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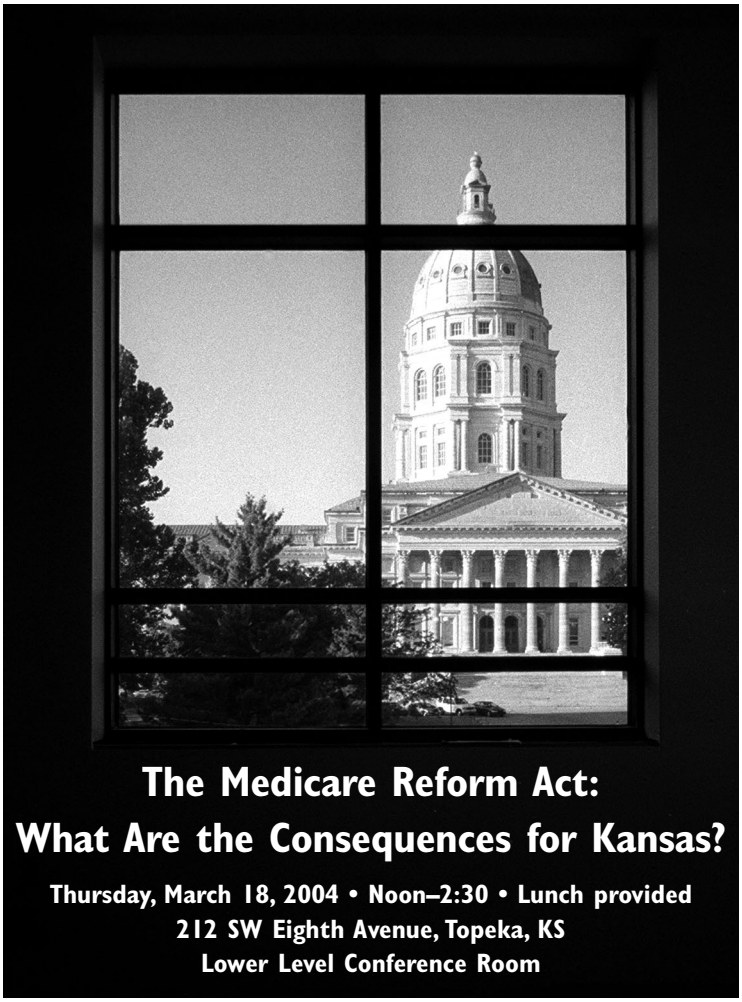

The Medicare Reform Act: What Are the Consequences for Kansas?

Thursday, March 18, 2004 • Noon–2:30 • Lunch provided
212 SW Eighth Avenue, Topeka, KS
Lower Level Conference Room

A DISCUSSION FEATURING

Liz Fowler, Ph.D., J.D.
Professional Staff
U.S. Senate Finance Committee

Robert L. Epps, M.P.A.
Health Insurance Specialist, Kansas City Regional Office
Centers for Medicare and Medicaid Services

Robert Day, Ph.D.
Director, Governor's Office of
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About the Forums

Kansas Health Policy Forums are a series of interactive sessions for policymakers examining a broad array of health issues. Forums present a wide range of national and local expertise on current health policy issues followed by facilitated discussion and dialogue in a non-partisan setting. Forum Briefs analyze issues, present relevant data and information, and are produced as background material for each forum. Kansas Health Policy Forums are presented by the Kansas Health Institute. Funding is provided by a grant from the Robert Wood Johnson Foundation, Princeton, N.J., and the Kansas Health Foundation, a Wichita-based philanthropy dedicated to improving the health of all Kansans.

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The Medicare Reform Act: What Are the Consequences for Kansas?

Introduction

Signed into law on December 8, 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, known as MMA, substantially expands the scope of the Medicare program to include a prescription drug benefit for seniors and a transitional prescription drug card. While the Act was hailed as a major step forward in expanding coverage, many questions about the administration of the program and added costs to the states remain.

