Joint Informational Hearing
of the
Assembly Committee on Health (Assemblymember Chan, Chair)
Assembly Committee on Aging and Long-Term Care (Assemblymember Berg, Chair)

MEDICARE DRUG COVERAGE: HOW IS IT GOING? WHAT IS THE STATE'S ROLE?

Tuesday, March 21, 2006
State Capitol, Room 4202
Upon Adjournment of Bill Hearing

On February 1, 2006, a joint Assembly-Senate informational hearing focused on the problems and potential solutions for assisting Californians dually eligible for Medi-Cal and Medicare (dual eligibles) during the implementation of the new Medicare drug benefit (Part D). This second hearing on the implementation of Part D will provide an update on the status of dual eligibles under Part D six weeks later and look at other Part D issues including the low-income subsidy and a comparison of various PDPs offered in California.

Medicare Part D

Medicare, the nation's health care program for seniors and disabled people, with over 40 million enrollees, began its new voluntary outpatient prescription drug coverage program, entitled Part D, on January 1, 2006. Part D was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Part D provides drug coverage to members through contracts with private stand-alone prescription drug plans (PDPs) and through Medicare Advantage drug plans (MA-PDs). PDPs and MA-PDs contract with pharmaceutical manufacturers and pharmacies to provide the drug benefit. In California there are a total of 47 PDPs and 113 MA-PDs. Monthly PDP premiums range from $5.41 to $66.08. MA-PD premiums range from zero to $50.84. In addition to premiums, in general, Part D requires beneficiaries to pay the first $250 as a deductible and then a 25% copayment for the next $2000

worth of drugs. Then, for the next $2850 worth of drugs, the beneficiary pays 100%. This $2850 gap in coverage is commonly known as the "donut hole." After a beneficiary's total drug spend reaches $5100 (for a beneficiary out of pocket cost of $3600), the beneficiary is responsible for paying 5% of all additional drug spending. Some Part D drug plans offer lower cost sharing and provide some coverage in the donut hole. Eligible Medicare beneficiaries who do not enroll in a Part D plan by May 15, 2006 are permitted to enroll during subsequent open enrollments periods but will be required to pay a premium penalty of 1% more per month for each month they delay.

Enrollment in Part D

The most recent statistics on Medicare prescription drug coverage nationally and in California are summarized in the following chart. CMS had estimated that 29.3 million beneficiaries would be enrolled in a Medicare drug plan in 2006. To reach that estimate another 13.4 million beneficiaries would need to sign up for a PDP or MA-PD by May 15, 2006. As of February 11, 2006, 5.3 million beneficiaries had newly enrolled in a PDP or MA-PD. Of note, 234,958 Californians have voluntarily enrolled in PDPs, while more than 1.2 million eligible Californians without other coverage have failed to sign up for the Medicare drug benefit. According to the Kaiser Family Foundation, of the total enrollment in MA-PDs nationally, 500,000 are new Medicare Advantage enrollees and 4.8 million are continuing enrollees.

Medicare Beneficiaries with Creditable Prescription Drug Coverage by Type, as of February 11, 2006, as reported by CMS

	CA #	US #
Total Medicare Beneficiaries	4,325,861	43,404,884
Beneficiaries with Drug Coverage	3,081,457	25,397,391
Beneficiaries in Stand-Alone PDPs	234,958	4,882,975
Beneficiaries in Medicare Advantage Drug Plans	1,221,574	5,337,343
Dual Eligibles (Auto-Enrolled into PDPs)	876,932	5,657,902
Beneficiaries in Employer Plans Taking Retiree Drug Subsidies	423,665	6,419,271
Federal Retirees (Tricare, FEHB)	324,328	3,099,900
Beneficiaries without a Known Source of Creditable Drug Coverage	1,244,404	18,007,493

Source: Kaiser Family Foundation, State Health Facts

Dual Eligibles and Part D

On January 1, 2006, nearly one million California dual eligibles whose prescription drug costs were previously paid by Medi-Cal had their drug coverage transferred to one of ten Medicare PDPs that are available without premiums for dual eligibles. Dual eligibles were supposed to be

auto-enrolled in one of these 10 PDPs in November 2005. This enrollment was on a random basis without regard to the PDP's formulary or pharmacy network. Once assigned to a PDP, a dual eligible then may switch to another PDP as often as once a month. However, transferring from one PDP to another may lead to a gap in coverage. Dual eligibles remain enrolled in Medi-Cal for services that Medicare does not cover, such as long-term care services and for assistance in payment of their Medicare premiums. Under Part D, dual eligibles are not responsible for deductibles, and do not have to pay for coverage in the donut hole. However, dual eligibles are required to pay co-payments ranging from $1 to $5. Under their prior drug coverage through Medi-Cal, dual eligibles were not required to pay copayments. Dual eligibles are sicker and poorer than the general Medicare population. According to the Kaiser Family Foundation dual eligibles use an average of 10 more prescriptions per month than non-dual eligible Medicare beneficiaries. As of February 11, 2006, dual eligibles accounted for 79% of all Californians enrolled in a PDP.

