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Part "D" Stands for "Deficit":

How the Medicare Drug Benefit Affects Medi-Cal

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The Medicare Prescription Drug, Improvement and Modernization Act, also referred to as the Medicare Modernization Act (MMA) makes significant changes to the federal Medicare program. The implementation of the Medicare drug benefit component of MMA, known as Part D, is likely to cause significant net financial losses to the state for years and have other major programmatic impacts on Medi-Cal. We recommend some limited actions and strategies the Legislature can take to address these potential problems. ■

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INTRODUCTION

The Medicare Prescription Drug, Improvement and Modernization Act, also referred to as the Medicare Modernization Act (MMA), became law on December 8, 2003. The MMA makes significant changes to the federal Medicare program. The scope of the legislation is so broad that it may be years before all of its initiatives are fully implemented and its overall ramifications are completely understood. The measure will have a number of significant fiscal effects, positive and negative, on various state programs.

This analysis examines the major policy and fiscal implications the establishment of the Medicare prescription drug coverage plan has for the state's Medicaid Program, which is known as Medi-Cal in California. In particular, this analysis focuses on the impact implementation of the Medicare Part D drug benefit will have on dual eligibles—beneficiaries who are fully eligible for both Medicare and Medi-Cal benefits—since they will be the Medi-Cal beneficiaries that are most directly affected by Part D. We also analyze the potential fiscal effect on the state of providing "wrap-around" coverage to the dual eligibles, the requirement under Part D that the state make "clawback" payments to the federal government, and other aspects of the new federal law.

In addition to the Part D prescription drug benefits, the MMA also includes a number of other benefit changes, such as additional preventative care benefits. However, an analysis of all of the changes made by MMA and their implications for state health programs is beyond the scope of this report.

BACKGROUND

Medicare at a Glance

Medicare is a federal health insurance program overseen by the Centers for Medicare and Medicaid Services (CMS) that provides coverage to eligible beneficiaries at federal expense through fee-for-service (FFS) and managed care arrangements. The FFS model is the traditional arrangement for health care in which providers are paid for each examination, procedure, or other service that they furnish. Medicare also contracts with selected managed care plans to provide services to beneficiaries. Medicare consists of four parts:

- ***Part A.*** The hospital insurance program that covers inpatient hospital, skilled nursing facility, hospice, and home health care.
- ***Part B.*** Optional supplementary medical insurance that covers physician and outpatient hospital care, laboratory tests, medical supplies, and home health care. About 95 percent of Part A recipients voluntarily enroll in Part B.
- ***Part C.*** These are managed care plans (referred to as Medicare Advantage) that provide both Part A and Part B benefits. Some of the plans provide

prescription drug benefits, although many enrollees face restrictions on these benefits such as an annual cap on pharmaceutical expenditures or limitations on which drugs may be purchased.

- ***Part D***. The new outpatient prescription drug benefit that will be implemented January 1, 2006.

Medicare Basics. Most individuals 65 and over are automatically entitled to Medicare Part A if they or their spouse are eligible for Social Security payments. People under 65 who receive Social Security cash payments due to a disability generally are eligible for Medicare after a two-year waiting period.

Medicare beneficiaries pay for their benefits through premiums, deductibles, coinsurance, and copayments which are defined below in Figure 1.

Medicare Drug Coverage Begins Soon. Medicare Part D will go into effect beginning January 1, 2006. As of that date, Medicare will begin to pay for outpatient prescription drugs through prescription drug plans (PDPs) or Medicare Advantage plans. Beneficiaries can remain in the traditional Medicare FFS program and enroll separately in PDPs, or they can enroll in integrated Medicare Advantage plans for all of their Medicare-covered benefits, including standard drug coverage. The PDPs and Medicare Advantage plans may also offer supplemental drug benefits beyond what is covered under the standard plan for an additional premium.

Figure 1

Insurance Terms—Definitions

Premium	An amount paid, often in installments, to purchase an insurance policy.
Deductible	An initial specified amount that an enrollee has to pay before the insurer begins to contribute towards medical costs.
Coinsurance	A set percentage of medical costs that enrollees must pay towards the cost of their medical care.
Copayment	A fixed fee that enrollees of a medical insurance plan must pay for their use of specific medical services provided by the plan.

