

Low-Income Medicare Beneficiaries: How the Reform Bills Address Their Drug Need September 5, 2003

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ED HOWARD: Good afternoon. Excellent new microphones, so there's no excuse for you not paying attention. I'm Ed Howard with the Alliance for Health Reform on behalf of the alliance chairman Jay Rockefeller and Vice Chairman Bill Frist and the other board members, thank you for coming. I'd like to welcome you here. We're here to discuss the Medicare plans being discussed by the House and the Senate and how each of those would affect some of the most vulnerable Americans, so-called dual eligibles, those who are eligible under both Medicare and Medicaid. As you will hear, often, this afternoon not all duals are treated the same either under current law or under the two versions of Medicare Prescription Drug Reform Legislation that have passed the respective houses. So, that's true both with respect to the mechanism used to help them, and in the amount of help that's being offered. Today we're going to explore those differences, try to understand the reasoning behind the two approaches, the potential impact not only on Federal and State Governments, but primarily on the dual eligibles themselves. I've got a word of caution here, unlike most of our briefings you're going to here a lot of acronyms and initials this afternoon. It's a complicated world we're about to delve into, and if you don't know what a SLIMBY or a QUIMBY or a QI-1 is, we hope that you will by the end of the afternoon. There is in your materials, I think is salmon colored, a reprint of some material from CMS that has some

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pretty good and useful definitions for you to help follow along. A couple of housekeeping things - as usual, we have a blue evaluation sheet in those same material packets that we hope you will fill out before you leave and help us improve these briefings as we go along. There are green question cards that you can use to raise appropriate questions when we're finished with the initial presentations, and microphones to which you can repair to offer your comments brief as they hopefully will be to get a response from our panelists, and as usual I want to thank Kaisernetwork.org. The camera you see at my left, your right, represents the availability later this afternoon of a video of this briefing. And, you'll find both on kaisernetwork.org and on the Alliance website at allhealth.org, materials that are in your briefing packets in digital form including the source lists and some of the links to other information as well. We're pleased to have as partners and supporters in this program, the Kaiser Commission on Medicaid and the Uninsured, which is a major project of the Kaiser Family Foundation. I want to thank Diane Rowland and Barbara Lyons and He Sing (MISSPELLED?), and the rest of the folks at the commission for their help in making sure that we could do this program today, and we do indeed have a terrific program for you. Panelists are going to help us explore what's in the different versions of the Medicare legislation about dual eligibles, and give you a chance to ask them questions to

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clarify it even further. Before we turn to those formal presentations, I'd like to ask the Kaiser Commission's Executive Director, coincidentally the foundation's Executive Vice President and one of the country's leading healthcare analysts, Diane Rowland to kick off the discussion. Diane?

DIANE ROWLAND: I'm very pleased to be here today, and to see so many people are interested in the dual eligibles, quite a combination of complexity when you move Medicare and Medicaid together and cover a population with both programs, but I think today's discussion is extremely important because when we think about the Medicare drug legislation, within that legislation we will do something to affect the coverage today of seven million low income Medicare beneficiaries who also depend on Medicaid to fill in Medicare gaps. What I'd like you to bear in mind as we talk about all the jargon terms and dual eligibles and SLIMBYs and QUIMBYs is to remember that these are Medicare's poorest. Three quarters of them have annual incomes below \$10,000 a year, most live on fixed incomes from their Social Security benefits, but they're also among the sickest and the most disabled of the Medicare population. A third have three or more limitations in activities of daily living compared to just twelve percent of the other Medicare beneficiaries. Over half are in fair or poor health. Twenty-three percent reside in nursing homes. Eleven percent have Alzheimer's. Twenty-two percent have diabetes. This is a

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population for which medications are very important, and chronic illness takes an ongoing toll in terms of their financial ability to make their needs despite their very low incomes. So, today as we engage in this discussion, we want to be sure that we remember that the label dual eligibles refers to really people struggling to cope that have much at stake in the policy debate going on over their coverage. It's not just about fiscal relief in states. It's about how we treat the very lowest income within the Medicare population. So, we thought one way to start the discussion and to keep that face and those voices in your mind was to bring a dual eligible to the debate today, and to have you just share some of the experiences of 68 year old Mildred Bennam of Bloomington, Illinois, who is a dual eligible and who has a few comments to offer to us about what it's like to be a dual eligible and how much her coverage means to her.

VIDEO: The Kaiser Commission on Medicaid and the Uninsured is currently profiling dual eligibles. Seven million low income people eligible for both Medicare and Medicaid, and while Medicare provides basic physician and hospital care, dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing, and to cover benefits Medicare does not such as prescription drugs and long health care. Now, you'll meet one person who depends on Medicare and Medicaid for assistance. This café is downtown Bloomington Illinois was the last place

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Mildred Bennam worked. I got to where I could hardly walk anymore so I had to quit. Well, it broke my heart. The 68 year old used to be the cashier until she was diagnosed with both rheumatoid and osteoarthritis. Mrs. Bennam also suffers from high blood pressure, difficulty breathing and glaucoma. Her daughter, Terry Falling said it was sad to see her decline. It seems like the last couple of years my mother's health has really gone down hill, and it went really fast. Mrs. Bennam lives in a small one-bedroom apartment by herself, or rather with her cat Ariel. She's very spoiled and I love her very much. And, passes her time with her life long passion, puzzles. I have puzzles, word puzzles, word games, I just love them all. But, she says, even the simple life would be impossible if it wasn't for medications. It kept me alive basically, but it made it possible for me to get up and walk around. I would just have to sit in a chair and I'd have to be in a wheelchair if I didn't have the medication that I have. Despite working all her life, Mrs. Bennam's monthly income is about seven hundred dollars from Social Security, putting her below the federal poverty line. Her medications, which Medicare doesn't cover, cost about five hundred. That's why she turned to Medicaid. She couldn't afford to take the medication she's on now, and get the treatments she's receiving without the Medicaid. And, because of her physical limitations, Medicaid also provides for someone to help her out a few times a week. She cleans, does

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laundry, takes me to the bank, anything I need that's necessary. Every time that I've taken her, you know I need to call her grandma. Such help allows her to live on her own, and to spend precious time with her grandsons. I had a talk with my sons that I didn't think that she was going to make it a whole 'nother year, and then when she started taking this medication and we saw a huge change and it's really meant the world to all of us that she's going to be around a lot longer. Long enough, perhaps Mrs. Bennam says to see some great-grandchildren.

ED HOWARD: All right, thanks very much. A moving piece. Let's put it into policy context now. Jocelyn Guyer is our first speaker. She's an associate director of our co-sponsor, the Kaiser Commission. Her areas of concentration are Medicaid and the S-CHIP programs. She's been a congregational staff member with Senator Pat Moniyhan during the Clinton Health Reform days, and was a senior analyst with the Center for Budget and Policy Priorities, and she's here to layout the basics of the dual eligible issues for us today, Jocelyn?