Key Provisions of the MMA

- Establishes a temporary prescription drug discount program for seniors
- Adds prescription drug coverage to Medicare in 2006
- Enhances Medicare payments for hospitals
- Restricts Medicare payments to new specialty hospitals
- Establishes tax-free "Health Savings Accounts" for those with high-deductible health insurance plans
- Revamps the Medicare Managed Care Program

Several key provisions of the Act are unresolved and await further guidance from the U.S. Department of Health and Human Services (HHS), leaving room for states to influence some of the final rules and regulations. It is also possible that Congress will attempt to clarify certain provisions of the MMA before the drug benefit is implemented in 2006. This Forum Brief provides a summary of the key provisions of the MMA, followed by a more detailed analysis of the new prescription drug benefit's impact on state expenditures and administrative responsibilities.

Overview of Key Provisions

Prescription Drug Discount Card

Beginning in May 2004, Medicare will offer a transitional prescription drug discount card in advance of the implementation of the drug benefit. Private, Medicare-endorsed plans through pharmacy benefit managers, wholesalers, retail pharmacies, insurers and Medicare+Choice plans are expected to offer a 10% to 25% discount on drug purchases and to charge an annual enrollment fee of up to $30. Anyone eligible for Medicare can participate in this program as long as they do not currently receive prescription drug coverage through Medicaid. Low-income seniors may be eligible for up to $600 in drug coverage (with 5% to 10% co-pays) in addition to their prescription drug card.

Prescription Drug Benefit

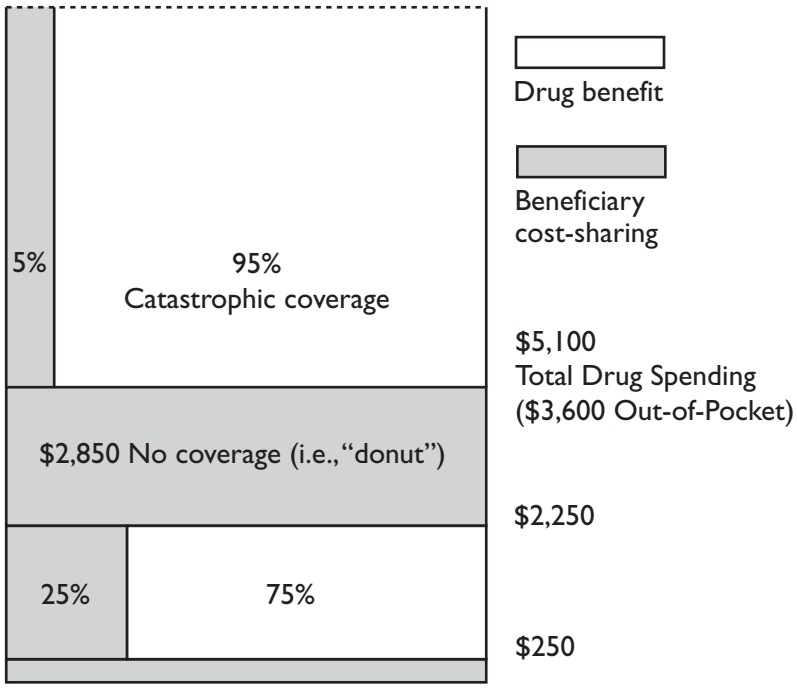
The MMA creates Medicare Part D to assist with coverage of outpatient prescription drugs, beginning January 1, 2006. This benefit is voluntary, but beneficiaries who enroll in the prescription drug benefit at any time after the initial enrollment period will incur a financial penalty. Private insurance plans will contract with Medicare to provide the prescription drug plans. The state Medicaid programs and the Social Security Administration will share responsibility for determining eligibility for the drug benefit. Similar to the drug discount card, anyone eligible for Medicare may participate in this benefit.

All those eligible for Part D must have at least two plans available from which to choose, or have access to a fallback plan offered by Medicare. They may choose between a stand-alone drug program, traditional Medicare HMO coverage along with the stand-alone program, or a health insurance plan offering the prescription drug benefit.

Eligible individuals with incomes above 150% of the federal poverty level ($13,965 for a single person and $18,375 for a couple) will pay an estimated $35 monthly premium for this benefit in addition to any other required Medicare premiums and co-payments. Coverage and out-of-pocket expenses for non-low-income beneficiaries are outlined in the adjacent figure.

