Improving Prescription Drug Access for Dual Eligibles After the Medicare Modernization Act

JESSICA NEIDHART AGOSTINHO*

The Medicare Modernization Act of 2003 ("MMA") provided a new prescription drug benefit for millions of Americans who receive healthcare through Medicare. However, for those individuals who qualify for both Medicare and Medicaid, "dual eligibles," the change has proved harmful. Prior to the MMA, states provided prescription drug benefits to their dual eligibles through Medicaid. The MMA prohibited states from providing this coverage by mandating that dual eligibles' prescription drug benefits would solely be provided through Medicare.

Neither the dual eligibles nor the states are receiving the benefits promised. The transition from Medicaid to Medicare was not smooth, as there were lapses in coverage for dual eligibles and increased prescription drug costs. In addition, the MMA was intended to reduce states' benefit expenditures in exchange for a reduction in states' ability to control the programs' costs. The federal government, however, has required states to return most of the savings from the transfer.

Advocates and academics have so far proposed only piecemeal improvements to address the MMA's problems, but none offer a comprehensive solution to improve administration, reduce dual eligibles' lapses in coverage, and lower overall drug costs. This Note argues that the MMA should be reformed to improve administration and reduce lapses in coverage, to allow for price negotiations and lower drug costs, and to give states the means to control their health care expenditures. This solution permits states to provide health care coverage for dual eligibles through Medicaid as they successfully did before the MMA.

* Managing Editor, COLUM. J.L. & SOC. PROBS., 2009–2010. The author would like to thank Professor David Super for his guidance, and the staff and editorial board of the *Journal of Law and Social Problems* for their assistance with the production of this Note.

I. INTRODUCTION

The Medicare Modernization Act ("MMA"),[1] enacted in 2003 and implemented in 2006, brought about significant changes to government-provided medical care. One of the most controversial provisions was the addition of a prescription drug benefit to Medicare, known as Part D.[2] The addition of this program affected not only Medicare enrollees but also many beneficiaries of its sister program Medicaid, and had a particularly negative effect on those who were eligible for both programs.[3]

A. OVERVIEW OF MEDICAID AND MEDICARE

The federal government enacted Medicaid in 1965 as a means-tested program to provide healthcare for a portion of the country's low-income population. It is by far the government's most costly means-tested program, with total spending exceeding $300 billion per year.[4] The federal government and the states jointly run the program, with federal contributions based on a matching formula that takes into account each state's contribution.[5] While both state and federal entities participate in setting eligibility levels, the federal government requires states to provide Medicaid for elderly and disabled individuals with income and asset levels low

1. Medicare Prescription Drug, Improvement, and Modernization Act (Medicare Modernization Act) of 2003, Pub. L. No. 108–173, 117 Stat. 2066 (codified as amended at 42 U.S.C. §§ 139A, 223, 299b-7, 1395–96, 4980G (2006)).

2. *Id.*

3. *Id.* The negative impact of the Medicare Modernization Act on dual eligibles will be discussed *infra* Part II.

4. A means-tested program bases eligibility on a potential applicants' income, assets, or both. Each means-tested program that the federal government administers uses a different formula to determine eligibility. In addition to Medicaid, other means-tested programs include Temporary Aid for Needy Families (TANF), food stamps, housing subsidies and public-housing programs. *See* APRIL GRADY, CONGRESSIONAL RESEARCH SERV., CRS REPORT FOR CONGRESS: MEDICAID FINANCING 1 (2008), http://assets.opencrs.com/rpts/RS22849_20080702.pdf; GOV'T ACCOUNTABILITY OFFICE, MEANS-TESTED PROGRAMS: DETERMINING FINANCIAL ELIGIBILITY IS CUMBERSOME AND CAN BE SIMPLIFIED (2001), http://www.gao.gov/new.items/d0258.pdf; STAFF OF H. COMM. ON WAYS & MEANS, 108th CONG., BACKGROUND MATERIAL AND DATA ON THE PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS § 15, 1 (Comm. Print 2004) [hereinafter Green Book], http://waysandmeans.house.gov/Documents.asp?section=813.

5. Green Book, *supra* note 4, at § 15, 26. The District of Columbia is considered a state. Puerto Rico and other U.S. territories are considered states for some purposes. 42 U.S.C. § 1301(a) (2006).

enough to qualify them for Federal Supplemental Security Income ("SSI").[6] States also have discretion to cover residents who have assets or income above this level; as of 2006, twenty-one states and the District of Columbia chose to do so.[7] Most of these states extended Medicaid coverage up to 100% of the federal poverty line.[8] Medicaid is really "not one program but many"[9] due to significant variations between states' coverage levels and eligibility requirements. Because of the varying standards, different groups often gain eligibility for Medicaid through different sets of federal and state rules.[10]

Medicare, the sister program of Medicaid, was also enacted in 1965 and provides healthcare for people over age 65 as well as some disabled persons younger than 65.[11] In contrast to Medicaid, the federal government alone operates Medicare.[12] Medicare is an entitlement program, meaning that anyone who meets the age or disability requirements is qualified regardless of income or assets.[13]

Medicare coverage is divided into several components. Medicare Part A covers inpatient hospital care after payment of a minimum deductible, up to 100 days of post-hospital skilled nursing care, home healthcare services for those who need care on an intermittent basis, and hospice care services to terminally ill bene-

6. Susan Adler Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will It be Good Medicine for U.S. Health Policy?*, 14 ELDER L. J. 237, 250 (2006). Eleven states use more stringent standards derived from pre-SSI programs designed for the aged, blind, and disabled. Green Book, *supra* note 4, at § 15, 25–26.

7. Channick, *supra* note 6, at 250.

8. FAMILIES USA, TROUBLE BREWING? NEW MEDICARE DRUG LAW PUTS LOW-INCOME PEOPLE AT RISK 2 (2005), http://www.familiesusa.org/assets/pdfs/Trouble_Brewing.pdf.

9. Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL'Y & L. 821, 824 (2003). In 1966, New York, with one of the most liberal Medicare-eligibility requirements, formerly covered all families making less than $6,000 per year, which included almost half of the state's residents. Twenty-five years later, thirteen states that choose to provide coverage beyond the federal minimum set their maximum income levels below $6,000. *Id.* at 826.

10. *Id.* at 829.

11. Green Book, *supra* note 4, at § 2, 2. In order to qualify as disabled, a person under 65 must be receiving monthly Social Security benefits on the basis of disability or must receive disability payments from the Railroad Retirement System. Green Book, *supra* note 4, at § 2, 5.

12. *Id.* at 3.

13. *See id.* at 5.

ficiaries.[14] Part A's financing comes primarily from a payroll tax contribution by employees and employers.[15] Medicare automatically enrolls most people over 65 into Part A, who had gained eligibility by contributing to payroll taxes during their working years.[16]

In contrast to Part A's automatic coverage, Part B is optional for Medicare beneficiaries.[17] Part B receives financing through a combination of general revenues and premium payments by beneficiaries who choose to enroll.[18] It covers doctors' services, other practitioners' services, such as psychologists and nurses, laboratory and diagnostic work, and some preventive services.[19] While Medicare generally did not cover outpatient prescription drugs prior to the MMA, Part B does cover a small class of drugs for organ transplants, kidney failure, and cancer.[20] Some Medicare beneficiaries participate in Part A alone, while others sign up for both parts A and B.[21]

B. THE MMA AND RESULTING CHANGES TO PRESCRIPTION DRUG COVERAGE

The newest component of Medicare is Part D, created in 2003 under the MMA.[22] Part D covers Medicare's outpatient prescription drugs and is available to nearly all senior citizens.[23] Similar

14. *Id.* at 9.
15. *Id.* at 3.
16. *Id.* at 5.
17. *Id.* at 2.
18. *Id.* at 3.
19. *Id.* at 9–10. Services covered under Part B include pap smears, diabetes management training, mammograms, certain other cancer screenings, and some home health care services not covered under Part A. *Id.*
20. *Id.* at 10.
21. In 1997, Congress enacted Part C, which allowed beneficiaries to opt out of fee-for-service coverage of parts A and B by enrolling in privately-run plans. The program was originally referred to as "Medicare+Choice" but later changed to "Medicare Advantage." First Med. Health Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 48 (1st Cir. 2007); Green Book, *supra* note 4, at § 2, 134, Medicare beneficiaries receive prescription drugs either through a prescription drug plan (PDP) that provides only drug coverage, or through a Medicare Advantage Plan. Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4194 (Jan. 28, 2005) (to be codified at 42 C.F.R. pts.400, 403, 411, 417, 423).
22. Medicare Modernization Act § 101(a)(2), 42 U.S.C. §§ 1395w-101 to 112 (2006).
23. Channick, *supra* note 6, at 237. As of 2003, approximately three-quarters of Medicare beneficiaries received prescription drug coverage from non-Medicare sources, includ-

to Part B, this coverage is voluntary for most Medicare participants.[24]

