Challenges of Serving Low-income Medicare Beneficiaries Impact of Cost Sharing

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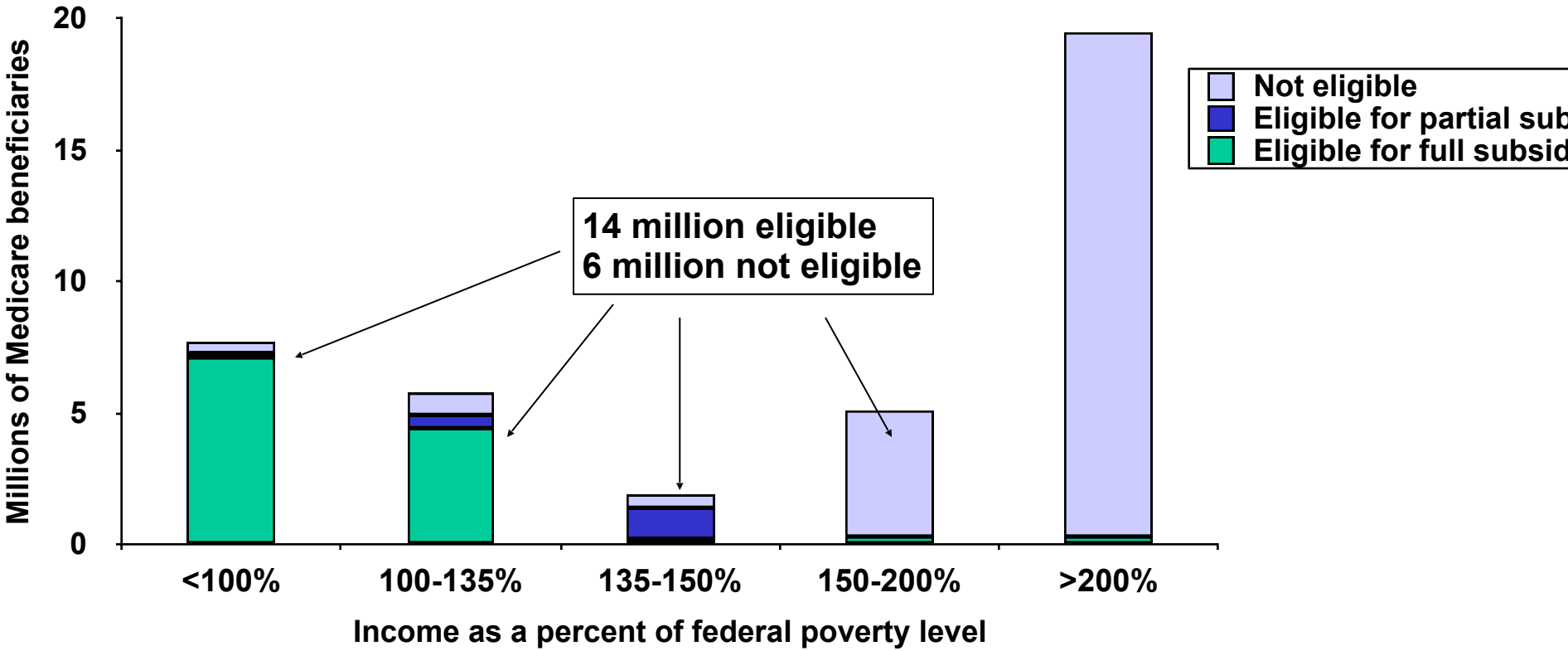
Medicare Part D Low-income Subsidies Provide Considerable Assistance

