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Medicare Prescription Drug Benefits
Implications for the States

Temporary Drug Card

The most immediate impact on the states is the new temporary prescription drug card that will be available from June 2004 through December 2005 for those on Medicare who are not dual eligibles. The \$600 annual subsidy for low income beneficiaries (below 135% of poverty level) is a tangible bit of relief for states presently running their own systems.

Many states, including Maine, have long been using state funds to provide drugs for the elderly poor. Now we may substitute the \$600 federal benefit for the first layer of these costs. 5500 of the 40,000 people presently on Maine's "Drugs for the Elderly" program will be able to take advantage of the federal benefit, thus saving the state about \$3 million per year.

In order to capture these savings, Maine has just passed a law requiring that elderly citizens "spend down" their federal benefit before tapping into the state program. Unfortunately, the existence of two over-lapping subsidy systems will be difficult to administer and confusing to vulnerable beneficiaries. States are not permitted to sponsor the temporary drug card.

It would have been better if states with their own systems in place had simply been permitted to do the job. Maine has a wealth of data concerning the drug needs of this population and is ideally prepared to issue a composite card with a blended benefit. Unfortunately, the law does not permit states to enter the game.

The temporary discount cards for those with higher incomes are unlikely to provide any benefit. Maine's existing drug program provides better prices and is available without having to pay a \$30 fee. We predict few takers for the federal temporary card.

The Permanent Plan in 2006

The 2006 permanent plan will remove about 41,000 covered lives from prescription coverage under Maine's Medicaid system. Although these dual eligibles are only 1/6 of our Medicaid population, they account for half of Medicaid prescription drug costs.

Maine and many other states are bargaining for enhanced rebates from manufacturers by using preferred drug lists and prior

authorization techniques that trade market share for price concessions. Removal of dual eligibles from this market will take away a major portion of the state's bargaining power. The exemption of Part D drugs from Medicaid "best price" restrictions is also likely to raise state costs.

Clawback provisions will require Maine to pay more for this coverage than it would have cost had it been left under Medicaid. While the clawback is nominally set at 90% of 2003 costs, the inflation adjustment from 2003 to 2006 is based on national trends outside of Medicaid. Maine's Medicaid Rx costs are among the most tightly controlled in the U.S. They have recently been rising at only 2% per capita per year. National rates outside of Medicaid, by contrast, have been 8 or 9%. Applying the national drug inflation rate (for 2004 through 2006) to the 90% clawback will yield a net cost to Maine and many other states that is higher than what it would cost if we were simply to retain this population on Medicaid -- an option not open to us.

Injecting at least two competing Medicare drug plans with conflicting formularies into our small market is likely to generate even more confusion than presently exists for doctors, pharmacists and patients. On the other hand, if the state itself were to join with risk bearing entities to coordinate the new part D benefits with existing PDLs from Medicaid and state-only programs, then the resulting consistency, symbiosis and enhanced market share might prove very beneficial indeed. Such alliances are specifically encouraged by the law. Nothing seems to preclude a state from actually becoming a plan sponsor, perhaps in joint venture with a regional insurer.

Eligibility for the low income component of the new program will be determined by the states. Although this administrative service will be paid for under Medicaid, the clawback formula creates an incentive for states not to encourage future enrollment. The fewer people who sign up, the smaller the clawback.

Sponsors of drug plans must be licensed by the states as risk bearing entities but the states are not permitted to collect a premium tax from them.

Employers that maintain drug coverage for retirees are entitled to a subsidy equal to 28% of the actuarial value of such coverage. Because states themselves are major employers providing retiree benefits, it appears that states may apply for this valuable subsidy along with private employers.

Other features of the new law include:

- required drug utilization and medication therapy management,
- development of electronic prescription systems,
- studies of regional variations in per capita spending,
- an evidence-based review of drug safety issues,
- grants to doctors for electronic prescription programs,

drug therapy quality improvement systems,
mandatory disclosure of costs for lowest priced generics, and
a State Pharmaceutical Assistance Transition Commission.

Throughout the new statute, Congress seems to be struggling to create a new market, to revive the failing Medicare + Choice (under a new name "Medicare Advantage") and to implement a medical voucher system for drugs. Interestingly, this new drug market includes and validates the concepts of guaranteed issue, guaranteed renewal and community rating, concepts which have been under attack in many states. Some suggest, however, that drug plan sponsors may find ways to introduce risk selection through adopting different mixes of drug formularies and incentives. Despite regulatory controls by CMS, sponsors may be able to appeal to healthy populations by brewing up alternative benefit cocktails whose underlying purpose is to exploit risk selection.

The new Medicare law exemplifies the tensions between efforts to lower prices through competition and to preserve profit incentives for the drug industry. No drug plan can minimize price without restricting choice. This tension divides people at each end of the political spectrum. AARP members are reported to be evenly divided between those who want choice and those who prefer low prices.

Those of us from state government are biased toward low cost because of our obsession with budgets. We live in a world of economic triage -- denying health care to some and granting it to others, in efforts to stretch scarce tax dollars to provide the greatest good for the greatest number.

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