The Effects of the Medicare Modernization Act on Dual Eligible Medicare Beneficiary Drug Benefits: Recommendations for Quality Maintenance

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American College of Physicians

This paper, written by Alex Bamiagis, MHS, was developed for the Health and Public Policy Committee of the American College of Physicians: Lynne M. Kirk, MD, *Chair;* Yul D. Ejnes, MD, *Vice Chair;* Vineet Arora, MD; Patricia P. Barry, MD; Karen Hsu Blatman; Herbert S. Diamond, MD; Joe E. Files, MD; Joel S. Levine, MD; Mark E. Mayer, MD; Thomas McGinn, MD; Robert M. McLean, MD; N.H. Tucker, MD. Approved by the Board of Regents on April 11, 2005.

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For questions about the content of this Position Paper, please contact ACP, Division of Governmental Affairs and Public Policy, Suite 800, 2011 Pennsylvania Avenue NW, Washington DC 20006; telephone 202-261-4500. To order copies of this Position Paper, contact ACP Customer Service at 800-523-1546, extension 2600, or 215-351-2600.

Executive Summary

The Medicare Prescription Drug Improvement and Modernization Act (MMA) includes provisions effecting change in health care on several levels. One change is the creation of a prescription drug benefit (Part D) for Medicare beneficiaries. Those eligible for both Medicare and Medicaid, also known as dual eligibles, will receive drug coverage under Medicare instead of Medicaid. Dual eligible beneficiaries cover several categories including the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB), and Qualifying Individuals (QI). This switch will entail many administrative and fiscal changes.

The fiscal implications include Medicare financing the benefits for dual eligible Part D benefits but also requiring states to pay back much of the financing through what some call "clawback" payments. Although Medicare will relieve much financial stress that states experience in funding dual eligible prescription drugs, states will spend more than they save in the short run. This outcome will heavily burden states with large budget shortfalls. The College believes policies directing states to help fund dual eligible prescription drugs should pose the smallest burden possible to the states.

Dual eligibles should not experience overly burdensome consequences from the MMA, especially regarding communication. Currently, the MMA does not require explicit communications to dual eligibles in terms of exactly which drugs on the formulary will be covered at what price but provides only cost-sharing information. The College calls for prescription drug plans in Part D to clearly communicate explicit, but not overly burdensome, formulary information to physicians with dual eligible patients so that dual eligibles will experience less confusion about their drug plans.

Also, dual eligibles should not experience adverse effects from the cost-sharing requirements that the MMA will bring. Previously, dual eligibles could not be denied prescription drug coverage if they could not meet their co-payment. Under the MMA, dual eligibles not only face the possibility of being denied coverage if a co-payment cannot be met, but they must also meet certain monetary thresholds before appealing coverage decisions. During appeals, the MMA forbids physicians to represent their dual eligible patients. This may be a significant problem for many dual eligibles with cognitive impairments. The College firmly believes these cost-sharing policies are unacceptable and must be altered to allow dual eligibles drug coverage when the co-payment cannot be met and to allow physicians to act as representatives for dual eligibles who appeal formulary decisions.

ACP Recommendations on Dual Eligible Medicare Beneficiaries

1. ***ACP supports changes in the "clawback" provisions of the Medicare Modernization Act to relieve short- and long-term financial pressures under state Medicaid programs that may occur due to the shift in dual eligible drug coverage from state Medicaid programs to Medicare.***
2. ***ACP believes that physicians must be provided with clearly communicated information that is detailed but user-friendly from prescription drug plans in Medicare Part D concerning what drugs will be available to dual eligibles and at what cost.***

3. ***ACP advocates that current minimum dollar thresholds for appealing prescription reimbursement decisions should be revised, or eliminated, and patient advocates should be permitted to help guide patients through the appeals process.***
4. ***ACP advocates that co-payments under the Part D benefit for dual eligibles be modified so that these co-payments are no higher than those under state Medicaid programs, with reasonable adjustments for inflation, etc., and that dual eligibles not be denied prescription drug coverage when they cannot afford the co-payment.***

Introduction

In December 2003, U.S. Congress passed the Medicare Prescription Drug, Improvement and Modernization Act (MMA), Public Law 108-173, creating the most significant changes in Medicare (and several other government programs) since the program's inception in 1965. The provisions included new funding for a Medicare prescription drug benefit, subsidies for managed care plans, tax breaks for new individual health savings accounts, subsidies to employer assistance for retiree health plans, and other items. Included in the MMA's drug benefit, also known as Medicare Part D, are many beneficiary protections for those who are dually eligible for both Medicare and Medicaid.

