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Budget Primer

Department of Aging

Senior's Pharmaceutical Assistance Programs

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The Department of Aging administers three low-cost prescription drug programs for Pennsylvania seniors:

- The Pharmaceutical Assistance Contract for the Elderly (PACE), enacted in November 1983 and implemented July 1, 1984, helps low-income seniors pay for their prescription medications.
- Act 134 of 1996 established the PACE Needs Enhancement Tier (PACENET) program to create a new tier of pharmacy benefits for qualified seniors who have incomes exceeding PACE's eligibility limits.
- Act 111 of 2006 established PACE Plus Medicare, a voluntary program for PACE and PACENET cardholders that coordinates PACE/PACENET pharmacy benefits with the federal Medicare Part D drug benefit.

This primer is an overview of Aging's pharmaceutical assistance programs, including descriptions of the eligibility criteria, benefits, program funding, enrollment history and expenditure trends. Detailed information on the Medicare Part D drug benefit can be found in the included appendix.

PACE and PACENET

Pharmaceutical assistance is available to seniors who are 65 years of age or older and do not receive prescription drug benefits through Medical Assistance (the name of Pennsylvania's Medicaid program). Seniors must be Pennsylvania residents at least 90 days prior to applying for assistance and must meet income eligibility requirements.

PACE is the traditional program for seniors whose annual income is $14,500 or less for a single person and $17,700 or less for a married couple. PACE cardholders pay no monthly fees or premiums, but must cover co-payments, which are $6 for generic drugs and $9 for brand-name drugs.

PACENET assists single seniors whose annual income is between $14,500 and $27,500 and married couples with incomes between $17,700 and $35,500. Seniors in PACENET pay a monthly premium equal to the Medicare Part D benchmark premium ($37.03 for 2019). In addition, PACENET cardholders pay higher co-payments for prescriptions: $8 for generic drugs and $15 for brand-name drugs.

Table 1. Income Eligibility and Costs

	PACE	PACENET
Income Eligibility:		
Single Individual	$14,500 or less	$14,500 to $27,500
Married Couple	$17,700 or less	$17,700 to $35,500
Monthly Premium (2019)	$0	$37.03
Co-Payments:		
Generic Drugs	$6 per Rx	$8 per Rx
Brand-Name Drugs	$9 per Rx	$15 per Rx

Both programs cover most medications requiring prescriptions, as well as insulin, syringes and insulin needles. Experimental medications and over-the-counter drugs are not covered by either program.

Eligibility for PACE and PACENET is determined by the applicant's previous calendar year's income. The income eligibility limits for each program are specified in the State Lottery Law. There is no automatic inflator or annual adjustment. The General Assembly has increased PACE eligibility four times since its inception and has increased PACENET eligibility three times. The current limits for PACE are in Act 37 of 2003, while the current PACENET limits are in Act 87 of 2018.

Table 2. Legislation Impacting Income Eligibility Limits		
Act #	**PACE**	**PACENET**
Act 63 - 1983 (established PACE)	$9,000 (single) $12,000 (couple)	
Act 202 -1984	$12,000 (single) $15,000 (couple)	
Act 36 - 1991	$13,000 (single) $16,200 (couple)	
Act 134 - 1996 (established PACENET)	$14,000 (single) $17,200 (couple)	$14,000 to $16,000 (single) $17,200 to $19,200 (couple)
Act 77 - 2001		$14,000 to $17,000 (single) $17,200 to $20,200 (couple)
Act 37 - 2003	$14,500 (single) $17,700 (couple)	$14,500 to $23,500 (single) $17,700 to $31,500 (couple)
Act 87 - 2018		$14,500 to $27,500 (single) $17,700 to $35,500 (couple)

In 2014, the General Assembly passed legislation (Act 12) to exclude annual Medicare Part B premiums from income when determining eligibility for PACE and PACENET. This change had the same effect as raising the income limits by that premium amount. For 2019, the excluded amount for most Medicare beneficiaries is $1,258.80 per individual and $2,517.60 for married couples.