JOCELYN GUYER: Thanks very much. What I'd like to do is spend a few minutes talking to you about who the dual eligibles are, and then turn to how they're treated under the House and Senate Medicare Bills. I'll also spend some time on how State Medicaid budgets are treated, because that's an important part of the picture, and there's some differences there in the House and Senate Bill. And, finally, if there's

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time, we'll talk about how other low-income individuals who aren't poor enough to qualify for Medicaid, but who may still need some are treated under the two bills. In terms of who the dual eligibles are which isn't just one, there are people who are both on the Medicare program but also enrolled in the Medicaid program. The vast majority of them are what we call Dual Eligible, which means they receive Medicare, and they're also qualified for the full range of benefits offered under the state's Medicaid program. For these people, Medicare serves as the primary payer of their healthcare needs, but to the extent that there are some gaps in that Medicare coverage like the lack of a prescription drug benefit or like the lack of a comprehensive long term care benefit, Medicaid steps in and fills those gaps in coverage. The other thing that Medicaid does is pay the Medicare premium and cost sharing obligations for a dual eligible. There's another group of dual eligibles who we call partial duals. They're on Medicare, and they qualify for a limited Medicaid benefit that provides them with assistance with their Medicare premiums, and to some extent cost sharing obligations, but they don't receive the prescription drugs and other services that Medicaid provides to full dual eligibles. It's really the full dual eligibles that we'll be talking about for most of today. So, that's who I'll be focusing on from here and out. To qualify for full Medicaid coverage as a person on Medicare, you basically have to be

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extremely low income. Under the Federal Minimum Standards for who states have to cover in terms of seniors and disabled people, you have to have income below 74% of the poverty line. That's about \$6,600 a year for a single person. You also have to have fewer than two thousand dollars in assets. Now, states have lots of flexibility to expand coverage beyond these federal minimum standards, and a large number of them have done so. As you can see in figure two, in the year 2000 there were about thirty-nine million Medicare beneficiaries. Of these 5.8 million were full dual eligibles. We represent fifteen percent or one in seven Medicare beneficiaries. As Diane said in her opening remarks, and as you can see in the figure three, the vast majority of dual eligibles are extremely impoverished and they also have far more extensive healthcare needs than other Medicare beneficiaries, and it's in large part because of those extensive healthcare needs that as shown in figure four, we find that dual eligibles account for a surprisingly large share of total Medicaid spending. Still on figure four, and if you look at figure four, what it shows is that in fiscal year 2002, spending on dual eligibles accounted for fully forty percent of total Medicaid expenditures, and that's even though Medicaid dual eligibles as a share of Medicaid enrollment are roughly one in six, one in seven Medicaid enrollees. The cost of providing prescription drugs alone to dual eligibles represents six percent of total Medicaid expenditures. Now, that may

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sound like a relatively small share in some respects, but it's been a source of tremendous concern in large part because Medicaid programs like other healthcare payers, have very much been struggling with the rapidly rising cost of prescription drugs and so, prescription drugs for dual eligibles have been an enormous source of fiscal pressure for the states. Figure five gives you a sense of why it is that dual eligibles in particular have been a source of concern over talk about prescription drugs in Medicaid. As you can see in the year 2000, if you looked at states and the federal government's prescription drug spending under Medicaid, roughly half of it was due to the cost of providing prescription drugs to dual enrollees. In terms of the prescription drug benefit available under Medicaid to beneficiaries, historically, it's been a very strong benefit. It's a benefit that's designed to provide Medicaid beneficiaries with all of the prescription drugs that they need at little or no cost, and that's reflecting the fact that these are extremely poor people who wills imply go without prescriptions if they need to make more than nominal copayment. That said, because of the rapidly rising cost of prescription drugs, because of ongoing state fiscal pressure, we've seen a tremendous movement in recent years to states taking very aggressive actions in their Medicaid programs to try to cut back on their prescription drug spending. We sponsored a survey earlier this year and it found that 45 states reported

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that just in the last several months, they had taken additional actions to cut back on prescription drug spending. We can see the array of strategies that states are using in figure six. I don't want to review the strategies in detail for you, but to sum them up some of them are relatively innocuous strategies that may simply help with controlling drug costs. Other raise, I think, some serious concerns about the quality of prescription drug coverage under Medicaid. They certainly suggest that there's a risk that as states increasingly pursue these strategies, the ability of Medicaid to beneficiaries to access prescription drugs, may be put at risk. In terms of how dual eligibles are treated under the two bills, figure seven addresses this issue. The House bill provides all Medicare beneficiaries include dual eligibles with the opportunity to sign up for the new Medicare prescription drug benefit. In that respect, the bill that's on the long standing structure that we've had in place between the Medicare and Medicaid programs. Under the House bill, Medicare is the primary payer of prescription drugs for dual eligibles to the extent that Medicare prescription drug benefits still has some holes in it, Medicaid steps in and fills the gaps in the Medicare prescription drug benefit. In comparison, under the Senate bill, people who are on Medicaid and have Medicaid coverage that includes prescription drugs, are not eligible to sign up for the new Medicare prescription drug benefit. And, the

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implications of that are discussed in figure eight. Obviously, that means if you're a dual eligible, you're not going to be part of the new Medicare prescription drug benefit if the Senate provision is adopted. Instead, you will continue to rely only on the Medicaid program for your prescription drug coverage, which means the quality of coverage you receive is probably going to depend on the state in which you happen to reside and the steps your state has been taking in recent years to try to control prescription drug costs. The other issue that's been raised about the Senate bill that I want to flag for you is that there's a possibility it could create some fiscal incentives, states to scale back optional expansions that they've done in Medicaid for seniors and for people with disabilities. Logic behind this concern is that the only way if the Senate bill is adopted, the only way that states can effectively shift the cost of prescription drugs for dual eligibles from the Medicaid program to the Medicare program is to make more people ineligible for Medicaid, because if you can't get prescription drugs under Medicaid, that means you can sign up under the Medicare bill for the new benefit. From a beneficiary perspective, one of the primary concerns about this possibility is that if states roll back optional expansions, they're not only rolling back prescription drug coverage, they're also rolling back the other services that Medicaid provides including long term care services, dental services,

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and an array of other benefits. Under the house bill, dual eligibles are eligible for their part benefit that's universally available to all Medicare beneficiaries and there's I think a good chance that they'll end up securing better coverage since they will have prescription drugs through both Medicaid and Medicare. States also have a very strong interest in what happens to dual eligibles, and the basic reason for that is states pay for on average forty-three percent of the cost of Medicaid services. On the other hand, they don't pay for any of the cost of providing Medicare. So, to the extent there is a shift, whether it's Medicaid versus Medicare, paying for prescription drug coverage for dual eligibles, it creates the potential for fiscal relief for states. Figure nine reviews for you some of the provisions related to states in the bills. As we just discussed under the House bill that kind of shift does take place. I think it's important to highlight, however, that in order to reduce the cost to the federal government of that shift in who pays for prescription drugs for dual eligibles, the House has what is called and under that provision the Federal government affectively recaptures share of the state fiscal relief to offset some of its costs from this shift. It's a complicated formula, but overall what it does is recapture a relatively large share of the state fiscal relief in the year 2006, and then that tapers down over time until by the year 2020, states retain all of the state fiscal

