

THE NEW MEDICARE PRESCRIPTION DRUG LAW:

Implications for Massachusetts State Health Programs



September 2004



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Important Data Qualification

Financial estimates in this report are intended to be illustrative only and are not intended to be true projections of the actual impacts on Massachusetts. Throughout the time this report was prepared, clarifications and proposed regulations for important provisions of the MMA law remained under discussion and development, which made an in-depth or precise financial analysis impossible. When practicable, this report does include financial estimates based on national data; however, the actual impact on Massachusetts quite likely will vary from these estimates.

Medicaid data are drawn from several sources. Data used within this report may not necessarily match data available from other reports from MassHealth.

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I. Executive Summary

The Medicare Modernization Act of 2003 enacted the most significant changes to Medicare since the program was adopted in 1965. The cornerstone provision of the law added a prescription drug benefit to Medicare, which will advantage many beneficiaries who now lack coverage for prescription drugs. At the same time, the new Medicare prescription drug coverage will have important fiscal and administrative implications for state Medicaid programs, including significant impacts on the prescription drug coverage for “dual” beneficiaries simultaneously enrolled in both Medicaid and Medicare.

A. Key Implications for Publicly-Supported Programs in Massachusetts

The MMA will have important implications for three key publicly-supported programs that provide prescription drug coverage in Massachusetts: MassHealth (the Massachusetts Medicaid program), Prescription Advantage and the Group Insurance Commission, which provides drug coverage to retired state employees.

MassHealth

- Effective January 1, 2006, MassHealth will end its coverage for most prescription drugs for its 190,000 elderly and disabled “dual eligibles.” Dual eligibles are individuals enrolled both in MassHealth and in the Medicare program.
- Medicare will assume responsibility for prescription drug coverage for dual eligibles and will administer the new drug benefit, but states will supply a significant share of the funding. States are required to pay a “maintenance of effort” amount, called a “Clawback” payment. The Clawback will recoup from states much of the savings states would have realized as a result of Medicare assuming responsibility for the drug benefit. The Clawback is based on actual state Medicaid spending for prescription drugs for dual Medicaid – Medicare enrollees in calendar year 2003. The clawback formula applies a national cost index to the base spending and, accordingly, advantages states whose actual Medicaid drug costs are growing faster, and disadvantages states whose Medicaid drug costs are growing more slowly than the national average.
- Massachusetts is a state that successfully applied aggressive pharmacy cost controls and substantially reined in Medicaid pharmacy spending in 2002. To the extent this constrained the 2003 base, this will be positive for the state. To the extent these measures continue to keep the Massachusetts Medicaid pharmacy cost trend below the national average, the Clawback will erode savings the state would have realized and Massachusetts might well pay more than it would have had the Medicare drug benefit not been enacted, at least in the early years of the benefit. In addition, the state will lose the ability to manage

the prescription drug benefit for duals, even as it must continue to finance the benefit through the Clawback.

- Final Clawback calculations cannot yet be done, as discussions continue between state Medicaid programs and CMS about the details of the formula. Nevertheless, it is clear at this point that the Clawback will likely keep Massachusetts from realizing the significant drug cost savings first thought available from a Medicare prescription drug program, particularly in the first years of the Medicare drug benefit.
- In addition to the Clawback liability, MassHealth will face other new expenses associated with the new Medicare drug benefit. Examples include:
 - Administrative costs of determining eligibility for low-income subsidies might cost the state as much as \$124 million over 10 years, extrapolating from national estimates.
 - A “woodwork effect” is almost certain to increase enrollment in MassHealth, as some applicants for the low-income subsidy discover they are eligible for full MassHealth benefits or for Medicare buy-in programs from the state. The cost for Massachusetts (extrapolated from Congressional Budget Office national projections) is estimated to be about \$228 million over the period from 2005-2013.
- A potential increase in state Medicaid spending would occur if state policy makers should decide to maintain current Medicaid drug coverage by “wrapping-around” the drug formularies of Part D drug plans. By law, federal Medicaid matching funds will not be available to states that choose to cover Part D drugs that are not included in the formularies of private Medicare drug plans. Thus any wrap-around coverage would have to be financed entirely with state funds.
- As full-benefit duals move to the federal Medicare plans, MassHealth may also lose purchasing power for its remaining pharmacy program, since dual eligibles account for such a significant proportion of Medicaid prescription drugs spending. As a result, multi-state purchasing pools might become a more appealing state option after implementation of the Medicare pharmacy benefit.
- MassHealth dual beneficiaries who are eligible for the Medicare drug benefit in January 2006 will likely notice changes in their drug coverage and their out-of-pocket costs under the new program compared to MassHealth. Copayments could be higher and formularies more restrictive. In addition, these beneficiaries for the first time will need to choose and enroll in a prescription drug plan, and there is a possibility that this process could be complex and confusing for some enrollees.

Prescription Advantage

The Prescription Advantage program will likely reap savings with the start of the Medicare drug benefit. (The transitional Medicare drug program now in place has already saved the state an estimated \$10 million.) Most Prescription Advantage members are eligible for the Medicare benefit, and many will qualify for the low-income subsidy. People who qualify for

the subsidy will, for the most part, be better off with the Medicare coverage than with Prescription Advantage. State policy makers are considering alternatives for the future of the Prescription Advantage program, and how to use these anticipated savings.

Health Benefits of Retired State Employees

The Group Insurance Commission, which provides benefits for 50,000 retired state employees who are Medicare beneficiaries, qualifies for the employer subsidy authorized in the Medicare Modernization Act. This subsidy was designed to encourage employers to maintain benefits for their retirees. Details of the subsidy are still to be determined but, based on actual GIC pharmacy spending in fiscal year 2003, the subsidy would have saved the state more than \$23 million in retiree benefit costs.

Net Impact

Over the three key programs, Massachusetts will realize a net gain from the implementation of the Medicare part D benefit in 2006.

B. Brief Background and Report Overview

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 (the “MMA”) was signed into law on December 8, 2003. The MMA amended the Social Security Act to bring major changes to Medicare. Among the most significant was a voluntary drug benefit under a new Part D of Title XVIII, the Title of the Social Security Act that authorizes Medicare. The new Part D drug benefit – by design – will have a dramatic financial and administrative impact on every state due to its interactions with state Medicaid programs, state pharmacy assistance programs and private employer retiree plans, including plans maintained by states for the benefit of retired state employees.

The New Medicare Part D Prescription Drug Benefit

The Part D drug benefit beginning January 2006 represents the most significant expansion of Medicare in the history of the program. Nevertheless, constraints on federal fiscal resources drove Congress to craft the benefit in a way that limited the impact on the federal budget. As a result, the Part D benefit requires significant cost sharing from beneficiaries and significant “maintenance-of-effort” funding from states. It also includes incentives for employers to maintain drug coverage under private retiree plans. The Part D benefit will be administered through private plans that will be expected to use tools – such as formularies and tiered copayments – to control costs. At the same time, Part D will provide generous coverage for low-income beneficiaries and for catastrophic drug costs for all Part D beneficiaries.

Interaction of Part D with Medicaid

Medicaid enrollees who are also enrolled in Medicare are known as “*dual eligibles*,” or simply as “*duals*.” When Part D coverage begins in 2006, state Medicaid programs will no longer qualify for federal Medicaid matching funds to provide prescriptions for duals if those drugs are covered under the Medicare Part D benefit. Like all other Medicare beneficiaries, duals will receive drug benefits by enrolling in one of the private Part D plans.

To help finance the Part D benefit, the MMA requires the Centers for Medicare and Medicaid Services (CMS) to recoup from each state an amount roughly equivalent to what the state would have paid for prescription drugs for duals if the Part D benefit had not been enacted. This recoupment is commonly referred to as the “Clawback.” Because of the Clawback, states generally will not realize significant savings. In fact, because of the way the Clawback is calculated, some states whose Medicaid pharmacy costs grow more slowly than the national average (due, for example, to aggressive pharmacy cost containment initiatives) quite likely will pay more.

A **hypothetical illustration** highlights the importance of the expenditure growth assumptions used in the Clawback calculation. The illustration uses assumptions for dual eligible enrollments and drug expenditures similar to Massachusetts and then compares that hypothetical Clawback amount to what the state would have spent in 2006 in the absence of the Clawback. Two scenarios were calculated:

- **Scenario 1** assumes a state pharmacy total spending growth rate (including recipient growth and drug product inflation) of 12 percent per year for 2004 to 2006. This growth is lower than the Clawback illustration, but likely reflects a reasonable estimate for a state that has implemented significant pharmacy cost containment measures. **Scenario 1 shows the Hypothetical State spending for prescription drug coverage for duals in 2006, after paying the Clawback, would be \$6.6 million (or about 2%) more than the state Medicaid spending would have been if Medicaid pharmacy spending trends had continued.**
- **Scenario 2** assumes a four percent pharmacy total growth rate in 2004 followed by a twelve percent increase in 2005 and 2006. These estimates are similar to Scenario 1 except they assume more significant pharmacy cost containment activity in 2004. **Scenario 2 shows the Hypothetical State spending in 2006, after paying the Clawback, would be \$26.8 million (or about 9%) more than its costs would have been if state Medicaid pharmacy spending trends had continued.**

The MMA also requires states to perform eligibility determinations for Part D low-income subsidies starting in July 2005. The law also requires the Social Security Administration (SSA) to do eligibility determinations, although the precise interaction between states and the SSA is not yet known. The Congressional Budget Office (CBO) has estimated that states will incur new administrative costs totaling \$3.1 billion for this function for the ten-

year period from 2004 to 2013. Massachusetts' share of this total would likely be approximately \$124 million in new State spending over the ten-year period.

The CBO has also estimated the fiscal impact on states of increased Medicaid enrollments that are expected to be generated by efforts to qualify Medicare beneficiaries for Part D low-income subsidies (referred to as the "woodwork effect"). The woodwork effect will not only impact the full-benefit Medicaid program, but also programs where the state pays for Medicare premiums, coinsurance, and deductibles.¹ Nationally, CBO has projected \$5.8 billion in new state costs over the period from 2005 to 2013. Massachusetts' share of this total would likely be approximately \$228 million.

In summary, implementation of the Part D benefit in 2006 will present state Medicaid programs with significant operational challenges and concerns in the following key areas:

- The calculation of the Clawback;
- The administration (and related cost) of low-income subsidy determinations;
- Coordination of benefits with Part D plans for drugs *not* covered under Part D; and
- The "woodwork effect".

