

August 2004

**State of Washington
Governor's Advisory Council on HIV/AIDS**

Impacts of the Medicare Modernization Act (MMA)
Findings and Recommendations

Background

The Washington Governor's Advisory Council on HIV/AIDS (GACHA,) began exploring the impacts of the Medicare Modernization Act (MMA) in January of 2004, and continues to monitor provisions of the planned reforms. In coordination with the Washington State Council on Aging, GACHA sponsored a public forum in Seattle on May 11, 2004 to assess the impacts of the Medicare reforms, particularly the new prescription drug benefit on those in the state who are dependent on Medicare and Medicaid for their health care needs. Testimony was taken from federal and state officials, medical and pharmaceutical providers, insurers, and the general public. (A meeting agenda with a list of participants is attached.) This report is based on testimony from that forum and GACHA's other efforts.

Summary of Key Findings

Findings for Dual Eligibles

Approximately 120,000 state residents, who receive prescription drug coverage from Medicaid are dually eligible for Medicare and thus will be eligible for the new Medicare Part D drug benefit on January 1, 2006. While enrollment in the benefit is technically voluntary, a dual eligible beneficiary has no other options since states are prohibited from using federal dollars to pay for or to supplement the prescription drug costs for these dual eligible patients once the benefit takes effect.

Unless the state chooses to use its own resources to pay for these drugs, dual eligible patients will have two choices: enroll in Medicare Part D, or go without drug coverage which will seriously endanger their health.

Under Medicare Part D, dual eligible patients will be worse off than with their current Medicaid coverage both in out-of-pocket

costs and coverage. Without state assistance, patients will be responsible for prescription co-pays which they do not currently have. Further, while the exact drug coverage of the new benefit is yet to be defined, patients and their physicians may have fewer choices with pharmacy benefit providers able to restrict what drugs are available under closed drug formularies. (A drug plan is considered “closed” because it can limit drug coverage to only those drugs on its formulary without regard to the medical needs of the individual.) Obtaining drugs not on the formulary can be problematic for most patients since physicians are prohibited from assisting patients in the appeals process. Dual eligible patients will also lose free access to certain over-the-counter drugs which today are provided at no cost by Medicaid. And, for the first time, dual eligible patients can be refused a drug by pharmacies if they can not make the co-payment. Further, dual eligible patients will have fewer choices in choosing a drug plan since only a plan with premiums at or below the region’s average will be fully subsidized and thus available to dual eligible patients.

This “closed” system amounts to a “tax” on pharmacies which don’t refuse the prescription. Retail pharmacies are unlikely to absorb the costs.

Under Medicare Part D, patient care and public health will suffer. While co-pays for most dual eligible patients will be small, ranging from \$1 to \$5 per drug, per month, many patients take five to ten medications, or more each month. Since most dual eligibles have incomes below \$571 per month, these co-pays (as much as 10% of monthly income) will impose a prohibitive financial burden on those already struggling to pay for food, rent, and transportation. In fact, co-pays of \$1 for Medicaid patients were tried in the past but abandoned. Co-pays will lead to patients stretching their medications (taking them less frequently than prescribed) or going without medications. (*Source: Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured, March 2003.*) The effect of this on individual health is clearly dangerous, but public health will also suffer with the potential of a rise in drug resistant organisms and viruses (such as HIV) which can be transmitted to others.

Findings for all Beneficiaries

A restricted and closed formulary will amount to “backdoor” drug rationing. If any drugs are prohibited through a closed formulary, or by process (through a complicated exception, pre-

authorization or appeals procedure,) many diseases may not be treatable. This is particularly true with regard to HIV disease where a closed formulary could leave individual patients only with drugs that are ineffective because of resistance, or not tolerated due to toxicity; this would amount to drug rationing.

Current insurance programs such as the Washington State Health Insurance Pool (WSHIP,) Evergreen Health Insurance Program (EHIP,) and the state's Early Intervention Program (EIP) may be able to provide assistance, but the extent of their ability to help is unclear and they will be of limited assistance to those most in need. WSHIP and EHIP may be able to assist non dual eligible patients but with the possible exception of EIP, none of the programs is able to currently assist with the co-payments for those who will be unable to afford them; and EIP uses federal dollars which may also be prohibited for use in assisting dual eligible patients with drug costs.