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relief from the new Medicare drug benefit. Under the Senate bill, that kind of shift can't take place. Instead, the Senate bill has some alternative provisions designed to provide some fiscal relief to states. The first one is that it says that if states are willing to agree to meet some minimum standards in their prescription drug benefit in Medicaid, the federal government will pick up one hundred percent of the cost in Medicaid program of paying for part B premiums for selected dual eligibles. There's a second provision that's designed to give states some incentives to maintain their optional eligibility expansions for seniors and disabled people under the Medicaid program, and that provision would pick up a hundred percent of the cost of part A deductibles and co insurance costs for people covered under the optional expansion. The lack of other provisions in the bill with a fiscal impact on states, I'm not going to have much time to talk about them, but I do want to note that both bills do envision states taking on major new responsibilities for administering their low income subsidy program. That's expected to cost states a fair amount of money. In the congressional budget office looked at these bills on net all of these provisions taken together, it estimated the Senate bill would provide twenty billion dollars of fiscal relief to States over the next ten years, while the House bill would provide 44 billion dollars. The last area to cover is the structure of the

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low income subsidy programs under the house and senate bills. These are programs that are designed to make it possible for low income people to meet the premium and cost sharing obligations under the next prescription drug benefit. There's lots of details, I refer you to the materials in the packet for the details, but really two key differences to highlight. First is that the Senate in general has more generous eligibility rules for who can qualify for it's low income subsidy program. It has a higher income cut-off, and it also doesn't require you to meet an asset test to receive at least some assistance under it's low income subsidy program. It however, because dual eligibles are excluded from the part D benefit in general, they're also excluded from this low income subsidy program. The other key difference that I would highlight is that the Senate bill provides a much more adequate level of subsidy to low income individuals, and to summarize it real quickly, basically under the House bill we're going to return briefly to the notion of a donut hole. For low income people, there's still a donut hole. There's a point at which when their drug costs reach an initial limit, after that initial limit, even if you're low income, you still are responsible for a hundred percent of your costs. In contrast, the Senate helps you with all of your drug costs picking up at least a substantial share even if your drug costs exceed an initial limit as long as you're in the low income subsidy program. So, it's a real

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different kind of subsidy structure. I think you can see the implications of this in figures eleven and twelve. Figure eleven shows that in total, the House bill is expected to cover 9.5 million people, seven million of whom are dual eligibles. In contrast, the Senate doesn't cover any dual eligibles but it covers more other low income individuals. In figure twelve just shows you graphically the implications of the difference in the adequacies of subsidy structure under the House and the Senate Low Income subsidy program.

ED HOWARD: Thank you very much, Jocelyn and somebody who later on did not get a copy of Jocelyn's paper that accompanies and covers in more detail the material that you just heard. How can people get a copy of that Jocelyn?

JOCELYN GUYER: There's a longer background paper that's (Unintelligible)

ED HOWARD: I should have said before Jocelyn spoke that her slides and the others you're hearing people talk from and see on the screen are in your material. So, you can follow along without having to write down everything you see on the screen. John McManus is our next speaker. John directs the staff at the House Ways and Means sub-committee on health chaired by Nancy Johnson, which means he didn't get much of an August vacation this year. His fall schedule doesn't look too attractive either as a matter of fact. The previous subcommittee chairman, John was the key staffer working on

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Medicare reform and prescription drug bills that were passed three years ago, and he's here to tell us why the house dual eligible provisions are far superior to those in the Senate bills, right John?

JOHN MCMANUS: John McManus, I appreciate you guys having me hear. It is a very timely meeting. I thought I'd first give you guys all a snapshot of where we are in the conference. We have had as Ed alluded to, a very productive August. I did have some time off. Amy and I both took a long lunch a week ago Thursday, and I also had Sunday afternoon off two weeks ago. It is really a massive undertaking that Congress is grappling with now. It is probably the biggest healthcare conference in terms of the complexity and the breadth of issues that we've been working on. The House bill is over 700 pages. The Senate bill is nearly a thousand pages, I believe. And, working in our bipartisan, bicameral structure, which we've been meeting almost everyday, we've gotten through almost a third of the bill. There are meetings going on right now that Amy and I are late for and we will be joining as soon as this is over, and we hope to have a meeting of the conference on Tuesday to announce where we have come to some closure. Obviously, there's open issues still going, and we will move on to some of the upper issues. This is one of those things. So, I think it's a very timely thing to have this. To understand where we came from in the House, I think it would be

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hopeful to understand where Chairman Thomas's vision is, and it's interesting because I was just looking through some clips that people that we happen to share in many respects a very liberal thinkers out there. I don't what that means, but it's interesting. I guess politics always makes strange bedfellows. But, Chairman Thomas basically believes that Medicare ought to be a senior's healthcare program. We have to first take care of seniors at the Federal level. Obviously, there's been a patchwork state effort to try to take care of some low income seniors as has been described all afternoon long. That has not done well for a lot of seniors and we can do a lot better. So, what we're trying to do is bring the low income seniors up to the Federal level, provide them a uniform guaranteed entitlement, and the cost sharing too, and subsidies that we have done through the Federal government. The House bill is not an attempt to provide the states fiscal relief, but it's incidental to the bill. My Senate colleague has some really good points that the states have been getting some very significant relief from the Federal government and I was saying there in still some dire straits but that is not the point of the bill. The point of the bill is to provide a uniform structured benefit guaranteed by Medicare, and the fact of the matter is when you look at seniors' healthcare, in 1984, Medicaid bore about thirty percent of the cost of seniors healthcare. It's not up to about forty percent. So, the costs

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have been going in the opposite way. This bill attempts to make a universal benefit available to all seniors regardless of income through Medicare. When you look at the Senate bill, I think Jocelyn pointed out quite well that it excludes 6.4 million beneficiaries from the Medicare drug benefit just because they're dual eligible. It's important to remember that the prescription drug benefit under Medicaid is voluntary. The states don't have to offer it. The states determine what the amount of the benefit is, called something in the Medicaid which I don't know it very well because we're on the Ways and Means committee, we don't have jurisdiction over this. It's both and duration. What that means is that under the Senate bill, they think they're having the same benefit, people could greatly scale back the scope of the Medicaid benefit, worse case scenario one prescription per month, one prescription per year. That is entirely acceptable under the Senate bill. They protected themselves by saying, you couldn't repeal all drug coverage, and they added the incentives that the previous speaker talked about in terms of the premium cost sharing for the low income that would be Federalized, but then the states would have to turn to the option of "Is it better fiscally for me given the fiscal problems I have to perhaps scale back or drop drug coverage, scale back dramatically drug coverage, which we know drug costs are exploding, but that's one part of healthcare, given that the premium assistance I'm getting under

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part B?" That is a gamble that we're not comfortable taking in the House bill. The second point as she also indicated are those 19 states who offer more generous coverage than what's required. Those people are at risk are going to try to address through the part A deductible cost sharing, but again, that does not assure anything. People are still at risk under the senate bill. One of the primary reasons though that Chairman Thomas felt that dual eligibles, and frankly all Medicare beneficiaries ought to have a Medicare drug benefit is that the drug benefit is far superior under both of our bills than what Medicaid currently offers. Let me give you some examples of that. Forty-one states in Medicaid now limit drug coverage in various ways. Many states like Arkansas, Alabama limit the number of prescriptions you can take. Thirty-six requires doctors to ask the Medicaid state agency whether they can have prior approval, it's called, or that patient's getting their bill, their drugs, and each state, as we know, has different coverage rules and it depends on where you live. Both the House and the Senate bill have important quality features for drug benefits that are not available under the Senate dual eligible structure obviously because they only pertain to Medicare benefits. We have detailed rules on development. We've got requirements on having multiple drugs in each therapeutic class. We have external appeals requirements. If you picked an eye coverage, we have important revolutionary and