Over the past 18 years, the General Assembly has enacted temporary moratoriums so seniors could maintain PACE and PACENET eligibility when their income exceeded the statutory limit solely due to a Social Security cost-of-living increase. These moratoriums have allowed tens of thousands of seniors to retain pharmaceutical assistance when annual Social Security cost-of-living increases would have otherwise disqualified them. The current moratorium, established by Act 62 of 2017, expires Dec. 31, 2019.

PACE Plus Medicare

The PACE Plus Medicare program supplements PACE/PACENET coverage with the Medicare Part D drug benefit. Each year, the department partners with select Part D plans authorized to provide Medicare drug coverage in Pennsylvania. PACE and PACENET cardholders are encouraged to enroll in the Part D plans the department has recommended for them, based on their prescription medications and pharmacy preferences.

Enrollment in the PACE Plus Medicare is voluntary. Cardholders who do not enroll in Part D plans continue to receive prescription benefits through the PACE and PACENET programs.

PACE Plus is designed to allow PACE and PACENET cardholders to keep their same prescription benefits (often at a lower cost) even though they are enrolled in Part D drug plans. When Medicare Part D does not provide a PACE/PACENET benefit, PACE Plus supplements the plan's coverage and fills the gap. Key elements of PACE Plus are summarized below.

Drugs. If a Part D plan's formulary (or drug list) does not include a PACE/PACNET medication, the PACE Plus program will either pay for that drug or work directly with the plan to process a prior authorization so that the drug is covered by the plan. Also, PACE Plus pays for drugs that cardholders purchase during the Part D deductible phase and in the "doughnut hole."

Co-Payments. PACE and PACENET cardholders enrolled in PACE Plus pay the lower of the PACE/PACENET co-payments and the Part D plan co-payments. If the Part D plan charges higher co-payments, the program pays the difference between the Part D co-payments and the PACE/PACENET co-payments.

Premiums. Part D monthly premiums depend upon whether the enrollee is a PACE cardholder or a PACENET cardholder.

PACE Plus pays the monthly premium if a PACE cardholder enrolls in a partner plan (the maximum amount paid by the program is the Part D regional benchmark premium: $37.03 for 2019). If a PACE cardholder selects a partner plan with a premium above the benchmark, the cardholder pays the difference. PACE cardholders who enroll in a non-partner plan must pay the plan's full monthly premium.

PACENET cardholders enrolled in a partner plan pay the plan's premium at the pharmacy when they have a prescription filled and never pay more than the cost of the medication. If the cost of the medication is less than the premium, the cardholder only pays the medication cost and the remaining amount of the premium owed is carried over until the next time another medication is filled. PACENET cardholders who do not enroll in a partner plan must pay the full premium directly to the plan each month, regardless of whether they had any prescriptions filled.

Low-Income Subsidy. The Department of Aging helps qualified seniors sign up for the federal Part D Low-Income Subsidy, allowing them to take advantage of drug co-payments that are significantly lower than those required by PACE and PACENET. Seniors must have annual income less than 150 percent of the federal poverty level and must meet an asset test to qualify for the subsidy.

- For 2019, the co-payments for PACE Plus cardholders qualifying for the Medicare Part D Low-Income Subsidy are $3.40 for generic drugs and $8.50 for brand-name drugs.

In addition to benefitting seniors, the federal Low-Income Subsidy yields significant savings for the PACE Plus program because the federal government (rather than PACE Plus) pays the Part D monthly premiums for qualified seniors as well as their annual deductibles and the cost of drugs purchases during the "doughnut hole." The amount paid by the federal government varies, depending upon the income and assets of the individual or married couple.