While the Medicare Modernization Act stops planned reductions in reimbursement rates, those rates will still not be adequate to prevent physicians from leaving the Medicare program. Thus, the current trend of medical providers refusing to accept Medicare and Medicaid patients is likely to continue to grow. This already means Medicaid patients must travel long distances to obtain care -- particularly for specialists -- and, those institutions still accepting such patients, such as Harborview in Seattle, are increasingly restricting access.

Many retirees in Washington State with employer provided health care coverage may lose that coverage. The forum was unable to assess how private employers in Washington State will react once the Medicare changes take effect. But new estimates by the U.S. Department of Health and Human Services suggest employers will eliminate drug benefits for 3.8 million retirees nationwide once Medicare offers coverage in 2006. It is not known whether this is merely a continuation of a trend by employers to reduce coverage, or is a direct result of the Medicare reforms. But whatever the cause, many retirees who lose their retiree health coverage in Washington state and who do not qualify for low-income prescription drug assistance but who have high drug costs will be facing co-payments and coverage gaps (the "donut hole") which either threaten their life savings, or will be unaffordable.

Patient privacy will be jeopardized. The MMA permits the

Secretary to waive beneficiary privacy protections and provide Medicare beneficiary identifying information to drug plans for marketing purposes. This is of significant concern to persons with stigmatized illnesses such as HIV.

Mass confusion can be expected with patients and providers unsure how the new drug benefit will affect them. For example, the state's Early Intervention Program can not at this date tell clients whether they qualify for the first change brought about by MMA, the prescription discount card. Further, a June 2004 survey by the Kaiser Family Foundation found 90% of those people on Medicare who currently have drug coverage through Medicaid (dual eligibles) were unaware that in January of 2006 their Medicaid drug benefits will end.

Patient confusion will continue even after a drug plan is selected since plan administrators can change formularies once a year and change prices on a weekly basis with no requirement that patients be informed when such changes take place.

Recommendations

1. The governor should lobby congressional and administration officials to allow Medicaid to use federal dollars to enhance the program, including offering wrap-around coverage for dual eligible patients.
2. If federal dollars continue to be unavailable, the state should use its dollars to provide wrap-around coverage for dual eligibles, and in anticipation, the governor should instruct the state Department of Social and Health Services (DSHS) to prepare cost estimates to state taxpayers for such coverage.
3. The governor should lobby congressional and administration officials to set the asset based threshold tests higher for low income assistance eligibility so life savings are not exhausted solely to pay for prescription drugs.
4. The governor should lobby congressional and administration officials to remove the prohibition on physicians taking part in the drug appeals process.
5. The governor should lobby state, congressional and administration officials to increase provider reimbursement rates for Medicare and Medicaid in order to ensure continued access to health care services for all of the state's residents.
6. The governor should lobby the U.S. Centers for Medicare and Medicaid Services (CMS) so that implementing regulations require

drug providers offer comprehensive formularies with a full range of available drugs, especially for special populations and the chronically ill. For example, plans should be mandated to cover all anti-virals for HIV.

7. The governor should lobby CMS so that regulations provide for a quick review and inclusion of newly approved drugs to a formulary.
8. The governor should lobby CMS so that regulations require a uniform exception, pre-authorization, and simple appeals process be mandated for all drug plans offered.
9. The governor should lobby CMS so that regulations provide for an immediate supply of drugs to patients for the duration of the appeals process.
10. The governor should lobby CMS so that regulations include stringent privacy protections so that beneficiary identifying information is not illness specific; for example, limit identifying information to name and address only.
11. The governor should request CMS clarify what role EIP, and other AIDS Drug Assistance Programs will be allowed to fulfill and EIP should prepare for a potential influx of clients.
12. WASHIP and Evergreen Health Insurance should gear up to offer a wrap-around coverage plan for Medicare patients who may lose retiree health coverage. If such coverage is found to be prohibited, administrators should seek the governor's assistance in eliminating the prohibitions.
13. The Statewide Health Insurance Benefits Advisors (SHIBA) should take the lead role in educating consumers with an emphasis on including pharmacists who will be on the frontlines. SHIBA should also consider establishing an ombudsman-like office to assist patients with appeals, should physicians continue to be prohibited from taking part in that process.