Some individuals, referred to as "dual eligibles," qualify for both Medicare and Medicaid.[25] Prior to the MMA, Medicare did not cover most prescription drugs and dual eligibles could only receive drugs through State Medicaid programs.[26] As with eligibility requirements, the states had discretion to determine which drugs they would cover for Medicaid recipients.[27] The MMA now requires that all dual eligibles receive prescription drugs through Medicare, thus barring state Medicaid programs from covering prescription drugs for dual eligibles if those drugs are available through Medicare.[28]

This shift in coverage has raised several significant issues for dual eligibles. First, the transition of dual eligibles' prescription drug coverage to Medicare was not seamless. It caused lapses in benefits for many dual eligibles who often have severe health problems and inadequate resources to pay for their prescriptions.[29] These administrative problems continue to affect Medicare- or Medicaid-eligible individuals who become dually eligible. The change has also altered the government's reimbursement and negotiation structure, resulting in higher drug costs for dual eligibles — the population least able to afford the price increases.[30]

---

ing pension plans, Medicaid, or private insurance plans, while one-quarter did not have any prescription drug coverage. *Id.* While supplemental plans were available, their premiums were increasing significantly. Eleanor Bhat Sorresso, *A Philosophy of Privatization: Rationing Health Care through the Medicare Modernization Act of 2003*, 21 J.L. & HEALTH 29, 37 (2008).

24. Sorresso, *supra* note 23, at 38.

25. Green Book, *supra* note 4, at § 15, 59.

26. *See id.* at 60.

27. *See* HENRY J. KAISER FAMILY FOUND., PERSPECTIVES ON MEDICARE PART D AND DUAL ELIGIBLES: KEY INFORMANTS' VIEWS FROM THREE STATES 9–10 (2007), http://www.kff.org/medicaid/upload/7639.pdf.

28. Social Security Act § 1935(d)(1), 42 U.S.C. § 1396u-5(d)(1) (2006); First Med. Health Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 49 (1st Cir. 2007); Indep. Living Ctr. of S. Cal., Inc. v. Leavitt, No. 2:06-cv-0435-MCE-KJM, 2006 WL 4498213, at *1 (E.D. Cal. June 29, 2006).

29. *See* Jonathan Oberlander, *Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act*, 32 J. HEALTH POL. POL'Y & L. 187, 188 (2007).

30. *See* Storman v. Cal. Dep't of Health Servs., No. CIV S-06-2892 GEB GGH PS, 2007 WL 763276, at *2 (E.D.Cal. Mar. 9, 2007).

Finally, while after the MMA states no longer spend state funds to provide prescription drugs to their Medicare-eligible Medicaid participants, they must pay back most or all of their savings.[31] As a result, states have lost much of their discretion over their healthcare costs but are still required to pay similar amounts. Under the prior arrangement, the federal government provided matching funds for states to pay for Medicaid programs.[32] It continues to do so for other portions of Medicaid that the MMA did not change but fails to provide matching funds for prescription drug coverage for dual eligibles.[33]

This situation calls for an extensive remedy. Scholars' previous piecemeal approaches may alleviate one of the MMA's problems, but they fail to address, and in some cases would exacerbate, other problems. A more comprehensive approach is necessary to address the multiple issues that changes to dual eligibles' coverage raise. This Note argues that, with the goals of adequate and affordable prescription drug coverage in mind, the most practical solution is to return dual eligibles' prescription drug coverage to state-run Medicaid plans.

Part II of this Note will examine how the MMA affects prescription drug access for dual eligibles and explain why the current approach is inadequate. Part III will then discuss the many existing reform proposals, which all recognize the need for at least minimal change. Part IV will explain why these proposals fail to address the entire issue and ultimately argues that restoring dual eligibles' Medicaid prescription drug benefits is the most effective way to improve coverage.

II. THE PROBLEM FACING DUAL ELIGIBLES

Close to nine million individuals are eligible for both Medicaid and Medicare because they qualify as low-income and elderly or disabled.[34] Dual eligibles tend to be among the most vulnerable

31. Channick, *supra* note 6, at 245–46.

32. HENRY J. KAISER FAMILY FOUND., MEDICAID: A PRIMER 19 (2009), http://www.kff.org/medicaid/upload/7334-03.pdf. The matching amounts range from 50% to 76%, with the nationwie figure around 57%. *Id.*

33. *Id.* The matching amounts range from 50% to 76%, with a rate of around 50% for most states.

34. Channick, *supra* note 6, at 250; HENRY J. KAISER FAMILY FOUND., THE MEDICARE PRESCRIPTION DRUG BENEFIT 2 (2009), http://www.kff.org/medicare/upload/7044-09.pdf.

Medicare beneficiaries due to their lack of resources, poor health status, and high need for medical services.[35] Dual eligibles account for approximately 18% of Medicaid participants[36] and around 20% of Medicare beneficiaries.[37] However, because they tend to use more resources than other Medicaid beneficiaries, dual eligibles consume more than 40% of Medicaid funding.[38]

Prior to the MMA, Medicare did not provide prescription drug coverage for its beneficiaries. As a result, dual eligibles received their prescription drug coverage from Medicaid, which covered prescription drugs at state-set rates.[39] The federal government did not require states to provide prescription drug coverage through Medicaid, but all fifty states offered prescription drug coverage in some form.[40]

With the MMA's implementation in 2006, Medicare began offering prescription drug coverage to all beneficiaries, including dual eligibles.[41] The federal government considers Medicaid a payer of last resort.[42] Thus, individuals who are eligible for both plans must receive their prescription drugs through Medicare. Some states have also enacted statutes barring their Medicaid

35. HENRY J. KAISER FAMILY FOUND., THE STABILITY OF MEDICAID COVERAGE FOR LOW-INCOME DUALLY ELIGIBLE MEDICARE BENEFICIARIES 1 (2006), http://www.kff.org/medicare/upload/7512.pdf. In comparison to Medicare beneficiaries who do not qualify for Medicaid, dual eligibles tend to be "older, less well educated, and more likely to be female, non-white, non-married, and residents of long-term care facilities." *Id*. at 5. As of 2005, more than half of dual eligibles did not have high school diplomas, more than 40% were members of racial and ethnic minorities, 62% lived below the poverty line, and over one third had mental disorders, Alzheimer's, or other forms of dementia. Robert Pear, *Lawsuit Seeks to Guarantee Coverage in Drug Shift*, N.Y. TIMES, Nov. 15, 2005 (citing a study by the Medicare Payment Advisory Commission).

36. HENRY J. KAISER FAMILY FOUND., DUAL ELIGIBLES: MEDICAID'S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES 1–2 (2009), http://www.kff.org/medicaid/upload/4091_06.pdf.

37. Based on estimated 45 million medicare beneficiaries. HENRY J. KAISER FAMILY FOUND.: STATE HEALTH FACTS http://www.statehealthfacts.org/profileind.jsp?ind=290&cat=6&rgn=1.

38. HENRY J. KAISER FAMILY FOUND., *supra* note 36, at 2.

39. Channick, *supra* note 6, at 245.

40. N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp. 2d 325, 326 (S.D.N.Y. 2005).

41. Medicare Modernization Act, 42 U.S.C. §§ 1395w-101 to 112 (2006).

42. Social Security Act § 1935(d)(1), 42 U.S.C. § 1396u-5(d)(1) (2006). Medicare is the primary payer, meaning that dual eligibles' prescription drugs that are covered under both Medicare and Medicaid must receive their coverage through Medicare.

programs from covering prescription drugs that dual eligibles receive through Medicare.[43]

States continue to fund many other components of Medicaid, including long-term care, which comprises two-thirds of Medicaid spending on dual eligibles.[44] Many also subsidize Medicare Part B premiums for dual eligibles.[45] State programs may cover certain drugs beyond those Medicare offers,[46] in which case dual eligibles may continue to receive their coverage for only these drugs through Medicaid.[47]

Dual eligibles and the physicians, pharmacists, nursing home attendants, advocates, and other parties who work with them face numerous challenges.[48] These include problems with determining eligibility, obtaining payment, and keeping costs down.[49] In addition, the overlap between Medicare and Medicaid has caused challenges in coordinating between states and the federal government.[50] The following sections discuss three of the greatest challenges.