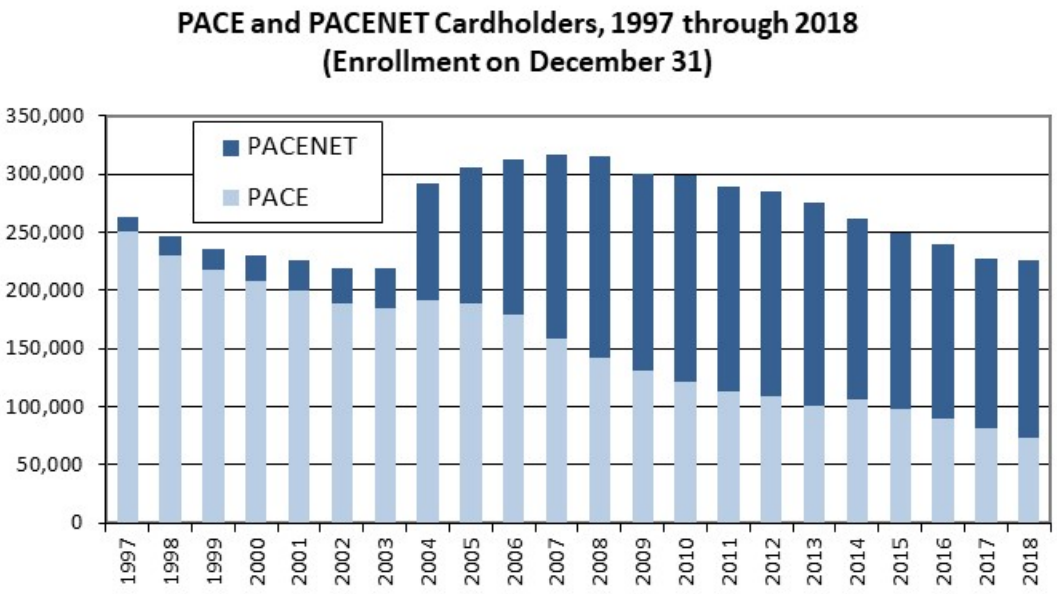
Enrollment Trends

Nearly 263,000 seniors benefited from the department's pharmaceutical assistance programs during 2018. This total included 89,885 PACE cardholders and 172,780 PACENET cardholders.

- 88.5 percent of all cardholders were enrolled in a Part D plan under PACE Plus Medicare.
- More than 72,000 PACE Plus enrollees qualified for the federal low-income subsidy.

The number of PACE and PACENET cardholders depends upon several factors, including: statutory changes that expand income eligibility requirements, changes in household income that push seniors above the income limits, and the other prescription drug coverage choices available to seniors (such as retirement benefits or Medical Assistance).

The bar graph below shows PACE and PACENET enrollment, as of Dec. 31, for calendar years 1997 through 2018. After six years of steady declines, overall enrollment increased significantly in 2004 after Act 37 of 2003 expanded income eligibility for both programs. After peaking in 2008, overall enrollments resumed their decline in 2009. Act 87of 2018 boosted PACENET enrollments during the final quarter of 2018 so overall enrollments ended the year basically unchanged.



SOURCE: PA Department of Aging, PACE Annual Reports, Table 4.1 (PACE and PACENET Cardholder Enrollments by Quarter)

Program Funding

The Pharmaceutical Assistance Fund is the state revenue source for the three prescription drug programs. It is comprised primarily of revenue annually transferred from the Lottery Fund.

The amount of the annual Lottery Fund transfer to the Pharmaceutical Assistance Fund is based on estimated state expenditures for the three programs. PACE and PACENET are paid entirely with state revenue, whereas federal Medicare funds are the predominant funding source for PACE Plus.

