

**ISSUES WITH A STATE-BASED LOW-INCOME PRESCRIPTION DRUG BENEFIT
FOR MEDICARE BENEFICIARIES**

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**“Creating a Medicare Prescription Drug Benefit:
Assessing Efforts to Help Low-Income Seniors”**

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Chairman Bilirakis, Congressman Brown, and distinguished Subcommittee Members, thank you for the opportunity to offer my views on a prescription drug benefit for Medicare beneficiaries. I am an Associate Professor at the George Washington University. I worked for the previous Administration as the Principal Associate Director for Health, Personnel and Veterans at the Office of Management and Budget and at the White House National Economic Council. My past policy experience and current research include the study of how to best provide a prescription drug benefit to Medicare beneficiaries.

¹ The views expressed in this paper do not represent those of George Washington University or the Department of Health Services Management and Policy.

SUMMARY

In this testimony, I would like to make two points. First, the quickest and most effective way to provide prescription drug coverage for the nation's low-income seniors -- as well as middle-class beneficiaries who also need such coverage -- is to enact a Medicare prescription drug benefit.

Evidence and analysis suggest that a new low-income prescription drug program neither provides immediate relief to all eligible low-income seniors nor prepares states for their role in supplementing a Medicare prescription drug benefit. These seniors would receive better, more accessible and, in some states, more immediate prescription drug coverage through Medicare.

Second, if adding a prescription drug benefit to Medicare is inevitable, now is the time to do it.

A Medicare prescription drug benefit enacted this year would provide all beneficiaries, including low-income seniors, with prescription drug coverage by 2005. The budget outlook, while weaker than in recent years, remains sufficiently strong to finance a meaningful Medicare prescription drug benefit, defined as one that ensures continuous insurance coverage, extra protection for financially vulnerable beneficiaries, and an affordable monthly premium. With a \$2.3 trillion surplus over the next 10 years, there is no budgetary reason to provide a drug benefit only to low-income beneficiaries or to skimp on a drug benefit for all beneficiaries. Moreover, it is probably more affordable to implement and improve a prescription drug benefit in this decade before Medicare is confronted with the challenges of the retirement of the baby boom generation. Finally, while other Medicare reforms are needed, none are as compelling or as difficult as adding a prescription drug benefit to Medicare. I urge this Committee and this Congress to make enacting a Medicare prescription drug benefit its first priority and its lasting legacy.

HELPING LOW-INCOME BENEFICIARIES ACCESS PRESCRIPTION DRUGS

There is no question that low-income Medicare beneficiaries need extra assistance in affording prescription drugs. About 40 percent of Medicare beneficiaries with income below \$20,000 lack coverage for prescription drugs.¹ The average Medicare beneficiary is projected to spend \$2,440 for prescription drugs in 2003²; even a fraction of this amount would consume a large proportion of a low-income beneficiary's income. All legislative proposals to add a prescription drug benefit to Medicare have, to different degrees, provided extra assistance to make Medicare drug coverage affordable for low-income beneficiaries.

As such, the question is not whether to help low-income beneficiaries, it is whether Congress should create a new low-income prescription drug program to provide relief before the implementation of a Medicare drug benefit. The President has proposed to do this. His budget includes a proposal that allows states to:

- Extend prescription drug coverage (as a stand-alone benefit) to Medicare beneficiaries with income up to 100 percent of poverty, with the Federal government matching state costs at the regular Medicaid matching rate (which averages a 57 percent Federal contribution); and
- Extend prescription drug coverage to beneficiaries with income from 100 to 150 percent of poverty, with a 90 percent Federal matching rate.³

Since this new benefit does not appear to be part of Medicaid, states could provide a less generous prescription drug benefit than Medicaid's (e.g., limit the amount of assistance) or cap

enrollment. This Federal funding could also be used by states to refinance existing state pharmacy assistance program spending.⁴ The President's budget estimates that this proposal costs \$77 billion over 10 years, 40 percent of its \$190 billion allocation for Medicare and prescription drugs. The Congressional Budget Office (CBO) estimates that the same proposal costs \$57 billion over 10 years.⁵

While some low-income seniors in some states would likely benefit from a state-based low-income drug policy prior to implementation of a Medicare benefit, evidence and arguments suggest that:

