ALASKA LEGISLATURE 2572

HOUSE and SFNATE FINANCE COMMITTEE FILES, 2003-2004

38

1 (2) be a resident of the state;
2 (3) have household income
3 (A) that does not exceed 135 percent of the federal poverty guideline
4 as defined by the federal Office of Management and Budget and revised under 42
5 U.S.C. 9902(2) to be eligible for cash assistance under (d) of this section or
6 prescription drug benefits under (e) of this section; or
7 (B) that exceeds 135 percent, but not exceeding 150 percent, of the
8 federal poverty guideline as defined by the federal Office of Management and Budget
9 and revised under 42 U.S.C. 9902(2) for prescription drug benefits under (f) of this
10 section;
11 (4) meet other eligibility requirements specified in this section and in
12 regulations adopted under this section; and
13 (5) apply on a form provided by the department; the department may use an
14 abbreviated form for individuals who received payments under an assistance program for
15 seniors paying $120 a month and administered by the department on or before March 31,
16 2004.
17 (d) An eligible individual who meets the income standard of (c)(3)(A) of this section
18 may receive cash assistance of $120 a month as far as practicable under appropriations
19 available to the program. The department may prorate the amount of cash assistance paid
20 under this subsection if the department estimates that appropriations for the program are not
21 sufficient to meet the demands for the program in a fiscal year. (A #1)
22 (e) In place of the cash assistance under (d) of this section, an eligible individual may
23 ~~make an irrevocable election~~ once annually elect to receive prescription drug benefits annually, provided in the
24 manner specified by the department in regulation. The total maximum prescription drug
25 benefits an individual may receive under this subsection in a fiscal year is $1,600. An
26 individual who has prescription drug coverage under AS 47.07 is not eligible to receive
27 prescription drug benefits under this subsection.
28 (f) An eligible individual who meets the income standard of (c)(3)(B) of this section
29 may receive only prescription drug benefits as provided in this subsection. The provisions of
30 (e) of this section apply to prescription drug benefits provided under this subsection except
31 that the total maximum prescription drug benefits that an individual may receive under this

subsection in a fiscal year is $1,000.

(g) To receive prescription drug benefits under (e) or (f) of this section, an eligible individual must assign to the department the individual's rights to payments under any other prescription drug program for a prescription drug benefit paid under this section. Payment may not be made under this section for an amount that would otherwise qualify for payment under another prescription drug benefit plan, except for prescription drug coverage received from health care facilities that operated under the authority of 25 U.S.C. 450 - 458 bbb-2 (P.L. 93-638).

(h) Except as otherwise provided in this subsection, the department may pay under (e) and (f) of this section only for a prescription drug, insulin, and insulin syringes. The department may not pay under (e) and (f) of this section for drugs used to treat obesity, baldness, infertility, or impotence; drugs that are prohibited from receiving funding under the medical assistance program in AS 47.07; smoking cessation products; drugs used for symptomatic relief of coughs and colds; oral vitamins; or brand-name multisource drugs if a therapeutically equivalent generic drug is on the market. However, the department may pay for brand-name multisource drugs if the prescriber writes on the prescription "The brand-name drug is medically necessary" and the prescriber states the reason that the brand-name drug is medically necessary. The department may also restrict coverage of drugs under (e) and (f) of this section to be consistent with the preferred drug list implemented by the department for purposes of the medical assistance program under AS 47.07.

(i) For a fiscal year in which prescription drug benefits under (e) and (f) of this section are not available for a full 12 months, the commissioner may prorate the total maximum amounts available under (e) and (f) of this section according to the number of months for which those benefits are available.

(j) The department may not make payment or authorize a benefit under this section to or on behalf of an individual residing in a public institution or nursing facility.

(k) An eligible individual who leaves the state may not receive cash assistance or prescription drug benefits under this section during the absence unless the individual temporarily leaves for one of the following reasons:

(1) medical treatment; or

(2) a vacation, business trip, or other absence of fewer than 30 consecutive

1 days, unless the individual has applied for and received a time extension from the department
2 for special circumstances.
3 (*l*) An individual who receives a determination under this section from the department
4 that denies, limits, or modifies prescription drug benefits or cash assistance under this section,
5 other than a determination under (d) or (i) of this section to prorate the amount of benefits or
6 assistance, may request a hearing before the department. The department shall adopt
7 regulations for the conduct of hearings under this subsection. The hearing process under this
8 subsection is not subject to AS 44.62.330 - 44.62.630. The decision of the department after a
9 hearing under this subsection is a final administrative order subject to appeal to the superior
10 court.
11 (m) An individual who receives assistance or benefits under this section when not
12 entitled to them because the information provided by the individual was inaccurate or
13 incomplete is liable to the department for the value of the assistance or benefits improperly
14 provided to the individual. In a civil action brought by the state to recover from the individual
15 the value of assistance or benefits improperly provided under this section, the state may
16 recover from the individual the costs of investigation and prosecution of the civil action,
17 including attorney fees as determined under court rules.
18 (n) Cash assistance provided under this section is inalienable by assignment or
19 transfer and is exempt from garnishment, levy, or execution as provided in AS 09.38.
20 (o) In this section,
21 (1) "commissioner" means the commissioner of health and social services;
22 (2) "department" means the Department of Health and Social Services;
23 (3) "eligible individual" means an individual who meets the requirements of
24 this section and regulations adopted under this section for eligibility for the program;
25 (4) "program" means the program established in this section;
26 (5) "public institution" means a governmentally owned establishment that
27 furnishes food, shelter, and some additional treatment or services to 16 or more persons;
28 (6) "resident" has the meaning given in AS 47.25.430(a).
29 * Sec. 2. The uncodified law of the State of Alaska is amended by adding a new section to
30 read:
31 TRANSITION: REGULATIONS. To the extent the regulations are not inconsist

1 with this Act, regulations adopted by the Department of Health and Social Services in 2003 to
2 provide cash assistance of $120 a month to seniors that are in effect on March 31, 2004,
3 remain in effect as valid regulations until the department adopts regulations under this Act
4 and those regulations take effect under AS 44.62. Upon the filing of regulations adopted
5 under this Act, the commissioner of health and social services shall post the regulations on the
6 department's Internet website.
7 * **Sec. 3.** (a) This Act is repealed on the date that the Medicare Part D benefit under P.L.
8 101-173 for prescription drugs for Medicare recipients is operational for recipients in this
9 state, as communicated to the commissioner of health and social services by the United States
10 Department of Health and Human Services.
11 (b) The commissioner of health and social services shall notify the revisor of statutes
12 of the date described in (a) of this section.
13 * **Sec. 4.** This Act takes effect April 1, 2004.

LEGAL SERVICES

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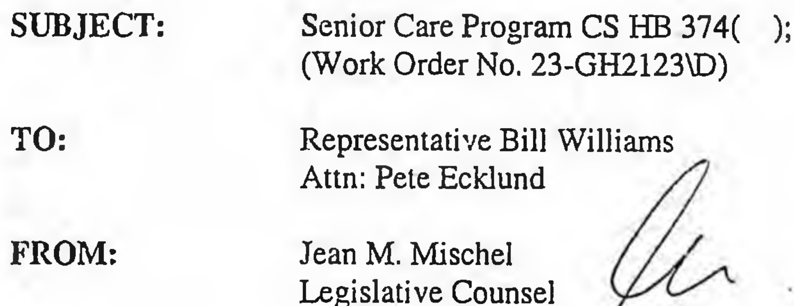
<u>**MEMORANDUM**</u> January 14, 2004

SUBJECT: Senior Care Program CS HB 374( );
(Work Order No. 23-GH2123\D)

TO: Representative Bill Williams
Attn: Pete Ecklund

FROM: Jean M. Mischel
Legislative Counsel



Enclosed is a blank committee substitute for HB 374 that makes technic..l and stylistic changes consistent with the Manual of Legislative Drafting (2003) and clarifies provisions that may be ambiguous or otherwise unclear.

The following is a detailed list of those changes.

Page 1, Title and subsection 1(a):
The term "SeniorCare" was rewritten as "senior care." The department will be free to promote the program as "SeniorCare" in the same way the department promotes Denali KidCare, but the proper statutory form is "senior care."

Page 1, line 7:
The sentence beginning with "The SeniorCare program is authorized to provide..." was rewritten as "Under the program, the department may provide..." "Program" is defined later in the bill to mean the senior care program.

Page 1, line 11:
Subsection (b)(1) was changed from "administer the SeniorCare program established under (a) of this section" to "administer the program."

Page 1, line 14:
The word "must" was changed to "shall."

Page 2, line 2:
The phrase "State of Alaska" was changed to "state."

Page 2, line 3:
Following "have" the word "household" was inserted to modify "income."

Page 2, line 4:

The phrase "of not more than" was changed to "that does not exceed."

Page 2, lines 4-5 and line 8:

The phrase "poverty level for this state" was changed to "poverty guideline as defined by the federal office of management and budget and revised under 42 U.S.C. 9902 (2)."

Page 2, line 7:

The phrases "of more" and "of more than" were changed to "exceeding" and "that exceeds," respectively.

Page 2, line 17:

The phrase "is authorized" was changed to "may" and "per month" was changed to "a month."

Page 2, line 19:

The phrase "authorized to be" was deleted and the word "section" was changed to "subsection."

Page 2, line 22:

The phrase "authorized in (d)" was changed to "under (d)."

Page 2, line 29:

The phrase "is authorized to" was changed to "may" and the comma following "benefits" was deleted.

Page 3, lines 4, 5 and 21:

The word "any" was changed to "a" or "an", as appropriate.

Page 3, line 6:

The phrase "any other" was changed to "another."

Page 3, line 7:

The citation to 25 U.S.C. 450-458 was changed to 25 U.S.C. 450-458bbb-2 for accuracy.

Page 3, line 9:

The phrase "is authorized" was changed to "may."

Page 3, lines 12-13 and line 20:

The word "Medicaid" was deleted and replaced with "the medical assistance program in."

Page 3, lines 14-16:
The word "brand name" was rewritten as "brand-name" and "multi-source" as "multisource."

Page 3, line 28:
The comma following "absence" was removed.

Page 3, line 29:
The word "reasons" was added after the word "following."

Page 3, line 31:
An extra space was removed after the word "absence", the word "less" was replaced with "fewer" and the word "consecutive" was inserted between the words "30 days."

Page 4, line 8:
The phrase "after a hearing under this subsection" was added after the word "department."

Page 4, lines 20-21:
The phrase "the Department of Health and Social Services" was changed to "health and social services."

Page 4, line 25:
The word "SeniorCare" was deleted.

Page 4, line 28:
The second use of the word "resident" was deleted.

Page 5, line 2:
The phrase "per month" was changed to "a month" and the phrase "before the effective date of this Act" was changed to "that are in effect on March 31, 2004."

Page 5, line 3:
The phrase "implementing this Act" was deleted.

Page 5, lines 5-6:
The phrase "the Department of Health and Social Services" was changed to "health and social services."

Page 5, line 6:
The phrase "shall notify the revisor of statutes of the effective date of the regulations and" was changed and moved to Section 3 as described below.

Page 5, lines 8-12, Section 3:

This section was split into subsections (a) and (b), the phrase "the commissioner of the Department of Health and Social Services certifies to the revisor of statutes that the commissioner received notification from the United States Department of Health and Human Services that" was moved to the end of the section and changed to ", as communicated to the commissioner of health and social services by the United States Department of Health and Human Services." The new subsection (b) incorporates language deleted in Section 2 as described above and reads: "(b) The commissioner of health and social services shall notify the revisor of statutes of the date described in (a) of this section." These changes were made in order to clarify the date on which the senior care program will be repealed. This clarification pinpoints the Medicare operational date as the repeal date. The problem with the original bill's language is that the notification by the federal authorities might occur before the starting date of the Medicare program, giving Alaska lead time. The CS version assumes that the legislature wouldn't want the state's program to be repealed until the federal program actually starts, not when the notification was received.

Please let me know if you have any questions or if any of the changes in the CS have substantive effects that are not in accord with your wishes.

JMM:med
04-029.med

Enclosure

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January 25, 2004

By hand delivery

Representative John Harris, co-chair
Senate Finance Committee
State Capitol, Room 507
Juneau, Alaska

Representative Bill Williams, co-chair
Senate Finance Committee
State Capitol, Room 515
Juneau, Alaska

Re: **HB 374: SeniorCare and Prescription Drug Coverage for Alaska's Medicare population**

Dear Representatives Harris and Williams:

I include some additional background on the issue of prescription drug coverage for Medicare-only eligibles (whether elderly or under 65).

One facet of the conversation is coverage for new, more effective oral medications for cancer. Previous cancer treatments had been covered by Medicare as injectable medications (chemotherapy) administered by physicians, hospitals or clinics on an outpatient basis. **The need for assistance in prescription coverage** for these new oral cancer drugs – which offer the promise of directly saving lives – **is no less urgent for Alaskans with cancer under 65** as it is for Alaskans with cancer who are over 65 years of age.

Another facet is the cheaper cost of prescription medications in Canada and other foreign countries. This is a very complex issue, with several conflicting interests at stake, and numerous suggested approaches to the issue. But the bottom line is: Alaskans under 65 with disabilities are driven by high prescription drug costs to seek discounts out of state in the same way that Alaska's Medicare-only seniors are driven across the border or out-of-state, at a loss of in-state revenues for Alaska's pharmacies and retailers. **The SeniorCare bill, if expanded to include Alaska's under-65, Medicare-only eligibles, will keep additional revenues in-state, and piggy back on the Administration's plans for cost-saving for public-funded prescription drug benefit programs for seniors, Medicaid-eligibles, and others in this area.**

Both the Council on State Governments[1] and the Alaska Prescription Drug Task Force[2] expressed the view that a prescription drug benefit for Medicare-only recipients should cover *both* seniors and persons with disabilities under age 65. Congress recognized the wisdom of this in the Medicare Prescription Drug, Improvement and

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[1] CSG, Governing Board/Executive Committee, *Resolution on Prescription Drug Coverage Under Medicare* (Dec. 8, 2002) reprinted at: http://www.csg.org/CSG/Policy/CSG+policy+positions/default.htm (under "2002 Annual Meeting Policy Resolutions," click on "Prescription Drug Coverage Under Medicare")(copy enclosed).

[2] Alaska Prescription Drug Task Force: Recommendations to Governor Tony Knowles (Oct. 1, 2002), at page 25 ("Alaska should establish a state-funded direct benefit prescription drug program. . . . The eligible population should be those over 65 and eligible for Medicare *and those under 65 who receive Medicare benefits due to disability*"), reprinted at: http://hss.state.ak.us/dsds/ (excerpt enclosed).

Modernization Act of 2003, which applies to seniors and under-65 Medicare-only eligibles alike. We think the prescription drug "bridge" bill (HB 374) could be easily be amended to include Alaskans under 65, and have drafted an amendment to do just that (copy enclosed).

However, if the committee decides that more information is needed before it can act to include this subpopulation, we urge instead the immediate passage of HB 374 out of the Finance committee. We do not want to slow the bill, and will continue our advocacy on this subject with the Administration and its advisory councils serving Alaskans with disabilities. We hope that if the committee cannot revise HB 374, another bill may be introduced that will address the prescription drug coverage needs of Alaska's under-65, Medicare-only recipients.

I understand that I may be permitted to make some verbal remarks to the House Finance Committee on January 27, after 1:30 p.m. I have been called away to Sitka on some urgent business relating to my clients, and will testify by telephone from the Sitka LIO on January 27.

Very truly yours,

Robert B. Briggs, staff attorney

CC: (w/ encls.)