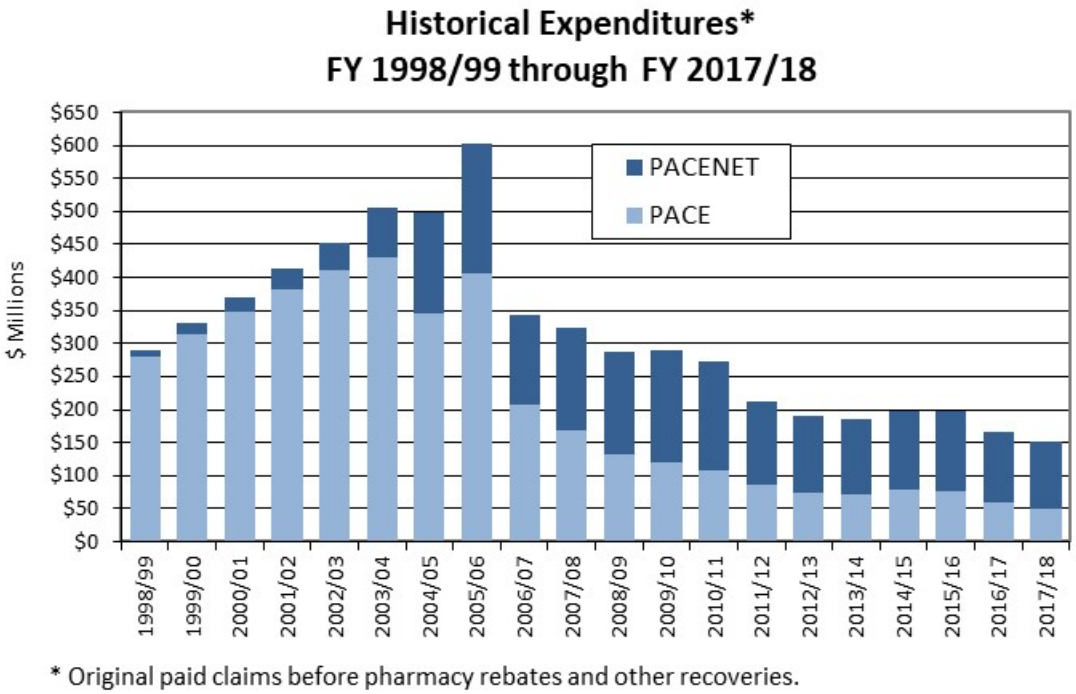
State expenditures in PACE Plus are only incurred to pay for the "wrap around" coverage provided to seniors enrolled in the program (the monthly premiums for PACE cardholders, differences in co-payments, PACE/PACENET drugs not covered by Part D plans, and the cost of drugs purchased during the deductible phase and while individuals are in the Part D "doughnut hole").

Because the federal government subsidizes most of the Medicare Part D drug benefit (roughly 75 percent for the overall population), enrolling seniors in PACE Plus substantially reduces state pharmaceutical assistance expenditures and frees Lottery Funds for other senior programs.

The more PACE and PACENET cardholders who are enrolled in PACE Plus, the more state costs can be shifted to Medicare; this is especially so for each PACE Plus enrollee who qualifies for the federal low-income subsidy that helps pay premiums, deductibles, and other "wrap around" costs that PACE Plus would otherwise have to cover.

To incentivize more cardholders to enroll in PACE Plus, Act 87 of 2018 allows the department to pay the Medicare late enrollment penalty for seniors who missed the federal deadline to sign up for Part D. For any senior who signs up late for Part D and qualifies for the federal low- income subsidy, Medicare will pay the penalty rather than PACE Plus.

The bar graph below shows historical state spending for pharmaceutical assistance provided to PACE and PACENET cardholders from 1998/99 through 2017/18 (the most recent fiscal year for data).



Source: PA Department of Aging, PACE Annual Report, Tables 2.1A and 2.1B (PACE and PACENET Claims and Expenditures by Semi-Annual Period Based on Date of Service)

The dramatic decrease in state expenditures after 2005/06 reflects the implementation of the PACE Plus program in September 2006 and the availability of federal Medicare funds to pay the prescription drug benefit for PACE Plus enrollees. The decrease beginning in 2011/12 includes savings from Medicare provisions in the Affordable Care Act that closed the Part D doughnut hole, reducing the "wrap around" cost that PACE Plus must pay for drugs purchased by enrollees in the doughnut hole.

APPENDIX A. The Medicare Part D Drug Benefit

Medicare Part D is a voluntary prescription drug benefit for people with Medicare, the federal health insurance program for seniors age 65 or older and non-elderly people with a permanent disability. It was created by the Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and began operating Jan. 1, 2006.

Individuals who enroll in Medicare Part D pay a monthly premium and any deductibles, copayments or coinsurance for their prescription drugs. Medicare provides a subsidy for eligible low-income enrollees to help pay their premiums and cost-sharing charges.

Medicare Prescription Drug Plans

The Part D drug benefit is offered through private plans approved by the Centers for Medicare & Medicaid Services (CMS). These include stand-alone prescription drug plans (PDPs), which only offer prescription drug coverage, and Medicare Advantage prescription drug plans (such as health maintenance organizations) that cover prescription drugs and all other Medicare benefits.

