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PRESCRIPTION DRUG INSURANCE PROGRAM

A Report to the Legislature

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EXECUTIVE SUMMARY

When individuals first enroll in Medicare, they can purchase a Medicare supplement policy to cover gaps in Medicare. These gaps include deductibles, co-insurance amounts and benefits Medicare doesn't provide, such as prescription drugs or long-term nursing care..

Medicare Supplement policies offer a wide variety of benefits, from basic to very comprehensive coverage.

If an individual purchases basic coverage or no coverage in the beginning, and later requires more comprehensive coverage or coverage for prescription drugs, problems can develop. With a poorer state of health, this individual may be denied these extras or may find the additional coverages unaffordable.

The Commissioner of Commerce is to study the feasibility of providing an insurance program administered by the Minnesota Comprehensive Health Association (MCHA) to provide prescription drugs to Minnesotans who are age 65 or older. This will be based on an independent actuarial analysis.

It is suggested that this study not be implemented for the following reasons:

1. It is estimated that if this program was developed, the costs would be unaffordable to most individuals;

2. A drug program will be available in 1999 through the Department of Human Services;
3. Medicare's benefits, along with Medicare supplement coverages will change beginning in 1999.
4. The availability of guaranteed issue and affordable drug riders is being studied.

This program was not funded for the actuarial study, but it is estimated that the cost of this program, would be unaffordable to most of its members.

The 1997 MinnesotaCare Legislation authorizes the Commissioner of Human Service to administer a drug rebate program for drugs purchased under a senior citizen drug program. The Commissioner is to establish and administer the senior citizen drug program by January 1, 1999, for qualified seniors who are eligible as qualified Medicare beneficiaries and not enrolled in other prescription drug coverage. Coverage is limited to prescription drugs covered under the Medical Assistance Program, subject to a deductible and a premium payment by the enrollee.

The Balanced Budget Act of 1997 creates a new section of Medicare law, Medicare "Part C" called Medicare+Choice. The purpose of Medicare+Choice is to create a new category of Medicare Managed Care plans and additional Medicare benefits, that will offer a wide range of options beyond the current HMO and traditional fee for-service system, while maintaining cost controls and quality of care. Currently the Health Care Finance Administration (HCFA) is

establishing regulations standards for these organizations, including benefit requirements, treatment of providers and coverage determinations.

The Minnesota Comprehensive Health Association (MCHA) is studying the possibility of offering prescription drug riders with their basic Medicare supplement policy. This will provide Minnesota residents the opportunity to purchase an affordable Medical supplement policy, which includes drug benefits at the time they enroll in Medicare or at a later date. Additionally, the extended basic Medicare supplement can be purchased through the MCHA, which covers between 80 to 100 percent of prescription drugs.

THE STUDY

Within the 1997 MinnesotaCare bill (Senate File 1208, Chapter 225, Article 2, Section 60) the Commissioner of Commerce is to study the feasibility of providing an insurance program to provide prescription drugs to Minnesotans who are 65 and older. The program shall be administered by the Minnesota Comprehensive Health Association, but shall be separate from the health coverage program operated by the Association under Minnesota statutes, Chapter 62E. In studying the feasibility of the program, the Commissioner shall incorporate to the extent feasible, the administrative procedures and health care delivery methods used by the association under Minnesota Statutes, Chapter 62E. The Commissioner shall study the program based on independent actuarial analyst and shall present the recommendations to the legislatures.

ACTUARIAL ANALYSIS

An independent actuarial study would have been required to determine if it would be feasible that the Minnesota Comprehensive Health Association (MCHA) provide a senior drug program. It was determined that the study would show that it would not be practical to develop this program.

Only those individuals in need of drug coverage would apply. This would cause the premiums to be quite high, and unaffordable to most Minnesotans. Additionally, by adding the administrative costs to the drug expenses, this program's costs could exceed over the counter drug costs.

MINNESOTA DEPARTMENT OF HUMAN SERVICE'S DRUG PROGRAM

The Commissioner of Human Service is to administer a drug rebate program for drugs purchased under the senior citizen drug program and requires a rebate from all manufacturers of covered drugs purchased through the Medical Assistance Program.

The Commissioner of Human Services is to establish and administer a senior drug program by January 1, 1999. To be eligible, qualified seniors must be Medicare beneficiaries and not enrolled in another prescription drug coverage. Coverage is limited to prescription drugs covered under the Medical Assistance Program. However, drugs cleared by the Federal Drug Administration (FDA) shall be available when prescribed for a medically accepted indication. Enrollees are required to pay an annual premium of $120 and be subject to an annual deductible of $300.

Applications and information on the program is to be available at county social service agencies, healthcare provider offices and agencies and organizations serving senior citizens. The program requires county social agencies to determine Medical Assistance (MA) spend-down eligibility for individuals who qualify for the senior drug program. This determination of eligibility is to be made within 30 days from the date the application is received.