How Medicare and Medicaid Interact

The Two Major Federal Health Programs. The two major federal health insurance programs are Medicare and Medicaid. Above, we discussed who is eligible for Medicare. Medicaid (known as Medi-Cal in California) provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). Medi-Cal is administered by DHS. The cost of Medi-Cal services is shared about equally between the state General Fund and federal funds.

Dual Eligibles. So-called "dual eligibles" are individuals who are entitled to Medicare Part A and/or Part B and who are also eligible for some form of Medicaid benefit. In California, there are about 1.1 million dual eligibles in the Medi-Cal Program. Dual eligibles tend to be in fair or poor health due to chronic illnesses and conditions such as heart problems or high blood pressure that require ongoing treatment.

Eligibility Determinations. Under federal law, state Medicaid programs are required to conduct eligibility determinations for certain Medicare programs in which the state shares in the cost, such as the Qualified Medicare Beneficiary program. Under the Medicare cost-sharing program, Medicaid programs may pay an individuals' Medicare costs. Because the medical care provided under Medicare is paid for at 100 percent federal expense, and because the federal government shares about 50 percent of the costs of Medicaid programs, this arrangement is favorable to the states.

In California, eligibility determinations for Medicare cost-sharing programs is delegated to county welfare offices. As we discuss later in this analysis, the implementation of the new Medicare Part D prescription drug benefit will require the county welfare offices to take on new eligibility determination responsibilities.

Medi-Cal Drug Benefits

Medi-Cal Offers a Wide-Ranging Prescription Drug Benefit. In order to remain in compliance with federal law, the Medi-Cal Program provides coverage for a wide range of prescription drugs. It currently spends about $3.3 billion total funds annually (net of rebates) on drug benefits, not including the significant additional but unknown cost of drugs provided to beneficiaries enrolled in Medi-Cal managed care health plans. The cost of prescription drugs for dual eligibles now accounts for about $1.8 billion total funds annually (net of rebates) or about 55 percent of total drug expenditures within the Medi-Cal fee-for-service program.

Preferred Drug Lists and Supplemental Rebates. Medicaid programs are permitted to have formularies or preferred drug lists (PDLs) that have the effect of establishing state preferences for the prescription of certain drugs, usually because they are deemed to be more cost-effective than other drugs in the same class. However, Medicaid formularies and PDLs are considered "open" because beneficiaries can still access nonformulary drugs that are not among those preferred if their doctor receives prior authorization from the state.

The PDL is a key tool that is often used by the state to bargain with drug manufacturers for supplemental rebates. The DHS so far has established contracts with nearly 100 manufacturers for supplemental rebates. When DHS and the manufacturer agree to a state supplemental rebate, the drug is placed on DHS' PDL which tends to increase the frequency of Medi-Cal prescriptions.

An Overview of the Medicare Prescription Drug Benefit

Eligibility and Enrollment. The MMA created the new Part D prescription benefit. Medicare will begin to pay for outpatient prescription drugs through private plans as of January 1, 2006. Medicare beneficiaries entitled to Part A or enrolled in Part B are eligible to enroll in part D and receive the new prescription drug benefit. For most Medicare beneficiaries, the initial open enrollment period will run from November 15, 2005 through May 15, 2006. Medicare beneficiaries who prefer not to have prescription drug coverage can choose not to sign up for the new benefit. Signups for drug coverage will be permitted after the May date. However, beneficiaries who choose to pass on enrolling during this initial period may face a late enrollment penalty.

Special Enrollment Requirements for Dual Eligibles. Because dual eligibles are eligible for Medicare, they are the Medi-Cal recipients most significantly affected by Part D. Dual eligibles are subject to special enrollment requirements under Part D. The enrollment period for dual eligibles begins November 15, 2005 and ends on December 31, 2005. During this voluntary enrollment period, dual eligibles may choose the PDP or Medicare Advantage plan that they determine best meets their needs. Any dual eligibles who have not enrolled in Part D during the voluntary enrollment period will automatically be enrolled in one of these plans as of January 1, 2006, and a Part D provider will be assigned to them. This automatic assignment of dual eligibles to drug plans will generally be made without any review as to whether a drug plan's formulary is the most appropriate one for them. However, dual eligibles will be permitted to transfer to another PDP or Medicare Advantage plan if they find that another provider would better meet their needs.