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it's things debated now by the staff as we sit here, electronic prescribing structure under both bills were it's mandatory, voluntary - the point is people get much better healthcare and the patients are going to know immediately before the prescription's even prescribed what drugs on the phone, what's preferred, what's drugs taken are going to adversely react with another drug. None of that's going to be available under the Senate bill for dual eligibles. Both bills have pharmacy therapy management programs for chronic diseases. It's really better health care. Part of what we've been trying to stress about the Medicare prescription drug benefit isn't just about cost, getting people's cost down. It's going to provide them better healthcare. One other feature that I don't think the Senate has fully thought through is as we know Medicare Advantage which is the integrated HMOs that currently offer any of them offer prescription drug coverage and they will be fiscally funded under both bills offer prescription drug coverage. They offer integrated care which we all know is the best kind of healthcare you can get. We want people a position a manager of healthcare to say, "We need to ultimate outcome for the patient. Here's what we're doing on prescription drugs. What is best for the patient?" Under the Senate bill, those who are dual eligible would have to continue to get their drug benefit through Medicaid, not through the new integrated plan. That's a Medicare benefit. I'd wonder how we could deal with

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that. One other important feature about having the low income in the Medicare risk pool, as we know both bills have pluralistic leverage structure where you have competing plans whether they be drug plans or integrated plans competing. They both have CBO scores and (UNINTELLIGIBLE), and we have full participation. We all know that there's going to be some people that's notwithstanding those estimates, some people up to thirty-five dollar premium or thirty dollar premium, that seems like a lot of money to me. I don't know if I want to join this program. By having a low income in their risk pool, notwithstanding some of them may consume more on average than other seniors, they're going to be fully subsidized by the Federal government, no bad debt problem whatsoever. They're going to have cost sharing and premiums are fully subsidized by the Federal government. That initiates an initial risk pool that you can get these plans up and running in a way that if you exclude them does not. Finally, I think it's important that prices in the pharmaceutical market be set by the market not by the government. We have a fundamental disagreement with our friends on the left on that. One of the provisions that came in the House bill, Chairman Thomas's amendment the nature of a substitute in committee last year, and of course it's in both bills now, was the ability to exempt prices negotiated by Medicare drug plans for Medicare seniors from the Medicaid best price. What does that mean? Currently, Medicaid best price

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says, "The best price that's negotiated in the market has to be given back to Medicaid." That turns into a rebate between that and the average price in the market. Study after study by the General Accounting Office, Congressional Office and others have shown that's created pricing discipline by the manufacturers. They're less interested in giving significant discounts if the discount they're giving to move market share for example of Pfizer Permanente, then has to be given as basically a tax to the Medicaid program. By getting these seniors into private healthcare programs, the Congressional Budget office, and by the way our bill in exempting Medicaid best price, we saved seniors eighteen billion dollars by encouraging steeper discounting by manufacturers. But, let me summarize where we are. Both bills had to make choices. We had a discreet amount of money, 400 billion dollars. To the Senator's credit, they tried to use the money they saved from excluding the dual eligibles, putting more money for those who were just above that poverty line, I guess is the way to say it. But, we think their bill leaves people vulnerable, keeps them in a government run systems which don't provide optimal care, which under both our bills the quality of healthcare. The Senate bill leads to fragmentation, less integration which we think, I think most healthcare policy experts are in agreement the more integration the better. Senate bill also fails to provide catastrophic protection for even the low income seniors. They have a

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percentage when you hit that. My colleague has her charts, and I guess some of them are helpful, some of them are not. We have a \$3,500 catastrophic, she's got a \$5,500 on her chart, and at \$3,500, no matter what your income is, you stop spending.

Okay? Secondly, the house bill by assuming some of the obligations, and we do it over a fifteen year period, all the states allows and requires for dual eligibles, the states to wrap around that coverage. So, when you say there's a donut hole at two thousand dollars, it's actually correct except you have to remember that the states now have freed up whatever the dollar amount is thirty or forty billion dollars over the ten year budget window, the wrap around coverage will give even better coverage for those who are currently dual eligible or to increase their income structure. Lastly, on the low income, the house bill triples asset test, the Senate bill, the asset test has never been indexed. The Senate bill leaves that at four thousand dollars. That's important because those who qualify for low income must both meet income structure and asset test. The question comes here is how do we merge these bills. That's where we need your guys' ideas. I think obviously the house bill is very strong in I think a partisan level, Amy can speak to that, that dual eligibles will be part of the Medicare drug benefit. I think we also recognize we have some shortcomings in the bill. We've got to do better by low income seniors who don't benefit from the state wraparounds. We're open to working

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with the Senate on that, and try to give better coverage. All this has to be done within the 400 billion dollar structure and in a context of what is everybody else get. One thing we did under our bill which we get criticized for, but we give everybody got up to two thousand dollars had the same donut basically. So, you're going to have to think about whether you want to march up through the income stream that different amounts for that and what the implications are for future Congresses, but those are my humble thoughts on the matter. And, I look forward to hearing your guys and your perspective. Thanks!

ED HOWARD: Thank you, John, and I think you've set up this discussion very well. Thanks very much. We're going to hear a somewhat different perspective, I believe from the north side of the capital as we hear from Lea Kegler, who is the health policy advisor for Senator Grassley's finance committee staff. She holds a Masters in Public Affairs from the LBJ School at the University of Texas at Austin, worked for the state Human Resources in Austin, and when Linda Fishman had a last minute conflict that kept her from joining us today, Lea gamely agreed to pinch hit. So, we're very happy to have her with us, and as John pointed out, she even has slides.

LEA KEGLER: Yes, I'd like to thank you all for inviting us to come and to have the Senate share it's rational on why S1 looks the way that it does. Chairman Grassley does

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feel very strongly about how S1 is, as it maximizes the benefit for those who need it the most. I think with the budget constraints we were looking to help those who didn't have prescription drug coverage, and so that's one of the main reasons we came up with the policy that we did and we'll discuss that too. I also just want to mention as far as how things are going with also remains optimistic, and I think it's sort of the farmer in him, and yesterday he said, "We're making progress everyday." So, it's just step by step and it's feeling very optimistic. So, next slide, please. So, to begin, I just wanted to walk through some of what the policy behind S1 is, and it really does work to maximize the coverage and provide quality, consistency and access to beneficiaries. Quality meaning assurance of the most generous benefit to the poorest of the poor. I mean, let's not kid ourselves, we all know that Medicaid has always been seen as a generous benefit package with it's nominal copays and it's broad coverage. S1 has protections built into it to help continue this. Those three protections are the states must maintain the Medicaid benefit as defined in the Medicaid statute. Secondly, beneficiary protections must be equal to what they are in the Medicare benefits, and thirdly there can be no limits on the number of prescriptions filled. We felt that this was very important to add to make this work. I think there are some very valid concerns being raised, and I think the Senate bill has done a

