



# **Medicaid Prescription Drug Coverage**

Primer

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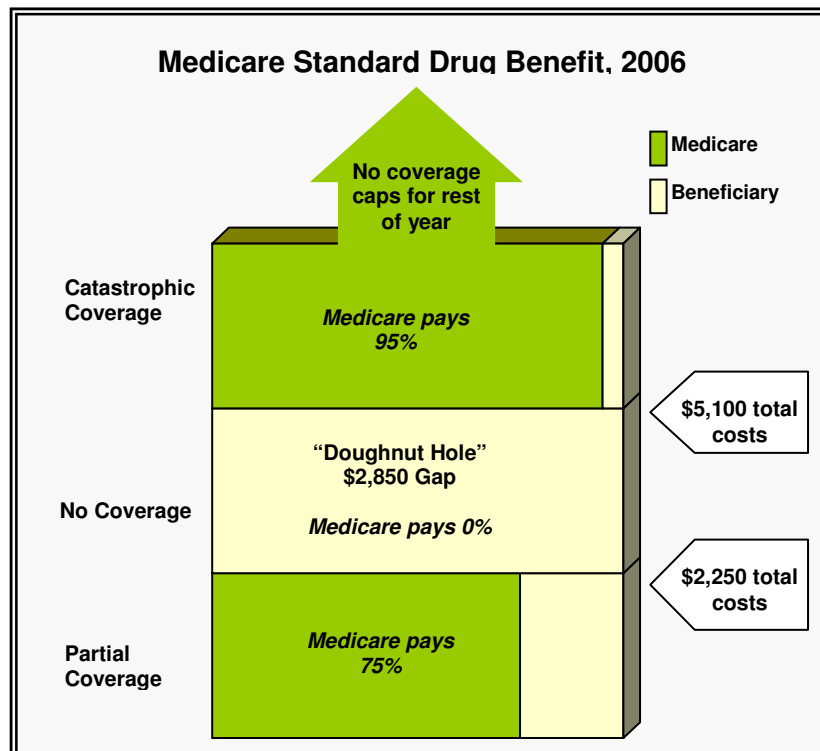
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| <p>What is Medicare?</p>                                       | <p>Created in 1965 as Title XIX, Medicare is the national health insurance program for U.S. citizens or permanent U.S. residents age 65 or older, certain people under age 65 with disabilities and those with End-Stage Renal Disease. In general, elderly Medicare recipients paid into the program for a minimum of 10 years through a required payroll deduction. Citizens and certain legal immigrants age 65 or older who have paid fewer than 10 years of such deductions can enroll in Medicare for a monthly premium.<sup>1</sup></p> <p>Medicare works something like private health insurance, requiring all recipients to cover deductibles, copayments and coinsurance costs. Medicare Part A coverage (hospital insurance) is provided to eligible recipients free of premium charges, but Part B, which covers outpatient care and doctor's services, is an optional coverage requiring payment of premiums.<sup>2</sup> The Part B monthly premium in 2005 is \$78.20.</p> <p>Part C provides for a managed care delivery system for Medicare Services, as opposed to the traditional fee-for-service program.</p> <p>Part D is the new prescription drug benefit that will be available in 2006.</p> |
| <p>How are Medicaid and Medicare related?</p>                  | <p>Though Medicare is administered and financed wholly at the federal level, state Medicaid programs are mandated to fully or partially cover deductible and coinsurance payments for certain low-income Medicare recipients. Thus, a significant portion of a state's Medicaid budget may be used to cover Medicare costs.<sup>3</sup> Under MMA, the states' Medicaid programs no longer will pay for prescription drugs for Medicare beneficiaries. As a result, states will be required to reimburse the federal government for drug expenses based on a formula that increases the reimbursement amount over time to reflect estimated growth in the Medicaid/Medicare population.</p>   |
| <p>What does "dual eligibility" mean and how does it work?</p> | <p>Dual eligibility refers to eligibility for both the Medicare and Medicaid programs. Medicaid funds may pay for premiums and other costs for low-income dual-eligible clients to access Medicare benefits. If both programs cover a service, Medicare funds would be used first, as Medicaid is the "payer of last resort," but often Medicaid provides more comprehensive benefits.<sup>4</sup> Dually eligible beneficiaries currently access Medicaid drug benefits, but will not be able to do so after Medicare Part D takes effect in 2006. At that time, they <i>must</i> enroll in a Medicare drug benefit plan or they will be automatically enrolled in one by the state.</p>   |

How does Medicare Part D work?