Drug Formularies and the Part D Benefit. The drugs covered under the Part D benefit would include biological products and insulin (such as medical supplies associated with injections) and some vaccines. However, drugs for which benefits are payable under Medicare Parts A and B are excluded from the Part D benefit. Also excluded from Part D coverage are certain categories of medication, such as, weight loss or fertility drugs.

The CMS contracted with United States Pharmacopoeia to develop a model drug classification system. The group recommended that prescription drug plans offer beneficiaries at least two drugs in each of 146 listed categories and classes. According to the CMS, the model guidelines provided by U.S. Pharmacopoeia are a starting point for PDPs and Medicare Advantage plans to use when structuring formulary categories and classes. The CMS will review individual formularies to ensure the adequacy of the drug benefit offered and prevent discriminatory practices. In addition, CMS has the authority to disapprove a PDP or Medicare Advantage plan with a benefit structure that would have the effect of discouraging the enrollment of certain groups of beneficiaries—for example, those who are mentally ill or who have AIDS.

The PDPs and Medicare Advantage Plans have the option of offering additional plans with richer benefits for an additional premium. In some cases, these plans with enriched benefits may better meet the needs of dual eligibles.

Appeals Process. The MMA requires that PDPs and Medicare Advantage Plans have in place grievance procedures and an appeals process in the event of disputes over which drugs they cover. Only beneficiaries can file an appeal and a physician or representative, such as a family member, can help in the appeals process. Beneficiaries could appeal a decision to deny them a drug that is not on a plan's formulary only in cases where the prescribing physician finds that all of the drugs on the plan's formulary for treatment of that medical condition would not be as effective or would have adverse effects on the patient.

How Part D Benefits Will Be Delivered. As noted earlier, Medicare Part D will be delivered through PDPs or Medicare Advantage health plans, under contract with the U.S. Department of Health and Human Services. The CMS is required by MMA to ensure that every Medicare beneficiary has a choice of at least two prescription drug plans, one of which must be a

PDP. The CMS has established 34 separate regions of the nation in which PDPs will operate—every PDP must serve an entire region. California has been established as a separate region.

Effective January 1, 2006, PDPs and Medicare Advantage plans that choose to offer Part D benefits must offer at least one plan in each region that includes standard Part D coverage. To be standard, benefits must be offered to beneficiaries on the following terms:

Beneficiaries will on average pay:

- An estimated $35 per month in premiums in 2006, although premiums paid under any particular plan may vary.
- The first $250 in total drug costs (which constitutes the deductible).
- 25 percent of total drug costs from $251 to $2,250.
- 100 percent of total drug costs from $2,251 to $5,100 (a gap in drug coverage widely called the "doughnut hole").
- Once total drug costs for an individual exceed $5,100, they would be subject to copayments ($2 for generic drugs and $5 for brand-name drug prescriptions) or coinsurance costs of up to 5 percent of their drug costs.

Low-Income Assistance for Part D. The MMA provides varying types of assistance to low-income individuals who meet certain income and asset level requirements in obtaining their Part D drug coverage. For example, dual eligibles who are residents of nursing homes will have their drugs covered 100 percent by Medicare and will face no premium, deductible, copayments, or coinsurance. Dual eligibles who are not in nursing homes will pay no premiums or deductibles, but will pay copayments. Specifically, those dual eligibles with incomes under 100 percent of the federal poverty level will pay $1 to $3 copayments; those dual eligibles with higher incomes will pay $2 to $5 copayments.

Certain other low-income beneficiaries, including some who are not dual eligibles, would also receive various types of assistance with their premiums, copayments, coinsurance, and deductibles.

Aggressive Implementation Schedule Planned. The CMS has established an aggressive timeline for choosing the providers that will deliver Part D benefits:

- ***June 6, 2005.*** Deadline for submitting bids to the CMS to establish Medicare Advantage prescription drug plans and PDPs.
- ***September 2005.*** The CMS awards bids to Medicare Advantage plans and PDPs.
- ***November 15, 2005.*** Enrollment period begins for Part D benefits.

