

Statement of

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before the

SENATE FINANCE COMMITTEE

on

**FINDING THE RIGHT FIT: MEDICARE, PRESCRIPTION DRUGS,
AND CURRENT COVERAGE OPTIONS**

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Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today on behalf of the nation's Governors.

Prescription Drug Coverage for Seniors

One of the most critical responsibilities we have is to protect and improve the health of our nation's citizens. To this end, the Medicare and Medicaid programs have been tremendously successful. Seniors are more likely to have health insurance coverage than any other group, and, together with Social Security, Medicare and Medicaid have drastically reduced the number of seniors living in poverty. In addition, they have given American families the assurance that they will not have to bear by themselves the burden of illness of their elderly or disabled parents or other family members.

Despite Medicare's success, the program faces enormous challenges. The benefits package simply does not meet the health care needs of seniors today. There is no comprehensive long-term care benefit, no real focus on preventive health and wellness, and as we will discuss today, no comprehensive outpatient drug benefit either. For the 5.4 million seniors fully eligible for both Medicaid and Medicare (dual eligibles), Medicaid provides coverage for all of their pharmaceutical needs. Other seniors receive drug coverage through Medicare+Choice plans, Medigap, employer-sponsored retiree coverage, state-funded assistance programs, or through costly out-of-pocket expenditures.

Any consideration of adding a prescription drug benefit to the Medicare program must recognize that states have shouldered much of these costs for years through Medicaid and state assistance programs, while these costs should have been borne by the federal Medicare program. If a drug benefit is added to Medicare, it should be administered through the Medicare program, not merely delegated to the states to administer on behalf of the federal government.

States have gained valuable lessons in providing drug benefits for Medicaid beneficiaries and would share best practices with the Health Care Financing Administration (HCFA) in making coverage decisions, negotiating rates, and contracting with pharmacy benefits managers.

For low-income Medicare beneficiaries, Medicaid fills the gaps in Medicare coverage by providing assistance for Medicare premiums and cost-sharing expenses and by covering the costs of outpatient prescription drugs and long-term care. Medicaid serves not only low-income Medicare beneficiaries but also higher income Medicare beneficiaries as well, who turn to Medicaid after exhausting their own resources to pay for their care.

Moreover, because Medicaid's role in providing coverage for these individuals is supplementary to Medicare, states are in an untenable position. States share the responsibility for providing coverage but lack any way to affect the policies that govern Medicare or to manage the up-front primary and acute care treatment decisions that drive beneficiaries' use of long-term care services and Medicaid spending. Governors ask that you remember the interrelation of the two programs and consider the potential implications for Medicaid before proposing changes to Medicare.

Since 1988, the federal government has increasingly passed on to the states the responsibility to cover the cost-sharing burdens of many low-income Medicare beneficiaries {e.g., the Qualified Medicare Beneficiary (QMB) Program, the Specified Low-Income Medicare Beneficiary (SLMB) Program, and the new groups of beneficiaries created by the Balanced Budget Act of 1997 (BBA) -- the Qualifying Individuals (QI)}. The nation's Governors want to ensure that elderly beneficiaries receive the best possible care and are committed to providing the highest quality of services to seniors who are eligible for Medicaid benefits. But for the QMBs and SLMBs and other groups, Congress should recognize that the strength and responsibility of the

Medicaid program is in providing high quality services, not in cutting checks. The Governors would therefore recommend that the patchwork of eligibility categories that provide only cost-sharing assistance be streamlined, simplified, and fully federalized.

Medicaid

Enacted at the same time as Medicare in 1965, and authorized under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program financed by state and federal governments and administered by the states. ~~There are variations in income eligibility thresholds and coverage among the states, depending on what criteria each state establishes.~~ Within broad national guidelines established by the federal government, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for such services; and administers its own program.

Since its enactment, Medicaid has changed and expansions require coverage for many groups, including the elderly up to 120 percent of poverty. It now covers more Americans than Medicare or any health insurer. It funds care for 1 in 8 Americans, 1 in 4 children, 40 percent of the births in the entire country, and approximately one-half of nursing home care. In 1990, Medicaid covered 28.9 million people. Due in large part to many state expansions, more than 41 million Americans received services through Medicaid in 1999 at a total cost exceeding \$200 billion.

