LOW-INCOME PRESCRIPTION DRUG PLANS:

AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

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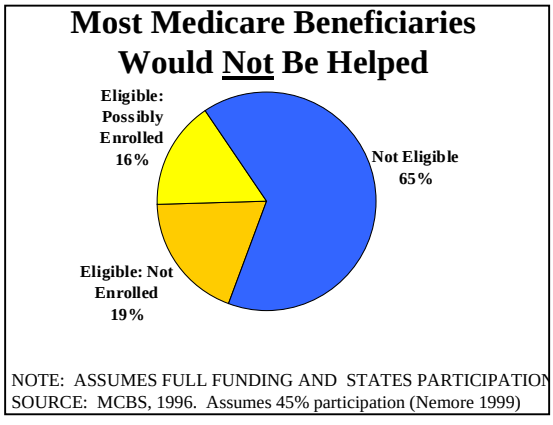
Executive Summary

The Senate Republican Leadership and some Republicans in the House have proposed state block grant proposals to provide prescription drug coverage for low-income seniors and people with disabilities. This study examines these low-income proposals, analyzes their shortcomings, and compares them to the President's voluntary Medicare prescription drug proposal. It concludes that the low-income proposals not only would exclude all middle-income Medicare beneficiaries from any assistance but would fail to achieve their stated objective: to provide meaningful assistance to low-income beneficiaries. Specifically, they would deny eligibility to about 25 million Medicare beneficiaries – most of whom lack affordable, dependable prescription drug coverage today. Due to notoriously low enrollment in state programs, the plans would inevitably not assist more than half of eligible low-income seniors. Even the minority of Medicare beneficiaries who overcome these hurdles and actually sign up for coverage would be enrolled in programs that could cap enrollment and/or the number and types of drugs covered. Furthermore, despite the proposals' goal of providing assistance immediately, it would take years to implement programs in all 50 states and, because funding is time-limited and insufficient, some states may not participate at all. Finally, a low-income program would delay enactment of a workable and meaningful Medicare prescription drug benefit that would more quickly be implemented nationwide and more effectively cover low-income beneficiaries.

CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PLANS

- **Explicitly exclude at least 25 million – two-thirds of – Medicare beneficiaries.** Although high drug costs and lack of drug coverage are not just problems for low-income beneficiaries, the most generous Senate Republican plan restricts block grant funding to those who are not eligible for Medicaid and have income below 175 percent of poverty (about $14,600 for singles, $19,700 for couples). Nearly 5 million people would be excluded because they are Medicaid-eligible and another 20 million have income above the eligibility cut-off. In 16 states, 75 percent or more of Medicare beneficiaries would be excluded while in 5 states, 80 percent or more of seniors would not be eligible. Specifically, the proposal would:

    - Exclude three-fifths (60 percent) of all seniors and people with disabilities who have absolutely no coverage for prescription drugs;
    - Exclude three of five Medicare beneficiaries with the highest drug costs;
    - Exclude three-fifths of the seniors who purchase Medigap private insurance, which is expensive and provides a limited benefit;
    - Exclude most Medicare managed care enrollees with unreliable and limited drug coverage that they are at risk of losing from year to year.



- **Less than half of the low-income Medicare beneficiaries that the plan purports to help would likely get drug coverage, even if fully implemented in all states.**

  - 55 percent of low-income Medicare beneficiaries currently do not enroll in Medicaid even though they are eligible**.** Medicaid provides prescription drug coverage for the lowest-income seniors and helps pay for Medicare premiums for those with income below 135 percent of poverty. However, 50 percent or more eligible beneficiaries are not enrolled in Medicaid in 30 states and more than two-thirds do not participate in 7 states. In contrast, 98 percent of eligible people nationwide enroll in Medicare.

  - Less than 800,000 seniors are enrolled in state pharmacy assistance programs. These state-initiated programs have low participation rates and exclude more than 90 percent of Medicare beneficiaries in 8 of the 14 states operating such programs in 1999.

  - Enrollment barriers are common. States have not made the strides in simplifying enrollment for the elderly that they have for children. To sign up for Medicaid, eligible seniors and people with disabilities must fill out long, complex applications (in 26 states); meet extensive documentation requirements for income and assets (in 41 states); and sign up through welfare offices (34 states have no outstationed eligibility workers).

  - Many seniors reject "welfare" programs. Complex enrollment procedures contribute to the belief that state assistance is "welfare," only for "poor people" and could jeopardize the financial well-being of spouses and children. Despite efforts to overcome this, these negative perceptions remain and serve as a significant barrier to enrollment.

- **Empty promise for those who actually enroll.** The Republican plans provide no assurance of what drug coverage beneficiaries receive; what you get depends on where you live.

  - Types of drugs covered and number of prescriptions filled may be limited. States could extend their current Medicaid or state drug assistance program benefits. Five state programs limit drug coverage to specific conditions or maintenance drugs. Fourteen programs limit the number of prescriptions that can be filled. For example, Texas, Oklahoma, and Wisconsin permit only 3 prescriptions per month.

  - No guaranteed access to needed drugs or local pharmacies. Under most low-income plans, there is no guarantee that, when a doctor prescribes a particular drug as medically necessary, the patient would get it. And, there is no assurance that seniors could continue to access local pharmacies.

  - Enrollment would inevitably be capped. With the Senate's $1.3 billion in 2001, states would not be able to provide prescription drug coverage to even the limited group of eligible beneficiaries. Much of this Federal funding would be used to replace current state funding (about $700 million in 1999), leaving at most only $119 per eligible low-income senior per year compared to average annual spending that exceeds $1,000. As such, states would inevitably have waiting lists.