This tight schedule could complicate the rollout of the new drug benefit to consumers. Under CMS' timetable, efforts to disseminate information about Part D coverage to Medicare beneficiaries to encourage their enrollment would begin just six weeks after PDPs and Medicare Advantage plans are selected to deliver the new drug benefit. Moreover, the specific drugs that would be included in the formularies of the PDPs and Medicare Advantage plans are not likely to be known until a few

weeks before the enrollment period opens on November 15. Whether or not a particular prescription drug is covered by a PDP or Medicare Advantage plan could significantly affect the decisions of individuals as to which Part D provider they choose.

Informing Beneficiaries About Their Part D Benefits. The CMS is increasing its efforts to provide information to beneficiaries about the new Part D drug benefit. The CMS indicates that it plans to mount an education campaign that will include the distribution of printed materials, a toll-free phone number, a Web site, and direct mailings to Medicare beneficiaries. The CMS also plans to work with the Social Security Administration and other federal agencies, states, employers, providers, pharmacists, and other health care providers to inform Medicare beneficiaries about the new benefit that will be available to them.

GOVERNOR'S BUDGET PROPOSAL

The Governor's budget plan would reduce General Fund expenditures for the Medi-Cal Program by about $747 million ($1.5 billion all funds) in the budget year in recognition of the savings to the state from no longer providing a drug benefit to the dual eligibles under Medi-Cal. These savings would be partially offset by a new payment that the state will have to make to the federal government known as a "phased-down state contribution" or, more commonly, as a "clawback" (we discuss the clawback provision in more detail below). This clawback payment is estimated to be $646 million General Fund in the budget year. As a result, the General Fund effect upon the Medi-Cal Program from the new Part D drug benefit is projected to result in net savings of about $100 million General Fund in 2005-06. As we discuss later in this analysis, this estimate of net savings is misleading when other factors relating to implementation of Part D have been taken into account.

NET FINANCIAL LOSSES LIKELY FOR YEARS

Savings Appear Short-Lived. Federal authorities, in their recent announcement of their new regulations to implement the new Medicare Part D benefit, have emphasized the potential savings that would accrue to the states under the new law. These savings to the states, they have indicated, would result primarily from a shift in drug coverage for Medicaid beneficiaries to the Medicare Program. Under Medicaid, their drug coverage is paid for partly at state expense. Under the Medicare Program, their costs would be borne primarily by the federal government.

Our analysis indicates, however, that the new Part D drug benefit will result in savings of about $100 million General Fund in 2005-06, but will probably be a losing proposition for the Medi-Cal Program beyond the budget year. This is partly due to the so-called clawback provision written into the new federal law, and the specific way this provision is being interpreted and implemented by CMS. The clawback provision

and other important changes resulting from MMA probably mean that, after a short-lived one- to two-year gain, the Medi-Cal Program will end up experiencing large net financial losses for at least several years afterward.

For example, the $100 million net savings figure identified above for 2005-06 is misleading. As noted above, the state currently collects rebates from drug companies under the Medi-Cal Program about one year after the drugs are purchased. The reduction in the level of drug purchases made in 2005-06 as a result of Part D means the amount of rebates that DHS collects will drop by about $273 million in 2006-07. This loss of rebate revenues would more than offset the $100 million net gain that will show up on the Medi-Cal Program books in 2005-06.

We estimate that the combined effect of the reduction in drug expenditures, the clawback payments, and the loss of drug rebates associated with the dual eligibles will result in cumulative additional General Fund costs to the state through 2008-09 of about $758 million. Figure 2 provides our estimates of the fiscal effect that the MMA will have on Medi-Cal Program finances over the next four years.

Complications for Dual Eligibles. As pointed out above, dual eligibles are the Medi-Cal beneficiaries that are most directly affected by the implementation of Medicare Part D. Our analysis indicates that the new program has some potential pitfalls for dual eligibles whose drug coverage would be shifted from Medi-Cal to Medicare. In some cases, these individuals may not be able to get the same drugs under Medicare that they now get under Medi-Cal, with unknown medical consequences. As a result, the state faces the difficult choice of whether to continue their state-supported drug benefits without any further financial support from the federal government. We outline our concerns over the potential impact of the new federal law below.

