

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Low-Income Benefit and Subsidies
Section 1860D-14

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) establishes the new Part D Medicare benefit that provides low-income seniors and individuals with disabilities who are covered by Medicare better choices and greater protections. The Medicare prescription drug bill preserves the universality of Medicare for all eligible beneficiaries including those now dually eligible for both Medicare and Medicaid. Unlike Medicaid, the new Medicare Part D benefit will provide a guaranteed benefit to all eligible seniors.

New Provisions in the MMA

Benefit Description

- Starting in 2006, the new Medicare drug benefit will provide drug coverage to low-income individuals eligible for Medicare, thereby reducing their health care costs.
- Dual eligible individuals – those qualifying for both Medicare and Medicaid -- will now receive their drug coverage through Medicare. State Medicaid programs will no longer provide coverage for prescription drugs for dual eligible individuals except for certain drugs that Medicare will not cover. Dual eligible individuals will automatically qualify for low-income subsidies of Part D premiums and cost-sharing.
- The low-income subsidy program provides premium and cost-sharing subsidies for three groups of Medicare beneficiaries. These low-income subsidy groups are:
 - Group 1: full dual-eligibles with incomes below 100% FPL
 - Group 2: full dual eligibles with incomes at or above 100% FPL, as well as non-dual eligible Medicare beneficiaries with incomes less than 135% FPL who meet three times the SSI asset test of \$6,000 for an individual and \$9,000 for a couple in 2006 (increased by the CPI-U in subsequent years).
 - Group 3: Medicare beneficiaries with incomes less than 150% FPL who meet the resource standard of \$10,000 for an individual or \$20,000 for a couple in 2006 (increased by the CPI-U in subsequent years).
- The low-income subsidies are structured as follows:

- Beneficiaries in Group 1 receive the following:
 - a full premium subsidy up to the benchmark premium amount;
 - a full subsidy for the deductible;
 - prescriptions with only a \$1 copayment for each generic drug or multiple source preferred drug and a \$3 copayment for any other drug, up to the out-of-pocket limit of \$3,600;
 - prescriptions with \$0 copayments after the out-of-pocket limit is reached; and
 - limits on late enrollment penalties -- twenty percent of any applicable late enrollment penalties would apply for the first five years, after which no penalty would be imposed.
- Beneficiaries in Group 2 receive the following:
 - a full premium subsidy up to the benchmark premium amount;
 - a full subsidy for the deductible;
 - prescriptions with only a \$2 copayment for each generic drug or multiple source preferred drug and a \$5 copayment for any other drug, up to the out-of-pocket limit of \$3,600;
 - prescriptions with \$0 copayments after the out-of-pocket limit is reached; and
 - limits on late enrollment penalties -- twenty percent of any applicable late enrollment penalties would apply for the first five years, after which no penalty would be imposed.
- Institutionalized persons who are full-benefit dual eligibles are exempt from cost sharing, regardless of whether they are in Group 1 or Group 2. They would not be required to use their personal needs allowance to pay cost sharing.
- Beneficiaries in Group 3 receive the following:
 - a reduction of their monthly premium determined on a sliding scale based on income;
 - a reduction of the deductible to \$50;
 - prescriptions with a 15% percent copayment, up to the out-of-pocket limit of \$3,600; and
 - after the out-of-pocket limit is reached, prescriptions with only a \$2 copayment for each generic drug or multiple source preferred drug and a \$5 copayment for any other drug.
- Cost-sharing (other than for full benefit dual eligibles with incomes below 100% FPL), deductibles and coinsurance for these groups are indexed beginning in 2007 by the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the U.S. for eligible beneficiaries as determined by the

Secretary of HHS for a 12 month period ending in July of the previous year, using a methodology determined by the Secretary. Cost-sharing for full benefit dual eligibles with incomes below 100% FPL) would be indexed to the CPI-U.

- The premium subsidy amount for a full subsidy eligible beneficiary (Group 1 or Group 2) is the low-income benchmark premium for a PDP region. The low-income benchmark premium is equal to the weighted average of premiums of all prescription drug plans offered by the same PDP or a weighted average of premiums of all prescription drug plans offered by multiple PDP sponsors in a region. A low-income subsidy may not be less than the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in a region.

Addressing Concerns About the MMA's Impact on Low-Income Individuals and the states

- The Medicare benefit **will not** result in a loss of coverage for dual eligibles.
- According to a recent Office of the Inspector General report, states have identified prescription drugs as the top Medicaid cost driver (FY 2002, Medicaid prescription drug expenditures totaled approximately \$29 billion or 12% of the Medicaid budget). From 1997 to 2001, Medicaid expenditures for prescription drugs grew at more than twice the rate of total Medicaid spending. These pressures on state budgets could have led to coverage restrictions.
- Eighteen states currently contain Medicaid drug costs by limiting the number of prescriptions filled in a specified time period, limiting the maximum daily dosage or limiting the frequency of dispensing a drug. Six states have pharmacy lock-in programs, which require beneficiaries to fill their prescriptions in one designated pharmacy. Some states also limit the number of refills. In contrast, this will not be permitted under the new Part D benefit.
- Medicare drug plans have the option to use formularies but they are not required to do so. If a plan uses a formulary, it must include "drugs" in each therapeutic category and class. A formulary cannot limit a category or class to just one drug. Plans will have an incentive to offer multiple drugs in a therapeutic class in order to attract Medicare beneficiaries to join their plans.
- The beneficiary protections in the Medicare drug benefit are more comprehensive than those now required of state Medicaid programs. For example, there are extensive information requirements in Part D so beneficiaries will know what drugs the plan covers before they enroll in the plan. The plans must set up a process to respond to beneficiary questions on a timely basis. Beneficiaries can also appeal to obtain coverage for a covered drug that is not on their plan's formulary if the prescribing physician

determines that the formulary drug is not as effective for the individual or has adverse effects.

- The MMA allows state Medicaid programs to continue to provide the so-called excluded drugs, such as certain psychotropic drugs, weight loss and gain drugs, and over-the-counter drugs, and to still be paid the regular matching amount by the Federal government.
- The new Medicare drug benefit will replace significant state spending for duals and state-only programs. States, in turn, could use their saved state dollars to wrap-around Medicare eligibles cost sharing requirements and provide supplemental drug coverage if they chose to do so.