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lot to address these concerns. Secondly, on consistency, the seniors who are dual eligible know and understand the Medicaid program. This especially pertains to seniors who are in long term care and nursing homes. There are over one million seniors who are dually eligible who are in nursing homes, and I'd like to pose to you today how did these seniors choose which private plan to go in? What if you have an 80 year old woman who has dementia who isn't lucky enough to have a family to take care of her? How do you propose that senior who decides which private plan they would like to enter? And, so that was something that also built into the decisions that we made in S1. Thirdly, access, I think we looked at sort of the system that is in the states and the great things that the states do right now, not even just for healthcare, but the Medicaid caseworkers because a lot of times they do enter the program through Medicaid really do a lot to be gatekeepers, to direct seniors to home and community based care, to the food stamp programs, to housing, to all kinds of state programs, and I think that's something that's really important, and we need to recognize that role that's being played and don't want to change that. Next slide, then the other thing which has been brought up is the math. There is only 400 billion dollars in the congressional budget resolution for prescription drug bill. This is a reality, and this is something that we've really been working with to try to figure out and so, as we talked with CBO

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and we've been trying to noodle over some different options and to think, CBO actually estimates that putting the low income subsidy structure of S1 which we'll talk about a little bit more and what S1 does for seniors into the HR1 structure with this claw back as we have discussed costs tens of billions of dollars, and it's not just tens of billions of dollars. It would actually add 80-85 billion dollars, 80-85 billion dollars to the cost of the house bill if we adopted the low income provisions that are in the Senate bill right now into the house structure. The Senate bill is just working to do the most for the most seniors who don't have access to drugs and trying to work within the congressional budget constraints. Next slide, and that said, as we think about it I think it comes down to a question of providing more state relief or more help to beneficiaries, and I just want to remind everyone that back in May during the growth package that states do get 20 billion dollars in state relief. Ten billion of that went specifically to FMAT, to Medicaid and ten billion of that is in the grants to states. So, that's 20 billion dollars. S1, the Senate bill adds 20 billion extra dollars that goes to the states as well. So, it's not as if we've forgotten about the states and not done anything. We're trying to look at the evidence that was out there, and we wanted to look both at states and the beneficiaries, next slide, which is exactly what we did. S1 is 30 billion dollars more generous to low income beneficiaries.

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In fact, according to Families USA, the Senate bill does much more to help the one out of three people on Medicare who need the help the most. Because S1 doesn't use these mechanisms, this claw back mechanism that we keep discussing it allowed the Senate bill to be more generous, next slide. This slide is a comparison of the two bills and sort of what it is able to do. You'll note that there's only 2.5 percent cost sharing in the Senate bill for those under a hundred percent of poverty, and about 9.3 percent on the house bill, and it's actually two dollars for generics and five dollars for name brand drugs, but we've had CRS do some analysis and they seem to think that's about 9.3 percent, and so that's - no that's not it, that doesn't end up that we worked with CRS, and so that's, and so I want to make sure that's exactly what's in their statute, but that's an estimate just so we can try and compare the two. Then, I also want to point to the donut hole which the Senate bill doesn't have, which is in the house bill, and just say that within that donut hole beneficiaries have to take care of that, but the states also do. That donut hole means that state Medicaid programs will be spending money and the seniors will be covering. This is more than just the rap of prescription drugs the state covers, the Medicare program wouldn't cover, this also includes money that's going to be spent by states, and so I think that's something else we really do want to point out and to be honest about this isn't federalizing the drug

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costs for duals. There are substantial drug costs that are still there, next slide. Then this is a very similar chart. It changes a little bit the cost sharing within our structure, and I just want to point that within the Senate bill we're looking at the SLIMBYs and the QI-1s and this is how we've done it. the SLIMBYs are specified low income beneficiaries and the QI-1s are qualified individuals. The senate bill works to sort of build off an existing structure within the Medicaid statute to provide this benefit. This is to help the states administer the low income benefit. There's also sort of extra cost sharing as far as administrative costs for the states to try and help them get these Medicare beneficiaries enrolled into the Medicare drug benefit. Next slide, and then also this is just the last slide, and this is an important slide for two reasons and that the comparison says 135-150, but the Senate bill actually goes up to 160 percent of the Federal poverty level, and this is important to also point out that within this benefit structure in the Senate bill, there's no assets test. So, there's no test to - there's no three times SSI or whatever it is, or SSI you know we talked about that as well, I think with the duals and the two thousand dollars. There's no assets test at all. So, if you are very poor, but for some reason have some assets that seniors are holding onto, they would still be able to get a generous drug benefit. Next slide, and I also just wanted to bring us home a little too and sort of look and see what this

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means to low income beneficiaries and what it means as far as out of pocket costs, and I think you all have my slides, so you can sort of go through them and look at these, and these slides are actually put together by - or the chart was put together by Families USA, and I kind of stole it from them. So, I thank them for that. And, as you can see if we just think about a beneficiary who has three thousand dollars in drug use, S1, by the way this is someone who is under a hundred percent of the federal poverty level, which means they make about \$9,700 a year in 2006, but they would have \$75 in costs, whereas they would have \$1,114 in costs in the Senate bill. Next slide, and we just sort of see the 100-135 percents on this, and we go to the next slide, and then we again look at the 135-150 and I guess I'd want to point here that let's look at another one with one of these seniors with \$5,000 worth of spending. That person would make about \$15,400 a year, and the difference between \$805 and \$3,710 is pretty significant. Next slide, so, in conclusion I just want to point out that S1 strives to answer the important question within a limited budget the best that it can, and S1 chooses the low income beneficiaries. Thank you.

ED HOWARD: Thank you, Lea. Amy Hall is our last congressional staff speaker. Amy's a professional staff member for the Democrats in the House Energy and Commerce Committee where she's been half dozen years or so. She's had some

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executive branch experience as well. We're going to just have republican staffers sharing their viewpoints with each other, but we thought that was sort of unseemly. So, we figured we'd better get a democratic view and Senator Rockefeller agreed with that. So, we asked Amy to join us and we're happy to have you.

AMY HALL: Thank you very much for including me on the panel. This is an issue that is very important to my boss, Mr. Dingle, as well as the other members on the Energy and Commerce Committee, and it's also an issue that's very important to the Medicare program and it's future as a universal health insurance program. I have a lot of points to cover, so I'm going to start with a little roadmap and then I'll try to go through each in a bit more detail. I think our main arguments and concerns about the Senate approach is first it's dangerous precedent. Second, it is unfair to the beneficiaries who've been taxes into the Medicare system all their life. Third, it's bad for care leaving people with a two-tiered benefit, and detrimental to the coordination of care. It's administratively complex for both the state, the federal government, and the beneficiaries, and either way you look at it, whether some people have talked about fiscal relief, either way you look at it there's still an expenditure of federal dollars and taxpayer dollars because to remember that Medicaid is financed significant share by the Federal government, and finally the