House Finance Committee
Joel Gilbertson, Commissioner, DHSS
Dennis DeWitt, Office of the Governor
Alaska Commission on Aging (Banarsi Lal, chairperson)
Alaska State Independent Living Council (Erma Perry, chairperson)
Governor's Committee on Employment and Rehabilitation of People with Disabilities
Pat Luby, AARP
Dave Fleurant, exec. dir., DLC-Anchorage

AMENDMENT TO

HOUSE BILL NO. 374

AMENDMENT NO. _____ OFFERED BY: __________

1 At page 1, line 1, delete "SeniorCare" and insert "Alaska Rx Care"

2 At page 1, line 6, delete "SENIORCARE" and insert "Alaska Rx Care"; delete

3 "SeniorCare" and insert "Alaska Rx Care";

4 At page 1, lines 7 and 11, delete "SeniorCare";

5 At page 2, line 1, delete "65" and insert "18";

6 At page 2, line 3, before "have income" insert: "be eligible for Medicare Part A, Part B or

7 both;" and renumber succeeding subsections

8 At page 4, line 25, delete "SeniorCare" and insert "Alaska Rx Care"

9 At page 5, line 2, delete "seniors" and insert "eligible individuals"

CSG GOVERNING BOARD/EXECUTIVE COMMITTEE

RESOLUTION ON

PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

WHEREAS, 40 million seniors and 5 million disabled Americans do not have outpatient prescription drug coverage under Medicare although Medicare is their primary source of insurance coverage;

WHEREAS, 38 percent of America's seniors and individuals with disabilities do not have any outpatient prescription drug coverage at all;

WHEREAS, The majority of Medicare beneficiaries must rely on other public and private health care programs to provide prescription drug coverage;

WHEREAS, Drug coverage can make a significant difference in the financial and physical health of Medicare beneficiaries because research indicates that those without coverage pay higher out-of-pocket costs for medications and also fill fewer prescriptions;

WHEREAS, Among all Medicare beneficiaries the average out-of pocket costs for prescription drugs is more than $1,000 per year;

WHEREAS, Prescription drug coverage options for seniors have diminished in recent years due to the decrease in prescription drug coverage offered by Medicare+Choice plans and by employers for retirees;

WHEREAS, The under-65 disabled population enrolled in Medicare also faces daunting challenges with access to and the affordability of prescription drugs due to low incomes, high medication use, poor health and few options for prescription drug coverage; and

WHEREAS, Prescription drugs are an integral part of modern medical care, making it possible for more Americans to lead longer, healthier and more productive lives; and

NOW THERFORE BE IT RESOLVED that The Council of State Governments strongly urges the President and Congress to pass legislation providing an outpatient prescription drug benefit under Medicare for America's seniors and individuals with disabilities who demonstrate an economic need.

source: http://www.csg.org/CSG/Policy/CSG+policy+positions/default.htm

Adopted on the 8th Day of December, 2002, at the
CSG Annual State Trends and Leadership Forum
In Richmond, Virginia

______________________________	______________________________
Governor Michael Huckabee 2003 CSG President	Representative Daniel Bosley 2003 CSG Chair

ALASKA PRESCRIPTION DRUG TASK FORCE

RECOMMENDATIONS TO GOVERNOR TONY KNOWLES

October 1, 2002

source: http://hss.state.ak.us/dsds

Introduction:

When Medicare was signed into law in 1965, little thought was given to providing a prescription drug benefit. Few prescriptions were regularly used as "preventive medicine" and those that were available were not that expensive. In today's medical world, prescription drugs are considered "smart medicine." Research has created thousands of new medications that are routinely used to avoid expensive surgery and maintain optimum health. Most employers routinely provide prescription drug coverage to their enrolled employees and dependents because it is an effective, economical tool in the health care resource box. Thirty-seven years after enactment, however, Medicare still does not provide a prescription drug benefit to Alaskans over 65 and younger persons with disabilities who are also covered under Medicare. Medicaid, on the other hand, recognizes that prescription coverage is an essential part of a health care plan.

In the absence of a federal plan, 34 states have established some type of program to provide pharmaceutical coverage or assistance to older persons or younger persons with disabilities who are not eligible for Medicaid. The programs vary in their approaches, their target population, and in the amount of assistance they provide. However, each shares a common element: it is designed to reduce the burden of prescription drug costs for a selected group in the population. In addition, some require a drug regimen review that usually results in lower costs as well as healthier residents.

The Task Force has reviewed the programs of each state, conferenced with staff experts at the National Conference of State Legislatures, solicited comments in writing and through a public hearing, and reviewed a variety of changes that might have some impact on reducing the cost of prescription drugs to Alaska's seniors. Current pharmaceutical costs were reviewed and projections are included for growth of Alaska's senior population. Baring Congress enacting a significant prescription drug program under Medicare, Alaska can expect increasing pharmaceutical costs for our older population and increasing costs to the Medicaid program. In 2001, pharmaceutical costs for all Alaskans went up over 25% and 27% for the Medicaid program. As Governor Knowles said on August 2, 2002…"we can't wait any longer--it's time to take action."

Task Force Members:
Robert Albertson, Chief Pharmacist, Alaska Pioneers' Home
Steven Ashman, Director, Alaska Division of Senior Services
Marie Darlin, Alaska Resident over age 50
Jeff Davis, Vice President and General Manager, Premera Blue Cross/Blue Shield of Alaska
Bob Lohr, Director, Alaska Division of Insurance
John Patrick Luby, Alaska Resident over age 50
Jonathan Sherwood, Manager, Alaska Division of Medical Assistance

Task Force Assignment # 6: Develop Recommendations For Regulations, Waiver Applications, and Legislation That This State Should Pursue In Assisting Alaskans With The Costs Of Their Prescription Drugs, And Project A Cost To The State For Each Recommendation

The task force considers it important to recognize that these recommendations do not focus solely on reducing the cost of prescription medications. It is equally important to consider improving the health status as an overall and appropriate goal. We have only to look to the experience of the Alaska Pioneer Homes to see this.

When the Pioneer Home staff pharmacists began to perform drug regimen reviews, the typical Pioneer (average age 89) was taking 14 medications. By a simple review of all medications and discussion with the resident and his/her physician, drug usage was cut by 50%. With only 7 medications, the overall health status of the residents improved and prescription drug expenses were significantly reduced.

1. Establish a direct benefit pharmaceutical program

It is the consensus of the task force that Alaska should establish a state-funded direct benefit prescription drug program for residents who meet age or disability and income requirements whose needs cannot be met by the other recommendations.

These programs, similar to programs adopted in many other states that have proven successful and have provided the greatest benefit to those most in need due to high and hard-to-control pharmaceutical costs.

The eligible population should be those over 65 and eligible for Medicare and those under 65 who receive Medicare benefits due to disability. The Legislature should determine the most appropriate income level. However, the income level should be above that for Medicaid eligibility and most states have selected a limit determined by the federal poverty level, e.g. 150% ($16,620 single, $22,395 couple) or 200% ($22,160 single, $29,860 couple) of the Federal Poverty Level.

One of the benefits of a state-funded direct benefit program would be that it qualifies for the Medicaid best price exemption and that it will help in negotiating the highest rebates.

Develop and implement formularies, preferred drug lists and/or prior authorization requirements as cost control tools, for negotiating manufacturer rebates, and for selecting the best therapeutic medication of "fail first" triaging of drug choices.

To reduce the state's share of the cost of a direct benefit pharmaceutical program, and to promote maintenance of individual and family responsibility, consideration should be given to requiring participant co-pays on a sliding scale basis. Sliding scales will allow the state to benefit those Alaskans with the greatest financial need. Other cost control techniques may include deductibles and maximum benefit limits.

The State should also consider including some or all of its direct benefit pharmaceutical program under a Medicaid waiver. This would allow some federal funds to be used to subsidize the costs of the program, although federal cost neutrality requirements for waivers may limit the amount available.

The State should consider adding a catastrophic benefit for those with higher incomes but extremely high prescription costs.

The State should consider a variety of delivery mechanisms but should maximize the opportunity for drug regimen reviews by pharmacists. The task force believes, based on the Alaska Pioneer Home experience, any drug regimen review process will result in reduced costs and reduced inappropriate usage.

In marketing a new state-funded direct assistance program, the State should look to the experience of the Denali KidCare program as a successful model of outreach and enrollment.

2. Establish a clearinghouse/education program on prescription drugs.

The task force recommends that Alaska establish a clearinghouse for information on prescription drugs and an educational outreach program.

Some private pharmaceutical companies have, individually or in collaboration with other companies, established free or deeply discounted prescription drugs to low-income individuals. It is difficult for individuals, physicians and pharmacists to stay up to date on the variety of available programs and the changes that the marketplace continues to create in regard to existing and new programs. The task force believes that the Department of Administration, Division of Senior Services, is a logical location for such a clearinghouse. The Division already performs extensive outreach throughout the State and houses a successful Medicare/Medicaid information program that acts as a clearinghouse on these topics. Likewise, DOA staff pharmacists of the Pioneer Homes already do outreach and education to older persons as well as to physicians and community and institutional pharmacists and other health care professionals. Funding for the Pioneer Home's outreach is temporary and should be made permanent.

A clearinghouse on available prescription drug programs can be developed with or without a direct benefit program. With a minimal investment, Alaska can greatly increase the utilization of free pharmaceutical programs from private companies by older and disabled Alaskans who meet the income parameters, as well as significantly enhance the knowledge of physicians and pharmacists about appropriate therapeutic substitutions, available generic substitutes, etc.

An educational component targeted toward consumers can include information on use of generics, therapeutic substitution as well as a drug regimen review that can act to counter the effects of direct to consumer prescription drug advertising.

An educational component targeted toward prescribing physicians should include cost information on brand name drugs, availability of less expensive generics, therapeutic substitution as well as information on conducting drug regimen reviews with patients. It will help balance the information currently provided by pharmaceutical companies encouraging the use and sale of their latest product.

3. Expand the use of the 340B program.

There are currently 34 facilities in Alaska that use the 340B program. Approximately 70 more sites are eligible. Under the 340B program, drug manufacturers must enter into agreements with the United States Department of Health and Human Services to provide covered outpatient drugs to participating entities at discounted prices. Federally Qualified Health Centers (FQHC) exist throughout Alaska. If all the entities eligible actually participated in the 340B program, discounts averaging 25-40% would be offered on most drugs and could be made available to financially needy older and younger disabled Alaskans from sites near them. The task force recommends that Alaska increase the use of safety net providers and expand the 340B drug pricing availability to more citizens throughout the State. Current and future 340B entities should be encouraged to apply to HHS as demonstration projects allowing them to expand access to more affordable medications to greater numbers of local citizens.

4. Use a preferred drug list or formulary and drug regimen review in the Medicaid program.

The task force recommends that the Alaska Medicaid program develop a preferred drug list or formulary that designates less expensive but therapeutically appropriate drugs. The Alaska Pioneer Homes already uses an approved formulary. Likewise, the task force recommends that the Medicaid program develop a drug regimen review similar to the successful reviews conducted by the Alaska Pioneer Homes.

Therapeutic substitution is the practice of dispensing an alternate chemical entity from the same therapeutic class for the drug that was ordered. In institutions like the Pioneer Homes, this is worked out prospectively as much as possible. In the event that a substitute has not been agreed upon up front, the pharmacist makes recommendations for alternate available choices to the ordering physician or other prescriber. This is different from generic substitution that is the substitution of exactly the same chemical entity and bio-equivalent drug product form for one of a different brand name.

Currently Alaska Medicaid recipients have a $2 co-payment for each prescription. The task force recommends that the Medicaid program consider changing the co-payments to a reduced amount for medications that are generic or on a preferred drug list and a higher amount for medications that are brand name, e.g. $1 or $2 for preferred drugs/generics and $3 or $4 for brand name medications.

5. Seek possible funding from private sources. The task force recommends that the State seek possible funding opportunities from private foundations interested in health issues. Many foundations are willing to collaborate with state government to develop models that reduce inappropriate prescription drug usage and costs.

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Get Mad

Medicare Non-Coverage of New Oral Cancer Treatments: A Hard Pill To Swallow

Other Fall 2001 Articles

- **Feature Article**
- **Science in the Spotlight**
- **Living Legend**
- **Alliance View**
- **15 Year Forecast**

Promising new drugs are revolutionizing the treatment of cancer. But as so often happens, the federal bureaucracy has yet to catch up with scientific advances. As a result, millions of Americans may be denied potentially life-saving cancer drugs.

The reason? As bizarre as it sounds, it's because some of the new the cancer treatments are in the form of ***pills***. That's right - pills that patients would swallow in the comfort and convenience of their own homes. Under current law, Medicare will not pay for ***oral*** cancer medications, only ***injectable*** medications given by physicians.

Until recently, traditional cancer treatments like chemotherapy were administered intravenously, done in hospitals or doctors' offices. Unfortunately, while the treatments kill cancer cells, they also kill healthy cells. That's what causes the devastating side effects like hair loss, nausea, and fatigue. But coming on the market is a new generation of "oral cancer therapies." These pills' more targeted approach is far less toxic, and produces fewer nasty side effects, than injections. These drugs have shown great promise in treating leukemia, breast and prostate cancer.

But these new drugs aren't cheap. A one-month supply of a typical new drug can cost up to $2,500. And because the drugs do not cure cancer, the drugs must be taken for life to keep the cancer at bay. Because cancer is predominantly a disease associated with aging, Medicare coverage for these cancer medications is essential. Medicare now covers more than 90 percent of current, injectable cancer treatments, but pays for only a fraction of the oral medications.

"This doesn't make any sense, and it needs to change," says Dwayne Howell, president and CEO of the Leukemia and Lymphoma Society.

Judy Orem, 57, is living proof of the new drugs' effectiveness. In December 1995, she was diagnosed with chronic myeloid leukemia, an aggressive bone marrow cancer. After enduring three years of debilitating Interferon treatments, she thought she'd come to the end of the line. "The doctors told me there was nothing more they could do,"

she says. But then she heard about clinical trials of a new cancer drug. She enrolled in the trial, made a remarkable recovery, and remains on the medication.

"If I were depending on Medicare to cover me, I wouldn't be alive today," Orem says. "I'd have died long ago."

While the 40 oral anti-cancer drugs currently on the market make up just five percent of available cancer treatments, researchers predict that figure will grow to at least 25 percent within a decade.

Sen. Olympia Snowe (R-Maine) says this disparity must be corrected, "As cancer therapy moves more toward reliance on oral drugs, Medicare coverage policy must be updated to cover the new therapies." In May, she joined forces with Sen. Jay Rockefeller (D-WV) to co-sponsor the "Access to Cancer Therapies Act of 2001."

Rockefeller says, "The bill will help ensure that seniors and the disabled will have access to oral cancer drugs as a part of their Medicare benefit." To date, 23 senators have signed on as co-sponsors in support of the bill. Similar legislation has been introduced in the House by Rep. Deborah Pryce (R-Ohio). At last count, 207 members have agreed to be co-sponsors of that bill.

Some House and Senate leaders would prefer that the legislation be part of a comprehensive Medicare drug benefits package. However, most Hill watchers say it would be 2004 at the earliest before a comprehensive drug benefits plan could take effect.

Judy Orem says cancer patients can't afford to wait that long. "People are dying because they're not able to get these new drugs. They've used the ones Medicare covered, and they don't work. The longer they wait to approve this, the more people will die."

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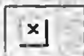

Feedback

WHAT YOU CAN DO:

The Alliance along with some 40 patient advocacy organizations representing millions of American families and many more scientific and academic groups support Secretary Thompson's endorsement of this lifesaving research, and will urge Mr. Bush to be "pro-life" and allow federal funding for embryonic stem cell research to continue. We urge you to:

- Write your local paper and encourage more news coverage on this discriminatory provision in Medicare and the chilling effects it has on patients. Draft up your own opinion and send it as a letter to the editor.
- Call, write, or E-mail your Senators and Representative, and urge them to support the Access to Cancer Therapies Act of 2001.
- Write or E-mail the White House to urge President Bush to sign legislation when it arrives on his desk.

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LETTER TO HOUSE COMMERCE COMMITTEE AND SENATE FINANCE COMMITTEE ADVOCATING PART B COVERAGE FOR ORAL ANTI-CANCER AGENTS (September 19, 2000)

September 19, 2000

The Honorable ......
Washington, D.C. 20510

Dear Senator ......:

The ongoing debate over prescription drugs has highlighted for the cancer community a major shortfall in coverage for life-extending therapies for beneficiaries diagnosed with cancer. While most anti-cancer drugs are currently covered by the program because they are "incident to" physician services, some important drugs remain unreimbursed—notably hormonal agents for breast and prostate cancer—because they are available only in oral dosage.

In addition, the drug discovery pipeline is about to release significant new oral anti-cancer compounds that are not covered under current Medicare law. Offering great potential for enhanced survival, these new agents are based on a variety of cellular mechanisms that inhibit proliferation of cancer cells. Yet without amendment to the Medicare statute, beneficiaries will not have access to these life-extending anti-proliferative cancer drugs.

Cancer is a disease of the elderly, and Medicare beneficiaries are disproportionately affected. Beneficiaries with cancer rely on Medicare to fund their often costly drug therapy, and special coverage rules have been adopted by Congress to meet the unique needs of cancer patients. Most importantly, because cancer therapy frequently employs drugs "off-label"—i.e., for disease indications not specifically approved by the Food and Drug Administration—the statute requires coverage of medically appropriate off-label drug usage in treating cancer patients.

These protections are absolutely essential for patients with cancer, and the cancer community strongly supports coverage for all anti-cancer agents, including oral drugs, in Medicare Part B. Only by expanding Part B coverage to include oral anti-cancer drugs can the program continue to provide comprehensive quality cancer care under the

supervision of a trained oncologist or other cancer specialist.

As the Presidential candidates debate prescription drug coverage for the elderly and this Congress considers end-of-session legislation, we believe now is the best time to add oral anti-cancer drug coverage to Part B. Coverage now will represent an impressive down payment on an overall Medicare drug benefit and will address concerns of cancer patients about their continuity and quality of care.

As representatives of people with cancer, cancer caregivers and cancer research organizations, we strongly urge your support for this urgently needed initiative.

Cancer Leadership Council

Alliance for Lung Cancer Advocacy, Support, and Education
American Society of Clinical Oncology
Cancer Care, Inc.
Cancer Research Foundation of America
The Children's Cause, Inc.
Coalition of National Cancer Cooperative Groups
Colorectal Cancer Network
Cure For Lymphoma Foundation
International Myeloma Foundation
Kidney Cancer Association
The Leukemia & Lymphoma Society
Multiple Myeloma Research Foundation
National Alliance of Breast Cancer Organizations
National Coalition for Cancer Survivorship
National Patient Advocate Foundation
National Prostate Cancer Coalition
North American Brain Tumor Coalition
Oncology Nursing Society
Ovarian Cancer National Alliance
Pancreatic Cancer Action Network
The Susan G. Komen Breast Cancer Foundation
US-TOO International, Inc.
Y-ME National Breast Cancer Organization

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Please send comments and suggestions to webmaster@cancerleadership.org.

