FFIS

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New Data Highlight Uncertainties Surrounding Medicare Drug Benefit

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Executive Summary

Recently published regulations and information from the fiscal year (FY) 2006 federal budget provide additional information on the costs of implementing the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-391). Five-year federal estimates now show that increased costs to the states for the Part D program almost entirely offset savings.

All employers—including states—will save from the MMA retiree drug subsidy provided to encourage them to retain their curren benefits. The Center for Medicare and Medicaid Services (CMS) reports that a series of options are available to states in structuring these benefits.

Background

The passage of MMA created a new Medicare Part D prescription drug benefit effective January 1, 2006. An estimated six to seven million new Part D beneficiaries currently are eligible for both Medicare and Medicaid. In the expectation that states would see a fiscal windfall from the federal government's assumption of what have been shared Medicaid costs for these "dual eligibles," section 103(b) includes a provision requiring a state payment supporting the Part D program. This payment, referred to in federal information as "state payments to the federal government for full-benefit dual eligibles" is popularly known as the "clawback." The clawback is designed to be 90% of estimated state savings in 2006, declining to 75% over 10 years.

Other MMA state government savings and costs include reductions in costs for 100% state-funded pharmacy assistance programs (see *Issue Brief 04-54*), costs for new Medicaid enrollees expected to be identified in the Part D enrollment process, foregone state revenue and additional state administrative costs. Finally, the provision giving all employers a tax-exempt subsidy of 28% of retiree drug benefits will benefit states as employers.

The clawback payments represent approximately 25% of the offsets that the Congressional Budget Office (CBO) estimated would hold the bill to a $400 billion total cost over 10 years (including provisions not related or tangentially related to the Part D program). Other offsets include Part D beneficiary premiums (35%) and federal Medicaid savings (45%). CBO estimated that the annual state clawback payments would grow by about $1 billion a year, with the decline in the state percentage from 90% more than offset by prescription drug cost increases. Over the first five federal fiscal years of Part D coverage, it was estimated that states would make almost $50 billion in clawback payments, the largest single flow of funds from states to the federal government in support of a totally federal program.

New Information on State Savings and Costs

CMS has published information in the MMA regulations on its estimates of the effect the new law would have on states. This information is shown in Table 1, and demonstrates that previous projections of state windfalls from the new program were wrong. State clawback payments over the five years are now estimated to total $55 billion. Table 1 shows that state Part D costs and savings are roughly equal, for the first years, with real savings perhaps beginning in the fifth year.

Table 1. Projected State Savings and Costs Due to the Medicare Drug Benefit
(calendar years; dollars in billions)

	2006	2007	2008	2009	2010	2006-20010
Part D Savings(-)/Costs(+)	**$0.1**	**-$0.1**	**-$0.2**	**-$0.5**	**-$0.8**	**-$1.7**
Part D Savings						
Reduction in State Medicaid Spending	-$10.0	-$11.2	-$12.5	-$14.0	-$15.6	-$63.4
Savings for State Pharmacy Assistance Programs	-0.6	-0.6	-0.6	-0.6	-0.6	-3.0
Part D Costs						
State Payments to the Federal Government for Full-Benefit Dual Eligibles	9.0	9.9	10.9	11.9	13.0	54.7
State Spending for New Medicaid Enrollees	1.5	1.6	1.8	2.0	2.2	9.1
Lost Revenue from Prohibition on Taxes on Premiums for Part D Coverage	0.1	0.1	0.1	0.1	0.1	0.5
State Administrative Costs	0.1	0.1	0.1	0.1	0.1	0.5

Source: FFIS restructuring of Table IV-4, Federal Register p.4490; January 28, 2005.

Perhaps of most concern is the $13.0 billion clawback estimates in the final year of the projection. As recently as June 23, 2004, the Medicare actuary's estimate of the clawback for *fiscal year* 2010 was $12.0 billion. Unlike Medicaid drug costs, states will have almost no power to control their clawback costs, which will be a function primarily of overall drug cost increases nationwide.

New Information on Federal Savings and Costs

The new regulations also published five-year cost and savings estimates for the federal government, with increases in Medicare spending partially offset by clawback payments and net Medicaid savings. These calendar year (CY) data are presented in Table 2.

Table 2. Impacts on Federal Medicare and Medicaid Spending of Implementing the Medicare Drug Benefit and Retiree Drug Subsidies
(calendar years; dollars in billions)

	2006	2007	2008	2009	2010	2006-20010
Medicare:						
Federal Spending Related to Medicare Part D, including the Retiree Subsidy	$69.7	$76.2	$83.3	$91.0	$99.2	$419.3
State Payments to Partially Offset Medicare Drug Costs for Dual Eligibles	-9.0	-9.9	-10.9	-11.9	-13.0	-54.7
Subtotal, Medicare Net Costs	60.6	66.2	72.5	79.1	86.1	364.6
Medicaid:						
Additional Federal Matching Payments for Newly Enrolled Dual Eligibles	2.0	2.2	2.5	2.7	2.9	12.3
Reduction in Federal Matching Payments for Medicaid Drug Expenditures to Dual Eligibles	-13.3	-14.9	-16.6	-18.5	-20.7	-84.0
Subtotal, Medicaid Net Savings	-11.3	-12.7	-14.1	-15.8	-17.8	-71.7
Total, Medicaid and Medicare	**$49.3**	**$53.5**	**$58.4**	**$63.3**	**$68.3**	**$292.9**

Source: FFIS restructuring of Table IV-3, Federal Register p.4486; January 28, 2005.