A. ADMINISTRATIVE INEFFICIENCY AND ERROR

The transfer of dual eligibles' prescription drug coverage from Medicaid to Medicare has caused gaps in coverage, forcing beneficiaries to wait for crucial medications or pay out of pocket. This problem initially arose during the transfer of existing dual eli-

43. *See, e.g.*, CAL. WELF. & INST. CODE § 14133.23 (West 2009) (eliminating the provision of drug benefits under MediCal, California's Medicaid program, for dual-eligible beneficiaries covered by Medicare).

44. HENRY J. KAISER FAMILY FOUND., *supra* note 36, at 2.

45. *Id.*

46. N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp. 2d 325, 326 (S.D.N.Y. 2005). Drugs covered by some state programs but not Medicare include drugs for anxiety and seizures, such as Xanax and Valium, as well as weight-loss and weight-gain drugs, which can be important for the elderly or those with chronic illnesses like HIV. FAMILIES USA, *supra* note 8, at 4; *see also* Centers for Medicare and Medicaid Services, Excluded Drug Coverage by State Medicaid Program, http://www.cms.hhs.gov/States/EDC/list.asp (last visited Nov. 21, 2009).

47. Storman v. Cal. Dep't of Health Servs., No. CIV S-06-2892 GEB GGH PS, 2007 WL 763276, at *2 (E.D.Cal. Mar. 9, 2007); *N.Y. Statewide Senior Action Council*, 409 F. Supp. 2d at 326.

48. *See* HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 9.

49. *Id.* at 14.

50. Channick, *supra* note 6, at 251.

gibles to Medicare, and individuals who become dually eligible today continue to experience similar problems.[51]

As of the MMA's effective date on January 1, 2006, Medicare drug plans were mandatory for all dual eligible participants.[52] The Secretary of Health and Human Services enrolled individuals who did not voluntarily sign up; if more than one plan was available a dual eligible individual's geographic area, the Secretary would randomly assign her to one.[53] The beneficiaries had no assurances that their assigned plans would cover the medicines they needed.[54] Some dual eligibles were erroneously assigned to more than one plan, while others were not assigned to any plan at all.[55] Compounding the problem, Medicaid coverage of prescription drugs ended on the same day that Medicare coverage commenced.[56] The lack of a grace period eliminated any margin for technological errors, mail delays, or any other "inevitable disruptions and confusion."[57]

In an effort to make the transition smoother, the Center for Medicare and Medicaid Services ("CMS")[58] eventually added a few weeks to the front end of the enrollment period so that dual eligibles would be informed of their auto-enrollment prior to the date of transition.[59] Advocacy groups still found this inadequate, arguing that CMS should continue to provide Medicaid benefits for dual eligibles after January 1, 2006 to avoid gaps in coverage.[60]

Several advocacy groups filed suit on behalf of dual eligibles. In *New York Statewide Senior Action Council v. Leavitt*, an advocacy group for senior citizens unsuccessfully sought an injunction

---

51. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 20–21.

52. *Id.* at 20.

53. N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp. 2d 325, 326 (S.D.N.Y. 2005).

54. Pear, *supra* note 35.

55. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 20.

56. MEDICARE RIGHTS CTR., MMA AND DUAL ELIGIBLES: A TRANSITION IN CRISIS 1 (2005), http://www.medicarerights.org/pdf/MMA_and_Dual_Eligibles.pdf.

57. *Id.*

58. CMS is the division of the U.S. Department of Health and Human Services that administers Medicare, Medicaid, and the Federal Children's Health Insurance Program (CHIP). Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov (last visited Nov. 21, 2009).

59. MEDICARE RIGHTS CTR., *supra* note 56, at 1.

60. *See* N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp. 2d 325, 326–27 (S.D.N.Y. 2005); MEDICARE RIGHTS CTR., *supra* note 56.

to require continued Medicaid coverage during the transition period.[61] Dual eligibles' poorly handled transition to Part D caused

> interrupted treatment, relapses, and hospitalization for some enrollees with severe mental illness . . . rampant confusion among seniors facing a dizzying choice of, on average, more than forty different Medicare drug plans . . . and the failure to enroll millions of low-income Medicare beneficiaries eligible for additional federal subsidies to help them pay premiums and cost sharing for their prescription drug coverage.[62]

Similar transition problems will continue for individuals who are, or will become, Medicaid eligible.[63] Approximately 10% of dual eligibles each year are new enrollees, which represents hundreds of thousands of individuals.[64] In addition, the dual eligibles who must switch plans, such as those who were assigned a plan that does not cover necessary prescriptions, encounter similar difficulties with the transfer.[65] Moreover, many dual eligibles do not receive or cannot understand the necessary information to help them enroll in or switch plans.[66]

Although intended to be seamless and cost-free, in practice the transfer from Medicaid to Medicare imposes financial costs on low-income beneficiaries, the individuals least able to afford them. For Medicare's purposes, dual eligibles are treated in the same manner as other beneficiaries who do not qualify for Medicaid,[67] and so their ability to pay is not taken into account when determining co-payments. Even those with incomes below the poverty line must make prescription drug co-payments between

---

61. 409 F. Supp.2d 325. The district court dismissed the case because the organizations could not yet identify specific individuals who would "slip between the cracks" because of the transition. *Id.* at 329–30. The court also found that even if the plaintiffs were individuals entitled to judicial review under the MMA, they had not exhausted their administrative remedies. *Id.*; *see also* Pear, *supra* note 35.

62. Oberlander, *supra* note 29, at 188–89 (citations omitted).

63. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 20–21.

64. HENRY J. KAISER FAMILY FOUND., *supra* note 35, at 8.

65. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 21–22.

66. *Id.* at 20–21.

67. Timothy Stoltzfus Jost, *The Most Important Health Care Legislation of the Millennium (So Far): The Medicare Modernization Act*, 5 YALE J. HEALTH POL'Y L. & ETHICS 437, 438–39 (2005).

$1 and $5,[68] amounts which dual eligibles often need assistance paying.[69] Under the new arrangement, some states supplement Medicare coverage by subsidizing dual eligibles' drug co-payments, while other states offer no assistance to low-income beneficiaries.[70]

Further complications arise when pharmacies refuse to dispense medications if co-payments are not made at the time of purchase.[71] Even in states that provide subsidies, some pharmacies have incorrectly assessed co-payments or erroneously required co-payments above the price limit.[72] As a result, some dual eligibles do not receive necessary drugs because they are unprepared or unable to pay for them.[73] Since the states are barred from using their Medicaid funds to cover drugs that are covered under Medicare,[74] patients must use Medicare coverage to obtain their prescriptions — even if that means they are unable to afford their medication. Both individuals and organizations representing dual eligibles have filed lawsuits complaining that dual eligibles are unable to afford medications.[75]

In the case of institutionalized dual eligibles, a subset of the dual-eligible population, Medicare's failure to pay adequate reimbursements has directly affected long-term care providers and pharmacies. Unlike other dual eligibles, institutionalized dual

68. Storman v. Cal. Dep't of Health Servs., No. CIV S-06-2892 GEB GGH PS, 2007 WL 763276, at *2 (E.D.Cal. Mar. 9, 2007).

69. First Med. Health Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 49 (1st Cir. 2007).

70. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 10. Along with several other states, Florida, home to approximately 400,000 dual eligibles, does not supplement Part D coverage with a "wraparound" for non-formulary drugs, nor does it provide a copayment subsidy. *Id.*

71. *Id.* at 16–17.