- **Implementation issues would delay low-income assistance – and a long-overdue Medicare prescription drug benefit.**

  - Would not provide prescription drug coverage to low-income seniors nationwide in 2001. It is extremely unlikely that all states would implement new prescription drug programs under this plan next year. Not only does the National Governors' Association oppose taking responsibility for prescription drugs, but the time-limited and inadequate funding in most plans would give states little incentive to invest in setting up new programs. Even if states did support this approach, it would take time to implement. The last three states started enrolling children in the bipartisan, state-supported Children's Health Insurance Program just this year -- 3 years after enactment. Finally, the Federal "default plan" to provide coverage in states that do not participate could not be operational in 2001 because new systems for income-based eligibility would be needed.

  - Low-income block grants would fail to help low-income beneficiaries but would succeed in delaying implementation of a Medicare prescription drug benefit. If enacted, the next Congress would likely spend more energy on fixing this flawed low-income plan than establishing an affordable, meaningful, and accessible Medicare prescription drug benefit option. More importantly, this interim step is not needed: Congress could pass a meaningful Medicare prescription drug proposal this year that would be available to all Medicare beneficiaries in 2002 and more effectively help low-income enrollees.

CLINTON-GORE ADMINISTRATION PLAN FOR MEDICARE DRUG BENEFIT

- **Ensures a Medicare prescription drug benefit option for all Medicare beneficiaries – including low-income seniors.** The President's plan would, beginning in 2002, offer all Medicare beneficiaries the option of reliable prescription drug coverage through traditional Medicare, managed care, or a retiree plan if available. It would help many more low-income beneficiaries than a block grant since 98 percent all people eligible for Medicare enroll.

- **Provides a meaningful benefit at an affordable premium**. Participants would pay a monthly premium of $25 in 2002 (no premium for the lowest-income beneficiaries) for coverage that has no deductible, pays for half of costs up to $5,000 when phased in, and limits the amount that a senior or person with disabilities pays for drugs to $4,000. All participants would benefit from privately-negotiated price discounts for all their drug costs.

- **Guarantees coverage of prescriptions that beneficiaries need at the pharmacies that they trust**. Because Medicare beneficiaries often have multiple, complex health problems, the President's plan would cover any drug that a doctor certifies is medically necessary, even if it is "off formulary." Also, recognizing the importance of using accessible, familiar pharmacies, the President's plan ensures access to all qualified community pharmacies.

- **Adequately financed and part of a plan to improve Medicare.** Extending Medicare solvency, improving efficiency, and restoring provider payments are important elements of the President's plan to modernize Medicare. Additionally, enough budget surplus should dedicated to finance a prescription drug benefit and take the Medicare trust fund off-budget.

LOW-INCOME PRESCRIPTION DRUG PLANS:
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PROBLEM OF THE LACK OF PRESCRIPTION DRUG COVERAGE

Prescription drugs have become central to health care, contributing to preventing, managing, and curing diseases. They are even more important to the elderly and people with disabilities on Medicare. However, Medicare does not cover outpatient prescription drug costs. Consequently, nearly half of beneficiaries go without coverage for part or all of the year[1] – about the same percentage as those who lacked hospital insurance when Medicare was created in 1965. Older Americans and people with disabilities without drug coverage typically pay 15 percent more than insurers who negotiate price discounts for the same prescription drug. As a result, uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.[2] The situation is even worse for rural Medicare beneficiaries, who are over 60 percent more likely to fail to get needed prescription drugs due to cost.[3] Medicare beneficiaries with disabilities face unique challenges, being less likely to have private coverage but needing more and different types of prescriptions than the elderly.[4] The absence of prescription drug coverage is also a barrier for people with disabilities who want to return to work.

CONGRESSIONAL REPUBLICAN LOW-INCOME PRESCRIPTION DRUG PROPOSALS

On September 7, 2000, Senator Roth (R-DE) introduced two similar bills (S. 3016 and S. 3017) to address the lack of prescription drug coverage for Medicare beneficiaries.[5] S. 3017, entitled the "Medicare Temporary Drug Assistance Act," would provide $29 billion in block grants to states for four years[6] to voluntarily provide prescription drug coverage to certain low-income Medicare beneficiaries. Senate Majority Leader Lott (R-MS) and Senate Majority Whip Nickles (R-OK) co-sponsored the less generous version of the proposal (S. 3016).

Under the more generous proposal, states would have the option of receiving time-limited Federal grants to provide prescription drug coverage to Medicare beneficiaries who are, in general, not eligible for full Medicaid (approximately above 75 percent of poverty) and have incomes below 175 percent of poverty ($14,600 for singles, $19,700 for couples). States could set the upper eligibility limit anywhere in this range, impose an assets test, and set caps on enrollment.

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[1] Stuart B; Shea D; Briesacher B. (January 2000). *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter.* New York: The Commonwealth Fund.

[2] Assistant Secretary for Planning & Evaluation. (April 2000). *Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President.* Washington, DC: U.S. Department of Health & Human Services.

[3] White House National Economic Council / Domestic Policy Council. (June 13, 2000). *Prescription Drug Coverage For Rural Beneficiaries: A Critical Unmet Need.*

[4] White House National Economic Council / Domestic Policy Council. (July 31, 2000). *Disability, Medicare and Prescription Drugs.*

[5] For the purpose of this paper, we have focused on S. 3017. S. 3016 sunsets on December 31, 2003, limits eligibility to those below 150 percent of poverty ($12,500 for singles, $16,900 for couples) and provides $17 billion.

[6] S. 3017 provides $1.3 billion in FY2001, $4.6 billion in FY2002, $9.7 billion in FY2003, $13.0 billion in FY2004.