Complete Findings

As of May, 2004 DSHS reported approximately 120,000 state residents were dually eligible for Medicaid and Medicare. The vast majority of Washington Medicaid recipients qualify because their incomes are below \$571, although income requirements vary among Medicaid programs. Individuals qualify for Medicare either because of age (65+), or a disabling condition such as AIDS. States currently can use, as Washington does, federal dollars to pay a share of its Medicaid coverage for these dual eligible individuals. Washington is one of 11 states nationwide not to require drug co-pays for its dual eligible patients. (*Source: Kaiser Family Foundation*)

Effective January, 2006, Medicare will offer a Part D Prescription Drug benefit and states will no longer be able to use federal dollars to pay the prescription drugs costs of dual eligible patients. States are not prohibited from using state dollars to pick up these costs, but with the state already facing multi-million dollar budget shortfalls, DSHS testified it is highly unlikely the state will automatically cover these costs.

The Medicare Part D benefit is voluntary. It will require payment of a monthly premium (expected to be \$35/month in 2006 and indexed to annual increases in program costs thereafter), and a \$250 deductible. After meeting the deductible patients will pay 25% of their drug costs up to the first \$2,250. Then, there will be a gap in coverage -- that is no coverage for the next \$2,850 in drug expenses. But, once a patient has paid \$3,600 in out-of-pocket drug costs, catastrophic coverage will kick in with further drug expenses limited to \$2 per generic drug/\$5 for brand name or 5%, whichever is less. These out-of-pocket costs will increase annually as they are indexed to rise with program costs. *(Source: Families USA analysis December 11, 2003.)*

For patients who are not dual eligible but have incomes below 150% of the federal poverty level and whose assets do not exceed \$10,000 for an individual/\$20,000 for a couple, premiums will either be waived or will be set to a sliding scale, and the deductible will not exceed \$50. After the deductible, co-pays for these individuals will be 15% with no gap in coverage. Once out-of-pocket spending for prescription drugs has reached \$808, co-pays will be no more than \$2 per generic/\$5 for a brand name drug. *(Source: Families USA analysis December 11, 2003.)*

Dual eligible patients will be exempt from most of the cost sharing described above. There will be no premium, deductible, or gaps in coverage. But dual eligible patients will be required to pay (depending on income levels) from \$1-\$2 per generic drug, and \$2-\$5 for a brand name drug. *(Source: Medicare Modernization Act)*

Health care professionals testified to the forum that 5-10 prescriptions per month are not an unusually high number for many dual eligible patients. At the high end, that could lead to \$50 a month in out-of-pocket drug costs. While it may not seem a lot, for a person of limited means trying to pay for food, rent, and transportation it could be prohibitive. In fact, co-pays of \$1 for Medicaid patients in Washington State were tried in the past but abandoned after less than one year. At the national level co-pays have lead to patients stretching their

medications or going without medications. (*Source: Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured, March 2003.*) The forum heard testimony that if that were to happen with HIV patients, not just individual health but public health will be seriously jeopardized with patients' individual treatment plans failing, and the potential for drug resistant strains spreading in the community. To prevent this, a representative of the Washington State Medical Association testified at the forum that the state had a "moral obligation" to offer patients wrap-around coverage.

Medicaid currently covers all drugs deemed medically necessary and even pays for over-the-counter drugs. The Part D benefit will be administered by pharmacy benefit management companies which will be allowed to design a closed drug formulary, with a requirement that only 2 drugs per therapeutic class be available. Health care professionals testified to the forum that in the case of HIV disease, where multi-drug regimens must be tailored to individual patients, any restriction of drug choice "will lead to inferior and possibly ineffective treatment." One panelist, Peter Shalit, M.D., PhD, said he "would have to consider not participating in such a system, on ethical grounds."

