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SENATE PRESCRIPTION DRUG BILL WOULD EXCLUDE MILLIONS OF LOW-INCOME BENEFICIARIES

Conferees Can Ensure All Medicare Beneficiaries Have Access to New Prescription Drug Benefit

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Summary

In 1965, Congress passed, and President Lyndon Johnson signed, legislation creating the Medicare program. One of the core principles of this new program was the promise that upon turning 65, all Americans would be eligible for Medicare. This tenet, known as universality, was written into the law to ensure that elderly individuals would have access to Medicare's basic package of health care benefits regardless of their income, place of residence, or ethnicity. This principle has been the bedrock of the program since its inception.

On June 27, 2003, the Senate and the House of Representatives both passed legislation (S.1 and H.R. 1, respectively) that would create a new prescription drug benefit under the Medicare program. The two bills differ in many important respects. One of the key distinctions between them lies in their treatment of about six million low-income Medicare beneficiaries who also are eligible for full Medicaid benefits, a group known as the "dual eligibles."

While many aspects of the Senate bill are preferable to corresponding elements of the House package, the Senate bill takes the unprecedented step of *excluding* approximately six million low-income seniors and people with disabilities who also are eligible for full Medicaid from receiving the new Medicare prescription drug benefit. Under the Senate bill, these low-income beneficiaries would be denied the Medicare prescription drug benefit and be expected to continue to receive drug coverage through Medicaid instead.

Never before in Medicare's history has a Medicare beneficiary been denied access to a covered Medicare benefit; Medicare has always been the primary payor for benefits that both Medicare and Medicaid cover. By departing from this basic principle, the Senate bill ventures into problematic territory. This aspect of the Senate bill could cause substantial numbers of low-income seniors and people with disabilities to have more restrictive government-sponsored drug coverage than is provided to middle- and upper-income elderly and disabled people. It also risks causing harm to low-income seniors and people with disabilities by creating a perverse incentive for states to scale back Medicaid eligibility for the elderly and disabled and thereby shift some Medicaid prescription-drug costs to the federal Medicare program. Such a step would cause affected seniors and people with disabilities to lose coverage for other vital services that Medicaid covers but Medicare does not, such as nursing home care, home and community-based services, and personal care services. The Senate bill consequently risks making health insurance coverage for many low-income elderly and disabled people *worse* than under current law.

Over time, the structural change that the Senate bill would make in Medicare by excluding the dual eligibles from Medicare drug coverage also would have a large impact on states. It would diminish states' ability, in the years when the baby boomers begin retiring in large numbers and the number of elderly people on Medicaid swells, to afford to maintain adequate health coverage through Medicaid for the millions of low-income seniors, people with disabilities, parents, pregnant women and children who rely upon it.

In recent years, Medicaid has borne an increasing share of the costs of providing health care coverage for the elderly and people with disabilities.[1] In 1984, Medicaid bore 30 percent of total public expenditures for health insurance for the aged and disabled, and Medicare paid for 70 percent. By 1998, Medicaid's share of these costs had risen to 40 percent, while Medicare's share had shrunk to 60 percent, a trend that has continued since then. This shift in costs from Medicare to Medicaid has squeezed state budgets, caused state Medicaid costs to rise more rapidly than would otherwise have been the case, and weakened states' ability to continue financing their share of Medicaid costs, especially during the current economic slump. This cost-shift has occurred largely because Medicare generally does not cover prescription drugs and long-term care, while Medicaid does.

Medical practice has changed in recent years. Hospital stays, for which Medicare is the primary payor for people enrolled in both Medicare and Medicaid, are now shorter. At the same time, there is greater reliance on drug therapies, the cost of which is borne entirely by Medicaid. These changes in medical practice have shifted more of the cost of providing health care for the low-income elderly and disabled population from Medicare to Medicaid and hence from the federal government to the states. Today, health care expenditures for dual-eligible beneficiaries account for one-third of all Medicaid expenditures, even though these beneficiaries make up only about 15 percent of Medicaid enrollees.

Fiscal pressures on states will intensify further as the baby-boom generation retires and the number of elderly people and people with disabilities increases. (As the population ages, the number of people with disabilities increases along with the number of elderly, since the incidence of disability increases with age.) Elderly and disabled beneficiaries have substantially higher health care costs than younger individuals such as parents and children. These demographic trends threaten to make it increasingly difficult for states to maintain their Medicaid programs in the years and decades ahead.

To address this problem and help states continue to afford to finance their share of Medicaid costs when the baby-boomers retire, the nation's governors have recommended that the federal government assume more of the cost of health insurance coverage for the dual eligibles. This step is likely to be necessary to avert deep cutbacks in state Medicaid programs that ultimately would affect many categories of Medicaid beneficiaries, including low-income children and their parents, as well as seniors and people with disabilities.