Out-of-Pocket Drug Spending

(Annual expenditures for prescription drug beneficiaries with incomes above 150% of poverty level)



Adapted from Fowler, 2004

Low-income subsidies. Individuals with low income who qualify for both Medicare and Medicaid, the dual-eligible population, may receive premium assistance through Medicaid. Some will also qualify for cost-sharing assistance. In addition, Medicare will waive the prescription drug benefit premium, deductible, and gap in coverage that non-low-income beneficiaries will incur. Prescriptions will cost this group a co-pay of $1 per generic prescription and $3 per brand name prescription.

Retiree benefits. To discourage employers from eliminating insurance benefits for retired employees, the federal government will subsidize employers for each Medicare beneficiary for 28% of the costs of drug coverage between $250 and $5,000, tax-free.

Increased Beneficiary Cost-Sharing

Beginning in 2007, the Medicare program will, for the first time, tie Part B beneficiary premiums to income by charging more to seniors with incomes above $80,000 per year or $160,000 per year for couples. Also, the MMA requires an increase in the Medicare Part B deductible from $100 in 2004 to $110 in 2005; after that, the deductible will be tied to increases in Part B spending.

Increased Payments for Physicians

The MMA eliminates planned reductions in the Medicare physician fee schedule in 2004 and 2005 and instead raises these payments 1.5% each year. The Act also provides a 5% payment enhancement for physicians practicing in designated shortage areas, and it reduces the payment differential levied against Kansas and other low-cost regions of the country.

Increases in Hospital Payments Favor Rural Providers

All hospitals will receive full inflationary increases in standard Medicare payments in fiscal years 2005, 2006, and 2007, if they submit specific quality of care data to HHS. Rural hospitals will also benefit from significant increases in both standard and disproportionate share hospital payments. The increases place rural hospitals on par with urban hospitals in calculating the labor costs in the Medicare payment formula. In addition, critical access hospitals, which will now include hospitals of up to 25 beds (up from 15), will benefit from a new cost-based reimbursement of 101%.

Moratorium on Payments to New Specialty Hospitals

The MMA also establishes an 18-month moratorium on physician self-referral to new specialty hospitals. The legislation grandfathers existing specialty hospitals and those already under development, but prohibits grandfathered facilities from adding investors, expanding to other specialty categories, or increasing beds by more than 50 percent. During the moratorium period, two federal agencies will conduct analyses of the issue.

New Health Savings Accounts

The MMA defines Health Savings Accounts (HSA) as tax-free savings accounts that can be established in conjunction with high deductible health insurance plans (minimum deductible of $1,000 for individual coverage and $2,000 for family coverage). Contributions are tax deductible, and neither earnings nor withdrawals are taxed so long as the proceeds are used for qualified health care expenses. Expenses that qualify for coverage under HSA funds include a wide range of health services. Both employers and employees may contribute to an HSA up to an annual maximum amount (lesser of the deductible or $2,250 for individuals, $4,500 for families). HSAs are fully portable from one employer to another and from one year to the next.

New Medicare Managed Care Program

The Medicare Advantage Program will replace the current managed care program, Medicare+Choice by 2010. Beginning in 2004, reimbursement rates for managed care plans will have to equal at least the traditional fee-for-service rate. The Act encourages plans to offer regional—rather than local or state-specific—coverage.

Reimbursement for Undocumented Immigrants

From 2005 to 2008, qualified providers (i.e., hospital, physician, or ambulance service provider) who provide care to undocumented immigrants may receive a capped payment from HHS for any unreimbursed care to this population. The amount appropriated to states from the annual amount of $167 million, will be based on the state's percentage of undocumented immigrants relative to other states and will be paid directly to providers.

Effect of the New Medicare Prescription Drug Benefit on Kansas

Although there are many provisions in the MMA that will undoubtedly affect the health care system, the new Medicare prescription drug benefit may have the largest direct impact on state government. The remainder of this Forum Brief focuses on the potential impact of the new drug benefit on state Medicaid costs and administrative responsibilities. The analysis begins with a description of how the new drug benefit will affect Medicaid recipients, continues with an assessment of state Medicaid spending and administrative responsibilities resulting from the new benefit, and concludes by identifying areas in which the state may be able to influence the way in which the new drug benefit is implemented.