Alliance for Retired Americans

source: http://www.retiredamericans.org/fridayalerts/2002/0524.htm

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May 24, 2002

Rx Express Rolls North

Friday Alert PDF

May 24th PDF

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Starting today, May 24, the Rx Express, organized by the Alliance for Retired Americans, will take busloads of senior citizens from states across the northern border to Canada to buy prescription drugs at costs far lower than in the United States. Today's bus will originate in Farmington, Connecticut, and will include a stop in Hartford to pick up additional passengers. Over the next month, hundreds of retired activists will make the trip to Canada. In many cases, the seniors will be joined on the bus by their Congressional Representatives

"The lengths that these senior citizens must go to get affordable prescription drugs underlines the importance of Congressional action on an affordable Medicare prescription drug benefit," notes Alliance Executive Director Edward F. Coyle. "Unfortunately, there are tens of millions of seniors who cannot easily travel to Canada and must continue to pay exorbitant prices to fill their prescriptions."

These trips represent the largest ever coordinated effort to send seniors to Canada for the purpose of buying prescription drugs. A news conference will be held in Washington, D. C. in June to report on the trips' successes and to renew pressure on Congress to act on a prescription drug benefit under Medicare.
In the next month, Rx Express trips will depart from the following cities:

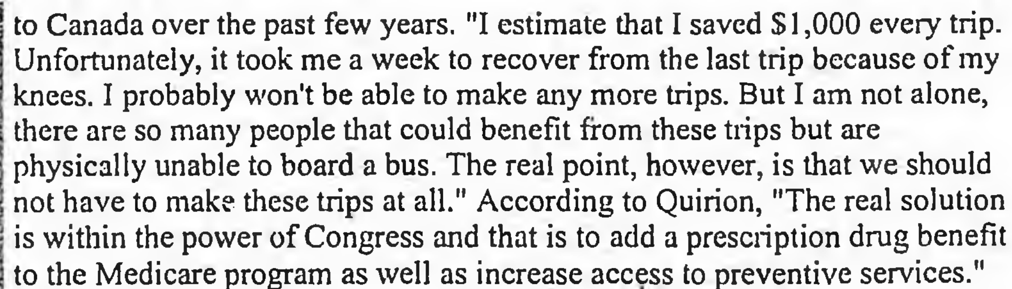
May 29-Philadelphia, Pennsylvania, with stops in Allentown, Hazelton and Scranton/Wilkes-Barre; and Mercer County, Pennsylvania.
May 30-Portland, Oregon; and Seattle, Washington.
May 31-Cleveland, Ohio.
June 10-Detroit, Michigan; Grand Forks, North Dakota; Pittsburgh, Pennsylvania; Grand Forks, Minnesota; Boston, Massachusetts; Manchester, New Hampshire; and Burlington, Vermont.
June 12-Milwaukee, Wisconsin.
June 14-Indianapolis, Indiana, with stops in Anderson and Fort Wayne.
June 18-Wilmer/Mankato, Minnesota.
Additional Rx Express trips in the planning stages for June include New York, Maine, Idaho, Alaska and Montana.

Drug Industry Scores Again
Last week, Friday Alert reported on the latest outrage by the Pharmaceutical Research and Manufacturers Association (PhRMA), the trade association for the drug industry, involving the spending of $3 million on a national television campaign using a front group, the United Seniors Association. The bogus ads promote a Republican prescription drug benefit under which the drug industry would benefit. Yet, despite a complaint filed with the Federal Trade Commission by a coalition of senior, consumer and labor groups, including the Alliance for Retired Americans, nothing happened to stop the ads. But when AARP, a major senior organization, launched a TV ad campaign aimed at urging seniors to save money by switching from brand-name drugs to generics, the big drugmakers demanded that the TV networks make AARP tone down its ads - which it did. "So, why, is it fair for the drug industry to use front groups to advance its agenda but a senior group is forced to moderate its message to keep the drug companies happy?" asks George J. Kourpias, Alliance President. "Can it be that the pharmaceutical industry spends a lot of its exorbitant profits on TV ads and the networks don't dare risk affending such a big advertiser?"

Alliance Participates In Two Capitol Hill Events
The Alliance for Retired Americans continued its high visibility on Capitol Hill again this week with appearances at two events. On Monday, Edward F. Coyle, Executive Director, joined Sen. Mark Dayton (D-MN) and key community activists at a news conference to discuss how President Bush's plan to make his massive tax cut permanent would jeopardize the future of Social Security. Coyle told participants, "The Alliance is prepared to be visible and vocal both in Congress and in public against any plan that threatens or undermines the financial stability of the Social Security system. We will keep pressure on our elected officials to ensure that they do not adopt any proposals that would cut or effectively reduce Social Security benefits, or would weaken, diminish or otherwise dismantle Social Security as it exists today." According to Coyle, "Social Security cannot be privatized without gigantic cuts in benefits and massive borrowing from other Federal funds - funds that are now in deficit as a result of the Republican tax cuts of 2002."

At a second event, on Thursday, Viola Quirion, an Alliance member from Waterville, Maine, told the Subcommittee on Oversight and Investiagations of the U.S. House Energy and Commerce Committee, "Prescription drugs should be one of the benefits of the Medicare program. Despite all the hopes placed in the Medicare+Choice program, it is not a solution. The share of Medicare+Choice enrollees with prescription drug coverage declined from 84 percent in 1999 to 67 percent in 2001. At the same time, premiums and co-payments are more costly. In half of the 33 states with Medicare+Choice plans with drug coverage, the average premium rose more than 100 percent in the past three years. Sadly for Maine residents, even if some were able to afford these increases, it doesn't make any difference-there is no Medicare+Choice plan in Maine. So trying to add preventive services coverage would be not help either."

Quirion, who suffers from ovarian cancer, said she has taken seven bus trips



to Canada over the past few years. "I estimate that I saved $1,000 every trip. Unfortunately, it took me a week to recover from the last trip because of my knees. I probably won't be able to make any more trips. But I am not alone, there are so many people that could benefit from these trips but are physically unable to board a bus. The real point, however, is that we should not have to make these trips at all." According to Quirion, "The real solution is within the power of Congress and that is to add a prescription drug benefit to the Medicare program as well as increase access to preventive services."

GOP Targets Seniors in 2002

Republican strategists have targeted seniors, Independents and women in the 2002 election campaign, saying their votes are key to victory. These strategists have gone so far as to issue specific recommendations for how GOP candidates should frame the debate on Social Security. For example, candidates are told to "attack the Democrats on some element of their Social Security plan . . . either they don't have a plan so they are willing to let it go bankrupt, they want to raise taxes, or they want to raise the retirement age." Another recommendation is "don't say 'privatization.' Instead say 'personal retirement accounts.'" So, much for truth in campaigning.

Friday Alert Archives

The Alliance for Retired Americans is a nationwide organization of three million un ...ces and other older and retired Americans working together to make their voices hear... the laws, policies, politics and institutions that shape our lives.

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DISABILITY LAW CENTER OF ALASKA

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230 South Franklin #206
Juneau, AK 99801
(907) 586-1627
FAX (907) 586-1066

January 21, 2004

By hand delivery

Representative John Harris, co-chair
Senate Finance Committee
State Capitol, Room 507
Juneau, Alaska

Representative Bill Williams, co-chair
Senate Finance Committee
State Capitol, Room 515
Juneau, Alaska

Re: **HB 374: SeniorCare and Prescription Drug Coverage for Alaska's Medicare population**

Dear Representatives Harris and Williams:

We are enthused with the Governor's proposal in HB 374 to provide a "bridge" prescription drug benefit for Alaskans over age 65. Many elder Alaskans have only Medicare as their health insurance, and Medicare currently provides no prescription drug coverage. HB 374 is a very important step in the right direction.

I enclose a summary, provided late yesterday as well to the Senate Finance Committee, of the impact of Public Law 101-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003.[1] Many of the benefits of this federal law do not take effect until 2006. SB 259 promises to provide a "bridge" for Alaska's elderly population until 2006.

It is worthwhile in the consideration of HB 374 to remember that a significant portion of Alaska's Medicare-eligible population is *under age 65*, and are essentially **barred from the HB 374 bridge**. Of these, we estimate approximately 225 Alaskans, with an annual estimated drug expense of $288,900, who could equally benefit from a program like HB 374.[2] We quote from a nationally published report on this subject: **"As policymakers co isider measures to improve drug coverage for the Medicare population, the unique and substantial needs of non-elderly beneficiaries with disabilities should not be forgotten."**[3]

Many of the people barred from the bridge of HB 374 are lifelong Alaskans with significant work histories, who now are totally and permanently disabled. Due to their unique circumstances, some face dauntingly high prescription drug expenses, but their income makes them ineligible for the most common benefit program, Medicaid. We pledge to work with the Administration and the Legislature to seek creative solutions to serve the needs of all Alaskans with disabilities.

Very truly yours,

Bob Briggs

Robert B. Briggs, staff attorney

CC: (w/ encls.)
House Finance Committee
Joel Gilbertson, Commissioner, DHSS
Dennis DeWitt, Office of the Governor

MEMBER·OF·THE NATIONAL ASSOCIATION·OF PROTECTION·& ADVOCACY SYSTEMS

[1] Source: Kaiser Family Foundation. Website address:http://www.kff.org/medicaid/4162.cfm.
[2] See attached analysis and reports that form the basis of these estimates.
[3] B. Briesacher, et al., *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits* (Sept. 2002)(copy enclosed). Website address: http://www.kff.org/medicare/6054.cfm.

ALASKA'S DISABLED MEDICARE BENEFICIARIES & THE DEBATE OVER DRUG BENEFITS: A FORGOTTEN POPULATION?

by Robert B. Briggs[1]
Disability Law Center of Alaska, Inc.

(January 20, 2004)

- 7,648 disabled Alaskans under age 65 receive Medicare

Most recent estimates we could find suggest that approximately 17% (7,648 out of a total 43,815) of Alaska's Medicare beneficiaries are under age 65.[2] By definition, these under-65 individuals are totally and permanently disabled. Most if not all of them receive Medicare as an adjunct to receiving Title II benefits based on a history of contributing 40 or more quarters into the Social Security trust fund. I.e., they have worked and paid Social Security taxes for ten or more years.

- 3,812 disabled Alaskans under age 65 receive Medicare who are not eligible for Medicaid

Many Medicare beneficiaries also are eligible for and receive Medicaid. Such so-called "dually eligible" persons already receive prescription drug benefits through Medicaid. The Kaiser Family Foundation reported 9,500 Alaskans[3] are so-called "*dual-eligibles.*" Subtracted from the total Medicare population (43,815), we estimate a total population of "*non-dual eligible*" Alaskans totaling *34,315.*

How many if these "non-dual eligibles" are under age 65? We could find no state-specific statistics. We did find a recent CMMS report published in June 2002 using 2000 data reporting that nationally 9% of the "non-dual eligible" population is under age 65.[4] If this national percentage also holds in Alaska, then 9% of Alaska's "non-dual-eligible" population are under age 65. I.e., we believe there are at least *3,812 former Alaskan workers with disabilities, under age 65, who are eligible for Medicare, but not Medicaid.*

- 1,606 disabled Alaskans under age 65 receive Medicare who are not eligible for Medicaid, and have no other prescription drug coverage

Some people on Medicare are quite wealthy, because entitlement to Title II Social Security benefits is established by age or disability, not income or resources. This contrasts with Supplemental Security Income (SSI) benefits, for which an individual must have income less than $545 per month and resources of under $2,000, or Alaska's Adult Public Assistant (APA) program, which pays out a cash benefit to bring individual income up roughly to $1,000 (with the same income and resource limits as SSI). This would be one reason for classifying a

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[1] Research assistance by Lynn Armstrong, Disability Law Center of Alaska, Inc., Juneau.
[2] Source: Kaiser Family Foundation, State Health Facts Online: Alaska:Medicare (data as of July 1, 2001). Website address: http://www.statehealthfacts.kff.org.
[3] Id.
[4] CMMS, *Program Information on Medicare, Medicaid, SCHIP and other programs of the Centers for Medicare & Medicaid Services* (June 2002), at page 3. Website address: http://www.cms.hhs.gov/charts/series/sec3-b3.pdf

Medicare recipient as a "non-dual-eligible" – the individual's income or resources are too high to be eligible for the very low eligibility limits of Medicaid or APA.

Some people have access to private health care through spouses, former employment, or can afford private health insurance. So not all the "non-dual eligibles" can be said to actually "need" a State general-fund funded prescription drug benefit. HB 374 wisely recognizes this by establishing income thresholds of eligibility of 135 and 150% of the federal poverty line.

How many "non-dual-eligible" Alaskans under age 65 need prescription drug benefits? While we have found no exact numerical estimates, a national report found that *21% of all Medicare beneficiaries under age 65 with disabilities had no prescription drug coverage, including Medicaid.*[5] If this percentage holds in Alaska, then 21% of Alaska's 7,648 under-65 Medicare beneficiaries – **1,606 individuals** – have no prescription drug benefits of any kind. The actual number may be higher, since the national report on the prescription drug coverage needs of the 2002 Medicare Disabled Beneficiaries report (Briesacher, et al.) included some health insurance options which may not be available in Alaska.

- 707 disabled Alaskans under age 65 receive Medicare who are not eligible for Medicaid, have no other prescription drug coverage, and are "medically indigent"

In one very real way, "gross income" is not an accurate measure of "need" in this context, because prescription drug costs can be so high. Briesacher et al. reported that the average annual drug spending for under-65 Medicare beneficiaries was nearly twice as high as for the elderly.[6] This is not because the population is profligate, but instead because the under-65 Medicare population is, on average, *more medically fragile* than the elder population. As such their medication needs are higher than average, and the costs of those medications is greater. Breischer, et al., at 17.

How many of Alaska's under-65, Medicare-only recipients are "medically indigent?" Briesacher et al. report (at page 6 and page 7, Fig. 3) that 19% of those with full-year prescription drug coverage spend more than 5% of their income on drug expenditures alone; 36% of those with part-year drug coverage spend more than 5% of their income on drugs; and *44% of Medicare beneficiaries under age 65 who lack drug coverage spend more than 5% of their income on prescription medications.drug expenditures alone.* So at the very least, there are approximately 707 Alaskan Medicare beneficiaries who have no source of prescription drug coverage, and who spend more than 5% of their income on medications. That is 707 individuals made "medically indigent" by drug costs alone.

- Roughly $726,400 to solve the problem for Alaskans "medically indigent" under-age-65 Medicare-only beneficiaries

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[5] This compares with 24% of Medicare beneficiaries age 65 and older. B. Briesacher, et al., *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits* (Sept. 2002). Website address: http://www.kff.org/medicare/6054.cfm.
[6] Id. at page 5.

Using 1998 figures, Briesacher et al. (at page 6) documented that Medicare beneficiaries under age 65 have higher average medication costs ($1,284 versus $841 per year for those over 65). With a standard Medicare-like co-pay of 20%, this would result in a total estimated cost of $726,400 per year to provide coverage to this medically indigent population ($1,284 x 707 x 0.80). This figure, however, is likely low, since these "medically indigent" Medicare beneficiaries by definition have prescription medication expenses that are even higher than the average Medicare beneficiary's expenses.

- Roughly $288,900 to help Alaska's under-age-65 Medicare-only beneficiaries with incomes under 200% of the federal poverty line

While we have not found exact figures, it is possible to project the number of Alaskans under age 65 who receive only Medicare and no other drug benefits, whose income is under 200% of the federal poverty line (FPL). The Kaiser Family Foundation, using CMMS statistics, estimates 7,680 of Alaska's Medicare beneficiaries have incomes between 100 and 199% of the FPL.[7] Applying the same percentages as above, then 14% (1,075 individuals) of this subpopulation is likely under age 65. As discussed above, if the national percentages reported in Briesacher, et al. are applicable to Alaska, 21% of this sub-subpopulation may be estimated to have no prescription drug coverage of any kind. Thus, if a benefit program were designed to serve Alaska's under-age-65, Medicare-only beneficiaries who receive no other prescription drug benefits, we estimate approximately **225 individuals** would be served. Using average statistics for drug expenditures from Briesacher, total cost per annum would be **$288,900** without any co-pay. This figure is probably low, due to old drug expenditure data, and more current data may yield a different estimated per capita drug expenditure.

[7] Source: Kaiser Family Foundation, State Health Facts Online: Alaska:Medicare (data as of July 1, 2001). Website address: http://www.statehealthfacts.kff.org.

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Implications of the New Medicare Prescription Drug Benefit for State Medicaid Budgets

For a number of years, Governors and other state policymakers have maintained that Medicare – rather than state Medicaid programs – should play the key role in providing prescription drug coverage to Medicare beneficiaries, including those who also qualify for Medicaid (i.e, the "dual eligibles").[i] The Medicare prescription drug bill signed into law by President Bush on December 8, 2003 includes dual eligibles in the new Medicare drug benefit as of January 1, 2006.[ii] Although the new law shifts drug coverage for dual eligibles from Medicaid to Medicare, it does not provide full fiscal relief to states or guarantee equivalent coverage to dual eligibles. A number of provisions in the law may actually adversely affect state Medicaid budgets and offset much of the Medicaid fiscal relief that state policymakers had long expected would accompany the adoption of a prescription drug benefit in Medicare.

This issue brief describes the key provisions of the new Medicare prescription drug benefit in terms of the potential impact on state Medicaid programs and budgets; reviews the Congressional Budget Office estimates available at this time on the effect of these provisions on state Medicaid expenditures; and discusses why the fiscal impact of the new Medicare prescription drug benefit on Medicaid budgets can be expected to vary widely across states. It does not address other provisions of the new Medicare law with a potential impact on states, many of which are not related to the creation of a new prescription drug benefit in Medicare (e.g., the law contains new Medicaid funds for payments to hospitals that serve a disproportionately large number of uninsured and Medicaid patients). Information on the overall effect of the law on states is not currently available from the Congressional Budget Office or other sources.

