Medicare Modernization Measure has Far-reaching Implications for States and Long-Term Care Programs

I. INTRODUCTION

In December 2003, Congress passed a historic measure changing the way Medicare beneficiaries receive prescription drug coverage. This measure, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, has far reaching implications for consumers, state Medicaid agencies, health care providers, and the public and private entities that provide benefits counseling and supports to Medicare and Medicaid beneficiaries.

The following ADRC-TAE issue brief provides:

- An overview of the measure;
- Resources for more information on the impact of the bill on states, consumers, and health providers; and
- Implications for states and ADRC projects as well as suggested action steps for ADRC projects.

II. BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MIMA) made a number of significant changes to Medicare law that affect ADRCs and the consumers they serve. Most notably, the Act established prescription drug coverage for Medicare beneficiaries, but the Act contains many other significant provisions. This section provides a summary of the key provisions of the Act.

A. Prescription Drug Benefits

MIMA establishes a Medicare Prescription Drug Benefit under Part D of the Medicare program. The benefit, which will begin in January 2006, will provide beneficiaries the option to enroll in a prescription drug plan, through which they will have access to covered medications. Medicare beneficiaries will have three ways to obtain prescription drug coverage:

1. Medicare Part D

Beginning in 2006, beneficiaries enrolled in traditional fee-for-service Medicare will be eligible to enroll for an optional prescription drug benefit under Medicare Part D.

2. *Medicare Advantage*

Medicare managed care programs, which were formerly known as Medicare+Choice, are expected to continue offering a wider range of benefits than does traditional Medicare, often including prescription drug coverage.

3. *Retiree health plan.*

Some retirees, generally less than one-third of Medicare beneficiaries, will continue to have health insurance with prescription drug coverage through their former employers.

To provide beneficiaries temporary assistance with the cost of prescription drugs until Medicare Part D begins, the Act establishes a Medicare Prescription Drug Discount Card. The card will provide beneficiaries access to discounts on their medications. A fuller description of the new prescription drug benefits follows.

B. Prescription Drug Discount Card

To provide Medicare beneficiaries temporary assistance with prescription drug costs, Congress created a Medicare prescription drug discount card program, which will begin no later than June 8, 2004. The program will end when the permanent Medicare prescription drug benefit (Medicare Part D) begins in June 2006.

Enrollment in the discount card program is voluntary and open to all Medicare beneficiaries except individuals who are dually eligible for Medicare and Medicaid. Dual eligibles will continue to receive prescription drug coverage through the Medicaid program until the permanent Medicare prescription drug benefit takes effect. HHS estimates that the cards will provide between 10 and 25 percent discounts on medications. There may be an annual fee of up to $30 to enroll. For certain low-income beneficiaries, HHS will pay the fee and will provide credits of up to $600 on the cards. Medicare guarantees that all beneficiaries will have the choice of at least two cards from two different card sponsors. Card sponsors are responsible for ensuring that beneficiaries have convenient access to pharmacies.

C. Medicare Part D Prescription Drug Coverage

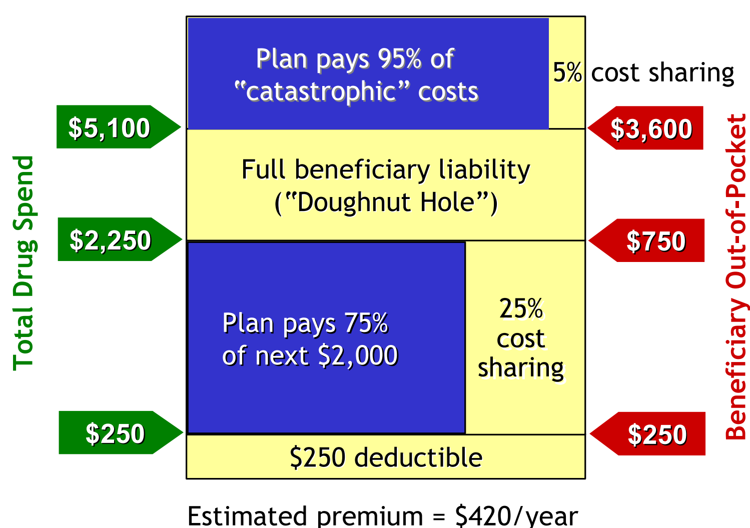
All Medicare beneficiaries entitled to Medicare Part A or enrolled in Medicare Part B are eligible for the Medicare Part D prescription drug benefit. Beneficiaries who have prescription drug coverage through Medicare Advantage or a retiree health plan are not eligible for the Medicare Part D benefit. Participation in the benefit is voluntary.

The benefit will be managed by private plans, which will provide coverage, establish premiums, ensure convenient access to medications through a network of pharmacies, manage utilization, and bear some of the financial risk of the program. To encourage plans to participate, federal subsidies will be provided.