States not only would have discretion to participate and to set eligibility rules under this proposal but could design their own drug benefit package. There are only two requirements. First, the drug benefit must be equal (or be equivalent) to a "benchmark" drug plan or an alternative plan approved by the Secretary of Health and Human Services. The benchmarks include the prescription drug coverage of: (a) the state Medicaid program; (b) the Blue Cross-Blue Shield Standard Option under the Federal Employees Health Benefits Program; (c) the health plan for state employees; (d) the largest HMO in the state; and (e) the state's low-income pharmacy assistance program. Second, states could not require premiums or cost-sharing for beneficiaries below 100 percent of poverty ($8,400 for singles, $11,300 for couples) and premiums or cost-sharing that exceeds 5 percent of family income for beneficiaries between 100 and 175 percent of poverty. The bill includes no requirement that the Federal funding be used for plans that cover all therapeutic classes of drugs, ensure access to medically necessary prescription drugs, a managed benefit with protections against adverse drug reactions, or guarantee access to local pharmacies.

The Federal government would distribute the proposal's annual funding through state-specific capped annual allotments, allocated on the basis of a state's proportion of Medicare beneficiaries below 175 percent of poverty. States must spend their annual allotment by the end of each year or the remaining funds are returned to the Treasury. Federal matching rates under these allotments would be 100 percent for assistance to those below 135 percent of poverty ($11,300 for singles and $15,200 for couples). For beneficiaries between 135 percent and 175 percent of poverty, states must contribute the same percentage matching payments that they do under the State Children's Health Insurance program (SCHIP). States may cap enrollment if funding runs out because eligible beneficiaries are not entitled to the benefits they receive under these programs. States may use this new Federal funding to replace current state funding for program beneficiaries receiving coverage under a state pharmacy assistance program.

Since states are not required to offer prescription drug coverage, the Senate Republican plan includes a Federal "default plan." The Health Care Financing Administration (HCFA), which runs Medicare, would contract with a pharmacy benefit manager (PBM) to provide a drug benefit in a state that declines to participate. This coverage would be equivalent to Federal employees' Blue Cross-Blue Shield Standard Option drug coverage and would be restricted to those who are ineligible for Medicaid and have incomes below 135 percent of poverty (HCFA may set a lower eligibility level if funding is insufficient). HCFA would receive 90 percent of the funds otherwise available to the state and would pay for administrative costs from that amount. This year, states would notify HCFA by December 31st about their intent to participate; if they do not, then HCFA would have to start coverage in that state one day later, by January 1, 2001. In subsequent years, states must give HCFA one month's notice.

Congressman Bilirakis (R-FL) has introduced a companion bill, H.R. 5151, in the House of Representatives that is very similar to the Senate Republican drug proposal. It provides for $36.9 billion in block grants to states for four years and expressly holds that states currently providing a pharmacy assistance program are under no obligation to continue their program or maintain the same effort or spending levels.

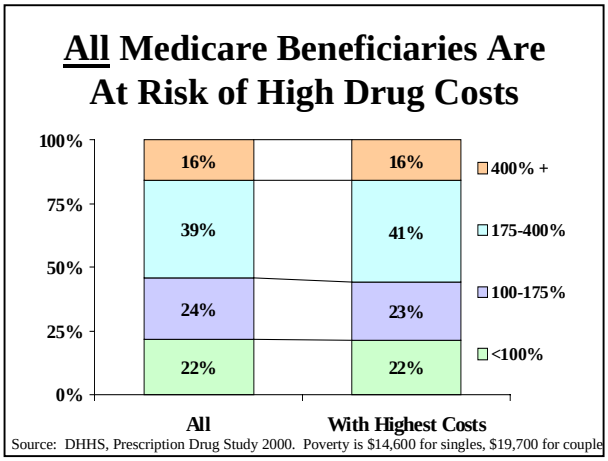
CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PROPOSALS

EXPLICITLY EXCLUDES AT LEAST 25 MILLION – TWO-THIRDS OF – MEDICARE BENEFICIARIES. Most low-income block grant plans restrict funding to those who are ineligible for Medicaid and have income below 175 percent of poverty (about $14,600 for singles, $19,700 for couples). Nearly 5 million would be excluded because they are Medicaid-eligible and another 20 million have income above the eligibility cut-off. [7] States do not have to expand to 175 percent of poverty, so the number of beneficiaries excluded would likely be higher. While Medicare's lack of prescription drug coverage disproportionately affects low-income beneficiaries who can least afford prescription drugs, it is not exclusively – or even disproportionately – a low-income problem. Medicare beneficiaries with no or inadequate coverage are scattered throughout the income distribution. The risk of having high prescription drug costs is also insensitive to income.

Vast majority of seniors excluded in most states. Forty states would have at least 70 percent of their seniors ineligible for assistance under the Senate Republican low-income block grant. In 16 states, the percent of excluded seniors is 75 percent or more, and in 5 states, the percent excluded is 80 percent or more. [8] (See Table 1).

Most of those who lack prescription drug coverage today would be excluded. About three-fifths (55 percent) of all Medicare beneficiaries who now have no coverage for prescription drugs throughout the year would be ineligible assistance under a low-income plan. Unlike the lack of health insurance among the non-elderly, the lack of drug coverage is not concentrated among those with low-incomes. The difference in the rate of lack of drug coverage among middle-income elderly (income greater than 300 percent of poverty) and poor elderly is 35 versus 24 percent. In contrast, the rate of uninsured children is nearly four times higher among poor children than those in families with income above 300 percent of poverty: 26 versus 7 percent. [9] Seniors and people with disabilities – even when they have adequate income – cannot always access and/or afford drug coverage from private health insurance. This is a particular problem for rural beneficiaries and the oldest seniors who are most likely to lack drug coverage.

Little relief for seniors and people with disabilities with high drug costs. Nearly three in five of Medicare beneficiaries with the highest prescription drug costs (57 percent) would not qualify for assistance under a low-income plan. In fact, the income distribution of the 20 percent of Medicare beneficiaries with the highest total drug spending is almost identical to that of all Medicare beneficiaries.[10] This shows that middle-income beneficiaries are at equal risk of having high prescription drug costs as those with low-income.