Dual eligibles are low-income individuals, who are elderly and/or disabled and qualify for coverage under both the Medicare and Medicaid programs. These programs complement each other, with Medicare paying for basic health coverage (Parts A and B) and Medicaid paying for premiums and cost-sharing for components and gaps in the Medicare program (such as long-term care services and, until 2006, outpatient prescription drugs). Medicare financing comes from federal funding, while Medicaid is a joint federal-state venture. The state provides both federally mandated and optional services that the federal government matches at different state rates. Dual eligible coverage costs have generated increasing pressure on already strained state Medicaid budgets as the number of eligible people and health care costs increase.

Under the new MMA provisions, dual eligibles will pay less out of pocket for their prescription drugs under Part D than other Part D beneficiaries. To offset the substantial additional costs of these enhanced pharmaceutical provisions, the MMA will implement major changes. These changes include alterations in the development of cost-sharing requirements, federal and state government roles for financing and administration, formulary development, and other MMA-related issues. In addition, the new federal coverage of dual-eligible beneficiaries will have major fiscal implications for those state programs that previously provided partial funding (matched by the federal government) for the cost of dual-eligible drug care.

Who Qualifies for Dual-Eligible Coverage

To qualify as a fully dual-eligible beneficiary, or Qualified Medicare Beneficiary (QMB), the beneficiary must have an income at or less than 100% of the Federal Poverty Level (FPL). In, 2004, the FPL was $9,573 for an individual younger than 65 years of age and $8,825 for someone older than 65 years of age. This number increased to $12,321 and $11,122 for married couples, respectively.[1] The Centers for Medicare & Medicaid Services (CMS) limits financial resources to $4,000 for an individual and $6,000 for couples in order to get coverage. These financial resources could include:

- Cash
- Bank accounts (such as savings and checking)
- Stocks, bonds, annuities, and CDs
- Real and personal property (*other* than a home or automobile)
- Trusts
- Life insurance, if face value is greater than $1,500
- Other items that may be converted into cash and used for food, clothing, or shelter[2]

However, a state may elect to use coverage criteria that are less restrictive than that mentioned above for determining resource limits under Section 1902(r)(2) of the Social Security Act, enabling a state to change dual eligible eligibility without being considered as changing the standard.[3] Monthly income must also be limited, according to the Supplemental Security Income program standards, for those in the continental United States to $769 for single individual dual eligibles or $1,030 for couples (Alaska and Hawaii have higher thresholds).[4] This income, under Section 209(b) of the 1972 Social Security Act amendments, is also subject to state control and allows a state to use its 1972 state assistance eligibility rules (that adjust for inflation) to increase the income limit.[5] If a state continues to use Supplemental Security Income program limits, the state must then allow individual eligible to "spend down" into Medicaid eligibility by deducting incurred medical expenses from income.

Though most of the MMA's focus for dual eligibles concerns QMBs, the category of dual eligibles also includes other low-income individuals that the MMA addresses. For example, a Specified Low-Income Beneficiary (SLMB) with income between 100% and 120% of the FPL is qualified to participate in Parts A and B but with Medicaid paying for their Part B premiums only. SLMBs also have asset limits equal to those in the QMB program. In addition to SLMBs, Qualifying Individuals (QIs) between 120% and 135% of the FPL (with QMB asset limits) have Medicaid pay their Part B premiums, but funding, which comes to states from block grants, is limited and therefore not guaranteed.

Elderly individuals generally cannot deduct their medical expenses in determining their income for Supplemental Security Income. Much variation among state programs stems from the high variation in dual eligible populations among the states. For example, the number of dual eligibles ranges from 6,000 in Wyoming to more than 900,000 in California.[6] The sources behind these differences can include many factors, such as population size, individual state Medicaid eligibility requirements, and outreach efforts to sign up those qualified for dual eligible status. The most recent data list the dual eligible population at more than 7 million, with 6.1 million of these persons receiving Medicaid coverage for prescription drugs, nursing home, other long-term care services, and other benefits not covered under the Medicare program. The Congressional Budget Office estimates that the latter number will increase to 6.4 million by 2006.[7]

Population Characteristics

The most recent data show that about two thirds of the dual eligible population is older than 65 years of age (with the rest of the population disabled), and most (72%) of these elderly beneficiaries are women (compared with 57% in the non-dual eligible Medicare population). Also, a higher percentage of dual eligibles tend to be either black or Hispanic. More than 20% live in nursing homes (compared with 2% of the non-dual eligible Medicare population), with more elderly dual eligibles than non-elderly dual eligibles living in nursing homes (26% vs. 12%, respectively). Those dual eligibles that live in the community are less likely than other Medicare beneficiaries to live with a spouse and more likely to live alone, with children, or with others.[8]