72. *Id.*

73. *Id.*

74. Storman v. Cal. Dep't of Health Servs., No. CIV S-06-2892 GEB GGH PS, 2007 WL 763276, at *2 (E.D.Cal. Mar. 9, 2007).

75. *See, e.g.*, *Storman,* 2007 WL 763276; Situ v. Leavitt, No. C06-2841 TEH, 2006 WL 3734373 (N.D. Cal. Dec. 18, 2006). In *Storman,* the plaintiffs alleged that they were forced to pay prescription drug co-pays that they could not afford, violating their Equal Protection Clause rights. Ultimately, the court dismissed the complaint because it found a rational relationship between the government's allocation of limited resources to dual eligibles and fostering recipient accountability. *Storman*, 2007 WL 763276, at *5. The court emphasized that "poverty alone is not a suspect classification demanding strict scrutiny," and thus the government only needed to demonstrate a rational basis for its action. *Id.*

eligibles are not required to make co-payments.[76] Their prescription drugs are dispensed by their long-term care facilities, which seek reimbursement from various private prescription drug plans ("PDPs") that have contracted with Medicare to provide drugs through Part D.[77] Once a beneficiary receives a prescription drug from the pharmacy, the pharmacy then bills the PDP for reimbursement for the price of the drug minus any co-payment made by the beneficiary.[78]

The Center for Medicare and Medicaid Services provides information to the PDP on whether the beneficiary must make a co-payment.[79] If the transaction is handled properly, an institutionalized dual eligible should not be required to make a co-payment at the time of purchase, and the PDP should reimburse the pharmacy for the full cost of the drug.[80] However, in many cases the participants have not been correctly identified as institutionalized, causing inadequate or late reimbursements to pharmacies, long-term care centers, and nursing homes.[81] In *Long Term Care Pharmacy Alliance v. Leavitt*, a representative of CMS admitted that there is "an 'inherent' lag time of at least one to seven weeks in the process by which CMS compiles data regarding which beneficiaries qualify as institutionalized dual eligibles."[82] While the case was ultimately dismissed for lack of standing, it illustrates the intrinsic challenges in transitioning from Medicaid to Medicare, for which the MMA was unprepared.

B. INCREASED PRESCRIPTION DRUG COSTS

In addition to transactional and administrative challenges, the transition of dual eligibles' prescription drug coverage from Medicaid to Medicare increased their costs for prescription drugs and simultaneously decreased the types of drugs available to them.[83] The Congressional Research Service ("CRS") found that "some

76. *See, e.g.*, Long Term Care Pharmacy Alliance v. Leavitt, 530 F. Supp. 2d 173, 176 (D.D.C. 2008).
77. *Id.* at 175–76.
78. *Id.* at 176–77.
79. *Id.* at 175.
80. *Id.* at 177.
81. *Id.*
82. *Id.*
83. *See* Sorresso, *supra* note 23, at 38.

non-institutionalized dual eligibles may pay more per prescription under the Medicare Part D benefit than they currently do under Medicaid."[84] The cost increase varies depending on income level as well as the type and number of prescription drugs used.[85]

The MMA adopted a "laissez-faire approach" to drug pricing.[86] While under Medicaid the government negotiates the drug prices, under Part D the negotiating power is transferred to PDPs, private entities who then negotiate drug costs directly with pharmaceutical companies.[87] The MMA expressly prohibits the Secretary of Health and Human Services ("HHS") from negotiating prescription drug prices on behalf of Medicare enrollees.[88] CRS found that while "[i]n theory, the federal government may be able to leverage its market share to negotiate lower prices," the "noninterference" clause prevents the government from seeking lower prices.[89] The House recognized this problem and, in January 2007, passed the Medicare Prescription Drug Price Negotiation Act.[90] The Act would have required the Secretary to negotiate drug prices for this coverage, but the Senate failed to pass the bill.[91]

Under Medicare, market forces are supposed to promote competitive drug pricing that is lower or equal to Medicaid coverage.[92] According to Harvard professors Richard Frank and Joseph Newhouse, it appears to have worked "reasonably well" for most beneficiaries.[93] Their study found an approximately 8% increase in the costs of prescription drugs for dual eligibles under Medi-

84. KAREN TRITZ, CONGRESSIONAL RESEARCH SERV., IMPLICATIONS OF THE MEDICARE PRESCRIPTION DRUG BENEFIT FOR DUAL ELIGIBLES AND STATE MEDICAID PROGRAMS 4 (2005), http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS21837022520 05.pdf.

85. *Id.*

86. Richard G. Frank & Joseph P. Newhouse, *Should Drug Prices Be Negotiated Under Part D of Medicare? And If So, How?*, 27 HEALTH AFF. 33, 33 (2008).

87. Sorresso, *supra* note 23, at 40.

88. GRETCHEN A. JACOBSON ET AL., CONGRESSIONAL RESEARCH SERV., PHARMACEUTICAL COSTS: A COMPARISON OF DEPARTMENT OF VETERANS AFFAIRS (VA), MEDICAID, AND MEDICARE POLICIES 4–5 (2007), http://lieberman.senate.gov/documents/crs/vapharma.pdf.

89. *Id.* at 5.

90. Medicare Prescription Drug Price Negotiation Act of 2007, H.R. 4, 110th Cong. (2007).

91. *Id.*

92. Frank & Newhouse, *supra* note 86, at 35.

93. Frank & Newhouse, *supra* note 86, at 34.

care as compared to Medicaid.[94] The study also found that for drugs that dual eligibles use most heavily, drug companies reported an increase in their profits after the transition from Medicaid to Medicare.[95]

While the precise source of this cost increase is unclear, it may signal that the bargaining power of PDPs is weaker than anticipated, and that they have limited incentives to bargain aggressively with drug companies.[96] In addition, for drugs that do not face fierce market competition or that have unique benefits, the MMA's system may not result in any significant cost savings.[97]

C. SHIFT IN STATE-FEDERAL RELATIONS

In addition to the challenges posed for dual eligibles, the shift in control from the states to the federal government also raises federalism concerns. The MMA bars state Medicaid programs from covering prescription drugs for dual eligibles if the drugs are covered under Part D.[98] Originally, proponents of the MMA claimed that the new arrangement would relieve states of the cost of providing prescription drug coverage to dual eligibles.[99] In return, Congress included a clawback provision that required states to return a portion of their savings to account for the shift in spending from the states to the federal government.[100] Under the MMA's system, instead of directly paying for the drugs, states must contribute to Part D plans for their dual-eligible citizens

94. Marilyn Moon, *Letter: Improve Treatment of Dual Eligibles*, 27 HEALTH AFF. 894 (2008) (referring to the Frank and Newhouse study).

95. Frank & Newhouse, *supra* note 86, at 36–37. The study noted that because Medicaid and PDP prices are confidential and statutorily protected, they could not do a direct comparison of prices paid. Instead, the professors looked at the Form 10-Q filings of several large pharmaceutical companies, which all noted favorable changes in prices resulting "from the shift of large numbers of users of antipsychotic medications" — often used by dual eligibles — "from Medicaid to Part D." *Id.*

96. *Id.* at 37.

97. Sorresso, *supra* note 23, at 40.

98. First Med. Health Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 49 (1st Cir. 2007). The MMA exempted territories such as Puerto Rico from this provision. *Id.*; *see* Social Security Act § 1935(e), 42 U.S.C. § 1396u-5(e) (2006).

99. *See* Robert Pear, *States Protest Contributions to Drug Plan*, N.Y. TIMES, Oct. 18, 2005.

100. *Id.*

who previously received prescription drug coverage under Medicaid.[101]

As noted in Part I, the federal government requires that states provide Medicaid to all individuals with income and asset levels low enough to qualify them for Federal Supplemental Security Income.[102] States also have discretion to cover residents who have assets or income above this level, and many do.[103] At the time of the MMA's enactment, twenty-one states and the District of Columbia covered some elderly and disabled people with incomes above the SSI level.[104] Traditionally, states were able to control their Medicaid spending levels by "altering eligibility, covered services, cost-sharing and premiums paid by beneficiaries, [healthcare] provider reimbursement rates, and other aspects of the program within broad federal guidelines."[105] The MMA deprives them of these mechanisms to alter spending by shifting all coverage decisions to Medicare.

Even though states are no longer responsible for covering dual eligibles and do not have control over the cost of coverage, the MMA's clawback provision requires states to pay the federal government a significant portion of the money they save by no longer providing prescription drug coverage to dual eligibles.[106] The Congressional Budget Office estimated that the clawback payments from states to the federal government will total $124 billion between 2006 and 2015.[107]

This clawback provision calculates payments using a formula based on four factors: (1) the amount each state spent per capita on Medicaid prescription drug benefits for dual eligibles in 2003; (2) nationwide prescription drug price inflation; (3) the number of dual eligibles enrolled in Part D from that state; and (4) a percentage based on the year in which the payment is calculated.[108] Of these factors, states only have control over the number of dual

101. Channick, *supra* note 6, at 251.
102. FAMILIES USA, *supra* note 8, at 1.
103. *Id.*
104. *Id.*; Channick, *supra* note 6, at 250.
105. GRADY, *supra* note 4, at 3.
106. Pear, *supra* note 99.
107. *Id.*
108. FAMILIES USA, *supra* note 8, at n.1. The fourth factor, the year of payment, establishes a percentage that states must pay. In 2006, states were required to pay 90% of their clawback amount, declining to 75% in 2013.

eligibles within their borders.[109] Thus, states must reduce the number of people covered above the SSI minimum to lower costs.[110] This may tighten Medicaid eligibility levels and reduce the number of low-income individuals who qualify for prescription drug coverage.[111] As early as 2005, Florida, Mississippi, and Missouri announced plans to cut coverage for some or all elderly and disabled enrollees with incomes above the federally-mandated level to reduce the states' financial burdens.[112] These cuts alone could affect over 200,000 former Medicaid recipients.[113]

In addition to reducing Medicaid eligibility in many states, the clawback provision also raises significant federalism issues. States are forfeiting flexibility in program administration while continuing to pay for Medicare under the new arrangement.[114] As law professor Susan Channick has observed, a federal law that requires states to pay a substantial portion of its costs while giving them limited control, as in this situation, is "unprecedented in the history of federalism."[115] Rather than relinquishing control over the prescription drug coverage of their residents and receiving cost savings in return, the states instead have similar prescription drug costs but severely limited means to control them.