Dual Eligibles' Drug Coverage Will Move from Medicaid to Medicare

Beginning in 2006, Medicare beneficiaries who are also eligible for Medicaid (known as "dual eligibles") will no longer receive prescription drug coverage through Medicaid. Instead they will receive assistance through private prescription drug plans that participate in the new Medicare Part D program. Dual eligible individuals, primarily low-income seniors and persons with disabilities, also will qualify for premium assistance and in some cases cost-sharing subsidies from Medicare for the prescription drug benefit.

In order to help defray the costs of the new Medicare drug benefit, states will be required to pay monthly maintenance of effort (MOE) payments to the federal government. These MOE payments are meant to replace a large percentage of the amount states would have paid for Medicaid prescription drug coverage for these dual eligibles.

Changes in Prescription Drug Coverage for Dual Eligibles

	Current Medicaid Coverage	What Will Change with Medicare Part D in 2006
Full Dual Eligibles (income ≤73% of federal poverty level)	• Medicare premiums, coinsurance and deductibles • Additional medical expenses not covered by Medicare, e.g., prescription drug coverage and long-term care	• Medicaid coverage will not change, except that prescription drug coverage will be offered through Medicare
Partial Dual Eligibles (income between 74% and 120% of federal poverty level)	• Medicare premiums • Medicare coinsurance and deductibles for some • No other coverage	• Medicaid coverage will not change • Will gain Medicare prescription drug coverage with no premium

The shift in coverage from Medicaid to Medicare holds implications for both beneficiaries and the state budget. Several issues for dual eligibles may be of interest to state policymakers:

- In order to maintain coverage, dual eligibles must be notified that their prescription drug coverage under Medicaid will end on December 31, 2005, and that they must enroll in the Medicare Part D benefit. States that are concerned about the loss or reduction of coverage for dual eligibles could develop an automatic enrollment process for the new Part D benefits.
- Each eligible person will have to choose from a list of private prescription drug plans. Although many of the plans will be similar, they are likely to differ at least in cost and in the list of drugs (called a formulary) they will cover. Making a plan selection is never easy, but it may be especially difficult for elderly people who are more likely to be on multiple drugs and individuals with cognitive impairments. Educating these beneficiaries about choosing a drug plan will play an important role in determining the effectiveness of their choice. While the MMA requires education of new and potential beneficiaries, it does not charge any particular state or federal agency to provide education of the dual eligibles about their choices.
- As prescription drug plans negotiate with manufacturers for the lowest price, each plan may end up with different lists of covered drugs. This may put dual eligibles at risk for losing access to the specific drugs prescribed by their doctors. For

example, beneficiaries who take drugs for multiple chronic conditions may not be able to easily receive those drugs if no drug plan covers all of those drugs, or if they choose a plan that does not cover all of those drugs. Beneficiaries must pay out-of-pocket costs for any drug not covered by the plan. The appeals process for gaining coverage for a specific drug is not well defined in the MMA.

- Unlike the protection under Medicaid, if a dual eligible cannot make a co-payment, the pharmacist can refuse to fill the prescription.

State Maintenance of Effort (MOE) Payments

Although expenditures will vary widely among the states, the overall expectation is that in the first six years, the MOE will result in costs to the states that are higher than current expenditures. The Act calls for relief to follow in the succeeding four years, with the expectation that the net effect for most states by 2015 will be negligible.

The primary determinant of state cost or savings within the prescription drug benefit of the MMA is the required MOE payment to the federal government. The MOE is based on per capita state expenditures for dual eligibles' prescription drug coverage in calendar year 2003. These payment amounts will be inflated by national growth in per capita drug expenditures and multiplied by the number of dual eligibles to yield an estimate of the prescription drug costs Medicaid would have incurred for the dual eligibles. These amounts are then reduced at a pre-defined percentage to determine the actual MOE payment.

This *holdback* percentage will start at 90% in 2006 and will fall gradually to 75%, where it will remain after 2015. The declining *holdback* percentage is designed to offset the anticipated growth in dual eligible beneficiaries.

