HEALTH POLICY MEMO

September 3, 2003

More Red Tape for the Poor?

Dual Eligibles in the Medicare Rx Bill

As the Senate and House work out an agreement about a prescription drug benefit in Medicare, one significant issue before them is whether seniors and people with disabilities who are enrolled in both Medicare and Medicaid ("dual eligibles") will receive the new Medicare prescription drug coverage.

There are more than 6 million dual eligibles who currently rely on Medicaid coverage to fill in the "gaps" in Medicare coverage.[1] While the Senate bill (S.1) provides more financial help to low-income beneficiaries, there is a problem with the bill's approach to dually eligible beneficiaries: The bill prohibits dual eligibles from receiving Medicare prescription drug coverage, requiring them instead to rely on their state's Medicaid prescription drug coverage. The House bill allows individuals to receive the Medicare drug benefit as they do other Medicare benefits, with states providing "wrap-around" coverage for prescription drug costs that the Medicare benefit does not cover. The House bill provision for dual eligibles would maintain the existing system of Medicaid "wrap-around" services to fill gaps in Medicare coverage for those individuals who qualify for both programs. The Senate bill would be a significant departure from traditional coverage for these beneficiaries.

This Senate approach to coverage for dual eligibles creates problems for both states and beneficiaries: It is of great concern to states because, in 2002, dual eligibles accounted for nearly half of all Medicaid prescription drug expenditures, of which states paid $5.6 billion.[2] Moreover, the Senate provisions open the door to myriad complexities in operating the program. Rather than merging a prescription drug benefit into their wrap-around billing procedures, state Medicaid agencies will be required to engage in a host of administrative procedures with the new, untested Medicare prescription drug plans to ensure continuous coverage for beneficiaries.

The Senate bill provision would not only undermine the universal nature of Medicare coverage by excluding some seniors and people with disabilities from Medicare's prescription drug coverage, it would also cause significant hardship for the many seniors and people with disabilities who are enrolled in Medicaid intermittently. Medicaid eligibility rules allow states to provide Medicaid coverage to people who have income over the eligibility limit if they have very high medical expenses relative to their income. This policy is called "spend down," because it allows people to "spend down" their income to the Medicaid eligibility level. Those who qualify for Medicaid by spending down are, by definition, people with serious health problems who are not in a good position to deal with paperwork and bureaucracy.

The following example demonstrates the hardship that the Senate provisions regarding dual eligibles would create for the thousands of low-income seniors who move in and out of Medicaid coverage each year.

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Mary and the Revolving Rx Coverage Door

MARY'S STORY: A CLOSER LOOK

Mary is a 67-year-old widow who lives alone. She takes several medications that are typical for someone her age and has drug expenditures of $2,968 per year. Mary's monthly income is $800. Mary is in traditional Medicare, and she enrolls in the Senate bill's low-income prescription drug benefit. The low-income subsidy reduces her out-of-pocket drug expenses to $148 per year. But over the course of a year, Mary is admitted to the hospital several times. In the spring, she has chest pains and a heart problem is discovered. During the summer, she faints one morning and is readmitted to the hospital so that her medication can be adjusted. When autumn comes, Mary gets a cold that develops into pneumonia and must be admitted into the hospital for a third time.

Although Mary normally has prescription drug coverage through Medicare, whenever she is admitted to the hospital, that coverage is disrupted. Each time Mary is admitted to the hospital, she incurs an $840 Medicare deductible; that deductible and other cost-sharing reduce Mary's income so she becomes eligible for Medicaid (she has spent down). Although Medicaid helps her with the other medical expenses she experiences from each of these incidents, it does not merely "wrap around" her Medicare drug coverage as it does with other Medicare coverage. Rather, because individuals who are enrolled in Medicaid do not qualify for the Medicare drug benefit, Mary must be disenrolled from her Medicare drug plan each time she gets onto Medicaid and then reenroll whenever her Medicaid coverage ends.

The Provisions for Dual Eligibles in S.1 are Unworkable: Mary's Story Continued

What happens when Mary becomes eligible for Medicaid?

- ✓ The state Medicaid agency must inform CMS that Mary is no longer eligible for drug coverage through the Medicare drug plan.
- ✓ CMS must inform Mary's private drug plan that she is no longer eligible for its coverage, and that plan must take steps to disenroll Mary.
- ✓ If Medicaid eligibility begins during a month in which Medicare has already paid the premium for Mary's enrollment in the Medicare drug plan, will Medicare be reimbursed for that expense or will the federal government pay twice for Mary's drug expenses that month—once for the Medicare drug plan and again for the federal government's share of her Medicaid drug expenses?
- ✓ Mary will have to find out whether the pharmacy that she uses with her Medicare drug coverage accepts Medicaid. If it does not, she will have to either get new prescriptions from her doctors for all of her medications or work with the pharmacy or Medicare drug plan to have her prescriptions transferred to a pharmacy that accepts Medicaid.
- ✓ Mary and her doctor will have to make sure that Medicaid covers her prescriptions. Her state may require prior authorization for one or more of her medications. It may also have a "fail first" requirement that will make Mary show that she has tried a less expensive medication that did not work for her before Medicaid will pay for her prescribed medication.

