Impact of the MMA on Dual Eligible Beneficiaries and State Medicaid Programs

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Key Provisions Impacting States

- Discount Drug Card
- Medicare Prescription Drug Benefit
- Employer Subsidy
- Income Relating Part B Premiums
- DSH Provisions
- Medigap Changes
- Pilot Program - Long Term Care Facility Background Checks
- Emergency Health Care -Undocumented Immigrants
- QI-1 Extension
- Cost Containment

Key Provisions continued

- Rural Equity Provisions
- Medicare Preventive Health Coverage
- Medicare Regulatory Reforms
- Hatch/Waxman Changes (Generic Drugs)
- Drug Reimportation
- Health Savings Accounts

Major Challenges for States

- Identifying State Resources for Program Implementation
- Educating Consumers/Public
- Determining Impact on the Medicaid Program
- Determining State Role Where Options are Available

Part D - Key State Issues

- Federal Assumption of Prescription Drug Benefit
- Medicaid Maintenance of Effort (Clawback")
- Medicaid Best Price
- Index Part B deductible
- Supplemental Rebates

Dual-Eligibles - Medicaid "Clawback" Concept

- The "claw-back" provision is a maintenance of effort (MOE) requirement based on state expenditures for Medicaid prescription drug coverage for full dual eligibles in calendar year 2003.
- Beginning at 90% in 2006, states will pay a decreasing percentage of the costs over a 10-year period that will end at 75% in 2014.

Claw Back

- The “claw-back” percentage will remain at 75% thereafter

State Program Administration

- Requires states, as a condition of receiving federal matching payments under Medicaid, to: (1) determine eligibility for premium and cost-sharing subsidies; (2) inform the Secretary regarding the eligibility determinations and provide other information as may be required by the Secretary; and (3) screen applicants for eligibility for other Medicare cost-sharing programs and offer to enroll them if they are eligible

State Program Administration cont.

- Provides no additional federal assistance for Medicaid program administration. Medicare Part D related activities would be matched at the regular 50 percent rate for program administration.

Medicaid Best Price

- Drug prices negotiated as part of the new Medicare law are **excluded from the calculation of the Medicaid "best price**."

MMA Medicaid "Best Price" Exclusions- Prices Negotiated for:

- Medicare-Endorsed Drug Card Programs
- Medicare Part D Prescription Drug Plans (PDPs)
- Medicare Part D Medicare Advantage Prescription Drug Plans (MA-PD)
- Qualified Retiree Prescription Drug Plans
- Purchases of Inpatient Hospital Drugs under the 340B program

Index Part B Deductible to Inflation

- Increases the Part B deductible from $100 in 2004 to $110 in 2005, to be updated annually by the same percentage increase as the Part B premium increase. *[States pay deductible for dual-eligibles]*

Supplemental Rebates

- While states continue to pay part of the cost of providing prescription drug coverage to dual-eligibles, states will no longer be able to use them as leverage in negotiating supplemental rebates.

State SPAP Options

- Repeal SPAP
- Wrap-around Federal Benefit (card fee, premiums, copays, deductibles, drugs not covered)
  - $125 million in grants available to approved SPAPs for coordination/education initiatives related to Part D implementation (first year grants were distributed to 21 states 10/28/04).

Federal Grants to SPAPs

- Connecticut - $2.5 million
- Delaware - $301,887
- Illinois - $2.8 million
- Indiana - $886,723
- Kansas - $106,906
- Maine - $2 million
- Maryland - $1.7
- Massachusetts - $4 million
- Michigan - $701,793
- Minnesota - $371,976
- Missouri - $965,647
- North Carolina - $1.1 million
- New Jersey - $11.3 million
- Nevada - $408,581
- New York - $17 million
- Pennsylvania - $11.7 million
- Rhode Island - $1.9 million
- Texas - $901,640
- Vermont - $163,560
- Wisconsin - $1.1 million
- Wyoming - $50,782

Subsidies - Qualified Retiree Prescription Drug Plans

- Authorizes subsidy of 28% of allowable costs over the $250 deductible and up to $5,000. Subsidy is excludable from taxation.
- “Qualified Plans” - Group health plans (welfare plans defined under ERISA, federal and state governmental plans, and church plans).

Subsidies - Qualified Retiree Prescription Drug Plans

- Note: Subsidy payments go to "plan sponsors." States should check state law regarding the definition of "plan sponsor" for the state retiree health plan(s).
- ADEA Question - Can employers provide different benefits to Medicare-eligible retirees and those not yet eligible for Medicare?

Income-Relate Part B Premiums

- Under $80,000 (25%)
- $80,000-$100,000 (35%)
- $100,000-$150,000 (50%)
- $150,000-$200,000 (65%)
- $200,000 (80%)

- Phased-in over 5 years, beginning in 2007
- Income levels doubled for married couples,

Other Medicaid Provisions

Disproportionate Share Hospital (DSH) Provisions

- Increases state DSH allotments in FY 2004 by 16 percent. Thereafter, allotments remain at the FY 2004 allotment level subject to the 12 percent limit established in BBA 1997 until the year in which current law "catches up" with the new proposal's allotments. When that occurs, allotment levels will be the previous year's allotment increased by the CPI-U, subject to the 12 percent limit.

DSH cont.

- Low DSH states will receive a 16% increase annually for five years.

DSH Reporting Requirements

- Requires states, as a condition of receive federal Medicaid payments, to submit to the HHS Secretary an annual report identifying:
  - each disproportion share hospital that received a payment;
  - the amount the hospital received; and
  - any other information deemed appropriate by the HHS Secretary to ensure that the payments were used properly.

Long Term Care Facilities Employee Background Checks

- Directs the Secretary to establish pilot projects to conduct national and state background checks on workers in long-term care settings, in up to 10 states
- Provides $25 million in mandatory funding for background checks
- Effective upon enactment. Pilot ends in FY 2007.

Emergency Health Care for Undocumented Immigrants

- Authorizes $250 million annually for FY 2005 - FY 2008 to reimburse providers for the uncompensated provision of emergency health care services to undocumented immigrants.
- $167 million to be allotted to the 50 states; $83 million to the 6 states with the highest number of apprehensions of undocumented immigrants.

Extends the QI-1 Program

- The MMA extended the authority for the QI-1 program through 9/30/04.
- The QI-1 program was recently extended until September 31, 2005 (S. 2618).
- The QI-1 program pays the Part B premium for Medicare beneficiaries with incomes between 120% - 135% of FPL, with limited assets.

Medigap Amendments

- Effective January 1, 2006, law prohibits the selling, issuance, or renewal of existing Medigap policies with prescription drug coverage to **Part D enrollees**.

Cost Containment

- Limits portion of Medicare spending derived from the federal treasury to 45%.
- Beginning in 2005, the Medicare trustees must issue a report whether projected "general revenue funding" will exceed 45%.
- If they report two consecutive years where Medicare spending exceeds 45% a "Medicare Funding Warning" is triggered.

Definitions

- General Revenue Funding - Total Medicare outlays - "dedicated resources."
- Dedicated Resources -
  - Hospital Insurance (HI) payroll tax
  - Taxation of OASDI benefits (Income Tax)
  - **State "Clawback" $$**
  - Medicare Premiums
  - Medicare Gifts

Other Major Provision

- Rural Equity Provisions
- Medicare Preventive Health Coverage
- Medicare Chronic Care Improvements
- Medicare Regulatory Reforms
- Access to Affordable Pharmaceuticals (Generic Drugs; Drug Reimportation)
- Tax Provisions (Health Savings Accounts)