- Not all states will participate, since many want neither the responsibility nor the costs of a prescription drug benefit for seniors (CBO assumes that states with 35 percent of eligible low-income beneficiaries would not participate in the President's proposal);
- Not all eligible individuals in participating states will enroll (CBO assumes that 40 percent of eligible low-income beneficiaries would not participate the President's proposal);
- Lack of benefit standards could result in access problems and defining benefit standards would likely cause delays in enacting and implementing legislation, given experience with the State Children's Health Insurance Program (CHIP); and
- Medicare could implement a prescription drug benefit faster than could 50 states, and would be more effective at assisting all low-income beneficiaries (CBO assumes that a Medicare

benefit with low-income protections would provide 100% of Medicare beneficiaries with drug coverage by 2005⁶ while a state-based low income benefit would provide 18% of low-income beneficiaries and 6% of all beneficiaries with drug coverage by 2007).

These points are described in greater detail below.

Low-income seniors in some states will not be eligible. States are strong and essential partners in providing needed health care to those low-income and disadvantaged populations who have no other health insurance options. Today, Medicaid covers as many people today as does Medicare; 30 percent of Medicaid beneficiaries are eligible at states' discretion.⁷ Recent experience with CHIP proves that policies to give states additional funding and flexibility -- when there is bipartisan and Federal-state agreement on the goal -- can successfully expand coverage and reduce the number of uninsured. In 2001, nearly 5 million children were helped by CHIP⁸ and the number of uninsured children in the United States fell in 1999 and 2000.⁹

However, recent arguments and evidence suggest that, even with the increased funding and flexibility, some states will not voluntarily extend prescription drug coverage to Medicare beneficiaries. Most governors and the National Governors' Association (NGA) have argued for years that the Federal government, not states, should bear responsibility for Medicare beneficiaries.¹⁰ States have expressed strong concerns about the sustainability of financing services not covered by Medicare and its premiums and cost sharing for low-income beneficiaries. These concerns extend to prescription drugs. Prescription drug costs are named by 48 states as a major factor in Medicaid cost growth.¹¹ In 2002, Medicaid will pay an

estimated \$28 billion for prescription drugs – nearly 20 percent of the nation’s total prescription drug spending.¹² This helps explain the official position of the NGA: “If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states and territories.”¹³

Reflecting these concerns, states’ efforts to extend prescription drug coverage, to date, have been limited. Only 15 states and the District of Columbia have elected to extend Medicaid coverage, including prescription drugs, to all poor seniors and people with disabilities.¹⁴ Ten of these states plus 14 others have implemented non-Medicaid state pharmacy assistance programs that provide partial or full coverage for certain low-income Medicare beneficiaries. An additional 5 states offer discounts (rather than coverage) for prescription drugs for certain low-income elderly.¹⁵ While the majority of states are involved in such activities, their combined impact is relatively small. Self-reported data suggest that states spend about \$1.7 billion on non-Medicaid prescription drug coverage¹⁶, less than 2 percent of CBO’s 2002 baseline for Medicare beneficiaries’ prescription drug spending.

States’ reaction to the President’s proposal to provide incentives to extend drug coverage to Medicare beneficiaries is likely to be mixed. States with existing programs would probably participate in the President’s proposal, since they could receive Federal matching payments for their existing programs. However, states with no or limited programs must balance the increased Federal contribution with the risk of rising drug costs, unmet need, and limited state budgets. This calculation is complicated by the temporary nature of a low-income drug program: it would stop providing primary prescription drug coverage when a Medicare benefit is implemented. All

proposals would shift primary coverage for prescription drugs to Medicare, leaving states with the much-simpler job of providing additional assistance with premiums and cost sharing, as they do today for Medicare's current benefits. As such, even those states that are willing to take on an extension of prescription drug coverage may find that the start-up costs for a temporary program outweigh the benefits of this time-limited assistance. One of CHIP's lessons is that considerable time and investment are required to set up a new health insurance program, especially if it is not a simple extension of Medicaid.