The combination of these and other factors may actually result in increasing state Medicaid expenditures – at least in the initial years of the program. Savings for states are more likely in later years.

Interaction of Part D with the Massachusetts Prescription Advantage Program

Massachusetts offers access to prescription drugs for tens of thousands of elders and individuals with disabilities through the state-sponsored prescription drug plan, "Prescription Advantage." Part D and Prescription Advantage differ in their eligibility requirements and the extent of the drug benefits they provide, but there will be substantial overlap and interaction between the two programs. The vast majority of Prescription Advantage enrollees (95 percent in 2002) are aged 65 or older. These elders and Prescription Advantage participants with disabilities are likely to be eligible for the Part D drug benefit.² Also, a large number of Prescription Advantage enrollees have low-incomes and are likely to qualify for Part D low-income subsidies.

Both Part D and Prescription Advantage provide lower cost sharing for persons with lower incomes. Prescription Advantage members that qualify for the Part D "full" low-income subsidy will enjoy a better benefit under Part D than under Prescription Advantage. Similarly, most Prescription Advantage members that qualify for the Part D "partial" low-income subsidy will likely fare better under Part D. However, for many

¹ This includes "Medicare Buy-in" eligibility categories: Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs).

² Individuals must have met the work history and other requirements to qualify for Medicare Part A, B, and D.

Prescription Advantage members that do not qualify for Part D low-income subsidies, the Part D standard benefit may not be as generous as the Prescription Advantage benefit. To ensure that these beneficiaries are made no worse off by enrolling in Part D, Massachusetts would need to supplement (i.e., “wrap-around”) the Part D benefit. However, the administrative challenges of doing so are likely to be significant.

Recently, the Commonwealth of Massachusetts, Executive Office of Elder Affairs (EOEA) announced that nearly 30,000 Prescription Advantage enrollees had been auto-enrolled into the interim Medicare prescription drug discount card “Transitional Assistance Program” (TAP). TAP provides a \$600 annual credit in 2004 and again in 2005 for eligible beneficiaries with annual incomes below 135% of the Federal Poverty Level (FPL). The EOEA estimates that TAP alone will save the Commonwealth of Massachusetts an estimated \$10 million.

As a result of these savings, the Part D benefit presents Massachusetts with an opportunity, for example, to:

- Recognize budgetary savings with regard to the Prescription Advantage program while maintaining current benefit levels for current beneficiaries;
- Expand Prescription Advantage benefit levels and/or enrollments within current budget levels, *or*
- Accomplish some combination of more modest budgetary savings and more modest benefit or enrollment enhancements.

Part D Impact on Health Benefits for Retired State Employees

The MMA provides subsidy payments to employers for each qualified covered retiree with drug coverage under the employer’s plan, when the plan *is actuarially equivalent* or better than the Part D drug benefit. As an employer, a state like Massachusetts that provides health coverage to retired state employees is eligible for these subsidies. The employer subsidy is equal to 28 percent of total drug costs (including plan and member payments) between \$251 and \$5,000 for each Medicare retiree.

The Massachusetts Group Insurance Commission (GIC) is the state agency that provides for health insurance to state employees, retirees and their dependents. For fiscal year 2003, GIC staff reported that 38,663 (75%) Medicare members had pharmacy costs above \$250. For these members, pharmacy costs were \$81.4 million between \$251 and \$5,000 per Medicare retiree. Applying the 28 percent employer subsidy to this amount would result in annual savings to Massachusetts of \$22.8 million.

II. Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) was signed into law on December 8, 2003. It is now referred to as the “Medicare Modernization Act,” or “MMA.” The MMA amended the Social Security Act to bring about the most significant changes to Medicare since its enactment in 1965. Most notably, the MMA added a voluntary drug benefit under a new Part D of Title XVIII, the Title of the Social Security Act that authorizes Medicare. The MMA also created an interim drug discount card program that was implemented in June 2004 and will end when the new Part D benefit begins in 2006. The Centers for Medicare and Medicaid Services (CMS) recently reported over four million Medicare beneficiaries had enrolled – more than half of the CMS enrollment goal of 7.4 million.³

The drug discount card program was implemented at the federal level by CMS, with limited impact and burden on states. The new Part D drug benefit, however, will – by design – have a dramatic financial and administrative impact on every state due to its interactions with state Medicaid programs, state pharmacy assistance programs and private employer retiree plans (including plans maintained by states for the benefit of retired state employees). This issue brief will examine the interaction of the new Part D drug benefit with certain health programs operated by the Commonwealth of Massachusetts.

Social Security Act Title XVIII (Medicare):

- **Part A** – Medicare hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
- **Part B** – Medicare medical insurance that helps pay for doctors’ services, outpatient hospital care, durable medical equipment, and some medical services not covered by Part A.
- **Part C** – Medicare Advantage that provides for delivery of Medicare benefits through private health plans – previously called “Medicare+Choice”.
- **Part D** – Medicare prescription drug coverage.

³ “Medicare Prescription Drug Card Enrollment Surpasses 4 Million Mark: Medicare Beneficiaries Seeing Real Savings,” Centers for Medicare and Medicaid Services Press Release, July 30, 2004, accessed at <http://www.cms.hhs.gov/media/press/releases.asp?Counter=1142>.

III. The New Medicare Part D Prescription Drug Benefit

Enactment of the Part D drug benefit is an historic expansion of the Medicare program that will provide beneficiaries long-awaited assistance with the high cost of prescription drugs. Constraints on federal fiscal resources, however, drove Congress to craft the benefit in a way that limited the impact on the federal budget. Thus, the Part D benefit requires significant cost sharing from beneficiaries, requires significant funding from states, and offers significant incentives to employers to maintain retiree drug coverage. The Part D benefit is to be administered through private plans that will be expected to use tools (such as formularies and tiered copayments) to control costs. At the same time, Part D provides generous prescription drug coverage for low-income beneficiaries as well as generous coverage for all Part D beneficiaries who incur high levels of drug costs that reach catastrophic thresholds.

Part D has a complex benefit structure resulting from efforts to provide a meaningful drug benefit through private plans that would be voluntary yet attractive enough so most elders would enroll (thereby avoiding the problem of “adverse selection”) while at the same time limiting the impact on the federal treasury. The following discussion highlights key design features of the Part D benefit.

A. Eligibility and Enrollment

Part D benefit coverage is to begin January 1, 2006. To be eligible, a beneficiary must be entitled to Medicare Part A or enrolled in Medicare Part B. Enrollment is voluntary. Initial open enrollment will begin November 15, 2005 and will run for six months. In later years, open enrollment will run from November 15 to December 31 for the next benefit year. Special enrollment periods will be established for involuntary loss of creditable drug coverage,⁴ errors in enrollment, discontinuance of coverage under a Medicare Advantage Prescription Drug plan during the first year of eligibility, and other exceptional circumstances.

Part D eligible individuals who do not enroll initially, or who have more than 63 days without creditable drug coverage, will be subject to a late enrollment penalty. The penalty is an amount added to the monthly premium. This penalty is equal to the *greater* of:

- An actuarial sound amount determined by the Secretary of HHS, or

⁴ “*Creditable prescription drug coverage*” means public or private drug coverage that actuarially equals or exceeds the actuarial value of standard prescription drug coverage under Part D (as determined by the HHS Secretary). Section 1860D-13(b)(4).

- One percent of the monthly premium for every month the individual did not have creditable pharmacy coverage.⁵

Late Enrollment Penalty Example:

Part D eligible without creditable drug coverage for 24 months:

• Monthly premium without penalty:	\$40.00
• 1% x 24 months:	<u>9.60</u>
• Monthly premium with penalty:	\$49.60

B. Beneficiary Cost-Sharing

The Part D “standard” drug benefit includes significant beneficiary cost-sharing, but also includes generous coverage once drug costs exceed a “catastrophic threshold.” For low-income beneficiaries (including persons who are enrolled in both Medicare and Medicaid), Part D provides subsidies that cover much of the out-of-pocket costs they would otherwise incur under the standard benefit. (See Appendix 1 for a side-by-side comparison of the cost-sharing requirements under the standard benefit and under the various low-income subsidy levels established under Part D.)

Out-of-Pocket Costs Under the Standard Benefit

Under the Part D standard benefit, each beneficiary in 2006 will pay:

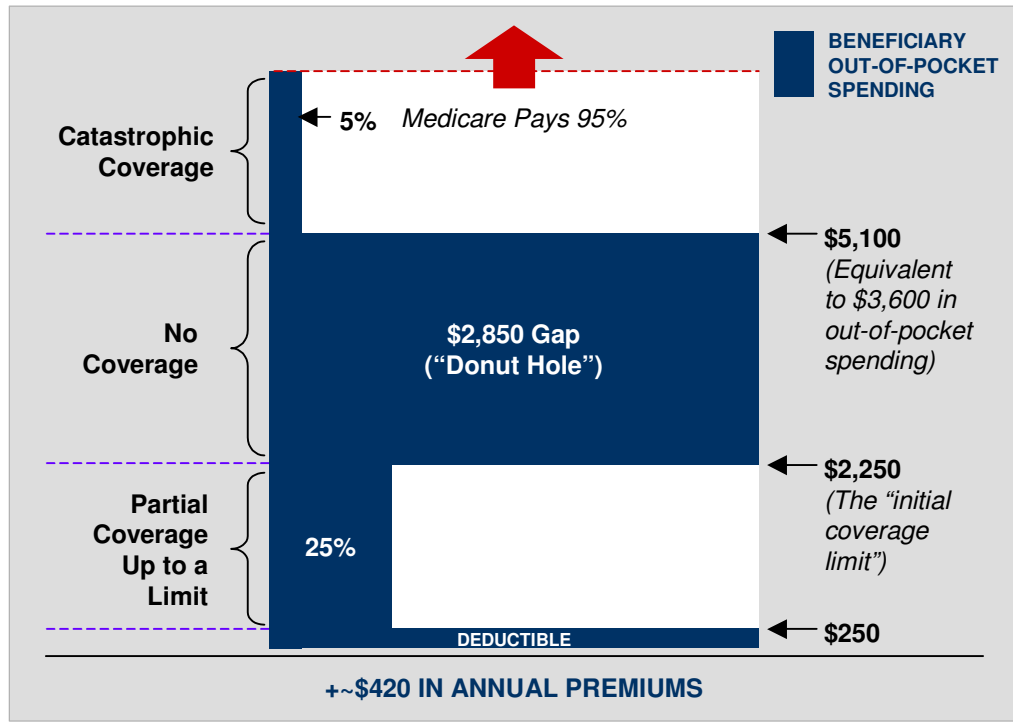
- A monthly premium estimated at \$35 per month (\$420 per year);
- An annual deductible of \$250;
- 25 percent of the drug costs between \$250 and \$2,250 (the “initial coverage limit”);
- 100 percent of the costs between \$2,250 and \$5,100 (the coverage commonly referred to as the “donut hole”), and
- Up to 5 percent of drug costs over \$5,100 (the “catastrophic threshold”).