While the MMA has many other flaws, the three broad issues discussed above are the most significant because their effects permeate the dual-eligible population. The administrative difficulties stem from a poorly managed transition from Medicaid to Medicare and the absence of a safety net to catch dual eligibles that might fall through the cracks. The attempt to allow market forces to regulate prescription drug costs has caused otherwise avoidable cost increases for the population that is least able to afford them. Finally, the change in state and federal roles has

109. Channick, *supra* note 6, at 251.
110. *Id.*
111. *Id.*
112. FAMILIES USA, *supra* note 8, at 2. The federal government mandates that states provide Medicaid coverage for those making less than 73% of the poverty line. Many states have chosen to extend coverage to those making above this level, often up to 100% of the poverty line.
113. Channick, *supra* note 6, at 251. The figure includes individuals affected by similar changes contemplated in North Carolina.
114. *Id.* at 246.
115. *Id.*

resulted in limited cost savings and a substantial loss of autonomy for states in their administration of Medicaid benefits.

III. EXISTING REFORM PROPOSALS

Despite the MMA's significant problems surrounding its transition of dual eligibles from Medicaid to Medicare prescription drug coverage, few major reform proposals exist. Most scholars and advocacy groups have suggested small adjustments to improve coverage for dual eligibles or make information more readily available to all Medicare Part D enrollees. As a result, each proposed solution addresses only a segment of the problem. These proposals range from simply increasing outreach for dual eligibles to broader structural changes in the way enrollees receive and pay for their prescription drugs. However, none successfully address all of the issues discussed above regarding the transfer of dual eligibles' prescription drug coverage from Medicaid to Medicare.

A. OUTREACH

One common complaint voiced by advocates for dual eligibles is a lack of effective communication between agencies and the dual eligibles that the MMA affected, particularly those who have limited English proficiency or literacy.[116] Outreach to inform dual eligibles about the prescription drug-benefits under Part D and its components may reduce confusion and assist with enrollment and administration.[117] Suggestions include assisting dual eligibles choose plans, ensuring that complete formulary information is available, and improving the quality of phone and online assistance.[118]

Following enactment of the MMA, CMS worked with state, local, and non-governmental groups at thousands of outreach events.[119] CMS established an online database to help Medicare

116. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 20.

117. *See id.* at 20–24.

118. *Id.* at 24, 27.

119. *Medicare Part D: Is It Working for Low-Income Seniors?: Hearing Before the S. Special Comm. on* Aging, 110th Cong. 18 (2007) [hereinafter *Kocot Statement*] (statement of Larry Kocot, Senior Advisor to the Administrator, Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services). *available at*

participants understand the various options available to them.[120] However, the effectiveness of this database will be limited because only 19% of seniors have internet access,[121] and the percentage of low-income seniors with internet access is likely even lower. Coordination with community-based organizations would probably be more effective at reaching this population, but the funding is insufficient for these organizations to reach the 42 million beneficiaries.[122] Ultimately, while communication may improve recipients' understanding of the existing plan, no amount of information can cure the numerous substantive problems inherent in the new plan's design.

B. ADMINISTRATIVE CHANGES

In response to the administrative issues that CMS found affected many dual eligibles' access to prescription drugs, CMS worked to improve its data systems, improve communications with pharmacies, and upgrade software to improve transmission of information between it and prescription drug providers.[123] For dual eligibles left unassigned to a Medicare prescription drug plan, CMS offered a "Point of Sale" plan where pharmacists could immediately enroll dual eligibles to provide coverage until the individual was correctly enrolled in a permanent plan.[124] Many pharmacists and others working with dual eligibles, however, did not know about this option or were unwilling or unable to apply it, undermining its effectiveness.[125]

Another potential remedy to ease the administrative burdens of Medicare coverage for dual eligibles is to lower the frequency of eligibility determinations, which would reduce the number of dual eligibles erroneously removed from the program.[126] The Kaiser Family Foundation has suggested that current annual

---

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_senate_hearings&docid=f:34647.pdf.

120. *See* Brian Biles, Geraldine Dallek, & Lauren Hersch Nicholas, *Medicare Advantage: Déjà Vu All Over Again?*, HEALTH AFF. 586, 588 (2004), http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.586v1.

121. *Id.*

122. *Id.*

123. Kocot Statement, *supra* note 119, at 18.

124. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 21.

125. *Id.*

126. *See* HENRY J. KAISER FAMILY FOUND., *supra* note 35, at 8.

assessments of eligibility are excessive and that less frequent redetermination of continued dual eligibility would both reduce administrative costs and ease the burden on dual-eligible enrollees.[127] The foundation notes that "[t]he conventional wisdom is that once Medicare beneficiaries qualify for Medicaid, they stay on it for life."[128] New entrants and death are the primary causes of turnover among dual eligibles, not loss of coverage from either voluntary withdrawal or administrative disentitlement.[129] The foundation cites two surveys demonstrating the low turnover among Medicaid enrollees.[130] In the first study, 84% of Medicare beneficiaries enrolled in Medicaid as of January 1995 maintained Medicaid eligibility through December of 1996.[131] The later study, conducted by the Kaiser Family Foundation, found that 60% of Medicare beneficiaries receiving Medicaid between 1997 and 2000 were continually enrolled, and that only between 4% and 7% of dual eligibles lost eligibility for Medicaid each year.[132]

Despite the evidence of low turnover, dual eligibles continue to face burdensome and costly annual eligibility redeterminations.[133] Noting that "dual eligibles experience minimal churning due to changes in income or assets, unlike younger, non-disabled Medicare recipients," the foundation concluded that the requirement of annual eligibility redeterminations may be excessive and less frequent assessments would be more practical.[134] This solution would save money and administrative resources as well as ease the burden on beneficiaries who would not be required to provide documentation of their current status as frequently.[135]

While each of the above approaches would ease the administrative burden, they do not address the issues of inadequate coverage, cost control, or state purging of low-income Medicaid recipients from their rolls.

---

127. *Id.*
128. *Id.* at 2.
129. *Id.* at 1.
130. *Id.* at 2, 5. While both were conducted prior to the MMA's enactment, the principles remain applicable.
131. *Id.* at 2.
132. *Id.* at 5. In addition, of those dual eligibles losing Medicare coverage during the four-year period, nearly 40% regained it within one year, but many had no supplemental health-insurance benefits for extended periods. *Id.* at 6.
133. *Id.* at 2.
134. *Id.* at 8.
135. *Id.*

C. PRICE CONTROLS

Other plan D reform proposals aim to improve Medicare's ability to negotiate lower prices with drug manufacturers. As noted in Part II.B above, the federal government cannot negotiate prices for prescription drugs under Medicare.[136] This restriction does not apply to state Medicaid plans.[137] Instead, under Medicare the PDPs are responsible for negotiating prices with prescription drug companies, which has caused an increase in drug prices for several pharmaceuticals that dual eligibles commonly use.[138]

In the 110th Congress, both the Speaker of the House and the Senate Majority Leader proposed repealing the ban on the federal government negotiating prices.[139] In 2007, the House passed a bill that would have required the Secretary of HHS to negotiate drug prices.[140] However, the bill did not pass the Senate; Senate Majority Leader Harry Reid cited the influence of the pharmaceutical and insurance industries as one reason for this failure.[141] A joint survey by the Kaiser Family Foundation and the Harvard School of Public Health found that 85% of Americans were in favor of permitting the federal government to negotiate drug prices for Medicare.[142]

---

136. JACOBSON ET AL., *supra* note 88, at 4–5; *see* Medicare Prescription Drug Price Negotiation Act of 2007, H.R. 4, 110th Cong. (2007).

137. JACOBSON ET AL., *supra* note 88, at 14.

138. *See* Frank & Newhouse, *supra* note 86, at 36–37.