In general, the benefit covers drugs that are covered by Medicaid, however plan sponsors may limit access to certain medications through formularies. Formularies are required to include drugs from all therapeutic classes or categories of drugs covered under Medicaid, but not necessarily all drugs within each class.

Beneficiaries will have the option of purchasing standard coverage or equivalent alternative coverage. As reflected in ***Figure 1*** below, in 2006, under standard coverage, beneficiaries will pay a $250 deductible and 25 percent of costs between $251 and $2,250. There is a gap in coverage, also referred to as a doughnut hole, between $2,251 and $3,600. In this range, beneficiaries must pay 100 percent of their prescription drug expenses and they are prohibited from purchasing a Medigap policy to cover these costs. When expenses exceed $3,600, beneficiaries will receive "catastrophic" coverage and will be responsible for only nominal cost sharing, which is defined as the greater of: (1) a co-payment of $2 for a generic or preferred drug and $5 for any other drug; or (2) five percent coinsurance.

Figure 1. Standard Benefit in 2006



D. Health Savings Accounts for Non-Medicare Beneficiaries

The Act also established Health Savings Accounts (HSA), which are tax-sheltered accounts that individuals can use to pay for qualified out-of-pocket medical expenses, including deductibles and co-payments beginning in 2004. Contributions that individuals make to their HSAs are tax deductible. HSAs are only available to individuals who are covered by high deductible health plans, which are defined as annual deductibles of at least $1,000 for individuals and $2,000 for families and out-of-pocket expenses limits for $5,500 for an individual and $10,000 for a family. Individuals eligible to establish a HSA may also have certain other types of coverage, in addition to their high-deductible plan. Permitted types of additional insurance include coverage for accidents, disability, dental care, vision care, and long-term care.

The maximum amount that individuals and families can contribute to their HSAs is the lesser of the amount of the annual deductible on their health plan or the maximum deductible permitted under an Archer Medical Savings Account high deductible health plan. Individuals aged 55 and older may make slightly higher contributions to their health plans. In 2004, their contributions may be $500 higher than the standard limit. This amount increases by $100 per year until 2009.

III. RESOURCES

In this section, ADRC-TAE offers some suggested resources for learning more about MIMA. Resources are grouped by stakeholder perspective. Organizing these materials may help Resource Centers educate staff about the implications of MIMA and to efficiently share information with local or regional partners.

A. General

1. Centers for Medicare and Medicaid Services (www.cms.gov)

The Centers for Medicare and Medicaid Services (CMS) is a valuable source of information about the Medicare Prescription Drug bill. The agency's website provides daily briefs about various aspects of the new law, answers to frequently asked questions, and updates on implementation (http://www.cms.gov/medicarereform).

2. Kaiser Family Foundation

The Kaiser Family Foundation (KFF), a private non-profit foundation that focuses on health policy research and analysis, provides a wealth of materials and resources related to the Medicare Prescription Drug bill on its website. Among the items on KFF's website that may be of interest to consumers, providers and states are a calculator to estimate an individual's out-of-pocket costs for prescription drugs under Medicare Part D and issue briefs on how the bill will impact specific groups of beneficiaries, such as institutionalized beneficiaries and dual eligibles. The KFF website features a complete section on the Medicare measure including a document providing insights on state implementation issues. To view these materials, go to http://www.kff.org/medicare/rxdrugdebate.cfm.

B. Resources for States

1. National Conference of State Legislatures (www.ncsl.org)

The National Conference of State Legislatures (NCSL) monitors federal policy initiatives for state legislators and represents their interests to the federal government. The NCSL website contains information on federal policy issues of interest to states, including a summary of the Medicare Prescription Drug bill (http://www.ncsl.org/statefed/health/ mcsum1210.pdf).

2. National Association of State Medicaid Directors (www.nasmd.org)

The National Association of State Medicaid Directors (NASMD), an association of state Medicaid officials, monitors federal Medicaid policy for state Medicaid agencies. NASMD's website offers a summary of the Medicare Prescription Drug bill and answers to frequently asked questions about the new law.

3. Kaiser Family Foundation

Kaiser Family Foundation (KFF) developed a paper on the implications of MIMA from a state Medicaid directors' perspective. To view this document, go to http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28814.

C. Resources for Providers

1. American Association of Family Physicians (www.aafp.org)

The American Association of Family Physicians (AAFP) website provides a summary of the Medicare bill for physicians.

2. American Hospital Association

The American Hospital Association (AHA) was a strong supporter of the measure. To view their position, go to http://www.hospitalconnect.com/aha/advocacy-grassroots/grassroots/advocacy/03MedicareRx031218.html.

D. Resources for Consumers

1. Centers for Medicare and Medicare Services (www.medicare.gov)

CMS has a website with information about Medicare that is targeted specifically to consumers. The agency has added a section to the website on the new Medicare law (www.medicare.gov/MedicareReform), which provides a summary of the Medicare prescription drug bill, answers to frequently asked questions, and a daily discussion of a particular aspect of the new law.