At the \$5,100 catastrophic threshold, the beneficiary would have incurred \$3,600 in out-of-pocket costs for covered Part D prescriptions. From that point forward in the year 2006, the beneficiary would pay the greater of (a) a \$2 copay for generics or a \$5 copay for brand drugs, or (b) 5 percent of actual drug costs as coinsurance.

⁵ The proposed Part D regulations state that CMS expects to specify a one percent per month late enrollment penalty amount during the first several years of the program until it has sufficient data to determine whether an alternative amount should be adopted. Federal Register, August 3, 2004 (Vol. 69, No. 148), pp. 46,684 – 46,685 (hereinafter “Part D Regs.”).

Figure 1 illustrates a beneficiary's out-of-pocket spending under the standard benefit in 2006.

Figure 1

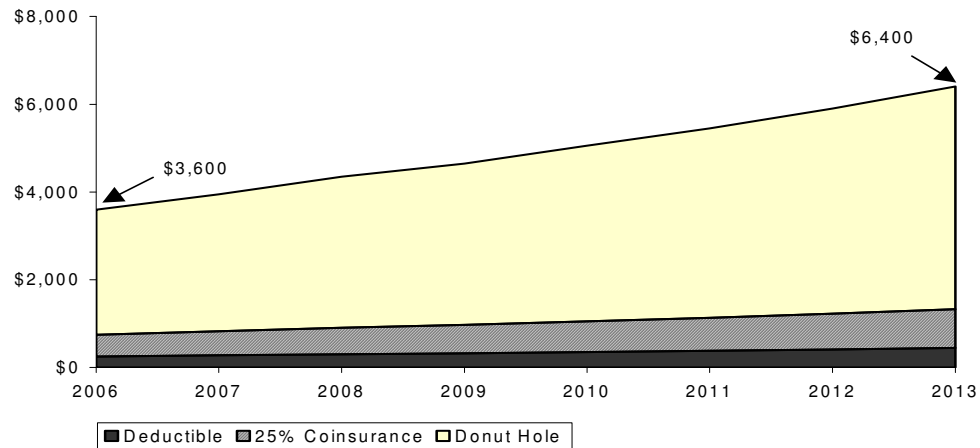


Adapted from "Medicare Fact Sheet: The Medicare Prescription Drug Law," Henry J. Kaiser Family Foundation, March 2004.

After 2006, the MMA indexes beneficiary cost-sharing to the growth in per capita spending for Part D drugs. As a result, the deductible is projected to increase from \$250 in 2006 to \$445 in 2013; the donut hole is projected to increase from \$2,850 to \$5,066 and the catastrophic threshold is projected to increase from \$5,100 to \$9,600.⁶ Figure 2 illustrates the projected growth in out-of-pocket costs.

⁶ Congressional Budget Office letter to Senator Don Nickles, November 20, 2003.

Figure 2 Growth in Out-of-Pocket Costs Below the Catastrophic Threshold (Excluding Premium)



Source: Congressional Budget Office, letter to Senator Don Nickles, November 20, 2003.

Low-Income Subsidies for Medicare Beneficiaries Not on Medicaid

Part D provides for two low-income subsidy levels: a *full subsidy* that relieves the beneficiary from all cost-sharing except for modest copayments below the catastrophic threshold, and a *partial subsidy* that imposes lower cost-sharing amounts than the standard benefit. To qualify for a low-income subsidy, a beneficiary must meet both an income and asset test. (See Table 1 below.) The proposed Part D regulation provides that the asset test would consider only (1) liquid resources that could be converted to cash within 20 days and (2) real estate other than applicant’s primary residence. Other non-liquid resources (e.g., a second car) would not be included.⁷

HHS Poverty Guidelines Federal Poverty Limit (FPL) for 2004			
Family Size	100% of FPL	135% of FPL	150% of FPL
1	\$ 9,310	\$12,568	\$13,965
2	12,490	16,862	18,735
3	15,670	21,155	23,505

Table 1 Eligibility and Cost-Sharing for Non-Dual Low-Income Subsidies

	Full Subsidy	Partial Subsidy
Income Limit	• 135% FPL	• 150% FPL
Asset Limit	• \$6,000 (individual) or \$9,000 (couple)	• \$10,000 (individual) or \$20,000 (couple)
Cost-Sharing	<ul style="list-style-type: none"> • No premium up to a benchmark • No deductible or coinsurance • Copayments of \$2 (generic) & \$5 (brand) below catastrophic threshold* • No cost-sharing above catastrophic threshold • No donut hole 	<ul style="list-style-type: none"> • Sliding scale premiums based on income • \$50 deductible* • 15% coinsurance below catastrophic threshold • Copayments of \$2 (generic) & \$5 (brand) above catastrophic threshold* • No donut hole

*Copays and deductibles beyond 2006 are indexed to growth in per capita expenditures for covered part D drugs.

⁷ Part D Regs., p. 46,726.

Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QIs) where the state pays only Medicare cost-sharing for premiums, coinsurance, and deductibles will be deemed eligible for the full subsidy.⁸

Low-Income Subsidies for Medicare Beneficiaries on Medicaid – “The Full-Benefit Duals”

Dual eligibles⁹ also benefit from federal subsidies that eliminate almost all out-of-pocket costs except for copayments on drug expenditures below the catastrophic threshold. (Institutionalized duals, such as nursing home residents, are relieved of *all* copayment requirements.) Copayments vary by income level. Oddly, copayments for the two income groups are subject to different growth indexes after 2006, described below.

Table 2 Cost Sharing for Medicare and Medicaid Full-Benefit Dual Eligibles

Under 100% FPL	At or Over 100% FPL
<ul style="list-style-type: none"> • \$1 (generics)/\$3 (brands) below the catastrophic threshold • Copay amounts indexed to the Consumer Price Index (CPI). 	<ul style="list-style-type: none"> • \$2 (generics)/\$5 (brands) below the catastrophic threshold • Copay amounts indexed to the growth in national per capita costs for Part D drugs.

C. Part D Plans and Drug Coverage Requirements

Part D Plans

The Part D benefit will be administered entirely through the following three types of private plans:

- **Risk-bearing Prescription Drug Plans (“PDPs”)**: stand-alone drug plans that will bid to serve entire regions (expected to include multiple states);
- **Risk-bearing Medicare Advantage Prescription Drug Plans (“MA-PDs”)**: integrated plans that will arrange for the delivery of all Medicare benefits, including the new drug benefit; and
- **No-risk “Fall-back” Plans**: plans that meet the requirements for a PDP except that they are not required to bear financial risk. CMS will contract with fall-back plans only in areas without at least two PDPs *or* one PDP and one MA-PD.

Alternative and Enhanced Prescription Drug Coverage

A Part D plan may develop “basic” alternative coverage in lieu of the standard benefit, if the plan sponsor can assure the following:

- The alternative plan is actuarially equivalent to the standard benefit;
- The maximum deductible does not exceed the deductible under the standard benefit; and

⁸ The proposed Part D regulations stipulate that these individuals qualify for full subsidies. Part D Regs, p. 46726.

⁹ Full-benefit dual eligible individual means a person who has eligibility for full-benefits under Medicaid or under a Section 1115 demonstration program, excluding Pharmacy Plus demonstrations.

- The alternative plan provides the same catastrophic coverage as the standard benefit.

A plan also has the option of providing “enhanced” alternative coverage, which exceeds the standard coverage by offering supplemental benefits.

Drug Coverage and Formularies

Part D will cover FDA-approved drugs required for Medicaid programs, insulin (including supplies for its administration), and smoking cessation drugs. Plans are *not* required to cover drug classes optional under Medicaid or drugs covered under Medicare Parts A or B (described in Appendix 2).

In contrast to Medicaid, Part D plans may create *closed* formularies, in which only certain drugs are covered. Or, they may use *open* formularies, in which all drugs are covered but beneficiaries receive preferred drugs for lower copays than non-preferred drugs. In either case, a plan’s formulary must include at least two drugs in each therapeutic category. CMS has asked the United States Pharmacopeia (USP) to develop model classes to help evaluate Part D formularies. To date, these classes have not been finalized. CMS will approve formularies to assure the design does not discourage enrollment of individuals with certain diagnoses.

Appeals for Drugs Not on Formulary

A beneficiary may appeal and gain access to a non-formulary drug. The individual’s doctor must certify that the drugs available on the formulary are not as effective or would adversely impact the beneficiary. If the appeal is successful, the beneficiary may obtain the drug as though it were on the formulary (or preferred), and any cost-sharing paid will count toward the out-of-pocket limit (for purposes of qualifying for catastrophic coverage).

CMS is proposing that Medicare PDPs have 14 days to respond to a request for drug coverage determination and another automatic additional 14-day extension — for a total of 28 days. Other proposed details of the Medicare exception process are described in Subpart M — Grievances, Coverage Determinations and Appeals of the CMS proposed regulations. Notable is that the Medicare process does *not* include the following mandatory Medicaid provisions listed at Section 1927 (d) of the Social Security Act.

- 24-hour response by telephone or other telecommunication device to a prior authorization for coverage exceptions, and
- Provision of at least a 72-hour supply of a requested drug in emergency situations.

No CMS Interference in Plan Negotiations on Price with Manufacturers or Pharmacies

The MMA expressly prohibits CMS from interfering with drug price negotiations among plans, pharmaceutical manufacturers, and pharmacies, setting drug prices directly, or mandating a specific formulary for the Medicare program.

IV. Interaction of Part D with Medicaid

When Part D coverage begins in 2006, the federal government will no longer provide funds to state Medicaid programs to cover drugs for persons dually eligible for Medicare and Medicaid (“*duals*”) if those drugs are covered under Part D. Instead, like all other Medicare beneficiaries, duals will receive drug benefits by enrolling in private Part D plans (PDPs, MA-PDs or fall-back plans). To help finance the Part D benefit, the MMA requires CMS to recoup from states much of the savings that states would otherwise have realized from shifting prescription drug coverage for duals to Medicare. This recoupment is commonly referred to as the “Clawback.” The MMA also requires states (and the Social Security Administration) to perform eligibility determinations for Part D low-income subsidies.