The Commissioner is required to report annually to the legislature on this program. The Commissioner can repeal the program if federal approval of a waiver to allow the Commissioner to provide prescription drug coverage for qualified Medicare beneficiaries whose income is less

than 150 percent of the poverty guidelines is received. The program requires the Commissioner to administer this senior drug program so that the cost to the state totals no more than four million dollars plus the amount of the rebate.

This program also requires the Commissioner to study and make recommendations on the implications to the senior citizen drug program if a health plan within the state offers a product that provides a prescription drug benefit as part of its standard coverage for Medicare enrollees. See information on possible drug riders to be offered by MCHA.

This drug program could provide assistance for uninsured persons and low-income seniors who lack access to prescription drugs coverage. It has been estimated that half of all seniors pay for prescription drugs on their own. Additionally, while persons over age 65 account for only 12.5 percent of the population in Minnesota, they purchase more than 25 percent of prescription drugs in this state. This hardship and burden is one that is very difficult for many low-income seniors to carry.

It has been reported that some seniors will not purchase drugs, or if they do, stretch out their dosage over a longer period of time than prescribed, thus jeopardizing the benefit of the drugs. Also, some seniors will forego general household expenses (adequate heat, proper clothing, general maintenance, reliable transportation, etc.) to be able purchase needed prescription drugs.

MEDICARE AND MANAGED CARE

Managed care encompasses a wide variety of arrangements, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Typically, managed care plans control costs by restricting enrollees choice of providers or by giving enrollees strong financial incentives to choose particular providers, usually through a lower premium health plan. Costs are usually reduced by managing enrollee's services. This can be an accomplished by reducing unnecessary hospitalization, tests, specialty referrals, or through programs that review the use of services.

Like traditional insurers, HMOs accept financial responsibility for a defined set of healthcare benefits in return for a fixed monthly per capita premium paid by or on behalf of each enrollee member. Unlike other insurers, the HMO directly provides or arranges for service through affiliated physicians, hospitals and other network providers, instead of simply paying medical bills.

The intent of the federal government in establishing HMO type Medicare supplement programs was to enable individuals to enroll in managed care organizations as an alternative to the traditional fee-for-service Medicare, and also to capture the efficiencies of HMOs and thus save Medicare money. In a HMO risk type of program, the HMO is paid a predetermined monthly amount (called the adjusted average per capital cost or AAPCC) for each Medicare enrollee regardless of the amount of Medicare covered service the enrollee uses. The HMO is at risk for providing any necessary service to an enrollee which may exceed their Medicare payment.

States like Minnesota, which are efficient and cost competitive, are paid dramatically less for their Medicare beneficiary than less efficient states. Because Medicare rules prohibit any rebate of premium back to the beneficiary, the high capitation rates in states such as Florida and California are used to increase benefits (prescription drug coverage), reduce or eliminate co-payments, or to lower premiums for non Medicare coverage services. For example, Medicare risk plans in 1995, in Hennepin County, received $363 per month per enrollee while in Florida , each beneficiary received $616 per beneficiary.

If Minnesota's predetermined monthly amount (AAPCC) could be increased, other needed coverages could be made available to the policyholder.

BALANCED BUDGET ACT OF 1997

The Balanced Budget Act of 1997 (BBA 97) includes provisions to increase the private plan options available to individuals or beneficiaries who are eligible for Medicare. BBA 97 creates a new section of Medicare Law, Medicare Part C, that will, in-addition to Medicare Parts A and B, offer healthcare security to America's senior citizens and disabled. The purpose of Medicare Part C is to implement a new program, Medicare+Choice. It will offer a wide range of options beyond Medicare managed care products and an additional fee-for-service system, while maintaining cost controls and quality of care.

The Act establishes a process through which elections of Medicare+Choice plans can be made and changed. It describes the benefits that have to be provided in Medicare Parts A and B, and any additional health services that will be offered or required by the Secretary of Health and Human Services. A new rate methodology will be developed that reflects the actual cost of delivering healthcare services in each particular geographic area..

Individuals entitled to Medicare Part A and enrolled under Part B would be able to elect to receive benefits through the existing Medicare fee-for-service program a Medicare risk HMO plan, or a Medicare+Choice plan. Medicare+Choice options would include:

1. Coordinated care plans including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and similar arrangements;

2. Plans offered by Provider-Sponsored Organizations (PSOs);
3. Medical Savings Accounts (MSA); and
4. Private fee-for-service plans.

Besides the current HMO and PPO arrangements, new additional choices would include PSOs, MSAs and private fee-for-service plans.

A PSO is defined as a public or private entity established by health care providers, which provide a substantial portion of health care items and services directly through affiliated providers who share directly or indirectly substantial financial risks. Because PSOs are direct service providers, their administrative and overhead costs could be less than an HMO's, freeing more funds to be spent on patient care.

Under a Medical Savings Account (MSA), seniors will be able to meet their health-coverage needs through a combination of a government-funded high-deductible insurance policy to cover big-ticket costs and a tax-free saving account to cover routine expenses. Seniors would also be able to use the saving-account money for a broader range of medical expenses than covered by Medicare, such as prescription drugs or long-term care.

Private fee-for-service plans will cover the same Medicare medical services as Medicare's fee-for-service program, but will be able to pay doctors much higher rates (115 percent of Medicare's fee schedule).