Dual eligibles are the most fragile members of the Medicare community both in terms of finances and health status. For example, most dual eligibles (71%) had incomes less than $10,000 as compared with only 12% of other elderly and 23% of non-elderly Medicare beneficiaries. Also, relative to the rest of the Medicare population, dual eligibles were more likely to rate their health as less than good (two thirds). This self-rating is not surprising, given that dual eligibles were more likely to have a chronic condition than other elderly Medicare beneficiaries: 31% of dual eligibles have had heart disease and 16% have had a stroke, compared with 23% and 10%, respectively, of the elderly non-dual eligible Medicare population. A disproportionate burden of disability also factors into the disease burden that dual eligibles bear since their elderly members are three times more likely to be disabled than the non-dual eligible elderly population.[9]

These disabilities manifest themselves as increased need for assistance in activities of daily living (ADLs). Those needing help with three or more ADLs (such as bathing, dressing, transferring, and eating) numbered 12% for elderly dual eligibles and only 3% for other elderly Medicare beneficiaries. Non-elderly dual eligibles also had significantly more difficultly with instrumental ADLs (such as light housework, preparing meals, average shopping, and managing bills) than other non-elderly Medicare beneficiaries.[10]

Expenditures

Of the $131 billion spent on dual eligibles, Medicaid covers about 38% and Medicare covers about 43%, but the spending proportion between programs for each dual eligibles varies depending on whether the dual eligible resides in a nursing home (primarily Medicaid) or in the community (primarily Medicare). Among the dual eligible population, those who live in nursing homes cost substantially more than those residing in the community. Those dual eligibles residing in nursing homes use $44,600 per year in health care expenditures (more than four times the amount of community-residing dual eligibles).[11]

Dual eligibles require a disproportionate share of funding for their needs as compared with other Medicare beneficiaries. Although dual eligibles represent 15% to 17% of the Medicare population, they account for 22% to 26% of Medicare funding. Furthermore, on average, each costs Medicare approximately 1.5 times as much as the non-dual eligible Medicare population: $8,559 is currently spent per dual eligible, and $5,399 is spent per non-dual eligible Medicare beneficiary. Total health care spending, which also includes Medicaid, supplemental insurance, and out-of-pocket expenditures in addition to Medicare, averages about $20,840 for dual eligibles, more than twice the amount for other Medicare beneficiaries.[12]

The drivers for these increased expenditures relative to other Medicare beneficiaries are a function of both a higher proportion of dual eligibles relative to non-dual eligibles using services and a more intense use of those services. For example, dual eligibles are more than twice as likely as non-dual eligibles to use skilled-nursing facilities. Also, a higher percentage of dual eligibles relative to non-dual eligibles use services such as inpatient hospital, physician, outpatient hospital, home health, skilled-nursing facilities, and hospice care. Expenditures are correspondingly higher in each of these categories for dual eligibles as opposed to non-dual eligibles. Of the most expensive 1% of Medicare expenditures, one third is from dual eligibles. Of the costliest 5%, one quarter is from dual eligibles.[13]

Even though the dual eligible population is disproportionately more expensive than the rest of the Medicare population, the individual dual eligible members do not compose a homogeneously expensive population. For example, the most expensive 20% is responsible for 80% of Medicare dual eligible costs. Also, the most expensive 5% of dual eligible beneficiaries account for 27% of *total* spending, including Medicare, Medicaid, supplemental insurance, and out-of-pocket spending. The more expensive members of the dual eligible population also include a disproportionate number of beneficiaries with cognitive or physical impairments that drive costs further upwards.[14]

Future Changes and Challenges from the MMA

As noted earlier, dual eligibles are the most vulnerable population among already vulnerable Medicare and Medicaid beneficiaries. This vulnerability has led to large disproportionate (relative to the rest of Medicare and Medicaid) expenditures at both the federal and state levels. The data also show that most of this funding supports a small subset in need of extra care.

The expenditures discussed have successfully fostered patient satisfaction for these needs; dual eligible beneficiaries have reported generally good access to care. For example, 84% of surveyed dual eligibles reported that they had someone (a physician or nurse) that they considered as their usual source of care, compared with 74.6% of Medicare-only beneficiaries. Also, less than 10% reported delays in seeking medical care, compared with 22.5% of non-dual eligible Medicare beneficiaries and 42% of those with other supplemental insurance. Finally, 88.1% and 86.5% of dual eligibles reported getting care as soon as they wanted or an appointment with regular care when they wanted, respectively.[15]