Source: DHHS, Prescription Drug Study 2000. Poverty is $14,600 for singles, $19,700 for couple

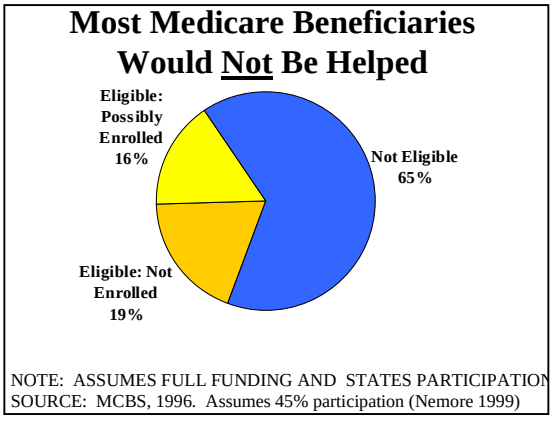
[7] Analysis of the 1996 Medicare Current Beneficiary Survey.
[8] Average Current Population Survey March 1997-99 for elderly with income between 75-175 percent of poverty.
[9] Analysis of the 1996 Medicare Current Beneficiary Survey for elderly; March 1999 CPS for uninsured children.
[10] Assistant Secretary for Planning & Evaluation. (April 2000). *Prescription Drug Coverage, Spending, Utilization, and Price: Report to the President.* Washington, DC: U.S. Department of Health & Human Services.

Excludes millions of Medicare beneficiaries with inadequate, expensive, and unreliable managed care or private insurance plans. Less than one-third of all Medicare beneficiaries have prescription drug coverage through a retiree health plan.[11] This leaves many middle-income seniors and people with disabilities who need prescription drug coverage only the choice of private Medigap insurance or, if available, a Medicare managed care plan. Premiums for private Medigap insurance with prescription drug coverage can be $100 more per month – and much higher for those over the age of 80.[12] Yet, three-fifths of the seniors who purchase Medigap private insurance have income above 175 percent of poverty.[13] In addition, low-income drug plans do nothing to help those who join Medicare managed care plans for prescription drug coverage since they would not directly reimburse plans for such coverage. Thus, those who remain in Medicare+Choice plans remain at risk of losing drug coverage.

LESS THAN HALF OF THE LOW-INCOME MEDICARE BENEFICIARIES THAT THE PLAN PURPORTS TO HELP WOULD LIKELY GET DRUG COVERAGE. The second, major concern with the low-income prescription drug proposals is that they build on state programs that have failed to effectively help low-income seniors and people with disabilities.

Most (55 percent) low-income Medicare beneficiaries eligible for Medicaid do not receive assistance. The lack of prescription drug coverage is not Medicare's only benefit gap. Medicare's benefits are less generous than 80 percent of large employers' fee-for-service health plans.[14] Thus, Medicaid assists the elderly and people with disabilities qualifying for Supplemental Security Income (SSI) and certain others who spend down their resources. In addition, states are required to cover Medicare premiums for those with income below 135 percent of poverty and its cost sharing for those with income below 100 percent of poverty. Despite their need for such assistance, about 55 percent of eligible low-income Medicare beneficiaries are not enrolled in Medicaid.[15] While the participation rate varies by state, it is 50 percent or less in 30 states and less than one-third in 7 states.[16] (See Table 1). Medicare beneficiaries who do not enroll in Medicaid tend to be older women who live alone and Hispanics.[17]

Combining the percent of Medicare beneficiaries who are eligible for any assistance with a 45 percent participation rate, only 16 percent of Medicare beneficiaries are likely to get any assistance under the low-income block grant plan (assuming full funding and full state participation).



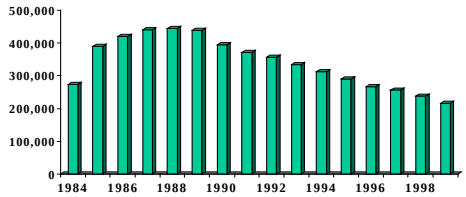
[11] Mercer-Foster Higgins (1999). The number of large firms providing retiree coverage dropped 25% from 1994-98.
[12] U.S. General Accounting Office. (March 1, 2000). *Medigap: Premiums for Standardized Plans that Cover Prescription Drugs*. Washington, DC: US GAO/HEHS-00-70R.
[13] Analysis of the 1996 Medicare Current Beneficiary Survey.
[14] Komisar HL; Reuter JA; Feder J.(June 1997). *Medicare Chart Book.*Washington, DC: Kaiser Family Foundation.
[15] Nemore PB. (December 1999). *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*. Washington, DC: Kaiser Family Foundation. GAO (1999) GAO/HEHS-99-61.
[16] Families USA. (July 1998). *Shortchanged: Billions Withheld for Medicare Beneficiaries.* Washington, DC: Families USA.
[17] Barents Group LLC. (April 7, 1999). *A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries.* Baltimore, MD: U.S. DHHS, Health Care Financing Administration.

State pharmacy assistance programs have not covered a meaningful number of seniors. Rather than extending Medicaid coverage to additional low-income elderly, a number of states have created partially to totally independent, state-funded programs to cover prescription drugs. Fourteen states had programs running in 1999, two states began programs this year, and six states are planning to but have not yet begun to enroll seniors. Benefit design, eligibility, and integration with the Medicaid prescription drug benefit vary by state. However, there is one constant: enrollment in these programs is low. Nationally, less than 800,000 seniors are enrolled in state pharmacy assistance programs. (See Table 1) In eight of the 14 state programs, 10 percent or fewer Medicare beneficiaries are enrolled. [18]

ENROLLMENT TRENDS IN PACE

In 1999, the Pennsylvania PACE program – the largest in the nation -- served 50 percent fewer Medicare beneficiaries (217,103) than in 1988 (443,518). Although the Governor expanded the program in 1996 and aimed to cover an additional 75,000 seniors, fewer people were enrolled overall in 1999, and his new PACENET program has covered less than 20,000 since 1996.