Each year, plans wanting to offer a Part D drug benefit must submit a bid to CMS together with information on the coverage provided, the actuarial value of the coverage, and the geographic region to be served. (Pennsylvania is part of region 6, which also includes West Virginia.) If the plan complies with federal requirements, CMS approves the plan and enters into a twelve-month contract.

CMS pays Part D plans a fixed monthly rate per enrollee. This rate, which is calculated annually based on the submitted bids, subsidizes about 75 percent of the cost of standard drug coverage. CMS also makes low-income subsidy payments to plans on behalf of their enrollees who qualify for assistance. The monthly premium charged to enrollees is equal to the difference between their plan's total premium and the amount subsidized by the federal government.

Formulary

Part D plans choose the specific generic and brand-name drugs to include on their formulary (list of covered drugs). CMS reviews each plan's formulary to assure they meet federal requirements.

Generally, the formularies must include at least two drugs in each therapeutic class or category of prescription drugs. Medicare requires plans to cover all (or substantially all) drugs in six categories: antidepressants, antipsychotics, anticonvulsants (to treat epilepsy and other conditions), antiretrovirals (HIV/AIDS treatment), immunosuppressants, and anticancer.

Federal law excludes the following drugs from Medicare Part D: over-the-counter drugs; most prescription vitamins and minerals (other than prenatal vitamins and fluoride preparations); barbiturates (unless used to treat epilepsy, cancer or a chronic mental disorder); and prescription drugs used for cough or cold relief, anorexia, weight loss or weight gain, fertility, cosmetic purposes or hair growth. Most plans do not include these drugs on their formulary.

Part D Benefit

All Part D plans must offer a "standard" drug benefit or an alternative of equivalent actuarial value (the average cost sharing under the alternative plan is comparable to the standard benefit).

The standard Part D benefit, as described in the MMA, consists of four payment phases.

- **Deductible.** At the beginning of the calendar year, enrollees pay the full cost of prescription drugs until they reach the annual deductible amount.
- **Initial coverage.** After meeting the annual deductible, enrollees pay 25 percent of total drug costs (or actuarially equivalent co-payments) and Medicare pays the remaining 75 percent until total spending for covered drugs reaches the initial coverage limit. Total spending includes the amount paid by the enrollee and the plan.
- **Doughnut hole**. Once the initial coverage limit is reached, enrollees enter the coverage gap (or "doughnut hole") where they remain until they qualify for catastrophic coverage. Prior to 2011, Medicare

provided no coverage during this phase and enrollees paid the full cost of their drugs. The Affordable Care Act of 2010 (federal health care reform) began closing the "doughnut hole" in 2011, gradually reducing enrollee coinsurance to 25 percent (the same as the initial coverage phase) by 2020.

- **Catastrophic coverage.** After enrollee drug spending reaches the out-of-pocket threshold, the enrollee qualifies for catastrophic coverage and pays significantly lower costs for their drugs (about 5 percent of drug costs). The out-of-pocket threshold only counts enrollee spending on qualified drug costs.

The following drug expenses count toward the amount Part D enrollees need to spend to reach the out-of-pocket threshold: the annual deductible, co-insurance/co-payments during the initial coverage phase, and amounts paid for prescriptions while in the doughnut hole. Also included is the manufacturer discount enrollees receive at the pharmacy for brand-name drugs purchased during the doughnut hole (see following section). Monthly premiums and payments for drugs not covered by the Part D plan are not countable expenses.

The deductible, initial coverage limit and out-of-pocket threshold are indexed to change each calendar year. Table A-1 shows the standard benefit parameters for 2018, 2019 and 2020.

- For 2019, a Part D enrollee must meet a $415 deductible before Medicare begins paying 75 percent of covered drug costs, up to the initial coverage limit of $3,820. At that point, the enrollee is in the doughnut hole and cannot exit until their total drug spending reaches the maximum out-of-pocket threshold of $5,100. Meeting this threshold triggers catastrophic coverage and, for the remainder of the year, the enrollee pays the greater of 5 percent of the drug cost or the following copayments: $3.40 per generic prescription and $8.50 per brand-name prescription.