Future changes authorized under the MMA aim to preserve and improve access to prescription drugs for dual eligibles. However, as the changes to the dual eligible program are currently structured, states and the dual eligibles they are trying to serve will face several challenges. Starting in 2006, Medicare will take over the prescription drug portion of dual eligible care that Medicaid currently provides. Under Medicare's new Part D program, dual eligibles will not have to pay a premium or deductible for drug costs, and there will be no "doughnut hole" or gap in coverage for drugs approved as part of their Medicare Part D drug plan. The "doughnut hole" refers to the lack of payment that Medicare provides to non-dual eligible Part D enrollees for out-of-pocket drug expenses that range between $2,250 and $3,600. Fully dual eligibles will pay only $1 for generic and multiple-source preferred drugs and $3 for brand-name or non-preferred drugs. There are no co-payments for covered drugs if care is received in a nursing home. Co-payments for prescription drugs that dual eligibles used previously ranged from $0.50 to $3.00 depending on the

particular state Medicaid program in which they were enrolled and the service or product. Beneficiaries could not be denied if they could not meet the co-payment. Under the MMA, the drug may be denied until the co-payment is met by the beneficiary. Please see Tables 2 and 3 for a comparison of the MMA's effect on dual eligible co-payments.

As discussed earlier, the MMA also provides for substantially lower out-of-pocket costs for other low-income Medicare beneficiaries who do not qualify as fully dual eligible. If the beneficiary is single and earns less than 135% (currently $12,123) of the FPL, he or she can receive a $600 credit on the prescription drug card for 2004 that the enrollee can use to spend on drug purchases (not including nominal co-insurance). If the beneficiary has a similar income in 2005, then he or she can also receive assistance with the amount, depending on when the beneficiary signs up for the drug discount card (see Table 1).

Starting in 2006, if the beneficiary earns less than 135% of the FPL with assets of less than three times the limit for Supplemental Security Income, there will be no premium, no deductible, and no gap in coverage for the voluntary prescription drug benefit. The beneficiary will pay $2 for generic or preferred multiple-source drugs, $5 for brand-name drugs, and $0 for total drug costs more than $3,600. The Supplemental Security Income asset limit is currently $6,000 for a single individual eligible or $9,000 for married couples. As with fully dual eligibles, not all assets are counted against a beneficiary in this calculation (please see earlier list on page 3).

If in 2006 the beneficiary earns between 135% and 150% (currently $13,471 for a single individual or $18,181 if married) of the FPL with assets less than $10,000 (or $20,000 for couples), there will be a sliding scale for the premium and a $50 deductible. Also, the beneficiary will pay 15% of drug costs with no gap in coverage, and $2 co-payments for generic or preferred multiple-source drugs and $5 co-payments for brand-name drugs after $3,600 in drug spending. Also, Medicare beneficiaries in nursing homes will not have co-payments for their drug benefit.

Table 1. Low-Income Discount Card Credits

Sign-Up Date	Credit
1 January–31 March 2005	$600
1 April–30 June 2005	$450
1 July–30 September 2005	$300
1 October–31 December 2005	$150

Source: 1-800-MEDICARE

Table 2. Cost-Sharing for Eligible Low-Income Patients

Dual-Eligible Beneficiaries With Incomes Less than 100% of FPL*	Incomes Less than 135% of FPL† and Assets Less than $6000/$9000‡	Incomes Less than 135% of FPL† and Assets Less than $10,000/$20,000	Incomes between 135% and 150% of FPL† and Assets Less than $10,000/$20000‡
• No premium • No deductible • No coverage gap • $1 co-payment (generic or preferred drug); $3 co-payment for brand-name drug • No co-payment if in nursing home • No co-payment more than $3600 limit	• No premium • No deductible • No coverage gap • $2 co-payment (generic or preferred drug); $5 co-payment for brand-name drug • No co-payment more than $3600 limit	• No premium • $50 deductible • No coverage gap • 15% co-insurance until $3600 in out-of-pocket expenses; • After $3600 limit: $2 co-payment (generic or preferred drug); $5 brand-name drug	• Sliding scale premium based on income • $50 deductible • No coverage gap • 15% co-insurance until $3600 in out-of-pocket expenses • After $3600 limit: $2 co-payment (generic or preferred drug); $5 for brand-name drug
4.4 million beneficiaries	6.9 million beneficiaries	0.7 million beneficiaries	1.4 million beneficiaries

*$9600/individual; $13,000/couple, estimated FPL in 2006.
†$13,000/individual; $17,500/couple.
‡Allowed assets per individual or per couple.
§$13,000–$14,400 individual eligible, $17,500–$19,500 couples.

Source: AARP. More than 11 Million Low-Income Medicare Beneficiaries will be Helped by the Medicare Rx Bill in 2006. January 2004. Accessed at www.aarp.org/legislative/prescriptiondrugs/rxchanges/Articles/a2003-11-25-lowincome.html on 9 December 2004.

