brand name copayment, depending upon the type and cost of the drug.

16. In addition to increasing costs, the Part D requirement would increase the complexity of selecting drug coverage for SeniorCare participants. Because of the variability in Part D benefit structure, formularies, and pharmacy networks, and the fact that these factors may change from year to year, Part D participants can have a complicated set of choices to make each year. SeniorCare program advocates often cite the simplicity of the program as a clear advantage over Part D. SeniorCare has a relatively simple application process, provides uniform coverage and has a simple copayment structure.

17. Another benefit to the current SeniorCare program is that it offers an alternative to Part D enrollment for some seniors who expect to have low drug costs. Medicare Part D imposes penalties for late enrollment in order to discourage eligible enrollees from deferring coverage until the time that they expect to incur significant expenses. This late enrollment penalty, which equals 1% of the monthly base premium for every month that an person goes without coverage after becoming eligible (generally at age 65), can be avoided if the person has other "credible coverage," which means drug coverage that is considered at least as good as the Part D coverage. SeniorCare is considered credible coverage, and it is considered likely that many current SeniorCare participants enroll in the program in order to avoid Part D premiums, while retaining the option to later enroll in a Part D plan without incurring the penalty. Under the bill, SeniorCare could no longer serve as an alternative to Part D participation.

Discussion of Alternatives

18. There are various SeniorCare modifications that could be considered to increase program revenues or reduce program costs, which could be adopted in addition to, or instead of, the Governor's Part D proposal. The following points discuss several possible alternatives, specifically changes to the enrollment fee and changes to the copayment requirements. Following an outline of these alternatives, the next points discuss the implications of changing program deductibles and a

proposal to replace deductibles with coinsurance payments. The total fiscal effect of any of these alternatives would be the net effect of the changes outlined below and the Committee's decision on the Part D requirement.

19. When SeniorCare was initially created in 2001, the enrollment fee was set at $20. The Legislature increased the fee to $30, starting on September 1 of 2003, but it has not been changed since that time. Since the fee has not been increased in 12 years, the Committee could consider an increase to this fee. Although enrollment fees are currently collected to cover administrative costs, the increment above $30 collected could deposited in a new PR appropriation for benefit costs, which would offset benefit costs that are currently paid from the program's GPR appropriation. The SeniorCare monthly average enrollment is projected at approximately 86,000 during the biennium, although the number of participants who pay the enrollment fee is expected to be approximately 90,000 per year. [The monthly average is lower than the annual enrollment because not all participants are in the program for a full 12 months.] Consequently, each $10 increase in the enrollment fee could be expected to generate revenue of approximately $900,000. Table 1 shows several options for an enrollment fee increase, as well as the annual revenue impacts in the biennium and the biennial total, assuming implementation on January 1, 2016.

TABLE 1

Estimated Revenue from Enrollment Fee Increases

Alternative	Increase	New Fee	2015-16	2016-17	Biennial Total
B1a.	$10	$40	$450,000	$900,000	$1,350,000
B1b.	20	50	900,000	1,800,000	2,700,000
B1c.	30	60	1,350,000	2,700,000	4,050,000
B1d.	40	70	1,800,000	3,600,000	5,400,000
B1e.	50	80	2,250,000	4,500,000	6,750,000

20. The revenue estimates provided in Table 1 assume that higher annual enrollment fees would not reduce the average number of individuals who would choose to enroll in the program. Significant increases in the fee may have this effect, particularly on individuals with lower household income. However, if fewer individuals enroll in the program as a result of the fee increase, SeniorCare benefits costs would decrease. It is not possible to estimate these potential behavioral effects.

21. In addition to, or instead of, an enrollment fee increase, the Committee could modify SeniorCare's copayment requirements to reduce program costs. Copayments under the program have not been increased since the program was created in 2001. As with an increase to the enrollment fee, SeniorCare participants would pay more for benefits under this alternative, although the amount would vary on the amount of drugs purchased during participants' benefits stage (after paying the deductible, if any). Since copayments reduce total program costs, the expenditure reductions would be shared between GPR and FED sources. Table 2 shows the estimated funding reductions associated with different copayment increases, including the biennial GPR reduction. The generic drug copayment could be changed independently of the brand name copayment.

