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The Federal Medicare Prescription Drug Bill Plan: Its Implications for the New England States

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On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Its centerpiece, and most costly provision, is a voluntary prescription drug benefit, to be delivered primarily through private entities under contract with the federal government beginning in 2006. Beyond this, the bill contains several additional provisions that also carry significant fiscal implications for the New England states. Chief among these is the new law's treatment of individuals eligible for both Medicare and Medicaid.

Medicare and Medicaid: Some Background

Medicare, formally Title XVIII of the Social Security Act of 1965, is a federal health insurance program that covers more than 35 million Americans aged 65 and older and 6 million younger, diasabled adults. The program's major components are the following:

- Part A covers inpatient hospital care, home health care following a hospital stay, and hospice care. The federal government finances it with payroll taxes accumulated in a trust fund.
- Part B, funded by beneficiary premiums (co-payments by Medicare recipients) and federal general revenues, covers physician and outpatient hospital care as well other medical screening and prevention services.
- Part D, funded from the same sources as Part B, is the new prescription drug benefit.[1]

The Congressional Budget Office (CBO) projects that Medicare spending, currently accounting for 13 percent of the federal budget, will grow by an average of 6.8 percent per year between 2004 and 2013. The Part A trust fund, whose balance is a common measure of the program's fiscal health, is expected to remain solvent through 2026. The new prescription drug benefit is the largest expansion of the program since its inception. The CBO estimates that providing this benefit will increase net federal outlays by a total of $395 billion over the ten-year period from 2004 through 2013. The new program's actual cost, $410 billion, will be partially offset by cost containment measures and administrative reforms within other areas of the Medicare program.[2]

Medicaid, formally Title XIX of the Social Security Act of 1965, is a medical entitlement program for certain individuals

and families with low incomes and limited resources. Within broad national guidelines established by the federal government, each state "establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program." Unlike Medicare, which is exclusively federally funded, the federal government shares responsibility for financing Medicaid with the states. It matches state spending for Medicaid services based on statutory formulae.[3] This matching rate, referred to as the Federal Medical Assistance Percentage (FMAP), is based on the per capita income of a given state and varies between 50 percent of state Medicaid expenditures to a high of 77 percent of expenditures. Here in New England, the FMAP is 50 percent for Connecticut, Massachusetts, and New Hampshire; 56 percent for Rhode Island; 61 percent for Vermont; and 66 percent for Maine. Additionally, the Jobs and Growth Tax Relief Reconciliation Act of 2003 temporarily increased each state's FMAP for the last two calendar quarters of FY2003 and the first three calendar quarters of FY2004. The FMAP of each New England state was increased by 2.95 percentage points.

On average, states spend about 15 percent of their budgets on Medicaid (Table 1). Here in New England, the unweighted average is around 18 percent and has been increasing. The thoughts of budget officials on this subject are perhaps best summed up by John Rogers, chairman of the Massachusetts House Appropriations Committee, who recently observed: "Medicaid is the black hole of the state budget. Every other program in our budget cannot escape its gravitational pull."[4]

Nationally, Medicaid spending grew by 13 percent in FY2002. Here in New England, it actually decreased in Massachusetts, as legislators decided to reduce benefits as part of a budget balancing strategy. Elsewhere in New England, states increased their outlays of Medicaid funds at rates ranging from 8 percent in New Hampshire to 13 percent in Vermont (Table 2). In FY2003, the rate of growth decelerated to 9 percent nationwide and to an unweighted average of 4 percent for the New England states.

Table 1. Medicaid as a Percent of Total State Expenditures

New England States

	FY2001	FY2002	FY2003
Connecticut	20	21	22
Maine	12	12	14
Massachusetts	25	23	24
New Hampshire	19	19	20
Rhode Island	17	18	17
Vermont	11	12	12