Table 3. Medicare Prescription Drug Co-Payment Policies for Dual-Eligible Beneficiaries Compared with Co-Payments that Will Apply to Most Dual-Eligible Beneficiaries under Medicare Part D

State	No Co-payments in Medicaid for dual eligibles	Medicaid co-payments always fall below Part D levels	Medicaid co-payments are the same or higher than Part D levels	Medicaid co-payments may be higher or lower than Part D levels depending on circumstances	Co-payment policy
Alabama**					
Alaska				•	$2 per Rx
Arkansas				•	$0.50 per Rx under $10; $1 per $10-$25 Rx; $2 per $25.01-$50 Rx; $3 per Rx over $50
Arizona	•				
California		•			Voluntary $1 per Rx
Colorado			•		$3 per Rx, excluding individuals exceeding maximum annual co-pay of $150
Connecticut		•			$1 per Rx, excludes persons in nursing facility/chronic disease hospital
Delaware	•				
District of Columbia		•			$1 per Rx
Florida	•				
Georgia				•	$0.50 per PDL Rx; $0.50-$3 per non-PDL Rx depending on cost
Hawaii	•				
Idaho	•				
Illinois			•		$1 per generic Rx; $3 per brand Rx
Indiana					
Iowa		•			$1 per Rx
Kansas				•	35% of enrollees have co-pay of $3 per Rx
Kentucky		•			$1 per Rx
Louisiana				•	$0.50-$3 per Rx depending on cost
Maine				•	$0.50-$3 per Rx depending on cost and brand/generic status
Maryland		•			$1 per generic Rx; $2 per brand Rx
Massachusetts				•	$2 per Rx
Michigan		•			$1 per Rx
Minnesota	•				
Mississippi Missouri	•		•		$1 per generic Rx; $3 per brand Rx
Montana				•	Up to $5 per Rx to a maximum of $25 per month
Nebraska				•	$2 per Rx
Nevada					
New Hampshire		•			$0.50 per generic Rx; $1 per brand Rx
New Jersey	•				
New Mexico	•				
New York		•			$0.50 per generic Rx and OTCs; $2 per brand Rx, excludes special needs (?)
North Carolina			•		$1 per generic Rx; $3 per brand Rx
North Dakota		•			$3 per brand Rx
Ohio					
Oklahoma				•	$1 per Rx under $30; $2 per Rx $30 and over
Oregon					
Pennsylvania		•			$1 per Rx
Rhode Island					
South Carolina				•	$2 per Rx
South Dakota				•	$2 per Rx unless in long-term care
Tennessee					
Texas	•				
Utah			•		$3 per Rx up to $15 per month
Vermont				•	$1 per Rx under $30; $2 per Rx $30-$50; $3 per Rx $50 and over
Virginia		•			$1 per generic Rx; $2 per brand Rx
Washington	•				
West Virginia				•	$0.50 per Rx under $10; $1 per $10-$25 Rx; $2 per Rx over $25
Wisconsin		•			$0.50 per OTC; $1 per legend (brand) Rx
Wyoming					
Column Totals	**11 states**	**13 states**	**5 states**	**14 states**	

Notes: *Under Part D, cost-sharing for dual eligibles will depend on their income and institutionalization status. For purposes of this table, KCMU compared the co-payment charges that currently apply under Medicaid to seniors and people with disabilities to those that will apply to noninstitutionalized dual eligibles with income below 100% of poverty under Part D in 2006 (i.e. $1 per generic prescription or preferred multiple source drug and $3 per brand name prescription. **Information not available for states shaded in gray.

SOURCE: Forthcoming KCMU report, *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003.*

Issues for States

The federal government will assume the costs of providing Part D drugs to dual eligibles but will require a financial maintenance of effort by states, meaning the states will still have a significant financial commitment to providing drugs to dual eligibles. Because the federal government provides the initial financing for drug benefits to dual eligibles under Part D (states will pay much of this back later), starting in 2006 state Medicaid programs will no longer receive federal-matching funds for providing drug coverage to dual eligibles enrolled in Part D because of the short-term transfer of financial responsibility from the states to the federal government. Once more, the states must pay much of this assistance back to the federal government (the provisions for these payments are discussed below). In 2006, more than 6 million dual eligibles will lose Medicaid coverage for their pharmaceutical needs regardless of whether they have enrolled in a Part D program. The MMA has provisions to automatically enroll dual eligibles into Part D, so their new drug benefits should continue in some form. However, the efficacy of this continuity assumes that CMS will have solved the logistic barriers necessary for outreach efforts to the dual eligible population, including people with cognitive impairments. As of their 17 August 2004 conference call, CMS had not yet explicitly addressed these barriers and was still asking for commentary. Despite the lack of detail, CMS Administrator Mark McClellan expressed optimism at a November 19, 2004 press conference that CMS's work with state Medicaid directors would prove effective when Medicare takes over the drug benefit for dual eligibles. The Medicaid prohibition includes supplemental funding that the states may have used previously for their Medicaid programs. State Pharmaceutical Assistance Programs can, if a state wishes, provide this supplemental coverage.

