Summary

Medicare Prescription Drug, Improvement, and Modernization Act

Please note that clarification and official guidance regarding the *Medicare Prescription Drug, Improvement, and Modernization Act* from the Department of Health and Human Services, the Department of the Treasury, the Internal Revenue Service, and the Center for Medicare and Medicaid Services has yet to be disseminated. Thus, this serves as a preliminary summary of the bill.

General

- There are currently over 40 million Medicare recipients. This number will double by 2030.
- The cost to the federal government of the Medicare bill is expected to be $400 billion over the next 10 years, and $1 trillion in years 11-20 .
- Because many of these provisions will not be implemented until 2006, it is likely that Congress may change portions of this bill, due to political pressures.

Prescription Drug Benefit

- Beginning in 2004, Medicare recipients may purchase a Medicare endorsed prescription drug discount card, providing an anticipated 10-25% discount on drug purchases. There will be an enrollment fee of up to $30, and recipients will be able to choose from at least two different plans.
- 3 million low income elderly will receive a $600 credit to their prescription drug discount card, and beginning in 2006, when the stand alone drug benefit program is implemented, premium, deductible and coverage gaps will be waived.
- Each Medicare drug plan may determine its own list of preferred prescription drugs. Thus, higher-cost or often-used drugs, may cost more for retirees.
- Beginning in 2006, the new prescription drug benefit will be implemented. Highlights of the basic drug coverage include:
    - $250 deductible
    - Anticipated $35/month premium
    - 75% coverage of drugs up to $2,250
    - No coverage for costs between $2,250 and $5,100 (the donut hole)
    - 95% coverage of drug costs over $5,100
- Prescription Drug Providers (PDPs) will provide the new prescription drug benefit to Medicare recipients. Health insurers and pharmaceutical benefit managers will act as PDPs negotiating directly with the pharmaceutical manufacturers.
- The Federal government is specifically prohibited from negotiating with pharmaceutical companies to obtain drugs for Medicare recipients.

Doctors, Hospitals, Other Facilities

- Doctors: currently required cuts in 2004 and 2005 will not occur. Instead, physicians will receive, at a minimum, a 1.5% increase, per year.
- Rural Assistance: Medicare will increase payments to rural hospitals and physicians totaling $25 billion/over 10 years.
- Hospitals will see an increase in payments that match the rate of change of the “market basket.” (A market basket is a price index used to determine hospital costs. It is a sampling of regularly purchased items that

hospitals make, determined by the Secretary of Health and Human Services every 5 years. It is likely that the Secretary will update these input items on a more regular basis.)

- Hospitals will need to furnish quality control information to the Centers for Medicare and Medicaid Services (CMS) beginning in 2005, or face a 4% reduction in market basket updates.
- A 5 year freeze on laboratory payments is included.

Medicaid/Dual Eligible Provision/Low Income Individuals

- In 2006, there will be 6.4 millions Americans who are in both the Medicaid and Medicare programs.
- The bill provides an additional $3 billion/10 years for Medicaid DSH payments.
- Low income individuals will receive little or no gaps in coverage, unlike the basic drug coverage plan. Cost-sharing and premium assistance will also be offered.
- Medicare will assume prescription drug costs of dual eligible individuals, however states will need to reimburse the federal government for most of these costs per a new formula described below. Medicare/Medicaid eligible individuals will have co-pays of $2 for generic, and up to $5 for brand name or non-preferred drugs. State Medicaid programs will likely not cover costs of drugs not covered through Medicare, as the federal government will not provide any funds to the states for this gap. The federal government currently covers 0% of the drug costs for low income and permanently disabled individuals. The states reimburse the federal government this amount, based on a formula. Beginning in 2006, the federal government will pay for 10% of these costs and that will increase to 15% in 2015.
- Low income qualification changes have been made to include "assets" which will change the equation as to who qualifies for low income assistance.

Retiree Benefits

- CBO estimates that 3.8 million retirees (approx 1.3 of the non-federal govt workforce) who have insurance from their former employer will see reduced coverage or elimination of their benefits.
- Beginning in 2006, employers will be subsidized by the federal government at a rate of 28% for the costs of drug coverage from $250-$5000 per Medicare enrollee. Numbers will be indexed thereafter. These payments to employers are tax-free, providing an additional benefit to the private sector.

Reimbursement for Undocumented Immigrants

- $1 billion in direct funding will be distributed to providers who care for undocumented immigrants.
- Congressman Dana Rohrabacher (R-CA) was promised that for his support of the Medicare bill, Congress will review a measure next year asking that health service providers administering care to undocumented immigrants must report these persons to the border patrol within two hours. Failure to do so will result in withholding the provider's reimbursement funds.

Health Savings Accounts (HSAs)

- Available in 2004, to all Americans under the age of 65. HSA's are in essence enhanced Medical Savings Accounts (MSAs).
- Contributions may be made by individuals, employers or family members.
- Contributions are tax free (if paid by employer, tax deductible if paid by the individual), as are distributions, if used for health care expenses (e.g., deductibles, co-pays, retiree health insurance, Medicare expenses, prescription drugs).
- Up to 100% of a health plan deductible may be contributed, up to $2600 (single policy) or $5,150 (family policy) per year. Unused portions may be carried over to other years.
- Those ages 55-65, may make a "catch-up" contribution of an additional $1,000/year, tax-free.

Medicare Advantage Program (replaces Medicare+Choice and takes effect in 2006 and thereafter)

- Studies indicate (Urban Institute, RAND, American Academy of Actuaries) that comprehensive employer based coverage costs could more than double once this is enacted.
- The federal government will contribute up to 45% of general-fund revenues to the outpatient and prescription drug segments of Medicare (Medicare B and D). However, this amount may not surpass the 45% amount, which could be problematic as drug and out patient costs rise in the years/decades ahead. Thus, severe cuts in the Medicare program, decrease in reimbursement rates and high co-payments could be implemented to maintain the 45% threshold.
- More details on this section will follow.

Medicare Competition Program

- Demonstration sites begin in 2010 in 6 metropolitan areas, allowing Medicare recipients to choose health care services from either Medicare or private insurers.