Is Your State Ready for 2006?
An Introduction to What the New Medicare Part D Prescription Drug Benefit Means for Medicaid

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA) made the biggest changes to Medicare in the program's four-decade history. This new law will also require big changes in state Medicaid and prescription drug assistance programs. It will therefore have substantial effects on low-income Medicare beneficiaries who also receive Medicaid—beneficiaries who are known as dual eligibles. Although many details of the Medicare prescription drug benefit will not take shape until federal regulations are finalized, the broad outlines of the program are becoming clear.[1]

This piece is an introduction to some of the issues created by the MMA. It describes the new drug benefit and outlines some of the major issues state policy makers and advocates need to consider as they plan to implement the new law, especially as it affects low-income Medicare beneficiaries. In future months, Families USA will publish a series of briefs on challenges and opportunities facing states as the new Medicare law is implemented.

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1. Overview:

The Major Changes Ahead for State Medicaid and Pharmacy Assistance Programs

Starting in 2006, a new Medicare prescription drug benefit will replace Medicaid drug coverage for low-income Medicare beneficiaries. State agencies and legislatures will need to make major policy decisions during 2004 and 2005 to prepare for these changes. Advocates need to ensure that these new policies help low-income seniors and people with disabilities obtain vitally important prescription drug coverage. Major changes include the following:

- The Medicare-approved drug discount card program that began in June 2004 is temporary. In 2006, it will be replaced by a new Medicare drug benefit called **Medicare Part D**. A special subsidy program will accompany Part D that will help low-income beneficiaries afford coverage.
- State Medicaid and pharmacy assistance programs will need to be adjusted to reflect the new Part D benefit and low-income subsidy.
- Starting in 2006, states will no longer be able to obtain federal Medicaid matching funds to cover drug benefits for dual eligibles. Dual eligibles will instead receive drug coverage through the new Medicare Part D and the associated low-income subsidy.
- States will be able to continue offering prescription drug coverage with state-only funds and can continue to receive federal Medicaid funds to supplement some gaps in Part D coverage.
- States will have substantial new administrative responsibilities in transitioning dual eligibles to the new Part D benefit.
- States also will share responsibility with the Social Security Administration for enrolling low-income Medicare beneficiaries in the new Part D low-income subsidy.
- States will have new obligations to screen and enroll applicants who qualify for other Medicare Savings Programs (Medicaid-run programs that help low-income Medicare beneficiaries pay for Medicare-related expenses such as premiums).
- Long-term care institutions will have to change the way they pay for their patients' prescription drugs.

In addition, state Medicaid budgets will be greatly affected, both positively and negatively:

- The transfer of dual eligibles' prescription drug costs to Medicare will reduce states' Medicaid costs.
- However, new payments from the states to the federal government required by the MMA will offset a large share of the Medicaid savings realized by the states.
- New administrative responsibilities will require additional state expenditures.
- Potential enrollment increases in Medicare Savings Programs could also lead to additional state Medicaid costs.

2. The Basics:

What Are Medicare and Medicaid? Who Are Dual Eligibles?

What's the difference between Medicare and Medicaid?

Medicare is the federal health insurance program for seniors (people age 65 and older) and for people with disabilities. Medicare is financed entirely by the federal government. In general, people's incomes are not taken into consideration in determining their eligibility for Medicare. There are approximately 40 million people enrolled in Medicare. From its creation in 1965 until passage of the MMA in 2003, Medicare did not include outpatient (pharmacy) prescription drug coverage.

Medicaid is a health insurance program for low-income children, parents, seniors, and people with disabilities. Also created in 1965, Medicaid insures over 51 million Americans. Medicaid is jointly financed by states and the federal government, and each state is responsible for administering its own Medicaid program (within rules set by the federal government). Every state's Medicaid program includes outpatient drug coverage, although the scope of these benefits varies from state to state. Medicaid also pays for most nursing home and other long-term care.