I. Key Provisions of the New Medicare Prescription Drug Benefit Affecting State Medicaid Budgets

Some of the most significant changes in the new law affecting state Medicaid spending include the following:

- **Dual eligibles are expected to secure drug coverage through Medicare; Medicaid no longer will finance drug coverage for this population.** As of January 1, 2006, dual eligibles are expected to secure their prescription drug coverage through Medicare under the new "Part D" of the program. On that date, states no longer can secure federal Medicaid matching funds for the cost of providing prescription drug benefits to dual eligibles who are eligible to enroll in Part D.[iii] As a result, states no longer will have to expend state Medicaid matching funds on providing prescription drug coverage to dual eligibiles. If dual eligibles do not enroll in a Part D plan or if they need more drug coverage than is

provided by their Part D plans, states can provide it to them using 100 percent state funds. The federal government, however, will not provide states with Medicaid matching funds for such expenditures.

- **Continued state financing of much of the prescription drug costs for dual eligibles through "clawback payments".** States are required to continue to finance much of the cost of providing the new Medicare Part D benefit to dual eligibles on an ongoing basis through monthly maintenance-of-effort or "clawback" payments to the federal government. The payments are designed to return to the federal government a significant share of the amount states would have spent on dual eligibles' prescription drug coverage under Medicaid if the new Medicare law had not been enacted. The share of such expenditures, described as the "takeback" share, is set at 90 percent in 2006 and tapered down to 75 percent for 2015 and later years. The size of the clawback payments for any given state in any given month will be determined by a complex formula, primarily based on the state's per capita expenditures on Medicaid prescription drugs for dual eligibiles in 2003 trended forward by per capita growth in prescription drug spending nationwide since 2003[iv]; the number of dual eligibles in the state who are enrolled in the new Part D program in the month in question; and the "takeback" share for the month in question.

- **Significant new responsibilities for administering Medicare's low-income subsidy program.** The law requires state Medicaid agencies and Social Security Offices to accept and evaluate the applications of Medicare beneficiaries seeking assistance under Medicare's Part D low-income subsidy program. The new Part D program will provide assistance with the Part D premium, deductible and cost-sharing obligations to Medicare beneficiaries with income below 150 percent of the poverty line who can meet an asset test. Over 14 million seniors are expected to be eligible for the new subsidy program in 2006, although not all of them are expected to participate.[v] Among those who do participate, a significant share may apply for coverage through Social Security Offices.[vi] However, even if a small share of eligible Medicare beneficiaries apply for assistance at state Medicaid agencies, states will incur new Medicaid administrative expenses as they hire staff and modify their computer systems to accommodate the applicants. Moreover, states are required to screen the Medicare beneficiaries seeking low-income subsidies for eligibility for selected categories of Medicaid eligibility that provide assistance with Medicare premium and/or cost-sharing obligations (i.e., the "Medicare Savings Programs"). If states find someone who is eligible for such assistance, they must offer the individual the chance to enroll in Medicaid. As a result, the new Part D low-income subsidy program is expected to have a "woodwork" effect that increases state Medicaid expenditures.

II. Overall Impact on State Medicaid Expenditures

In a November 20, 2003 letter to Senator Don Nickles, the Congressional Budget Office provided estimates of the effect on state Medicaid expenditures of the three provisions

described above. According to CBO, the elimination of Medicaid-financed prescription drug coverage for dual eligibles will reduce state Medicaid spending by some $115 billion between federal fiscal year 2004 and 2013. Over the next ten years, however, CBO estimates suggest that states will see 85 percent of this $115 billion in Medicaid fiscal relief disappear due to the mandatory clawback payments ($88.5 billion), higher enrollment in Medicaid when people come into Medicaid offices to apply for the Part D low-income subsidy program ($5.8 billion), and new administrative responsibilities ($3.1 billion). The net fiscal relief to state Medicaid programs over the next ten years is expected to total $17.2 billion. Nearly 80 percent of this fiscal relief is expected to occur in the last four years (2010 – 2013) of the 10-year period evaluated by CBO.

In the short-term, the Congressional Budget Office estimates suggest that the new law will actually increase state Medicaid spending. Between fiscal year 2004 and 2006, new state Medicaid costs due to the Medicare bill are expected to exceed Medicaid fiscal relief by $1.2 billion. The primary reason for the net expense to state Medicaid budgets in the short-term appears to be that states' clawback payments to the federal government in 2006 are expected to exceed the amount of fiscal relief states will secure as a result of no longer providing Medicaid-financed prescription drug coverage to dual eligibles.

While the CBO estimates assess the impact of some of the major changes in the Medicare law related to the new prescription drug benefit, they are not designed to represent a comprehensive assessment of the law on state finances. They do not take into account provisions unrelated to prescription drug coverage that may benefit states, such as an increase in federal funds available for disproportionate share hospital (DSH) payments; an extension of funding for a Medicaid program that pays the Medicare Part B premiums of selected beneficiaries with income up to 135 percent of poverty (i.e., the "QI-1 program"); and new funds for providing health care services to undocumented immigrants. They also do not take into account states' savings on the cost of drug coverage for retired state employees or State Pharmacy Assistance Programs, or new Medicaid costs for dual eligibles that states are expected to incur due to the increase in Part B deductibles.

III. State-by-State Variation in the Impact of the Medicare Law on Medicaid Budgets

The CBO estimates of the impact on state Medicaid budgets of key provisions of the new Medicare law suggest that nationwide states may retain roughly 15 percent of the fiscal relief they otherwise would secure as a result of no longer providing prescription drug coverage to dual eligibles. For any given state, however, the impact could vary significantly from this nationwide figure. Given the complexity of the law, it is likely to be some time before state-by-state estimates of its impact are available, but the following factors are likely to play a key role in determining how states fare:

- **The trajectory of state Medicaid spending on prescription drugs for dual eligibles in the absence of the Medicare law.** The clawback payments that states must make each month to offset the cost to the federal government of

providing Part D drug coverage to dual eligibles are based in part on national growth over time in per capita prescription drug expenditures. Under their Medicaid programs, however, some states likely would have seen the per capita cost of providing prescription drug expenditures to dual eligibles rise more rapidly than a nationwide average, while other states would have experienced relatively modest growth. The states that would have experienced relatively modest growth, however, still must make payments to the federal government based on a nationwide trend.

- **State Medicaid expenditures on prescription drugs for dual eligibles in 2003.** A second key factor in determining the size of each state's clawback payments to the federal government for Part D benefits is its per capita state Medicaid expenditures on prescription drugs for dual eligibles in 2003. This figure varies widely across states because some states offer more comprehensive prescription drug benefits and/or are currently more aggressive about adopting cost-control measures than others. The clawback formula effectively freezes these state-by-state variations in place, requiring states that offered relatively expensive benefits to pay the federal government more than their counterparts with narrower benefits or more aggressive cost controls. (Table 1 provides state-by-state information on per capita state Medicaid expenditures for prescription drugs for dual eligibles in 2002, the latest year for which data are available. These figures vary for the reasons noted above, and because states have different federal Medicaid matching rates. The clawback formula takes into account changes over time in states' Medicaid matching rates).

- **The number of dual eligibiles in each state who enroll in the new Part D benefit.** The cost of the new Medicare law in any given state will depend on the number of dual eligibles who enroll in the new Part D benefit. In 2006, the size of states' clawback payments to the federal government is expected to increase by an average of $1,260 for each dual eligible who enrolls in Medicare Part D coverage.[vii] (The fiscal cost to an individual state associated with the enrollment of a dual eligible in Part D will vary widely because it is based on each state's expenditures on prescription drugs for dual eligibles in 2003 trended forward at a national growth rate.) Since states' clawback payments are determined in part based on the number of dual eligibles who enroll in Part D coverage, the new law actually creates an incentive for states to reduce the size of their dual eligible populations with Part D benefits to reduce the burden of their clawback payments.

- **Whether a state decides to supplement the Part D benefit in any way.** The impact of the Medicare law on state Medicaid budgets also will depend on whether a state elects to use its own funds without federal Medicaid matching to address gaps for dual eligibles if Part D plans do not cover the full array of drugs that are needed due to restrictive formularies or if the Part D cost-sharing obligations exceed the amount a state deems reasonable for dual eligibles. Given that states are facing ongoing fiscal problems, many states may not elect to use state-only funds to fill gaps in Part D coverage or may elect to to fill some of the

gaps only for selected groups, such as the mentally ill or HIV-positive individuals who may be particularly vulnerable if they experience a deterioration in coverage.

While it is impossible at this time to assess how these, as well as other factors, will affect individual states, some states undoubtedly will fare better than others. States with relatively comprehensive Medicaid prescription drug benefits are likely to fare less well than their counterparts with more limited coverage because they are likely to face large maintenance-of-effort payments to the federal government due to their per capita expenditures on prescription drugs for dual eligibles in 2003. At the same time, the tradition of providing comprehensive prescription drug coverage to dual eligibles may lead policymakers in these states to feel particularly compelled to use state funds to address some of the gaps that could emerge in the scope of the Part D coverage available to dual eligibles.

Conclusion

It will likely be some time before individual states are able to fully evaluate the effect of the new Medicare prescription drug benefit on their Medicaid budgets and dual eligible populations. For now, however, it seems clear that the law provides substantially less Medicaid fiscal relief than states had long expected would accompany the addition of a prescription drug benefit to Medicare, as well as raises a number of questions regarding how dual eligibles will fare under the new Medicare law. Because of the diversity in states' situations and policies, wide variation in the impact on states and their budgets can be expected.

This issue brief was prepared by Jocelyn Guyer with the Kaiser Commission on Medicaid and the Uninsured. She was assisted by many of her colleagues at KCMU, as well as by Andy Schneider of Medicaid Policy, LLC.

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[i] Unless otherwise noted, "dual eligible" is used throughout this issue brief to refer to individuals with both Medicaid and Medicare coverage who are entitled to full Medicaid benefits. It does not include individuals, often known as "partial dual eligibles," who are eligible for assistance from Medicaid only with their Medicare cost-sharing obligations.

[ii] H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The law does not simply add a prescription drug benefit to Medicare, but also makes a number of other changes to the Medicare program Medicaid, prescription drug policy, and other areas. This issue brief, however, addresses primarily only those provisions of H.R. 1 related to the new Medicare prescription drug benefit that affect Medicaid.

[iii] The bar on receiving federal Medicaid matching funds for prescription drug coverage extends to all dual eligibiles with full Medicaid benefits covered under state plan amendments, including dual eligibles covered at state option. One exception is that states can secure Medicaid matching funds for providing drugs to dual eligibiles that Part D plans are not allowed to cover. The classes of drugs that fall under this exemption are: 1) anorexia, weight loss, or weight gain drugs; 2) fertility drugs; 3) drugs used for cosmetic purposes or to promote hair growth; 4) medicines used for the symptomatic relief of cough and colds; prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations); 5) over-

the-counter drugs; 6) barbiturates; and 7) benzodiazepines. The law does not clearly address the issue of whether states can continue to receive federal Medicaid matching funds for the cost of providing prescription drug benefits to seniors and people with disabilities covered under Medicaid Section 1115 waivers.

[iv] The measure of national growth in per capita prescription drug expenditures will be based on National Health Expenditure Survey estimates of per capita prescription drug spending growth through 2006 and on the growth in per capita Part D spending in 2007 and later years. The law provides more detail on the formula than is presented here, but also leaves a number of issues unresolved. For example, the law is ambiguous as to whether the per capita expenditure figure that is used in the clawback formula will be based on total Medicaid prescription drug spending in 2003 divided by the number of dual eligibles or the total Medicaid prescription drug spending in 2003 on dual eligibles divided by the number of dual eligibles.

[v] Congressional Budget Office, letter to Senator Don Nickles, Chairman, Committee on the Budget, November 20, 2003.

[vi] Even if subsidy-eligible individuals apply for assistance through Social Security Offices, states may have a role to play in their eligibility determinations because the level of subsidy that someone receives depends on whether he or she is a dual eligible. Thus, depending on how the option to apply for coverage through Social Security Offices is implemented, states may need to provide or verify information on the Medicaid status of dual eligibiles when they seek to enroll in the new low-income subsidy program through a Social Security Office.

[vii] KCMU estimates based on trending forward the average per capita state expenditure on prescription drug coverage for dual eligibles in fiscal year 2002 by national projected growth in per capita prescription drug spending through 2006. The resultant figure was multiplied by 90 percent to approximate the average amount by which states' clawback payments will increase in 2006 per additional dual eligible enrolled in Part D. The data on average state expenditures per dual eligible in 2002 were provided by the Urban Institute and projections of per capita growth in prescription drug expenditures through 2006 were taken from National Health Expenditure Survey Projections prepared by CMS, Office of the Actuary, February 2003.

Source: http://www.cms.hhs.gov/charts/series/sec 3-b3.pdf

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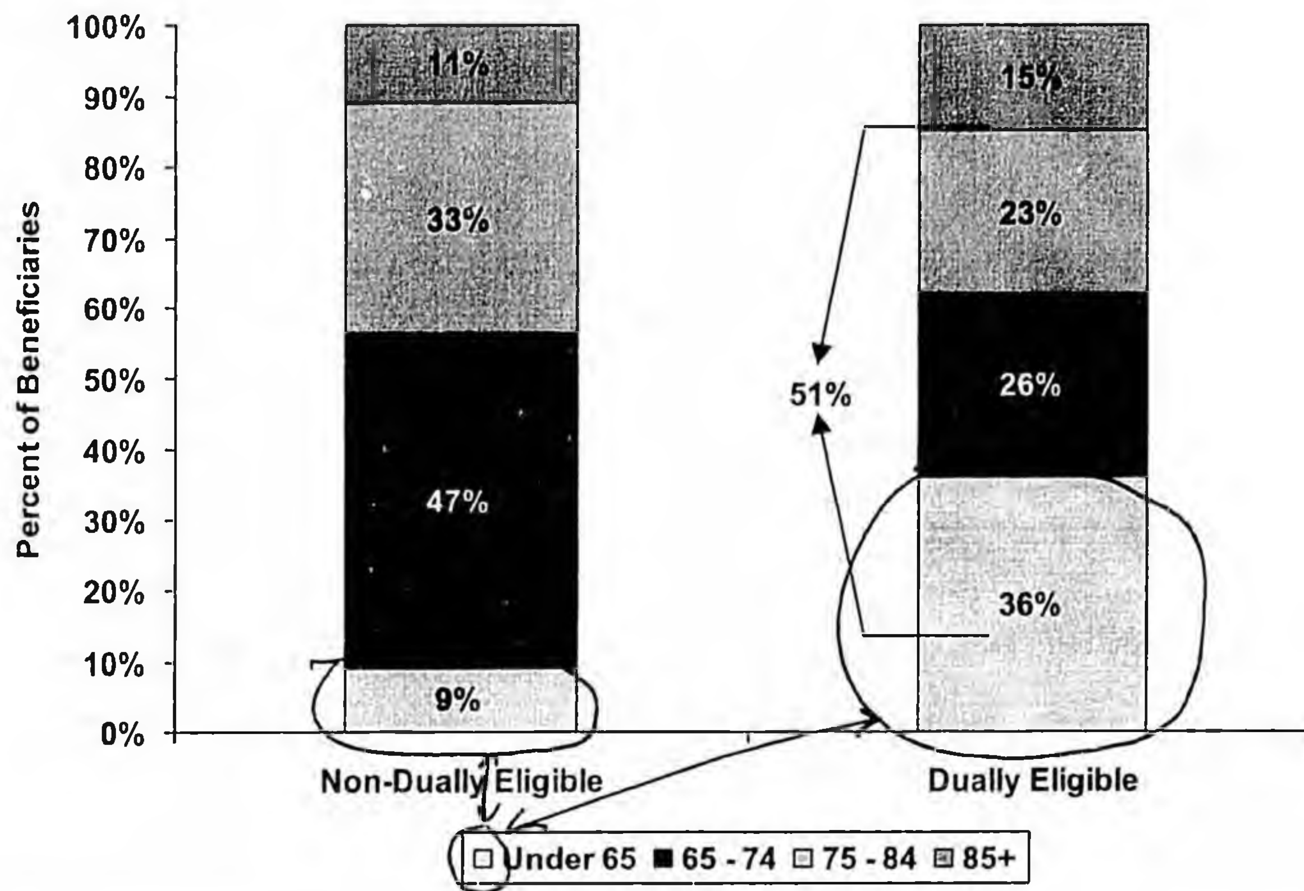
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

3. Dually Eligible Beneficiaries

Proportion of Medicare Dually Eligible and Non-Dually Eligible Beneficiaries, by Age, 2000

Over half of the dually eligible population are under age 65 or over 85.

