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Issue Brief

AMERICAN ACADEMY of ACTUARIES

Medicare Modernization Act: Financial Issues for State Medicaid Programs

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), a prescription drug benefit will be provided for the Medicare eligible population. Section 103 of the MMA outlines issues associated with the Medicaid program and the dual eligible population. This document identifies several provisions of the MMA that may have an impact on state Medicaid budgets.

i. Federal Assumption of Medicaid Prescription Drug Costs for Dual Eligible Individuals

MMA Section 103 provides for the transfer of prescription drug coverage for dual eligible individuals from state Medicaid programs to the federal Medicare Part D program. The Medicaid full-benefit dual eligible population will receive a benefit package that does not include deductibles or coinsurance, although there may be copayments. Each state will be responsible for paying a monthly contribution to the federal government to help defray the cost of the prescription drug benefit for dual eligibles. The formula for calculating the monthly State Contribution payment that begins in 2006 will be as follows:

- Start with prescription drug expenditures for the full-benefit dual eligible population in 2003, based on state-specific data from the Medicaid Statistical Information System (MSIS) and other available sources –
 - Convert drug expenditures for full-benefit dual eligibles (excluding managed care enrollees) to a per capita basis
 - Exclude expenditures for drugs not covered under Part D (if a state has non-covered optional drugs, those will still be financed as they are now)

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- MMA does not indicate whether to use a fiscal or calendar year basis, or whether to use a paid or incurred basis (although a calendar year, paid basis is anticipated)
- Reduce by Medicaid Prescription Drug Rebate Program percentage –
 - Equal to the aggregate rebate payments received divided by total Medicaid prescription drug expenditures (for all beneficiaries, not just the full-benefit dual eligibles)
- Estimate the actuarial value of drug expenditures for the full-benefit dual eligibles enrolled in Medicaid managed care plans
- Develop a composite per capita rate by blending the non-managed care and managed care per capita amounts
- Adjust by the Federal Medical Assistance Percentage (FMAP) –
 - This is achieved by multiplying the composite per capita rate by 100% - FMAP for the month in which the State Contribution payment is made
- Trend forward to 2006 by the annual percentage change in the per capita prescription drug expenditures from the National Health Expenditure (NHE) projections
- Multiply the trended per capita amount by the phased-down State Contribution factor –
 - The factor for 2006 is 90%
 - This subsequently is reduced annually by 1⅓%
 - Reductions continue until 2015, when the factor will be 75%
- Multiply the trended and adjusted (for the State Contribution factor) per capita amount by the number of full-benefit dual eligible recipients in the specified month, including all spend-down recipients that met the spend-down threshold
- In subsequent years, the per capita State Contribution payment will be increased by the rate of growth of overall per capita Part D expenditures.

Attachment 1 shows a sample calculation as presented by the Centers for Medicare and Medicaid Services (CMS) during a March 25, 2004 conference call.

Under this program, prescription drug expenditures for a state Medicaid program should be reduced. However, the savings in 2006 – as a percentage of what prescription drug expenditures would have been in the absence of MMA – may or may not be 10% (i.e., one minus the State Contribution factor). The following items may influence the overall level of a state's savings:

- The NHE rate of growth used to project the per capita amount may differ from an individual state's rate of growth for prescription drug expenditures. For example, trend reductions due to cost containment initiatives implemented between 2003 and 2006 will not be reflected

- The rebate adjustment will be calculated in the aggregate, whereas the actual cost reduction due to pharmaceutical rebates may vary between the full-benefit dual eligibles and the remaining Medicaid population
- Depending on the timing of payments in 2006 to CMS, a state may pay an additional month of pharmacy services for the full benefit dual eligibles. This results from paying for both the fee-for-service claims that were incurred prior to 2006 and the State Contribution payments to CMS.

ii. Potential Enrollment Effect

MMA provides for subsidies for low-income Medicare beneficiaries. Under MMA, the states are required to make determinations of eligibility for premium and cost-sharing subsidies. (In addition to the state efforts, the Social Security Administration (SSA) also will be making eligibility determinations for these subsidies.) As part of the eligibility determination process, the states are also required to screen for eligibility and enrollment of beneficiaries for other medical assistance programs. It is anticipated that through the eligibility and enrollment screening process, the states (and the SSA) will identify eligible individuals who are not currently enrolled as full-benefit dual eligibles or as a partial-benefit recipients under the Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary programs. The states are required to offer enrollment to these individuals under the state Medicaid plan.

