



## January 2004 LINKS

### **PRESIDENT SIGNS MEDICARE OVERHAUL BILL THAT ADDS PRESCRIPTION DRUG COVERAGE**

President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (H.R. 1) on December 8, 2003, adding an estimated cost of \$410 billion over ten year to the federal budget. H.R. 1 represented a compromise of separately passed House and Senate bills. The massive 700-page legislation (MPDIMA) **represents the largest expansion of Medicare since its enactment in 1965, adding a new prescription drug benefit for all 41 million seniors and people with disabilities who are currently beneficiaries.** [Note: There are nearly six million persons with disabilities under age 65 who are Medicare beneficiaries.]

The passage of the legislation fulfills a long-sought health care priority of Congress and the President, but was passed amidst heated debate and controversy on both sides of the aisle and still raises questions about completely addressing the most pressing issue for many beneficiaries—the control of rising drug prices. Ironically, the new law prohibits the federal government from using its purchasing power to negotiate drug prices with pharmaceutical entities.

The new drug discount card program is slated to begin this spring and is envisioned as a transition to the comprehensive benefit that is to be launched in 2006. A final rule governing the discount card was expected within days of the President signing the bill. The new drug benefit and the new Medicare Advantage (formerly, Medicare+Choice program) programs are slated to begin January 1, 2006. With the rulemaking process generally taking about 18 months from start to finish, little wiggle room is left for CMS to get the Medicare Advantage operational.

Now, the huge task of implementing this new complex (already dubbed MPDIMA by experts and pronouncing the new acronym as *em-puh-dee-ma*) rests with the Centers for Medicare and Medicaid Services—just as current CMS Administrator Tom Scully departs the agency on December 15<sup>th</sup>. H.R. 1 gave CMS a total of \$1 billion for 2004 and 2005 to implement the bill. The agency have to interpret more than 300 provisions in what is likely to be the most scrutinized process ever undertaken by the agency.

#### **General Overview**

The sweeping overhaul of Medicare was passed 220-215 just before dawn on November 22 by the House, following an unusual extension of the normal 15-minute time limit for votes to almost three hours when it became apparent that the bill would not initially pass

that chamber. The Senate spent the next three days debating the conference report, although Democratic-led filibuster and procedural efforts failed to keep the bill from passing 54-44 on November 24<sup>th</sup>.

The new law creates **a new and voluntary prescription drug benefit** which can be purchased by all Medicare beneficiaries with the federal government paying for some or all the costs of the drug premium and co-pays. Among the most hotly debated provisions are those providing new subsidies as incentives to private health plans intended to encouraging beneficiary enrollment—not just for the new prescription drug benefit (Part D), but for all of the traditional Medicare fee-for-service health care benefits (Part A and B), and a new demonstration program to begin in 2010 which will require traditional, fee-for-service Medicare plans to compete, directly on price, with private health plans in certain parts of the country. Supporters claim that the subsidies to private health plans are needed to help them be able to compete with traditional Medicare (level the playing field) and will go into effect prior to the demonstration program; while the demonstration is intended to test the cost-effectiveness of traditional Medicare vis-à-vis private plans. However, it is anticipated that beneficiaries in the demonstration areas will have to pay more in premiums to remain in fee-for-service Medicare since healthier beneficiaries will opt to participate in less costly private plans.

These two provisions and the first ever asset-test added by the new law were among the most hotly debated provisions. Supporters argued that Medicare needed to be modernized by transforming the program into one that provides *premium supports* and looks to the private market to hold down costs. Critics of the compromise argued that the new law would undermine the universal coverage and Federal guarantee of defined health benefits to Medicare beneficiaries, driving younger and healthier beneficiaries into private plans and leaving sicker and more costly beneficiaries in the traditional Medicare plans.

With a Congressional limitation of \$400 billion for the new prescription drug coverage, Congress sought a trade-off in providing more generous subsidies for very low-income beneficiaries by creating a gap in coverage of drug purchases (the so-called doughnut hole) before restoring coverage at a *catastrophic* level. The new law also provides subsidies to employers to encourage continued drug coverage to retirees. Not all of the new law and costs relate to a Medicare prescription drug benefit. H.R. 1 includes a provision renaming and expanding private medical savings accounts available to all Americans and provides increases to hospitals and doctors. And, unfortunately, the new law—while using federal funds to subsidize prescription drugs for *dual eligibles* (individuals eligible for both Medicare and Medicaid), *takes back* much of the savings to state Medicaid programs.

With only one week between passage of H.R. 1 and this issue of LINKS sent to printer, many details of this legislation is still unknown. For more details of the new law, see *Highlights* in box opposite this page. As briefings on the new law are held and more information on the new law are learned, ANCOR will provide additional information to members. For more information on the new law, go online to [www.kaiserfoundation.org](http://www.kaiserfoundation.org) and [www.families.org](http://www.families.org).