Medicaid expenditures for prescription drugs almost doubled in the years between 1993 and 1998, rising from \$8 billion to almost \$14 billion, despite a marked decrease in the total number of beneficiaries utilizing prescription drugs (from 24 million to 19 million) over the same period. Over that period, the average drug expenditures per beneficiary increased from \$333 to \$699 per year. Prescription drug expenditures, at approximately 10 percent, represent the third largest component of the Medicaid budget, behind hospitals and nursing homes, and expenditures are increasing at approximately 18 percent per year.

Medicaid Drug Rebate Program

Under current Medicaid law, coverage of prescription drugs is an optional service. All states have elected to cover prescription drugs and in order to do so, must abide by the rules of the rebate program. Basically, the program provides an incentive for states by requiring the drug companies to offer discounts to the states on prescription drugs. In return, states are essentially obligated to cover all prescription drugs developed by the major drug companies and approved by the Food and Drug Administration (FDA).

Because Medicaid is an “all-or-nothing” program, every individual on the program is entitled to receive the drug benefit. Medicaid will reimburse for essentially any pharmaceutical prescribed by a physician with little or no cost-sharing requirement on the part of the beneficiary. There is a brief list of prescription drugs that states are not required to cover (hair growth, smoking cessation, weight loss/gain, fertility, etc.), and some states have implemented limits on the number of prescriptions per month that are available.

There are increasing concerns from some state Medicaid agencies that the Drug Rebate Program no longer adequately meets the needs of state Medicaid programs. Considering the rapid growth already happening in prescription drug costs and the changes that will happen in the health care system as the baby boom generation ages, it is clear that some changes in the program will help states better manage the pharmaceutical benefit. One of the biggest concerns is that in the more than ten years since the enactment of the Drug Rebate Program into law, final regulations on the program have never been promulgated. The absence of effective, enforceable final regulations creates uncertainty for federal and state policymakers in assessing how well the program works, how best to resolve disputes over prices and rebates, and the full range of cost-control options available under the law.

Dual Eligibles

Although states play a key role in funding the services provided to many low-income seniors, the most evident connection between Medicare and states is for individuals eligible for both Medicare and Medicaid coverage. Approximately 15 percent of Medicare beneficiaries also are eligible for Medicaid. These dually eligible beneficiaries, however, account for 30 percent of all Medicare spending, or about \$62 billion in fiscal 1997.

Dually eligible beneficiaries also are an expensive population for Medicaid programs. Although they account for only 16 percent of Medicaid recipients, dual eligibles account for 35 percent of Medicaid expenditures, or about \$58 billion in fiscal 1997.

Dually eligible beneficiaries are a particularly vulnerable and high-cost group. Compared with other Medicare beneficiaries, dual eligibles are more likely to suffer from chronic illness and require significant long-term care and social support services. They also are more likely to live alone or in a nursing facility and are less likely to have a living spouse. Of course, dually eligible beneficiaries are much poorer, on average, than other Medicare beneficiaries, with 80 percent of dual eligibles having annual incomes of less than \$10,000.

Dually eligible beneficiaries also are different from other Medicare beneficiaries in another, very important way: they do not have the same financial incentive to choose among fee-for-service and managed care options, based on differences in price and benefits, because Medicaid programs cover their out-of-pocket costs and provide comprehensive coverage. National data show that dual eligibles are 75 percent less likely than other Medicare beneficiaries to enroll in managed care plans.

The majority of the 6 million dually eligible beneficiaries, about 5.4 million, receive full Medicaid coverage. Medicaid provides coverage for their Medicare premium and cost-sharing expenses and for services not covered by Medicare, including long-term care and outpatient prescription drugs.

The remaining 600,000 beneficiaries are not eligible for full Medicaid coverage but do receive Medicaid assistance for Medicare premiums and/or cost-sharing expenses. They include individuals with incomes up to 120 percent of the federal poverty level (i.e. QMBs and SLMBs) and, at least through 2002, individuals with incomes between 120 percent and 175 percent of the poverty level (QIs).

