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The Voice for Health Care Consumers

SPECIAL REPORT

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Trouble Brewing? New Medicare Drug Law Puts Low-Income People at Risk

Summary of Analysis

When it was enacted, the Medicare Modernization Act (MMA) was touted as a program that would help all Medicare enrollees, particularly the neediest, obtain quality prescription drug coverage. Now, as implementation nears, there is evidence that a flaw in the MMA will cause serious—perhaps irreparable—harm to many of the most vulnerable elderly and people with disabilities. Those most at risk are the 6.4 million low-income individuals who receive both Medicare and Medicaid, also known as "dual eligibles."

This threat to dual eligibles arises from a provision of the MMA that requires states to contribute to the financing of the new drug benefit. This provision, known as the "clawback" payment, establishes a complex formula[1] to determine how much states must pay to the federal government for drug coverage for dual eligibles. Because there is only one factor in the formula that is within the power of states to control—the number of dual eligibles enrolled in the state's Medicaid program—the clawback formula creates a perverse incentive for states to cut dual eligibles off the Medicaid program.[2]

Since dual eligibles will begin receiving drug coverage through Medicare (rather than Medicaid) when the MMA benefit begins on January 1, 2006, dropping Medicaid coverage for dual eligibles might sound harmless at first blush. It isn't. In fact, dual eligibles dumped from Medicaid will suffer in two important ways. First, they will lose an array of essential health care services that are covered by Medicaid, but not by Medicare. These services include dental, vision, and hearing coverage, as well as personal care services that allow them to remain at home rather than moving to an institution. Second, many will lose access to the drugs they need and/or will have to pay more for drugs. (These harmful effects are described in greater detail below.)

Federal law requires states to provide Medicaid to the poorest of the elderly and people with disabilities—those with incomes low enough to qualify for the federal Supplemental Security Income (SSI) program. However, states have been permitted to offer this coverage to people with incomes above the SSI level, and 21 states and the District of Columbia had chosen to do so as of 2003, when the MMA was enacted. (Those 21 states are as follows: Arizona, Arkansas, California, Florida, Hawaii, Illinois, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, and Virginia.)

Now the clawback provision is encouraging states that recognized the value of providing additional health coverage to more vulnerable elders and people with disabilities than required by law to cut back on this coverage. Already, before Medicare drug coverage has even begun, three states—Florida, Mississippi, and Missouri—have announced plans to cut off tens of thousands of vulnerable elderly and people with disabilities from Medicaid, and at least one other state—North Carolina—is considering a similar step. Without corrective action, the clawback provision may lead to enormous harm to the most vulnerable among us.

The Clawback Payment and What It Means to States

Currently, dual eligibles receive their drug coverage through state Medicaid programs. On January 1, 2006, when the MMA is implemented, dual eligibles will begin receiving drug coverage through the Medicare drug benefit rather than through Medicaid. Other Medicaid coverage, including long-term care, personal care, and other services, will not be directly affected. However, in order to help finance the new Medicare drug benefit, states are required to pay the federal government most of the savings that they would realize from no longer having to provide prescription drugs to dual eligibles in their Medicaid programs. This payment is called the "clawback" payment because the federal government is seen as "clawing back" the savings that would otherwise have accrued to the states.

The clawback is especially burdensome to states because, with one exception, the size of states' payments is locked in indefinitely. The only way states can reduce their clawback payments is by reducing the number of dual eligibles currently enrolled in Medicaid.

States Have Begun Cutting Back

Florida, Mississippi, and Missouri have recently announced that they plan to reduce or eliminate Medicaid coverage for some or all elderly enrollees and people with disabilities—most of whom are dual eligibles—with incomes above $579 per month (for an individual in 2005). The Florida and Mississippi cuts will take effect on January 1, 2006, when the Medicare drug benefit starts; the Missouri cuts take effect earlier.[3] A fourth state, North Carolina, is considering similar cuts.