In preparing for the implementation of the Part D benefit in 2006, state Medicaid programs are faced with significant operational challenges and concerns in the following key areas:

- Calculation of the Clawback;
- The administration (and cost) of eligibility determinations for the low-income subsidy;
- Coordination of benefits with Part D plans for drugs *not* covered under Part D; and
- An increase in Medicaid enrollment that is expected as Medicare beneficiaries seek to qualify for Part D low-income subsidies (referred to as the “woodwork effect”).

Instead of savings, the combination of these and other factors mean that the Part D benefit may actually result in increased state Medicaid expenditures – at least in the initial years of the program. These concerns and challenges are discussed below in the context of Massachusetts’s Medicaid program, MassHealth.

A. MassHealth Overview Description

Massachusetts is well known for its comprehensive public health care programs, including its Medicaid program (commonly referred to as “MassHealth”). In fiscal year (FY) 2004, MassHealth provided health care services for 930,000 persons (out of a total state population of 6.4 million¹⁰), expending \$6.2 billion gross (including both federal and state funds). Total Medicaid spending (both state and federal shares) accounted for about 29 percent of all state spending.¹¹ Because Massachusetts is a relatively high-income state

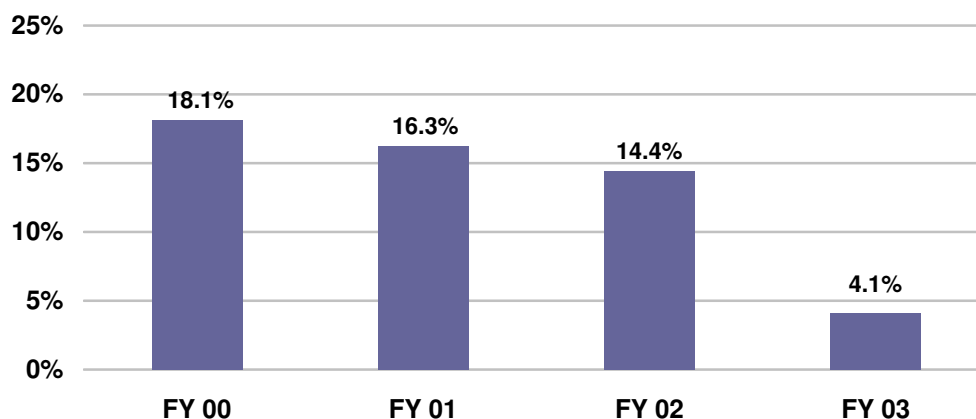
¹⁰ U.S. Census Bureau, “*Massachusetts Quick Facts*,” accessed at <http://quickfacts.census.gov>.

¹¹ Waldman, B., Medicaid Director, *MassHealth Reorganization Information Session*, April 2004, accessed at [http://www.mass.gov/Eoohs2/docs/masshealth/whatsnew/reorginfosession\(04-28-04\).pdf](http://www.mass.gov/Eoohs2/docs/masshealth/whatsnew/reorginfosession(04-28-04).pdf)

relative to the rest of the nation, its federal Medicaid matching rate (known as the “Federal Medical Assistance Percentage,” or “FMAP”) is 50 percent – the statutory minimum.¹²

During FY 2003, MassHealth paid approximately \$970 million for over 16.4 million Medicaid prescriptions.¹³ Like most other states in recent years, Massachusetts has focused intensive efforts on slowing the rate of growth of its Medicaid drug expenditures. In 2002, MassHealth adopted several pharmacy cost control strategies including changes to copayments, dispensing fees, and ingredient cost payments (described in Appendix 3), and the implementation of the MassHealth Drug List with prior authorization, step therapy, and generic incentives. By FY 2003, pharmacy spending growth had slowed to 4.1 percent compared to 14.4 percent in FY 2002.¹⁴ (See Figure 3) Also, growth in the average cost per prescription slowed to four percent, compared to 15 percent in the previous year.

Figure 3 MassHealth - Pharmacy Spending (Prior to Manufacturer Rebates)
Percent Change Year-To-Year



Source: HMA estimates based on data provided by MassHealth and a Report to the General Court.

B. Phased-Down State Contribution – The Clawback

States struggling with the rapid growth of Medicaid drug spending hoped and expected that a new Medicare pharmacy benefit would provide significant state fiscal relief. Instead, states are now concerned that the Clawback will eliminate virtually all fiscal relief, especially in the early years of the benefit. (Note: The Clawback is also sometimes referred to as a state “maintenance of effort” payment. CMS is now calling the Clawback the “Phased-Down State Contribution.”)

¹² FMAP rates are calculated based upon a state’s per capita income compared to the national average per capita income and may be no less than 50 percent and may not exceed 83 percent. Federal Register, December 3, 2003 (Vol. 68, No. 232), pp. 67676-67678.

¹³ This Medicaid pharmacy spending was offset by approximately 20.5 percent in manufacturer rebates available under federal law.

¹⁴ Percentages calculated from data provided in Division of Health Care Finance and Policy, “Report to the General Court: Payments for Prescribed Drugs, Commonwealth of Massachusetts,” April 1, 2004, accessed at www.mass.gov/dhcfp.

“Even under the best scenarios, the State will be shouldering a significant financial responsibility in the drug area, for the foreseeable future. The feds will pick up more, but we will maintain a significant financial responsibility.”

– Observation of a State Medicaid Director¹⁵

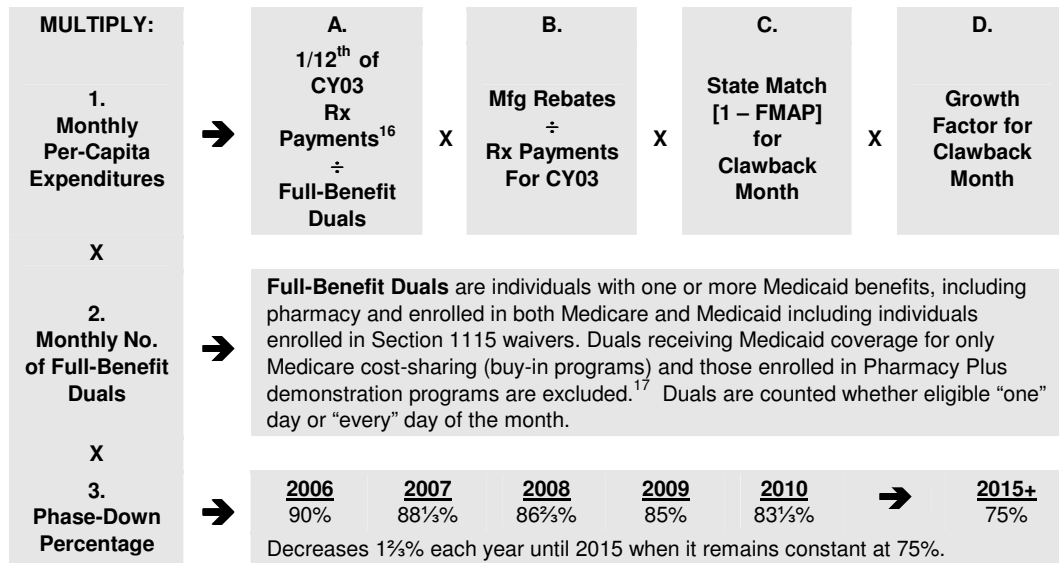
Clawback Formula

The Clawback theoretically approximates savings a state would realize by divesting itself of prescription drug costs for duals. The MMA requires states to remit a large portion of these theoretical savings on a monthly basis to CMS. Meanwhile, states will lose the ability to manage the prescription drug benefit for duals, even as they must continue to finance it through the Clawback. The MMA provides for a ten-year partial phase-down of the Clawback amount starting at 90 percent in 2006 (in other words, allowing the states to retain ten percent of the adjusted base costs, trended forward), and decreasing to 75 percent in 2015 and thereafter. There is no end to the state Clawback obligation.

The Clawback amount is based on a complex formula that starts with the calculation of a state’s per capita drug expenditures in the base year, 2003. That amount is trended forward for future years using national growth trends. A state’s monthly Clawback amount will equal the updated per capita amount multiplied by the number of full-benefit duals in the state in that month, and then discounted by the applicable phase-down percentage. Figure 4 depicts the Clawback formula.

¹⁵ V. Smith, S. Kramer & J. Guyer, “*Coordinating Medicaid and Medicare Prescription Drug Coverage: Findings from a Focus Group Discussion with Medicaid Directors*,” Kaiser Commission on Medicaid and the Uninsured, November 2003, accessed at <http://www.kff.org/Medicaid/4153.cfm>.

Figure 4 Clawback Formula



National Growth Trend Concerns

The Clawback formula may or may not result in a fair estimate of a particular state’s Medicaid savings from Part D for a number of reasons. One of the most significant of state concerns is that the national growth trend factors that CMS will use to calculate the 2006 Clawback may exceed a state’s Medicaid pharmacy spending trends. For 2006, CMS will use National Health Expenditure projections¹⁸ to determine the growth factors to calculate the per capita expenditure amount for each state. In 2007 and later years, CMS will use a different national trend: the annual percentage increase in average per capita expenditures for covered Part D drugs in the United States. For a state (like Massachusetts) that implemented pharmacy cost containment measures during 2003 and 2004, the base year likely will not reflect future years, and the national growth factors will likely exceed the rate of growth in state Medicaid pharmacy expenditures. For example, the full effect of the initiatives listed in Table 3 will *not* be included in the base year calculation of the Clawback.

¹⁶ Rx payments include payments for dispensing fees and payments for only Part D covered drugs.

¹⁷ This includes the following “Medicare Buy-in” eligibility categories: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QIs). Pharmacy Plus Medicaid waiver enrollees are also excluded from the definition of a full-benefit dual.

¹⁸ The CMS Office of the Actuary publishes National Health Expenditure Estimates.

Table 3 MassHealth Pharmacy Initiatives Not Fully Reflected in the Clawback

Date Implemented	
June 2003	Prior Authorization for selected anticonvulsants, antidepressants, and asthma drugs
July 2003	Prior Authorization for certain atypical anti-psychotics
December 2003	Dispensing Fee change from \$3.50 (brands) and \$5 (generics) to a flat \$3
February 2004	Pharmacy copayments for generic drugs lowered to \$1 and brands increased to \$3
FY04 Savings Summary	Preferred Drug List (\$99 million); Generic pricing changes & increased utilization (\$50 million); Early refill monitoring (\$14 million)

(Appendix 3 provides a history of MassHealth pharmacy reimbursement and copays.)