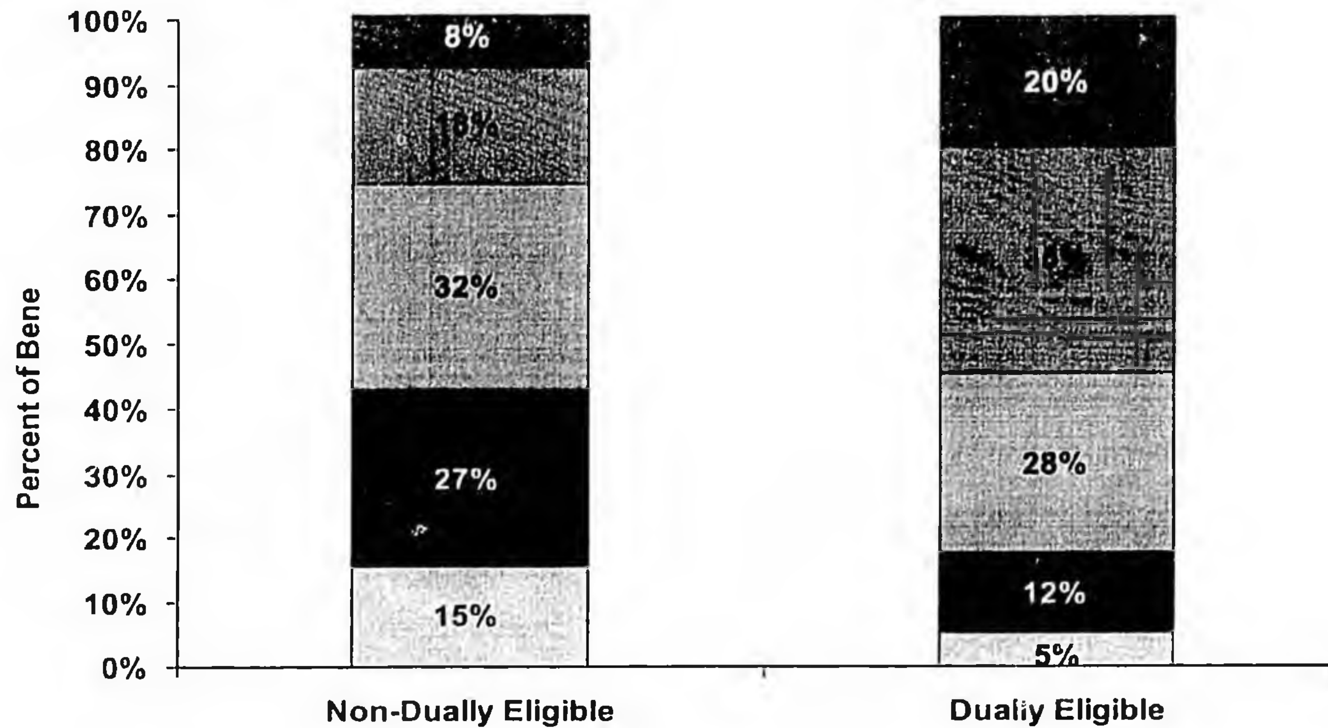


Note: Dually eligible beneficiaries are Medicare beneficiaries that also receive Medicaid coverage.

Source: CMS, Office of Research, Development, Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

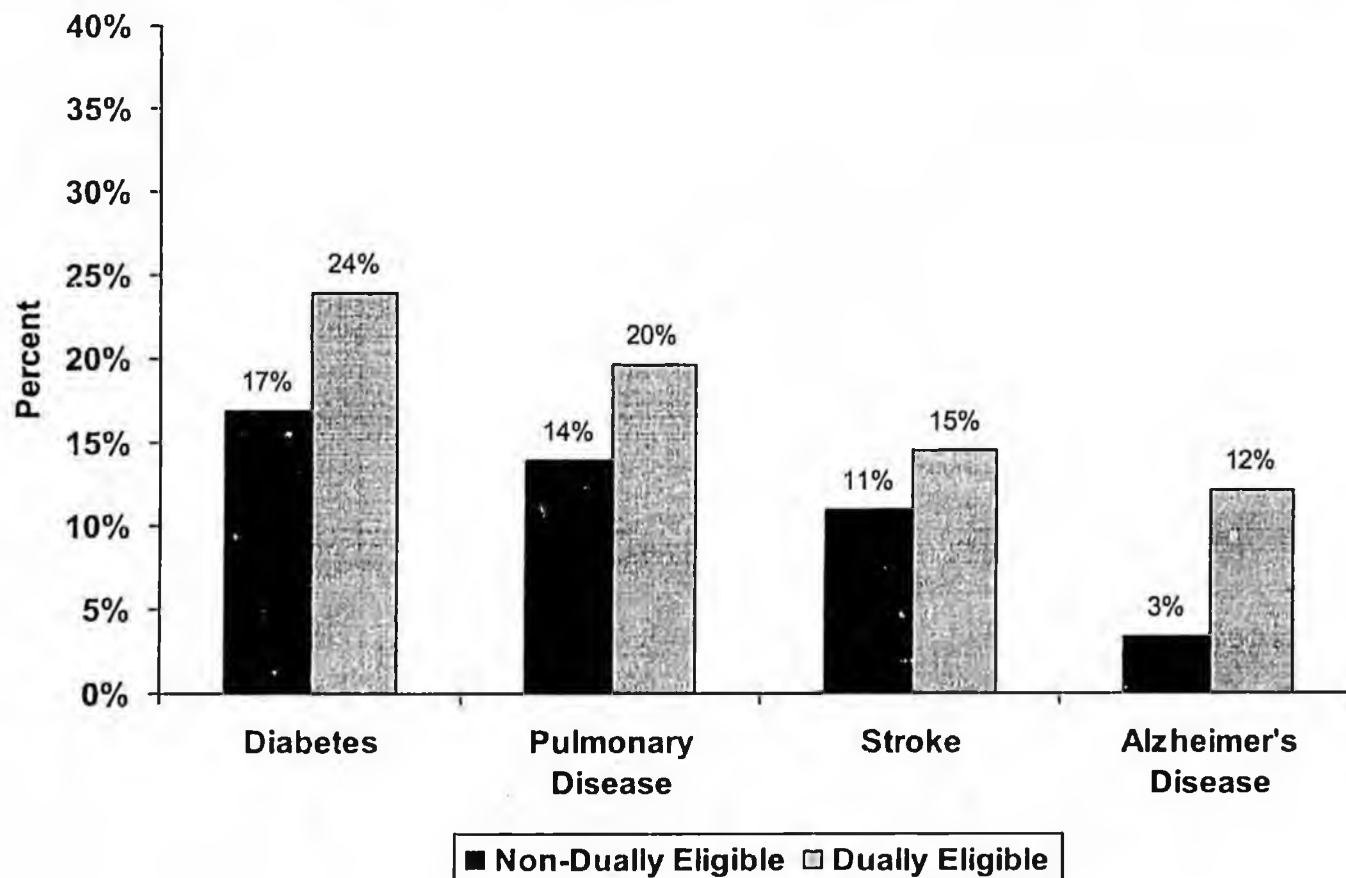
Self-Reported Health Status of Dually Eligible and Non-Dually Eligible Beneficiaries, 2000

Over half of the dually eligible population is in poor or fair health.



Percent of Non-Dually Eligible and Dually Eligible Beneficiaries with Selected Diseases and Chronic Conditions, 2000

The dually eligible population has higher rates of debilitating diseases and conditions such as pulmonary disorders and Alzheimer's disease.

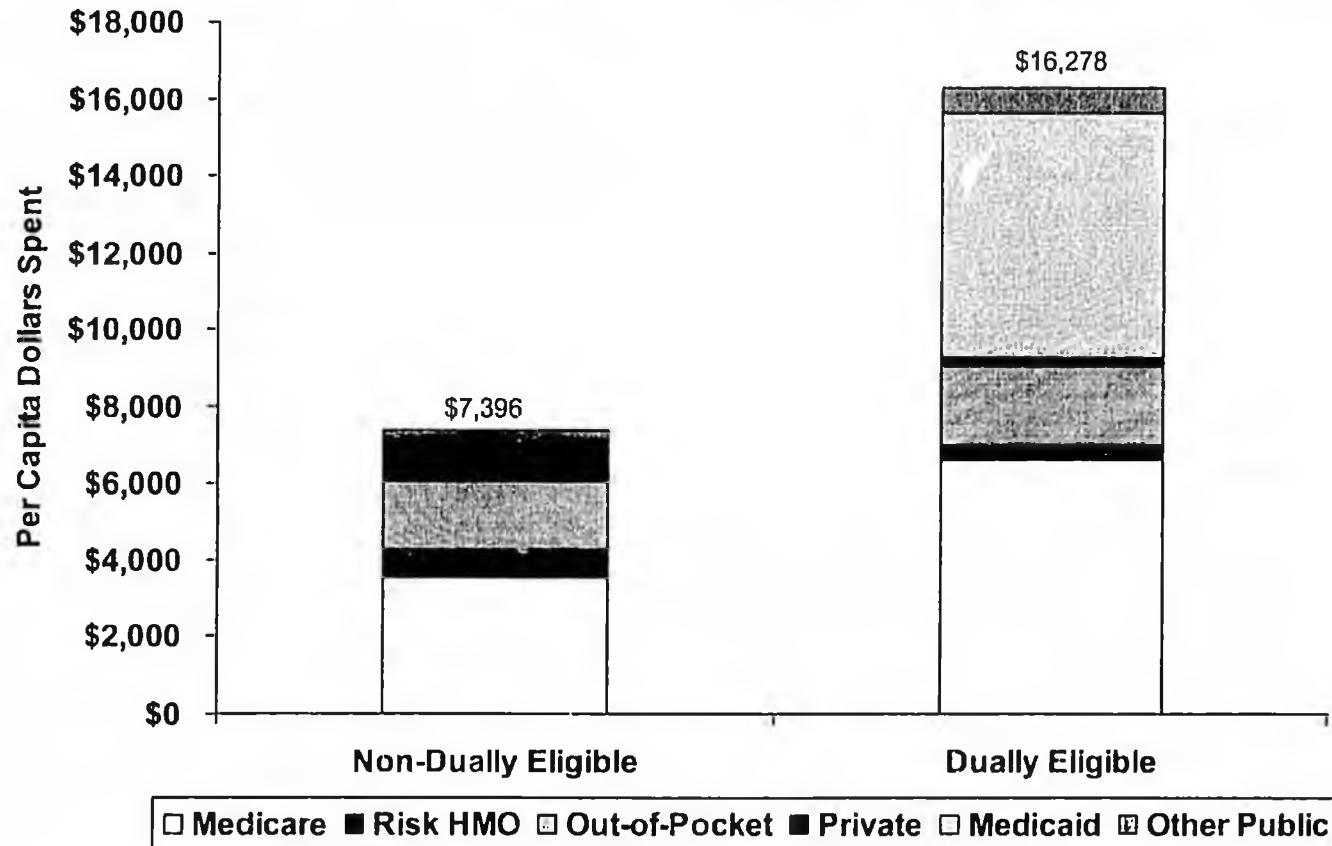


Note: Dually eligible beneficiaries are Medicare beneficiaries that also receive Medicaid coverage.

Source: CMS, Office of Research, Development, Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Total Health Expenditures by Payer for Dually Eligible and Non-Dually Eligible Beneficiaries, 1999

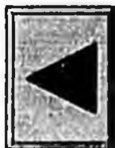
Health expenditures for the dually eligible population were more than double that of the non-dually eligible.



Note: Out-of-Pocket does not include premium payments. Payers will not sum to total due to some small categories being omitted. "Other Public" includes VA, DOD, and state-based pharmaceutical assistance programs.

Source. CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and UseFile.

End of Chapter



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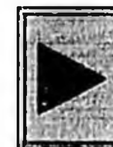

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Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate Over Drug Benefits

About 5 million Americans under age 65 qualify for Medicare coverage because they are totally and permanently disabled. They are more likely than the elderly to live in poverty, to be in poor health, and to experience difficulties living independently and performing basic daily tasks. A new study from The Commonwealth Fund and the Henry J. Kaiser Family Foundation, reports that the disabled have few options other than Medicaid for obtaining prescription coverage. In Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate Over Drug Benefits, Becky Briesacher, Bruce Stuart, Jalpa Doshi, and Sachin Kamal-Bahl of the University of Maryland, and Dennis Shea of the Pennsylvania State University, conclude that a Medicare drug benefit designed for the elderly will not suffice for the disabled unless their particular needs are assessed and addressed.

- Report

Information provided by the Medicare Policy Project
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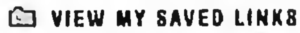

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MEDICARE'S DISABLED BENEFICIARIES: THE FORGOTTEN POPULATION IN THE DEBATE OVER DRUG BENEFITS

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and

Dennis Shea
The Pennsylvania State University

September 2002

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EXECUTIVE SUMMARY

The ongoing debate over the addition of a prescription drug benefit to Medicare's benefit package has focused primarily on the needs of the elderly. The needs of Medicare's nonelderly, disabled beneficiaries have received considerably less attention. There are around 5 million Medicare enrollees who are under age 65 but qualify for Medicare because they are totally and permanently disabled. Prescription drug coverage is critical for this population, which is more likely than the elderly to live in poverty, be in poor health, and experience difficulties living independently and performing basic daily tasks.

This analysis draws upon the 1998 Medicare Current Beneficiary Survey Access to Care and Cost and Use Files to describe the prescription drug experiences of Medicare beneficiaries under 65 who are living with disabilities. The key findings are:

- The disabled are heavy users of medications, filling more prescriptions than the elderly in 1998 (34 vs. 25, respectively) and spending more on drugs annually ($1,284 vs. $841).
- Overall rates of drug coverage throughout 1998 were comparable for under-65 disabled and elderly beneficiaries (79% and 76%, respectively). Medicaid was the primary source of drug coverage for the under-65 disabled, assisting one of three such beneficiaries, but was the source for only one of 11 seniors. Elderly beneficiaries, on the other hand, were more likely to have prescription coverage through an employer-sponsored health plan.
- Out-of-pocket drug spending varies by source and stability of coverage. Under-65 disabled beneficiaries who lacked drug coverage for the entire year in 1998 had significantly higher out-of-pocket spending ($499) than did those with full-year coverage ($314).
- Out-of-pocket drug spending also varies widely by type of coverage. For disabled beneficiaries under age 65 who had drug coverage through Medigap, out-of-pocket costs averaged $601 in 1998—more than was paid by those without Medigap coverage ($499). Disabled beneficiaries with employer-sponsored drug coverage and those enrolled in Medicaid had average out-of-pocket drug costs of $375 and $199, respectively.
- Disabled beneficiaries' high drug costs and low incomes make paying for prescription medications particularly burdensome. More than a quarter (27%) of all under-65 disabled beneficiaries spent 5 percent or more of their annual incomes on

prescription drugs in 1998, with the proportion rising dramatically for those with coverage for only part of the year (36%) or no coverage at all (44%).

- Access problems are exacerbated for those with unstable or no drug coverage, particularly among the disabled. Compared with those with full-year coverage, disabled beneficiaries without prescription benefits were nearly three times more likely not to fill all of their prescriptions and more than twice as likely to delay care because of costs.

- The types of medications typically used by the disabled differ considerably from those used by the elderly. Psychotherapeutics, for example, are the prescriptions most commonly filled by the disabled (57% use this group of drugs), but they rank only 10th among drugs used by the elderly (23%). The disabled are also far heavier users of analgesics and central nervous system drugs, whereas the elderly are most apt to use heart medications.

The under-65 disabled Medicare population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills. Yet with the exception of Medicaid, disabled Medicare beneficiaries have few options for obtaining stable and comprehensive prescription drug coverage. All of these factors place the disabled at special risk.

Some policymakers have proposed linking a Medicare drug benefit to the medications most often used by the elderly. If that were to happen, the findings presented here suggest that the disabled would be systematically disadvantaged. If the drug benefit consists mainly of government subsidies to private insurers, few disabled beneficiaries are likely to receive assistance. While most recent Medicare prescription drug benefit proposals do not consider restricting the benefit to those medications most often used by the elderly, as some earlier proposals did, this does not mean that access to medications for disabled Medicare beneficiaries would not be difficult. Formulary restrictions, drug utilization review, and other administrative mechanisms can and have been used by public and private payers to restrict access to certain drugs, especially newer, more effective, yet more expensive, psychotherapeutics.[1] As policymakers consider measures to improve drug coverage for the Medicare population, the unique and substantial needs of nonelderly beneficiaries with disabilities should not be forgotten.

[1] L. Gorman. "Treatment Denied: Colorado Health Care 'Reform' and the Mentally Ill." Independence Institute Issue Paper, July 31, 2001.

MEDICARE'S DISABLED BENEFICIARIES: THE FORGOTTEN POPULATION IN THE DEBATE OVER DRUG BENEFITS

INTRODUCTION

Despite concerns about aging baby boomers swamping the Medicare program, beneficiaries under age 65 who are entitled through the Social Security Disability Insurance (SSDI) program represent the fastest-growing segment of the Medicare population. There are around 5 million people who are under age 65 and qualify for Medicare on the basis of disability, representing nearly 14 percent of all Medicare beneficiaries. By 2010, this group is expected to number 7.6 million, or almost 17 percent of the Medicare population.[2] The needs of the under-65 disabled population on Medicare have gone largely unnoticed in the debate over improving prescription drug coverage for Medicare enrollees. Typically, policy proposals extend drug coverage to all Medicare beneficiaries, including the under-65 disabled, but design features and need assessments have still focused almost exclusively on the elderly. The prevailing wisdom seems to be that a benefit designed for the elderly will also work for the disabled. Policies based upon that assumption could prove problematic for a population as vulnerable—and as poorly researched—as Medicare's disabled.

