Issues Surrounding Medicare Reform on Prescription Drugs for Rural Maryland Citizens

I. What we know?

1. Rural citizens are disproportionately older and poorer than urban citizens with more dependence on Medicare and a higher proportion of their income already dedicated to health care. (2, 6, 7, 9,10)
2. Preventative health care programs, specifically access to medicines in combination with a wellness center reduces cost to hospitals. (Minutes of 5-19-04 RMC Health Committee)
3. Average prescription prices in Maryland are greater than most states and increasing at a greater rate than 42 other states. (12)
4. The State of Maryland will most likely benefit financially from the changes even after clawbacks --could be around $53M; however, to meet gaps in coverage for some citizens, the 2005 General Assembly will need to act. (4)

II. What do we NOT know that we need to know?

Key Questions to Ask and Answer

What are the issues? The current situation related to each issue?
What could be the situation after Medicare law, prescription drug related changes go into effect?
What other issues aren't yet identified?
How are issues inter-connected?
Who could be/will be impacted, that is has a stake in the issue?--Are any citizens disproportionately affected? i.e. rural residents?
What could be the intended outcomes and unintended outcomes of action? inaction?
What are possible implications for action by the Maryland General Assembly?
When must actions be taken?
What's the imperative for action?
Other questions?

III. What are the Key Issues? (Issues 1-4 are rephrased from the NRHA, 2)

1. **Equity.** The State of Maryland should maintain equity vis-à-vis benefits and costs among its beneficiaries, who should neither be disadvantaged nor advantaged merely because of where they live.
    a. No Maryland citizen should be worse off because of the Federal prescription drug legislation.
    b. Rural citizens should not be disproportionately affected by changes in the law.

    Current Status:

    Status after law?

2. **Access**. The State of Maryland should ensure that beneficiaries have reasonable access to all medical services, including having essential services within a reasonable distance/time of their residence and being able to afford medically necessary services.
    a. All citizens should have adequate access to not only the drugs, but counsel on drug interactions.

    Current Status:

    Status after law?

3. **Costs**. The State of Maryland should include mechanisms to make the costs affordable, both to the beneficiaries and to the taxpayers financing the program.
    a. Although block grants look flexible to the state it would likely have a disproportionate negative impact on rural beneficiaries and on rural providers (10).

    Current Status:

    Status after law?

4. **Quality.** The State of Maryland should promote the highest attainable quality of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.
    Money saved by Medicare reform should be dedicated to health care programs.

    Current Status:

    Status after law?

5.
    Current Status:

    Status after law?

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IV. Synopsis of Materials Reviewed by Health Working Committee

1. **State Affairs: The impact of Medicare Rx on the States: An Analytical Framework.** An AARP Background Paper, February 2004. General overview of changes noting the overall impact of reform will be contingent on what states currently have in place and what responsibility they want to maintain after changes. Paper suggests that low-income beneficiaries receiving no benefits currently will benefit the most as they will get coverage while *those in states with generous coverage will probably see a reduction in their benefits.* Clearly notes that all states will benefit financially from the federal government assuming a greater share of prescription drug cost and that "states can use State-only funds to improve the benefit for low-income people (e.g., to "wrap around" the coverage lapse and other beneficiary co-payments). They cannot use Medicaid funds for this purpose" (p. 2).

2. **Protecting Rural Beneficiaries with a Medicare Prescription Drug Benefit.** National Rural Health Association. "In keeping with its mission to improve the health of rural Americans through appropriate and equitable health care services, the National Rural Health Association convened a meeting of experts in rural pharmacy in January of 2003, to discuss the rural implications of a Medicare Prescription Drug Benefit and offer suggestions on how best to design a benefit so as to protect rural beneficiaries. This report synthesizes the findings and recommendations of those experts. Their consensus: *Unless a benefit is designed with rural beneficiaries in mind, great damage could be done - damage that could be irreversible."* (from NRHA website). This is an excellent condensation of multiple sources of information including RUPI and Office of the Inspector General and gives a theoretical framework to priorities set forth above. Would be useful for each member of committee to have a copy and be familiar with. Download at http://www.nrharural.org/pagefile/GovAffairs.html#top.

3. **State Medicaid Managed Care Evaluations and Reports Themes, Variations, and Lessons.** CHCS (Center for Health Care Strategies, Inc.) Resource Paper, May 2004. Nice overview / comparison of how four states – Arizona, Maryland, Rhode Island, and Virginia – have evaluated and reported on their Medicaid managed care programs. *Notes that Maryland has done a great job with its relationship with UMBC to evaluate and instigate change when necessary and developing a plan-specific report card that would be useful to have [*not yet found online.] Makes some interesting points about how and why to present information and data to different audiences. They suggest that most legislators have little interest unless they are given a reason to be interested and that briefs should be short and to the point.

4. **Impact of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 on Current Maryland Prescription Drug Programs.** Dept. of Legislative Services Office of Policy Analysis, January 2004. Clearly puts forth the expected impact of change, including fiscal impact, on the state of Maryland. Although they note that complete financial impact is indeterminate they suggest that even after paying "clawback" money that Maryland could benefit approximately $53 million dollars. They give a couple of individual examples of changes on senior citizens, but is not comprehensive enough to be useful. *Concludes that "if the General Assembly is interested in maintaining programs to provide prescription drug coverage for seniors or low income individuals, current programs could be restructured to address the need for gaps in coverage" (p.9) and should be examined during the 2005 session.* Clearly, now is the time to suggest improvements of modifications.