To date, a state's ability to evaluate the fiscal impact of the Clawback has been hindered, since many policies and procedures are under development or have yet to be addressed at the federal level. Exact data simulations are not yet possible. Table 4 below provides a **hypothetical illustration** of the Clawback for a state with dual eligible enrollments and drug expenditures similar to Massachusetts.

**Table 4 HYPOTHETICAL STATE
2006 Medicare Clawback Calculation**

1.	2003 Fee-For-Service Full Benefit Duals	190,000
2.	2003 Dual Rx Spending For Part D Drugs (Gross)	\$530 M
3.	2003 Gross Per Capita	\$2,789
4.	2003 Adjusted Gross Per Capita (after deducting drug rebates of 22%)	\$2,176
5.	Growth Factor Adjustment, 2004-2006 ^(a)	138.4%
6.	2006 Projected Per Capita (Gross)	\$3,011
7.	2006 Projected Per Capita - State share (50%)	\$1,505
8.	2006 Projected Dual Enrollment ^(b)	213,724
9.	2006 Phased-Down Percent	90%
10.	2006 Estimated State Clawback (#7 * #8 * #9)	\$289.5M

(a) Growth trends from 2004 to 2006 are the National Health Expenditure Projections – not individual State trends.

(b) 2006 Dual Enrollment is trended based on CBO estimates of 4% annually or 112.5% compounded.

Table 5 below illustrates the importance of the growth assumptions used in the Clawback by providing a comparison of what the state (from Table 4 above) would have spent without the Clawback under two different scenarios that assume different spending growth rates. Under both scenarios, the state spends less than under the Clawback in Table 4.

**Table 5 HYPOTHETICAL STATE
Payments Under Current Medicaid Funding: Two Scenarios**

	Scenario 1	Scenario 2
1. 2003 Fee-For-Service Full Benefit Duals	190,000	190,000
2. 2003 Dual Rx Spending For Part D Drugs (Gross)	\$530 M	\$530 M
3. Drug Spend Trend, 2004 – 2006 (includes enrollee growth & drug inflation)	140.5%	130.5%
4. 2006 Dual Rx Spending (Gross)	\$744.6 M	\$691.4 M
5. 2006 Dual Rx Spending - State Share (50%) ^(a)	\$372.3 M	\$345.7 M
6. 2006 Adjustments for Rebates and Other Recoveries ^(b)	-24%	-24%
7. 2006 Adjusted Dual Rx Spending (State)	\$283.0 M	\$262.7 M

(a) Per Capita spending is replaced with Total Pharmacy Spending eliminating the need for enrollment adjustors.

(b) Rebate adjustment assumes a three-year average rate of 22 percent.

Scenario 1: This scenario assumes an annual growth in total state pharmacy costs for dual eligibles that would average 12 percent per year for the three years from 2004 to 2006. This rate of annual growth might reflect, for example, annual average growth rates for per capita drug product inflation of 7 percent to 8 percent, and annual average growth in the number of dual eligibles of 3 percent to 4 percent. Note that the annual rate of per capita cost growth under this scenario is lower than the per capita growth rate over this period for the National Health Expenditures that will be used by CMS for the Clawback calculation. However, this rate of Medicaid cost growth might be a reasonable estimate for a state that has implemented significant pharmacy cost containment measures.

Under Scenario 1, the state would make a Clawback payment that would be \$6.6 million more (about 2% more) in 2006, compared to what State Medicaid pharmacy spending for duals likely would have been in the absence of the Medicare Part D benefit and the Clawback payment.

Scenario 2: This scenario assumes an annual average total growth rate of about nine percent, which for this scenario was assumed to be four percent total pharmacy spending growth rate in 2004 followed by a twelve percent increases in 2005 and 2006. Again, these are rates of growth for total drug spending. Thus, they include annual average growth in per capita costs of perhaps 6 percent and annual average growth in dual eligible enrollment of about three percent. This Scenario is otherwise similar to Scenario 1 except it assumes more significant pharmacy cost containment activity in 2004.

Under Scenario 2, the state spending would make a Clawback payment that would be \$26.8 million more (about 9% more) in 2006, compared with what the State Medicaid pharmacy spending for duals likely would have been in the absence of the Medicare Part D benefit and the Clawback payment.

Note that the outcomes in these scenarios depend entirely on the assumptions. Other outcomes are possible, including outcomes where the state might pay less under the Clawback.

Other Clawback Concerns

While the growth trend assumptions used to calculate the Clawback are likely to be the most significant fiscal variable for states in assessing the fiscal impact of the Clawback, states have other issues, concerns and challenges as well, including the following.

- **The technical complexity of identifying spending for drugs not covered under Part D (that states may continue to cover under Medicaid.)** Inability to accurately identify spending for these drugs may result in an overstatement of the 2003 base year, and thus the Clawback amount. On September 9, 2004 CMS distributed a list of drugs that will be excluded from the calculation of the Clawback. Because states will have ongoing financial responsibility for some or all of these drugs, they have an interest in ensuring that costs for these drugs are not included in the Clawback. Examples of Part B and Part D restricted drugs are listed in Appendix 2. Non-covered Part D drugs include the following categories.
 - Drugs Covered under Medicare Part B. These include selected self-administered drugs and drugs dispensed by nursing homes and other specialty pharmacies. Coverage is sometimes limited to selected diagnoses or to specific circumstances under which the drug is administered or dispensed, adding to the complexity of accurately identifying the related drug spending. The MMA requires CMS to study the impact of merging Part B drug coverage into Part D. Until a decision is made, states may continue to pay Part B deductible and coinsurance for these prescriptions.
 - Optional Medicaid Drug Classes. These include a number of drugs commonly covered by state Medicaid programs including over-the-counter drugs, barbiturates used for seizures and benzodiazepines for anxiety. If a state chooses to continue coverage, federal Medicaid matching funds will continue to be available.
- **The Clawback formula includes an offset for manufacturer rebates, but not for other state recoveries (e.g., third party liability and post-payment audit recoveries).** This has the effect of overstating the 2003 base from which the Clawback is calculated and so increases the Clawback amount.
- **The Clawback payment will not account for the differences between the Part D benefit and a state's Medicaid drug benefit.** For example, Part D plans are expected to have formularies and exception processes that are more restrictive than those that exist in most state Medicaid programs. The Clawback amount will be derived from the 2003 Medicaid benefit – not from the actual Part D benefit, which is likely to be less comprehensive, more restrictive and to have a lower actuarial value.
- **Part D pharmacy costs for duals in capitated managed care plans are included in the Clawback.** The MMA mandates that the “estimated actuarial value of prescription drug

benefits provided under a capitated managed care plan” be used for the Clawback calculation for these duals. Due to the complexities arising from retroactive Medicare disability eligibility determinations, there is the potential for states to pay for drug costs twice – in their capitation rates and in their Clawback payments. States will have to assess the impact, set “estimated actuarial value,” and revise capitation rates, as necessary.

- **Instructions regarding the process to identify full-benefit duals have not been finalized.** In particular, states have not received clarification on how individuals with retroactive eligibility for Medicaid and/or Medicare will be handled.

C. Low-Income Subsidy Eligibility Determination

The MMA requires both states and the Social Security Administration (SSA) to determine eligibility for the Part D low-income subsidies. The proposed Part D regulations specify that states must begin taking applications by July 1, 2005.

**Table 6 New Administrative Costs for Massachusetts Medicaid
Based on CBO Estimates, July 2004**

Year	Massachusetts General Fund
2004	\$4 million
2005	\$4 million
2006	\$12 million
2007	\$12 million
2008	\$12 million
2009	\$12 million
2010	\$16 million
2011	\$16 million
2012	\$16 million
2013	\$20 million
2004 - 2013 Total	\$124 million

Source: HMA estimates based on CBO projections.

CMS has provided states with some guidance regarding income and asset tests, but has not provided detailed information that would allow states to develop automation support systems or coordination protocols with the Social Security Administration. Because eligibility for the subsidies goes up to 150 percent FPL, states could receive applications from individuals that have not previously applied for current programs. While the MMA allows 50 percent FMAP for new staff and related costs associated with this function, states will be required to supply their share of the funds needed to draw down the federal matching funds to meet this new demand.

The Congressional Budget Office (CBO) has estimated that states will incur new administrative costs totaling \$3.1 billion for the ten-year period from 2004 to 2013.¹⁹ Massachusetts Medicaid spending historically has represented approximately four percent of the national total.²⁰ Using a four percent factor, HMA projected that new state administrative costs would total \$124 million over the 2004-2013 period, as detailed on the Table 6.

D. No Wrap-Around FMAP for Part D Drugs

Long-standing federal law governs payment coordination between Medicaid and Medicare Parts A and B. Medicare is the primary payer and Medicaid pays for beneficiary deductibles and coinsurance and “wraps around” Medicare coverage gaps (e.g., most prescription drugs, nursing home stays, vision care services, etc.). In an unprecedented departure from this historic structure, the MMA provides that federal Medicaid matching funds are not available for drug classes covered by Part D or for related cost-sharing for duals. (The MMA does not affect the availability of federal Medicaid matching funds for Medicaid’s share of Medicare Part B drugs and Part D restricted drugs, as discussed above.)

As noted previously, Medicare formularies must include at least two drugs in a class. The appeal process for exceptions for Part D coverage may be less responsive than Medicaid’s prior authorization process. Current Medicaid law stipulates that states must provide a 24-hour response to prior authorization requests and provide for at least a 72-hour supply of a requested drug in an emergency situation.²¹ There is no similar requirement in Part D. Consequently, states anticipate pressure to bridge the gap between Part D and current Medicaid coverages – in spite of the lack of federal matching funds. Until specifics of the Medicare plan formularies are known, a thorough assessment of this impact is not possible.