139. JACOBSON ET AL., *supra* note 88, at 2; *see also* Press Release, The Henry J. Kaiser Family Found., New Poll Finds Broad Support Among Democrats, Independents, and Republicans for Drug Price Negotiation, Reimportation, and Prioritizing Children for Coverage of the Uninsured (Dec. 8, 2006), http://www.kff.org/kaiserpolls/pomr120806nr.cfm.

140. H.R. 4. The relevant language states that "Notwithstanding any other provision of law, the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered Part D drugs for Part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan." *Id.* at 2.

141. Medicare Prescription Drug Price Negotiation Act of 2007, S. 3, 110th Cong. (2007). Senate Democrats sought to invoke cloture, which would have required an immediate vote on the bill, but did not receive the required sixty votes. Klaus Marre, *Senate GOP Blocks Medicare Part D Negotiation Bill,* HILL, Apr. 18, 2007, *available at* http://thehill.com/homenews/news/11611-senate-gop-blocks-medicare-part-d-negotiation-bill.

142. Press Release, The Henry J. Kaiser Family Found., *supra* note 139. The Kaiser Family Foundation poll found bipartisan support for allowing the government to negotiate prices — 92% of Democrats, 85% of Independents, and 74% of Republicans. *Id.*

The Congressional Research Service has suggested several methods to decrease out-of-pocket prescription drug costs for all Medicare Part D enrollees, two of which involve price controls that make Medicare coverage more similar to Medicaid.[143] The first establishes a ceiling price for Medicare, similar to the limits imposed on Medicaid prescription drug coverage.[144] However, CRS notes that this only assures that prices will not increase above a set level, and does not necessarily translate into lower prices for consumers because there is no guarantee that costs lower than the ceiling will be passed along to consumers.[145] The second option is to mandate that manufacturers provide rebates to Part D prescription drug plans, similar to Medicaid's rebate system.[146] These lower costs should then theoretically be passed along to beneficiaries through lower premiums or co-payments.[147]

According to CRS, by reducing the reimbursements paid to the pharmaceutical companies and thereby decreasing the profits available for pharmaceutical research, both ceiling prices and rebates may indirectly affect access to "future innovative drug products."[148] However, this is true for any cost control measure that reduces the reimbursements paid to pharmaceutical manufacturers. Setting price ceilings too low might cause drug companies to decrease research and development, or prescription drug coverage outside of Medicare to significantly increase in price, which would harm other consumers. In determining price limits, therefore, a balance must be struck between lowering dual eligibles' out-of-pocket expenses and the need to avoid shifting too much of the burden elsewhere.

Similarly, Professors Frank and Newhouse suggest requiring manufacturers to sell drugs that dual eligibles use to Medicare plans at prices approximating Medicaid rates.[149] Frank and Newhouse note that although they considered proposing that

143. JACOBSON ET AL., *supra* note 88, at 16–18.
144. *Id.* at 16–17.
145. *Id.* at 16.
146. *Id.* at 17.
147. *Id.*
148. *Id.* at 16–17.
149. Frank & Newhouse, *supra* note 86, at 40. Frank is the Margaret T. Morris Professor of Health Economics in the Department of Health Care Policy at Harvard Medical School. Newhouse is the John D. MacArthur Professor of Health Policy and Management at Harvard University.

dual eligibles be transferred back to Medicaid, they rejected the idea because they feared it would cause distortions to private-sector prices.[150] Under Medicaid's "best price" rule, Medicaid prescription drug prices are tied to the lowest rates paid by private payers.[151] This weakens private insurers' bargaining power by incentivizing manufacturers to offer the private insurers fewer and smaller price concessions, knowing that they must offer the same concessions to Medicaid.[152]

Rather than transferring dual eligibles back to Medicaid and potentially increasing the influence of the best-price policy on private insurers' prices, Frank and Newhouse suggested "a targeted set of price controls for the drugs used by dually eligible beneficiaries that are decoupled from private-insurer prices."[153] This would help reduce the discrepancy between Medicaid and Medicare Part D prescription drug prices, and it would avoid harming dual eligibles' ability to obtain prescription drugs.

CRS, as well as several senators, proposed amending the Part D program to resemble the Veterans Affairs ("VA") prescription drug program.[154] The VA pharmaceutical procurement system uses pricing the federal government sets in the Federal Supply Schedule ("FSS"), which provides pricing for all products the federal government uses — including office supplies, equipment, and pharmaceuticals.[155] FSS prices for brand-name drugs must not exceed the prices that the pharmaceutical manufactures charge their Most-Favored Customers ("MFCs") under similar terms and conditions.[156] MFCs include customers or classes of customers that receive the best discounts or price arrangements on a particular item from a particular supplier.[157]

---

150. *Id.*

151. Richard G. Frank & Joseph P. Newhouse, *Letter: Dual Eligibles: The Authors Respond*, 27 HEALTH AFF. 894–95 (2008).

152. *Id.*

153. *Id.*

154. JACOBSON ET AL., *supra* note 88, at 16–17; 149 Cong. Rec. S15,882-03 (2003).

155. JACOBSON ET AL., *supra* note 88, at 8–9 ("The FSS is open to all federal agencies in the executive, legislative and judicial branches — including the VA, Department of Defense (DOD), Public Health Service (PHS), Bureau of Prisons — and several other purchasers including the District of Columbia, and Indian tribal governments.").

156. *Id.* at 9.

157. *Id.* Under the Veterans Affairs' (VA) program. which uses MFC pricing, the pharmaceutical manufacturers must provide the VA with a commercial-price list for the proposed items and disclose the recent prices granted to MFCs. *Id.*

Alternatively, the pricing could be structured like the Medicaid "best price" rebate system, which requires that Medicaid receive the lowest price at which a drug manufacturer sells its product or 15.1% less than the average manufacturer price for the drug, whichever is lower.[158] Both programs are designed to ensure that the price enrollees pay for government plans is no higher than the price beneficiaries pay for private prescription drug plans.

Price controls would help to alleviate cost increases that some dual eligibles face due to their transfer from Medicaid to Medicare. Price controls would also strengthen the federal government's ability to secure the lowest prices for not only dual eligibles, but all Part D beneficiaries. If pricing were the only issue, price controls might be an effective way to address this challenge. However, the price-control proposals fail to address the transition's significant administrative challenges, thus presenting an incomplete solution.[159]

D. STRUCTURAL CHANGES

Some sources discuss transferring dual eligibles back to Medicaid as an option.[160] As noted above, Frank and Newhouse considered but ultimately rejected this option because of concerns that the "best price" rule would cause distortions in private-sector drug prices.[161] Increasing the percentage of the population Medicaid covers would further decrease the bargaining power of private insurers by requiring that any discounts or savings offered to them would also need to be available to Medicaid.[162]

The minority staff of the Committee on Oversight and Government Reform similarly noted that one option "is to return the dual-eligible population to the Medicaid program for the purposes

158. Frank & Newhouse, *supra* note 86, at 35. The "average manufacturer price" (AMP) is the "price at which manufacturers sell to wholesalers net of prompt-pay discounts." *Id.* at 43 & n.10.

159. Combining the various proposals is one option for improving the current arrangement. This will be discussed *infra* Part IV.

160. *See* COMM. ON OVERSIGHT & GOV'T REFORM, REPUBLICAN STAFF ANALYSIS, COMPARING MEDICARE AND MEDICAID DRUG PRICING: APPLES, ORANGES, AND WINDFALLS 3 (2008); Frank & Newhouse, *supra* note 151, at 894-95.

161. Frank & Newhouse, *supra* note 151, at 894–95.

162. *Id.*

of providing prescription drug coverage."[163] The report ultimately rejected this approach, finding that although it would expand the Medicaid price controls to the dual-eligible population, it would only shift costs elsewhere.[164] This Note argues that, with some alterations, returning dual eligibles to Medicaid prescription drug coverage is in fact a viable and practical solution to the challenges that Part D poses.

Each of the proposals outlined above addresses one of the three main challenges posed by the MMA's transfer of dual eligibles' prescription drug coverage from Medicaid to Medicare. However, none of them attempt to solve the multiple issues with one comprehensive solution.