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### **Highlights of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MPDIMA)**

- **Cost Containment:** For the first time, federal spending on Medicare will be subject to a cap that requires Congress or the President to respond (e.g., reduce Medicare benefits or provider payments, or raise Medicare contributions) if general revenue spending exceeds 45% of Medicare spending.
- **Prescription Drug Cost Containment:** The new law prohibits Medicare from negotiating with pharmaceutical companies for the cost of drugs. Currently, the Federal government allows Medicaid programs to use its purchasing power to modify drug costs for beneficiaries.
- **Drug Discount Card: Beginning April 2004,** the law authorizes Medicare beneficiaries to be able to purchase a new discount card for \$30 per year. Low-income Medicare beneficiaries (those with incomes below 135% of the federal poverty level or \$12,123 for a single individual) would receive an additional \$600 in annual assistance in 2004 and 2005—with the subsidy imbedded in the discount card like a prepaid telephone card. HHS estimates that the cards would provide 15%-25% savings per prescription until the permanent prescription drug benefit is established in 2006. Beneficiaries will still pay a co-pay of 5% to 10% on each drug purchase.
- **New Prescription Drug Benefit: Beginning in January 2006,** Medicare beneficiaries would have access to a new **voluntary** prescription drug benefit. The new benefit will be provided through private prescription drug plans that contract with the Medicare program. The premium is *estimated* to cost \$35 and includes a \$250 annual deduction. Federal Medicare would pay 75% of annual coverage (beneficiary out-of-pocket costs of 25%) up to \$2,250 in prescription drug purchases. However, beneficiaries with prescription drug expenses **between \$2,250 and \$5,100 will have to pay the full cost of the prescription drugs (Medicare would pay for no drug purchases)**—although the **beneficiary must continue to make the \$35 per month premium payment**. This gap in prescription drug coverage has been referred to as the *doughnut hole*. Insurance coverage does not **begin again until beneficiary drug expenses reach \$5,100** (catastrophic coverage level) and then the government pays for 95% of prescription drug expenses. Managed care plans (soon to be called Medicare Advantage), like those currently in Medicare+Choice, can also provide the new benefit. Beneficiaries will have to sign up with a plan offering the drug benefit in their area. Medicare is required to contract with at least two plans that provide prescription drug coverage. In areas where there is only one plan or no plan, the

Federal government will provide a plan with those *fall-back plans* offering the standard benefit. Private plans can charge different premiums and also charge different copayments as long as the entire plan is equal in value to the standard Medicare plan. The drug coverage can also vary from plan to plan—with not all plans covering the same drugs.

- **Low-Income Beneficiaries:** The new law provides **additional assistance to low-income Medicare beneficiaries** (including those eligible for Medicare and Medicaid coverage--*dual eligibles*). Beneficiaries with incomes up to 135% of the federal poverty level (\$12,123 in annual income for singles) **and with assets below \$6,000 for an individual (excluding the value of a home or car worth \$4,000)** would only pay \$1-\$2 per generic prescription drug and \$3-\$5 per brand-name drug. The level of assistance depends on whether the individual is eligible for Medicaid in a particular state as well as the size of income and assets. However, this new asset test is estimated to disqualify 2.8 million very low-income Medicare individuals (*dual eligibles*) who currently receive Medicaid prescription drug coverage from this new additional assistance.
- **State Medicaid Savings Returned to Federal Government:** Although states will receive some Federal relief for Medicare picking up some of the costs of prescription drug coverage now paid for by Medicaid, the savings to states is modified substantially by other provisions of the new law. **First, the new law prohibits states from using Medicaid funds, as is currently allowed, for prescription drug coverage expenses—even for coverage that will not be paid for by the new Federal prescription drug benefit. The new law affects the structure of Medicaid programs by removing the Medicaid wrap-around for dual eligibles. Secondly, beginning in 2006-2014, states must return 90% of their so-called Medicaid savings (based on spending the state would have paid monthly for the total number of dual eligibles) back to the Federal government (*clawback*) as a result of the new federal prescription drug coverage of dual eligibles. After 2014, the payment back is reduced to 75%.**
- **New Private Health Insurance Demonstration:** For some on both sides of the aisle in Congress, this was one of the more controversial issues—either because it subjected Medicare to private competition or because it did not go far enough in overhauling the Medicare program. **Beginning in 2010**, private insurers will be able to begin bidding to serve Medicare beneficiaries (not just for prescription drug coverage, but full health care coverage) in geographic regions set up in 2006. Payment rates will be based on a blended average of the bids. The traditional Medicare program would compete with private plans in up to six metropolitan statistical areas beginning in 2010.
- **Retiree Coverage:** Employers will receive \$70 billion in subsidies and tax breaks over 10 years to encourage them to continue offering health care for their retirees. Employers would be able to provide premium subsidies, cost-sharing assistance for retirees who enroll in a Medicare drug plan or integrated plans.

- **Health Savings Accounts (HSAs):** Among the most controversial provisions, and one not included in either the Senate-passed or House-passed Medicare prescription drug bill, is a new health care tax shelter added by conferees. The new law, set to begin in 2004, expands the limited medical savings account (MSAs) demonstration by allowing any taxpayer—not just Medicare recipients—to establish a health savings account with a high-deductible health insurance plan to *save tax-free* and withdraw money *tax-free* to pay for medical expenses. **An employer could contribute to an individual's HAS, with those contributions excluded from the individual's taxable income.** .
- **Durable Medical Equipment (DME):** Freezes Medicare rates for durable medical equipment from 2004 to 2006 and subjects DME providers to competitive bidding beginning in 2007 in certain areas.