Probably reflecting some of these issues, CBO did not assume that all states would participate in the President's low-income prescription drug proposal.¹⁷ States where 65 percent of eligible low-income beneficiaries live are assumed to participate. In other words, an estimated one in three low-income Medicare beneficiaries would not be eligible for assistance under the proposal.

Low-income programs often miss many eligible seniors. A problem that has plagued Medicaid and other state-based programs for Medicare beneficiaries is low participation. Since the early 1990s, Medicaid has been authorized to pay Medicare's premiums and most cost sharing for poor beneficiaries.² Nearly one in four Medicare beneficiaries is eligible for some type of Medicaid assistance, yet only about 45 to 55 percent of eligible beneficiaries are estimated to enroll in such programs.¹⁸ Some of this may be explained by the lower priority that

² The Qualified Medicare Beneficiary (QMB) program pays for Medicare's premiums, deductibles and coinsurance for all beneficiaries whose income is below 100 percent of the Federal poverty level and whose resources are at or below twice the SSI limits. The Specified Low-Income Medicare Beneficiary (SLMB) program pays for the Medicare Part B premium (not the Part A premium) for beneficiaries with income between 100 and 120 percent of poverty. The Qualified Individual-1 (QI-1) program provides states an option – with 100 percent Federal funding through a capped grant that expires in FY 2002² – to pay for the Part B premium for beneficiaries with income between 120 and 135 percent of poverty. And the Qualified Beneficiary-2 (QI-2) program uses the same structure as QI-1 to subsidize the part of the Medicare Part B premium attributable to the increase in that premium do to shift of the home health benefit to Medicare Part B.

states give to this population versus others, like children. For example, one study found that only 24 states used a simplified application, 12 states had outreach materials about eligibility in other languages, and about one-third of states made eligibility screening tools available to outside agencies (e.g., clinics, senior centers rather than welfare offices)¹⁹ – all strategies used by most states in CHIP. Lack of information, misperceptions about eligibility, and reluctance to ask for help appear to be equally important barriers to enrollment. A focus-group study found that being “in the right place at the right time” had a greater impact on enrollment than official outreach efforts.²⁰ Some state prescription drug programs have experienced similar problems. Several of the major state programs (e.g., Massachusetts and New York) found that they had to change and increase their outreach efforts due to low enrollment and that, even with changes, enrollment has been lower than expected.²¹

CBO assumed that, within states that extend coverage through the President’s proposal, 60 percent of eligible low-income beneficiaries would participate when state programs are fully implemented, in 2007. This participation rate drops to 39 percent when compared to the low-income beneficiaries who would be eligible if their states participated; 18 percent when compared to all low-income beneficiaries (including those covered by Medicaid); and 6 percent when compared to all Medicare beneficiaries regardless of income.

Lack of a standard prescription drug benefit could cause access and other problems. Even the minority of low-income beneficiaries that would be helped by this proposal may find that this help is limited. It appears that states have full discretion under the President’s proposal to determine the nature of the drug coverage offered to low-income beneficiaries. Under Medicaid

rules, states may limit the number of prescriptions filled per month, but cannot charge significant cost sharing, place dollar limits on the amount of coverage, use restrictive formularies, or limit enrollment through caps. Such practices are common in state pharmacy assistance programs: several states require a \$500 deductible for some or all participants (e.g., AZ, NY, PA, SC); some states cap the annual amount of assistance a beneficiary may receive (e.g., IN, MO, WI, NC, OR); and a smaller number of states limit the type of drugs that are covered (e.g., KS covers only maintenance drugs).²² Thus, what low-income Medicare beneficiaries would get under a state-based program would depend on where they live.

Research suggests that practices like high cost sharing or enrollment caps could defeat the goal of improving access to prescription drugs for low-income seniors. A recent study found that one-third of non-elderly Medicaid beneficiaries in states with aggressive cost-control methods (e.g., restricting the number of covered prescriptions, imposing cost sharing) could not get a prescription drug due to cost.²³ Experience with CHIP shows that enrollment caps could make the already-difficult challenge of encouraging low-income seniors to enroll even more daunting. When North Carolina capped its enrollment of children at 72,000, actual enrollment fell by over 20,000 children, in part due to a loss of trust in the program. A local official stated, “We think we’re going to have to put more energy in because this program hasn’t delivered. It was shut down for nine months; now we have to build people’s support and confidence that this is a real program that’s going to be continuing.”²⁴