2. AARP (www.aarp.org)

The AARP website provides information about the new law for Medicare beneficiaries, including answers to frequently asked questions, a drug benefit calculator, and information for low-income beneficiaries.

IV. IMPLICATIONS FOR ADRC PROJECTS

In this section, ADRC-TAE offers commentary on possible implications of MIMA to Resource Center projects. Implication statements are aligned with key ADRC work areas. Observations are offered both from the perspective of the ADRC grant projects' perspective as well as from the perspective of operating Resource Centers.

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<tr><th rowspan="2">Bill Provision</th><th rowspan="2">State Impact</th><th colspan="4">ADRC Impact</th></tr>
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<tr><td rowspan="2">Prescription Drug Discount Card</td><td rowspan="2">State Prescription Drug Discount Plans. Many states offer seniors a discount prescription drug plan. With Medicare now offering prescription drug discount coverage to seniors, some states may choose to eliminate or scale back their programs. However, if the Medicare plan is not as generous as state plans, states may decide to maintain them as wrap-around coverage.</td><td>Development and Implementation</td><td>Most single state Medicaid agencies (SSMA) will be investing significant staff and resources in the analysis of MIMA implications and planning changes in the state's program. Grantees may find SSMAs more difficult to engage during this period.</td><td rowspan="2">Functions – Awareness and Information, Assistance, and Access</td><td rowspan="2">ADRC staff, especially benefits counselors will need training on MIMA to provide consumers up to date information on pending changes. They also will need an ongoing stream of information on changes to state prescription drug coverage as well as access to explanatory materials to share with consumers. It would benefit ADRCs to establish a formal process with their state Medicaid agencies and SHIPs for the ongoing communication of information about implementation of MIMA. It may also be possible for ADRCs to leverage SHIP resources related to training, materials, and volunteers. Because Section 1915(c) waivers must be cost neutral, i.e., cost no more than the institutional equivalent, states also will have to re-calculate the cost effectiveness assumptions for all home and community-based waivers; this work may have implications for waiver cost projections.</td></tr>
<tr><td>MIS</td><td>ADRC MIS that include information on client benefit access will need to include a field for the new drug benefit for Medicare eligible individuals.</td></tr>
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Bill Provision	State Impact	ADRC Impact			
		ADRC Work Area	*ADRC Grant Project Implications*	*ADRC Work Area*	*Operating ADRC Implications*
Medicare Part D	**State Medicaid Expenditures.** Dual eligibles receive prescription drug coverage through Medicaid, but when Medicare Part D begins, Medicare is expected to become their primary provider of prescription drug coverage. This will reduce state Medicaid expenditures by approximately $115 billion in the next decade. However, states are required to return most of that savings to the federal government. According to the Congressional Budget Office, taking into account these paybacks to the federal government and increased state Medicaid administrative expenses, states will save an estimated $17.2 billion in Medicaid expenditures over the next 10 years.	Development and Implementation	Ibid	Functions -- Awareness and Information, Access	Again, ADRC benefits counselors will need to be fluent in these changes and their implications for consumers and their families. ADRCs also will need to keep abreast of the waiver budgetary implications to fully understand any changes in states' home and community-based services options.

Bill Provision	State Impact	ADRC Impact			
		ADRC Work Area	***ADRC Grant Project Implications***	***ADRC Work Area***	***Operating ADRC Implications***
Medicare Part D	**State Medicaid Administrative Responsibilities.** The Act requires state Medicaid agencies and the Social Security Administration to accept, review and assess low-income Medicare beneficiaries' applications for financial assistance under Medicare Part D. Though not all of the 14 million beneficiaries estimated to be eligible for financial assistance will apply, state Medicaid agencies will need to prepare to process these applications, which will likely involve updating software and hiring additional staff. States will receive federal matching funds at their customary matching rates for the administrative cost of determining low-income eligibility.	Development and Implementation	ADRC Grant project staff will need to determine whether their project sites will perform this screening and intake process along with state, regional or local Medicaid eligibility offices. ADRC projects will need to consider whether or not there are budgetary ramifications for participating. Assisting state Medicaid agencies in this function might provide a partnering opportunity between ADRC projects and SSMAs.	Functions – Access MIS	ADRCs assisting consumers with eligibility determination and program intake will need to be trained on these new options and have the information technology to record and track eligibility and access. There is also the opportunity for Medicaid funds to cover these activities.
Health Savings Accounts (HSA)	States will need to make decisions regarding whether HSAs will be counted when determining Medicaid eligibility.	Function – Awareness and Information, Assistance	ADRC projects will need to develop training curricula for benefits counselors that include information on how to use HSAs to cover LTCI.	Function – Awareness and Information	Benefits counselors will need to assist consumers and families to decide whether HSAs are a good option and what the impact will be on other benefits and LTC needs planning.