In the sections that follow, we also discuss various factors related to Medicare Part D implementation that could increase cost pressures on the state. These are summarized in Figure 3 (see next page).

Figure 2

Fiscal Impact of New Medicare Drug Benefit As Reflected in the Governor's Budget Plan[a]

(In Millions)

	2005-06 (Half-year)	2006-07	2007-08	2008-09
Reduced Drug Costs	-$747	-$1,617	-$1,818	-$2,043
Clawback	646	1,428	1,574	1,737
Reduced drug rebates	—	273	620	705
Annual Impact	**-$101**	**$84**	**$376**	**$399**
Cumulative Impact		**-$17**	**$359**	**$758**

[a] 2006-07, 2007-08, and 2008-09 figures are LAO estimates.

Federal Clawback Formula Disadvantages California

State Becomes a Revenue Source for Federal Government. Effective January 1, 2006, Medicare Part D will offer outpatient prescription drug coverage to the approximately 1.1 million dual eligibles in Califor-

nia. As noted earlier, the proposed Medi-Cal budget assumes that state General Fund costs will decrease by $746 million in 2005-06 due to this shift in their coverage.

However, MMA does not allow California or other states to keep all of these savings. The measure includes a clawback provision that requires states to pay back most of their estimated savings to the Medicare program to help pay for the Part D benefit. States are required to pay the federal government 90 percent of their estimated savings in calendar year 2006. During the following nine years the clawback percentage is reduced by 1.66 percent per year until it reaches 75 percent, then remains set at that level.

Beginning in January 2006, California is required to make a monthly clawback payment that is to be deposited into a federal government account. The amount of each state's monthly payment is determined by a complex formula with several components, including the amount the state spent on drugs covered by Part D for dual eligibles in calendar year 2003 on a per-person basis and the rebates received by a state from drug manufacturers.

Federal Clawback Reduces Savings to States. The CMS has issued final regulations that will determine how the clawback formula will be applied to each state. The DHS concluded that the regulation adopted by CMS unduly disadvantages California by overstating the true net costs it had incurred in the past for providing prescription drugs to dual eligibles—a key component of the federal clawback formula. The DHS found that the proposed clawback formula inaccurately calculates the rebates collected from drug suppliers for 2003 by using the dollar amount of rebates collected in 2003. The department indicates a more appropriate calculation, which would have taken into account rebates collected in 2004, would reduce the state's clawback payments by $91 million a year. Although the regulations have been

Figure 3

How the Medicare Part D Benefit Could Be Costly to Medi-Cal

	Annual Cost
Wrap-Around Under existing state law, the state provides wrap-around coverage.	Unknown, potentially low hundreds of millions of dollars.
Clawback Effect Provision requires the state to pay the federal government back most of the state's savings from no longer providing drug coverage to dual eligibles.	$646 million in 2005-06.
Reduced Drug Rebates The state's drug rebates will be reduced because fewer drugs will be purchased.	$273 million beginning in 2006-07, and larger amounts thereafter.
Supplemental State Rebates The state's ability to negotiate supplemental drug rebates with pharmaceutical manufacturers may be negatively affected when the volume of drugs that the state purchases decreases.	Unknown, potentially up to tens of millions of dollars.
County Administration Creates additional workload in county welfare offices by requiring them to do eligibility determinations for Medicare Part D low-income assistance.	Unknown.
Woodwork Effect May result in increased Medi-Cal caseloads because county welfare offices will have to screen people applying for low-income Medicare Part D assistance for some Medi-Cal low-income assistance programs.	Unknown, probably relatively small.

finalized, the CMS has not yet determined the amount of the state clawback payment. The deadline for the CMS to announce state clawback payments is October 15, 2005.

MMA Creates New Eligibility Administration Costs

New Federal Mandate. The MMA requires state Medicaid agencies and federal Social Security Administration offices to accept and evaluate the applications of Medicare beneficiaries seeking assistance under Medicare's Part D low-income assistance program. These agencies must also periodically recertify that the low-income beneficiaries are still eligible to receive the additional assistance from Medicare. In California, the responsibility for making Medicaid eligibility determinations has generally been delegated to county welfare offices, who receive state and federal funding under the Medi-Cal Program to carry out these duties. As a result, it appears all but certain that counties will incur at least some new administrative costs to carry out these new duties mandated under MMA. The Governor's budget plan does not propose any additional funding to the counties to reimburse them for this additional workload. At the time this analysis was prepared, the availability of federal funds to reimburse the counties for the additional workload was not clear.