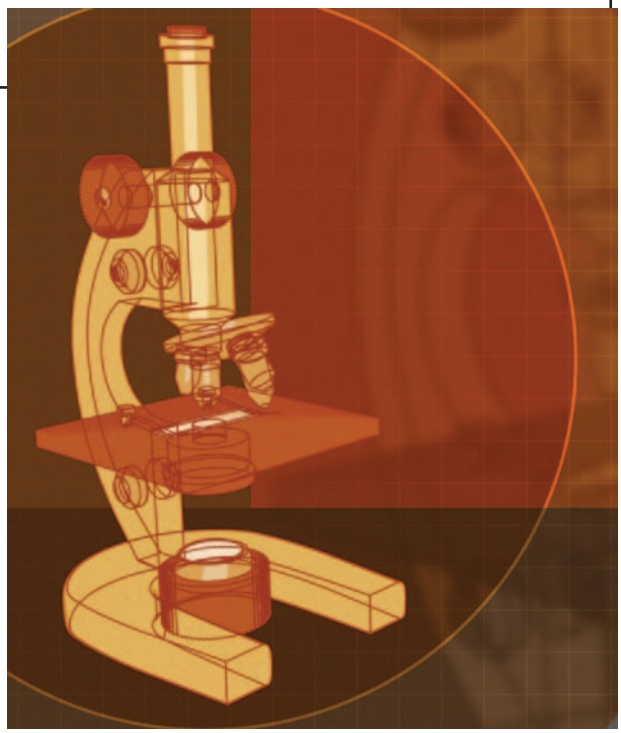
Source: National Association of State Budget Officers, state budget documents.

Table 2. Medicaid Spending in New England

State Funds Only

	Millions of Dollars			Annual Percent Change in Expenditures	
	FY2001	FY2002	FY2003*	FY2001 to FY2002	FY2002 to FY2003
Connecticut	2972	3272	3445	10.1	5.3
Maine	447	494	502	10.5	1.6
Massachusetts	5642	5259	5496	-6.8	4.5
New Hampshire	457	492	534	7.7	8.5
Rhode Island	568	639	633	12.5	-0.9
Vermont	215	243	255	13.0	4.9

*Estimated
Source: National Association of State Budget Officers, 2002 State Expenditure Report, November 2003; State of Vermont, Joint Fiscal Office.



Nevertheless, over the past several years, Medicaid spending has generally grown faster than state and local outlays as a whole. Among the principal drivers of the rapid increase in costs is a subgroup of Medicaid recipients referred to as "dual eligibles."

The Medicare/Medicaid Nexus: "Dual Eligibles"

Although Medicare and Medicaid are self-standing programs, serving distinct populations, certain Medicare beneficiaries with low incomes and limited resources may also receive assistance through the Medicaid program. Nationally, an estimated seven million disabled and/or elderly persons participated in both programs in 2002. These "dual eligibles" accounted for 15 percent of all Medicaid enrollees

Table 3. Dual Eligibles and Full Dual Eligibles in New England, 2002

	Dual Eligibles	Duals as a Percent of All Medicaid Enrollees	Duals as a Percent of Aged and Disabled Enrollees	Full Dual Eligibles	Full Duals as a Percent of All Dual Eligibles
Connecticut	83,000	17	71	76,000	92
Maine	49,000	21	64	42,000	85
Massachusetts	216,000	17	61	193,000	89
New Hampshire	20,000	16	72	19,000	93
Rhode Island	33,000	16	59	27,000	82
Vermont	28,000	17	73	22,000	77

Source: Urban Institute estimates based on data from Medicaid Statisical Information System.

nationally in 2002. Here in New England, the proportion was 17 percent.

The majority of these low income and low net worth individuals, roughly 88 percent of all dual eligibles in New England in 2002, are eligible for full Medicaid benefits (Table 3). For these beneficiaries, state Medicaid programs pay for services such as prescription drug coverage and long-term care that, although not available through Medicare, are offered as part of a state's Medicaid benefits package (Table 4). Beyond these fully eligible individuals, federal law mandates partial Medicaid coverage for four other groups of qualified beneficiaries (Table 5).

Table 4: Full Medicaid Eligibility Pathways for Medicare Beneficiaries, 2003

Full Eligibility Categories	Income Eligibility	Asset Limit	Medicaid Benefits
Supplemental Security Income (SSI) Cash Assistance Related (mandatory)	Generally 74 percent of the Federal Poverty Level (FPL) for individuals and 82 percent for couples.	$2,000 individual; $3,000 couple	"Wrap around" Medicaid benefits including long-term care and prescription drugs. Medicaid pays Medicare premiums and cost-sharing.
Poverty Related (optional)	Up to 100 percent of the FPL.	$2,000 individual; $3,000 couple	"Wrap around" Medicaid benefits including long-term care and prescription drugs. Medicaid pays Medicare premiums and cost-sharing.
Medically Needy (optional)	Individuals who spend down their incomes to state-specific levels.	$2,000 individual; $3,000 couple	"Wrap around" Medicaid benefits (may be more limited than those for SSI recipients). Medicaid may also pay Medicare premiums and cost sharing, depending upon income.
Special Income Rule for Nursing Home Residents (optional)	Individuals living in institutions with incomes up to 300 percent of SSI.	$2,000 individual; $3,000 couple	"Wrap around" Medicaid benefits including long-term care and prescription drugs. Medicaid pays Medicare premiums and cost-sharing.