A Medicare prescription drug benefit that adheres to basic Medicare principles — under which *all* Medicare beneficiaries, including dual eligibles, receive drug coverage through

[1] Leighton Ku, *Shifts in Costs from Medicare to Medicaid is a Principal Reason for Rising State Medicaid Expenditures*, Center on Budget and Policy Priorities, March 3, 2003.

Medicare — would be an important step in this direction. It would help ease the looming long-term state Medicaid financing crisis, which eventually will pose serious difficulties for the nation's low-income population and the U.S. health care system, if not addressed. While the House prescription drug bill has serious shortcomings in a number of other areas where the Senate bill is preferable, the House bill takes a much sounder approach with regard to prescription drug coverage for the dual eligibles, including them under its Medicare drug benefit.

The Senate bill charts a different course, and its shortcoming in this area was highlighted in a recent letter from the National Governors Association to Senate Finance Committee Chairman Charles Grassley (R-IA) and Ranking Member Max Baucus (D-MT). The governors wrote: "A major reason that states currently have a long-run structural problem in their fiscal outlook is that they have absorbed responsibility for dual eligibles. This [the Senate] provision would continue to shift appropriate federal costs to states."[2]

Risks to Poor Elderly People and People With Disabilities

The adverse effects of the Senate bill's exclusion of the dual eligibles from the Medicare drug benefit would extend well beyond the fiscal impact on states. Under federal law, states generally are required to extend eligibility for full Medicaid coverage *only* to those elderly and disabled people who qualify for the federal Supplemental Security Income program (SSI). The SSI income limit is low — just 74 percent of the poverty line for elderly and disabled individuals.[3] States are allowed to set their Medicaid income limits for the elderly and disabled somewhat higher — for example, up to 100 percent of the poverty line — and 19 states that contain 49 percent of the nation's seniors do so.[4] Under the Senate bill, these 19 states would have an incentive to scale back eligibility for Medicaid coverage part or all of the way to the federal minimum level of 74 percent of the poverty line. By doing so, these 19 states would shift from Medicaid to Medicare, and hence to the federal government, the costs of prescription drug coverage for the elderly and disabled people who would no longer be eligible for Medicaid.

The low-income seniors and people with disabilities who would lose regular Medicaid coverage would qualify for the new Medicare drug benefit. But they would lose access to other essential services covered solely by Medicaid, such as home and community-based care and personal care services, long-term nursing-home care, vision care, audiology and dental services.[5] They also could lose coverage for certain acute-care services in cases where beneficiaries need a level of service that exceeds the scope or limits of the Medicare benefit, such as annual physical

[2] Governor Paul Patton (D-KY) and Governor Dick Kempthorne (R-ID), *NGA Letter to Chairman Grassley and Ranking Member Baucus*, June 11, 2003.

[3] The federal income limit for elderly and disabled couples is 82 percent of the poverty line.

[4] National Association of State Medicaid Directors, the Center for Workers with Disabilities and the American Public Human Services Association, *Aged, Blind and Disabled Medicaid Eligibility Survey*, June 27, 2002. The survey finding that 19 states have broader eligibility criteria reflects state practices in 2001.

[5] Some states that scale back Medicaid eligibility in this manner might be able to maintain Medicaid coverage for nursing home care coverage and certain other services for affected beneficiaries by establishing or modifying their existing "medically needy" optional coverage category.

exams.[6] For poor people with disabilities and very frail seniors, loss of this coverage could be a considerable blow.

The Senate bill implicitly acknowledges this danger. It includes a provision authored by Senator Orrin Hatch to address the perverse incentive for these 19 states to scale back their eligibility criteria. The Hatch provision would provide these 19 states with additional federal funding if they continue to use eligibility criteria for elderly and disabled beneficiaries that are broader than the minimum eligibility criteria required under federal law.[7]

The funds that the amendment would provide to states that maintain broader eligibility criteria, however, are likely to be insufficient to accomplish this task. The Congressional Budget Office estimates the Hatch provision would provide $3.5 billion over 10 years to states. With prescription drug costs raising sharply, these modest funds are likely to prove increasingly inadequate as time goes by to overcome the perverse incentive for states to scale back coverage. The Senate bill consequently sets the stage for actions over time in various states to scale back Medicaid coverage for all but the poorest elderly people and people with disabilities. (The 19 states in question are California, Florida, Hawaii, Illinois, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, and the District of Columbia.)

Senate Bill Creates Two-Tiered Program

States have the option under Medicaid law of providing prescription drug coverage to Medicaid beneficiaries, and all 50 states and the District of Columbia have elected this option. But states provide widely varying degrees of drug coverage to their elderly and disabled Medicaid beneficiaries. Many states place limits, which can be very restrictive, on the number of covered prescriptions their Medicaid programs will cover. Many states also restrict access to some drugs.