These cuts are occurring in states that have previously expanded Medicaid coverage beyond the federally mandated minimum level. State Medicaid programs are required by federal law to cover the elderly and people with disabilities with incomes up to 73 percent of the poverty level ($579/month for an individual). Twenty-one states—including these four—and the District of Columbia have gone further in covering these individuals: Most have extended coverage to residents with incomes up to 100 percent of the poverty level ($798/month for an individual in 2005).[4]

The following table shows the estimated numbers of elderly and people with disabilities who will lose Medicaid in the four states that have implemented, or are considering, cuts. The right-hand column shows the incomes of these individuals. Nearly all of these tens of thousands of people live in poverty.

Table 1

Who are the elderly and people with disabilities losing Medicaid coverage?

State	Estimated Number Losing Coverage in FY2006	Income Range of Those Losing Coverage (Dollars/year for an individual)
Florida	77,000	$6,948-$8,422
Mississippi	65,000	$6,948-$12,920
Missouri	8,660	$8,135-$9,570
North Carolina (proposed)	65,000	$6,948-$9,570

How These Cutbacks Hurt

Dual eligibles tend to be sicker than the average Medicare enrollee—over half are in fair or poor health. Among the elderly, dual eligibles are more than twice as likely to have health problems as are other Medicare enrollees.[5] Many have multiple conditions requiring complicated, comprehensive treatment.

The people who will be hit hardest by the loss of Medicaid coverage are those who currently live at home or with their families, rather than in long-term care facilities. They will lose the additional important services that Medicaid has provided. What's more, their new Medicare drug coverage will not be as good as the coverage they received through Medicaid.

Lost services

Medicaid provides essential health services that are not covered through Medicare. The services covered by Medicaid vary from state to state and include the following:

- Personal care services that assist with activities of daily living such as eating and bathing
- Vision coverage, including eyeglasses
- Dental coverage, including dentures
- Podiatry coverage that is essential for diabetics and other patients
- Hearing coverage, including hearing aids
- Non-emergency transportation to medical appointments
- Case management services, which help people coordinate medical, social, and other services so they remain healthy and independent longer

Each of these services is vital to maintaining the health and well-being of the elderly and people with disabilities. For example, personal care services allow individuals to receive assistance in their homes with simple activities, such as eating and bathing. Without this help, many would have to move to institutions to get the care they need. The importance of vision and dental coverage for low-income elderly and people with disabilities is obvious—many cannot afford eyeglasses or dentures on their limited incomes. Without eyeglasses, they are unable to function in their homes or communities. Without dentures, they cannot eat a normal diet. Hearing coverage is similarly important—hearing aids are vital, especially among the elderly, to enable them to continue to live on their own or with their families.

Podiatry is another service that Medicaid can cover and that is also at risk. This kind of care is especially important for diabetics. Without podiatry coverage, diabetic patients may lose their ability to walk or, worse yet, risk requiring amputation. Like many other serious conditions, diabetes is more prevalent among dual eligibles than it is in the general Medicare population.[6]

One service that all state Medicaid programs *must* cover is non-emergency transportation, which enables patients to get to their doctors' appointments and other essential medical services. Many dual eligibles cannot afford a car or are unable to drive themselves due to their age or disability. Without Medicaid to cover their transportation to their appointments, they will likely postpone seeing their doctors until they have urgent—and expensive—conditions.

Weaker drug coverage

Under the new Medicare drug benefit, most dual eligibles will be required to pay the lowest copayments, generally $1 per prescription for generics and $3 for brand-name drugs.[7] Low-income people who are not enrolled in Medicaid—including any current dual eligibles dumped by state programs—will have higher copayments of $2 for generics and $5 for brand-name drugs, even if they have the same income as other individuals who are enrolled in Medicaid. While these higher amounts may seem small, they can create significant barriers for low-income people. It is not unusual for an individual who is a dual eligible to take seven or more prescriptions a day.[8] Therefore, the seemingly small difference in cost can, over time, have a substantial impact on the budget of a person with a below-poverty income. What's more, under the Medicare drug law, the copayments for those who lose Medicaid coverage will increase much faster than the copayments for those who continue to be dual eligibles and remain in Medicaid. If dual eligibles lose Medicaid coverage, they will face not only higher copayments, but also copayments that will go up more rapidly over time.

