SB 282

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FISCAL AND POLICY NOTE
Revised

Senate Bill 282 (Senator Middleton, *et al.*)
Finance Health and Government Operations

Maryland Pharmacy Programs - Modifications and Subsidies for Medicare Drug Benefits

This bill makes a variety of changes to State drug assistance programs in relation to the new Medicare Part D prescription drug benefit. Medicare Part D beneficiaries with household incomes at or below 300% of the federal poverty level guidelines (FPG) are eligible for State subsidies for their cost-sharing requirements under Medicare.

The bill takes effect July 1, 2005. The provisions changing the Senior Prescription Drug Program (SPDP) and the Maryland Pharmacy Assistance Program (MPAP) take effect the later of January 2006 or on the availability of Medicare Part D drug benefits.

Fiscal Summary

State Effect: Senior Prescription Drug Assistance Program (SPDAP) special fund expenditures would increase by $196,100 in FY 2006 to provide subsidies to Medicare Part D coverage. Medicaid expenditures (50% general funds, 50% federal funds) could decrease by $11.9 million in FY 2006. Future year estimates reflect inflation and annualization.

($ in millions)	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Revenues	$0	$0	$0	$0	$0
GF Expenditure	(5.9)	(14.9)	(16.6)	(18.5)	(20.6)
SF Expenditure	.2	.2	.2	.2	.2
FF Expenditure	(5.9)	(14.9)	(16.6)	(18.5)	(20.6)
Net Effect	$11.7	$29.6	$33.1	$36.9	$41.0

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

SPDAP: The bill renames the Senior Prescription Drug Program to the Senior Prescription Drug Assistance Program (SPDAP) and makes various changes to eligibility requirements and benefits. SPDAP provides Medicare Part D beneficiaries who meet program eligibility requirements with a State subsidy for a portion of their: (1) Medicare Part D prescription drug plan premium and deductible; or (2) Medicare Advantage Plan premiums and deductibles related to a prescription drug benefit.

The SPDAP subsidy must be equal to: (1) for individuals who do not qualify for a federal low-income subsidy, at least $25 per enrollee per month; (2) for individuals who qualify for a partial federal low-income subsidy, the lesser of $25 or the full amount of the enrollee's share of the premium; and (3) the total amount of Medicare Part D or Medicare Advantage Plan deductibles, less a copayment or coinsurance amount. An enrollee must pay a copayment or coinsurance amount, instead of a deductible, equal to the initial copayment or coinsurance a month for which the enrollee is responsible under the enrollee's plan.

The bill specifies that in addition to premiums collected, the SPDAP fund also includes money deposited by a nonprofit health service plan. A nonprofit health service plan is required to deposit into the SPDAP fund the amount necessary to operate and administer SPDAP each quarter.

Maryland Pharmacy Assistance Program: The bill excludes Medicare-eligible individuals from coverage under MPAP. The Department of Health and Mental Hygiene (DHMH) must provide information to ineligible MPAP applicants regarding other programs that they may be eligible for, including the Maryland Medbank Program and the SPDAP.

Maryland Pharmacy Discount Program: The bill repeals the Maryland Pharmacy Discount Program (MPDP) that provides drug discounts and subsidies for Medicare beneficiaries.

Medicare Option Prescription Drug Program: The bill establishes the Medicare Option Prescription Drug Program (MOPDP) within the Medicaid program. MOPDP provides a low-income Medicare-eligible individual with a coordinated prescription drug plan that minimizes an individual's cost-sharing requirements. The program is open to any

individual who: (1) is a State resident; (2) is a Medicare beneficiary; (3) is not enrolled in a Medicare Advantage Plan or other public or private insurance program, except for Medicaid and MPAP, that provides prescription drug benefits; (4) has an annual income below 150% FPG; and (5) meets the asset test established for Medicare Part D. Individuals who are dually-eligible for Medicare and Medicaid, or Medicare and MPAP, may be automatically enrolled. They have the option to elect out.

DHMH may contract with one or more prescription drug plans to coordinate the prescription drug benefits provided under the program and Medicare Part D drug benefits. It is the intent of the General Assembly that the Medicare Option Prescription Drug Program be the payor of last resort and only cover costs for enrollees that are not covered under Medicare Part D.

The bill extends the termination date for SPDP from June 30, 2005 to June 30, 2007. The Maryland Health Insurance Plan (MHIP), which administers SPDP, may extend benefits to current enrollees until February 1, 2006.

Current Law: SPDP provides prescription drug coverage to Medicare beneficiaries with incomes up to 300% of FPG. SPDP's termination date is June 30, 2005.

Background: SPDP is scheduled to terminate June 30, 2005, although several bills have been introduced this session to extend the termination date. The Governor's proposed fiscal 2006 budget for SPDP is $27.3 million. Contingent on the enactment of HB 148/SB 127 (Budget Reconciliation Act of 2005), which extends SPDP's termination date to January 1, 2006, SPDP must transfer $11.75 million to the Medicaid Maryland Pharmacy Assistance Program.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a voluntary prescription drug benefit as Medicare Part D. It is slated to begin providing comprehensive drug coverage in January 2006. Until then, the plan provides a discount prescription drug card, giving all Medicare enrollees a discount on prescription drugs and providing a subsidy to certain low-income enrollees.