Source: Kaiser Commission on Medicaid and the Uninsured.

Table 5: Partial Medicaid Eligibility Pathways for Medicare Beneficiaries, 2003

Full Eligibility Categories	Income Eligibility	Asset Limit	Medicaid Benefits
Qualified Medicare Beneficiaries (QMBs) (mandatory)	Up to 100 percent of FPL.	$4,000 individual; $6,000 couple	No Medicaid benefits. Medicaid pays Medicare premiums and cost-sharing.
Specified Low-Income Medicare Beneficiaries (SLMBs) (mandatory)	Between 100 percent and 120 percent of FPL.	$4,000 individual; $6,000 couple	No Medicaid benefits. Medicaid pays Medicare premiums (Part B only).
Qualified Working Disabled Individuals (QWDIs) (mandatory)	Working, disabled individuals with incomes up to 200 percent of FPL.	$4,000 individual; $6,000 couple	No Medicaid benefits. Medicaid pays Medicare premiums (Part A only).
Qualifying Individuals (QIs) (optional)	Between 120 percent and 135 percent of FPL.	$4,000 individual; $6,000 couple	No Medicaid benefits. Medicaid pays Medicare premiums (Part B only). Federally funded, no state match. Participation may be limited by funding.

Source: Kaiser Commission on Medicaid and the Uninsured.

In the aggregate, these dual eligibles, despite representing a relatively small proportion of all Medicare beneficiaries (less than 20 percent of recipients), are extremely costly to the states. Here in New England, total expenditures on dual eligibles ranged from a high of 69 percent of all Medicaid spending in Massachusetts to a low of 38 percent in Vermont (Table 6). By far, the largest broad category of expenditure is for long-term care, representing roughly 70 percent of total dual eligible spending. The second largest category of expenditure nationally is prescription drugs. Here in New England, however, prescription drug spending, although the second largest category of spending in Connecticut and Vermont, ranks below spending on premiums and acute care subsidies in Maine, Massachusetts, New Hampshire, and Rhode Island (Table 6).

Because caring for dual eligibles is so expensive, both on a per capita basis and as a proportion of overall Medicaid costs (Table 6), these individuals have become a significant point of debate between states and the federal government. States, facing record budget deficits and severe fiscal constraints, have argued that the federal government should assume full responsibility for the cost of covering dual eligibles. The federal government, facing its own deficit dilemma has, to date, been unwilling to assume this additional cost.[5]

The new Medicare prescription drug law provides some fiscal relief to the states in this area. The extent of this relief, however, remains unclear.

The Prescription Drug Law

The new prescription drug law is the largest expansion of the Medicare program since its inception. Consequently, as stated by the Congressional Budget Office, there is "a great deal of uncertainty about its budgetary impact and a wide range of possible outcomes." The CBO's estimate of the program's cost to the federal budget is the result of extensive analyses of the pharmaceutical drug market, the Medicare program, and the likely responses of potential enrollees. Similarly detailed analyses at the state level have not yet been conducted. Despite this lack of specific projections, it is safe to say that, given the structure of the cost-sharing arrangements contained in the new law, any fiscal relief flowing to the states will be years away.

Under the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as of January 1, 2006, dual eligibles will receive prescription drug coverage under Medicare Part D. As a result, states will no longer need to cover them with their own outlays. If dual eligibles do not enroll in Part D, or if they need more coverage than is available under their Part D plan, states can provide it to them using their own funds, but they will no longer receive a Medicaid match. In other words, if states choose to provide coverage above federally established Part D levels, they do so at their own expense.

In and of itself, this assumption of prescription drug costs by the federal government should save the states hundreds of billions of dollars. Several other provisions of the new law, however, significantly lower the savings that states will actually achieve. Chief among these is a "clawback" provision requiring states to continue to finance some of the cost of providing the prescription drug benefit to dual eligibles. Under the new law, states are required to make a payment to the federal government equal to the product of three factors: first, a "take-back" factor (set at 90 percent in 2006 and dropping to 75 percent in 2015); second, the monthly number of dually eligible enrollees in Medicaid and Medicare; and third, a per capita amount designed to approximate the amount it would have cost the states for full-time Medicaid prescription drug coverage for fully eligible dual enrollees.[6]

The Congressional Budget Office estimates that, nationally, the elimination of Medicaid-financed prescription drug coverage for dual eligibles will reduce state Medicaid spending by approximately $115 billion between FY2004 and FY2013. Over this same time period, the CBO estimates that approximately $89 bil-