IV. PROPOSED SOLUTION: RETURN DUAL ELIGIBLES TO MEDICAID

The current prescription drug coverage for dual eligibles strikes an awkward and contentious balance between federal-government control and state funding, with additional state supplemental prescription drug coverage at state officials' discretion. This forces dual eligibles, who are overwhelmingly poor and uneducated,[165] to navigate not one but two government-benefits programs, which have "complicated and sometimes conflicting rules."[166] Apart from the burden on beneficiaries, the current scheme also raises issues of administrative burden, errors, cost control, and federalism.[167]

Dual eligibles would be better served and less likely to fall through the cracks if one of the two entities fully, or almost fully, provided their prescription drug coverage. Although plan D's restriction of prescription drug coverage to only Medicare may seem like a workable idea, this Note has shown that this often not the case. Instead, returning dual eligibles' prescription drug cover-

163. COMM. ON OVERSIGHT & GOV'T REFORM, *supra* note 160, at 3.

164. *Id.*

165. HENRY J. KAISER FAMILY FOUND., *supra* note 35, at 1; Pear, *supra* note 35.

166. JENNIFER RYAN & NORA SUPER, NAT'L HEALTH POLICY FORUM, ISSUE BRIEF: DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID: TWO FOR ONE OR DOUBLE JEOPARDY? 10 (2003), http://www.nhpf.org/library/issue-briefs/IB794_Duals_9-30-03.pdf.

167. *See, e.g.*, Channick, *supra* note 6.

age to Medicaid is a more administratively feasible and less problematic course.

A. MEDICARE COVERAGE ALONE: AN IMPRACTICAL OPTION

Even if the government mandated that all prescription drug coverage for dual eligibles be handled through Medicare, it would still need to tolerate a significant level of subsidization from Medicaid. In addition to dual eligibles, states also subsidize co-payments, premiums, and deductibles for some low-income Medicare beneficiaries who do not qualify for full Medicaid.[168] These groups include Qualified Medicare Beneficiaries ("QMBs"), who have incomes no greater than 100% of the poverty line, Specified Low-Income Medicare Beneficiaries ("SLMBs"), who have income no greater than 120% of the poverty line, and other groups who do not qualify for full Medicaid but meet other income and asset limits.[169]

Dropping all Medicaid subsidies for dual eligibles would create a counterproductive result because dual eligibles, who have less income and fewer assets than the QMBs and SLMBs, would receive less co-payment, premium, and deductible assistance. Medicare, as a non-means-tested program, is not equipped to subsidize low-income beneficiaries' coverage. Medicaid subsidization remains necessary to ensure that dual eligibles receive at least the same level of assistance as higher-income beneficiaries.

While permitting only Medicare coverage for dual eligibles' prescription drug coverage would satisfy the requirement that Medicaid be the payer of last resort[170] because Medicare would be the primary prescription drug provider for this population, it would also create several negative results. For many dual eligibles this would reduce the drugs covered, as some state Medicaid plans cover more than the current Medicare minimum requirement,[171] thus limiting prescription drug choices for dual eli-

168. *See* Green Book, *supra* note 4, at § 15, 38–39.
169. *Id.*
170. RYAN & SUPER, *supra* note 166, at 5.
171. *See* Storman v. Cal. Dep't of Health Servs., No. CIV S-06-2892 GEB GGH PS, 2007 WL 763276, at *2 (E.D.Cal. Mar. 9, 2007); N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp .2d 325, 326 (S.D.N.Y. 2005).

gibles.[172] Relying on Medicare alone would increase costs because Medicare Part D prescription drug coverage is likely more costly than Medicaid prescription drug coverage due to the program's restrictions on price negotiations.[173]

In addition, allowing only Medicare prescription drug coverage would not avoid the challenges of coordinating Medicare and Medicaid coverage for dual eligibles because the arrangement would still require primary Medicare coverage with Medicaid supplementation. This approach also would not address the federalism issues raised by the compulsory state contributions to Medicare Part D coverage for their dual-eligible populations. To require the states to continue paying funds back to the federal government for Medicare coverage of dual eligibles would not solve the problem of states' inability to control their Medicaid costs through means other than tightening eligibility requirements.[174]

B. THE RIGHT SOLUTION: RESTORING MEDICAID COVERAGE FOR DUAL ELIGIBLES

A more effective and feasible option than limiting dual eligibles' coverage or restricting them to Medicare coverage is to return them to Medicaid coverage through the states. This approach was proposed in the original Senate version of the MMA, which intended to optionally offer Part D for Medicaid beneficiaries;[175] however, the provision was eliminated from the final bill.[176] In addition, several of the existing proposals discussed in Part III above recognize the benefits of Medicaid's design, as they suggest changes that would make Medicare's prescription drug coverage more like Medicaid's.[177] All of the sources recognize that Medicaid, not Medicare, is the best provider of prescription drug benefits for dual eligibles.

172. *See* Channick, *supra* note 6, at 248.

173. *See* Frank & Newhouse, *supra* note 86; *see* discussion *supra* Part II.B (evaluating cost controls).

174. *See* Channick, *supra* note 6, at 251.

175. S. 1, 108th Cong. (2003).

176. *See generally* RYAN & SUPER, *supra* note 166, at 2.

177. *See* discussion *supra* Part III.C*;* JACOBSON ET AL., *supra* note 88, at 14–16; Frank and Newhouse, *supra* note 86, at 40.

1. *Benefits of Returning Dual Eligibles to Medicaid Coverage*

Allowing Medicaid to cover dual eligibles presents numerous benefits. First, it lowers costs for prescription drug consumers by permitting government providers to negotiate drug costs. Unlike the Medicare,[178] State Medicaid plans are permitted to negotiate costs, and the "best price" provision allows them to ensure that Medicaid receives prescription drug prices at least as low as those of private plans.[179] The lower prices would be passed along to enrollees.[180]

As previously noted, Professors Frank and Newhouse expressed concern that transferring dual eligibles to Medicaid would increase the use of the best-price provision and, as a result, would decrease the power of private insurers to negotiate drug prices because any benefit a prescription drug company offered to a private insurance plan would also need to be available to Medicaid.[181] However, this challenge existed prior to the MMA, and state Medicaid plans still provided prescription drug benefits for dual eligibles.[182] The best-price provision apparently did not impede Medicaid-covered prescription drugs.

In addition, use of the best price provision would create greater equity between prescription drug prices for dual eligibles and individuals that can afford private plans or receive private health insurance from employers. As dual eligibles are a generally poor and sickly population,[183] they should pay prescription drug prices that are no higher than those with greater ability to pay. This is true even if lowering prices for dual eligibles means reducing the ability of private insurers to offer price breaks.

Transferring dual eligibles' prescription drug coverage to Medicaid would also avoid the MMA's administrative challenges. Under the MMA, Medicare must provide dual eligibles' primary

178. *See* JACOBSON ET AL., *supra* note 88, at 4–5.

179. Frank & Newhouse, *supra* note 86, at 35; Sorresso, *supra* note 23, at 40; *see* discussion *supra* Part III.

180. JACOBSON ET AL., *supra* note 88, at 16–17. This provision would not be appealing to pharmaceutical companies, as their strong resistance to the Medicare Prescription Drug Negotiation Act of 2007 may have contributed to its failure. Marre, *supra* note 141.

181. Frank & Newhouse, *supra* note 866, at 895–95.

182. N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp. 2d 325, 326 (S.D.N.Y. 2005).

183. *See* Robert Pear, *Subsidies to Poor Pose a Hurdle to Compromise on Medicare Bill*, NY TIMES, July 21, 2003.

prescription drug coverage; however, states often provide subsidization and wrap-around coverage through Medicaid, causing complicated administrative issues and inconsistency.[184] Currently, dual eligibles' ability to obtain needed drugs depends on the state programs' level of Medicare supplementation through copay subsidization or other supplemental coverage.[185] As a result, Medicaid continues to play a significant role in dual eligibles' prescription drug coverage, but the arrangement is administratively more complicated than necessary.

Finally, Medicaid coverage would also eliminate the imbalance of power between the states and the federal government inherent in the current arrangement,[186] as the states would regain control over how they spend their Medicaid dollars. Prior to the MMA, nearly half of states voluntarily offered coverage to residents with income above the federally mandated levels.[187] While there is no guarantee that they would do so again under this arrangement, it is likely that at least some would return to the higher coverage levels that they offered prior to the MMA. At a minimum, coverage would be no lower in any state than it would be under Medicare.[188] Additionally, states could manage costs through a variety of means beyond simply reducing the number of covered beneficiaries.[189] In the past, state administration of the Medicaid prescription drug plans has created the incentive to be efficient and

184. Some states choose to offer additional benefits to dual eligibles to supplement their coverage under Medicare; these plans are deemed to "wrap around" the Medicare benefits to provide additional coverage. *See* HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 10, 17–20.

185. *Id.* at 36.