Enrollment in PACE



Source: Pennsylvania Department of Aging (2000); Pennsylvania Legislature.

Enrollment barriers exist in many state programs for the elderly. Another reason why state programs have not reached their enrollment goal is the difficulty of the enrollment process. States have not made the same strides in simplifying Medicaid enrollment for the elderly as they have for children. To sign up for Medicaid, eligible seniors and people with disabilities must fill out long, complex applications (in 26 states); meet extensive documentation requirements for income and assets (in 41 states); and go to welfare offices (34 states have no outstationed eligibility workers). Also, at least 18 states recover Medicare cost sharing payments from the estates of deceased beneficiaries, causing fear that their estates will be tapped when they die.[19] In contrast, states have employed a number of strategies to simplify enrollment for uninsured children.[20] And, unlike Medicare, Medicaid requires redetermination of eligibility at least once a year, and two state pharmacy assistance programs require participants to re-enroll on a monthly basis.[21]

Lack of awareness – and reluctance to participate in perceived "welfare program" – limit enrollment. Studies have found that beneficiaries are frequently unaware of state-based low-income assistance programs or their eligibility for them. It also appears that the social stigma of enrolling in Medicaid-related programs ("poor people's programs") and misperceptions about the effect of enrollment on immigration status and inheritance for spouses and children prevent enrollment. Despite concerted efforts by the Clinton-Gore Administration, advocates and some states, these negative perceptions persist.[22]

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[18] General Accounting Office (September 2000*). State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U. S. GAO; GAO/HEHS-00-162.
[19] Nemore PB. (December 1999). *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*. Washington, DC: The Henry J. Kaiser Family Foundation.
[20] Cox L; Cohen Ross D. (April 2000). *Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.
[21] General Accounting Office (September 2000*). State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U. S. GAO; GAO/HEHS-00-162.
[22] General Accounting Office. (April 1999). *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment*. Washington, DC: U.S. GAO/HEHS-99-61.

LIMITATIONS ON PRESCRIPTION DRUG COVERAGE IN STATE PROGRAMS

LIMITS ON NUMBER OF PRESCRIPTIONS*	LIMITS ON TYPES OF DRUGS**
Arkansas	Illinois
Florida	Maine
Georgia	Maryland
Michigan ***	Rhode Island
Mississippi	Vermont
Nebraska	
North Carolina	
Oklahoma	
South Carolina	
Tennessee	
Texas	
West Virginia	
Wisconsin	
Wyoming (state & Medicaid program)	

*Some Medicaid programs limit number of prescriptions that may be filled per month. **Non-Medicaid programs. ***State program; limits coverage to 3 months per year.
Sources: CCH; NGA 2000; National Pharmaceutical Council 1998; GAO

EMPTY PROMISE FOR THOSE WHO ACTUALLY ENROLL. For those seniors and people with disabilities who qualify for coverage and apply, additional barriers to meaningful drug coverage remain under the low-income proposal.

Permits limits on types of drugs covered and the number of prescriptions that can be filled. Despite the fact that virtually all of the funding for coverage in low-income plan is Federal, states have discretion to design the scope of the drug benefit. They could use block grant funds to extend their current Medicaid or state drug assistance program benefits. Five of the 14 state pharmacy assistance programs limit drug coverage to specific conditions or maintenance drugs (e.g., Maryland only covers maintenance drugs). In addition, 14 state programs limit the number of prescriptions that can be filled. For example, Texas, Oklahoma, and Wisconsin permit only 3 prescriptions per month.

Permits states to limit access to medically necessary drugs. Low-income proposals generally allow states to limit the ability of a doctor to prescribe a medically necessary drug. Specifically, they would permit burdensome appeals or prior authorization requirements. Thus, a senior with cancer who is eligible and enrolls may not get coverage for needed prescription drugs.

Could restrict access to a local pharmacy. The Senate Republican bill provides no assurance that beneficiaries could continue to use their local pharmacies. Local pharmacies play an important role in quality of care for the elderly and people with disabilities who tend to use a large number of medications that interact and can cause complications. In addition, Medicare beneficiaries are not as mobile as other Americans so geographical access is important.

Enrollment would inevitably be capped. States would have the discretion to set the upper eligibility limit under this program at any level above Medicaid and below 175 percent of poverty. They could also impose assets tests. Most disturbingly, states could – and would probably – cap enrollment. States would not be able to provide prescription drug coverage to even the limited group of eligible beneficiaries with the Senate Republican's $1.3 billion in 2001. While average annual spending on prescription drugs exceeds $1,000, this funding would provide at most only $119 per year per eligible senior (see Table 1). This would be even lower when taking into account people with disabilities. Much of this Federal funding would be used to replace existing state funding. In 1999, 12 states spent about $700 million on non-Medicaid drug programs.[23] Four of these states (Connecticut, Maryland, New Jersey, Pennsylvania) could entirely substitution their state spending with their Federal funding under this plan. Another three states (Illinois, Maine, New York) could use more than half of their Federal allotment to replace all of their state spending. This does not take into account potential substitution in Medicaid. Thus, even if a state were to effectively encourage low-income seniors to apply, those seniors would inevitably end up on waiting lists.

[23] General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U. S. GAO; GAO/HEHS-00-162.

IMPLEMENTATION ISSUES WILL DELAY LOW-INCOME ASSISTANCE – AND A LONG-OVERDUE MEDICARE PRESCRIPTION DRUG BENEFIT. While there is general agreement that Medicare beneficiaries need a prescription drug benefit as soon as possible, the Congressional block grant plans would not provide prescription drug coverage to low-income beneficiaries nationwide in 2001. The proposals would be more effective at delaying implementation of a meaningful Medicare prescription drug benefit than at helping low-income seniors immediately.