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5. **Views of the New Medicare Drug Law: A survey of People on Medicare**. The Kaiser Family Foundation/Harvard School of Public Health, August 2004. A nationally representative random sample of those over 65 years of age, an over sample of African Americans over age 65 and a separate sample of 250 respondents ages 18-64 with physical and/or mental disabilities who receive Medicare. Report was on current perceptions of the upcoming Medicare changes. Generally showed that most people surveyed had unfavorable perceptions, were confused and their votes in the 2005 General Election will likely be influenced by the situation.

6. **University of Maryland Statewide Health Network Survey Analysis**. University of Maryland School of Medicine Center for Health Disparities to Address Racial, Ethnic, and Geographic Barriers to Care, July 2004. Available at http://medschool.umaryland.edu/disparities/results.html Reinforces the premise that there is disparity in the quantity and quality of health care in rural areas. Results are broken by multiple categories, but most importantly by county and most *show unfavorable results for the rural counties of Maryland.* Picking some key statistics and monitoring over time might be useful to gauge impact. Contains items on prescription drugs.

7. **Long-term Care in Rural America.** An Issue Paper prepared by the NRHA, May, 2001. Available at http://www.nrharural.org/pagefile/issuepapers/ipaper21.html "This paper provides background information on the status of long-term care in rural America. Long-term care for purposes of this paper is defined as a comprehensive range of health, personal and social services delivered over time to meet the needs and increase the quality of life of older adults, especially those with chronic illnesses and disabilities. Guiding principles for the National Rural Health Association to employ regarding long-term care policies and regulations of older adults are delineated. Finally, four priority areas for action are identified to address the challenges for long-term care in rural America and the implications for rural health care providers and the older adults they serve" (from the website*). Excellent support for disparities in health care being provided in rural areas of America and for priorities noted above.*

8. **Decline in the Federal Medicaid Match Rate Will Hit States Hard: 36 States will Lose at Least $100 Million.** Elizabeth Pham and Emil Parker, June, 2004. A study looking at all states but notes that *Maryland will lose ~$230,000,000 in federal matching money.* Hard to understand true impact because nothing is noted about the gains from the federal government taking on greater share of prescription coverage.

9. **Health Insurance Access in Rural America.** NRHA Policy Brief, March 2004. Available at http://www.nrharural.org/dc/policybriefs/insurance.pdf. "Living in rural America increases the risk of being uninsured. This is primarily because the rural economy tends to be dominated by smaller employers and the self-employed, and because rural residents are more likely to work for low-wage employers. Both small and low wage employers are less likely to offer health insurance. When rural residents enter the private insurance market, they are likely to pay higher administrative fees, find fewer health insurance choices, and be underinsured. *Rural residents pay a higher proportion of their income for health insurance, because premium rates in rural America are comparable to or even higher than those in urban areas, but average income is lower"* (from website). Quantified data showing the above and supporting given priorities.

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10. **Federal Medicaid Reform, A Rural Perspective.** NRHA Policy Briefs, April & May 2004. Available at http://www.nrharural.org/dc/policybriefs/medicaidpolicy.pdf "Medicaid is a joint state and federal health care entitlement program currently facing a number of challenges. Many rural community members and providers are dependent on Medicaid, and the NRHA is committed to assuring that proposed changes in Medicaid address the unique needs of rural and frontier communities" (from website). Again, excellent support that there is already a disparity in health care to rural areas and that changes will most likely increase that disparity.

11. **Maryland Prescription Drug Programs.** Created by the Maryland Assistance Program, Maryland Dept. of Health and Mental Hygiene, January 2004. Overview and previous three years of state-only spending through current assistance programs. Total funds in millions: FY 01 $248.3; FY 02 $298.1; FY 03 $331.0.

"Affordable Pharmaceuticals: The States and Medicare" (video) (transcript) How is the new Medicare prescription drug benefit affecting state governments? What pharmaceutical policy decisions are states making in their Medicaid, discount and subsidy programs to accommodate or go beyond the new law? Who really will pay the bills? This session examines the issues and the ways states are dealing with them. A presentation of the National Conference of State Legislatures (www.ncsl.org) with support slides available at http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1229.

Speakers:

- **Joan Henneberry**, chair, Rx Transition Commission, Department of Health and Human Services
- **Cheryl Matheis**, director, State Affairs, AARP
- **Robert Perkins**, executive director, Together Rx Discount Program
- **Paul Reinhart**, Medicaid director, Michigan Department of Community Health on Medicaid Pharmacy Cost Containment: No Good Deed Goes Unpunished
- **Vernon Smith**, principal, Health Management Associates on The Medicare Prescription Drug Benefit: Issues and Implications for States.

12. **A Rural Maryland Snapshot: Focus on Prescription Medicines.** Created by Pam Christoffel for the Rural Maryland Council and the Maryland Rural Health Association. Contains basic rural Maryland facts and information about rural health and health insurance issues. Provides data from the Kaiser Family Foundation regarding prescriptions in Maryland: number filled; average cost, and change in prices. Describes the five the Maryland Pharmacy Programs. Also contains thirteen data charts.

This document is available at:
http://www.hhp.umd.edu/FMST/fis/current.htm
or
www.rural.state.md.us

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