According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid programs in 41 states limit prescription drug coverage for low-income seniors in varying ways. Some states like Arkansas limit the number of prescription drugs under Medicaid to three a

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[6] Medicare covers physician services but only a limited number of preventive services. It does not cover routine physicals.

[7] Under the Hatch provision, the federal government would pay 100 percent of the costs that state Medicaid programs incur in paying the Medicare Part A deductibles and cost-sharing charges for Qualified Medicare Beneficiaries with incomes between the federal minimum Medicaid eligibility criteria for elderly and disabled people — generally 74 percent of the poverty line for individuals — and 100 percent of the poverty line. Currently, the federal government pays the same share of these costs as it does of all other Medicaid benefit costs, which, on average, is 57 percent of such costs.

There would be no requirement under the Hatch provision for states to maintain their current Medicaid income eligibility limits for seniors and people with disabilities. States would receive funding to cover the Medicare Part A deductible and cost-sharing charges for each beneficiary with income between the federal minimum eligibility levels and the poverty line. A state that currently covers seniors and people with disabilities up to 100 percent of the poverty line could decrease eligibility to 80 percent of the poverty line and receive additional federal funding for beneficiaries with incomes between the federal minimum eligibility level and 80 percent of the poverty line.

month regardless of the beneficiary's medical condition and need for medication.[8] At least 36 states require, and others are considering requiring, that doctors obtain special pre-approval from state Medicaid agencies — known as prior authorization — before Medicaid will cover certain prescription drugs for a beneficiary.[9] Such restrictions are being used with greater frequency by states as they struggle to balance their budgets.

In every other area where Medicare and Medicaid both cover a benefit, Medicare serves as the primary payor, and all seniors and people with disabilities who are eligible for Medicare receive the basic benefit that Medicare provides. *Medicaid* serves as the secondary payor, and if the coverage that Medicare provides for a service is more limited than the coverage Medicaid provides — as is the case, for example, with nursing home care — Medicaid pays for the additional coverage that a beneficiary may need.[10] The Senate bill abandons this longstanding arrangement, however, by excluding the dual eligibles from the drug coverage that Medicare would provide to all other beneficiaries.

As Urban Institute president Robert Reischauer observed in a recent article on the Senate and House bills: " The difference for [the dual eligible] beneficiaries is more than a matter of which program pays for their prescriptions. Because each state determines its own Medicaid drug benefit, the drug plan available to dual eligibles will vary [under the Senate bill] depending on where they live. Although many state Medicaid programs have provided generous prescription drug coverage in the past, spiraling Medicaid costs and severe budget difficulties have forced many of them to cut back….Thus, Medicare's poorest participants — those who qualify for Medicaid — could find themselves with stingier drug coverage than other beneficiaries." (A longer excerpt from the Reischauer article can be found on page 6.)

Risk of Reductions in Health Care Coverage for Low-Income Seniors and People with Disabilities

Prescription drug costs have been increasing more rapidly than the costs of other health care services. With rising Medicaid costs intensifying the pressure on state budgets, a requirement that Medicaid continue to shoulder full responsibility for prescription drug benefits for dual-eligible beneficiaries in the future would make cutbacks in state Medicaid considerably more likely in the years ahead.

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[8] Renee Schwalberg, et. al., *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights*, Kaiser Family Foundation, October 2001.

[9] Schwalberg. See also National Pharmaceutical Council, *Pharmaceutical Benefits under State Medical Assistance Programs*, 2002. There is increasing concern that restrictive prior authorization can discourage beneficiary access to medically necessary drugs. As of yet, however, there generally has been little monitoring by states of the effects of prior authorization on beneficiary access. See Jane Tilly and Linda Elam, *Prior Authorization for Medicaid Prescription Drugs in Five States: Lessons for Policy Makers*, Kaiser Family Foundation, April 2003.

[10] For example, if a dual-eligible elderly or disabled beneficiary needs nursing home services, Medicare in many cases will pay for the first 100 days in a skilled nursing facility. Medicaid will then cover costs after this Medicare benefit has been exhausted.

A Call from Robert Reischauer for Conferees to Maintain Universality

In a recent op-ed article in the *New York Times*, Robert Reischauer called on Congress to maintain Medicare's universality.[a] Reischauer is currently president of the Urban Institute and vice-chair of the Congressionally chartered Medicare Payment Advisory Commission (MedPAC). He was Director of the Congressional Budget Office from 1989 to 1995. Reischauer wrote:

"In its headlong rush to provide a prescription drug benefit for the elderly and disabled, Congress risks abandoning a fundamental principle that has been a hallmark of Medicare since the program's inception in 1966. That principle — universality — ensures that all Medicare beneficiaries, no matter where they live or what their financial circumstances, are eligible for the same basic benefits….