Financing Part D: The Clawback

Part D's implementation marks the first time since the enactment of the Medicare and Medicaid programs in 1965 that a specific Medicare benefit is financed in part by state payments. The mechanism through which the states will help finance the new Medicare drug benefit is popularly known as the "clawback" (the statutory term is "phased-down state contribution"). In brief, the clawback is a monthly payment made by each state to the federal Medicare program beginning in January 2006. The amount of each state's payment at least theoretically was designed to roughly reflect the expenditures of a state's own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles. For calendar year 2006, states are required to pay the federal government 90% of their estimated savings, as calculated by CMS, now that Medicare has assumed responsibility for dual eligible drug benefits. The percentage of estimated savings due to the federal government under the clawback drops each year by 1.67% until the it reaches 75% in 2015 (and thereafter). California was initially informed that its clawback amount for 2006 would be $1.172 billion, which was higher than the state's estimated savings under Part D. Subsequently, CMS revised downward the amounts of each state's clawback. California's revised clawback amount is $1.059 billion, or $113 million less than the initial amount. According to the Governor's office, the revised clawback amount "saves" California $60 million over what the state would have spent on prescription drugs for dual eligibles in 2006. A multi-state lawsuit has been filed claiming that the clawback is unconstitutional. California is not a party to that suit.

Part D's Low Income Subsidy: A Missed Opportunity

Despite the criticism leveled at the MMA since its enactment, one segment of Americans appeared to receive a sizeable new benefit under Part D's low income subsidy (LIS). LIS offers many non-Medicaid low income individuals a drug benefit nearly equivalent to that provided to dual eligibles with zero premiums, copays limited to $2 to $5, and no coverage gap in the "donut hole." To qualify for the full LIS, a Medicare beneficiary must have income less than 135% of the federal poverty level (FPL) (below $13,230 for an individual, $17,820 for a couple) and assets of less than $6,000 for an individual or $9,000 for a couple. Assets are generally defined as resources that can be converted to cash within 20 days, such as stocks, bonds, checking, savings, and retirement accounts. A principal home, car, and life insurance policies with a face value up to $1,500 do not count toward the asset limit. Also excluded from assets are certain

savings for funeral or burial expenses. A second LIS tier for individuals with 135% to 150% FPL (and assets of less than $10,000 per person) provides for a reduction in premiums, deductibles, and cost sharing compared to the general Medicare population. According to the Kaiser Family Foundation, an estimated 2.4 million Medicare beneficiaries who would be potentially eligible for low-income subsidies because their incomes are below 150% of poverty will not qualify for additional assistance because their assets exceed the eligibility threshold.

LIS enrollment is voluntary and generally carried out at the federal Social Security Administration (SSA). CMS estimated that 8.1 million Americans qualify for LIS, and that 4.6 million would enroll by May 15, 2006. However, the most recent enrollment statistics from SSA show that as of January 27, 2006, only 1.36 million individuals have been enrolled in LIS nationally, and only 66,857 in California.

Problems with Part D Implementation

As reported at the February 1, 2006 Joint Legislative Hearing, there have been innumerable complaints about the implementation of Part D, the inadequate preparedness and performance of both CMS and PDPs, and the resulting consequences for Medicare beneficiaries. Common complaints include data system failures, overcharging for prescriptions, lack of coverage provided by PDPs, PDPs failing to accommodate non- and limited-English speaking enrollees, and the inability of beneficiaries and pharmacists to reach Medicare or PDP call centers or getting inaccurate information when they did. These challenges have been particularly difficult for beneficiaries dually eligible for Medi-Cal and Medicare (dual eligibles) who previously received their drug coverage through Medi-Cal. As a result, California along with more than 30 other states began paying for dual eligible drugs that should have been available under Part D. With assistance from the state, dual eligibles' access to needed prescription drugs improved, but underlying problems affecting all beneficiaries remain. The degree to which CMS and the PDPs have resolved, or failed to resolve, these problems may well be masked by the state's emergency assistance.

State Action

On January 12, 2006, in response to the problems California dual eligibles were having accessing needed prescription drugs, the Governor directed the Department of Health Services (DHS) to immediately implement a 5-day emergency program to pay for dual eligibles' drugs not available through their Medicare coverage. On January 13, the Governor, along with the majority and minority legislative leaders from the Assembly and Senate, sent a letter to Secretary Leavitt of the federal Health and Human Services Department, expressing concern over the initial implementation of the MMA, explaining California's emergency program, and asking for reimbursement for the costs of this program. The problems experienced in California were mirrored nationwide. Ultimately, at least 37 states instituted emergency coverage programs for their dual eligibles.