The financing structure for Part D is sometimes referred to as a “doughnut” structure because it provides assistance for preliminary drug costs (up to \$2250), then no assistance (the “doughnut hole”) until beneficiaries incur \$5100 in drug expenses. After that, Medicare provides catastrophic coverage for almost all drug costs for the remainder of the calendar year.

Basics of the plan for 2006:

- ◆ \$35 monthly premiums, in addition to premiums required for participation in Medicaid Part B.
- ◆ \$250 deductible
- ◆ 75% coverage up to first \$2250 in drug expenses. This amounts to \$750 in actual out-of-pocket expenses for beneficiaries if they spend the entire \$2250.
- ◆ “Doughnut Hole” gap begins at \$2250, and beneficiaries pay 100 % of all drug costs up to \$5100 in total spending. This amounts to \$2850 in total out-of-pocket spending for beneficiaries, excluding premiums, before coverage resumes.
- ◆ When coverage resumes, beneficiaries pay the greater of 5% coinsurance or copayments for prescriptions (\$3 for generics, \$5 for brands).
- ◆ Starts over each calendar year
- ◆ Deductibles and out-of-pocket expenses will increase over time.
- ◆ Assistance for low-income beneficiaries.



Examples of how this structure affects beneficiaries are provided on the next page.

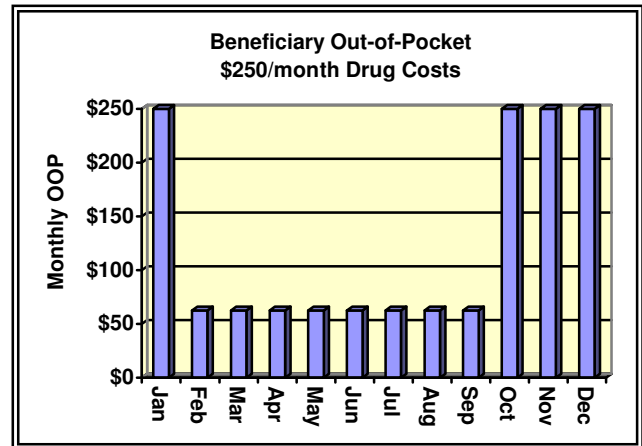
How will this “doughnut hole” affect beneficiaries with moderate prescription drug needs?

Using a monthly drug cost of \$250 as an example, the graph shows the actual out-of-pocket (OOP) costs that the beneficiary will pay each month, excluding monthly premiums.

In January, the beneficiary will pay the full \$250 in costs to meet the deductible.

From February to September Medicare Part D pays 75 percent of costs, so the graph reflects the 25 percent coinsurance payments from the beneficiary.

In September, the total cost of drugs will reach \$2250, triggering the “doughnut hole” coverage gap. Accordingly, the beneficiary pays all drug costs for the remainder of the year.



How will it affect beneficiaries with high prescription drug needs?

Using a monthly drug cost of \$500 as an example, the graph shows the actual out-of-pocket (OOP) costs that the beneficiary will pay each month, excluding premiums.

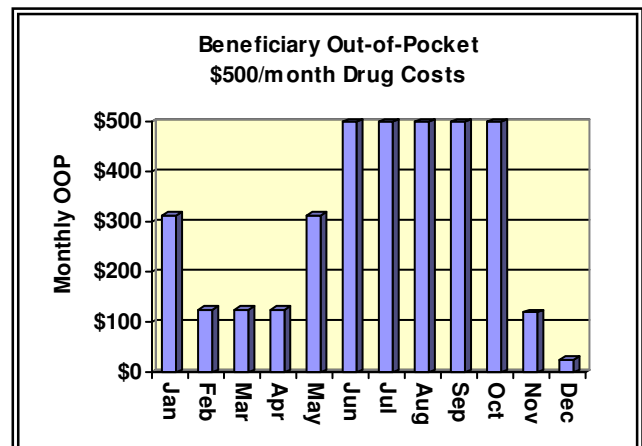
In January, the beneficiary will pay the \$250 deductible, plus 25 percent of the remaining \$250 in expenses (\$312.50 total).

From February to April Medicare Part D pays 75 percent of costs, so the graph reflects the 25 percent coinsurance payments from the beneficiary (\$125).

In May, the total cost of drugs will reach \$2,250, triggering the “doughnut hole” coverage gap. Accordingly, the beneficiary pays 100 percent of costs starting in mid-May, as well as all drug costs through October.

In October total drug costs will reach \$5,000, very close to the \$5,100 trigger for catastrophic coverage under Medicare Part D. Accordingly, November reflects a significant drop in costs to the beneficiary (from \$500 down to \$120).

In December, the beneficiary will pay only a 5 percent coinsurance payment (\$25), or copayments for prescriptions (\$2 for generics or \$5 for brands), whichever is *greater*.