"In their conference to reconcile the two bills,…members of both the House and Senate should work to ensure that Medicare's universal nature is preserved.

"To save money, the Senate proposal would deny the new drug benefit to the 6.4 million Medicare beneficiaries — about one in six — who, because of their limited incomes, are also fully eligible for Medicaid, the program that covers the health care costs of some of nation's poorest residents. These so-called dual eligibles would be required to obtain drug coverage through their state's Medicaid program. Under current practice, Medicare pays first for services provided to dual eligibles, while Medicaid picks up any costs or charges Medicare doesn't cover.

"The difference for these beneficiaries is more than a matter of which program pays for their prescriptions. Because each state determines its own Medicaid drug benefit, the drug plan available to dual eligibles will vary depending on where they live. Although many state Medicaid programs have provided generous prescription drug coverage in the past, spiraling Medicaid costs and severe budget difficulties have forced many of them to cut back. Some have imposed limits on the number of prescriptions that a beneficiary can fill each month; others have restricted access to some drugs. Thus, Medicare's poorest participants — those who qualify for Medicaid — could find themselves with skimpier drug coverage than other beneficiaries.

"In addition to being unjust, denying Medicare's poorest participants access to a benefit available to other Medicare beneficiaries imposes an unfair burden on hard-pressed states, which already pick up the 43 percent of the Medicaid bill that the federal government does not cover. Once Medicare starts providing drug coverage, states will be tempted to shift some of their burden for dual eligibles, which constitutes more than one-third of total Medicaid costs, to federally financed Medicare. (They can do this by simply lowering their maximum income limits for full Medicaid eligibility.)

"If states yield to such pressures, millions of low-income elderly and disabled Medicare beneficiaries could find themselves without a Medicaid safety net. They will no longer be dual eligibles, and thus will qualify for a Medicare drug benefit, but they will be denied Medicaid's coverage for other services."

[a] Robert D. Reischauer, "When More Means Less," *New York Times*, July 16, 2003.

The number of dual eligibles, now approximately six million, is projected by CBO to reach 6.4 million by 2006, and is expected to grow substantially in years after that as the baby-boom generation ages. As a result of both this growth in the dual-eligible population and the escalating cost of prescription drugs, the cost of providing drug coverage to dual eligibles will mount sharply in coming years and decades. This may leave states little choice in the future but to cut back their Medicaid programs in ways that would likely affect both dual eligibles and other Medicaid beneficiaries.

In addition, as noted above, by making those low-income Medicare beneficiaries who also receive Medicaid ineligible for the Medicare drug benefit, the Senate bill would create a perverse incentive for some states to scale back Medicaid eligibility for elderly and disabled beneficiaries. Such actions would make the low-income beneficiaries who were dropped from Medicaid eligible for the federal Medicare drug benefit, shifting the costs of their drug coverage entirely to the federal government.

Prescription drug coverage currently represents only about 10 percent of total state Medicaid expenditures. But it is the fastest growing element of Medicaid costs. Medicaid drug costs rose at an average annual rate of nearly 20 percent between 1998 and 2000. By comparison, overall Medicaid costs increased at an average annual rate of 8.8 percent over the same period.[11] (Data for years after 2000 are not yet available, but the evidence suggests that Medicaid prescription drug costs continued to grow at a rapid pace.) In a survey conducted in 2002, half of the states identified the rising cost of prescription drugs as the single most significant driver of Medicaid costs. Some 44 states listed rising prescription drug costs as one of the three top factors driving Medicaid cost growth. As a result, the 19 states with broader Medicaid eligibility criteria for elderly and disabled beneficiaries could well conclude that the savings they would glean on drug costs from scaling back Medicaid eligibility would outweigh adverse effects on beneficiaries.

Other groups of Medicaid beneficiaries could be at risk, as well. Facing serious fiscal difficulties, many governors and state legislators increasingly are looking to reductions in Medicaid as a way to help fill budget holes. Although the recent Medicaid reductions that many states have instituted have included the placement of new restrictions on prescription drug benefits that disproportionately affect seniors and people with disabilities, the reductions in Medicaid eligibility that various states have imposed have focused more heavily on low-income working parents and, in some cases, their children.[12]

Given these trends and the fiscal pressures that state Medicaid programs will encounter as the baby boomers age, making dual-eligible beneficiaries ineligible for the new Medicare drug benefit — and thereby compelling Medicaid to absorb the rising prescription drug costs of this population — would likely lead over time to state actions further rolling back Medicaid services and eligibility. It would likely result in actions to scale back coverage for low-income parents and children as well as seniors and people with disabilities. If states are not absolved of fiscal responsibility for providing costly prescription drug coverage for the growing number of dual eligibles, coverage for many other groups of Medicaid beneficiaries may contract.