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approach taken in the house bill which was also taken in the house democratic bill and as well as the tri-partisan bill, enjoys broad bipartisan support as well as support from the outside in particular advocacy groups and other groups. So, when you can have, Mr. Thomas' staff, and Mr. Dingle's staff sitting up and agreeing with each other, you can be pretty sure there's some broad support behind a particular proposal. So, to my first point, this would be the approach taken in the Senate bill would be the first time in history that Medicare was not a universal program. Medicare offers benefits to all who become eligible whether you're poor, whether you're not poor, whether you're green or blue or pink. And, beneficiaries would be excluded just because, just by virtue of being low income they would get the rest of their coverage from medicare, but would be excluded for one particular benefit. A number of members of congress have spoken eloquently on the importance of universality in Medicare, and Mr. Dingle in particular has grave concerns about fragmenting the program because he believes that the great success of Medicare has been its universality. And, even the President himself reinforced this notion that all seniors should be on Medicare. The president has some principles on the universality of the benefit and in June he said, all low income seniors should receive extra help so that all seniors will have the ability to choose a Medicare option that includes a prescription drug benefit. In addition,

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on excluding the duals for Medicare would be a vast inequity as I mentioned earlier, these beneficiaries have worked all their life and paid taxes into the system, and every other benefit that's covered, Medicare services are primary payer and Medicaid provides supplemental coverage, beneficiaries have earned the right to be on Medicare and get their coverage through Medicare. In this instance, the approach taken in the Senate bill, the low income seniors would in essence be subsidizing higher income seniors drug benefits without having access to the same benefits because they're paying into the system, but getting nothing back out in the case of drugs. The other point is, there are other groups of people out there who currently have drug coverage who we're not picking on, so to speak, there are people with excellent employer sponsored coverage. People with good coverage through state pharmacy assistance programs. People who have Medigap coverage. These people are allowed under the Senate approach to be a part of the Medicare drug benefit. So, why is it that we're just picking on one particular group, arguably the group that's most in need of a drug benefit through Medicare where care can be coordinated and managed appropriately? In addition, to my second point, the structure raises concerns about the effect on beneficiaries. As John McManus, I think, alluded to and Jocelyn did as well, low income seniors could receive a much lesser benefit under Medicaid. States could deny access to drugs that

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are covered by Medicare. They can pose limits on prescriptions. Thirteen states currently do have monthly caps on the limits on prescriptions, one notorious being Texas that has I believe a three prescription limit per month, and other states right now as a result of budgetary pressures are considering further restricting limits on the number of prescriptions like Alabama, Colorado, Louisiana, Connecticut, Florida, Indiana, and Maine or Massachusetts, are contemplating cost sharing increases and there's a trend towards pharmacy cost waivers which would just cap the amount of drug coverage dollar amount you could get each month regardless of what you need. So, I think the real question is not whether dual eligibles will get a better benefit under Medicare or Medicaid because as with other coverage, or other benefits I should say, Medicare provides the coverage and Medicaid wraps. In the instance of the Senate bill, these dual eligibles will be getting somewhat of a short shrift because they wouldn't have the benefit of Medicare being there to provide the primary benefit and then Medicaid wrapping. In addition, as Jocelyn alluded to this could have the affect of causing individuals as states scale back their coverage of losing other critical benefits like personal care services, nursing benefits, community care, acute care services, benefits that are often critical for the dual eligible population as they tend to have more chronic care or higher rates of disability and the like. And, in addition, it

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would be bad medicine. I think the state folks will tell you and one of the things we've heard from the states is one of their problems is that they would like to get a handle on is they have no ability to coordinate or to manage their drug benefit that they provide because the script is written by a medicare doctor, but then it's filled at a Medicaid pharmacy and paid for by Medicaid, and there's no integration. In the house and senate bills, more so in the house bill I believe, have some interesting programs for disease management which attempt to get a handle on coordinating care and getting this population which so badly needs to have a managed system for their various diseases that they have seniors and individuals with disabilities wouldn't get the benefit of that system. So, fully integrating a key benefit prescription drugs is really a critical step in improving the health outcomes and improving on the current system's flaws. In addition, I raise the point about the system being complex and confusing and upturning the apple cart, changing the system from the way it's worked over the past 35 years is going to result in just what you'd expect, and upturned apple cart and a lot of confusion on the part of states, the federal government, and beneficiaries. States and employers and anybody who offers coverage now, knows how to navigate the current system, and even in the case of Medicaid, you've got - in California, Medicaid routinely pays the MedicarePlus Choice premiums, pharmacy comp payments for

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private plan enrollees dually eligible for both programs. In Texas, the state managed care program supplements coverage for dual eligibles enrolled in private plan options. So, the states know how to work this system and they've been doing it. So, it shouldn't be that much of a stretch to have them continue doing it. And, in addition, there are hundreds of thousands of Medicaid, or Medicare beneficiaries that go in and out of Medicaid each month. These individuals have incomes that fluctuate monthly. You have some seniors, as you know, senior's incomes tend to decline with age, could be Medicare eligible until their 75 and then would have to go get their benefit from Medicaid when they spend down or when they lose all their assets and enter into nursing homes. So, you'd have people sort of flopping in and out of this benefit, which would result in a lot of confusion, and in addition there are different rules in both programs. Beneficiaries would be faced as they switch in and out of the programs with different formularies. They may have to switch pharmacies because the pharmacy that participates in the Medicare plan may not be a Medicaid pharmacy. They may have new prior authorization rules, new limits on the number of prescriptions. This population being older, more frail, less educated, sicker, with multiple chronic conditions is probably not the population to try an experiment with of designing a new coverage system. So, the only other point I think that I would make is that this isn't about fiscal

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relief as John said, the fact that states get any benefit from this was sort of incident to providing a larger prescription drug benefit. They really had no intention to do that when they designed it, and it's unsustainable to expect states to be able to afford and maintain any meaningful prescription drug benefit over time for this population. And, if the federal government doesn't come in and treat the dual eligibles like the rest of the Medicare population, you're going to see two things happen. First, it will hinder state's ability to meet the other basic health needs for their residents. As costs rise for states and the drugs for dual eligibles cost states almost six billion dollars a year, as these costs rise, tough coverage decisions will have to be made in terms of what the state can afford with respect to drugs for the elderly, drugs for the disabled, coverage for pregnant women, coverage for children, and the other people that they provide health insurance to, at a time of record budget deficits having states take on what is clearly a Medicare coverage responsibility will crowd out their ability to provide other care. And, in addition, this could result with people having a two-tiered drug benefit. Medicaid programs squeeze by fiscal pressures we'll increasingly find ways to discourage enrollment and contain costs, possibly at the expense of access to needed medicines for very vulnerable population. So, with that being said, as I mentioned earlier, the approach taken in the House bill also taken in the tri-

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partisan bill and the house democratic bill is one that has brought support and there are certainly other important protections in the Senate bill for low income beneficiaries which I think that also brought broad support, but we should not upturn the apple cart and should preserve Medicare's universality. Thank you.

ED HOWARD: Thanks Amy. Our final presentation is by Mike Robinson who has been very patient listening to these other folks describe the federal issues. He's the Medicaid commissioner in the Kentucky cabinet for health affairs. He too is a pinch hitter for the cabinet secretary, Marsha Morgan who had a family emergency. You'll find Marsha's name on the slides that are in your materials as a matter of fact. Mike's a veteran of state government in Kentucky and his governor Paul Patton was the main force behind the letter in your materials in which the governors, every one of them ask for the conferees the source of prescription drugs for this new benefit. Mike, thanks for joining us on such short notice. We look forward to hearing from you.