Dual eligible enrollment in the state will likely increase, given the probable popularity of the Medicare drug benefit and the requirement of states to screen all who apply for the new Medicare benefits for Medicaid eligibility, and then to enroll all who are eligible. In 2003, Kansas had approximately 46,000 dual eligibles enrolled in Medicaid and Medicare. Estimates as to how many new beneficiaries will be added into Part D vary. Preliminary estimates from the Kansas Department of Social and Rehabilitation Services (SRS) suggest that there may be few additional persons who would qualify as full dual eligibles who are not already enrolled. However, the number of persons who would apply and qualify as a partial dual eligible could double with the addition of the drug benefit. (see definition in box on next page). If this assumption holds true, increased expenditures for Kansas would include the addition of Medicare premiums and cost-sharing for partial dual eligibles.

State Administrative Responsibilities

The prescription drug benefit increases the responsibility of both the state Medicaid program and the Social Security Administration in determining eligibility for enrollment and low-income subsidies. The division of responsibility between Medicaid and the Social Security Administration has not yet been defined, but it seems likely that state Medicaid agencies will incur substantial expenses to organize and administer these tasks.

Program administration may entail computer system enhancements, increases in eligibility determination staff and substantial staff training. Resources for the new activities are not identified in the legislation, suggesting that states will split costs with the federal government as is the case with other Medicaid administrative expenses.

Coordinating and administering the systems and management applications for multiple programs will be complex because eligibility rules, schedules, and philosophies differ greatly among programs. Using the Kansas' State Children's Health Insurance Program (SCHIP) as an example, adding a new program creates substantial challenges. Adding the Medicare Part D

Effect of the Drug Benefit on the State Medicaid Program

Enrollment

Full Dual Eligibles (income ≤73% of federal poverty level)

- Kansas expects the new Medicare drug benefit to attract few new enrollees to Medicaid in this category. In 2003, there were 36,338 beneficiaries in this group.

Partial Dual Eligibles (income between 74% and 120% of federal poverty level)

- New Medicare drug benefit could cause Medicaid enrollment to as much as double in this category. In 2003, there were 7,533 beneficiaries in this group.

Costs

- All new dual eligible enrollees will increase Medicaid's coverage of Medicare premiums and cost-sharing
- New full dual eligible enrollees will also increase expenditures on medical services other than prescription drugs
- Prescription drug costs will decrease through Maintenance of Effort payments
- Conducting eligibility determination and enrollment for Medicare Part D, subsidies, and drug discount card will require substantial new state fiscal resources for:
  - o Computer system enhancements
  - o Increases in eligibility determination staff
  - o Substantial training of staff

drug benefit may be as complicated as adding the SCHIP program, and it is likely to require a focused effort and significant state resources.

Supplementing the New Medicare Benefit

A pivotal decision left to the states' discretion is whether to fund gaps in coverage that could arise for dual eligibles if, for example, plan formularies are restrictive, or if pharmacists refuse to fill prescriptions when dual eligibles cannot make a co-payment. States must fund those costs with 100 percent state funds. The extent to which supplemental drug coverage for dual eligibles would increase state expenditures will vary according to what potential gaps a state elects to cover and the administrative costs that would accompany systems changes and staff time required to accomplish supplemental coverage. Like most states, Kansas has focused primarily on preparing for the drug discount card program and has not yet assessed potential gaps in Part D coverage. It remains to be seen what, if any, out-of-pocket expenses states may choose to cover for dual eligibles.

Opportunities for State Input

While the MMA's net effect on the state's budget over the course of the next 10 years is undetermined, new administrative responsibilities appear to be significant. Since these new responsibilities are not clearly defined in the legislation, there is an opportunity for states to weigh in on the clarification of the Act as the federal rules and regulations are being developed, and as Congress considers modifications to the Act.

In particular, states need clarification about Medicaid's role in eligibility determinations and enrollment for the new drug benefit, and whether additional resources will be allocated to states to accomplish these new responsibilities. Further clarification is also needed about which agency will be responsible for education and outreach to recipients, and whether additional funds will be allocated for this purpose.

Finally, state policymakers may want to identify and convey any concerns they may have about the restrictions of the prescription drug plans, since any restrictions in these private drug lists could put pressure on the state to offer supplemental coverage to dual eligibles.