States generally oppose filling in Medicare's gaps – and specifically oppose taking responsibility for prescription drug coverage. The Clinton-Gore Administration has worked successfully with states on a number of policy initiatives, most notably the creation and implementation of the State Children's Health Insurance Program. These initiatives have succeeded due to state and bipartisan Congressional support. The same does not hold true for the Senate Republican block grant proposal for prescription drugs. States have generally opposed increasing their role in filling in gaps in Medicare. They are specifically concerned about prescription drugs given these rapidly growing costs.

NATIONAL GOVERNORS' ASSOCIATION:
CONCERNS ABOUT STATE PRESCRIPTION DRUG PLAN

- **On Medicare:** "The Governors want to ensure that elderly beneficiaries receive the best possible care, but the Medicare program is a federal program and the federal government should bear all of the costs of serving this dually-eligible population, including full federal responsibility for prescription drug costs." (HR-16-3-9)
- **On Prescription Drugs:** "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." (HR-39)
- **On Time-Limited Programs (SCHIP funding is for 10 years; Senate Republican drug plan is for 4 years)** "The design, development, and implementation of a health insurance program such as S-CHIP takes time. For states to enroll children, educate families about the benefits of a managed care delivery system, ensure that necessary services are received, and ensure that claims are submitted and subsequently paid, Governors must be confident that a stable funding stream will be available to provide health care services to beneficiaries." (HR-15-4)

Low-income proposals make it even more unlikely that states expand drug assistance programs. The low-income proposals' Federal funding is time-limited, inadequate, and capped – features which would discourage states from participating. States without pharmacy assistance programs today would have to pass enabling legislation, develop administrative systems, hire and train eligibility workers, develop claims payment systems, and conduct outreach campaigns to raise awareness. State officials would be concerned about launching such an initiative if Federal funding is temporary, since states would inevitably have to continue to provide such coverage if efforts to pass a Medicare prescription drug benefit fail. In fact, if states provide assistance, there could be less pressure to enact a Medicare drug benefit, leaving states permanently responsible. In addition, the Federal allotments under the Senate Republican plan are small, and may not be sufficient to justify the start-up costs. Finally, Federal responsibility and liability are capped. Given the rapidly rising costs of prescription drugs, states would be put in the untenable position of cutting back on either enrollment or benefits if cost growth exceeds Federal funding growth.

Even if states unanimously supported a low-income prescription drug proposal -- as they did with the State Children's Health Insurance Program (SCHIP) -- it would take significant time to implement. The legislation providing funding for SCHIP was passed on August 5, 1997. States began receiving funding on October 1, 1997. Twenty states did not begin enrollment in the first

year, and three of these states only began enrollment in 2000 -- nearly 3 years after enactment.[24] Thus, even under the best case scenario – where all states support the approach and it is fully funded -- it is virtually impossible that low-income seniors nationwide would have access to this new prescription drug coverage in 2001.

Federal "default plan" may be impossible to implement – and definitely could not be operational in 2001. Recognizing that some (and perhaps most) states would not want to expand prescription drug coverage, most low-income proposals would require the Health Care Financing Administration (HCFA), which runs Medicare, to establish a prescription drug benefit for low-income seniors and people with disabilities in states that opt out. Medicare has no history of or ability to selectively provide benefits based on beneficiaries' income. It would likely take Medicare longer to develop such systems than states and could, under no scenario, be operational and enrolling low-income beneficiaries on January 1, 2001, as the law requires.

Creating a new state program would divert energy and resources from implementing a Medicare prescription drug benefit. The Federal and state effort needed to make a low-income prescription drug proposal a success would likely exceed that which is needed to create a Medicare prescription drug option. If the Senate Republican proposal were enacted, the next session of Congress would more likely focus on fixing this flawed, state-based low-income program rather than creating a Medicare prescription drug benefit. More importantly, this interim step is not needed: Congress could pass a meaningful Medicare prescription drug proposal this year that would go into effect for all Medicare beneficiaries in 2002. It would be more effective at covering low-income beneficiaries since 98 percent of seniors participate in Medicare. This low-income proposal would be more effective at diverting attention from and delaying a meaningful Medicare prescription drug option than it would be in assisting the low-income seniors that it purports to help.

CLINTON-GORE ADMINISTRATION PRESCRIPTION DRUG PROPOSAL

The Clinton-Gore Administration would establish a Medicare prescription drug benefit that is optional, affordable, meaningful, and accessible for all seniors and eligible people with disabilities beginning January 1, 2002. The benefit would have no deductible and pay for half of the costs of drug costs up to $5,000 when fully phased in. Participants would pay no more than $4,000 in out-of-pocket drug costs annually. Premiums for this coverage would be $25 per month starting in 2002 while low-income beneficiaries (with incomes below 150 percent of poverty, $12,500 for singles, $16,900 for couples) would pay no to lower premiums and cost sharing. The Congressional Budget Office estimates that 100 percent of Medicare beneficiaries without prescription drug coverage – including all low-income beneficiaries – would participate. According to the HCFA Actuary, the cost of the program is $253 billion over 10 years.

This Medicare drug benefit option would be integrated into beneficiaries' health plan choices, so that eligible seniors could choose to get their prescriptions through the traditional fee-for-service program, managed care, or a retiree health plan if available. Beneficiaries in traditional fee-for-

[24] U.S. Health Care Financing Administration (HCFA). (January 2000). *The State Children's Health Insurance Annual Enrollment Report, October 1, 1998 - September 30, 1999*. Washington, DC: U.S. DHHS.

service would receive their drug coverage through pharmacy benefit managers (PBMs) in the same way that most privately insured Americans do. PBMs would negotiate drug discounts on behalf of Medicare beneficiaries. Seniors who have retiree health insurance that provides drug coverage at least as good as the President's benefit could choose to keep that coverage. Medicare would contribute to part of its premium subsidy to employers in order to encourage them to maintain retiree coverage. In addition, for the first time in program history, Medicare managed care plans would receive direct payments for the provision of a prescription drug benefit. This should stabilize the Medicare managed care market and contribute towards making it more competitive. In fact, in 2001, plans will be paid to provide to their enrollees a drug benefit that is similar to the President's benefit, until the benefit is implemented one year later.