Table A-1. Medicare Part D Standard Benefit Parameters

	2018	2019	2020
Deductible	$405	$415	$435
Initial Coverage Limit	$3,750	$3,820	$4,020
Out-of-Pocket Threshold *	$5,000	$5,100	$6,350
Catastrophic Coverage Cost- *Enrollees pay the greater of 5 drug costs or the following co-*			
Generic Drugs	$3.35 per Rx	$3.40 per Rx	$3.60 per Rx
Brand-name Drugs	$8.35 per Rx	$8.50 per Rx	$8.95 per Rx

** The 2020 increase of $1,250 is due to expiration of a provision in the Affordable Care Act that temporarily slowed the growth in the out-of-pocket threshold between 2014 and 2019.*

Most plans offer actuarially equivalent coverage that varies from the standard benefit in terms of the deductible and cost-sharing requirements. In addition to this required minimum coverage, Part D plans may offer enhanced coverage for an additional premium, providing more generous benefits than the standard.

For 2019, 30 stand-alone PDPs were approved to offer the Part D drug benefit in Pennsylvania. Of these, six offered enhanced coverage and the rest provided the basic actuarially equivalent benefits. Below are some other key statistics for the PDPs serving Pennsylvanians:

- Monthly premiums range from $14.50 to $156.
- Nine PDPs have no deductible. Fifteen plans charge the standard $415 deductible; the others charge a lower amount.
- The number of medications on plan formularies range from 2,906 to 4,302.
- Six plans offer some level of gap coverage in excess of the mandated discounts (see below) so enrollees may pay less for drugs while in the doughnut hole.

Closing the Doughnut Hole

Since 2011, the Affordable Care Act has been closing the Part D doughnut hole through a combination of discounts and subsidies. As summarized below, ACA phased in these discounts and subsidies over a 10-year period so individuals would pay no more than 25 percent of drug costs by 2020.

- Beginning in 2011, pharmaceutical manufacturers must offer Part D enrollees a 50 percent discount on the price of covered brand-name drugs during the doughnut hole. The value of the discount counts toward the enrollee's out-of-pocket threshold.
- Federal subsidies for generic drugs (beginning in 2011) and brand-name drugs (beginning in 2013) gradually increase Medicare Part D coverage in the doughnut hole to 75 percent and 25 percent, respectively.

Table A-2 illustrates how the ACA, as modified by the Balanced Budget Act of 2018, closes the doughnut hole for generic drugs and brand-name drugs. The green column shows the enrollee's share of costs for drugs purchased in the doughnut hole. (Part D plan share reflects Medicare coverage funded with the subsidies provided by the federal government.)

Table A-2. Cost Sharing in the Doughnut Hole

	Generic Drug Purchases		Brand-Name Drug Purchases		
Year	Enrollee Share	Part D Plan Share	Enrollee Share	Manufacturer Discount	Part D Plan Share
2006-2010	100%		100%		
2011	93%	7%	50%	50%	
2012	86%	14%	50%	50%	
2013	79%	21%	47.5%	50%	2.5%
2014	72%	28%	47.5%	50%	2.5%
2015	65%	35%	45%	50%	5%
2016	58%	42%	45%	50%	5%
2017	51%	49%	40%	50%	10%
2018	44%	56%	35%	50%	15%
2019 *	37%	63%	25%	70%	5%
2020 and thereafter **	25%	75%	25%	70%	5%

The Balanced Budget Act of 2018 included modifications to the ACA, reducing enrollee coinsurance for brand-name drugs to 25 percent beginning in 2019 and thereby closing the brand-name doughnut hole one year sooner than the ACA. Congress shifted additional brand-name drug costs to pharmaceutical manufacturers, increasing the discount to 70 percent (up from the 50 percent required in the ACA), and decreased Medicare Part D's coverage for brand-name drugs to 5 percent (down from the ACA's stipulated coverage of 20 percent in 2019 and 25 percent in 2020 and thereafter). Congress did not change the generic drug doughnut hole, which remains on schedule to close in 2020.