This analysis was conducted to provide policymakers with better information on disabled beneficiaries' need for prescription coverage. It uses 1998 data from the Medicare Current Beneficiary Survey to: (1) compare disabled and elderly Medicare beneficiaries on various dimensions, including demographic characteristics, prescription drug coverage, patterns of drug use and spending, and reported problems with access to care; and (2) compare the characteristics and prescription drug use patterns of disabled Medicare beneficiaries with drug coverage across a range of sources, both for the full year and for only part of the year, and those without it. It also evaluates the impact of specific drug benefit programs available to the disabled in certain states and counties.

Finally, to determine whether the needs of the SSDI population differ according to type of disability, sub-analyses were performed for people with mental and physical impairments; results are presented in detail in the Appendix.

---

[2] Qualifications for Medicare disability entitlement are strict: workers can receive Social Security Disability Insurance (SSDI) assistance only after being diagnosed with qualifying medical conditions that are expected to last at least 12 months or result in death. Except for persons diagnosed with end-stage renal disease or amyotrophic lateral sclerosis, SSDI beneficiaries must complete a 24-month waiting period before Medicare benefits commence. National Economic Council, Domestic Policy Council, *Disability, Medicare, and Prescription Drugs*, The White House, July 31, 2000.

Study Methods

Data for this study were obtained from the 1998 Medicare Current Beneficiary Survey (MCBS) Cost and Use and Access to Care files. The MCBS is a longitudinal survey, conducted in the home, of a representative national sample of the Medicare population.[3] The MCBS oversamples beneficiaries under the age of 65, making it one of the best data sources for studying the disabled population. The population for this study consisted of all elderly and disabled Medicare beneficiaries living in the community (e.g., not in an institution) for at least part of the year in 1998.[4] All analyses applied sampling weights to provide nationally representative population estimates.[5] State and county residence codes in the MCBS were used to assess the effects of policies intended to improve access to prescription drug coverage for disabled beneficiaries. The availability of Medicare+Choice plans varies by county and was determined from plan listings obtained from the Centers for Medicare & Medicaid Services (CMS).

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[3] The MCBS is conducted under the auspices of the Centers for Medicare & Medicaid Services (CMS). Begun in the fall of 1991, the MCBS includes interviews with over 12,000 Medicare beneficiaries three times a year using computer-assisted personal interviewing. MCBS interviewers collect extensive information on individuals' use and expenditures for health services, including prescription drugs, source of payment, type of health insurance, access to care, and health and functional status. The interviewers also collect information on socioeconomic status and demographic characteristics.

[4] To distinguish beneficiaries by disabled or elderly entitlement status, the authors used the Medicare administrative designation given as of December 31, 1998. This designation limits the disabled population to only those under the age of 65, since the status effectively disappears once disabled beneficiaries become Medicare-eligible by age. Excluded from the sample are beneficiaries institutionalized year-round and a small group of beneficiaries entitled only through end-stage renal disease.

[5] All analyses used sampling weights supplied for each individual in the MCBS and clustering corrections using survey software in *Stata 7.0.* The authors computed mean values and standard errors around each estimation. Rather than report the standard errors, they followed the practice recommended in the MCBS guidelines of identifying values with standard errors exceeding 30 percent of the estimate. Estimates with a relative standard error greater than 30 percent are designated as potentially unreliable in the tabled findings.

FINDINGS

Beneficiary Characteristics

In 1998, Medicare beneficiaries included approximately 4.8 million community-dwelling disabled and 33 million elderly. The typical disabled beneficiary is a middle-aged (mean age=49.9), unmarried man. At least one of four is nonwhite or Hispanic (Table 1). By contrast, most elderly beneficiaries fall between the ages of 65 and 74 (mean age=74.9), a majority is female, and most are married. Fewer than 15 percent are minorities. Disabled Medicare beneficiaries are at significant economic disadvantage compared with elderly beneficiaries. Medicare's disabled are twice as likely as seniors to live under the federal poverty level (45% vs. 20%), and nearly 80 percent live on modest incomes under 200 percent of the poverty level, compared with just over 50 percent of seniors.[6] Disabled beneficiaries with mental impairments are especially likely to have incomes below the poverty level (Appendix Table A1).

Measures of health status indicate that disabled beneficiaries have much poorer physical, mental, and functional levels than do the elderly. The disabled are twice as likely to report being in fair or poor health (59% vs. 23%) and twice as likely to have trouble performing at least one "activity of daily living" (44% vs. 26%) or one "instrumental activity of daily living" (36% vs. 16%). (Activities of daily living include getting out of bed and being able to feed yourself, while instrumental activities of daily living include using a phone, going shopping, or preparing meals.) The disabled also bear a heavy disease burden compared with nondisabled individuals of the same age. Furthermore, despite being considerably younger than the elderly, disabled beneficiaries are as likely to report having three or more chronic conditions.

Opportunities for Obtaining Prescription Drug Coverage

More than three-quarters of all elderly and disabled Medicare beneficiaries maintained some form of prescription drug coverage in 1998. While rates of continuous and part-year drug coverage were about the same among both elderly and disabled beneficiaries, there were substantial differences in the sources and generosity of coverage (Figure 1). In general, the disabled rely far more heavily than the elderly on public programs for protection from prescription drug costs and, among those with private coverage, their benefits tend to be less generous.[7]

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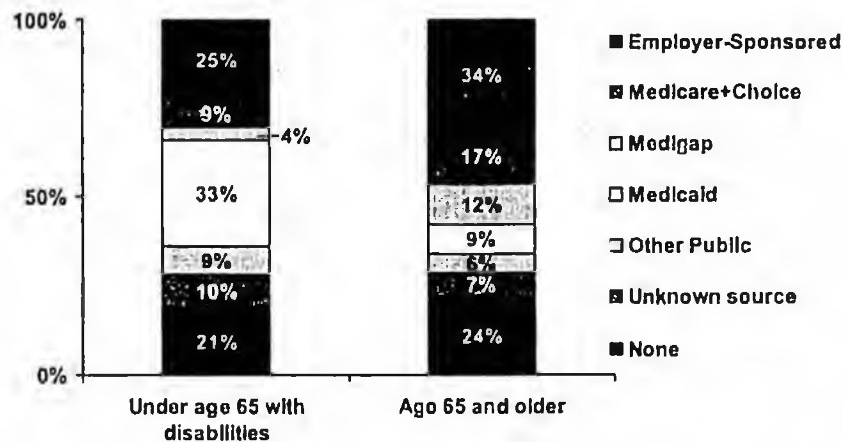
[6] These estimates are higher than those reported from the Current Population Survey (CPS). The major reason for this discrepancy is that the CPS counts all sources of household income while the MCBS counts only income received by the beneficiary or spouse.

[7] Medicaid provides a substantial portion of drug coverage for the disabled with mental impairments (45%) (Appendix Table A1). For those with only physical impairments, drug coverage comes most often through employer-based insurance (30%), although Medicaid is a close second source (25%). Both disabled groups show lower than average enrollment in Medicare managed care plans with drug benefits.

Figure 1. Sources of Prescription Drug Coverage Among Medicare Beneficiaries Throughout 1998, by Entitlement Status



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

In 1998, one of three disabled beneficiaries received drug benefits from Medicaid—through either traditional Medicaid or the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs—compared with only one of 11 of the elderly (9%).[8] More than one of 12 disabled beneficiaries (9%) obtained drug coverage through other public sources such as the Veterans Administration and state-funded pharmacy assistance programs, compared with one of 16 elderly beneficiaries (6%). Public coverage is particularly prevalent among those with mental impairments (Appendix Table A1).

Private sources of drug coverage are less commonly used by the disabled. For instance, one of four disabled beneficiaries obtained drug coverage from employer-based insurance, compared with one of three elderly beneficiaries. Fewer than 9 percent (8.8%) of the disabled had drug coverage from Medicare HMOs and less than 4 percent received any drug benefits from Medigap plans. The elderly have coverage at rates two and three times higher, respectively, from these sources of coverage.

Differences in sources of coverage among elderly and disabled beneficiaries are due in large part to differences in access to benefits. In 1998, for example, only seven of the 13 states with a state-funded pharmacy assistance program offered eligibility to disabled

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[8] National Economic Council, Domestic Policy Council. *Disability, Medicare, and Prescription Drugs.* The White House, July 31, 2000. Twenty-eight percent of the disabled had no prescription coverage in 1996, 22 percent had drug benefits from employer-based coverage, 3 percent from Medigap plans, 4 percent from Medicare managed care plans, and 43 percent from Medicaid.

persons under age 65.[9] While 11 states and the District of Columbia provided full Medicaid benefits—including drug coverage—to all Medicare beneficiaries enrolled in their QMB program and, in some cases, their SLMB+ program, the lack of such coverage in the majority of states creates particular challenges for beneficiaries with disabilities.[10]

In terms of private-sector coverage opportunities, access to individually purchased Medigap policies is guaranteed to the disabled in only nine states. Six states have guaranteed-offer laws that ensure the disabled access to standardized Medigap policies (Plans A through J), although only three of these plans (H, I, and J) include drug coverage. Three states guarantee Medicare beneficiaries with disabilities access to Medigap policies with drug coverage that existed before the standardized Medigap policies were developed.

Among all the public and private sources of drug coverage, only one—the Medicare+Choice program—provides widespread opportunities to the disabled population (Table 2). In 1998, nearly 72 percent of disabled beneficiaries lived in counties served by at least one Medicare+Choice plan, even though these plans are not available in all counties. By contrast, only 14 percent of Medicare's disabled resided in states with Medigap guaranteed-offer laws and about 20 percent in states that granted access to drug coverage through QMB/SLMB+ or state-funded pharmacy assistance programs.

Not surprisingly, drug coverage rates among disabled beneficiaries living in these states and counties appear to be higher than average, suggesting that these policies might be providing some assistance. Nearly 40 percent of the disabled living in QMB/SLMB+ states received drug benefits from Medicaid in 1998, a rate that is a third higher than that among beneficiaries living in states without such programs. State pharmacy assistance programs are one of several other public sources of prescription drug coverage for the disabled. While the MCBS does not identify the other public sources, this study's results show that, in states that have pharmaceutical assistance programs, more than 15 percent of the disabled have prescription drug coverage, compared with just 7.5 percent in states without such programs. This indicates that the programs can work to obtain coverage for the disabled. Likewise, living in counties served by Medicare+Choice plans appears consistent with having higher rates of prescription coverage, especially private coverage

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[9] According to the National Economic Council report, as of 2001, 24 states had some form of pharmacy assistance program, but only nine states offered eligibility to disabled beneficiaries. K. Fox, T. Trail, S. Crystal. *State Pharmacy Assistance Programs: Approaches to Program Design*. The Commonwealth Fund, May 2002. In 1998, the seven states with drug programs that offered eligibility to the under-65 disabled were Connecticut, Illinois, Maine, Maryland, New Jersey, Vermont, and Wyoming.

[10] P. B. Nemore. *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*. The Henry J. Kaiser Family Foundation, December 1999. The 11 states were Florida, Hawaii, Maine, Massachusetts, Mississippi, Nebraska, New Jersey, Pennsylvania, South Carolina, Utah, and Vermont.

(39.9% vs. 27.8%). On the other hand, living in a state that guarantees access to a Medigap plan appears to entail far less advantage. Whether any of these programs actually generated additional prescription coverage for the disabled population is difficult to assess without further analysis. However, the magnitude of differences associated with QMB/SLMB+ and Medicare+Choice programs strongly implies that at least these two programs have had that effect.

Prescription Use and Spending

Having reliable prescription coverage is arguably more important for the disabled than it is for the elderly, given the much higher drug utilization and expenditure rates among disabled beneficiaries. While both the disabled and elderly were about equally likely to fill at least one prescription in 1998, the average number of prescriptions filled by disabled users (34) was much higher than for elderly prescription users (25) (Table 3 and Figure 2). Mean annual prescription spending for the disabled was almost 50 percent above that for the elderly ($1,284 vs. $841). With high prescription costs and low incomes, the disabled are particularly hurt by gaps in coverage or loss of benefits. A greater number of disabled beneficiaries than seniors spent 5 percent or more of their annual income on drugs (27% vs. 22%); the proportion who spent 5 percent or more of their income was even greater among the disabled with gaps in coverage (36%) or no coverage at all (44%) (Figure 3). Of course, these disparities reflect differences in baseline income levels, as well as in drug-related health care needs.

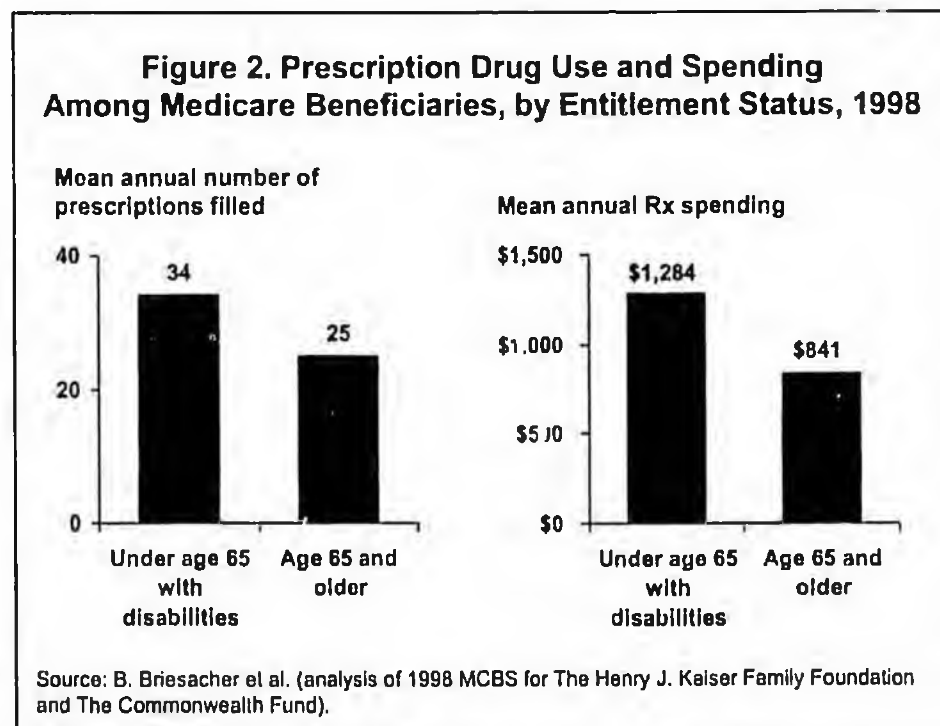
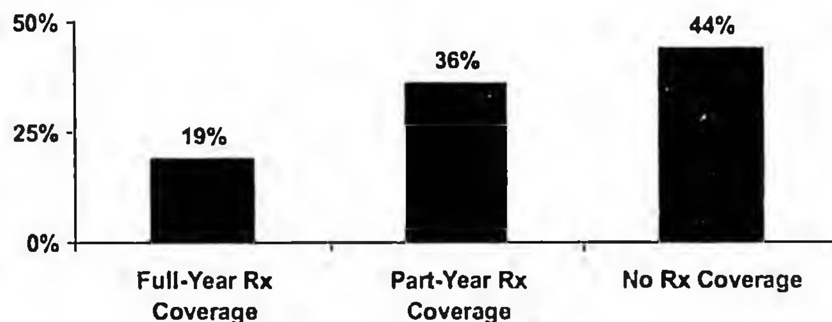


Figure 3. Out-of-Pocket Spending on Prescription Drugs as a Share of Income Among Beneficiaries Under Age 65 with Disabilities, by Drug Coverage Status

Percent of < 65 beneficiaries with disabilities spending 5 percent or more of their income on Rx

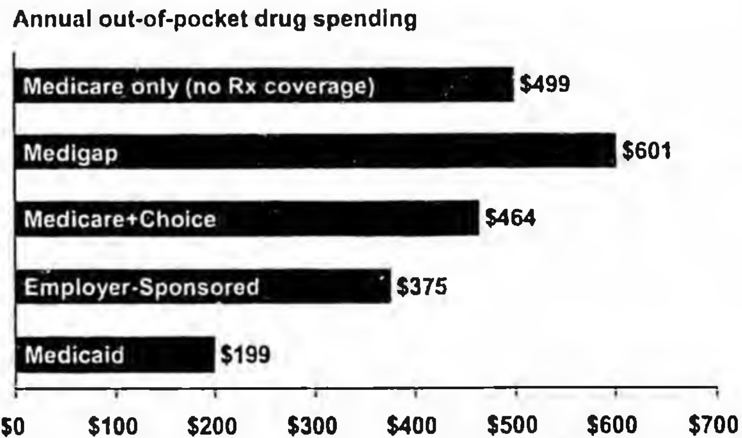


Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

As Table 3 clearly demonstrates, prescription drug coverage has a strong influence on average drug use and spending by disabled beneficiaries. While 75 percent of disabled beneficiaries without drug coverage filled at least one prescription during the year, over 90 percent of those with at least some drug coverage did so. Disabled beneficiaries without drug benefits filled 10 to 13 fewer prescriptions, on average, than those with drug benefits. As a result, mean annual prescription expenditures for the noncovered disabled are 60 to 70 percent below expenditures for those with some drug coverage. Although this may be partially attributable to the higher likelihood of disabled beneficiaries with greater prescription drug needs opting for coverage, the differences are striking and much larger than those found among elderly beneficiaries with and without drug coverage.