The DHS has entered into discussions with federal authorities regarding how these costs might be minimized, such as by having the county welfare offices bundle together multiple Part D applications and forward them to Social Security Administration offices for eligibility determinations. However, at the time this analysis was prepared, no specific steps to reduce county costs had been announced.

These costs could be low if the public response to outreach efforts for the new Medicare Part D benefit is weak. If the public response is strong, however, the counties' new administrative duties under Medicare Part D could translate into cost pressures for the state.

"Woodwork Effect" Another Risk to State

The availability of low-income Part D drug subsidies could also indirectly increase state costs for the Medi-Cal Program in another way, often referred to as the woodwork effect. We noted earlier that state Medicaid programs are required to conduct eligibility determinations for certain Medicare cost-sharing programs under which Medicaid programs may pay an individual's Medicare costs. As county welfare offices perform eligibility determinations for Part D low-income assistance, they must also screen for eligibility for the Medicare cost-sharing programs. This could result in increased Medi-Cal caseload and costs for participants in these programs.

The exact effect on state Medi-Cal caseloads and expenditures is hard to predict and will depend largely on the effectiveness of the forthcoming federal campaign to encourage applications for Part D drug benefits. The additional costs will probably not be great compared to the current overall Medi-Cal Program enrollment—perhaps even as little as hundreds of new applicants on a statewide basis.

State's Leverage to Negotiate Rebates May Be Reduced

We noted earlier that DHS' budget proposal assumes that the rebates the state receives from drug manufacturers will decrease by about

$273 million in 2006-07 as a result of the implementation of the Part D benefit and dual eligibles receiving their drugs under Medicare instead of Medi-Cal. That $273 million decline in rebates represents only the partial-year effect of Part D implementation. We estimate that the full annualized loss of Medi-Cal rebate revenues could be more than $620 million in 2007-08.

In addition to the direct reduction in rebates, the implementation of Part D could reduce the state's bargaining power with drug manufacturers for drug rebates under the Medi-Cal Program. The anticipated decrease of more than 50 percent in the amount of drug purchases being made under the fee-for-service component of Medi-Cal as a result of dual eligibles shifting from Medi-Cal drug coverage to Medicare drug coverage could weaken DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions of dollars annually.

Drug Coverage for Some Dual Eligibles Might Be Disrupted

Shift in Drug Coverage Could Be Disruptive. As we have discussed, the PDPs and Medicare Advantage Plans who begin to deliver the Part D drug benefit will not be obligated to cover all available drugs. They will be permitted to adopt formularies that pick and choose the most cost-effective drugs, within federal constraints, so long as those formularies comply with CMS rules. Thus, it is possible—even likely—that some Medi-Cal dual eligibles who currently receive a relatively wide-ranging drug benefit may not be permitted by their Medicare provider to continue to receive the same medication they are now taking.

The extent of this potential problem cannot be predicted at the time of this analysis because the CMS has not selected its Medicare Part D providers and those providers have not yet adopted their formularies.

A change in copayment requirements could also potentially disrupt the drug coverage now provided to Medi-Cal dual eligibles. In theory, Medicaid beneficiaries are obligated to make copayments toward the cost of their prescription drugs (as well as for other types of medical services). Medi-Cal requires a copayment of 50 cents to $3 per prescription. However, under federal Medicaid law, pharmacies (as well as other types of medical providers) are not permitted to deny access to prescription drugs to beneficiaries who indicate that they are unable to make a copayment. We are advised that for these reasons, pharmacies frequently do not collect these copayments. However, we are not aware of any similar constraint on collecting copayments for the new Medicare drug benefit established by the MMA. We believe providers may deny a drug prescription to any beneficiary who does not make a copayment.