E. Woodwork Effect Will Increase The Number of Medicaid Enrollees

When individuals enroll with a Part D plan, or apply for the new Medicare low-income subsidies, some beneficiaries will learn for the first time that they are eligible for Medicaid and will enroll. This “woodwork effect” will increase the number of dual eligibles. It may significantly increase Medicaid expenditures, since Medicaid will then pay both for health care services and for Medicare cost-sharing on premiums, deductibles, and coinsurance. (The MMA stipulates when states screen applications for low-income subsidies, they must also screen applicants for Medicare cost-sharing for QMBs and SLMBs.) Estimating the effect of this phenomenon on an individual state is difficult. At the national level, the CBO

¹⁹ Congressional Budget Office, “A Detailed Description of CBO’s Cost Estimate for the Medicare Prescription Drug Benefit,” July 2004, accessed on August 23, 2004 at <http://www.cbo.gov/ftpdocs/56xx/doc5668/Report.pdf>. (Hereinafter “CBO, July 2004 Report”).

²⁰ B Bruen and J Holahan, Shifting the Cost of Duals Eligibles: Implications for States and the Federal Government, November 2003, accessed at: <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=27097>

²¹ Section 1927(d) (5) of the Social Security Act

has estimated that the Part D low-income subsidies would induce additional Medicaid enrollment that would reach 1.3 million by 2013. CBO estimates that the vast majority of the 1.3 million new enrollees would be QMBs and SLMBs and that only approximately 100,000 would be the more costly full-benefit dual eligibles. CBO predicted the woodwork effect would increase national Medicaid costs over the period from 2005 to 2013 by an estimated \$13.5 billion (\$5.8 billion in state general funds).²²

Massachusetts Medicaid spending for dual beneficiaries (QMBs, SLMBs, and full-benefit duals) represents approximately 4 percent of the national total.²³ Assuming similar enrollment for each state in the nation, HMA estimated that Massachusetts state general fund costs would total \$228 million over the period from 2005 form 2013, as detailed on Table 7.

**Table 7 Woodwork Effect on Massachusetts Medicaid
Based on CBO Estimates, July 2004**

Year	Massachusetts General Fund
2005	\$4 million
2006	\$8 million
2007	\$20 million
2008	\$24 million
2009	\$28 million
2010	\$32 million
2011	\$36 million
2012	\$36 million
2013	\$40 million
2004 - 2013 Total	\$228 million

Source: HMA estimates based on CBO projections.

F. Other Financial Impacts on Medicaid

Manufacturer Rebates

As full-benefit duals move to the federal Medicare plans, states will lose purchasing power for their remaining pharmacy programs, since dual eligibles account for about half of the dollar volume of Medicaid prescription drugs. Reduced volume will affect Pharmacy Benefit Manager (PBM) administrative costs. For states with a supplemental rebate program, the loss of purchasing power will affect rebate negotiations with manufacturers. Multi-state purchasing pools for both supplemental rebates and PBM administration might become more appealing state options after implementation of the Medicare pharmacy benefit.

²² CBO, July 2004 Report.

²³ B Bruen and J Holahan, Shifting the Cost of Duals Eligibles: Implications for States and the Federal Government, November 2003, accessed at: <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=27097>

Full-Benefit Duals in Nursing Homes

As a result of their complex medical conditions, nursing home residents consume the greatest amount of medicines in the Medicare population.²⁴ There are significant challenges that are unique to this population in terms of the risk-based private prescription drug coverage model adopted by Medicare

A nursing home facility traditionally contracts with one pharmacy. Centralizing pharmacy services improves quality of care through standardization of drug administration, staff training, utilization and clinical reviews.²⁵ The contract pharmacy routinely provides 24-hour delivery services, packaging and distribution systems. Often nursing home pharmacies maintain formularies specific to the needs of the facility.²⁶

A number of important questions remain unanswered on how this population and its specialized pharmacy delivery system will be integrated into the Medicare prescription drug benefit. How will this beneficiary population (sometimes not competent) make decisions on their choice of a Part D plan that will best meet their prescription needs? How will a nursing home facility coordinate multiple Part D plans, each with a different pharmacy network and formulary? These questions remain under study by CMS. An assessment of the impact will depend on how CMS resolves these issues.

Systems Development

In addition to systems development of the low-income subsidy, states will have to implement the following automation changes:

- Modify the pharmacy point-of-sale claims processing to block payment of prescriptions for Medicaid duals;
- Develop monthly files of Medicaid duals for CMS and SSA;
- Develop tracking systems to assure Medicaid duals are enrolled in Part D; and
- Develop coordination with Part D plans (including necessary modifications to Medicaid third party liability recovery systems).

G. MMA Impact on Medicaid Full-Benefit Dual Eligibles

Medicaid full-benefit dual eligibles could have different copayments and drug coverages than their current Medicaid pharmacy benefit and will have to make decisions regarding their Part D plan enrollment.

²⁴ Long Term Care Pharmacy Alliance Statement on the Medicare Prescription Drug Legislation, accessed from <http://www.ltcpa.org> on August 8, 2004.

²⁵ Smith, V, Kramer, S, and Guyer, J. *Coordinating Medicaid and Medicare Prescription Drug Coverage, Findings from a Focus Group Discussion with Medicaid Directors*, Kaiser Commission on Medicaid and the Uninsured, November 2003.

²⁶ Schneider, A, *Briefing Note: Dual Eligibles in Nursing Facilities and Medicare Drug Coverage*, Kaiser Commission on Medicaid and the Uninsured, November 2003.

Part D Copays Differ From Medicaid

For Medicaid, federal regulations stipulate that copayments must be set based on service cost and cannot exceed \$3. The maximum copayment limit has not changed for over 20 years. Nursing home residents have no Medicaid copayments. MassHealth copayments are currently \$1 for generics and \$3 for brands-name drugs.

Under Part D, duals who are institutionalized will also have no copayments. Other duals will have copayments in 2006 of \$1 to \$5 (below the catastrophic threshold—see Table 2 above.)

Federal Maximums for Medicaid Copayments

Copayment Maximum	Service Payment
\$0.50	\$10 or less
\$1.00	\$10.01 to \$25
\$2.00	\$25.01 to \$50
\$3.00	\$50.01 or more

Unlike Medicaid, these Part D copayments will be adjusted annually for inflation. As a result, over time duals will have higher copays than non-dual Medicaid enrollees. The MMA also does not offer protection for duals who cannot pay copayments. Medicaid members are not required to pay copayments if they cannot afford them.

Part D Enrollment Complex

Although enrollment in Part D is voluntary for Medicare beneficiaries, duals must enroll with Medicare to maintain drug coverage since their current Medicaid pharmacy benefit will no longer be available in 2006. The MMA mandates that CMS develop procedures to assist duals and to automatically enroll them in a Part D plan. Medicaid pharmacy coverage ends January 1, 2006. The proposed regulation stipulates that duals, who fail to enroll during their initial enrollment period, will be automatically enrolled in a Prescription Drug Plan (PDP) or Medicare Advantage–Prescription Drug plan (MA-PD). The full benefit duals' transition from Medicaid pharmacy coverage to Medicare is summarized below.

Table 8 Full Benefit Duals' Timeline For Enrollment into Part D in 2005 -2006

11-15-2005	Initial enrollment starts. Full benefit duals have the option to enroll directly with a PDP or with a MA-PD (if enrolled in the Medicare Advantage plan). CMS envisions the full benefit duals initiating enrollment with paper forms.
01-01-2006	Part D begins. Medicaid no longer provides pharmacy coverage to full benefit duals.
05-15-2006	Initial enrollment ends. Full benefit duals who failed to enroll with a PDP or MA-PDP will be auto-enrolled into a Medicare pharmacy plan. If there is more than one plan, plan assignment will be random to those plans that have monthly premiums are below the low-income subsidy premium benchmark.
06-1-2006	Since the effective date of Part D coverage is the first day of the month after the enrollment application is made, June 2006 would be the soonest Part D would become effective for auto-enrollment duals.

The Medicaid population may not understand the need to enroll in Part D. If enrollment is based on paper forms as CMS envisions in its proposed regulations, it will be slow and inefficient – especially given the 6 to 7 million full benefit duals across the nation. Delays in Part D enrollment will cause gaps in prescription coverage for the full benefit duals. Duals will have an option to decline enrollment or change plans.

Additional Premium Payments

If a dual voluntarily chooses a Medicare plan with monthly premiums that exceed the low-income subsidy benchmark premium, he or she is responsible for paying the difference between the premium and the low-income subsidy amount.

Formulary Decisions Will Be Difficult

Certain full-benefit duals may have difficulty evaluating multiple plan options and understanding why some of their medications may no longer be covered as under Medicaid.

Navigating the Medicare appeals process for exceptions is likely to be cumbersome. The Medicare process appears to lack protections provided by Medicaid statute, including 24-hour turnaround for coverage exceptions under prior authorization and provision of a 72-hour supply of medication in emergency circumstances.

V. Interaction of Part D with the Prescription Advantage Program

With the start of the state-sponsored prescription drug plan, “Prescription Advantage,” in 2001, Massachusetts expanded access to prescription drugs for tens of thousands of elders and individuals with disabilities. As of January 2003, over 80,700 persons were enrolled. For calendar year 2002, the Commonwealth reported Prescription Advantage benefit costs of \$87.1 million²⁷ and for FY 2005 the state budget includes \$110 million of funding.²⁸

Although Part D and Prescription Advantage differ in their eligibility requirements and the extent of the drug benefits they provide, there is substantial overlap between the two programs. The vast majority of Prescription Advantage enrollees (95 percent in 2002) are aged 65 or older. These elderly and disabled Prescription Advantage participants are likely to be eligible for the Part D drug benefit.²⁹ Also, a large number of Prescription Advantage enrollees have low-incomes and are likely to qualify for Part D low-income subsidies. Recently, the Commonwealth of Massachusetts, Executive Office of Elder Affairs (EOEA) announced that nearly 30,000 Prescription Advantage enrollees had been auto-enrolled into the interim Medicare prescription drug discount card “Transitional Assistance Program” (TAP). TAP provides a \$600 annual credit in 2004 and 2005 for eligible beneficiaries with annual incomes below 135 FPL. The EOEA estimates that TAP alone will save the Commonwealth of Massachusetts an estimated \$10 million.³⁰

For purposes of this report, it was not possible to quantify the potential fiscal value to the Commonwealth of the overlap between Part D and Prescription Advantage. Estimating the value of the overlap, however, will be an important analysis for the Commonwealth to undertake as it considers potential Prescription Advantage program changes to allow for coordination with the Part D benefit in 2006 and beyond. The Part D benefit presents Massachusetts with many options for consideration, including to:

- Recognize budgetary savings with regard to the Prescription Advantage program while maintaining current benefit levels for existing beneficiaries;
- Expand Prescription Advantage benefit levels and/or enrollments within current budget levels, *or*

²⁷ Jennifer Davis Carey, Executive Office of Elder Affairs, Commonwealth of Massachusetts, “Prescription Advantage Report Update, January 1, - December 31, 2002” accessed at <http://www.800ageinfo.com> on July 10, 2004 (hereinafter, “Prescription Advantage CY 2002 Update”).

