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MEDICARE AGREEMENT WOULD MAKE SUBSTANTIAL NUMBERS OF SENIORS AND PEOPLE WITH DISABILITIES WORSE OFF THAN UNDER CURRENT LAW

by Edwin Park and Robert Greenstein

A substantial number of the 6.4 million low-income Medicare beneficiaries who also are eligible for Medicaid and currently receive prescription drug coverage through Medicaid would be made worse off under the Medicare conference agreement. Those who would be adversely affected are among the sickest and most vulnerable Medicare beneficiaries.

Under current law, when a benefit or service is covered by both Medicare and Medicaid, Medicare serves as the primary payer, and Medicaid "wraps around" that coverage. Medicaid fills in gaps in coverage that exists under the Medicare benefit. It also picks up most or all of the beneficiary co-payments that Medicare charges.

But the emerging conference agreement would make an unprecedented change in how Medicare and Medicaid work together. It would largely *eliminate* Medicaid's supplemental — or "wrap around" — role under the new Medicare drug benefit. As a result, substantial numbers of poor elderly and disabled people would be forced to pay significantly more for their prescriptions than they now do. Those who could not afford the higher co-payments could lose access to some of the prescription drugs they need. In addition, in cases where Medicaid covers a prescription drug but the private plan that administers the Medicare drug benefit in the local area does not provide that drug under Medicare, poor elderly and disabled beneficiaries who now receive the drug through Medicaid could lose access to it. Given their limited incomes, such people generally would not be able to afford such drugs on their own.

The elimination of Medicaid wrap-around coverage has been added in recent days in the conference in order to save money by reducing Medicaid costs. The resulting savings have apparently been used elsewhere in the drug bill to satisfy more powerful constituencies.

1. **Most low-income seniors and people with disabilities who qualify for Medicaid would be charged higher co-payments for prescription drugs under the new Medicare drug benefit than they now pay under Medicaid. This could discourage some poor beneficiaries — particularly those who have serious medical conditions and need a large number of prescriptions — from obtaining all of the drugs they need.**

   - Under current law, low-income beneficiaries who qualify for both Medicare and Medicaid (a group known as the "dual eligibles") either receive prescription drugs free of charge or are charged nominal amounts such as $1 or $2 per month per prescription. (State Medicaid programs may charge these individuals a maximum of $3 per month per prescription, but few states charge that much. Research has

shown that, given the low-income status of these people, Medicaid co-payments at that level can discourage the purchase of medically necessary drugs.[1])

- Under the Medicare conference agreement, dual eligibles with incomes below 100 percent of the poverty line would be charged $3 per prescription per month for brand-name drugs and $1 per prescription per month for generic drugs. Those with incomes above 100 percent of the poverty line would pay $5 per prescription per month for brand-name drugs and $2 per prescription per month for generics. There would be no ceiling to limit the total monthly charges imposed on a poor beneficiary who is sick and has a large number of prescriptions. Individuals in nursing homes, however, who constitute nearly one-quarter of the dual eligibles would be exempt from any co-payments as under current law. (Note: most dual eligible beneficiaries who have incomes above the poverty line are a group known as the "medically needy;" they qualify for Medicaid because they incur high medical costs that reduce their *disposable* incomes to below the poverty line. Many of these people live in their own homes but require intensive and costly long-term care services. Although these individuals technically have incomes above the poverty line, much of their income is consumed by high medical costs.)

- As a result, three-quarters of the 6.4 million dual eligibles would be charged more for drugs than under current law. Depending on how the conferees settle an issue that has yet to be resolved, the increased co-payment charges could become quite large over time.

  Specifically, while the $1 and $3 amounts for those below the poverty line ($8,980 for an individual) would be increased at the rate that the Consumer Price Index increases, the $2 and $5 amounts for those above it would *be raised annually by the percentage that Medicare drug costs increase per beneficiary*. The Congressional Budget Office projected earlier this year that such drug costs would rise at least 10 percent per year. Yet these low-income elderly and disabled Medicaid beneficiaries above poverty — who generally already have catastrophic medical costs — subsist on small Social Security payments that are increased annually in accordance with the Consumer Price Index. The CPI rises much more slowly than prescription drug costs; the CPI — and hence Social Security benefits as well —are increasing about two to three percent per year. The Congressional Budget Office projects that in the years ahead, *Medicare drug costs will rise about four times faster than the CPI.*

  Thus, if the co-payment charges that dual-eligible beneficiaries must pay are raised each year at the rate that drug prices increase, low-income elderly and disabled people who now receive prescription drugs free of charge or at very low cost through Medicaid will face co-payment charges that rise much faster than their incomes.

[1] Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 7, 2003.

2. **Some low-income Medicare beneficiaries could lose access to particular drugs they currently are prescribed through Medicaid if those drugs are not covered under their Medicare drug plan's formulary.** Under the new Medicare drug benefit, each Medicare drug plan could have its own list of covered prescription drugs. The only requirement is that the private drug plans that will administer the Medicare drug benefit must cover at least one drug per "therapeutic class." (There is no generally accepted definition of what constitutes a class of drugs.) Some private drug plans may exclude certain high cost drugs for financial reasons; the drug itself is very expensive or the beneficiaries who often need it have higher-than-average drug costs. If a prescription drug that a beneficiary needs is not covered by the private plan, the beneficiary may use a Medicare appeals process, but how effective this appeals process will be in providing access to medically necessary drugs is unclear.

   The conference agreement would prohibit Medicaid from wrapping around Medicare by covering a prescription drug that a low-income elderly and disabled beneficiary may need but that is not included in the Medicare drug plan's formulary. Yet certain specific drugs may be the only drugs that are effective for an individual patient; such drugs can be necessary to ensure that the patient receives appropriate care even though other drugs in the same therapeutic class are intended to treat the same condition. In some such cases, if a poor elderly or disabled individual enrolled in Medicaid is unable to get a drug because it is not one of the drugs covered under the Medicare drug plan in which the individual has enrolled, the patient's health may suffer.

Conclusion

The conference agreement's unprecedented step in prohibiting Medicaid from fulfilling its traditional wrap-around role, coupled with the co-payment charges the bill would impose on dual eligibles, would result in several million of the nation's poorest and frailest seniors and disabled people paying more for drugs than under current law. The effects would be largest on those who need a large number of prescriptions.

To avert such an outcome, states would have to elect to wrap around the new Medicare drug benefit *at 100 percent state cost*. According to a report by the Kaiser Commission on Medicaid and the Uninsured, based on discussions with state Medicaid directors, "to maintain the same coverage, states that historically have provided a comprehensive prescription drug benefit to dual eligibles under Medicaid would be forced to use their general revenue funds to finance...the wrap-around on their own. To the extent they cannot find ways to supplement the Medicare coverage, many dual eligibles could end up with worse drug coverage than they currently receive through Medicaid."[2]

In many states, already strained state budgets are unlikely to be able to absorb the financial cost of providing wrap-around coverage solely with state funds. If so, substantial numbers of low-income elderly and disabled people who are enrolled in both Medicaid and Medicare would be adversely affected by the new legislation.

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[2] Vernon Smith, Sandy Kramer and Jocelyn Guyer, "Coordinating Medicaid and Medicare Prescription Drug Coverage," Kaiser Commission on Medicaid and the Uninsured, November 2003.