State Pharmaceutical Assistance Programs can provide supplemental drug coverage to beneficiaries by purchasing extra benefits from a Part D drug plan or providing a supplemental benefit program for drug benefits beyond Part D. The MMA defines State Pharmacy Assistance programs as entities (not including Medicaid agencies) that provide funding to Medicare beneficiaries for making drug purchases. State Pharmaceutical Assistance Program payments for dual eligibles count toward the out-of-pocket threshold that Medicare will pay for only those cost-sharing subsidies provided as Part D drug pharmaceutical benefits. There will be no payments from the federal government for supplemental benefits that a state may wish to provide that do not fall under Part D coverage.

States will be required to make a "clawback" payment to the federal government each month equal to the product of:

- A numerical "take-back" factor (the number modifying the magnitude of the state's payment to CMS), which is set at 90% for 2006 and phased down to 75% for 2015 and later years;
- The number of dual eligible beneficiaries enrolled in Part D and full Medicaid coverage in that month; and
- A per capita amount designed to approximate the amount a state would have spent each month on prescription drugs per dual eligible in the absence of the Medicare bill. This "per capita amount" is based on a state's per capita Medicaid spending on Part D-covered prescription drugs for full dual eligibles in 2003, trended forward through 2006. The basis for this trending will be the growth in national per capita growth in Part D spending.

Although states will no longer have to fund drug benefits for their dual eligible populations under their Medicaid programs, implementing the new drug benefit will continue to require a significant expenditure from their budgets. The Congressional Budget Office expects that states will collectively save $115 billion from fiscal year 2004 to fiscal year 2013 by not directly paying for a drug benefit, but 85% of this will go back to the government through the "clawback" payments described above. Also, the savings do not accrue until the latter years. Finally, in the short term (2004–2006), the Congressional Budget Office also estimates state budget costs to outweigh relief to state Medicaid programs by $1.2 billion.[16]

Replacing federal Medicaid reimbursement with federal Medicare coverage for prescription drugs becomes more problematic for states when viewed in light of the difficult budget crises that most states have found themselves in recently. For example, budget shortfalls for 2004 were estimated to total near $70 billion, meaning the larger items on state budgets will most likely be targeted for trimming.[17] Education usually takes the largest portion of state budgets, but Medicaid often is the runner-up with Medicaid dual eligible beneficiaries averaging around 20%[18] of Medicaid state budgets. This significant percentage makes it unlikely that dual eligibles will escape unscathed from any state cutbacks to their Medicaid programs. States have consistently claimed that the federal government should do more to cover low-income beneficiaries; hence it is unlikely that State Pharmaceutical Assistance Programs will pick up any slack left in the MMA implementation considering how difficult it was to do when federal-matching payments were available.

Issues for Beneficiaries

Dual eligibles consistently suffer from several afflictions. These conditions necessitate that Medicare Part D coverage be prepared to undertake a population whose individuals may have several conditions, including physical impairments and limitations (such as blindness, spinal cord injury, severe mental or emotional disorders) and disabling conditions (including cancer, cerebral palsy, cystic fibrosis, Down syndrome, mental retardation, Parkinson disease, multiple sclerosis, autism, and HIV/AIDS).[19] The requirements for drugs for several of these conditions could easily multiply this nominal cost-sharing into an amount that becomes an extraordinary burden on the low-income dual eligibles population. This issue becomes more significant when one considers that dual eligibles can now be denied coverage should they not meet the co-payment requirement (not previously the case under the Medicaid-matching system).

Furthermore, the current Medicaid-matching system covers all FDA-approved drugs of every manufacturer that has entered into an agreement with the Secretary of Health and Human Services. However, under the MMA, Part D plans only have to provide two or more drugs in each therapeutic category. Part D plans will have a significant degree of discretion over which drugs they wish to include, which may mean a medically necessary drug will not be on their formulary. This possibility is not too different from current state trends that have begun to rely more on cost-control, as well as utilization controls.[20] Prescription drug plans (either stand-alone or part of a Medicare Advantage plan) have significantly more incentive than states to use these practices as they are rewarded by the federal government for lower bids from less expenditures and penalized for the opposite. There may be other more open plans that a dual eligible could select but at a correspondingly higher premium that could price them out from receiving the necessary medication. However, there have always

been, under the current dual eligible program, appeals processes. These appeals processes allow a beneficiary to appeal any denial, termination, or reduction of benefits within 90 days of the action.[21] Furthermore, if the dual eligible files the appeal within 10 days of notice of the termination, the benefit is automatically continued until a decision is made.