Congress could and probably would limit the potential health and financial consequences of unrestricted benefit flexibility through standards – especially since the proposed Federal

investment exceeds that of CHIP. Yet, the process of developing those standards would take time and is not without controversy. It took months for the House, Senate and White House to come to agreement over the minimum benefit standards for children in CHIP and, in fact, these standards were among the last issues resolved in the entire Balanced Budget Act of 1997. It is not safe to assume that achieving a bipartisan consensus on standards for a new low-income prescription drug program will be easier than it was in CHIP -- or less contentious than the process of developing a Medicare prescription drug benefit itself.

Medicare would be more effective at quickly providing a meaningful drug benefit to all low-income beneficiaries. If Congress is seeking the most effective way to provide prescription drug coverage to low-income Medicare beneficiaries, it should look to Medicare. Experts agree that all Medicare beneficiaries, including those with low income, would be eligible for and receive prescription drug coverage under proposals that include adequate Federal assistance.³ All major proposals charge no prescription drug premium for beneficiaries with income below 150 percent of poverty, and most proposals subsidize cost sharing for those with income below 135 percent of poverty.⁴ As such, Congress has already come close to consensus on providing a meaningful prescription drug benefit for low-income beneficiaries. This benefit may be accessible more quickly for many (if not most) low-income seniors through Medicare than through a state-based low-income program. If enacted this year, a Medicare benefit could be implemented in 2005, two years before CBO assumes that states that opt for the President's plan

³ CBO estimated that proposals by President Clinton and Senator Robb would ensure that 100 percent of Medicare beneficiaries have prescription drug coverage; proposals by Senators Breaux and Frist and HR 4680 would exclude 8 to 18 percent of Medicare beneficiaries, respectively (CBO, April 8, 2002).

⁴ Note that proposals by Senators Breaux and Frist and HR 4680 include benefit "gaps", meaning that the insurance benefit is capped at an annual dollar limit after which beneficiaries pay 100 percent of drug costs until their total out-of-pocket spending exceeds a stop-loss. Neither proposal subsidizes low-income beneficiaries for prescription drug spending in this gap (which would total \$4,700 in 2005) (CBO, April 8, 2002).

would fully implement their programs (see Exhibit 1). While 2005 may seem too long to wait, consider that if Congress had passed a drug benefit in 1999, when the current debate over a prescription drug benefit began, Medicare would be providing prescription drug coverage today.

IMPORTANCE OF ENACTING A PRESCRIPTION DRUG BENEFIT THIS YEAR

Providing relief to low-income beneficiaries is one of several reasons why Congress should pass a Medicare prescription drug benefit this year. While weakened, the budget outlook is strong enough to pass a meaningful prescription drug benefit. In March, CBO projected a Federal budget surplus totaling \$2.3 trillion over the next decade.²⁵ Medicare was created during a time of budget deficits, and all subsequent health reforms have been enacted during periods with far fewer Federal resources. An \$750 billion investment, which could buy a decent prescription drug benefit with an affordable premium, would represent about one-third percent of the projected surplus and would equal the amount in the President's budget for Medicare and tax cuts combined.⁵ Thus, different policy priorities are what drive discussions of rationing or scaling back on a meaningful prescription drug benefit, not real budget constraints.

Not only can this nation afford a prescription drug benefit; we may not be able to afford to wait. In the next decade, not only will Medicare enrollment surge as the baby boom begins to retire, but the first round of genetically engineered drugs may begin entering the market.²⁶ It seems inevitable that Medicare will cover these prescription drugs for this population, but waiting to implement a new benefit until that point is probably more expensive than implementing it now.

