FACT SHEET

MEDICARE

THE MEDICARE PRESCRIPTION DRUG LAW

March 2004

Overview

Enacted December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L.108-173) creates a new drug benefit as Part D of Medicare. The drug benefit begins January 2006; until then, there is an interim Medicare-endorsed drug discount card and transitional assistance program. The new law also includes other changes for beneficiaries, including increases in the Part B deductible, income-relating the Part B premium, and new preventive benefits.

Transitional Discount Card Program

Beginning June 2004 (ending by January 2006), Medicare beneficiaries have access to Medicare-endorsed drug discount cards, estimated to produce savings of 10-5% overall, although no minimum discount is required. Enrollees can sign up for only one Medicare-endorsed card per year.

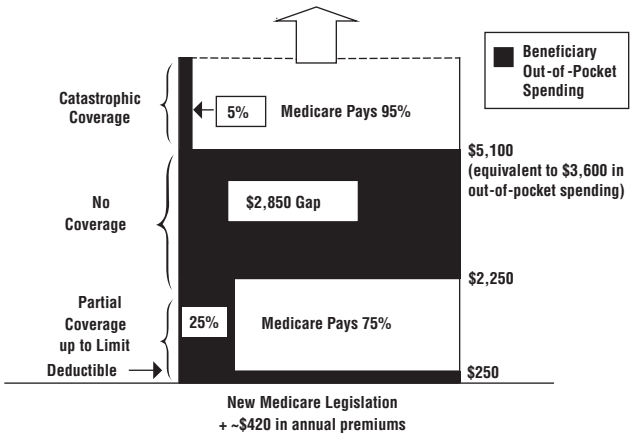
For beneficiaries with incomes below 135% of poverty ($12,569/single; $16,862/couple in 2004) who do not have private or Medicaid drug coverage, the government provides $600 per year for drug expenses in 2004 and 2005 and pays the annual enrollment fee.

The Part D Prescription Drug Benefit

Medicare will begin to pay for outpatient prescription drugs through private plans beginning in January 2006. Beneficiaries can remain in the traditional FFS program, enrolling separately in private prescription drug plans (PDPs), or they can enroll in integrated Medicare Advantage (MA) plans for all Medicare-covered benefits, including drugs. If two or more risk-bearing plans are not available (including at least one PDP), Medicare will contract with a "fallback" plan to serve beneficiaries in that area.

Figure 1

Medicare Beneficiaries' Out-of-Pocket Drug Spending Under New Medicare Rx Benefit, 2006



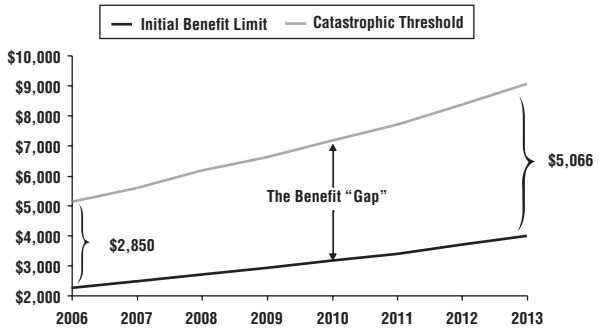
Under the standard benefit, beneficiaries in 2006:

- Pay the first $250 in drug costs (deductible);
- Pay 25% of total drug costs between $250 and $2,250;
- Pay 100% of drug costs between $2,250 and $5,100 in total drug costs (the $2,850 gap or "hole in the doughnut"), equivalent to $3,600 out-of-pocket;
- Pay the greater of $2 for generics, $5 for brand drugs, or 5% coinsurance after reaching the $3,600 out-of-pocket limit ($5,100 catastrophic threshold).

The deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending. As a result, the benefit gap is projected to increase from $2,850 in 2006 to $5,066 in 2013.

Figure 2

Growth in the Benefit Gap, 2006-2013



SOURCE: Congressional Budget Office letter to the Honorable Don Nickles, November 20, 2003.

Plans are permitted to offer an alternative benefit design provided the alternative plan is actuarially equivalent and does not increase the Part D deductible or out-of-pocket limit. Plans are required to provide drugs in each therapeutic class or category but have flexibility to establish preferred drug lists. They may also create a preferred network of pharmacies and reduce beneficiary cost-sharing for drugs dispensed by preferred pharmacies.

Beneficiaries will pay an estimated $35 per month in premiums for basic drug coverage in 2006 (with premiums likely to vary across plans), in addition to the Part B premium. Plans may also offer supplemental benefits for an additional premium.

Low-Income Assistance

Medicare will provide additional assistance to beneficiaries who qualify based on low incomes and limited assets. CBO estimates 14.1 million beneficiaries will be eligible for such assistance.

Beneficiaries who are eligible for full Medicaid benefits (~ 6.3 million dual eligibles) will begin to receive drug benefits under Medicare rather than Medicaid in 2006. They will pay no premium or deductible, and no drug costs above the out-of-pocket threshold. Below the threshold, those with incomes under 100% of poverty will pay $1 to $3 copays; those above the poverty line will pay $2 to $5 copays.

Beneficiaries with incomes below 135% of the poverty level and assets under $6,000/single; $9,000/couple (~ 5.8 million

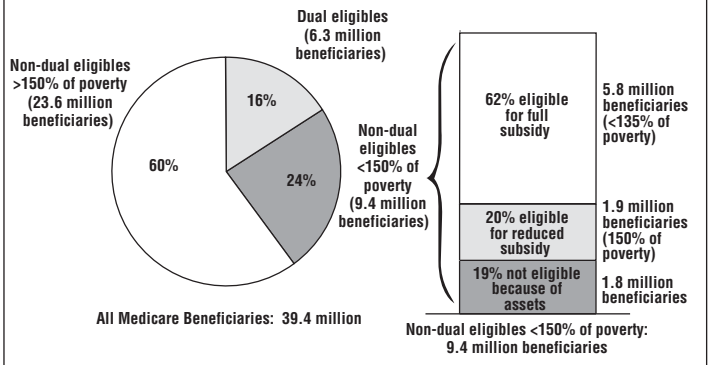
people) will receive a subsidy to cover the average premium for basic coverage in their region. They will pay $2 to $5 copays with no deductible and no cost-sharing above the out-of-pocket threshold.