The program is projected to have net budgetary costs of $419 billion over its first five years, reaching $99 billion in CY 2010. Additional information from the budget indicates that the total cost will be $1.2 trillion over the program's first 10 years, with offsets reducing the federal government's net budgetary costs to $720 billion. This increase is substantially more than the $395 billion 10-year

cost originally projected by CBO. The primary reason for the difference is that the CBO cost estimate was for FYs 2004-2013, which includes 2.25 years before Part D becomes effective. However, the difference also reflects a learning process on the part of government actuaries and economists. There remain substantial uncertainties for the federal government in these estimates, and even more uncertainties for states.

Clawback Issues

A state's clawback payment for any given month is equal to the product of a three-part multiplication:

1. Phase-down percentage (P). This is 90% for CY 2006, phasing to 75% in CY 2015.
2. Per capita expenditures (PCE). This is the state's share of its per capita Medicaid expenditure for covered drugs for dual eligible in CY 2003, increased by the growth in per capita prescription drug spending nationally, and adjusted for the change in the state's relevant federal medical assistance percentage (FMAP). For persons in managed care, it is the actuarial value of prescription drug benefits that will be counted for the purposes of PCE.
3. Number of dual eligibles (DE). This is the number of dual eligibles in the month who are enrolled in the Part D program and have been determined by the state to be eligible for full Medicaid benefits. Since some dual eligibles are made so by state option, DE is the only part of the calculation somewhat under state control.

A number of issues have surrounded the calculation of the clawback. First, FY 2006 is a year of unusually large FMAP reductions for most states (See *Issue Brief 04-41*). These FMAP reductions are expected to continue, increasing clawback amounts.

Second, once the baseline PCE is established, increases in drug spending nationally will increase state clawback costs irrespective of the situation in the state. States will be responsible for paying part of the cost of a program over which they have no control.

Third, many states contend that the PCE base is not being appropriately determined. In particular, many states have moved aggressively in recent years to obtain supplemental rebates from drug manufacturers. However, a large share of these rebates is paid after the year to which they apply, and using cash levels produced by the Medical Statistical Information System (MSIS) for PCE overstates the real accrued cost of many states' FY 2003 programs. CMS has moved in FY 2006 to using an accrual ("incurred but not reported") basis for overall Medicaid accounting, but has insisted on a cash basis for determining the PCE base. The MMA itself directs the secretary of Health and Human Services to "use data from the Medical Statistical Information System (MSIS) and other available data."

Finally, the lack of valid information on the clawback creates substantial budgeting problems for states. The secretary is required to notify each state of its PCE no later than October 15 for the upcoming calendar year (*i.e.*, October 15, 2005, for calendar year 2006). Until then, the state has little data on which to calculate payments for a fiscal year already in progress.

Options for States on Employee Retirement

Drafters of MMA were concerned that employers now covering retiree drug costs in their benefit packages would drop them, increasing Part D costs and perhaps reducing benefits. As a result, the MMA included a subsidy equal to 28% of retiree drug costs between $250 and $5,000 in the hope that employers and unions now providing prescription drug coverage would continue. These subsidies are tax-free, increasing their value to plan sponsors subject to taxation. To qualify for the subsidy, the sponsor must demonstrate that its coverage is at least as generous as defined standard coverage under the new benefit. MMA regulations estimate that states will receive $1 billion from this subsidy in CY 2006, increasing to $1.5 billion in CY 2010.

CMS emphasizes that employers and unions have options in structuring a benefit to receive the subsidy, and that they may change this option in future periods if they so choose.

- They may set up their own separate supplemental plans and coordinate benefits with the coverage offered by Part D plans in which their employees enroll. This provides help in cost sharing similar to current ways they supplement the standard Medicare Part A and B benefits.
- They may pay for enhanced coverage through a Part D plan to subsidize more of the retirees' cost-sharing and provide additional benefits. CMS reports that it plans to use its waiver authority to allow sponsors to make special arrangements with Part D plans for, or offer their own Part D plans to, their retirees. These waivers would allow employers to provide more flexible benefits and to limit enrollment to their retirees.
- Regardless of whether they choose to provide additional coverage that supplements Medicare prescription drug coverage, sponsors also may provide extra help by assisting their retirees in paying for some or all of the Part D beneficiary premiums.

CMS expects to continue to offer guidance on a range of issues. States may contact the CMS Employer Policy & Operations Group (EPOG) at epog@cms.hhs.gov. In addition, automatic e-mail notification of CMS activities of interest to sponsors is available by subscribing to the MMA employer/union issues listserv at http://www.com.hhs.gov/mailinglists.

Observations

The implementation of the MMA introduces substantial uncertainty into both federal and state budgeting. For states, it comes at a difficult time. Most states' FMAPs will decline in FY 2006, many substantially, and these reductions are projected to continue. In addition, recurring federal budget deficits have resulted in proposals to reduce federal funding for grants-in-aid, both in Medicaid and elsewhere. It is difficult to deal with uncertainty during periods of budget surplus; dealing with it over the coming years during the expected decline in federal support will be even more difficult.

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