"Wrap-Around" Coverage Would Be Costly to Provide. As noted earlier, Medi-Cal provides a wide-ranging drug benefit. This drug coverage remains in place under state law and does not automatically change with the implementation of Medicare Part D. Thus, absent a change in current law, the state will provide what amounts to wrap-around coverage to dual eligibles beginning January 1, 2006. The result would be that beneficiaries could keep their same medications without disruption and without copayments. Our analysis indicates, however, that providing wrap-around coverage would probably prove to be costly to the state

in the short term and even more costly over time. As noted earlier, of the $3.3 billion total funds (net of rebates) the state currently spends on drugs, about 55 percent or about $1.8 billion is for dual eligibles.

Effective January 2006, the state loses almost all federal matching funds for drugs provided to dual eligibles under the Medi-Cal Program. As a result, almost any wrap-around coverage that the state provides for dual eligibles would be paid for entirely with state General Fund resources.

While the initial cost could be significant—potentially in the low hundreds of millions of dollars annually—these costs to the state could grow rapidly. To the extent that the private providers scaled back the coverage provided under the Part D drug benefit, such as by enforcing stricter formularies, more drug coverage and costs would almost automatically shift to the state's wrap-around coverage.

Over time, we believe these circumstances would take considerable pressure off of the federal government to provide a wide-ranging drug benefit to dual eligibles, since any dual eligible denied their preferred drug by a PDP or a Medicare Advantage Plan could receive it from a state wrap-around program—at no cost to the federal government.

Medicare Part D Could Result in Some Offsetting State Savings

While the clawback and other provisions of Medicare Part D could prove costly to the state over time, some aspects of the MMA could result in some partially offsetting reductions in state costs.

Drug Costs Embedded in Some State Program Budgets. Certain state agencies and groups of medical providers who provide services to Medicare beneficiaries have historically built the costs of drug coverage into their operations. For example, the cost of providing prescription drugs is embedded in the rates that the state now pays to certain Medi-Cal managed care providers, and in funding for developmental centers operated by the Department of Developmental Services (DDS) and state hospitals operated by the Department of Mental Health (DMH).

The implementation of Medicare Part D means that the drug costs in these programs will decrease as drug costs for Medicare patients shifts to the new Part D program. However, our analysis indicates that the budgets for these other programs have not been adjusted in the Governor's budget plan to reflect these potential savings. Their rates and funding levels could be adjusted to reflect this anticipated decrease in their drug costs.

We estimate that fully recognizing these adjustments for the startup of Medicare Part D drug coverage could collectively result in significant General Fund savings of about $100 million in 2005-06, and about $200 million annually by 2006-07.

Enrolling More in Medicare Might Reduce State Costs. While it is relatively easy to enroll aged persons in Medicare, federal eligibility rules make the enrollment of disabled persons, such as the mentally ill, a potentially lengthy and difficult process. For example, federal rules generally require that someone who qualifies as being disabled wait two years before they receive Medicare benefits. These potential barriers to Medicare enrollment mean it is likely that some state-supported programs that serve persons with disabilities, such as county mental

health systems, may not have taken all steps possible to enroll all eligible persons who need medications on a long-term basis into the Medicare Program.

Many such individuals have their medication costs—long-term costs that can be significant—covered under Medi-Cal. Our preliminary analysis indicates that it might be possible for the state to eventually reduce its Medi-Cal prescription drug costs by enrolling more such disabled persons in Medicare. The potential savings that could be achieved under this approach are unknown at this time.

New Medicare Benefits Could Reduce Other Program Costs. The MMA made a range of other changes in Medicare benefits, such as authorization for certain forms of preventative care. It is possible that some of these preventative medical services are now being paid for entirely under the Medi-Cal Program because they were not previously covered by Medicare. To the extent this is the case, it may be possible for the state to recognize Medi-Cal savings by shifting the cost for these services to Medicare. However, no such adjustments for coverage are now reflected in the Governor's budget plan for Medi-Cal.

ANALYST'S RECOMMENDATIONS

Tough Choices, Little State Control. The arrival of Medicare Part D drug coverage leaves the state in a difficult position. For the most part, the effects of the new federal law are beyond the control of California and any other state. Nevertheless, there may also be some limited actions and strategies the Legislature could adopt to help to partly offset the deficits that will probably result from the advent of Part D drug coverage. We discuss our recommended approach below.