The fiscal stakes for states are high. In 2002, Medicaid spent an estimated $13.1 billion to provide prescription drug benefits to the six million dual-eligible beneficiaries, with states paying about $5.6 billion of this sum. The dual eligibles accounted for nearly half of all Medicaid expenditures for prescription drugs in 2002, a fraction that will only grow larger as the

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[11] Vernon Smith et al., *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Family Foundation, September 2002.

[12] See Melanie Nathanson and Leighton Ku, *Proposed State Medicaid Cuts Would Jeopardize 1.7 Million People: An Update*, Center on Budget and Policy Priorities, revised March 21, 2003.

baby boomers retire.[13] If the federal government does not begin to shoulder more of these costs, many — if not most — states ultimately will face a choice between making painful cuts in their Medicaid programs, raising taxes significantly, cutting other parts of their budgets sharply, or taking a combination of such steps. The consequences for states will be especially stark in economic downturns that occur in future decades, when the health care costs that states incur for low-income elderly and disabled beneficiaries will remain high while state revenues shrink.

These pressures will be ameliorated if Medicare's universality is maintained. The transfer of financial responsibility for providing drug coverage to the dual eligibles from Medicaid to Medicare, as would occur over time under the House bill, would free up scarce state health care funds, making the preservation of overall health coverage for millions of vulnerable low-income Medicaid beneficiaries more secure.

Other Fiscal Relief for States in Senate Bill Inadequate to Address These Concerns

The Senate bill does contain a few provisions to ease fiscal pressures on states. These provisions, however, are inadequate to address the problems that the bill's exclusion of dual-eligible beneficiaries would likely cause over the long term.

The principal Senate provision intended to provide financial relief to states would change the federal-state financing arrangements regarding the payment by Medicaid programs of certain Medicare costs. Under current law, state Medicaid programs must pay the Medicare Part B premiums, Medicare deductibles, and Medicare cost-sharing charges for all low-income Medicare beneficiaries who meet the federal minimum eligibility criteria for Medicaid. State Medicaid programs also must pay the Medicare Part B premiums, Medicare deductibles, and Medicare cost-sharing charges for elderly and disabled people who are not poor enough to meet the federal minimum standards for Medicaid coverage but do have incomes below the poverty line and assets of less than $4,000 for an individual and $6,000 for a couple.[14] This group of Medicare beneficiaries is known as "Qualified Medicare Beneficiaries," or QMBs. States can elect to provide full Medicaid coverage for QMBs, or they can cover only the Medicare premium, deductible, and cost sharing charges for these beneficiaries.

Under the principal Senate provision that provides some relief to states, the federal government would begin picking up 100 percent of the costs that state Medicaid programs incur

[13] Stacy Berg Dale and Jim M. Verdier, *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles*, The Commonwealth Fund, April 2003. The Dale-Verdier study does not factor into its estimates the Medicaid savings derived from rebates that drug manufacturers pay to states, although the study assumes that these rebates reduce drug expenditures by about 18 percent. The figures cited here incorporate the rebate savings in order to provide a more precise estimate of the level of Medicaid spending on prescription drugs for the dual eligibles.

[14] State Medicaid programs also are required to pay the Medicare Part B premiums (but not Medicare deductibles or co-payments) for Medicare beneficiaries who have incomes between 100 percent and 120 percent of the poverty line and assets of less than $4,000 for an individual and $6,000 for a couple. These beneficiaries are known as Specified Low-Income Medicare Beneficiaries, or SLMBs. Finally, states receive a fixed allocation of federal funding to help pay for the Medicare Part B premiums for low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of the poverty line.

in paying the Medicare Part B premiums for Qualified Medicare Beneficiaries whose incomes exceed the federal minimum eligibility criteria for Medicaid but are below the poverty line, provided that a state meets a specific condition, described below. Currently, the cost of paying the Part B premiums for these beneficiaries is split between the federal government and the states in the same manner as other Medicaid benefit costs, with the federal government paying an average of 57 percent of the costs and states paying an average of 43 percent.[15]

To obtain this relief, states would have to ensure that the prescription drug coverage they provide to elderly and disabled beneficiaries under Medicaid meets new federal minimum standards, which the Senate legislation would establish. In particular, to receive this additional federal funding, states would have to remove limits on the number of prescriptions per month their Medicaid programs cover. (States would *not* have to remove the limitations many of them have imposed, under which doctors must obtain prior approval from state Medicaid officials for prescriptions for various types of drugs.) Thus, to secure the increased federal financial support, many states would have to make their Medicaid prescription drug coverage more comprehensive, which in turn would raise state Medicaid costs.