The forum also heard concerns voiced from health care professionals regarding pre-authorization and appeals procedures. With paperwork taking up so much time already, they strongly urged that all plans be required to adopt a uniform pre-authorization plan. And, the health care professionals were dismayed that the new law specially prohibits them from pursuing appeals on behalf of patients who are denied coverage for any particular drug, calling it "rationing by inconvenience." The fact the new Medicare law makes no provision for emergency supplies of newly approved medications, or unapproved (pending any appeal) may be especially problematic for patients who need uninterrupted drug therapy.

The extent of assistance available from existing insurance programs such as the Washington State Health Insurance Pool (WSHIP,) Evergreen Health Insurance Program (EHIP,) and the Department of Health's Early Intervention Program (EIP) is not totally clear.

For the patients who are not dual eligible and able to afford its premium based plan, WSHIP, which covers individuals in high risk pools, anticipates being able to offer wrap-around coverage for Part D; and the new benefit may actually allow WSHIP to lower its premiums.

Current WSHIP co-pays of \$5-\$10 per prescription would be unaffected.

Evergreen, which is designed for patients not on Medicaid, may be able to pay Part D premiums for non dual eligible patients, but is unlikely to be able to cover co-pays or for the gap in drug coverage which Evergreen expects its clients would reach by mid-March of any calendar year. It expects it would refer patients to EIP.

EIP, which covers patients with incomes up to 300% of the federal poverty level, uses a mix of state and federal dollars. At the time of the forum administrators were unsure what assistance they would be able to provide patients. But it seems certain EIP would not be able to use its federal dollars to assist dual eligible patients with their co-pays.

While the Medicare Modernization Act stops planned reductions in reimbursement rates, health care professionals told the forum the rates are still not adequate to prevent physicians from leaving both Medicare and Medicaid. Several medical practices in the state have already closed to new Medicaid patients, and some are now closing to new Medicare patients as well. For example, Medicaid patients must already now travel long distances for access to specialists. Most specialists in private practice in Seattle now refuse new Medicaid patients and a significant number (all of the Poly Clinic for example) are no longer providing consultation on new Medicare patients either. Beyond the reimbursement rates, physicians also expressed concerns that the new Medicare law would make it even more difficult and frustrating to provide care for Medicare patients, leading to a further exodus of participating physicians.

The forum was unable to assess how private employers in Washington State will react once the Medicare changes take effect. (The Association of Washington Business declined to participate.) The new law does provide incentives for private employers to continue offering retiree health coverage through limited tax credits. Still the credits will not totally cover an employer's health costs for its retirees.

New estimates by the U.S. Department of Health and Human Services suggest employers will eliminate drug benefits for 3.8 million retirees nationwide once Medicare offers coverage in 2006. It is not known whether this is merely a continuation of a trend by employers to reduce coverage, or is a direct result of the Medicare reforms. But whatever the cause, many retirees in Washington state who lose their retiree health coverage and who do not qualify for low-income

prescription drug assistance but who have high drug costs, will be facing co-payments and coverage gaps which either threaten their life savings, or will be unaffordable.

All panelists at the forum agreed on one thing: confusion over the new benefit will be widespread. Competing plans will be offered in Washington State. Each will be allowed to establish its own formulary. Patients, many of whom have limited resources, disabilities, and other impairments will be faced with the complicated task of determining which plan is best for them. And, that plan can change from year-to-year.

A preview of what is to come may be reflected in a Kaiser Family Foundation Health Poll conducted in June of 2004. It found 90% of the current dual eligibles nationwide were unaware that in January of 2006 they would lose their Medicaid drug coverage.

Pharmacists are expected to be on the front lines. It is at the pharmacist counter where most patients today learn what their drug coverage does, or does not pay for.

State officials suggested that to be effective, education campaigns for Part D should begin as early as November of 2004.

The Statewide Health Insurance Benefits Advisors (SHIBA) advocates for and educates consumers about insurance needs. It has volunteers in all of the state's 39 counties and is able to provide training and materials, including culturally appropriate language translation of materials. Its existing network allows it to play a central role in education and ombudsman efforts.