There is an appeals process in the MMA as well that will replace the dual eligible appeals process, but the MMA appeals process may be difficult for several reasons. First, the MMA requires that certain monetary thresholds be met for an appeal to be heard at the initial level ($100) or at the level of a judicial appeal ($1,000).[22] However, a beneficiary disputing a $25 per month denial would have to wait until the dispute piled up over 4 months before the appeal could even be heard. Such an interruption in a needed medication regimen for vulnerable people such as dual eligibles could adversely affect their health. Furthermore, under Medicare prescription drug law, only beneficiaries may act as agents on their own behalf for these appeals (essentially hindering physicians as acting as advocates for their patients) unlike in the Medicare Advantage program where an individual's representative or treating physician can take a representative role. Not having a representative can place a particularly hard burden on certain dual eligibles that may have cognitive disorders, further hindering them from participation in Medicare Part D.

Plan selection is made even more difficult, because under the MMA (unlike in the previous Medicaid system for reimbursing pharmaceuticals), beneficiaries will only be provided with information on premiums and deductible costs in conjunction with cost-sharing rules. Until a beneficiary actually enrolls, they will not know what specific drugs will be covered or the cost-sharing for specific drugs. These omissions may stem from a drug plan's need to determine first its population before it can begin an accurate risk assessment complete with the necessary underwriting. However, this necessity does not change the fact that a population with a heavy disease burden will most certainly need to understand what medication is available. Otherwise, beneficiaries could find themselves lost among a sea of appeals that can drown out their health care.

Recommendations

1. ***ACP supports changes in the "clawback" provisions of the Medicare Modernization Act to relieve short- and long-term financial pressures under state Medicaid programs that may occur due to the shift in dual eligible drug coverage from state Medicaid programs to Medicare.***

College policy states that any legislative changes affecting the Medicaid program, as the MMA does, should preserve the safety net function of Medicaid. Although states may achieve long-term savings from shifting drug coverage from the state Medicaid programs to Medicare, the "clawback" provisions will return most of these savings to the federal government and may not adequately compensate the state, particularly in the short term, for their increased expenditures under the State Pharmacy Assistance Programs (which may be needed to support the state's safety net features for pharmaceuticals to a vulnerable population, dual eligibles). This shortage will occur if the savings to Medicaid programs do not accrue faster from federally purchased drugs. To alleviate the problem, several alternatives are available for modifying the "clawback" payments. Congress could increase federal financing and scale back the state share of responsibility. The federal share could be gradually increased until full payment is met. Front-loading the "clawback" formula would provide states meaningful short-term relief.

2. ***ACP believes that physicians must be provided with clearly communicated information that is detailed but user-friendly from prescription drug plans in Medicare Part D concerning what drugs will be available to dual eligibles and at what cost.***

ACP guidelines on formularies advocate that patient formulary education should detail how the formulary functions and discuss how co-payment and/or deductible requirements may affect their pharmacy benefits. Knowing how the formulary functions inherently includes knowing the drugs that would be available at the formulary's different price levels. Such information should obviously be available to physicians, because physicians, especially internists, act as both the principal points of care and the sources of guidance through complex health systems. Navigating through health care is already a difficult task for most patients. Persons eligible for both Medicare and Medicaid often have additional challenges and difficulty coping. To compound these challenges by turning prescription drug plans into mystery boxes is a disservice to a community that needs help. CMS has tried to address this issue by working very closely with State Health Insurance Programs in an attempt to successfully market the MMA to those who may benefit. These collaborative efforts must include making physicians aware of the pharmaceuticals that will be available to their dual eligible patients. Accommodating the underwriting requirements and risk adjustment procedures of managed care companies should not override the needs of beneficiaries to obtain sufficient information through their doctors to make informed decisions about their health care coverage. To go beyond this impasse, it may be necessary for the Secretary in conjunction with State Health Insurance Programs to provide prescription drug plans with summary data (not patient identifiable) about the population eligible for their programs (including dual eligible populations), facilitating managed care procedures. Once this communication is carried out, prescription drug plans must clearly communicate to physicians what drugs may be available to the dual eligible population if dual eligibles are to participate.