- ✓ If Mary lives in a state that has a limit on the number of prescriptions Medicaid will cover each month, she may have to pay out of pocket for some of her medications, even though her Medicare drug coverage had no such limits. (The Senate's Medicare bill offers states an incentive to eliminate such limits, but there is no guarantee that all states will accept this incentive.[3])

What happens when Mary becomes ineligible for Medicaid?

- ✓ Will the Medicaid agency automatically reenroll Mary in the Medicare drug plan? Is there a guarantee that there will be no gap between the end of her Medicaid coverage and the date Medicare coverage take effect? If Mary has to reapply on her own, she is at greater risk for having a gap in coverage. Mary may not know exactly when her Medicaid coverage ends, or she may not be able to get to the SSA or Medicaid office in time. If she does have to reapply, what proof would she need to show that she will not, in fact, be eligible for Medicaid the following month? Due to her "spend-down" status, will Mary have to bring in her medical bills to prove that she will not have reached her spend-down amount by the first of the following month?
- ✓ Does Mary have to apply for the Medicare low-income drug benefit again? Will she have to submit verification forms again, or will the Medicaid agency use the information it has on file to determine her eligibility for the low-income benefit?
- ✓ Mary will have to decide whether to enroll in the same plan she was enrolled in previously. If she does not enroll in the same plan, she will have new procedures, potentially a different formulary, and a different list of pharmacies to learn. The plan will have higher administrative costs because of Mary's multiple enrollments and disenrollments.
- ✓ Mary will have to find out whether the pharmacy that she uses with her Medicaid drug coverage accepts her Medicare drug plan. If it does not, she will have to either get new prescriptions from her doctors for all of her medications or work with the Medicaid pharmacy to have her prescriptions transferred to a pharmacy that accepts her Medicare drug plan or send them to the mail-order pharmacy that her drug plan uses.
- ✓ Mary may have to switch medications if any of her Medicaid-covered medications are not covered on her Medicare drug plan's formulary.

This disparity between the treatment of dual eligibles and other Medicare beneficiaries opens the door for a series of complicated administrative issues for the thousands of consumers who go on and off Medicaid during the year, as Mary does. These issues will lead to confusion for consumers, possible disruption in coverage for consumers who have difficulty dealing with this potential administrative morass, and increased administrative costs for both programs. And, while the new system would be difficult for anyone to navigate, results from the National Adult Literacy Survey indicate that 44 percent of seniors have very low literacy skills.[4] In addition, many have Alzheimer's or other forms of cognitive impairment that will make coping with this complex system difficult, if not impossible

These complexities will increase the likelihood of seniors and people with disabilities who are eligible for Medicare drug coverage falling through the cracks and going without this very important coverage. Without coverage, seniors like Mary may not be able to afford their medications and will thus be at increased risk of having a serious medical emergency. The potential for medical emergencies as well as the time and effort required to coordinate two federal programs could not only harm Mary but could also raise administrative and health care costs for both Medicare and Medicaid. Failing to provide the prescription drug benefit through Medicare for all Medicare beneficiaries is bad for consumers and bad for the Medicare and Medicaid programs.

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[1] Kaiser Commission on Medicaid and the Uninsured, *Dual Enrollees: Medicaid's Role for Low-Income Medicare Beneficiaries*, (Washington: Kaiser Commission on Medicaid and the Uninsured, February 2003).

[2] Stacy Berg Dale and James Verdier, *State Medicaid Prescription Drug Expenditures for Medicare–Medicaid Dual Eligibles: Estimates of Medicaid Savings and Federal Expenditures Resulting form Expanded Medicare Prescription Coverage*, (New York: Commonwealth Fund, April 2003).

[3] Ruth Parker, Scott Ratzan, and Nicole Lurie, "Health Literacy: A Policy Challenge For Advancing High-Quality Health Care" *Health Affairs* 22, no. 4 (July/August 2003): 147-153).

[4] S. 1 offers states a "buy-out" of their responsibility for Part B Medicare premiums for Specified Low-Income Medicare Beneficiaries (SLMBs) as an incentive for eliminating limits on the number of prescriptions Medicaid will cover. There is, however, no guarantee that states that have prescription limits in Medicaid will take the incentive and remove those limits.