Regardless of their plan choice, all Medicare beneficiaries enrolled in the prescription drug option would have access to all prescriptions deemed medically necessary by a physician, even if not on the formulary of their PBM or managed care plan. In addition, beneficiaries would continue to be able to receive their prescriptions from their community pharmacies.

COMPARISON OF THE CLINTON-GORE AND REPUBLICAN LOW-INCOME PLAN

Middle-income widow with annual income of $18,000. An 85-year old widow, with annual income of $18,000 (just over 200 percent of the poverty limit), has lived independently for the 15 years since her husband died. She currently does not qualify for Medicaid prescription drug coverage and cannot afford Medigap prescription drug coverage. However, she has developed congestive heart failure which, along with her arthritis, costs her $9,000 per year – half of her income.

- *Republican Low-Income Plan* would exclude this elderly widow from eligibility because her income is too high. She would receive no assistance under this plan.

- *Clinton-Gore Plan* would offer her a premium of $25 per month in 2002 for a price discount of at least $900 and coverage of $4,100 for savings (net of premiums) of $4,700.

Low-income person with disabilities with Parkinson's disease. A 46-year old electrician has been developed Parkinson's disease. He had to stop working at the age of 43 and became eligible for Medicare at the age of 45. He can no longer work. A new medication that helps control muscle tremors that would enable him to return to work has been developed. However, it costs $600 per month – on top of his $250 per month for prescriptions to alleviate his related conditions. His annual total prescription drug costs are $10,200 and are not covered by Medicare. His income from part-time work is $5,000 per year.

- *Republican Low-Income Plan* would allow the state that this person resides in to limit the types of drug covered. This state could decide not to cover this new drug that would enable this electrician to return to work full time. As such, if he decided to enroll, he could get assistance for $3,000 of his $10,200 in drug costs – the uncovered prescription drug costs would still exceed his annual income.

- *Clinton-Gore Plan* would not charge this person premiums or cost sharing and would pay for all of his prescription drug costs, enabling him to take the new drug and return to work. He would save the full $10,200 per year.

Low-income retired couple. The Smiths, a married couple in their late seventies, have an annual income of $15,190. Mr. Smith has diabetes and poorly controlled hypertension. They live in a state that has implemented the new low-income prescription drug program, but only 30 percent of the eligible population has enrolled in the program, because it has not been well advertised. The Smiths would apply for assistance, but they don't know about the program. They are spending more than one-third of their income on Mr. Smith's medications.

- Even though the *Republican low-income* plan should help this couple, it does not. Because of the difficulty of reaching out to a low-income population, confusing, complicated, and overly burdensome application process, and the strict income-based enrollment requirements, state-based programs have limited success in identifying and enrolling eligible seniors. Unfortunately, even though they should be helped by this program, the Smiths are just two of the millions of older Americans that receive no assistance from the Republican proposal.

- *Clinton-Gore Plan* would provide the Smiths with a comprehensive prescription drug benefit, eliminating all of the couple's out-of-pocket medication expenses. In addition, because the application process would be modeled after the one used to enroll in Medicare Part B, which covers 98 percent of all seniors, the Smiths would be able to access the assistance for which they are eligible.

Low-income single adult who receives assistance under the Republican plan. Mr. Jones, a 75-year old senior with an annual income of $14,195, is enrolled in his state's prescription drug benefit program. Although he found the application process burdensome and humiliating, as he is embarrassed about participating in a welfare program, he enrolled because the cost of his heart medication was too much for him to handle on his own. He is concerned about his sister, who also has high prescription drug costs. She has the same income as he does, but she lives in a different state that has limited the benefit to seniors with annual incomes of less than $8,350, and so she is ineligble for assistance. They feel this is very unfair.

- *Republican Low-Income Plan* creates 50 separate state programs with a patchwork of benefits and different eligibility levels. Many seniors, like Mr. Jones, suffer from the welfare stigma associated with a benefit limited to low-income seniors. And his sister – even though states have the option to cover seniors at her income level – is not guaranteed coverage.

- *Clinton-Gore Plan* would ensure that both Mr. Jones and his sister receive a guaranteed, comprehensive prescription drug benefit that is easy to access because the application process would be modeled after the one used to enroll in Medicare Part B, which covers 98 percent of all seniors. Because it is a Medicare benefit, there is no welfare stigma associated with enrolling in the program, and both Mr. Jones and his sister do not have to be ashamed about the assistance they receive.

SIDE-BY-SIDE COMPARISON OF PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT VERSUS REPUBLICANS' STATE BLOCK GRANT PLAN

	Clinton/Gore & Democrats	Republican Low-Income Block Grant
Who's Covered	**All** seniors and people with disabilities who lack reliable drug coverage today would gain coverage under this plan	**Fewer than one-third** of seniors and people with disabilities would be eligible and **less than half** of those would likely participate
What Do You Get	**Defined Benefit**: No deductible, 50 percent coinsurance up to $5,000 in costs when phased in. Out-of-pocket spending limited to $4,000	**Unknown**. States determine benefit that could include restrictions on the number and types of drugs covered
How Much Does it Cost	No premium for those with income below 135 percent of poverty; sliding scale premium for those with income between 135 and 150 percent of poverty; $25 per month in 2002 for all other participants	**Unclear**: No premium below those with 100 percent of poverty; state-defined premium, not to exceed 5 percent of income for beneficiaries between poverty and the state-defined upper eligibility limit
Are Seniors and People with Disabilities Ensured Choice	**Plans**: Yes. In fee-for-service, managed care, or retiree plans if eligible **Drugs**: Yes. Doctor-prescribed drugs are guaranteed without going through insurer or HMO **Pharmacies**: Yes. All local, qualified pharmacies would be accessible	**Plans**: No. States would not have to pay managed care or retiree plans that offer seniors drug coverage. **Drugs**: No. The legislation provides no guarantees of access to needed drugs **Pharmacies**: No. States could restrict participating pharmacies
Start-Date	**2002**	**Unknown**
Part of Larger Plan to Reform Medicare	**Yes**	**No**