In addition, the Medicare drug benefit will not cover some very important drugs that are often covered by Medicaid. These drugs include benzodiazepines like Xanax and Valium, which help with anxiety and seizures; weight-loss and weight-gain drugs, which are important for the elderly or those with chronic illnesses like HIV; and prescribed over-the-counter medications. Dual eligibles in each of the four states with proposed cuts had coverage for benzodiazepines under Medicaid. But after January 1, 2006, those who lose Medicaid will also lose coverage for these drugs. Patients who lose Medicaid and need these drugs will have to find alternatives, such as state-funded programs, or risk going without these drugs altogether. In such dire cases, their health may very well worsen.

Some People with Disabilities Will Lose Coverage Altogether

As states reduce their Medicaid income eligibility limits in an effort to reduce the number of dual eligibles, other groups may unintentionally be hurt. Some people with disabilities, for example, may lose their Medicaid coverage and be left with no health care coverage at all.

In addition to covering the elderly, the Medicare program provides health coverage to people with disabilities who are younger than 65. By law, however, people with severe disabilities must wait 24 months before they can receive Medicare coverage. If their *Medicaid* coverage is cut during this waiting period, then these people are left with no health care coverage until the 24 months have elapsed.

Another group that will suffer as a result of the clawback provision is low-income people who have disabilities that are not severe enough to meet Medicare's stringent standards. These people rely on Medicaid for critical health care services. If they lose their Medicaid coverage, they will be left with no coverage at all.

If a state cuts dual eligibles and does not apply for a waiver to continue providing coverage to these people with disabilities or otherwise exempt them from the cut, they will lose their health coverage completely. They will join the ever-growing ranks of the uninsured and will likely have to rely on costly emergency rooms and other safety net providers for their care.

MMA Also Threatens Drug Coverage of Dual Eligibles Who Remain in Medicaid

Dual eligibles who escape state cutbacks and remain enrolled in Medicaid are also in jeopardy from implementation of the MMA. When they lose their Medicaid drug coverage and it is replaced by Medicare drug coverage at the beginning of 2006, dual eligibles will be automatically enrolled in a Medicare drug plan. This auto-enrollment is intended to prevent gaps in drug coverage. The plan will be chosen at random from the lower-cost plans in their region. There will be no attempt to ensure that the plan in which they are auto-enrolled covers the drugs they need or includes their usual pharmacy. As a result, some dual eligibles may be unable to obtain the drugs they need when the new Medicare program begins.

In addition, unless the automatic enrollment process works flawlessly, some dual eligibles are likely to lose coverage altogether. Given the immense administrative and technical challenges presented by this transition, which involves transferring data on 6.4 million individuals, many of whom have cognitive limitations and other disabilities, errors would seem to be inevitable.

Concerns for the Future

Currently, 21 states and the District of Columbia offer coverage in their Medicaid programs to dual eligibles with incomes above the federally mandated minimum (73 percent of the poverty level, $579/month in 2005). Although there is no way to predict which states in particular will follow the lead of Florida, Mississippi, and Missouri in cutting these enrollees, it is highly likely that other states will at least consider such cuts as they look for ways to reduce spending. North Carolina, for example, has been debating similar cuts during its budget process this year, and next year, when states encounter the full reality of clawback payments, more may follow.

As long as the current structure of the clawback payment remains in place, states looking to save money will be tempted to cut back Medicaid eligibility for dual eligibles. In future years, the clawback is likely to become increasingly unpopular, as states will, understandably, object to paying for drug coverage that is provided by the federal government. Dual eligibles and other elderly individuals and people with disabilities are likely to be the victims.

Conclusion: Fixing the Problem

The perverse incentive of the MMA's clawback financing must be remedied before more states implement devastating cuts targeted at some of the lowest-income Medicare enrollees. There are both short-term and long-term solutions to this problem. In the short term, state policy makers must be shown the harmful consequences of reducing the state's clawback payment by dumping Medicaid coverage for elderly and disabled citizens. These people will lose access to essential medical services that enable them to live with family or on their own in the community. Without these services, their health will suffer, and they will be more likely to need expensive emergency or long-term care. Medicare's drug benefit is simply not as good as the drug coverage provided under Medicaid. It is more expensive, and it will not cover as many drugs, leaving individuals to fill the gaps on their own or through other state programs. Finally, some people with disabilities will become completely uninsured *without even saving the state money on its clawback payment*.