Beneficiaries with incomes below 150% of the poverty level and assets under $10,000/single; $20,000/couple (~1.9 million people) will receive premium subsidies on a sliding scale. They will pay a $50 deductible, 15% coinsurance up to the out-of-pocket threshold, and $2 to $5 copays above the threshold.

Low-income beneficiaries will have to meet both an income and asset test to receive assistance for the first time in Medicare. An estimated 1.8 million beneficiaries who meet the income test will not qualify for assistance as a result of the asset test (CBO).

Figure 3

Eligibility for Low-income Assistance, 2006



Note: 100% of poverty is equal to $9,310/single; $12,490/couple in 2004.
SOURCE: Congressional Budget Office, November 2003.

Interaction With Other Coverage

The new benefit is expected to result in changes for those who currently supplement Medicare from other sources.

Medicare Advantage (formerly Medicare+Choice) plans, which provided prescription drug coverage to 18% of non-institutionalized beneficiaries in 2001, will be required to offer basic drug coverage in 2006 (except private fee-for-service and MSA plans). They may also offer additional drug benefits for an additional premium.

Employer-sponsored plans assisted 34% of beneficiaries in 2001. In 2006, employers that elect to provide prescription drug benefits comparable to Part D will receive subsidies from Medicare, which will pay 28% of costs between $250 and $5,000 in drug expenses per retiree. As a result of the new law, CBO estimates that nearly one in five Medicare beneficiaries with retiree coverage would lose drug benefits from an employer plan.

Medigap plans provided supplemental coverage to 23% of all beneficiaries in 2001 and drug coverage for 7% of the total Medicare population. In 2006, Medigap insurers will not be allowed to issue new policies that include or supplement Part D coverage. Beneficiaries who already have Medigap drug policies may keep those policies (but could face a premium penalty should they choose to enroll in Part D at a later date). Medigap will include two new packages that provide catastrophic (non-Rx) coverage.

Medicaid, a source of supplemental coverage for 12% of non-institutional beneficiaries in 2001, will no longer offer drug coverage to dual eligibles; instead, they will have to enroll in Part D plans for their drug benefits.

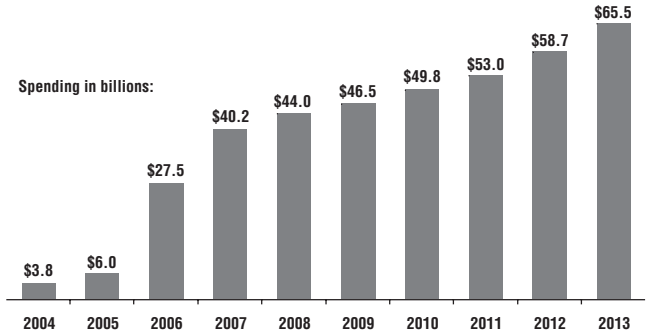
States will pay Medicare a share of the aggregate amount they would have spent on prescription drugs for dual eligibles if the law had not been enacted, resulting in an $88.5 billion "clawback" 2006-2013. Medicaid spending is projected to decrease by $17 billion across all states over this period, mostly after 2008. States may only use state dollars, not federal Medicaid matching funds, to help with cost-sharing or to cover drugs that are not on a Part D plan's formulary.

State Pharmaceutical Assistance Programs, serving 1.3 million elderly and under-65 disabled beneficiaries in 2002, will be permitted to supplement Part D coverage.

Figure 4

Total Direct Spending Projections, MMA 2003

($394 billion, 2004-2013)



Note: Incorporates spending for Rx ($409 billion) and other provisions. Excludes revenue effects ($0.5 billion).
SOURCE: Congressional Budget Office letter to the Honorable William "Bill" M. Thomas, November 20, 2003.

Other Benefit Changes

The Part B deductible, set at $100 since 1991, will increase to $110 in 2005 and will rise by the annual percentage increase in Part B expenditures thereafter.

The Part B premium ($66.60 in 2004) covers 25% of Part B costs and is currently uniform for all beneficiaries. Beginning in 2007, it will be higher for those with incomes over $80,000/single ($160,000/couple). CBO estimates this will affect 1.2 million beneficiaries in 2007 (2.8 million by 2013).

Preventive benefits, including an initial routine physical examination, cardiovascular blood screening tests, and diabetes screening tests and services, will be added in 2005.

Expenditures

CBO estimates the new law will increase direct spending outlays by $395 billion between 2004 and 2013. The legislation consists of an estimated $409.8 billion for the prescription drug benefit, which includes $192 billion in low-income subsidies and $71 billion in direct subsidies for employers. In addition, the legislation includes $14.2 billion for Medicare Advantage plans and $19.9 billion for rural providers. Offsets include beneficiary premiums ($131 billion); state Medicaid "clawback" payments (-$88.5 billion); efforts to address waste, fraud, and abuse (-$31.3 billion); provisions to income-relate the Part B premium (-$13.3 billion); and indexing the Part B deductible (-$11.6 billion).

Note: Estimates of supplemental coverage based on Laschober analysis of MCBS "Access to Care File," 2001, for Kaiser Family Foundation, 2004.

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