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| <p>How does Part D coverage differ from current Medicare drug benefit options?</p> | <p>Most Medicare beneficiaries are enrolled in the traditional fee-for-service program that does not offer drug benefits. Slightly more than 10 percent of beneficiaries are enrolled in Medicare Advantage plans, some of which provide limited drug coverage. In 2004, however, nearly 30 percent of Medicare Advantage enrollees nationwide had no drug coverage. When the MMA Medicare drug benefit takes effect, insurers must offer at least one plan with drug coverage in each service area. Beneficiaries enrolled in fee-for-service coverage may enroll in a stand-alone prescription plan. Approved drugs will be restricted based on formularies designed to provide at least two options for each drug category and will vary among plans.</p> <p>Many beneficiaries have been using Medicare-approved drug discount cards that became available in May 2004. Beneficiaries will be able to use these cards until December 31, 2005. They were designed to provide a transition to help people with Medicare save money on prescription drug costs until the prescription drug plans become available.</p> |
| <p>Does everyone have to participate in the new plans?</p>                         | <p>The new drug coverage is voluntary, but delayed enrollment in Part D will result in permanent increased premiums. This penalty applies to anyone who does not enroll in a plan during the first enrollment period in which they are eligible. There is an exception is for those enrolled in employer-sponsored or other private insurance plans who switch to Medicare later. The private plans must provide drug coverage that is equal to or better than the Medicare coverage.</p> <p>More specifically, for every month that a beneficiary delays enrollment in a Part D plan, he or she will pay an additional one percent in premiums each month for life.</p>   |
| <p>How will it affect dual-eligible beneficiaries?</p>                             | <p>Currently, dual-eligible beneficiaries are covered under Medicaid, which generally allows three prescriptions per month for outpatient drugs, with exceptions for children under 21 and adults enrolled in Medicaid managed care plans.<sup>5</sup></p> <p>Beginning in January 2006, dual-eligible beneficiaries will be enrolled in a Medicare drug plan, and will no longer be able to access Medicaid drug benefits. They will not pay premiums or the annual deductible, but will be required to pay a copayment of \$1-\$5 for each prescription, depending on their income and assets.</p>   |
| <p>Will all prescription drugs be covered?</p>                                     | <p>No, but the new drug plans must cover at least two drugs in each therapeutic class. Because each plan can establish its own formulary, based on federal guidelines for choosing which drugs to offer, the drugs offered will vary from plan to plan. For dually-eligible beneficiaries, the state Medicaid program may opt to cover drugs that are not allowed under the Medicare Part D plan.</p>  |

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| <p>Will there be any other programs to assist with drug expenses for low-income beneficiaries?</p> | <p>Beneficiaries dually eligible for Medicaid and Medicare will give up Medicaid coverage and automatically be enrolled in a Medicare drug plan in 2006. They will pay no premiums or deductible and have no coverage gap. They will pay \$1 per prescription for generics and \$3 for brand names. Copays will be waived for those in nursing homes.</p> <p>Enrollees with incomes below 135 percent of the Federal Poverty Limit (FPL), or about \$13,000 (\$17,600 for couples) in 2006 and assets of under \$6,000 (\$9,000 for couples) will pay no premium or deductible and have no coverage gap. They will pay \$2 for generics, \$5 for brand names and nothing above the catastrophic limit.</p> <p>Enrollees with incomes between 135 and 150 percent of FPL, and assets under \$10,000 (\$20,000 for couples) will pay premiums on a sliding scale, a \$50 deductible and 15 percent of drug costs with no gap in coverage. Copayments for prescriptions are lower, and they do not pay coinsurance for catastrophic coverage</p> |
| <p>What is the timeline for all of these changes?</p>  | <p>U.S. Health and Human Services Commission agencies have already begun notifying Medicare beneficiaries about the new plan. Low-income citizens started applying for financial assistance in June, and received letters of eligibility notification in August. Following is the timeline for the remainder of 2005.</p> <p><b>September:</b> Medigap insurers and employers inform beneficiaries about their options for 2006.</p> <p><b>October:</b> Broad notification and comparison information about plans available via the Centers for Medicaid and Medicare site, <a href="http://www.cms.gov">www.cms.gov</a>. Insurers will market their plans.</p> <p><b>November:</b> Enrollment begins on the 15<sup>th</sup>.</p> <p><b>December:</b> Enrollment continues through May 15<sup>th</sup> before late enrollment penalties begin. Dual-eligible Medicaid coverage and discount card program end on the 31<sup>st</sup>.</p> <p><b>January 2006</b> Coverage begins.</p>  |

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