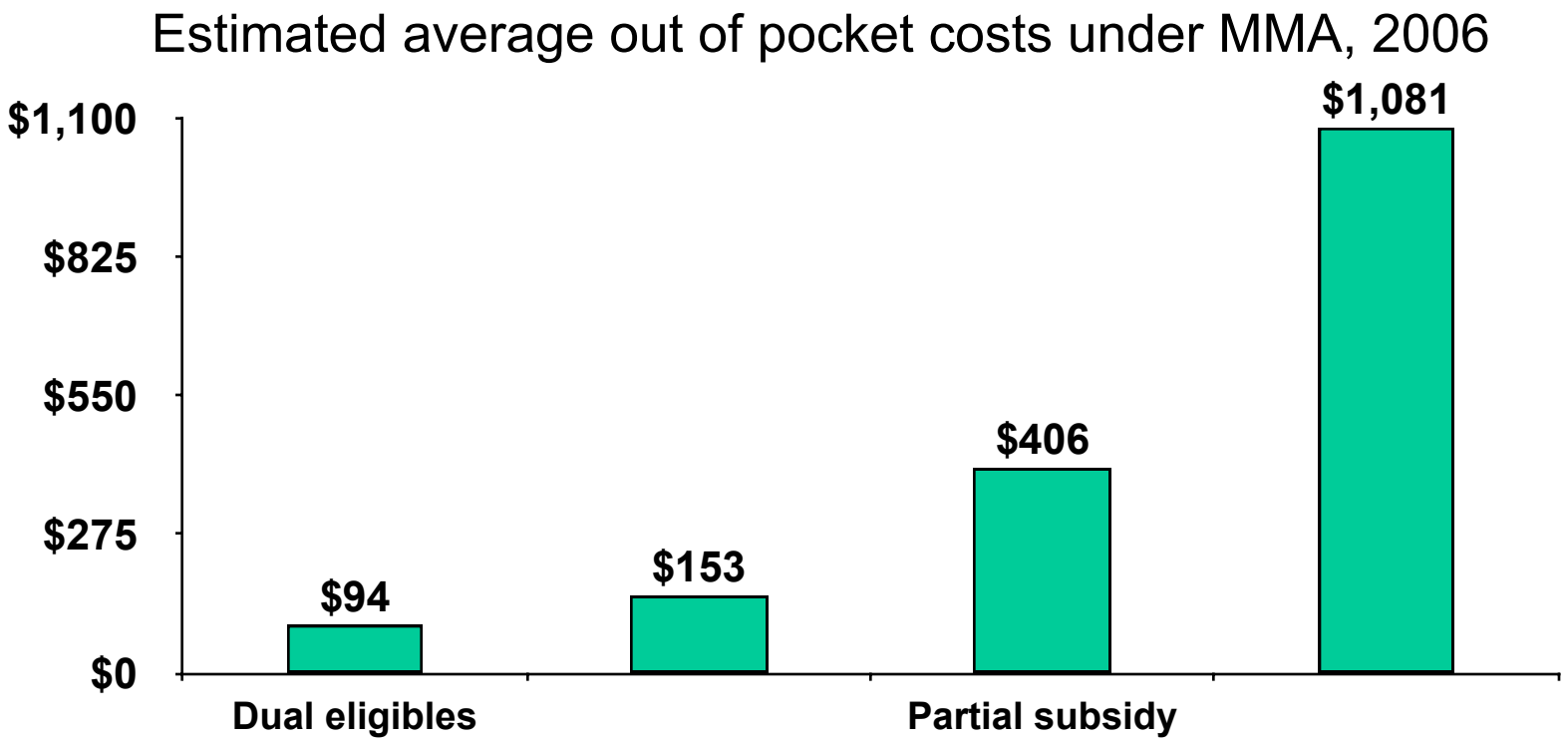
Income and Asset Eligibility Requirements	Benefit
Medicare Full Dual Eligibles	No premiums or coinsurance Copays $1/$3 <100% FPL Copays $2/$5 >100% FPL
Income up to 135% FPL Assets <$6,000 single /$9,000 couple	No premiums or coinsurance Copays $2, $5 up to limit
Income 135-150% FPL Assets <$10,000single/ $20,000 couple	Premium sliding scale Deductible $50 Cost sharing 15% to catastrophic, $2/$5 after limit
Standard benefit	Premium, deductible, cost sharing, and gap until limit

Part D Low-income Subsidies Are A Valuable but Limited Safety Net



Source: U.S. Congressional Budget Office, July 2004

Why the Low-income Subsidy is Critical



Source: Actuarial Research Corporation and Kaiser Family Foundation, November 2004