State Medicaid programs also would have to bear another new cost. They would be required to determine the eligibility of elderly and disabled people for a new system of *Medicare* low-income subsidies, which the legislation would create. The legislation would establish a new set of federal subsidies to make the Medicare drug benefit affordable for low-income seniors and people with disabilities who are *not* enrolled in Medicaid. (See the box on page 10.) Under the Senate bill, states would initially bear 25 percent of the administrative costs incurred in determining eligibility for these subsidies. In 2007 and all years thereafter, states would bear 40 percent of these new costs.

The Congressional Budget Office estimates that the net overall effect of these (as well as other) provisions in the Senate bill would be to reduce state Medicaid expenditures by $20 billion over the next ten years, compared to what CBO projects that states would spend under current law. This $20 billion figure should be viewed in two contexts. First, $20 billion over ten years is much smaller than the cost that state treasuries are incurring in providing prescription drug coverage to the dual eligibles through Medicaid. The state share of Medicaid drug costs for dual-eligible beneficiaries was $5.6 billion in 2002 alone, and this figure is projected to rise to much higher levels in the years ahead. Second, CBO's estimate of a $20 billion state "saving" represents a saving in relation to CBO's "baseline" estimate of what state Medicaid expenditures will be over the coming decade, under current law. The baseline assumes very large increases in state Medicaid expenditures over the next ten years. In particular, the baseline assumes that a number of states will institute new Medicaid prescription drug-only programs for low income seniors who are not eligible for full Medicaid benefits. The $20 billion in savings that CBO projects is apparently based on the premise that states will establish new Medicaid drug-only programs over time but terminate these programs if a federal Medicare prescription drug benefit is made available. In other words, the $20 billion in projected state savings apparently includes billions of dollars in assumed savings from the assumed termination of state Medicaid drug-only

[15] The cost of covering the Medicare *deductibles* and *cost-sharing* for all QMBs would continue to be borne by state Medicaid programs under the normal federal-state financing arrangements that apply to other Medicaid benefit costs.

programs *that do not currently exist* but that CBO expects states will establish in coming years.[16] Given the large budget deficits and structural budget problems that states face, as well as the mounting cost of prescription drugs, there is serious question about the baseline assumption that states will expand their Medicaid programs and further increase their Medicaid expenditures by establishing costly Medicaid drug-only programs. Currently, most states are paring back their Medicaid programs, not expanding them.

Finally, it bears noting that the principal Senate provision to accord some relief to states — the aforementioned provision under which the federal government would pay 100 percent of the cost of Medicare Part B premiums for certain Qualified Medicare Beneficiaries if states removed certain restrictions on their Medicaid drug coverage — would be likely to have an unintended and unwelcome effect. This provision would intensify the perverse incentive for states that have Medicaid income limits higher than the federal minimum limit of 74 percent of the poverty line to scale back Medicaid eligibility for elderly and disabled people. If states eliminate limits on the number of prescriptions that a beneficiary may have (so that the federal government will assume the full cost of Medicare Part B premiums for their Qualified Medicare Beneficiaries), that will increase the cost per-beneficiary that states incur in providing Medicaid drug coverage to their elderly and disabled beneficiaries. That, in turn, will heighten the incentive for states that currently extend Medicaid to elderly and disabled people with incomes above 74 percent of the poverty line to drop Medicaid coverage for some or all of these people, in order to shift a portion of the costs of their *now-more-expensive* Medicaid drug coverage to Medicare.

Conferees Can Fix this Problem

The Medicare legislation that the House of Representatives has approved includes provisions that raise substantial concerns, ranging from inadequate premium and cost sharing subsidies for low-income elderly and disabled people to risky Medicare privatization proposals to the inclusion of costly tax provisions that could weaken employer-based health coverage and adversely affect poor, older, and sicker workers. Unlike the Senate bill, however, the House measure does uphold the universal nature of Medicare benefits with respect to low-income beneficiaries. Under the House bill, the Medicare drug benefit would be extended to all Medicare beneficiaries, including those who qualify for Medicaid.

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[16] CBO's estimate of $20 billion in net reductions in state costs over the next ten years assumes state savings of nearly $13 billion from the elimination of state Medicaid programs under which certain low-income elderly people not eligible for regular Medicaid coverage can receive a prescription-drug-only Medicaid benefit. Four states currently operate such programs, under what are known as "Pharmacy Plus" waivers from the U.S. Department of Health and Human Services. With enactment of a Medicare prescription drug benefit, states with these Pharmacy Plus waivers would be likely to terminate them.

Only a portion of the $13 billion in assumed savings appears to represent savings from termination of these four state Pharmacy Plus programs. The CBO baseline apparently assumes that a number of additional states will institute these programs in coming years in the absence of a Medicare drug benefit. CBO's estimate of $13 billion in state savings in this area apparently assumes substantial savings from the termination of state Pharmacy Plus waiver programs that are not currently in existence but that the CBO baseline assumes will be established in coming years. Given the severity of state fiscal problems, the CBO baseline may assume significantly more state expansion in this area — and thus, considerably more state savings from the termination or lack of establishment of such waiver programs — than would actually occur.