Table 6. Medicaid Expenditures for Dual Eligibles in New England, 2002

	Millions of Dollars					Spending Per Dual Eligible (Dollars)	Total Dual Eligible Spending as a % of Total Medicaid Spending
	Total	Premiums & Medicare Acute	Prescribed Drugs	Other Acute Care	Long-Term Care		
Connecticut	2,252	148	201	74	1,829	27,000	46
Maine	645	73	106	108	357	13,116	45
Massachusetts	3,638	440	408	305	2,485	16,818	69
New Hampshire	455	62	52	6	335	22,500	46
Rhode Island	715	157	63	7	488	21,837	52
Vermont	248	28	58	13	149	8,782	38

Source: Kaiser Commission on Medicaid and the Uninsured. State of Vermont, Joint Fiscal Office.

lion, or roughly 77 percent, will flow back to the federal government in the form of the mandatory clawback payments. Precise state level estimates, because of the high number of unknown variables, are not possible to construct at this time. However, the U.S. Department of Health and Human Services' administrator for Medicare and Medicaid, the Centers for Medicare and Medicaid Services (CMS), estimates that, between FY2006 and FY2013, Connecticut will save $549 million; Maine, $161 million; Massachusetts, $996 million; New Hampshire, $203 million; Rhode Island, $204 million; and Vermont, $76 million. Most of these savings will not materialize until after 2010 as the clawback percentage drops.

In the near term, the Congressional Budget Office estimates that the new law will actually cost some states more in Medicaid spending. This is the result of clawback payments in 2006 that will, possibly, remain larger than the amount of fiscal savings that certain states will secure as a result of no longer providing prescription drug coverage to dual eligibles. The clawback payments are based, in part, on estimates of national growth over time in per capita prescription drug expenditures. States that would have experienced relatively modest growth must still make payments to the federal government based on the nationwide trend. Additionally, the new law places significant new responsibilities on states to administer Medicare's low income subsidy program. As a result of these new requirements, states will likely incur substantial administrative costs that will, again, offset savings resulting from the elimination of state funded dual eligible drug coverage.

Moving Forward

Given the complexity of the prescription drug law, the peculiarities of state Medicaid programs, shifting enrollment patterns, and lags in the release of state-level Medicaid data, it will likely be some time before estimates of the fiscal impact of the new law are developed for each of the New England states. The trajectory of state-level prescription drug expenditures, dual enrollment patterns, and current state prescription drug expenditure levels will all affect the net savings, if any, that states will enjoy under the new law.

Additionally, a key question moving forward for the New England states, and a large determinant of the overall savings the new law could potentially yield for the region, is how policymakers choose to supplement the new Part D benefit. If states choose to use their own funds to supplement the drug coverage available under Medicare, the new prescription drug law may result in limited savings – if any – for New England.

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[1] The Balanced Budget Act of 1997 (BBA) added Part C, called Medicare+Choice, to Medicare. The Act expanded the types of private health plans (such as private fee-for-service, medical savings accounts, preferred provider organizations, and provider-sponsored organizations) with which the Centers for Medicare and Medicaid Services (CMS) – Medicare's administrator – can contract.

[2] CBO estimates the cost of the new Medicare law at $410 billion over ten years. On January 29, 2004, the Bush administration said that the new law will cost roughly $530 billion over the next ten years. On February 2, 2004, CBO Director Douglas Holtz-Eakin, in a letter to the Chairman of the House Budget Committee, addressed the discrepancy by saying, "To date, we have not received any additional data or studies that would lead us to reconsider our conclusions. Therefore, CBO believes its estimate is sound and has no reason, at present, to revise it." The estimates released by CBO are, to date, significantly more detailed than the Adminstration's estimates. This article relies on CBO estimates unless otherwise stated.

[3] Section 1905(b) of the Social Security Act specifies the formula for calculating Federal Medical Assistance Percentages as follows: "'Federal medical assistance percentage' for any state shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum…"

[4] Scott S. Greenberger, "House Panel Forecast Bigger Deficit," *The Boston Globe*, January 14, 2004.

[5] See, for example, letter from Governor Dirk Kempthorne, Governor John Hoeven, Governor Jeb Bush, Governor John G. Rowland, and Governor Robert L. Erlich, Jr., to Tommy Thompson, U.S. Secretary of Health and Human Services, July 10, 2003.

[6] Gross per capita drug expenditures are equal to the weighted average of prescription drugs covered under state Medicaid programs in 2003 and an estimated actuarial drug benefit value adjusted annually to 2006 by the percent change in per capita prescription drug expenditures based on National Health Expenditure projections.