While prescription drug utilization among the disabled did not vary substantially by source of drug coverage, there were notable differences in out-of-pocket spending across sources of coverage (Figure 4). For instance, out-of-pocket costs for disabled beneficiaries under age 65 who had drug coverage through Medigap averaged $601—more than was paid out-of-pocket by those without coverage altogether ($499). Those with employer-sponsored drug coverage and those enrolled in the Medicaid program had average out-of-pocket drug costs of $375 and $199, respectively.

Figure 4. Out-of-Pocket Spending on Prescription Drugs Among Beneficiaries Under Age 65 with Disabilities, by Source of Drug Coverage



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

Tracing spending to the source of coverage reveals that, while the elderly pay a higher percentage of their total drug costs out-of-pocket, disabled beneficiaries actually have higher out-of-pocket costs (Table 4). Among those with drug benefits from Medicare managed care plans, disabled beneficiaries paid nearly double the amount paid out-of-pocket for medications by the elderly. Indeed, except for Medicaid beneficiaries, the disabled spent 19 to 42 percent more out-of-pocket for their prescriptions than the elderly when covered by the same types of insurance plans.

The disabled also tend to pay more, as a share of their incomes, toward drug expenses, regardless of type of coverage. Twice as many disabled as elderly beneficiaries with employer-sponsored plans or Medicare+Choice coverage spent at least 5 percent of their incomes on prescription expenses.[11] Only Medicaid offered substantial relief to the disabled in terms of keeping out-of-pocket costs low relative to income.

Because of the number and types of prescription drugs they use, as well as their lower likelihood of having generous employer-sponsored coverage, Medicare's disabled

[11] The relationship between drug coverage and drug use patterns is generally similar for mentally and physically impaired disabled beneficiaries, except for people with gaps in coverage. For the mentally impaired, those with part-year drug benefits used far fewer medications on average (29) than those with continuous full-year coverage (36) (Appendix Table A2). By contrast, disabled beneficiaries with part-year benefits and only physical impairments filled about the same number of prescriptions as those with coverage for the entire year (36 vs. 37). These patterns are difficult to explain since the generosity of part-year coverage is about the same for both groups.

beneficiaries receive considerably less protection through private sources of drug coverage than do the elderly.

Access Problems and the Need for Prescription Coverage

The disadvantages faced by the disabled described thus far translate into difficulty gaining access to needed medical care and prescription drugs. Compared with 17 percent of the elderly, over a third of the disabled population experienced at least one access problem, including: failure to fill prescribed drugs, trouble getting health care, delays in care because of cost, failure to see a physician for a health problem, and having no usual place of care (Table 5). The disabled are three to four times more likely than seniors to experience difficulties in filling prescriptions, getting care, affording timely treatment, and seeing physicians when sick. Only one measure, having a usual place of care, affects both groups similarly. Two areas are particularly problematic for the disabled: delays in medical attention because of costs and failure to see a doctor when necessary. While 18 percent of disabled beneficiaries identified each of these problems in 1998, only 4 percent of elderly beneficiaries reported delaying care because of cost and only 6 percent went without seeing a doctor even when they were experiencing a health problem.

Access problems are exacerbated for those with unstable drug coverage or no coverage at all, particularly the disabled. Disabled beneficiaries without prescription benefits are nearly three times more likely to fail to fill all of their prescriptions and more than twice as likely to delay care because of cost compared with those with full-year coverage. While about a quarter (24%) of the disabled with gaps in prescription coverage did not see a doctor when they had health problems, only 14 percent of those with continuous coverage did so. The disabled with prescription drug coverage may also have more comprehensive supplemental coverage for other benefits such as physician services, cost-sharing, and billing in excess of Medicare allowed charges. Prescription drug coverage, therefore, may be a proxy for comprehensive supplemental coverage that removes access barriers not just to prescription drugs but to other services as well. For the disabled population as a whole, the only access measure that appears to be unaffected by prescription coverage is "trouble getting health care." As with the other measures, however, the disabled on the whole experience far greater problems on this dimension than do the elderly.[12]

Commonly Used Prescriptions

Another potential issue for the disabled lies in the types of medications they typically use, which differ considerably from those used by the elderly. Table 6 presents the 10 therapeutic drug classes most commonly taken by each entitlement group.

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[12] The disabled with mental and physical impairments were quite similar in their vulnerability to access barriers (Appendix Table A4).

Psychotherapeutics rank as the most-filled drug category among the disabled (filled by 57% of this group) but rank only 10th for the elderly (23%). The disabled are also far heavier users of analgesics and central nervous system drugs than are the elderly, who are most apt to use heart medications.[13] Some policymakers have suggested tying a Medicare drug benefit to the medications most often used by seniors. If that were to happen, the data presented here suggest that the disabled would be systematically disadvantaged.

Table 1. Characteristics of Elderly and Disabled Community-Dwelling Medicare Beneficiaries, 1998

Beneficiary Characteristics	Under Age 65 Beneficiaries with Disabilities	Over Age 65 Beneficiaries
All beneficiaries	4.8 million	33.2 million
Gender		
Female	42.4%	57.5%
Male	57.6	42.5
Race		
White	74.1%	86.7%
Black	16.7	7.9
Other	9.2	5.4
Hispanic ethnicity		
Hispanic	11.3%	6.4%
Non-Hispanic	88.8	93.6
Marital status		
Married	43.9%	56.4%
Single	56.1	43.6
Income in relation to Federal Poverty Level (FPL)		
< 100% FPL	45.3%	20.0%
101%–200% FPL	31.7	32.8
> 200% FPL	23.0	47.2
Self-reported health[a]		
Excellent	4.0%	16.1%
Very good	10.7	28.8
Good	25.6	32.5
Fair	32.9	16.3
Poor	26.4	6.2

[13] Within the disabled population, cardiopulmonary medications are more commonly prescribed to those with only physical impairments, while central nervous system medications are more typical for those with mental impairments (Appendix Table A5). Psychotherapeutic use figures prominently in the medical care of both groups: eight in 10 disabled beneficiaries with mental impairments took a least one psychotherapeutic medication in 1998, compared with four in 10 with only physical disabilities. Both groups are heavy users of analgesics.

Beneficiary Characteristics	Under Age 65 Beneficiaries with Disabilities	Over Age 65 Beneficiaries
Activities of daily living[a]		
0	55.9%	74.2%
1–2	27.4	17.5
3–6	16.7	8.3
Instrumental activities of daily living[a]		
0	63.6%	84.5%
1–2	26.3	11.1
3–5	10.1	4.4
Self-reported chronic conditions[a]		
Mental disorder	36.0%	3.6%
Osteoporosis	9.9	13.4
Alzheimer's disease	1.3	2.4
Arthritis	52.3	59.7
Hypertension	46.4	55.6
Heart condition	34.8	41.3
Chronic lung disease	26.2	14.2
Cancer	19.6	31.6
Diabetes	19.1	15.9
Stroke	12.2	10.4
Number of chronic conditions[a]		
0	8.9%	9.4%
1–2	44.4	43.7
3–4	32.0	36.9
5 or more	14.7	10.0
Source(s) of drug coverage[b]		
Employer plan	24.9%	33.6%
Medicare HMO	8.8	17.2
Individual Medigap	3.8	11.6
Medicaid[c]	33.0	9.4
Other public plan[d]	8.5	6.2
Some coverage but not reported[e]	10.3	6.7
Duration of drug coverage[f]		
Full-year coverage	60.1%	58.5%
Part-year coverage	18.8	17.5
No drug coverage[f]	21.2%	24.0%

Activities of daily living include getting out of bed and being able to feed yourself; instrumental activities of daily living include using a phone, going shopping, or preparing meals.

[a] Calculated only for those beneficiaries who were interviewed on health status in the community setting.

[b] Categories are not mutually exclusive.

[c] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[d] Other public plans include such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[e] Comprises beneficiaries who reported no drug coverage yet had third-party payments for prescriptions.

[f] Calculated only for those beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table 2. Availability of Selected Drug Benefit Programs for Disabled Community-Dwelling Medicare Beneficiaries, by Payers and Duration of Drug Coverage, 1998

	Under Age 65 Beneficiaries with Disabilities							
	Lives in State with QMB/SLMB+ Entitlement[b]		Lives in State with Pharmacy Assistance Program[a]		Lives in State with Medigap Guaranteed-Offer Laws[c]		Lives in County with Medicare+Choice Plan(s)	
	Yes	No	Yes	No	Yes	No	Yes	No
All Beneficiaries	21.4%	78.6%	21.1%	87.9%	14.0%	86.0%	71.6%	28.4%
Third-party payers								
All private sources[d]	41.5%	35.0%	33.1%	36.9%	43.6%	35.3%	39.9%	27.8%
Employer	25.7	24.7	23.9	25.1	31.7	23.9	25.6	23.7
Medicare HMO	11.7	8.0	5.9*	9.2	8.5*	8.9	12.2	0.5*
Individual Medigap	5.1	3.5	3.8*	3.8	5.4	3.5	3.6	4.1
All public sources[d]	44.3	36.7	41.0	38.0	38.9	38.2	37.5	40.4
Medicaid	39.9	31.1	32.4	33.0	35.3	32.6	32.4	34.4
Other public[e]	7.9	8.6	15.5	7.5	8.6	8.4	8.3	9.0
Duration of drug coverage[f]								
Full-year	71.9%	56.9%	59.5%	60.2%	70.2%	58.4%	61.5%	56.8%
Part-year	13.6	20.2	19.0	18.7	13.4	19.7	19.8	15.8
No drug coverage[f]	14.5	22.9	21.5	21.7	16.4	22.0	18.7	27.4

* Relative standard error greater than 30 percent.

[a] Eligibility for program includes disabled beneficiaries under age 65 (CT, IL, ME, MD, NJ, VT, WY).

[b] Full Medicaid benefits, including drugs, are given to QMB/SLMB+ beneficiaries (DC, FL, HI, ME, MA, MS, NE, NJ, PA, SC, UT, VT).

[c] Includes beneficiaries under the age of 65 with disabilities in six states (KS, ME, MI, NH, OR, PA) with guaranteed-offer laws targeted to the disabled, ensuring them access to standardized Medigap policies that may include Plans H, I, and J, along with those in the three states (MA, MN, WI) that offer pre-standard Medigap policies with drug coverage to all beneficiaries.

[d] Categories are not mutually exclusive.

[e] Other public plans includes such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[f] Calculated for only those disabled beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Tabl ... welling
Medicare Beneficiaries. bv Presence and Duration of Drug Coverage, 19! [a]

Prescription Use and Spending	U ... ies with Disabilities				Over Age 65 Beneficiaries			
	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage
Beneficiaries filling at least one prescription	91.1%	95.8%	94.4%	75.0%	90.0%	92.2%	90.6%	84.2%
Mean number of prescriptions filled per year by users	33.5	36.5	32.9	23.3	24.7	26.0	25.1	20.8
Mean annual prescription drug spending	$1,284	$1,560	$1,283	$499	$841	$974	$772	$568
Mean annual prescription drug spending out-of-pocket	$388	$314	$496	$499	$379	$278	$460	$568
Percent of drug spending paid out-of-pocket	43.7%	26.4%	49.6%	100.0%	56.0%	37.1%	64.3%	100.0%
Out-of-pocket prescription drug spending as percent of annual income[b]								
0–5%	73.1%	80.7%	64.3%	55.7%	77.7%	86.3%	71.4%	59.8%
5% or more	26.9%	19.3%	35.7%	44.3%	22.3%	13.7%	28.6%	40.2%

[a] Sample consists of beneficiaries who had full-year Medicare entitlement.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table 4. Pre[illegible]nity-Dwelling Medicare Beneficiaries, by Source of Drug Coverage, 1998

Prescription Use and Spending	Under Age 65 Beneficiaries with Disabilities					Over Age 65 Beneficiaries				
	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public
Beneficiaries with no prescriptions filled	7.1%	5.5%*	5.6%	5.9%*	4.3%*	8.3%	8.3%	10.2%	11.4%	5.3%
Mean annual number of prescriptions filled by users	34.7	37.5	33.4	34.0	37.6	32.0	22.5	23.8	25.5	29.6
Mean annual prescription drug spending	$1,352	$1,247	$1,566	$1,354	$1,629	$1,004	$646	$980	$858	$1,069
Mean annual prescription drug spending out-of-pocket	$199	$464	$375	$601	$484	$179	$255	$264	$507	$393
Percent of drug spending paid out-of-pocket	21.1%	46.2%	29.4%	52.1%	41.6%	24.4%	50.2%	33.7%	64.2%	46.4%
Out-of-pocket prescription drug spending as percent of annual income[b]										
0–5%	84.2%	67.7%	79.2%	61.9%	64.5%	82.8%	86.0%	90.2%	69.9%	70.3%
5% or more	15.8%	32.3%	20.8%	38.1%	35.5%	17.2%	14.0%	9.8%	30.1%	29.7%

* Relative standard error greater than 30 percent.

[a] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table 5. Acc[illegible] nunity-Dwelling Medicare Beneficiaries, by Presence and Duration of Drug Coverage, 19[illegible] [a]

Access to Care Measure	Under Age 65 Beneficiaries with Disabilities				Over Age 65 Beneficiaries			
	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-year Rx Coverage	No Rx Coverage
Failed to fill prescribed drugs	6.4%	4.2%	7.7%	11.6%	2.2%	1.9%	2.0%	3.1%
Had trouble getting health care	9.1	8.0	12.3	9.7	2.3	2.3	3.2	1.9
Delayed care because of cost	18.4	11.8	28.3	29.0	4.2	3.0	5.3	6.0
Had health problem but did not see MD	18.1	13.9	23.7	25.5	6.1	5.7	5.7	7.3
Has no usual place for care	7.4	5.0	6.6	15.5	5.9	4.1	6.7	9.6
Any of the above access measures	35.0	27.8	43.5	49.2	16.5	14.2	18.2	21 2

[a] Sample consists of beneficiaries answering Access to Care questions of the 1998 MCBS and who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table 6. Most Commonly Filled Prescriptions for Elderly and Disabled Community-Dwelling Medicare Beneficiaries, by Therapeutic Drug Class, 1998

Therapeutic Drug Class	Under Age 65 Beneficiaries with Disabilities % (Rank)	Over Age 65 Beneficiaries % (Rank)
Cardiovascular	38.3 (3)	46.4 (1)
Cardiac drugs	33.4 (6)	40.4 (2)
Diuretics	25.9 (9)	34.2 (3)
Antiinfectives	41.5 (2)	28.1 (4)
GI preps	34.9 (5)	26.8 (5)
Hormones	30.8 (8)	24.1 (6)
EENT preps	—	23.8 (7)
Antiarthritics	31.6 (7)	23.1 (8)
Autonomic drugs	—	23.0 (9)
Psychotherapeutics	57.4 (1)	22.9 (10)
Analgesics	36.1 (4)	—
CNS drugs	22.1 (10)	—

Source: Medicare Current Beneficiary Survey, 1998.

CONCLUSION

These findings show that the disabled population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills. Yet, they have few places to turn for relief. Except for Medicaid, which serves as the major source of drug coverage for this population, the avenues by which needy disabled individuals can gain prescription coverage are heavily constrained. Few SSDI disabled are employed, which makes access to employer-sponsored coverage impossible except for those fortunate enough to have it from a previous employer or through a spouse's employer. The availability of Medicare+Choice plans has declined steadily since 1999, and there is evidence that some managed care plans may be discouraging the disabled from enrolling or inadequately serving those with more severe medical needs.[14]

Medicaid plays a pivotal role in providing services to disabled beneficiaries who have high medical costs and heavy prescription drug needs, but recent budget pressures could compromise that coverage. In 1998, elderly and disabled beneficiaries accounted for more than two-thirds of all Medicaid spending and four of five Medicaid dollars spent on prescription drugs.[15] State approaches to restoring solvency to their Medicaid budgets feature strategies designed to contain rising prescription drug costs, such as limits on the number of prescriptions that Medicaid will cover, drug formularies based on prior authorization, and increased copayments. Unless carefully designed and monitored, these policies may undermine the safety net that Medicaid provides to low-income disabled beneficiaries.

Clearly, the most effective way to protect the disabled from the high costs of prescription drugs would be for Congress to enact a comprehensive Medicare drug benefit. However, not just any drug benefit will suffice: the special needs of the disabled require explicit attention. For example, if the Medicare drug benefit were tightly crafted around the medical conditions and prescription use patterns of the elderly population, the disabled—particularly those with mental impairments—would be placed at a severe disadvantage. Mental illness is the single most common qualifying disorder for SSDI, accounting for 25 percent of all new awards, but many disabled beneficiaries also have

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[14] See M. Gold, L. Nelson, R. Brown et al. "Disabled Medicare Beneficiaries in HMOs." *Health Affairs* 16 (September/October 1997): 149–62; and M. A. Laschober, P. Neuman, M. Kitchman, et al. "Medicare HMO Withdrawals: What Happens to Beneficiaries?" *Health Affairs* 18 (November/December 1999): 150–57.

[15] J. Guyer, *The Role of Medicaid in State Budgets*, prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2001.

severe physical conditions such as seizures or paralysis that are relatively uncommon among the elderly.[16]

The high cost-sharing provisions included in most proposals for a Medicare drug benefit would also prove problematic for many disabled beneficiaries. One common provision in the last round of Medicare drug benefit proposals was 50 percent coinsurance for beneficiaries with incomes as low as 135 percent of the federal poverty level. Another feature was the so-called "hole in the donut," a corridor of unprotected coverage for mid-range prescription expenses. Such provisions would place elderly and disabled alike at risk for substantial out-of-pocket costs, but the risk is substantially greater for the disabled, who are less likely to have back-up coverage or incomes sufficient to support uncovered prescription drug purchases. In short, a Medicare drug benefit designed for the elderly will not suffice for the disabled unless their particular needs are assessed and addressed.

