



FEDERAL FUNDS WATCH

Volume IX, Issue 3

December 10, 2003

MEDICARE REFORM LEGISLATION

On December 8, 2003, the President signed into law the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (Act). The Act provides for the largest overhaul to the Medicare program since its creation in 1965. Highlights of the bill follow.

Prescription Drug Benefit

Through the federal government, Medicare provides health benefits to persons who are 65 years of age or older and certain people with disabilities or end-stage renal disease. Medicare Part A provides hospital insurance, and Medicare Part B covers physicians' services and outpatient hospital services. Medicare+Choice (Part C) offers beneficiaries managed care and other health plan choices. The Act renames Part C "Medicare Advantage."

The new law creates a voluntary, outpatient prescription drug benefit under Medicare Part D. This benefit will be provided through private, risk-bearing plans and will be available in January 2006. Persons who are entitled to Part A or enrolled in Part B are eligible for the drug benefit. Approximately 2.4 million Texans will be eligible for the new benefit. In

FY 2003, drug costs for Medicare beneficiaries averaged \$2,440 according to the Congressional Budget Office. Table 1 details the benefit and enrollees' cost-sharing components.

Subsidies for Low-Income Beneficiaries

The Act also provides for premium subsidies for low-income beneficiaries. Enrollees with household income less than 135% of the Federal Poverty Level (FPL) will receive a 100% premium subsidy and are not subject to a deductible. Enrollees with income between 135 and 150% FPL will receive a premium subsidy on a sliding scale basis and are subject to a \$50 deductible. There is an asset test for both groups. In 2003, 150% FPL equates to an annual household income for two persons of \$18,180. About 40% of all Medicare beneficiaries fall within 150% FPL. Medicaid recipients are eligible for the subsidy.

Transitional Programs

Until the prescription drug benefit becomes available in 2006, the Act provides for a voluntary drug

Table 1
Enrollees' Annual Costs for Medicare Prescription Drug Benefit¹

	Federal Poverty Level (FPL)		
	<135%	135-150%	>150%
Average Premium	\$0	\$0 - 35/month	\$35/month
Deductible	\$0	\$50	\$250
Co-insurance			
Expenditures up to \$2,250	Nominal Co-pays ²	15%	25%
Expenditures of \$2,251-\$3,600	Nominal Co-pays	15%	100%
Expenditures over \$3,600	\$0	Nominal Co-pays	5% ³

Notes:

¹Premiums, deductibles, and the co-insurance thresholds are subject to a growth factor.

²Nominal co-payments depend on enrollees' income and the type of drug. The range is \$1 to \$5.

³The cost-sharing requirement is the greater of \$2 for generics or preferred drugs and \$5 for other drugs, or 5% of the total drug cost.

Source: Legislative Budget Board.

discount card program and transitional assistance for low-income Medicare recipients. Enrollment will begin in April 2004 and end in December 2005. For beneficiaries with household income less than 100% FPL, the federal government will pay 95% of drug costs, not to exceed \$600 per year. For persons with income between 100% and 135% FPL, the federal government will pay 90% of drug costs (up to \$600). The federal government also pays enrollment fees for drug discount cards for low-income participants. Persons enrolled in both Medicare and Medicaid ("dual eligibles") may not enroll in the drug discount program or receive transitional assistance.

State Budget Impact

Texas and the federal government currently share in the cost of prescription drugs for the dual eligibles, based on the Federal Medical Assistance Percentage (FMAP) (approximately 60% federal; 40% state). Under the Act, the federal government will assume these costs beginning in 2006. However, the Act requires states to return most of the savings to the federal government. In FY 2003, the average monthly number of dual eligibles in Texas was 315,717, and the estimated cost for providing prescription drugs to this group was \$235.0 million in General Revenue. In FY 2006, states must pay the federal government 90% of what the state would have spent. The percentage decreases by 1.67% per year to 75% in FY 2015 and thereafter. Preliminary estimates of General Revenue savings are \$71.0 million for the 2006-07 biennium and \$1.2 billion over 10 years.

The state must also submit information to the federal government to identify eligibles for the transitional programs. Further, the state must determine eligibility for the low-income subsidy program and provide state match for those costs (generally at 50%).

To address concerns that employers currently offering prescription drug benefits to Medicare recipients would drop coverage, the Act also provides for a 28% premium subsidy for drug costs between \$250 and \$5,000 to employers who continue benefits. State retirement systems can qualify for this subsidy.

Reduction in Part B Premium Subsidies

For beneficiaries with gross income exceeding \$80,000 for individuals or \$160,000 for couples, the Act reduces current Part B premium subsidies on a sliding scale basis. There is a five year phase-in of the new premiums starting in FY 2007.

Drug Pricing Cost Containment

The Act amended existing drug patent laws that delayed the entry of generic drugs to the marketplace. The Act also allows reimportation of prescription drugs from Canada if the Secretary of the US Department of Health and Human Services certifies that such drugs are safe.

Medicaid Disproportionate Share Hospitals Payments (DSH)

Medicaid DSH payments assist hospitals that serve significant numbers of low-income and uninsured patients. Each state will receive a 16% increase over its FY 2003 DSH allotment. Texas will receive \$900.7 million in DSH payments for FY 2004 (an increase of \$124.2 million over FY 2003). This annual allocation continues through 2010; beginning in 2011 this amount may be adjusted by the Consumer Price Index.

Federal Reimbursement for Emergency Health Services to Undocumented Immigrants

The Act appropriates an estimated \$250.0 million annually for FYs 2005-08 for federal reimbursement of emergency health services furnished to undocumented immigrants. Two-thirds of the total (\$167.0 million) will be distributed to eligible providers based on each state's share of undocumented immigrants. Texas' allocation is estimated at \$24.8 million for FY 2005. The remaining funds (\$83.0 million) must be distributed in the six states with the highest number of undocumented immigrant apprehensions (based on data from the US Department of Homeland Security). Eligible providers in Texas will receive an estimated \$25.0 million in FY 2005 under this provision. Hospitals, physicians, and providers of ambulance services will be eligible for reimbursement from both allocations.