Senate Bill Substantially Better than House Bill In Making Medicare Drug Benefit Affordable

As this analysis explains, the House bill is strongly preferable to the Senate bill with regard to coverage for the dual eligibles. In numerous other respects, however, the Senate bill is superior. This is particularly true of the differing Senate and House provisions regarding subsidies to make the Medicare drug benefit affordable to low-income Medicare beneficiaries who are *not* dual eligibles.

Millions of low-income elderly and disabled people are not eligible for full Medicaid coverage, and thus do not get drug coverage through Medicaid. As described elsewhere in this analysis, in the majority of states, the Medicaid income limit for elderly and disabled individuals is just 74 percent of the poverty line, and the Medicaid asset limit for such individuals is $2,000. As a result, many poor elderly and disabled people are not eligible for Medicaid. Such low-income people would receive their drug coverage through Medicare under both the Senate and House bills.

Under both bills, the premium, deductible, and co-payment charges tied to the Medicare drug benefit would exceed what low-income elderly and disabled beneficiaries generally could afford to pay. The cost of the premium for Medicare drug coverage would be about $35 a month ($420 a year). There also would be an annual deductible of $275 in the Senate bill and $250 in the House bill, as well as coinsurance or co-payment charges for each drug purchase. To make the new drug benefit affordable to low-income beneficiaries who are not dual eligibles,[17] the Senate and House bills provide subsidies to these beneficiaries. The subsidies would be made available to beneficiaries with incomes up to 150 percent of the poverty line ($13,470 for an elderly individual living alone) under the House bill, and to beneficiaries with incomes up to 160 percent of the poverty line ($14,368 for an individual) under the Senate bill. There also would be an assets test applied (the assets test does not apply to some individuals in the Senate bill). The subsidies for people in the upper parts of these income ranges would be smaller than the subsidies for people with lower incomes.

Yet while the Senate and House bills both include such subsidies for low-income beneficiaries, the adequacy of these subsidies differs markedly between the two bills. Of particular note, the House bill provides *no low-income subsidies whatsoever* in the bill's "coverage hole." Under the House bill, once a Medicare beneficiary has incurred $2,000 in covered prescription drug costs in a year, there would be no further drug coverage that year — and no low-income subsidies either to make prescribed drugs affordable — until the beneficiary's out-of-pocket drug costs reached $3,500. This feature of the House bill would likely result in serious hardship for low-income beneficiaries (other than dual eligibles) with high prescription drug costs.

The Senate bill avoids this problem. First, it has a much smaller "coverage hole." Drug coverage would stop only after a beneficiary's covered drug costs exceed $4,500 in a year, rather than $2,000. Second — and most important — under the Senate bill, the low-income subsidies *would* be available in the coverage hole, so that drugs remained affordable to low-income beneficiaries even after they had incurred $4,500 in drug costs. As a result, the severe hardship that poor beneficiaries with high drug costs could experience under the House bill would be averted. (For further information on the large differences between the Senate and House provisions pertaining to these low-income subsidies, see two Families USA reports: "What's in the House and Senate Medicare Prescription Drug Bills?," July 17, 2003 and "Low Income Prescription Drug Benefit: Key Differences between House and Senate Medicare Bills," July 10, 2003.)

[17] As this paper explains, dual eligibles would not qualify for the Medicare drug benefit under the Senate bill. Under the House bill, dual eligibles would be covered by the Medicare drug benefit, and *Medicaid* would pay the premium, deductible, and cost-sharing charges that are not covered by the Medicare low-income subsidies.

This would ensure that all Medicare beneficiaries have access to the Medicare prescription drug benefit, and it would thereby prevent low-income beneficiaries who are dual eligibles from having skimpier drug coverage. It also would place low-income beneficiaries at substantially lower risk of losing critical Medicaid benefits because their state scaled back Medicaid eligibility.

Furthermore, the House approach to this matter has the virtue of providing states with needed long-term fiscal relief from mounting Medicaid costs. Under the House bill, Medicare would gradually assume an increasing share of the drug costs that states incur for the dual eligibles, over a 15-year period.[18] Without such a step, it will be increasingly difficult for states to sustain their Medicaid programs over the long term.

When the Senate was debating the prescription drug legislation in June, Senator Jay Rockefeller offered an amendment to make the drug benefit in the Senate bill available to all Medicare beneficiaries, including the dual eligibles. Had the amendment passed, the Senate bill would closely mirror the House bill in this respect. The Rockefeller amendment fell short by a few votes, losing 51-47. This indicates that the majority of the House and nearly half of the Senate agree on the importance of maintaining universal access to Medicare benefits. This matter could be resolved by action by the conferees to adopt the House approach on this matter.