TABLE 2

Estimated Expenditure Decrease for Generic Copayment Increase (Currently $5)

		2015-16		2016-17		Biennial	
Alternative	Increase	GPR	FED	GPR	FED	GPR	FED
B2a.	$1	$215,000	$295,000	$430,000	$590,000	$645,000	$885,000
B2b.	2	430,000	590,000	860,000	1,180,000	1,290,000	1,770,000
B2c.	3	645,000	885,000	1,290,000	1,770,000	1,935,000	2,655,000
B2d.	4	860,000	1,180,000	1,720,000	2,360,000	2,580,000	3,540,000
B2e.	5	1,075,000	1,475,000	2,150,000	2,950,000	3,225,000	4,425,000

Estimated Expenditure Decrease for Brand Name Copayment Increase (Currently $15)

		2015-16		2016-17		Biennial	
Alternative	Increase	GPR	FED	GPR	FED	GPR	FED
B3a.	$1	$70,000	$95,000	$140,000	$190,000	$210,000	$285,000
B3b.	2	140,000	190,000	280,000	380,000	420,000	570,000
B3c.	3	210,000	290,000	420,000	570,000	630,000	860,000
B3d.	4	280,000	380,000	560,000	760,000	840,000	1,140,000
B3e.	5	350,000	480,000	700,000	950,000	1,050,000	1,430,000

22. An increase to the enrollment fee has a more targeted impact on GPR expenditures than an increase to copayments, since the fee revenue could be used fully to offset GPR costs. Copayments reduce program costs, and since program costs are shared between GPR and FED fund sources, the amount of the additional cost to recipients only partially offsets GPR costs.

23. A change could also be made to program deductibles, but this would have a smaller impact on GPR-funded costs. The state does not receive drug rebate revenues on drug purchases made during a SeniorCare participant's deductible phase. Therefore, any increase in the deductible would reduce program costs, but would also reduce rebate collections proportionally. Accordingly, only approximately 17% of an increase to the $500 deductible and 36% of an increase to the $850 deductible would go toward a reduction to GPR costs.

24. Another program modification that has been suggested would be to replace the program deductible with a 50% coinsurance payment, capped at the current deductible level. To illustrate, a participant currently in the $500 deductible category would pay 50% of all drug costs from the start of the plan year for the first $1,000 of drug purchases, instead of paying 100% of the first $500 of drug purchases. SeniorCare, instead of having no costs for the first $500 and 100% of costs (net of copayments) thereafter, would pay 50% of all drug costs through the first $1,000, then all costs (net of copayments) thereafter.

25. The coinsurance approach has two chief advantages. First, the state would receive more rebate revenue with a coinsurance program than under the current deductible model. Under

drug rebate agreements, manufacturers pay rebates only when the program incurs costs, and so do not owe rebates for drug purchases made during a participant's deductible phase. If the deductible were replaced with a coinsurance requirement, then the program would incur costs from the start of each plan year, thereby increasing the total base of drug expenditures subject to rebate payments.

26. The second advantage of a coinsurance model would be lowered costs for most participants in the deductible enrollment categories, compared to the current deductible program. With a coinsurance requirement, the program would pay 50% of the costs from the beginning of the plan year.

27. It should be noted that the program would incur higher, all-funds costs under this model. However, additional rebate revenue would be sufficient to more than offset higher program costs, and would result in lower net GPR and FED costs. It is estimated that a change to a coinsurance model would reduce net GPR expenditures by an estimated $1.1 million annually, once fully phased in.

28. Although the coinsurance model would eventually result in lower GPR and FED costs, these savings would not be realized initially, for two reasons. First, there is a six-month delay between the time a drug is purchased and the time that the state collects the rebate revenue associated with that purchase. Since the coinsurance model would result in higher program costs (all funds) from the start of implementation, but would only increase revenue after six months have elapsed, GPR and FED costs would increase initially, relative to current law. Second, there would be a gradual phase-in of both higher costs and higher rebates since current SeniorCare participants may be at any point in their 12-month plan year at the time of implementation. That is, initially, the program would trigger higher rebates only for those participants who would otherwise still be in their deductible phase. For all others, the program's costs and rebates would not change until they start their next 12-month plan year. Because of this rebate delay and phase in, the additional GPR-funded program costs would exceed offsetting rebates during the first full year of implementation.