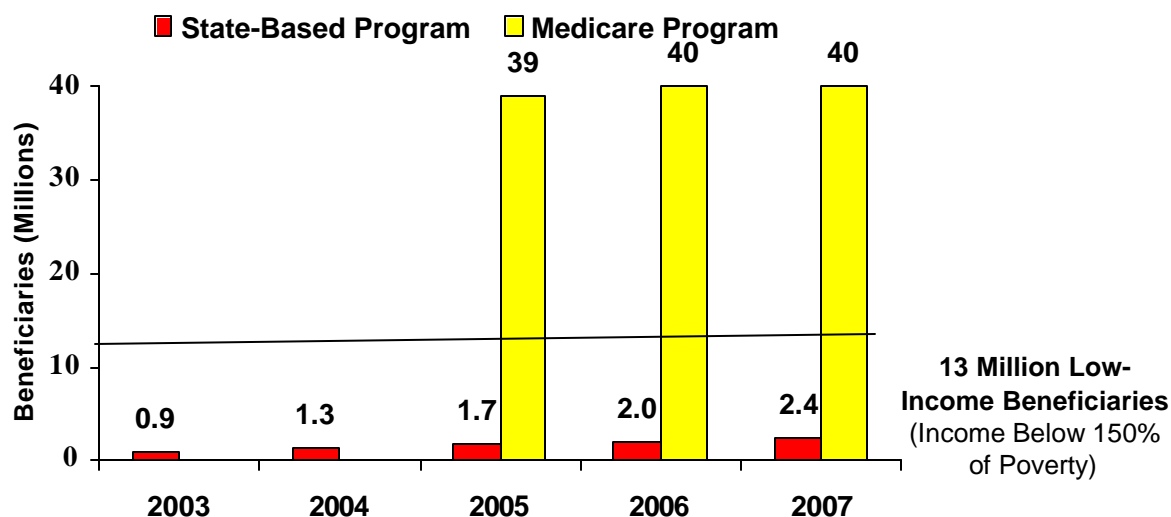
⁵ The President's budget includes \$603 billion for tax cuts and \$169 billion for Medicare for FY 2003-12, according to CBO.

This is because operating a Medicare drug benefit in the next several years without the cost pressures of the baby boomers would allow for learning from early mistakes and making mid-course corrections. These same mistakes committed in the next decade would probably be many times more expensive.

Finally, Medicare faces no equally compelling problem in 2002. Its cost growth is under control and its Hospital Insurance Trust Fund is solvent through 2030. Medicare's provider payment rates may need adjustments, per the recommendations of the Medicare Payment Assessment Commission²⁷, but these adjustments are minor relative to the cost and need for a drug benefit. Supplemental coverage, through private sources and Medicare managed care, is deteriorating, but the fact remains that 3 times as many beneficiaries lack prescription drug coverage as lack supplemental coverage (37.7 versus 12.5 percent in 1999).²⁸ In contrast, developing a bipartisan Medicare prescription drug benefit is a major undertaking that I would argue should be put ahead of all other Medicare reforms as well as legislative efforts to provide stop-gap and interim prescription drug coverage. Each year, a greater number of Medicare beneficiaries lose their prescription drug coverage, causing problems in accessing needed drugs.²⁹ Prescription drug costs are crippling not only for low-income beneficiaries but also for the millions of middle-income beneficiaries whose limited savings are being eroded by the costs of needed medications. The time is right to make the necessary investment and enact the single Medicare reform that has eluded so many Congresses: the addition of a meaningful prescription drug benefit to Medicare.

Exhibit 1. Projected Enrollment in Prescription Drug Options

Medicare Could Cover All 13 Million Low-Income Beneficiaries by 2005



Source: Congressional Budget Office estimates of the President's state-based program and Clinton's and Robb's Medicare prescription drug proposals (includes those in retiree plans receiving Medicare subsidies and in VA, DOD coverage), March, April 2002

NOTES:

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² Crippen DL. (March 7, 2002). "Projections of Medicare and Prescription Drug Spending," Testimony before the Committee on Finance, United States Senate. Washington, DC: Congressional Budget Office.

³ Office of Management and Budget. (February 2002). *Budget of the United States Government*. Washington, DC: U.S. Government Printing Office.

⁴ National Governors Association. (February 22, 2002). "Medicare / Prescription Drug Coverage for Seniors: Issues," http://www.nga.org/nga/lobbyIssues/1,1169,D_2009,00.html.

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⁸ Centers for Medicare and Medicaid Services. (February 6, 2002). "The State Children's Health Insurance Program Annual Enrollment Report, Federal Fiscal Year 2001." Baltimore, MD: CMS.

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