Conclusion

Since Medicare's creation in 1965, universality has been one of its hallmarks. Seniors and people with disabilities who qualify for Medicare are eligible for all of the benefits that the program provides, regardless of their income or geographical location. The Senate legislation departs from this tradition, denying access to the new Medicare drug benefit to more than six million Medicare beneficiaries who also are eligible for Medicaid. The Senate bill creates a two-

[18] Under the House bill, the federal government would gradually assume the lion's share of state Medicaid drug costs for the dual eligibles. As noted above, the dual eligibles would qualify for the Medicare drug benefit, with the federal government becoming the primary payor for prescription drug costs for this population. That would greatly reduce the costs that state Medicaid programs incur for drug coverage for these beneficiaries. The House bill is structured, however, so that states do *not* receive all of these savings right away. Rather, the realization of these savings by state Medicaid programs would be phased in over 15 years. This phase-in would be accomplished through another provision of the House bill, which initially requires state Medicaid programs to pay the cost of the *Medicare* low-income subsidies for dual-eligible beneficiaries. (These new subsidies are designed to make the premiums, deductibles, and cost-sharing charges that accompany the Medicare drug benefit affordable to low-income beneficiaries.) Medicaid's share of the costs of these Medicare subsidies would be phased down over time, so that at the end of 15 years, Medicare was paying the full cost of these Medicare subsidies. At that point, the financial relief that states would receive under the House legislation would reach its full dimensions.

This does not mean, however, that *all* prescription drug costs that Medicaid currently pays on behalf of the dual eligibles would ultimately be assumed by Medicare. To the contrary, state Medicaid programs would continue to bear some significant costs even at the end of the 15-year period. Medicaid would continue to be the secondary payor for drug costs for the dual eligibles and thus would fill holes in the Medicare drug benefit. Those holes would be substantial, especially under the House bill. Under that measure, Medicare would not pay for any portion of a beneficiary's prescription drug costs in excess of $2,000 a year until the beneficiary's out-of-pocket costs for prescription drugs reached $3,500. State Medicaid programs would need to provide prescription drug coverage for dual eligibles in this "coverage hole."

Universal Coverage, High-income Beneficiaries, and Means-testing

The House bill contains a provision that would means test the new Medicare prescription drug benefit by placing restrictions on Medicare catastrophic drug coverage for people with incomes of more than $60,000 a year. This House provision is problematic. It, too, would undermine the universality of Medicare benefits, and it almost certainly would be costly and inefficient to administer since Medicare offices lack information on beneficiaries' current incomes.

A far sounder and more efficient approach would be to maintain the universality of Medicare *benefits* and to means-test Medicare *premiums,* using the tax system to collect the higher premium payments that high-income beneficiaries would owe. (All seniors, however, should receive a premium subsidy of some kind to discourage their dropping out of the program. High-income beneficiaries tend to be healthier, on average, than other Medicare beneficiaries, and the Medicare risk pool could be adversely affected if they left the Medicare Part B program.) Using the income tax for this purpose would be essential. Otherwise, Medicare offices would have to begin functioning like welfare offices in order to determine which beneficiaries have incomes sufficiently high to owe a larger premium amount. Attempting to collect higher premiums from upper-income beneficiaries through the Medicare program rather than through the tax system also would require substantial increases in the size of the Medicare bureaucracy and would raise Medicare administrative costs significantly. In addition, it would be less accurate than using the tax system for this purpose. When the Congressional Budget Office and the Office of Management and Budget examined this issue in 1997, they concluded that half of the potential revenue from setting higher premium levels for upper-income beneficiaries could be lost if collection of the additional premium payments was administered by the Department of Health and Human Services rather than done through the tax code.

tiered Medicare system that excludes many seniors and people with disabilities essentially because they are poor.

The Senate approach would result in some low-income elderly and people with disabilities having less adequate drug coverage than other elderly and disabled individuals. It also could lead to a number of states scaling back Medicaid eligibility for the elderly and disabled, which would result in a loss of coverage for nursing home care, home and community based services, and personal care services for affected beneficiaries. In addition, other Medicaid beneficiaries such as children, pregnant women and working mothers would be more likely to face substantial reductions in Medicaid eligibility or benefits over time, as states were forced to allocate increasing shares of their Medicaid budgets to cover the health care costs — and particularly the mounting prescription drug costs — of their growing elderly and disabled caseloads.

House and Senate conferees have an opportunity to maintain the basic principles of the Medicare program, protect low-income Medicare beneficiaries, and lessen the possibility of future state actions that reduce or eliminate health coverage for many vulnerable Americans. They can do so by adopting the House approach of including, rather than excluding, the dual eligibles under the new Medicare prescription drug benefit.