186. *See* discussion *supra* Part II.C*;* Channick, *supra* note 6, at 251; Pear, *supra* note 99.

187. FAMILIES USA, *supra* note 8, at 1–2. The twenty-one states, plus the District of Columbia, which provided Medicaid coverage for individuals who did not qualify under the federal standards are from many different regions: Arizona, Arkansas, California, Florida, Hawaii, Illinois, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, and Virginia.

188. All states offer Medicaid prescription drug coverage for Medicaid recipients who are not dual eligibles. If Congress was concerned that some states might drop dual eligibles' drug coverage, it could adopt a provision similar to the proposed Senate version of the MMA — which stated that Medicare coverage is an available option when states do not cover dual eligibles. *See* Medicare Prescription Drug Price Negotiation Act of 2007, H.R. 4, 110th Cong. (2007).

189. *See* Channick, *supra* note 6, at 251.

"innovative in the design of their state pharmacy assistance programs."[190]

Transferring dual eligibles' coverage to Medicaid also eliminates the means-tested component of Medicare. The federal government did not originally intend Medicare to be a means-tested program, unlike Medicaid,[191] and this approach returns the means-testing requirements to the program that was originally designed to address them. Making Medicare into a means-tested program weakens its universal appeal, undermines its political support, and "threatens to trigger the exit of higher-income enrollees from the program if they no longer see it as a good deal," potentially leaving Medicare with a less-wealthy and more sickly population that would incur higher healthcare costs.[192]

2. *Challenges of Medicaid Drug Coverage for Dual Eligibles*

Providing dual eligibles' prescription drug coverage through Medicaid has two potential disadvantages. First, it would violate the requirement that Medicaid be a payer of last resort for prescription drug coverage.[193] However, the argument that State Medicaid plans may not offer prescription drug coverage to dual eligibles so that they remain the payer of last resort is undermined because the prohibition does not apply to all Medicaid programs, demonstrating that it is not a universal requirement. For example, in barring states from providing any health services for dual eligibles when the services are available through Medicare, Congress expressly exempted territories other than the fifty states and District of Columbia,[194] despite the fact that these entities are treated as states under Medicaid.[195] Thus, Congress has recognized that there are circumstances where Medicaid is not the payer of last resort. Exempting dual eligibles' prescription

190. *Id.* at 274.

191. *See* Green Book, *supra* note 4, at § 2, 5 (describing eligibility requirements for Medicare).

192. Oberlander, *supra* note 29, at 209.

193. 42 U.S.C. § 1396a(a)(25) (2006).

194. § 1396u-5(e); *see* First Med. Health Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 49 (1st Cir. 2007).

195. § 1301(a); *Vega-Ramos*, 479 F.3d at 53 n.5; *see* § 1396u-5(e) (referring to "a State, other than the 50 States and the District of Columbia"). Puerto Rico is treated as a state for Medicaid purposes, as well as the Virgin Islands, Guam, Northern Mariana Islands, and American Samoa in some cases. 42 U.S.C. § 1301(a).

drug coverage from this requirement is a unique, but not unprecedented, option.

Second, returning dual eligibles' prescription drug coverage to the states may increase coverage discrepancies between residents of different states, and between dual eligibles receiving their coverage from Medicaid and higher-income beneficiaries who do not qualify for Medicaid — and therefore receive their coverage from Medicare. But any situation where states have discretion to supplement federal minimums will result in different levels of coverage, as some choose to provide more generous benefits to expand the classes of eligible beneficiaries.[196] Even in the current system, some states choose to cover drugs beyond those included in Medicare Part D or subsidize their dual eligibles' prescription drug copayments.[197] This state discretion causes widely differing coverage levels for enrollees.[198]

Congress should address this potential for discrepancy between states by setting consistent national standards for coverage, as it currently does for other aspects of Medicaid.[199] With only one exception, the Medicare Part D benefit was designed to cover the same prescription drugs that the states are required to cover under Medicaid, meaning the coverage levels are similar and any differences are likely to be greater coverage under Medicaid.[200] This approach would afford states flexibility to supplement their coverage with optional programs, similar to how they currently do by providing additional services beyond the federal minimum.[201] Alternatively, rather than mandating certain coverage levels, the government should tie federal matching funds to coverage at a minimum threshold to strongly incentivize states to provide a certain level of coverage, without making it a true

196. *See, e.g.*, HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 10.

197. *Id.*; *see also* Storman v. Cal. Dep't of Health Servs., No. CIV S-06-2892 GEB GGH PS, 2007 WL 763276, at *2 (E.D.Cal. Mar. 9, 2007); N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp. 2d 325, 326 (S.D.N.Y. 2005).

198. HENRY J. KAISER FAMILY FOUND., *supra* note 27, at 10.

199. *See* Green Book, *supra* note 4, at § 15, 32–41. For example, the federal government requires that states provide a minimum level of Medicaid coverage for all individuals whose low income and asset levels qualify them for SSI. States may choose to cover residents whose incomes exceed the SSI levels, and many do. *See* discussion *supra* Part I.

200. TRITZ, *supra* note 84, at 3. The only exception is smoking cessation drugs, which are covered under Part D but are not mandatory for State Medicaid plans. *Id.*

201. Green Book, *supra* note 4, at § 15, 50. Examples of additional covered services include eyeglasses, prosthetic devices, and chiropractor visits. *Id.*

mandate. The government currently uses this approach to control some aspects of State Medicaid coverage by making federal matching funds available if states choose to include them in their Medicaid programs.[202]

The original version of the MMA the Senate proposed did not prohibit State Medicaid programs from providing prescription drug benefits for their dual eligibles.[203] Instead, the bill proposed that the Secretary of HHS will provide Congress with recommendations for creating a voluntary Part D enrollment.[204] However, some members of Congress and other advocates expressed concern about the creation of a dual system of prescription drug coverage for Medicaid-qualified and non-Medicaid-qualified seniors.[205] The final version of the bill prevented states from continuing to cover dual eligibles through Medicaid, partially because of these concerns.[206] In addition, leaving dual eligibles under the State Medicaid programs rather than the federal Medicare system "could be risky for the elderly if states later cut drug benefits or eligibility to rein in costs in Medicaid."[207]

Returning dual eligibles to their former Medicaid coverage is not enough to ensure adequate prescription drug benefits due to the risk of inequities in coverage between dual eligibles receiving benefits through Medicaid and wealthier Medicare recipients. To address these issues, Congress should require a minimum level of prescription drug coverage through state Medicaid programs to ensure that the dual eligibles receive the same benefits as Medicare-only recipients. The government has set minimum standards for state-run Medicaid in other areas, such as eligibility requirements, so this approach would not be unprecedented.[208]

This approach will restrict states less than the current requirement that they reimburse the federal government with their savings from the transfer of dual eligibles' prescription drug coverage to Medicare because they will have discretion to control

202. *Id.* at 49.
203. S. 1, 108th Cong. (2003).
204. *Id.*
205. *Id.*; 149 Cong. Rec. S15,882-03 (2003) (statement of Senator Charles Grassley, R-Iowa).
206. COMM. ON OVERSIGHT & GOV'T REFORM, *supra* note 160, at 2.
207. Pear, *supra* note 183 (citing advocates for low-income people).
208. Channick, *supra* note 6, at 250.

their costs through means other than reducing eligibility.[209] In addition, they would have the option to improve coverage beyond the federal government mandate, potentially improving prescription drug access for dual eligibles. Due to this mandated minimum level of coverage, dual eligibles will receive at least the same level of prescription drug benefits as wealthier Medicare recipients under the federal plan, and superior benefits if states continue to offer a higher level of coverage.

V. CONCLUSION

Administering prescription drug benefits for dual eligibles presents complex issues. The dual-eligible population is among the "poorest of the poor, the oldest of the old and the sickest of the sick."[210] However, the current method of providing prescription drugs through Medicare Part D, supplemented and funded by the states, is ineffective. The transfer of dual eligibles from Medicaid prescription drug coverage to Medicare has caused lapses in coverage due to administrative errors and higher prescription drug costs. The transfer has also raised federalism concerns because of the changes to the federal-state relationship.

While numerous researchers, government agencies, and other groups have suggested piecemeal changes to solve one of the three major problems, the only way to comprehensively address these interrelated problems is to completely transfer dual eligibles' prescription drug coverage to Medicaid. Although this approach raises new problems, it is ultimately a simpler and more equitable way to provide prescription drugs to dual eligibles.

209. *See* FAMILIES USA, *supra* note 8, at 2.
210. Pear, *supra* note 183.