MIKE ROBINSON: Thank you, Ed. I really appreciate this opportunity. It's very difficult to follow this group of distinguished panelists. They made a lot of the points that I was planning to make in my presentation. What I'll try to do is perhaps as we go through the slides, Kentucky has the impact to a certain degree. Before I begin though, I'd like to maybe

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elevate not the debate, but the issue. We've talked a lot about the future of Medicare, but what is done in this bill will also have a tremendous impact on the future of Medicaid. Currently, the system in Kentucky and other states is not ideal. States are being forced to make some very difficult choices as many of them we would prefer not to make, but because we have the obligation to balance expenditures or revenue, we are trying to do what we can to limit the damage so to speak to that safety net. If there's anything that they agreed on in the debate about Medicaid reform, it was the fact that dual eligibles were the number one priority and they felt that the federal government needed to begin to take over that responsibility where it should lie anyway. So, why should drug coverage be extended? I think I agree with some of the comments that were made earlier. I think every senior should be eligible regardless of income. If medicare is going to provide pharmacy benefits then they should be provided to everyone. It should ensure that low income seniors are treated the same. I think previous speakers had made some very valid points about the variety of state programs throughout the country. Currently, Kentucky does not place a cap or a limit on the number of prescriptions per month, but I'll be honest with you, that has to be one of our considerations going forward as we try to balance our budget. Next slide, please. I think our current healthcare is uncoordinated. It's very difficult to manage.

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There's no involvement in primary care or preventive care, and it's a piecemeal approach to our sickest and most vulnerablest citizens. Rising healthcare costs have hit state budgets where revenues are declining. Let's take a couple of minutes to explain what our strategy has been. In Medicaid there's only three things that you can control. You can control reimbursement to providers. You can control the services that you provide, and you can also control to a certain degree the number of eligibles. Now, with the fiscal relief act, one of those conditions are that once you accept the money on fiscal relief that you can not make any eligibility changes beyond September 2nd. Our provider network is already suffering from three years of frozen reimbursement rates, and in many states there have been across the board cuts of as much as five percent. The only thing that leaves us to manage or to control our costs is services. And, nobody in the Medicaid program wants to trim or cut back on the services of an already meager program. On average, and it's true in Kentucky, we spend about 22 percent of our state budget on the Medicaid program. In terms of Medicaid funds going to nursing facility beds, our percentage is a little higher there, it's more like 75-80 percent. Next slide please, I think the discussion about prescription drug program and coverage is a good start. It's a good start on a larger picture of what we're going to do with both Medicaid and Medicare in this country. Now, we need a

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healthcare policy where we can begin to build the bridges between federal and state responsibilities and develop a seamless quilt as opposed to the kind of patchwork that we have right now. Last slide please, no matter what we do, it's going to be a challenge in managing the problems and managing the available resources, but I'm very hopeful that with the debate that's currently going on, that we can take a meaningful step to try to provide a healthcare network in not only my state, but in all states where seniors are taken care of as well as all individuals who are economically deprived and need the kind of healthcare coverage that we all want from them. And, with that, I'd like to thank you very much for this opportunity and turn it back over to Ed. Thank you.

ED HOWARD: Thanks very much, Mike. We have the opportunity for questions, as I mentioned there are floor microphones which are a new and improved version, and there is the opportunity to write questions on green cards, which if you do and hold them up, a member of our intrepid staff will come and pluck it from your fingers. We urge you if you do come to the microphone to keep your questions short, urge our panelists to respond in as brief a way as you can so we can get as many questions covered as we possibly can. And, I ask you to identify yourself before you ask your question. Go ahead Alan.

ALAN GLASS: Alan Glass with Senator Biden. I have question for the panel about this whole issue of universality

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and making sure that everybody is covered for their drugs under the Medicare program. As I understand it, in both bills and all the proposals, there are some groups that are going to be carved out. For example, the two million or so people in the tri-care senior program have a separate funded program and are not going to get drugs through Medicare, I don't know, but other federal programs, but also retiree health programs. In fact, both bills have incentives to provide to employers so that they will maintain retiree health coverage so that retirees will not have to participate in the Medicare drug program. So, my question is using that analogy, why not do the same thing for the dual eligibles? Why not provide an incentive as we do for the private companies, for Medicaid programs to continue to provide the drug program? For example, establishing the FMAT for prescription drugs somewhere between the current level which it is under the senate bill and a hundred percent which it would be under the house bill, so something like what we do for SCHIP?

JOHN MCMANUS: I'll take a shot at that. The tri-care program is not carved out in the house bill, Alan. I don't think it is on that one, no. What we've done is we've heard from a lot of retirees and the employer community that they're pretty happy with what they have, and what we've tried to do is maximize the dollars on the table, that if people can stay in those, we think very well operating programs, they'd like to

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stay there. To the degree they stay there under both the House and Senate bill, we save money because we're subsidizing about two thirds. Also, they're getting an indirect subsidy through the tax code for providing employer sponsored coverage. Anyone who is in a current employer plan is always free to leave that plan. They can always sign up with a different drug benefit. So, they're not excluded from the Medicare program. The only issue is whether they're happy with what they have, is there some incentive for employers to maintain that coverage?

LEA KEGLER: Yeah, I would agree. I'm not necessarily the employer person on our staff. So, I probably won't be as informed on this as I should be, but I think that there are incentives for people to stay in the plans, and if seniors like what they have, the benefit is voluntary. They don't have to enter into the prescription drug program, and then more specifically looking at different incentives and things like that, I don't think that we've looked at those sorts of things thus far. I think in some ways the claw back does do that, which is what is in the House bill although it's complicated and sort of convoluted and hard to explain how that works, but I also just want to sort of point out, sort of thinking back to May too as far as bringing the FMAT into the debate would probably be very difficult, I know at least from the senate republican perspective, there's some strong feelings about whether or not, whether it be FMAT at all is the best way to go

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about doing things, and I think we saw that in the debate in May and I think that's sort of helps - I mean that would make it a little bit more explosive.

MALE: I have two questions.

ED HOWARD: Would you identify yourself?

PAUL PRACT: My name is Paul Pract (misspelled?). I'm a reporter for Inside CMS. For Lea Kegler, you said that the senate provides an extra 30 billion in low income assistance drug coverage, but that CBO says that to tack on the Senate low income provisions under the house bill it would cost 80-85 billion. I don't understand that discrepancy.

LEA KEGLER: Well, that discrepancy is actually looking at what the benefit structure is. Within my packet there's a slide, and when you look at the comparison between the house and the Senate bill, when there is that donut in the house bill, there is a high cost of actually filling that in, and so that the difference in the benefit structure, the actual structure of the benefit is where those difference of costs come from.

JOHN MCMANUS: On Lea's slides indicates the House (unintelligible) is 5,500. That is not accurate. It's 3,500. It's lower than the Senates. The full catastrophic, and then there's some slides from Families USA that shows some people spending \$3,700 - \$3,800. Obviously, if you've got a \$3,500 catastrophic, that's where your catastrophic is. You don't

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spend more than that. On the two thousand dollar limit, keep in mind that sixty percent of seniors spend less than two thousand dollars. So, this is not an issue for sixty percent of seniors. It's those that spend above that.