TABLE 1. STATE DATA

	EXCLUDED	LOW PARTICIPATION		LIMITED COVERAGE	STATE FUNDING		
	Percent of Seniors Not Eligible	Percent of Eligible Medicare Benes. NOT in Medicaid	Seniors Enrolled in State Programs	Medicaid or State Program Drug Limits	Allotments (Millions)	Current Non-Medicaid $ (Millions)	New Dollars Per Eligible Elderly
Alabama	69%	48%			$28.6		$159
Alaska	81%	na			$6.5*		$1,089*
Arizona	75%	63%			$19.4		$140
Arkansas	64%	53%		Number	$18.5		$144
California	75%	12%			$121.0		$146
Colorado	80%	21%			$10.7		$153
Connecticut	79%	43%	29,969		$13.7	$15.7	$0
DC	72%	67%			$6.5*		$312*
Delaware	74%	61%			$6.5*		$255*
Florida	74%	50%		Number	$90.8		$134
Georgia	75%	42%		Number	$32.3		$176
Hawaii	81%	49%			$6.5*		$215*
Idaho	71%	46%			$6.5*		$163*
Illinois	75%	70%	49,186	Type	$50.1	$34.1	$48
Indiana	71%	65%			$26.0		$130
Iowa	74%	15%			$13.3		$135
Kansas	74%	60%			$13.8		$143
Kentucky	70%	39%			$23.1		$163
Louisiana	61%	48%			$26.3		$134
Maine	72%	44%	25,000	Type	$7.6	$4.7	$64
Maryland	78%	64%	33,185	Type	$20.1	$26.9	$0
Massachusetts	74%	52%	27,492		$28.1	$6.3	$112
Michigan	74%	52%	12,968	Number	$43.6	$5.2	$125
Minnesota	72%	54%	1,200		$17.4	$1.2	$122
Mississippi	59%	15%		Number	$19.2		$154
Missouri	76%	59%			$25.4		$145
Montana	76%	63%			$6.5*		$264*
Nebraska	67%	69%		Number	$9.0		$126
Nevada	73%	66%			$6.6		$120
New Hampshire	75%	76%			$6.5*		$196*
New Jersey	74%	44%	195,005		$32.7	$248.0	$0
New Mexico	72%	57%			$9.4		$167
New York	72%	40%	113,000		$92.0	$77.8	$22
North Carolina	70%	32%		Number	$42.9		$161
North Dakota	65%	80%			$6.5*		$218*
Ohio	74%	67%			$53.0		$143
Oklahoma	71%	61%		Number	$20.1		$157
Oregon	78%	49%			$13.8		$160
Pennsylvania	74%	65%	235,758		$64.1	$209.3	$0
Rhode Island	64%	72%	29,776	Type	$7.4	$2.3	$91
South Carolina	65%	36%		Number	$23.9		$165
South Dakota	72%	59%			$6.5*		$230*
Tennessee	70%	19%		Number	$29.4		$162
Texas	69%	59%		Number	$84.1		$147
Utah	83%	47%			$6.5*		$203*
Vermont	71%	40%	9,428	Type	$6.5*		$342*
Virginia	77%	59%			$29.9		$168
Washington	81%	59%			$16.7		$171
West Virginia	63%	63%		Number	$14.9		$136
Wisconsin	73%	53%		Number	$20.1		$124
Wyoming	72%	53%	491	Number	$6.5*	$0.6	$389*
TOTAL	**73%**	**48%**	**762,458**	**19**	**$1,297.0**	**$632.1**	**$119**

* States with statutory minimum allotments rather than allotments based on formula.

NOTES ON STATE DATA.

Column 1. Three-year average number of elderly with income below 75 and above 175 percent of poverty. Does not include people with disabilities. Medicare beneficiaries with disabilities have lower income which lowers the percent of all Medicare beneficiaries excluded.

Column 2. Percent of Medicare beneficiaries eligible for the Medicaid QMB / SLMB programs who are not enrolled. From: Families USA. (July 1998). *Shortchanged: Billions Withheld for Medicare Beneficiaries.* Washington, DC: Families USA. About 98 percent of people eligible for Medicare participate.

Column 3. Number of participants in state programs in 1999. General Accounting Office (September 2000*). State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U.S. GAO; GAO/HEHS-00-162.

Column 4. Limits on prescription drug coverage. "Number" indicates that a participant's number of covered prescription is limited; "type" indicates that prescriptions only for certain conditions / types of drugs are covered. Note that Michigan limits the number of months per year that a senior qualifies for prescription drug coverage. Source: CCH; NGA 2000; National Pharmaceutical Council 1998.

Column 5. Estimates of state allotments under S. 3017, calculated using the five-year average number of Medicare enrollees with income below 175 percent of poverty. Includes territory set-aside and floors. States with asterisks get the minimum allotment of $6.5 million.

Column 6. Estimate of non-Medicaid State spending net of rebate. Note that not all states get the entire amount of the rebate; state spending is likely somewhat higher. General Accounting Office (September 2000*). State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U.S. GAO; GAO/HEHS-00-162.

Column 7. State allotments divided by number of seniors with income between 75 and 175 percent of poverty. Before calculating amount per eligible elderly, current net state prescription drug spending is subtracted. States that currently have state spending that exceeds their allotments are assumed to use the entire amount of the allotments to replace state spending. Note that states that get the minimum allotment of $6.5 million have much higher dollars per eligible elderly person than they would have received without this minimum allotment.

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