MMA and Low-income Beneficiaries: Medicare/Medicaid Dual Eligibles

6.3 Million dual eligibles move from state Medicaid programs to private drug plans:

- Autoenrollment approved
- Use of formularies
- Copayments for dispensing
- Appeals process differs
- Changes in disease management – issues with coordination

MMA and Low-Income Beneficiaries: Non- Dual Eligibles

- **Additional 3-5 million non/Medicaid low-income beneficiaries may receive subsidies**
  - **Must enroll**
- **Other low-income beneficiaries will not receive subsidies**
- **1.5 million now have pharmacy coverage through state pharmacy assistance programs (SPAPs) but most will <u>not</u> be eligible for subsidy**
  - **Eligibility averages 222% FPL (most states above 150% FPL)**
  - **SPAP asset test uncommon**
  - **Most SPAP benefits more generous than MMA**

Source: Rutgers CSHP, 2004

States are Considering Options to Supplement Part D Coverage

- SPAP wraparound coverage will count toward true out of pocket costs (TrOOP) toward catastrophic
- States may cover
  - Premiums, deductibles, copays or gaps
  - Non-formulary/ out of network meds
- States may also contract out to prescription drug plans for wrap around coverage
  - May co-brand and market with preferred plans
- States may choose not to provide supplemental coverage

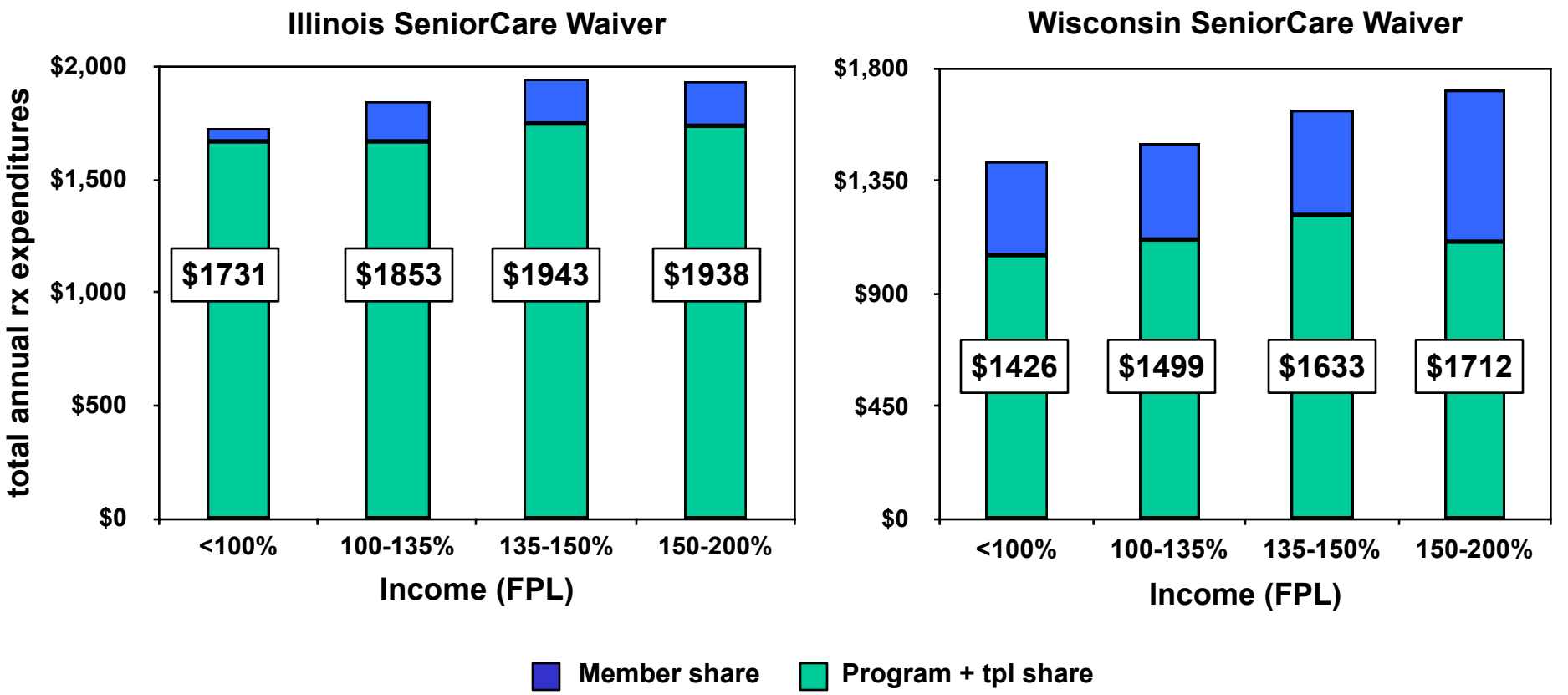
Estimating the Impact of Prescription Cost Sharing for Low-income Seniors