Not included in these population figures are low-income Medicare beneficiaries who are eligible for Medicaid coverage but who decide to forgo such assistance or who are not aware that assistance is available. States have been criticized for failing to enroll 100 percent of eligible seniors in these programs. Although states take their responsibilities seriously and are working with HCFA to identify effective outreach methods, in many cases, the cost of outreach exceeds the value of the benefit to the individual. It simply is not worth the effort for many seniors to apply for federal assistance to receive as little as \$1.07 per month.

Allowing the Social Security Administration or some other federal agency to provide assistance to these beneficiaries would streamline a cumbersome system and ensure greater program participation. This common-sense solution would help reverse the trend of creating a patchwork of optional and mandatory eligibility categories that is confusing to both caseworkers and beneficiaries. It would also recognize that the strength of the Medicaid program is in providing vital health care services to low-income beneficiaries, not in cutting checks for a few dollars each month.

Lessons

In order for a Medicare prescription drug benefit to maximize its potential, there are a number of key lessons to be learned.

- If a universal benefit is created within the Medicare program, it must be a truly federal benefit. Although states have picked up an increasing share of the burden through Medicaid and state-only programs, these are “band-aids” and should not be viewed as an alternative to a comprehensive Medicare benefit. States have borne the costs of the federal responsibility in this area for many years and should not be penalized by maintenance of effort provisions, either in Medicaid or in the state-funded assistance programs.
- To the extent that full or partial subsidies for the low-income are created or enhanced, it is critical that they be federally financed. Otherwise, any benefit that relies on recipient cost sharing will simply be a cost-shift to the Medicaid program, which finances all forms of cost sharing for dual eligibles. To the extent to which states are required to administer a subsidy program, 100 percent federal financing should be provided not only for the cost of the benefit, but also for the cost of its administration.
- There must be the ability for the federal government to negotiate on the basis of price (or to be able to contract with entities that can). Although imposing price controls is an extreme measure that would be controversial, there must be recognition that the volume of drugs purchased under Medicare should drive the market price down to an affordable level.
- The key to an effective pharmaceutical benefit is management. Whether this is disease-specific management for conditions like diabetes or general case management for seniors who take multiple prescriptions, this tool clearly improves health outcomes and reduces waste and misuse.
- Aggressive utilization review is extremely important in reducing inappropriate prescribing. Reviews on the front end, such as prior authorization or on the back end, such as a comprehensive drug utilization review board, are vital to ensuring that physicians are prescribing and seniors are receiving the most appropriate medications.
- Almost unheard of in 1965, prescription drugs are now as important to seniors’ health as hospital coverage and physician services. With the increasing importance of both pharmaceuticals and the pharmaceutical industry, any decisions about coverage and costs will be highly visible and highly politicized.
- It is critical for Medicare to utilize an effective information system. With the right hardware and software in place, pharmacists can have enough information at their fingertips to know which doctors are prescribing which drugs for each patient; to be able to do real-time prior authorization; and to be able to prevent contraindications from drug interactions. A well-trained, well-equipped pharmacist is critically important to the smooth operation of a drug benefit.
- Because there is likely to be too little money in the system to provide all drugs for all beneficiaries, and there are legitimate concerns about subsidizing certain types of drugs, some choices will need to be made about coverage. The Medicaid program allows states to deny coverage for certain drugs, such as those used for hair growth, weight loss/gain, fertility, and smoking cessation. This list is appropriate as a model for Medicare but should also contain provisions for dealing with so-called “lifestyle drugs.” With limited budgets, government programs should be focused on providing medically necessary treatments. Therefore additional provisions need to be incorporated to allow the program to target resources on necessary treatments.
- If a voluntary benefit is created within the Medicare program, there must be a mechanism to allow states to require enrollment for individuals dually eligible for Medicare and Medicaid. Dual eligibles currently have 100 percent of their out-of-pocket costs paid for by the Medicaid program, and there is no incentive for them to enroll in a voluntary drug benefit. This is also true for any aspect of the

program that relies on fiscal incentives or market decisions to influence beneficiary behavior.

I thank you again for the opportunity to be a part of this hearing. I look forward to answering any questions