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Ethics Journal of the American Medical Association
July 2005, Volume 7, Number 7

Policy Forum

The Medicare Prescription Drug Law: Implications for Access to Care

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The Medicare Modernization Act (MMA) of 2003 provided the largest benefit expansion in Medicare's history. Since its beginning in 1965, Medicare has never covered prescription drugs. Medicare recipients have had to seek drug coverage from a variety of other sources, including the joint federal/state Medicaid program which serves low-income individuals. But under the MMA, elderly and disabled participants will be able to obtain coverage for outpatient prescription drugs beginning in January 2006 through Medicare Advantage or private stand-alone drug plans. General skepticism about the adequacy of the benefit conferred through the newly enacted "Medicare Part D," however, has raised the question of whether it really improves the elderly's access to prescription drugs.

Medicare Part D, which includes government subsidies for prescription drug coverage and guaranteed ability to enroll, will no doubt be helpful to some. The new law will effectively result in the government's paying 75 percent of the cost of a benefit that will, in turn, cover about half of all drug costs for those who enroll. But since the drug benefit is not fully comprehensive, its overall impact will be mixed. How much it will improve the situation for a given Medicare beneficiary will depend on that individual's income and secondary insurance coverage.

Those who currently have no private supplemental coverage and are spending high amounts on drugs will be better off under the new Medicare plan. Individuals who now purchase prescription drug coverage through private supplemental plans (known as "Medigap") are also likely to benefit. Premiums for the Medigap plans that cover prescription drugs average about \$2300 to \$2700 per year, of which approximately \$700 to \$1100 goes towards prescription drug coverage [1]. Medicare Part D offers better coverage than these Medigap plans for half the cost of the Medigap premiums.

People who are eligible for low-income subsidies established through the MMA but whose incomes are too high to be eligible for Medicaid will also have generous coverage that they otherwise could not afford. That is, in many states eligibility for Medicaid protection is limited to people with incomes below 74 percent of the federal poverty level. The low-income subsidies, on the other hand, extend to those with incomes up to 150 percent of the poverty level. Thus, individuals with incomes ranging from about \$7000 to \$14 000 will have access to a good drug benefit.

But others may not benefit as much from the new law. Those whose incomes and assets place them just above the threshold for the low-income subsidies are unlikely to

be able to afford the Part D premiums and copays and may choose to forgo coverage. For example, a person who makes \$14 000 per year (approximately 150 percent of the federal poverty level) must spend \$670 up front on the annual premium and deductibles before being able to take advantage of Medicare Part D. For many in this income range, these fees would constitute a significant financial burden.

Finally, 2 groups may actually be *disadvantaged* by this new legislation. First, those with generous supplemental retiree coverage may lose their private drug benefits or see them reduced. Employer-sponsored retiree insurance has been declining for a number of years, and there is concern that employers may decide to substitute Medicare Part D for the prescription drug benefits they currently offer, or drop drug coverage altogether. In fact, to minimize occurrence of the latter, the MMA legislation includes subsidies for employers who offer coverage at least as generous as that offered by Medicare. So, some companies may be able to reduce their coverage and still receive subsidies for what they do offer. It will be difficult, however, to sort out whether changes that occur in retiree plans are a result of a longstanding trend or specifically induced by the new legislation.

Those likely to be the most disadvantaged by the new law are those known as dually eligible beneficiaries, the 6.4 million Medicare recipients, who currently receive prescription drug coverage through Medicaid. Because Medicare has never before covered prescription drugs, Medicaid has paid for the medication costs for this population. In 2006, this group will have to switch from Medicaid to Medicare Part D plans in order to continue receiving prescription drug benefits, but may face decreased benefits and higher payments under the new plan.

Medicare Part D offers generous subsidies and coverage for those who are dually eligible, but it establishes copays that are generally higher than what many states currently require members of this group to pay. Specifically, at least 11 states do not currently charge a copay, and 13 states have copayments lower than the established Part D levels. Thus, dually eligible beneficiaries residing in these states who represent 3.9 million people or 63 percent of all full benefit, dually eligible beneficiaries are likely to see increases in their out-of-pocket costs for prescription drugs.

Private drug plans that participate in Medicare Part D have considerable flexibility in deciding which medications to cover and are only required to cover 2 drugs in each “therapeutic class.” In contrast, Medicaid currently provides access to a wide and comprehensive list of drugs, and states cannot deny coverage for medications that are deemed medically necessary. Consequently, those with dual eligibility may find themselves unable to obtain needed medications that are not included in their Part D plan’s formulary. The only way to acquire medications not included is to shift to a new plan or to file and win an appeal—a complicated process that may be difficult for participants to navigate.

Historically Medicaid programs have been able to supplement coverage gaps in Medicare benefits, but the MMA now specifically prohibits states from using federal matching payments to supplement Part D coverage for full benefit dually eligible

beneficiaries [2]. States may supplement Part D benefits using their own funds, although they are not obligated by law to do so. Given the tight fiscal situations that many states are in and the pressures to cut the growth in Medicaid spending, many state officials have signaled that they are unlikely to supplement Part D plans [3]. Adding prescription drugs to the Medicare benefit package has been a controversial issue for a long time. The overall inadequacy of the benefit package is a result of an attempt to keep costs down. Thus, the protections afforded are not as well-designed as they could be, leaving some groups with continued drug affordability problems while creating some new problems that do not exist under the current system. Ultimately, if we want Medicare to be a comprehensive and high quality health insurance, then we have to be willing to finance it adequately.

References

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2. Sec. 103(c) / 1935(d)(1). *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*. Available at: www.cms.hhs.gov/medicarereform/MMAactfulltext.pdf. One exception is that states can use matching funds for certain drugs that Part D plans are not required to cover.
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