3. ***ACP advocates that current minimum dollar thresholds for appealing prescription reimbursement decisions should be revised, or eliminated, and patient advocates should be permitted to help guide patients through the appeals process.***

Dual eligibles, by definition, are people in difficult financial situations. To require that they build up to a $100 or $1,000 dispute before meeting appeal criteria is an unreasonable financial barrier. Waiting for a $100 dispute may mean delaying medication for several months to bundle payments to the necessary threshold and delaying needed care, while a $1,000 judicial decision could stretch this period to the better part of a year. It is understandable that the federal government wishes to avoid frivolous claims being brought forth, but there may be a better method of accomplishing this objective. Instead of relying solely on flat dollar amounts, an alternative standard may be to allow disputed claims that meet a certain percentage of a dual eligible monthly medication bill (e.g., 90%). This standard would make it more likely that a dual eligible brings forth a claim only when needed, and that the claim will not take an undue, and potentially dangerous, amount of time to amass. If no federal policy can meet such a goal, then monetary thresholds for appeals should be eliminated. Dual eligibles may still need a guide or representative to make sure they understand all of the procedures and are represented as effectively as possible. For this reason, physicians, with their unique and medically valid perspective, should be able, if they wish, to act as an advocate for a dual eligible patient who is engaging in the appeals process.

4. ***ACP advocates that co-payments under the Part D benefit for dual eligibles be modified so that these co-payments are no higher than those under state Medicaid programs, with reasonable adjustments for inflation, etc, and that dual eligibles not be denied prescription drug coverage when they cannot afford the co-payment.***

College policy on Medicare prescription drug benefits states that the highest priority should go toward providing prescription drug benefits for those most in need: low-income beneficiaries who do not have access to drug coverage under other plans. The policy further states this goal could be accomplished by waived or reduced cost-sharing requirements for low-income beneficiaries. Legislation that will effectively increase co-payment amounts, although not in every state, is not in the spirit of College policy. Although the amounts themselves may still be nominal, the frequent drug usage that accompanies the high number of chronic conditions multiplies these co-payments, making them much more difficult for dual eligibles. Furthermore, the MMA now allows a dual eligible beneficiary to be denied coverage if the co-payment cannot be met (unlike previous Medicaid rules). Since the data show that many dual eligibles are in fact women or minorities, denying coverage because a dual eligible cannot meet the co-payment worsens the problem of disparities in health care, a vital College concern.[23] Also, even before passage of the MMA, evidence showed that imposing co-payments in Medicaid programs results in drug access problems for beneficiaries.[24] Furthermore, findings have demonstrated that this burden disproportionately affects those in poor health.[25] Denying coverage because a beneficiary cannot meet the co-payment only compounds the problem. Therefore, Medicare drug coverage for dual eligibles should not allow for disqualification of coverage because the dual eligible cannot meet the co-payment. Some may argue that applying leniency toward co-payment requirements is financially irresponsible. However, when co-payments for necessary medications become unnecessarily prohibitive, public policy must turn to other solutions for controlling expenses. For example, moving to larger supplies of drugs (e.g., 90-day, instead of 30-day allocations) would only require a beneficiary to make one co-payment instead of several that could financially strain a beneficiary over time. Also, looking toward mail delivery may be another method of lowering costs[26] to make up for leniency in enforcing co-payments. However, mail-order pharmaceuticals do not involve the face-to-face benefits that pharmacists can provide in counseling the patient with respect to prescription drugs.

Summary

The dual eligible population has the greatest need and, correspondingly, the highest costs for both Medicare and Medicaid. These disproportionate costs, relative to the rest of the Medicare population, stem from a higher morbidity burden, including more chronic disease that leads to more frequent and intense use of services. Despite the higher cost as a whole, dual eligibles are not homogeneous in their health status, and the largest costs often occur with those beneficiaries in the worst health status. Despite this cost concentration, dual eligibles still greatly need medical service, and recent data suggest that they are satisfied with the care they receive.

The growing dual eligible population will face new challenges as the Medicaid reimbursement system that formerly paid for dual eligible medications is replaced by the new MMA Part D plans. Whatever changes occur, states will need financing at the federal level for prescription drugs to be as upfront as possible to maintain their Medicaid programs (that provide other benefits to dual eligibles). Also, when these plans are implemented, dual eligibles will need guidance from their prescription drug plans and, in the case of appeals, from appropriate experts (including physicians) in navigating their pharmaceutical purchases. However, for dual eligibles to receive this advice, formulary information needs to be clearly communicated to physicians. These experts become especially important when dual eligibles need medical or legal advice to assist with appeals for needed medications. Such assistance could include effective representation or advocacy from a lawyer or a dual eligible personal physician (if the physician chooses to do so). This need arises from a population whose medical care is extensive, but with proper treatment, appropriate financing, and clear communication, their needs can be met.

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