Medicare Part D coverage, which begins in 2006, includes a $35 monthly premium, a $250 annual deductible, and 25% cost-sharing up to the initial $2,250 coverage limit. If an enrollee purchases additional drugs beyond the $2,250 limit, the enrollee must pay all costs of drugs between $2,250 and $5,100 the first year. If an enrollee spends more than $3,600 total out-of-pocket, the enrollee is subject to 5% cost sharing or certain low copayments. SPDP premiums and copayments are lower than the estimated average Medicare Part D costs (see **Exhibit 1**). Medicare beneficiaries with incomes below 150% FPG will pay lower premiums based on a sliding scale and 5% coinsurance.

Exhibit 1

Expense	SPDP	Medicare Part D
Annual Premium	$120	$420 (estimate)
Annual Deductible	None	$250
Coinsurance	$10/20/35 per drug	25%
Benefit Limit	$1,100	$2,250*

**This is the initial benefit limit, after which an enrollee is responsible for the next $2,850 drug costs ("doughnut hole"). After a member has expended this amount on drugs, Medicare pays 95% of the annual drug costs over $5,100.*

Medicare beneficiaries of all income levels will have access to a federally-subsidized drug benefit under Part D. With Medicare-funded drug coverage, State pharmacy assistance programs like SPDP will be relieved of significant prescription drug costs they are paying for many lower-income individuals. State pharmacy assistance programs, by coordinating drug coverage with Part D benefits, will be able to provide more coverage or maintain coverage for enrollees at a lower cost.

State Fiscal Effect: SPDAP special fund revenues and expenditures would be maintained beyond fiscal 2005 due to repeal of SPDAP's termination date, and modifying SPDP from an insurance plan to a subsidy program that coordinates coverage with Part D is expected to be budget-neutral with respect to drug expenditures. Administrative costs, however, would increase. Special fund expenditures could increase by an estimated $196,126 in fiscal 2006, which accounts for a 90-day start-up delay. This estimate reflects the cost of hiring three analysts to manage contracts with Part D carriers and administer coordination of coverage for benefits paid out under Part D. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$179,581
Operating Expenses	16,545
Total FY 2006 SPDAP Expenditures	**$196,126**

Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

Medicaid expenditures could decrease by $11,891,271 (50% general funds, 50% federal funds), which assumes a January 1, 2006 start-up date for MOPDP. This estimate

reflects the reduced cost of prescription drugs from switching MPAP enrollees who are Medicare-eligible into the new MOPDP. It reflects the cost of hiring 10 staff to implement and administer MOPDP. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses The information and assumptions used in calculating the estimate are stated below:

- 150,000 individuals enroll in MOPDP;
- Medicare pays $182 million for enrollees' drug costs;
- MOPDP pays $6 million for the enrollees' cost-sharing requirements (*i.e.,* copayments, coinsurance, deductibles);
- MOPDP receives $29.5 million revenues from prescription drug rebates;
- MOPDP pays $10 million for risk adjustment (increased utilization); and
- MOPDP administrative costs, including computer programming, enrollment packets/brochures, and 10 staff is $1,608,729.

Salaries and Fringe Benefits	$343,036
Cost to Cover Enrollee Cost-sharing Requirements	6,000,000
Risk Adjustment for Increased Utilization	10,000,000
Computer Programming	1,000,000
Enrollment Brochures/Packets/Outreach	200,000
Other Operating Expenses	65,693
Rebate *Revenues*	(29,500,000)
Total FY 2006 MOPDP Expenditures	**($11,891,271)**

Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

Additional Comments: Under the new Medicare Part D prescription drug benefit, state pharmacy assistance programs (SPAPs) will achieve significant savings when Part D becomes effective (January 2006), since many of the drug costs will be paid by Medicare. There is some concern, however, that SPAPs are being designed in a manner that

maximizes state prescription drug rebates to the detriment of Medicare Part D beneficiaries and the Medicare program.

Centers for Medicare and Medicaid Services (CMS) recently issued a memorandum to state Medicaid directors, indicating concern about SPAPs that eliminate choice for low-income individuals by automatically enrolling them into one preferred prescription drug plan (PDP), particularly if the preferred PDP then transfers cost savings back to the states at the expense of Medicare beneficiaries. CMS advises these types of programs do not meet the definition of SPAPs under Medicare Part D. In these cases, states would receive rebates and other financial concessions from drug manufacturers in exchange for steering individuals to a particular PDP. Transferring rebates to states instead of using them to lower drug costs would likely result in higher costs for Medicare beneficiaries and the Medicare program.

It is unclear whether MOPDP as proposed would meet the federal definition of an SPAP, since it would automatically enroll specified low-income individuals in one PDP. It should be noted that while DHMH may automatically enroll specified low-income individuals like those dually-eligible for Medicare and Medicaid, enrollees may elect to opt out of MOPDP at any time.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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