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[16] M. H. Davis, E. O'Brien, "Profile of Persons with Disabilities in Medicare and Medicaid." *Health Care Financing Review* 17 (1995): 179–211.

APPENDIX

In addition to comparing elderly and SSDI disabled beneficiaries, this analysis profiled differences in drug coverage, use, and cost for disabled persons with and without mental impairments. These results are presented here in a set of tables that parallel those in the main report. Evidence of mental impairment was drawn from two main sources derived from protocols developed by Rosenbach (1995), including the primary or secondary cause of disability entitlement and self-reported health conditions.[17] During the health status section of the MCBS interview, disabled respondents are asked whether they have ever had any of 30 medical conditions (including three questions about mental impairments, mental disorder, mental retardation, and Alzheimer's disease) and if these conditions caused their disability entitlement. Both entitlement cause and self-reported conditions are necessary for identifying mental impairments, since approximately 25 percent of the disabled sample list "other reason" or no recorded cause of entitlement. Included in this group are beneficiaries who answered the facility version of the survey, which includes additional mental condition indicators: mental disorder, Alzheimer's disease, manic depression, depression, dementia, and schizophrenia. Using these criteria, the authors classified 1,887 disabled MCBS respondents into two groups: those with evidence of mental impairment (882) and those with other impairments (1,005).

Appendix Tables A1 through A5 present the findings from this analysis. Although those with mental impairments and those with physical impairments both depend heavily on medications, those with mental impairments are at a substantial economic disadvantage, making access to publicly funded drug coverage especially critical. The share of beneficiaries under the age of 65 with disabilities living in poverty rises to a majority (58%) for those with mental impairments (including those with physical impairments as well), compared with 37 percent of those with physical impairments only. There are surprising similarities between those with mental impairments and those with physical impairments in terms of burden of illness. Disabled beneficiaries with physical impairments only most commonly suffer from arthritis (59%), hypertension (50%), and heart conditions (39%). Nearly as many of those with mental impairments suffer from the same physical conditions (e.g., 42% have arthritis and 40% have hypertension).

The two groups did differ in their sources of prescription drug coverage, however. Only a quarter (24%) of disabled beneficiaries with mental impairments had their drug insurance from employers or Medicare HMOs, compared with 41 percent of those with

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[17] M. Rosenbach. "Access and Satisfaction Within the Disabled Medicare Population." *Health Care Financing Review* 17 (1995): 147–67.

physical impairments only (Table A1). While mean drug use was about the same for both groups (33 vs. 34 prescriptions per year), out-of-pocket costs vary, with those with mental impairments having considerably lower out-of-pocket spending than those with physical impairments alone ($337 vs. $425) (Table A2). Finally, the vast majority of disabled beneficiaries with mental impairments take psychotherapeutic agents (80%), while the most commonly filled prescriptions among beneficiaries with physical impairments alone are cardiovascular medications (filled by 47% of this group) (Table A5).

Table A1. Characteristics of Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type, 1998

Beneficiary Characteristics	Disabled with Mental Impairment(s)*	Disabled with Physical Impairment(s) Only
All beneficiaries	1.1 million	3.7 million
Gender		
Female	42.4%	42.4%
Male	57.6	57.6
Race		
White	77.4%	72.0%
Black	13.1	19.2
Other	9.6	8.9
Hispanic ethnicity		
Hispanic	11.3%	11.2%
Non-Hispanic	88.7	88.8
Marital status		
Married	29.2%	54.0%
Single	70.8	46.0
Income in relation to Federal Poverty Level (FPL)		
< 100% FPL	57.9%	36.6%
101%–200% FPL	25.7	35.8
> 200% FPL	16.4	27.6
Self-reported health[a]		
Excellent	6.5%	2.4%
Very good	12.9	9.1
Good	27.7	24.2
Fair	30.1	34.8
Poor	22.6	28.9
Activities of daily living[a]		
0	64.4%	50.2%
1–2	21.4	31.4
3–6	14.2	18.4

Beneficiary Characteristics	Disabled with Mental Impairment(s)*	Disabled with Physical Impairment(s) Only
Instrumental activities of daily living[a]		
0	58.4%	67.1%
1–2	29.9	23.9
3–5	11.7	9.0
Self-reported chronic conditions[a]		
Mental disorder	89.4%	0.0%
Osteoporosis	8.4	10.9
Alzheimer's disease	3.2	0.0
Arthritis	42.1	59.2
Hypertension	40.3	50.4
Heart condition	29.1	38.7
Chronic lung disease	24.5	27.3
Cancer	16.6	21.6
Diabetes	14.3	22.3
Stroke	11.0	12.9
Number of chronic conditions[a]		
0	4.3%	12.0%
1–2	45.9	43.5
3–4	30.9	32.7
5 or more	19.0	11.9
Source(s) of drug coverage[b]		
Employer plan	17.0%	30.4%
Medicare HMO	6.6	10.4
Individual Medigap	4.0	3.7
Medicaid[c]	44.6	25.0
Other public plan[d]	11.0	6.7
Some coverage but not reported[e]	9.3	11.0
Duration of drug coverage[f]		
Full-year coverage	60.7%	59.6%
Part-year coverage	18.4	19.1
No drug coverage[f]	21.0%	21.3%

* Includes those with only mental impairments as well as those with both mental and physical impairments.

Activities of daily living include getting out of bed and being able to feed yourself; instrumental activities of daily living include using a phone, going shopping, or preparing meals.

[a] Calculated for only those beneficiaries who were interviewed on health status in the community setting.

[b] Categories are not mutually exclusive.

[c] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[d] Other public plans includes such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[e] Comprises beneficiaries who reported no drug coverage yet had third-party payments for prescriptions.

[f] Calculated for only those beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table A2. Prescription Drug Use and Spending for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Presence and Duration of Drug Coverage, 1998[a]

Prescription Use and Spending	Disabled with Mental Impairment(s)*				Disabled with Physical Impairment(s) Only			
	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage
Beneficiaries filling at least 1 prescription	89.5%	94.1%	94.1%*	71.8%	92.3%	97.1%	94.2%**	77.3%
Mean annual number of prescriptions filled by users	32.7	36.4	28.7	23.5	34.0	36.6	35.8	23.1
Mean annual prescription drug spending	$1,217	$1,481	$1,159	$506	$1,332	$1,619	$136	$495
Mean annual prescription drug spending out-of-pocket	$337	$244	$450	$506	$425	$367	$528	$495
Percent of drug spending paid out-of-pocket	40.8%	22.7%	48.7%	100.0%	45.8%	29.0%	50.3%	100.0%
Out-of-pocket prescription drug spending as percent of annual income[b]								
0–5%	74.1%	82.1%	66.8%	52.6%	72.5%	79.7%	52.5%	57.8%
5% or more	25.9%	17.9%	33.2%	47.4%	27.5%	20.3%	37.5%	42.2%

* Includes those with only mental impairments as well as those with both mental and physical impairments.

** Relative standard error greater than 30 percent.

[a] Sample consists of beneficiaries who had full-year Medicare entitlement.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table A3. Prescription Drug Use and Spending for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Source of Drug Coverage, 1998

Prescription Use and Spending	Disabled with Mental Impairment(s)*					Disabled with Physical Impairment(s) Only				
	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public
Beneficiaries with no prescriptions filled	7.3%	13.9%**	5.5%**	7.4%**	6.0%**	6.8%	1.8%**	5.7%**	4.8%**	2.4%**
Mean annual number of prescriptions filled by users	33.6	36.5	35.2	34.2	36.5	36.1	37.9	32.6	33.9	38.8
Mean annual prescription drug spending	$1,365	$1,216	$1,481	$1,526	$1,421	$1,337	$1,261	$1,598	$1,227	$1,861
Mean annual prescription drug spending out-of-pocket	$173	$477	$400	$407	$382	$231	$458	$365	$744	$597
Percent of drug spending paid out-of-pocket	20.0%	42.9%	33.3%	42.7%	42.8%	22.4%	47.5%	28.0%	58.8%	40.2%
Out-of-pocket prescription drug spending as percent of annual income[b]										
0–5%	84.0%	60.6%	79.5%	72.5%	60.3%	84.5%	70.4%	79.1%	54.4%	69.0%
5% or more	16.0%	39.4%	20.5%	27.5%	39.7%	15.5%	29.6%	20.9%	45.6%	31.0%

* Includes those with only mental impairments as well as those with both mental and physical impairments.

** Relative standard error greater than 30 percent.

[a] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Beneficiaries with Disabilities by Disability Type and Presence and Duration of Drug Coverage, 199[illegible][a]

Access to Care Measure	Disabled with Mental Impairment(s)*				Disabled with Physical Impairment(s) Only			
	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage
Failed to fill prescribed drugs	6.5%	5.1%	8.1%	9.8%	6.2%	3.5%	7.4%	12.9%
Had trouble getting health care	11.9	10.9	12.7	14.3	7.0	5.7	11.[illegible]	6.5
Delayed care because of cost	19.7	15.8	22.8	29.5	17.4	8.7	32.3	28.7
Had health problem but did not see MD	18.8	17.2	20.6	22.6	17.5	11.4	26.0	27.4
Has no usual place for care	8.9	6.6	9.7	15.6	6.3	3.7	4.3	15.4
Any of the above access measures	37.0	33.7	38.8	46.1	33.6	23.1	46.9	51.4

[a] Sample consists of beneficiaries answering Access to Care questions of the 1998 Medicare Current Beneficiary Survey and who had full-year Medicare entitlement.

* Includes those with only mental impairments as well as those with both mental and physical impairments.

Source: Medicare Current Beneficiary Survey, 1998.

Table A5. Most Commonly Filled Prescriptions for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Therapeutic Drug Class, 1998

Therapeutic Drug Class	Disabled with Mental Impairment(s)* % (Rank)	Disabled with Physical Impairment(s) Only % (Rank)
Cardiovascular	27.0 (5)	46.8 (1)
Cardiac drugs	18.8 (10)	44.6 (3)
Diuretics	—	35.0 (9)
Antiinfectives	36.1 (2)	45.5 (2)
GI preps	26.1 (7)	41.5 (5)
Hormones	21.2 (8)	38.1 (7)
EENT preps	20.8 (9)	20.9 (10)
Antiarthritics	26.9 (6)	35.1 (8)
Autonomic drugs	—	—
Psychotherapeutics	79.6 (1)	39.6 (6)
Analgesics	28.8 (4)	41.7 (4)
CNS drugs	30.7 (3)	—

* Includes those with only mental impairments as well as those with both mental and physical impairments.

Source: Medicare Current Beneficiary Survey, 1998.

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#544 *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources* (August 2002). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this policy brief, the authors suggest that a modest Medicare prescription drug benefit could be crafted that provides some coverage to all beneficiaries while protecting those with low-incomes and high out-of-pocket expenses.

Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap? (July 31, 2002). Dana Gelb Safran, Patricia Neuman, Cathy Schoen, Jana E. Montgomery, Wenjun Li, Ira B. Wilson, Michelle S. Kitchman, Andrea E. Bowen, and William H. Rogers. *Health Affairs* web exclusive. Article available online only at http://www.healthaffairs.org/WebExclusives/Safran_Web_Excl_073102.htm.

Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States (July 2002). Michelle Kitchman, Tricia Neuman, David Sandman, Cathy Schoen, Dana Gelb Safran, Jana Montgomery, and William Rogers. Copies of this report (#6049) are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533, http://www.kff.org.

#530 *State Pharmaceutical Assistance Programs: Approaches to Program Design* (May 2002). Kimberley Fox, Thomas Trail, and Stephen Crystal, Rutgers Center for State Health Policy. State pharmacy assistance programs for Medicare beneficiaries help only a small proportion of the Medicare population—just 3 percent, or 1.2 million beneficiaries out of 39 million nationwide. According to the authors, a federal program is needed to fill this gap in coverage, and it should coordinate with the 23 state programs currently in place.

#538 *A Medicare Prescription Drug Benefit: Focusing on Coverage and Cost* (April 2002). Juliette Cubanski and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, discusses the significant policy challenge of designing an effective and politically viable Medicare prescription drug benefit. Available online only at www.cmwf.org.

#537 *Medicare Managed Care: Medicare+Choice [illegible] Years* (April 2002). Colleen L. Barry and Janet Kline. This issue brief, prepared for the [illegible] Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, examines trends in enrollment, benefits and premiums, plan payments, and satisfaction and quality in Medicare+Choice. Available online only at www.cmwf.org.

#533 *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002* (March 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. In this report (available on the Fund's website only), the authors note that while increases in monthly premiums will affect all enrollees in 2002, sicker beneficiaries will bear the brunt of changes in the structure of prescription drug benefits and cost-sharing requirements as more plans restrict drug coverage to generics only and raise cost-sharing requirements for services such as inpatient and outpatient hospital care.

Testimony on Proposed SeniorCare Program
Marie Darlin, Coordinator
AARP Capital City Task Force

Alaska House of Representatives
Finance Committee
January 20, 2004

Good Afternoon, Co-Chairs and Committee Members. My name is Marie Darlin and I am a volunteer with AARP Alaska. I serve as the Coordinator of our Capital City Task Force. AARP has over 76,000 members in Alaska.

As you know, 2003 was a difficult year for many older Alaskans, particularly for those of us over age 72. We made our financial plans for retirement based on our Social Security, savings and investments, pensions for some of us, and the Alaska Longevity Bonus.

We have to plan our budgets and watch our expenses carefully. Most of us are not going to be able to return to the work force if we find we have not planned well financially. "What we have is what we've got".

When the Governor eliminated the Longevity Bonus, it hurt many of us in the pocketbook.

In addition, as we age we also take more prescription drugs. ~~Unfortunately, those same prescription drugs that help us deal~~ with ~~chronic illnesses~~ have also ~~been increasing~~ in costs at rates much ~~higher than normal inflation~~. According ~~to the Kaiser Family Foundation~~ some sources, prescription drug increases in Alaska are higher than in any other state.

The loss of the Longevity Bonus compounded with the disproportionately high increases in prescription medications over the past few years have forced many older Alaskans to rethink how they can manage their retirement budgets.

Although the Senior Assistance Program did not replace the Longevity Bonus, it does help over 7,000 of our lowest income older Alaskans determine how to pay their day to day costs, especially for prescription drugs.

Congress has passed and the President has signed the federal Medicare prescription drug bill which will take effect on January 1, 2006. Although not perfect, this bill will significantly help an estimated 23,000 older Alaskans ~~who are below 150% of the federal poverty level~~. However, implementation is two years away.

The proposed SeniorCare program will help during ~~that~~ This two year period. Older Alaskans who are eligible will be able to choose between continuing to receive a monthly Senior Assistance Program check of $120 or, if they have high prescription drug costs, participating in the Alaska SeniorCare prescription program which will give them drug coverage equivalent to $133 monthly.

SeniorCare will also also provide a maximum of $1,000 prescription drug coverage annually to older eligible Alaskans who fall between 135% and 150% of the federal poverty level. These

individuals have not been eligible for the Senior Assistance Program but many of them have high prescription drug costs. DHSS estimates that there are 2,200 older Alaskans in this category.

I want to emphasize that any financial assistance to help older Alaskans cope with escalating prescription drugs costs will be welcome.

We know there are still specific details to work out concerning enrollment, subsidy arrangements, etc. and we will be glad to work with you, our elected officials, and the administration to assure that the system is "user-friendly".

The SeniorCare proposal also includes two additional staff for a Senior Information Office. Access to information is critical for older citizens and family members who may be caregivers. AARP welcomes the two new staff positions but we also recognize that the Alaska senior population is growing…and growing…and growing. The number of families providing some type of assistance to older family members is also growing. I am sure many of you have this situation in your own families. It is a significant challenge to be able to render helpful information to an individual asking about help for an aging-related problem in Kake or Sutton, Clam Gulch or Kipnuk. Some of these questions are pretty hard to resolve in the middle of Anchorage and Fairbanks. Our only caution is that this is just a first step. Many people who will be calling for assistance will just need to know a local doctor that accepts Medicare or the location of the senior center. Others will be agonizing over a parent with worsening Alzheimer's or they have just been notified that their spouse is being discharged and they have no idea how to take care of him at home. These staff will need to know what services are available in Glennallen and Delta Junction. They will be asked if a particular assisted living facility in North Pole is "any good." Delivering quality

Delivering quality service for senior information is a tough job. This is an area that will only grow as our population continues to age.
AARP strongly supports the third part of the SeniorCare program: the Preferred Drug List, or PDL, for Medicaid.

Most countries, the Veteran's Administration, the Indian Health Service, more than half of the states, and many private employers utilize some form of a "preferred drug list." It doesn't make sense to pay for a more expensive drug when a less costly medication is available that is just as if not more effective. The prescription program under SeniorCare will also use the Preferred Drug List. We think this makes sense for consumers as well as for the State and will result in the use of the most effective therapeutic medications as well as those at the lowest cost.

I would offer one final comment. When we first heard about the SeniorCare proposal, our first question was "how will we pay for it?" AARP members are parents and grandparents. We want to be certain that we are not supporting a new benefit for older persons that will result in a decrease in funding for a neo-natal program. We are all in this together. We are all Alaskans, no matter what our age.

Thank you.

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