iii. Part B Deductible Increase

Beginning in 2005, MMA increases the Part B deductible from \$100 to \$110. The Part B deductible will subsequently increase by the annual percentage increase in the monthly actuarial rate of the Part B program. The Part B deductible amounts are reimbursed by state Medicaid agencies under the full-benefit and partial-benefit programs. For Qualifying Individuals (QIs) with income up to 135% of FPL, there will be an extension of the 100% federal funding for Medicaid programs which pay these Medicare Part B premiums.

iv. Medicaid Best Price

MMA provides for the exclusion of the drug prices established under the Part D benefit program from the determination of the Medicaid best price amount. The exclusion may influence the Medicaid best price amount, subsequently influencing the rate of payment for prescription drugs for the Medicaid recipients that are not covered as dual-eligible recipients.

v. Administrative Expense

As previously indicated, the state Medicaid agencies will have the responsibility for the determination of eligibility for low-income subsidies. The eligibility determination will result in an increase in administrative costs for the state programs, and this increase will occur prior to 2006.

vi. State Pharmacy Assistance / Senior Pharmacy Benefit Programs

With the creation of a Medicare Part D prescription drug benefit, state Medicaid agencies (or applicable state government entities) may be able to redirect funds that have been allocated to State Pharmacy Assistance / Senior Pharmacy Benefit programs. These programs have been supported through state-only general revenues, CMS waivers and Tobacco Settlement funds. The state agencies that run the programs may be able to modify them to expand benefits to additional populations or to cover other program costs.

States may use these programs to reimburse low-income enrollee coinsurance or enrollment fees. Many such programs have current eligibility limits which go as high as 200% FPL, or even above. Given this, some of the State Pharmacy Assistance / Senior Pharmacy Benefit enrollees will be subject to coinsurance and enrollment fees under the MMA.

ATTACHMENT 1

Illustrative Calculation of State Phased-Down Monthly Contribution for 2006

<u>Item</u>	<u>Illustrative Value</u>	<u>Source</u>
(1) Gross per-capita Medicaid expenditures for prescription drugs in 2003 for full-benefit dual eligibles not receiving drug coverage through a Medicaid managed care plan, excluding drugs not covered by Part D	\$2,000	MSIS data
(2) Aggregate state payments under rebate agreements for 2003	\$100,000,000	CMS-64
(3) Gross state Medicaid expenditures for prescription drugs in 2003 from CMS-64	\$500,000,000	CMS-64
(4) Rebate adjustment factor	20%	(2) / (3)
(5) Adjusted 2003 gross per capita Medicaid expenditures for prescription drugs for full-benefit dual eligibles not in managed care plans	\$1,600	(1) x [100% - (4)]
(6) Estimated actuarial value of prescription drug benefits under capitated managed care plans for full-benefit dual eligibles in 2003	\$1,500	To be determined
(7) Average number of full-benefit dual eligibles in 2003 who did not receive covered outpatient drugs through Medicaid managed care plans	90,000	MSIS data
(8) Average number of full-benefit dual eligibles in 2003 who received covered outpatient drugs through Medicaid managed care plans	10,000	MSIS data
(9) Base year state Medicaid per capita expenditures for covered Part D drugs for full-benefit dual eligible individuals (weighted average of (5) and (6))	\$1,590	$[(7) \times (5) + (8) \times (6)] \div [(7) + (8)]$
(10) 100% minus Federal Medical Assistance Percentage (FMAP) applicable to month of state contribution (as a proportion)	40%	Federal Register
(11) Applicable growth factor (cumulative increase from 2003 through 2006)	50%	NHE projections
(12) Number of full-benefit dual eligibles for the month	120,000	State-submitted data
(13) Phased-down State Contribution factor for the month	90%	Specified in statute
(14) Phased-down State Contribution payment for the month	\$8,586,000	$1/12 \times (9) \times (10) \times [1 + (11)] \times (12) \times (13)$