- **Brandeis/JEN Evaluation of the Impact of Pharmacy Plus Waivers in Illinois and Wisconsin (CMS 500-00-0031/TO2)**
- **Analysis of cost sharing and plan design strategies in two waiver states (RWJ HCFO 050507)**
- **Looks specifically at non-Medicaid, age 65+, incomes up to 200% FPL**
- **Impact of insurance plan design on Medicare beneficiaries – enrollment and spending**

What is the Effect of Filling in Gaps in Coverage for Low-income Seniors?

- **We measure the impact of small (and large) differences in cost sharing**
  - **None vs. $1/$4 vs. $5/$15**
  - **First dollar vs. $500 deductible**
  - **“Soft cap” versus no benefit cap**
- **We assess the importance of the low-income subsidy, and design and cost of wrap around coverage**

Prescription Drug Costs for Enrolled Populations Differ with Benefit Design and Income



Note: Members enrolled full 12 months, program year 1, 2002-2003, before rebates.

Low Income Enrollees Show Strong Response to Cost Sharing

Average expenditures and use for *matched sample* across states*

	Illinois $1/$4 copayments, first dollar			Wisconsin $5/$15 copayments/deductible		
FPL	Mean Rxs	Mean Rx Expenditures	Percent Generic	Mean Rxs	Mean Rx Expenditures	Percent Generic
<100%	45.4	$1828	49.5%	39.2	$1416	52.2%
100 – 135%	46.6	$1877	48.1%	44.3	$1631	53.6%
135 – 150%	47.2	$1972	48.4%	45.7	$1720	52.1%
150 – 200%	47.1	$2005	46.7%	47.1	$1832	50.2%

*Illinois enrollee sample and Wisconsin controls 2002-2003, matched for age, gender, race, income urban/rural, medical diagnoses and prior year Medicare Part A and B utilization

Deductibles Limit the Number of Medications Purchased

- Lower use of prescriptions prior to meeting the deductible
- 23 percent fewer purchases during deductible period, compared to 7 percent for members of same program but not subject to deductible
- After deductible is met, greater use of medications, also related to income
- Indicates low income beneficiaries may not be able to pay full costs during the deductible (or in coverage gaps)

More Generous Benefits Draw a Healthier Low-income Population

	Odds Ratios Enrollee Disease Prevalence Compared to Non-enrollees		
	Illinois SC (more generous) (<200% FPL)	Wisconsin SC (less generous) (<200% FPL)	Wisconsin SC with Deductible (even less generous) (160-200% FPL)
Heart Disease*	1.43	1.52	1.61
CHF*	1.86	2.04	1.99
Stroke*	1.36	1.40	1.50
COPD	1.54	1.54	1.61

* Significant difference across programs
Source: JEN Associates analysis of SeniorCare program enrollees and Medicare Parts A and B 2002 claims

Implications for MMA

- The low income subsidy will be a critical factor for beneficiaries
- 1/3 with incomes below 200% FPL not eligible for Part D subsidy
- Even small differences in cost sharing affects this group
- Different response to deductibles and cost sharing than in higher income populations
- Additional access issues for the very poor (<100% FPL)
- More generous benefits encourage more widespread enrollment
- States supplemental benefits will be important to ensure access