²⁸ Commonwealth of Massachusetts Executive Office of Elder Affairs website accessed at http://www.mass.gov/portal/index.jsp?pageID=eldersterminal&L=3&L0=Home&L1=Health+Care&L2=Prescription+Advantage&sid=Elders&b=terminalcontent&f=pa_fy_funding&csid=Elders (hereinafter “EOEA website”).

²⁹ Prescription Advantage CY 2002 Update.

³⁰ EOEA website.

- Accomplish some combination of more modest budgetary savings and more modest benefit or enrollment enhancements.

A. Prescription Advantage Overview

Regardless of income, Massachusetts residents who are not receiving prescription drug benefits under Medicaid are eligible for Prescription Advantage when they are:

- **Age 65 or older** with any income level; or
- **Under 65 and disabled** with income at or below 188% of the Federal Poverty Level.

Like Part D, the Prescription Advantage benefit structure is variable and provides greater benefits for persons with lower incomes. For 2004, there are six different plan levels (based on income) with varying premium, copayment and deductible requirements. Copayment amounts are tiered to encourage the use of generic drugs, preferred brand drugs, and the mail-order service. (See Table 9.)

Table 9 Prescription Advantage Rate Schedule ³¹

Plan Levels	Federal Poverty Level (FPL)	Monthly Premium (Per Person)		Quarterly Deductible (Per Person)	Prescription Copay*		
		Single or 1 Spouse	Married Couple		Generic	Preferred Brands	Other Brands
1	0-135%	\$0	\$0	\$0	\$9	\$23	\$45
2	135-188%						
3	188-225%	\$15	\$12	\$25	\$12	\$30	\$50
4	225-300%	\$25	\$20	\$50			
5	300-500%	\$50	\$40	\$100			
6	500% and over	\$99	\$74	\$125			

* Copays are for a retail prescription that is allowed to be up to a 30-days supply. A mail order prescription may be for up to a 90-days supply. Mail order copays are approximately twice the retail amount.

Prescription Advantage also caps annual enrollee costs for deductible and copays at the lower of \$2,000 or 10 percent of income for single enrollees and the lower of \$3,000 or 10 percent of combined income for couples. After reaching this maximum, only monthly premiums continue. Unlike Part D low-income subsidies, Prescription Advantage does *not* impose an asset test. CBO estimates that 1.8 million, or 13 percent, of the 13.6 million Part D eligible persons with income at or below 150 percent of poverty will be ineligible for low-income assistance because of assets above allowable levels.³²

³¹ Prescription Advantage Application Form and Instructions Updated July 2004, <http://www.800ageinfo.com> accessed on July 10, 2004

³² CBO July 2004 Report.

B. Comparison of Part D and Prescription Advantage Benefits

Both Part D and Prescription Advantage provide greater benefits, through lower cost sharing, for persons with lower incomes. Tables 9, 10 and 11 below compare the standard benefit and low-income subsidies available under Part D with the different Prescription Advantage plan levels. As Table 10 illustrates, Prescription Advantage members that qualify for the Part D “full” low-income subsidy will enjoy a better benefit under Part D than under Prescription Advantage. Similarly, most Prescription Advantage members that qualify for the Part D “partial” low-income subsidy may fare better under Part D. (See Tables 9 and 10.) However, for many Prescription Advantage members that do not qualify for Part D low-income subsidies, the Part D standard benefit may not be as generous as the Prescription Advantage benefit. To ensure that these beneficiaries are made no worse off by enrolling in Part D, Massachusetts would need to supplement (i.e., “wrap-around”) the Part D benefit. The administrative challenges of doing so are likely to be significant.

Table 10 Prescription Advantage Plan Level 1: Comparison with Part D

	Prescription Advantage Level 1	“Full” Low-Income Subsidy	Medicare “Partial” Low-Income Subsidy	Standard Benefit
FPL Income Criteria	Below 135%	Below 135%	Below 150%	N/A
Asset Test	None	\$6,000 Individual \$9,000 Couple	\$10,000 Individual \$20,000 Couple	None
Monthly Premium	\$0	\$0	\$0 to \$35 Sliding on Income	Est. \$35
Deductible	\$0	\$0	\$50 Annually	\$250
Cost-Sharing After Deductible	Retail Copays: \$9 Generic \$23 Preferred \$45 Others	❶ For Rx Costs below \$5100: Copays of \$2 Generic \$5 Brand ❷ For Rx Costs \$5100 & Over \$0	❶ For Rx costs below \$5100: 15% Coinsurance ❷ For Rx costs above \$5100: Copays of \$2 Generic \$5 Brand	❶ Initial Coverage \$250 to \$2250 Rx Cost: 25% Coinsurance ❷ Donut Hole \$2250 - \$5100 Rx Cost: 100% Coinsurance ❸ Catastrophic Coverage \$5100 & Over Rx Cost: <i>Greater of:</i> - 5% Coinsurance, <i>or</i> - Copays of \$2 Generic \$5 Brand
Maximum Out-Of-Pocket (Excluding premium)	Lower of: ❶ 10% gross household income ❷ \$2000 (single) \$3000 (couple)	N/A	N/A	N/A

Prescription Advantage plan level 1 members who meet Medicare asset tests of \$6,000 (individual) and \$9,000 (couple) qualify for *lower* cost-sharing under the Part D “full” low-income subsidy. If Part D plan formularies are comparable to Prescription Advantage,³³ these level 1 members would be better off under Part D than under Prescription Advantage. If plan level 1 members have somewhat higher asset amounts that do not exceed \$10,000 (individual) and \$20,000 (couple), they will qualify for the Part D “partial” low-income subsidy and pay monthly premiums from \$0 to \$35 based on income. After the \$50 deductible is met, Part D cost-sharing at 15 percent of the prescription cost will likely be lower than Prescription Advantage copayment levels. Prescription Advantage plan level 1 members not meeting *either* the full or partial Part D low-income subsidy asset tests are eligible for the Part D standard benefit which would be less advantageous for the member than Prescription Advantage.

Table 11 Prescription Advantage Plan Level 2: Comparison with Part D

	Prescription Advantage Level 1	Medicare “Partial” Low-Income Subsidy	Standard Benefit
FPL Income Criteria	135% to 188%	Below 150%	N/A
Asset Test	None	\$10,000 Individual \$20,000 Couple	None
Monthly Premium	\$0	\$0 to \$35 Sliding on Income	Est. \$35
Deductible	\$0	\$50 Annually	\$250
Cost-Sharing After Deductible	Retail Copays: \$9 Generic \$23 Preferred \$45 Others	❶ For Rx costs below \$5100: 15% Coinsurance ❷ For Rx costs above \$5100: Copays of \$2 Generic \$5 Brand	❶ Initial Coverage \$250 to \$2250 Rx Cost: 25% Coinsurance ❷ Donut Hole \$2250 - \$5100 Rx Cost: 100% Coinsurance ❸ Catastrophic Coverage \$5100 & Over Rx Cost: <i>Greater of:</i> - 5% Coinsurance, <i>or</i> - Copays of \$2 Generic \$5 Brand
Maximum Out-Of-Pocket (Excluding premium)	Lower of: ❶ 10% gross household income ❷ \$2000 (single) \$3000 (couple)	N/A	N/A

³³ At the time of the writing of this report, the full nature of Part D plan formularies remains unknown and will ultimately depend on the competitive plan bidding process and regulatory decisions made by CMS regarding formulary adequacy.

For 2004, Prescription Advantage plan level 2 covers persons with incomes from 135 percent to 188 percent FPL. Level 2 members with incomes *below* 150 percent FPL and assets that do not exceed \$10,000 (individual) or \$20,000 (couple) will qualify for the Part D partial low-income subsidy. Although the Part D partial low-income subsidy includes a monthly sliding scale premium and a \$50 annual deductible (and Prescription Advantage plan level 2 requires no premium or deductible), total Part D cost-sharing *may* be lower due to lower coinsurance requirements (15 percent) after the Part D deductible is met, compared to Prescription Advantage level 2 copayments of \$9 to \$45. However, for participants that reach Prescription Advantage’s out-of-pocket maximums, Prescription Advantage may be less costly.

Table 12 Prescription Advantage Plan Levels 2-5: Comparison with Part D

	Medicare	Prescription Advantage Plans				
	Standard Benefit	Level 2	Level 3	Level 4	Level 5	Level 6
FPL Income Criteria	N/A	135%-188%	188%-225%	225%-300%	300%-500%	500%+
Asset Test	None					
Monthly Premium	Est. \$35	\$0	\$12 to \$15	\$20 to \$25	\$40 to \$50	\$74 to \$99
Deductible	\$250	\$0	\$25 Quarterly	\$50 Quarterly	\$100 Quarterly	\$125 Quarterly
Cost-Sharing After Deductible	<ul style="list-style-type: none"> ❶ Initial Coverage \$250 to \$2250 Rx Cost: 25% Coinsurance ❷ Donut Hole \$2250 - \$5100 Rx Cost: 100% Coinsurance ❸ Catastrophic Coverage \$5100 & Over Rx Cost: <i>Greater of:</i> - 5% Coinsurance, <i>or</i> - Copays of \$2 Generic \$5 Brand 	Retail Copays: \$9 Generic \$23 Preferred \$45 Others	Retail Copays: \$12 Generic \$30 Preferred \$50 Others			
Maximum Out-Of-Pocket (Excluding premium)	N/A	Lower of: ❶ 10% gross household income ❷ \$2000 (single) \$3000 (couple)				

Prescription Advantage plan level 2 members with income or assets *above* the partial low-income subsidy limits and plan level 3, 4, 5 and 6 members would be eligible for the Part D

standard benefit only. For many of these members, especially members in levels 2, 3 and 4, Prescription Advantage likely provides a more advantageous benefit than Part D.