29. The Department indicates that implementation of coinsurance model would take longer than other program modifications, and likely could not be initiated until 2016-17, meaning that the net GPR program costs would be higher in the biennium, relative to current law (because of the rebate delays and phase in issues described above). In addition to higher net GPR costs for benefits, the Department would also incur costs to make modify the system that pharmacies use to track participant and program payments. The Department estimates that system modifications could cost up to $1.0 million (although a more precise estimate would require consultation with the Department's contractor). For these reasons, the coinsurance approach would not be a viable alternative if the Committee's interest is in reducing GPR costs during the 2015-17 biennium.

30. In the event that the Committee decides to delete the proposed Part D requirement, additional funding ($5,198,000 GPR, $5,198,000 FED, and $22,046,700 PR in 2015-16 and $10,396,000 GPR, $10,396,000 FED, and $44,093,400 PR in 2016-17) would be needed to reverse the appropriation reductions under the bill [Alternative A2].

31. The state receives federal Medicaid matching funds for the cost of benefits provided to SeniorCare participants with annual incomes not greater than 200% of the FPL (the no deductible

and $500 deductible groups), but funds benefits for participants with higher incomes with GPR. Federal Medicaid matching funds are available under the terms of a waiver agreement with the federal Centers for Medicare and Medicaid Services (CMS). The current waiver authority will expire on December 31, 2015, if not renewed. The Department has notified CMS of its intent to apply for a renewal of the waiver under the current program structure, but would formally apply for a renewal with a modified program if the Governor's proposed changes under this item, or any other program changes, are approved. Under the bill, the implementation of the Part D requirement would be contingent on the approval of CMS, and any other alternatives adopted would also carry that contingency clause.

ALTERNATIVES

A. Medicare Part D Requirement

1. Approve the Governor's recommendation to require, as a condition of eligibility, that SeniorCare participants purchase a Medicare Part D plan, and to reduce funding for the program by $32,442,700 (-$5,198,000 GPR, -$5,198,000 FED, and -$22,046,700 PR) in 2015-16 and $64,885,400 (-$10,396,000 GPR, -$10,396,000 FED, and -$44,093,400 PR) in 2016-17 to reflect this change.

2. Delete provision.

ALT A2	Change to Bill
GPR	$15,594,000
FED	15,594,000
PR	66,140,100
Total	$97,328,100

B. Other SeniorCare Program Modifications

1. Increase the SeniorCare enrollment fee by adopting one alternative shown in the table below, effective January 1, 2016. Direct the Department to deposit the amount collected from each fee collected that exceeds $30 to a newly-created PR appropriation for SeniorCare benefits. Increase PR-REV and PR appropriation by the amounts shown in the table corresponding to the fee increase and reduce GPR by the same amounts.

Alternative	Increase	New Fee	2015-16	2016-17	Biennial Total
B1a.	$10	$40	$450,000	$900,000	$1,350,000
B1b.	20	50	900,000	1,800,000	2,700,000
B1c.	30	60	1,350,000	2,700,000	4,050,000
B1d.	40	70	1,800,000	3,600,000	5,400,000
B1e.	50	80	2,250,000	4,500,000	6,750,000

2. Increase SeniorCare copayments for generic prescriptions by adopting one alternative

shown in the table below, effective January 1, 2016, and reduce GPR and FED appropriations as shown in the table.

		2015-16		2016-17		Biennial	
Alternative	Increase	GPR	FED	GPR	FED	GPR	FED
B2a.	$1	$215,000	$295,000	$430,000	$590,000	$645,000	$885,000
B2b.	2	430,000	590,000	860,000	1,180,000	1,290,000	1,770,000
B2c.	3	645,000	885,000	1,290,000	1,770,000	1,935,000	2,655,000
B2d.	4	860,000	1,180,000	1,720,000	2,360,000	2,580,000	3,540,000
B2e.	5	1,075,000	1,475,000	2,150,000	2,950,000	3,225,000	4,425,000

3. Increase SeniorCare copayments for brand name prescriptions by adopting one alternative shown in the table below, effective January 1, 2016, and reduce GPR and FED appropriations as shown in the table.

		2015-16		2016-17		Biennial	
Alternative	Increase	GPR	FED	GPR	FED	GPR	FED
B3a.	$1	$70,000	$95,000	$140,000	$190,000	$210,000	$285,000
B3b.	2	140,000	190,000	280,000	380,000	420,000	570,000
B3c.	3	210,000	290,000	420,000	570,000	630,000	860,000
B3d.	4	280,000	380,000	560,000	760,000	840,000	1,140,000
B3e.	5	350,000	480,000	700,000	950,000	1,050,000	1,430,000

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