The US Department of Health and Human Services (HHS) is to establish by April 1, 1998, the solvency requirements for the PSOs, and on June 1, 1998, the regulation standards for Medicare+Choice Organizations, including benefit requirements, treatment of providers and coverage determinations.

Information will be provided to promote an informed selection among these options, beginning in November of 1998. Beginning in November of 1999, there will be an annual coordinated election period, during which individuals will be able to change to a different plan for the following calendar year.

Each Medicare+Choice plan must offer the full range of Medicare primary, acute and skilled nursing services and may offer additional benefits, including vision, hearing and pharmacy services.

As previously discussed, Medicare does not pay for most out-patient prescription drugs. However it does pay for certain drugs used in connection with home infusion or inhalation equipment, drugs prescribed for a dialysis or transplant patient, and certain oral cancer drugs. The Balanced Budget Act will increase payments for these items, pay a dispensing fee to pharmacies and authorize coverage anti-nausea cancer drugs.

The act also requires new prevention incentives which include annual mammograms, pap smears and pelvic exams, prostate cancer screening tests, colorectal screenings, diabetic out-patient self-management training services and additional coverage for blood glucose monitors and testing strips, bone mass measurements, and requires a study of the potential expansion or modification of prevention and other services covered under Medicare.

A new methodology for determining payment to Medicare+Choice plans will be developed, replacing the AAPCC method. Payments will be made in advance for each covered individual and will be based on such risk factors as age, disability status, gender, institutional status and other factors that are determined to be appropriate to insure actuarial equivalence. These Medicare+Choice plans must provide additional benefits if they have an excess amount of premiums.

There will be savings in health care costs with the pending changes of benefits and coverages under the BBA. These changes include the revisions to the compensation formulas that will be more fair to Minnesota plans, new additional drug coverages and prevention services, and new mandated benefit requirements.

It is quite possible that the savings generated from these changes could be passed on to the beneficiary enrollee in the form of additional benefits provided by the Minnesota health carriers.

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

The Minnesota Comprehensive Health Association (MCHA) was established in 1976 to provide affordable health insurance to eligible Minnesota residents. Minnesotans turn to MCHA to provide coverage when they are unable to obtain it in the private market for reasons that include: they have exhausted their COBRA benefits, dependent coverage is not offered through their employer, changes have occurred in self-insured employer or union plans, employees are seeking coverage while fulfilling a 12 to 18 month probationary employment, or when an employer becomes bankrupt. MCHA currently has over 26,000 enrollees and provides benefits that are very comprehensive with rates that are affordable.

MCHA offers two Medicare supplement policies, extended basic and basic. The extended basic covers all Part A and B Medicare deductibles and co-insurance amounts, and 80 percent of prescription drugs and other Medical expenses not covered by Medicare. The basic plan has limited coverage covering the Medicare Part A and B co-payments, but no coverage for Part A and B deductibles or prescription drugs. Additional riders can be purchased to cover the Part A and Part B deductibles, but not for prescription drugs.

MCHA is currently studying the possibility of offering prescription drug riders under the basic Medicare supplement plan. One rider would cover 50 percent of prescription drug costs during the year, while the other would do the same but have a $1,200 maximum benefit for prescription drug.

Currently in Minnesota, when individual turns age 65 or enrolls in Part B of Medicare, they can purchase any Medicare supplement product available, without underwriting or pre-existing conditions provisions applying to them. However, once this six month period is up, they can be subject to underwriting requirements. If an individual initially does not purchase a policy with prescription drugs, later develops a need for this benefit, he/she can purchase the extended basic Medicare supplement plan through MCHA. However, for some this can prove to be unaffordable. By having MCHA also offer the basic prescription drug riders, Minnesota's residents will be able to purchase affordable drug coverage along with their MCHA Medicare supplement policy.

SUMMARY

For a number of Minnesota residents covered by Medicare, coverage for prescription drugs is a needed health benefit. However, for some, appropriate or affordable drug coverage has been unattainable.

Beginning in late 1998 and early 1999, additional programs in Minnesota and new Medicare coverages will produce positive results for seniors in need of prescription drug coverage.

The Department of Human Services' Senior Drug program will start in 1999. With changes to Medicare and Medicare Supplement products, affordable drug coverages should be available. Thus, having the Minnesota Comprehensive Health Association develop a senior drug program would be duplicative and not feasible at this time.

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Section 60. - PRESCRIPTION DRUG INSURANCE PROGRAM

The commissioner of commerce shall study the feasibility of providing an insurance program to provide prescription drugs to Minnesotans who are 65 and older. The program shall be administered by the Minnesota Comprehensive Health Association, but shall be separate from the health coverage programs operated by the association under Minnesota statutes, chapter 62E. In studying the feasibility of the program, the commissioner shall incorporate, to the extent feasible, the administrative procedures and health care delivery methods used by the association under Minnesota Statutes, chapter 62E. The commissioner shall study the program based upon independent actuarial analysis, and shall present recommendations to the legislature by December 15, 1997.

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