C. State Pharmaceutical Assistance Program (SPAP) Provisions in MMA

Under the MMA, Prescription Advantage is considered a “State Pharmaceutical Assistance Program” (SPAP). SPAPs are given special consideration under Part D compared to Medicaid and employer-sponsored plans. In general, the MMA requires Part D beneficiaries to pay deductible and cost-sharing requirements themselves in order to reach the “catastrophic threshold” at which point Part D will then cover 95 percent of the cost of drugs. In 2006, a Medicare beneficiary with the Part D standard benefit will have to pay \$3,600 in total out-of-pocket costs (referred to in the MMA as the “out-of-pocket threshold”) before reaching the catastrophic threshold.³⁴ Unlike Medicaid or private employer-sponsored plans, the MMA allows SPAP expenditures to count towards an enrollee’s out-of-pocket threshold making it possible for SPAPs to “wrap-around” the Part D benefit. Other special considerations for SPAPs in the MMA include:

- Allowing SPAPs to use Medicare Part D identification cards for their programs;
- The appropriation of \$62.5 million (nationally) in both fiscal year 2005 and 2006 for SPAP grants to be used to coordinate benefits with Part D and for enrollee education and counseling; and
- The creation of a State Pharmaceutical Assistance Transition Committee that is charged with making recommendations to promote coordination between Part D and SPAPs.

The ability for SPAPs to wrap-around Part D coverage presents states with SPAPs, like Massachusetts, with several alternatives to supplement Part D, including redesigning their SPAPs to:

- Pay cost-sharing (premiums, copayments and deductibles) for certain Part D eligible SPAP enrollees based on income;
- Pay a portion of cost-sharing for all Part D eligible SPAP enrollees so that they are held to cost-sharing levels that they would have incurred under the SPAP; and/or
- Fill in the donut hole for all enrollees, or enrollees that meet criteria established by the state.

CMS must establish coordination between Part D and SPAPs for (1) Premium Payment and (2) Supplemental Prescription Drug Benefits.
Section 1860D – 23 (a) of the MMA.

³⁴ The catastrophic threshold is equal to \$5,100 in total drug costs in 2006.

VI. Part D Impact on Health Benefits for Retired State Employees

The MMA encourages employers to offer drug coverage to employees and provides subsidy payments to employers for each qualified covered retiree with drug coverage under the employer's plan that is *actuarially equivalent* or better than the Part D drug benefit. States, like Massachusetts, that provide health coverage for retired state employees are also eligible for these subsidies. The employer subsidy is equal to 28 percent of total drug costs (including plan and member payments) between \$251 and \$5,000 for Medicare retirees.

The Massachusetts Group Insurance Commission (GIC) is the state agency that provides for health insurance to state employees, retirees and their dependents. During fiscal year 2003, GIC administered benefits for 267,000 total covered lives of which 50,000 were Medicare beneficiaries. Pharmacy benefits cover most drugs without dollar caps. Member copays are tiered and vary for retail and mail order pharmacies:

Table 13 Massachusetts GIC Tiered Copays

Copay Tiers	Retail Pharmacies	Mail Order Pharmacy
Generic Drugs	• \$7	• \$20
Preferred Drugs	• \$20	• \$40
Non-Preferred Drugs	• \$40	• \$70

For fiscal year 2003, GIC staff reported that 38,663 of the Medicare members enrolled in the GIC's indemnity plan had pharmacy costs above \$250. (This represented 75% of all GIC Medicare members and 84% of indemnity members). For these members, pharmacy costs were \$81.4 million between \$251 and \$5,000. **Applying the 28 percent employer subsidy to this amount would result in a savings to Massachusetts of \$22.8 million.**³⁵ The savings estimate would be even larger if the drug spending of Medicare retirees enrolled in managed care plans were included.

Details of the subsidy process are still under development by the federal government. It is anticipated that employers will have to develop extensive data exchange systems with the federal government to substantiate subsidy payments.

³⁵ Czekanski, C, Assistant Director and Program Manager, Group Insurance Commission, *The Medicare Part D Drug Benefit – Implications for a State As an Employer*, Presentation to Conference of National Academy for State Health Policy, August 1, 2004.

VII. Conclusion

The new Part D drug benefit will – by design – have a dramatic financial and administrative impact on every state due to its interactions with state Medicaid programs, state pharmacy assistance programs and private employer retiree plans (including plans maintained by states for the benefit of retired state employees).

In the early years of the Part D benefit, increased Medicaid costs are likely – especially for a state whose Medicaid pharmacy costs are growing more slowly than the national average (due, for example, to aggressive Medicaid pharmacy cost containment initiatives). A state in this position may find that the Clawback calculation overstates the savings that the state would otherwise have expected from shifting prescription costs for duals to Medicare. In this case, State costs may actually increase. State Medicaid programs will also incur new administrative costs to carry out eligibility determinations for the Part D low-income subsidies. The Part D low-income subsidies are also expected to generate increased Medicaid enrollments and related costs for states (the “woodwork effect”).

In spite of potential increases in Medicaid costs, Massachusetts may accrue a net benefit from the new Part D drug benefit due to the savings that can be achieved for Prescription Advantage and state retiree pharmacy costs.

During the next several years, the state will have to tackle many difficult implementation and coordination issues including:

- Undertaking an analysis of the financial implications of the Medicaid Clawback;
- Undertaking an analysis of the fiscal value of the overlap between Part D and the Prescription Advantage program to support a restructuring of Prescription Advantage;
- Coordinating enrollment of dual eligibles into the new Part D plans; and
- Developing new software systems to support the low-income subsidy eligibility determinations and to coordinate the state’s programs with the Part D benefit.

Finally, because of the complexity of Part D, Massachusetts citizens are likely to turn to the state for guidance and for assistance to fill the gaps in Medicare pharmacy coverage.

APPENDIX 1: Medicare Prescription Drug Benefit Structure — 2006

Provisions	1. Medicaid Full-Benefit Duals	2. Low-Income Subsidies (Not Medicaid Dual)		3. Standard Benefit
		“Full” Low-Income Subsidy	“Partial” Low-Income Subsidy	
Income Criteria Federal Poverty Level	Below 100%	Below 135%	Below 150%	N/A
Asset Test	State Rules	\$6,000 ² Individual \$9,000 ² Couple	\$10,000 ² Individual \$20,000 ² Couple	None
Estimated Monthly Premium	None under benchmark	None under benchmark	\$0 to \$35 Based on Income	\$35
Annual Deductible	None	None	\$50 ¹	\$250 ¹
Cost Sharing For Initial Coverage Period	Institutionalized \$0 Below 100 FPL² \$1 Generic \$3 Brand At or Above 100% FPL¹ \$2 Generic \$5 Brand	\$2 Generic ¹ \$5 Brand ¹	15% Coinsurance	25% Coinsurance up to \$2,250 ¹
Coverage Gap “Donut Hole”	None	None	None	\$2,250- \$5,100 ¹ in Covered Costs
Catastrophic Coverage	Coverage resumes after the <i>out-of-pocket</i> threshold reaches \$3,600 (or \$5,100 in drug costs) . ¹ Out-of-pocket is defined as “ <i>incurred drug costs for covered Part D drugs</i> ” during the Deductible and Cost Sharing for the Initial Coverage and Gap Periods. Incurred Costs may be paid (1) by the beneficiary or another individual, such as a family member; (2) by State Pharmaceutical Assistance Programs; or (3) on behalf of Medicaid duals or other Low-Income Subsidy persons.			
Catastrophic Cost Sharing	None	None	\$2 Generic ¹ \$5 Brand ¹	Greater of: 5% Coinsurance or \$2 Generic ¹ \$5 Brand ¹

Notes:

¹ Deductibles, copays and the out-of-pocket threshold are indexed to the “annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States, as determined by the [HHS] Secretary for the 12-month period ending in July of the previous year...” See 1860D – 2(b)(6) of the law.

² The Medicaid Dual copay for duals with incomes below 100% FPL and Low-Income Asset Test is indexed to the Consumer’s Price Index. See 1860D – 14 of the law.

APPENDIX 2: Definition of Part D Drugs

Part D Covered Drugs	Examples of Part D Excluded Drugs		
	Part A Drugs	Part B Drugs	Optional Classes Under Medicaid
<ul style="list-style-type: none"> • FDA-approved drugs & biologicals specified in Medicaid law • Insulin & medical supplies for its administration • Smoking cessation products • Vaccinations licensed under Section 351 of the Public Health Service Act 	<ul style="list-style-type: none"> • Drugs used during a Medicare covered “nursing home” stay • Drugs used during a “hospital” stay • Drugs used during hospice services 	<ul style="list-style-type: none"> • Immunosuppressants: Sandimmune • Nebulization Drugs: Alupent, Atrovent, Intal, etc. • Oral Anti-Cancer Agents: Cytoxan • Diabetic Supplies: Blood glucose monitors, blood glucose test strips, etc • Anti-Emetics: Kytril, Zofan, etc. • Dialysis Drugs: Epogen, Procrit, etc. • Antihemophilic Drugs: Hemophil-M, Feiba, etc. • Multiple Sclerosis Drugs: Avenox 	<ul style="list-style-type: none"> • Products for weight loss/gain • Fertility products • Cosmetic or hair growth products • Cough & colds preparations • Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations • Over-the counters (OTC) available without a prescription • Barbiturates: Phenobarbital, etc. • Benzodiazepines: Valium, Ativan, Librium, etc.

APPENDIX 3: History of Recent MassHealth Pharmacy Reimbursement³⁶

Begin Date	Ingredient Cost	Dispensing Fee	Copayments
11-1-2002	Lower of: <ul style="list-style-type: none"> Federal Upper Limit Price MassHealth Upper Limit Price Usual & Customary Charge Wholesaler Acquisition Cost + 6% 	<ul style="list-style-type: none"> \$3.50 brands \$5.00 generics \$5.00 unit dose return fee 	\$0.50
01-01-2003	No Change	No Change	\$2.00
12-01-2003	No Change	<ul style="list-style-type: none"> \$3.00 brands & generics \$5.00 unit dose return fee 	No Change
02-01-2004 Current	Lower of: <ul style="list-style-type: none"> Federal Upper Limit MassHealth Upper Limit Usual & Customary Charge Wholesaler Acquisition Cost + 6% 	<ul style="list-style-type: none"> \$3.00 brands & generics \$5.00 unit dose return fee 	<ul style="list-style-type: none"> \$1.00 generics \$1.00 over-the-counters \$3.00 brands

³⁶ Division of Health Care Finance and Policy, "Report to the General Court: Payments for Prescribed Drugs, Commonwealth of Massachusetts", April 1, 2004 accessed at <http://www.mass.gov/dhcfp>

MassHealth policy regulations accessed at <http://www.mass.gov/dma>



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