On January 17, 2006, the Governor extended his original emergency order an additional four days. On January 21, AB 132 (Nunez), Chapter 2, Statutes of 2006 was enacted. AB 132 provided statutory authority for the Governor's action, extended the emergency program until January 27, 2006, authorized the Governor to extend it an additional 15 days, and appropriated

$150 million from the General Fund. On January 27, the Governor extended the emergency drug coverage for an additional 15 days.

SB 1233 (Perata), Chapter 7, Statutes of 2006, enacted on February 9, 2006, extended authority for that drug coverage until February 15, 2006, and permitted the Governor to extend it for additional periods of up to 30 days each, but in no case beyond May 16, 2006. The Governor has subsequently extended that coverage twice so that it currently runs until April 16, 2006.

Through March 16, 2006, DHS reports having reimbursed pharmacies $39.7 million dollars for 585,864 claims for 190,846 beneficiaries. The peak period for claims under this emergency coverage was the week of January 14-20, 2006 when the state received 78,633 claims. Although the level has decreased, claim volume since mid-February has been averaging over 58,000 per week. For the week of March 4-10, 2006, DHS received 60,467 claims. According to DHS, large numbers of these prescriptions are provided by pharmacies who specialize in services to people in nursing facilities, people with AIDS/HIV, people with mental diseases and people who require home infusion therapy.

CMS Response

On January 13, 2006, CMS sent a directive to all PDPs to take immediate steps to ensure that low-income beneficiaries were not charged more than $2 for a generic drug and $5 for a brand-name drug and to strengthen implementation of PDP formulary transition policies. The New York Times reported that the Bush Administration also told PDPs they must cover a 30-day transition supply of drugs that beneficiaries were taking prior to the start of the new program. The copayment limits are required by law. In prior advice to PDPs, the Bush Administration had recommended a 30-day transition supply but had not required it. Subsequently, CMS required PDP transition coverage for dual eligibles (and others who enrolled in Part D prior to March 1, 2006) to run until April 1, 2006.

In response to state demands for reimbursement for the cost of providing drugs to dual eligibles, CMS initially stated that it had no statutory authority to make such payments and that states would need to recoup costs by billing PDPs. However, on January 24, 2006, CMS announced that, under its waiver authority, states would be paid for the cost of providing emergency coverage to dual eligibles through February 15, 2006. Subsequently, CMS extended the period for reimbursement to the states. Federal reimbursement for drugs provided by California for dual eligibles is scheduled to terminate on March 31, 2006 and for administrative costs associated with providing those drugs on April 7, 2006.

Governor's March 16, 2006 Letter to Secretary Leavitt

On March 16, 2006, the Governor wrote Secretary Leavitt, requesting an extension of California's reimbursement waiver beyond its scheduled termination date of March 31, 2006. In his letter the Governor stressed that a number of factors will be converging on April 1, 2006 that will put great strain on Part D. Those factors include: the end of CMS-mandated 90 day transition drug coverage; the elimination of enrollment in multiple PDPs; the continuation of first-of-the-month enrollment lag issues; and dual eligibles running out of their December 2005 100-day supplies of medication provided by Medi-Cal. The Governor also expressed concerns about the capacity of CMS and PDPs to handle casework and prescription drug volume if

California were to terminate its dual eligible drug coverage program.

Pending Legislation

AJR 40 (Chan) urges Congress and the President to enact H.R. 3861, the Medicare Informed Choice Act of 2005. HR 3861 would extend the deadline for enrolling in Part D without penalty until December 31, 2006 and protect Medicare beneficiaries, who mistakenly sign up for Part D, from losing existing retiree coverage.

AB 1930 (Berg) requires DHS to provide prescription drug coverage for residents of long-term care facilities who are eligible for full Medi-Cal benefits unless the resident is enrolled in, and has active drug benefits under Medicare drug plan. AJR 40 and AB 1930 are scheduled to be heard by the Assembly Health Committee on March 21, 2006.

AB 2170 (Chan), which will be before the Assembly Health Committee later this year, creates a report card on quality of care and access for Medicare Part D plans.

AB 2956 (Lieu) states legislative intent to establish a statewide program to aid seniors in understanding the prescription drug benefit under the Medicare Program

On March 15, 2006, the U.S. Senate voted 76-22 to approve a fiscal year 2007 budget resolution amendment that would authorize, but not require, Secretary Leavitt to extend the May 15 enrollment deadline.