Recognize Savings From MMA for Some Departments and Programs. We recommend that the budgets of DDS and DMH be adjusted to take into account the reduction in their drug costs that is likely to result from the implementation of Medicare Part D. The Department of Finance (DOF) should be directed to work in consultation with these departments to provide the Legislature at budget hearings with an estimate of these savings after the effects of recent federal regulations to implement Part D have been evaluated. The Legislature should then adjust the 2005-06 budgets of these departments accordingly to reduce General Fund expenditures. Similarly, we recommend that the rates paid by the state Medi-Cal Program to managed care providers be adjusted to reflect the shift of drug coverage costs for dual eligibles served by these programs to Medicare Part D. Such an adjustment could achieve General Fund savings of as much as $100 million in 2005-06.

Avoid Commitment to Wrap-Around Coverage. In order to avoid a significant potential cost to the state, we recommend that the Legislature adopt the statutory language that the administration has proposed to eliminate wrap-around coverage. Our analysis indicates that providing wrap-around coverage would probably result in additional state expenditures in the low hundreds of millions of dollars annually—costs likely to increase significantly in the future. It is also premature to consider providing any

form of wrap-around coverage for dual eligibles until the PDPs and Medicare Advantage Plans have been selected by the CMS and the specific formularies they will offer have been determined. If the state moves now to fill in any gaps in Medicare Part D coverage, it may unintentionally take the pressure off of CMS and its network of providers to provide wide-ranging drug coverage that will meet the needs of dual eligibles.

Seek Modifications in the MMA. Last year, the Legislature approved Senate Joint Resolution 25 (Ortiz) which urged the U.S. Congress and the President to modify the MMA in ways that would make the new federal law less burdensome to states. We recommend that the state continue to appeal to the federal government to make the Medicare Part D drug benefit for dual eligibles as comparable as possible to the drug benefit now available under Medicaid. For example, a modification of Medicare copayment rules to conform to Medicaid standards would ensure that dual eligibles who were unable to make copayments would not be denied their access to drugs. The state should also continue to make its case for modifications to the clawback calculations so that California's clawback payments will accurately reflect the drug rebates the state collected for 2003 and thereby avoid overpayments of about $91 million annually.

Examine How to Increase Enrollment in Medicare and Part D Coverage. In order to ensure a successful transition for dual eligibles from Medi-Cal drug benefits to Medicare Part D drug benefits, we recommend that the Legislature direct DHS to report at budget hearings on its outreach efforts to dual eligibles, whether federal funds are available to states to support such efforts, and what efforts are being made to obtain any available funds.

We also recommend that DMH be directed to assess and report to the Legislature at budget hearings regarding whether all disabled individuals in their community programs who have a significant long-term need for medications are being systematically enrolled in Medicare. If DMH were to determine that more of its clients could be enrolled in Medicare over time, the Legislature could then examine strategies to eventually shift them (after the required two-year waiting periods) from state-supported Medi-Cal drug coverage to the Medicare Part D program.

Defer Budget Adjustments for County Administration. At this time, we recommend against making any adjustments to the Medi-Cal budget for county eligibility administration. We recognize that counties could incur additional workload from the new federal mandate that they process applications for Part D assistance for low-income persons. In our view, however, it is the responsibility of the federal government to either provide financial assistance to counties to handle these tasks, or to permit counties, as DHS has suggested, to shift most of this workload to Social Security Administration offices. In any event, it is unclear at this time whether any significant increase in workload will be experienced at county welfare offices.

Defer Budget Adjustment for Medi-Cal Caseload. At this time, we recommend against making any caseload adjustments to account for the woodwork effect. We recognize that there is the potential for increased caseload in the Medicare cost-sharing program. However, we do not believe that any increase in caseload that

may occur would be significant and any necessary adjustment could be made at a later time.

Adjust Medi-Cal Costs for New Medicare Benefits. Finally, DOF and DHS should examine whether the inclusion of preventative benefits for Medicare services authorized in the MMA would have the effect of reducing any present costs to the Medi-Cal Program of providing these same services. They should be required to report their findings at budget hearings, and the Legislature should reduce the Medi-Cal budget accordingly to reflect the shift of any such costs to the Medicare Program.