In the longer term, the financing of the Medicare drug law must be fixed. It is unreasonable to make states pay for a federal Medicare drug benefit, particularly when their Medicaid budgets are already stretched. Congress needs to consider alternative means of financing that enables states to maintain their commitment to dual eligibles without being saddled with added costs for doing the right thing. Ideally, the clawback payment would be eliminated, although that might require some additional federal resources to make up for the lost funds. At the same time, however, Congress should explore options to bring down the cost of the Medicare drug benefit. For example, allowing Medicare to negotiate directly for drug prices would produce substantial savings.

Short of eliminating the clawback payment, there are other ways of encouraging states to provide vital Medicaid coverage. For example, states that cover dual eligibles beyond the federal minimum could be relieved of a portion of their clawback payments. Ideas like these will become increasingly important as the Medicare drug benefit takes effect. Without changes in the law, the health of some of the most vulnerable Americans is at risk.

References

[1] The clawback formula is based on multiplying four factors:

1) the amount the state spent per capita on Medicaid prescription drug benefits for dual eligibles in 2003 (the year the MMA was passed);
2) nationwide prescription drug price inflation;
3) the number of dual eligibles enrolled in Part D from that state;
4) the year in which the payment is calculated—in 2006, states must pay 90 percent of their clawback amount to the federal government. The amount declines to 75 percent by 2013.

[2] A Mississippi state senator stated last year that the state has the choice of dropping dual eligibles off of Medicaid or paying the federal government. Alfred Chiplin, Gill Deford, Vicki Gottlich, and Patricia Nemore, "Dazed and Confused: Navigating the Abyss of the Medicare Act of 2003 for Low-Income Beneficiaries," 38 *Clearinghouse Review* 443 (November-December 2004).

[3] Missouri's cuts are currently scheduled to take effect on August 28, 2005. The implementation date, as well as other aspects of the cuts, may be challenged in court. SB 539 in Missouri (signed into law by Gov. Blunt on April 26, 2005) allowed coverage for the elderly and people with disabilities to be rolled back to the federal minimum (SSI income eligibility level) unless additional funds are appropriated annually to cover the cost of their care. Funds have been appropriated for FY2006 to cover the elderly and people with disabilities with incomes between the federal minimum and 85 percent of the federal poverty level. If these additional funds had not been appropriated, 14,600 Missourians would have lost coverage beginning August 28, 2005. Blind individuals are exempt from this law, and coverage will be maintained at 100 percent of the federal poverty level for this population.

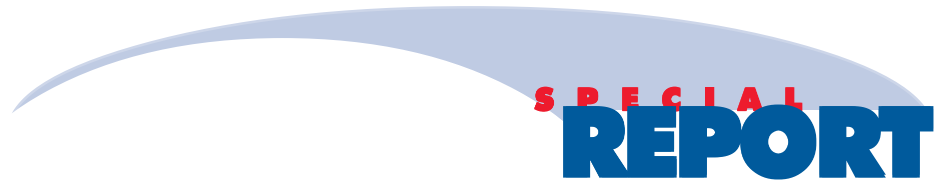
[4] The following 21 states and the District of Columbia had expanded Medicaid coverage above the federal minimum as of 2003: Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia (unpublished data from Families USA).

[5] Judy Kasper, Risa Elias, and Barbara Lyons, *Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps* (Washington: Kaiser Commission on Medicaid and the Uninsured, March 2004).

[6] Diabetes affects 25 percent of elderly dual eligibles, compared to 17 percent of other elderly Medicare enrollees. Kasper, et al., op. cit.

[7] Dual eligibles who live in nursing facilities or other institutions will not have to pay a copayment for their prescription drugs in Medicare. These copayment amounts are for drugs purchased in 2006. They will increase annually based on the increase in the consumer price index.

[8] Michael Perry, Michelle Kitchman, and Jocelyn Guyer, *Medicare's New Prescription Drug Benefit: The Voices of People Dually Covered by Medicare and Medicaid* (Washington: Henry J. Kaiser Family Foundation, January 2005).



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