AMY HALL: Can I add just one thing? Just keep in mind, and I made this at the beginning of my points, but never got to more fully flush it out is that, in terms of talking about whether Medicaid's going to pay for or Medicare is going to pay for it. There still a significant federal expenditure because Medicaid dollar by the federal government, and in fact funding for Medicaid is even more inequitable because some states are going to be getting almost 80 percent on the dollar from the Feds like Mississippi, New Mexico and other states, and states like New York or Iowa or states with lower FMATS are going to be getting less federal money, and so there's still a tax payer expenditure. It's just where exactly on the ledge this is going to get accounted for, and so our feeling is that the principle of universality is very important and you can deal with the issues of CBO costs. The house dealt with it through the claw back. The Rockefeller Amendment dealt with it as well through a claw back. There are ways to address the CBO issues that come up in terms of costs of whether or not this is a Medicare cost or Medicaid costs and how much it's going to take out of the 400 billion dollars so to speak.

ED HOWARD: Before we take another question, let me

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just read a card if I can that's sort of on the same topic and I guess it would be John and Amy who would be the principle responders. Taking up the question of how much gets spent and therefore what it would cost the various levels of government. The questioner writes, congressional staffer, Medicaid pays very low prices for prescription drugs. Under the various proposals, Medicare will almost certainly be paying much higher prices for prescription drugs than does Medicaid, doesn't this cost saving factor support the idea of providing the coverage to duals through the Medicaid program rather than through the new Medicare drug plan.

JOHN MCMANUS: Actually that was one of the points I thought I had made. I'll try to make it again. I guess I wasn't very clear about it. Under the Medicare bill in the house and in the senate, in fact, we've exempted the Medicaid best price from the negotiations just as they do for the VA. What that means is we're getting steeper discounts as notified by the CBO who evaluates this proposal, 18 billion dollars for ten years, because the Medicaid best price structure has created pricing discipline where the manufacturers aren't interested in getting any big discounts. That's had a market wide affect on the amount of discounting in the market. So, we got better prices under the Medicare program using the free market by getting rid of the Medicaid best price control. That's what I find one of the great benefits of the house bill.

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AMY HALL: Just to add to that, I think regardless of whether or not what kinds of discounts you think private plans may get because they're somewhat untested, we would argue and actually did argue in committee last year when we marked up the Medicare bill that Medicaid shouldn't be excluded. This is sort of one of the differences between the democrats and the republicans I think on the house side. That Medicaid shouldn't be excluded if Medicare can in fact get better discounts. So, I'll just add that to John's point.

LEA KEGLER: I'll just respond really quickly. Yes, the Senate bill does enjoy that 18 billion savings that John has mentioned as well. And, I think that as my presentation showed, there were other considerations that we made when we made the policy decisions to keep the duals in Medicaid. Also looking at the quality and seeing access that I talked about. Not just financial, but we looked at those other things as well, but John is exactly right that it is in both bills.

ED HOWARD: Let's go to this microphone if we could.

KIM GLAND: Kim Gland from the Medicare Rights Center, and I have a question I think a few of you could probably answer, but Amy raised this issue of basically administrative complexity under the Senate bill, and the question is if we're under the senate bill, we're basically reversing the way that Medicare currently coordinates with supplemental insurance like Medicaid and private plans, and the question is for states and

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also the federal government and people with Medicare, how do we think that will play out and whether we think that might add to some kind of more complexity in the system than already exists.

ED HOWARD: Anyone want to try that. There's also in your materials a piece by Families USA that uses an illustration of somebody who's probably moving back and forth that presents some administrative questions for either one of these proposals.

AMY HALL: Well, I can just add one thing really quickly, I don't know if this is exactly addressing your question, but I do want just to explain real quickly why the Senate bill uses the QUIMBY SLIMBY QI-1 structure, these are programs that have been around since 1988, and they have very poor. There isn't that much enrollment in those programs, and so by building on that, these seniors are also going to get the benefit of having their premiums and copays paid for as well, and so I think that was - that played into that decision and that's also very important. So, yes, but some new costs and it's administrative complex in some ways, but it does mean that the existing system's there, and beneficiaries who are entitled to something will get that.

MIKE ROBINSON: Admittedly, I don't all the aspects of the senate bill, but from the descriptions that I've read, Medicaid is very, very complicated right now, not only for state officials, but for the recipients, and if there's any

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frequency of going on and coming off back and forth, it's very difficult to communicate those changes to recipients that the administrative staff is very difficult to keep track of that. So, I would think the more complex we make the system, in delivering the benefits will have a negative impact on people's access to benefits because they won't know where to go, won't understand what they have to do in order to sign up and be covered by whatever benefits.

LEA KEGLER: May I respond to that as well? I think that we have done a lot of thinking about the medically needy population which you are talking about. I will concede that right now in the senate bill that there aren't the necessary protections that may need to be in there for the population that's jumping on and off the Medicaid program, but I think there's ways to take care of it. Thus far, in the conference, we've worked on the prescription drug card and I think we found some ways that could probably work and maybe the beneficiary should be eligible for that benefit for the Medicare benefit that's going on and off, and they become eligible for Medicaid. Maybe they should have a - for Medicaid for the medically needy pathway, maybe that beneficiary should then become eligible for Medicare in a year, and then at that time, CMS should reassess or I think there's ways to look at and it's definitely something we're aware of it, but it's something that we're thinking about as well, and I think there's ways to address it.

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AMY HALL: The only thing I would add to this is that in terms of why do we want to design a new system when the system that we have today works very well. I mean, 99 or 98 percent of those who are eligible for Medicare are enrolled. There's a central system for getting information out, there's consistency across all the 50 states and the territories. And, when you move to Medicaid, everybody is well aware of the problems that you have in terms of getting eligible people enrolled in Medicaid, getting information out to people, and states have been trying over the years to do a much better job of this, but unfortunately, they're a long way from being, from the 99 percent rate that Medicare has, and the outreach and enrollment and information activities of states unfortunately tend to suffer when they are in times of fiscal crisis. So, those are sort of problems we need to think about in terms of designing a new system when the one we have is doing a fairly good job, and we've been encouraging CMS over the years to even improve on their outreach information campaigns and we have a good infrastructure to do that nationally.

LEA KEGLER: I don't mean to go back and forth with Amy, but I think we have a really good system in place right now. The beneficiaries are getting their benefits through Medicaid and so, I think it's a misnomer to say that we're setting up this new system. I mean everyone's getting a new system in some ways, but the Medicaid benefit does work.

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There's obviously 6.4 million people who are dually enrolled and are getting Medicaid prescription drug benefits right now. So, I just, there's a question there as well.

DIANE ROWLAND: I know our time is coming to a close, and I would say that this or all of the various alliances that I've worked on co-sponsored with Ed, generated the most questions and leaves the most green cards unanswered of anyone which I think speaks to both the importance of this issue, and I think our speakers have really helped you to understand the various issues going into this debate. So, I would just like to thank everyone on the panel and all of you for attending, and I know Ed wants to remind you to fill out your evaluation sheet before you leave, but I think this has been a really great session and thank you all for coming, and I hope this has stimulated some more thought and debate on how to resolve these issues. Thank you.

[END OF RECORDING]

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