Dual Eligibles: People who are covered by both Medicare and Medicaid

Full dual eligibles: People who are enrolled in both Medicare and the full Medicaid benefit program are called *full dual eligibles* because they receive the full range of benefits from both programs. Over 6.1 million low-income seniors and people with disabilities are enrolled in *both* Medicare and Medicaid.[2] Typically, dual eligibles use their Medicaid insurance to cover prescription drugs and long-term nursing home care—services that Medicare does not cover. Beginning in 2006, however, full dual eligibles will get their prescription drug coverage through the new Medicare drug benefit rather than through Medicaid.

Partial dual eligibles: An additional 1.1 million seniors and people with disabilities with slightly higher incomes are enrolled in one of three Medicare Savings Programs (MSPs) that help pay for their Medicare premiums and cost-sharing.[3] Enrollment in these programs has historically been low, and at least 40 percent of those who qualify have not enrolled.[4] The programs are administered by state Medicaid programs and are called Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individuals 1 (QI-1). Collectively, beneficiaries in these programs are called *partial dual eligibles* because they do not receive other Medicaid benefits. The eligibility criteria and benefits for each category are shown in the table below.

	Income*	Assets*	What's Covered?
Qualified Medicare Beneficiaries (QMBs)	Equal to or less than 100% of the federal poverty level	Up to $4,000 for individuals or $6,000 for couples	All Medicare premiums and all Medicare cost-sharing
Specified Low-Income Medicare Beneficiaries (SLMBs)	Between 100% and 120% of the federal poverty level	Up to $4,000 for individuals or $6,000 for couples	Medicare Part B monthly premiums
Qualifying Individuals 1 (QI1s)**	Between 120% and 135% of the federal poverty level	Up to $4,000 for individuals or $6,000 for couples	Medicare Part B monthly premiums (Here, enrollment is not an entitlement—it is limited by a federal funding cap.)

*States can broaden coverage by using "less restrictive methodologies" in calculating income and assets under Section 1902(r)(2) of the Social Security Act: see Andy Schneider, *The Medicaid Resource Book* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2002).

**The QI-1 program expires on September 30, 2004. Congress is considering whether to extend the program.

3. The New Medicare Part D Prescription Drug Benefit:
How Will It Work for Low-Income Beneficiaries?

The Medicare prescription drug benefit marks a significant change in the way Medicare works. Private plans will play a leading role in delivering prescription drug coverage. Participation in the prescription drug benefit is optional for all Medicare beneficiaries—no one is required to join a plan. However, low-income beneficiaries will have no realistic alternative.

Starting in 2006, states will no longer receive federal matching funds to provide Medicaid prescription drug coverage for dual eligibles. As a result, states will certainly curtail or eliminate drug coverage for these beneficiaries in their Medicaid programs. Full dual eligibles will therefore definitely need to enroll in the new Medicare benefit starting in 2006, because their Medicaid drug benefits will stop at the end of 2005. Implementing this transition smoothly will be a major challenge for states, as well as federal agencies and beneficiaries.

Prescription drug benefits under Medicare will be implemented in two phases: first, Medicare-approved discount cards, which became available in June 2004 (see below); and second, the full Medicare Part D benefit and accompanying low-income subsidy, which will take effect on January 1, 2006 (see page 6).

Phase One: Medicare-approved discount cards and transitional assistance

From June 2004 through the end of 2005, Medicare beneficiaries can purchase Medicare-approved discount cards from private companies. These cards enable beneficiaries to get discounts on prescription drugs. The cost of the cards and the amounts of the discounts vary depending on the card and the prescriptions a beneficiary uses.

Full dual eligibles who receive drug coverage through Medicaid CANNOT receive a Medicare discount card. They should continue to receive their prescription drug coverage through Medicaid until January 2006.

All other low-income Medicare beneficiaries whose incomes are below 135 percent of the federal poverty level (in 2004, $12,569 for an individual, $16,862 for a couple), including partial dual eligibles, are eligible to receive additional transitional assistance. Those who qualify for transitional assistance do not have to pay for a card, and they will receive a $600 subsidy in 2004 and another $600 subsidy in 2005 to help pay for prescription drugs. (Beneficiaries will still have a 5 percent or 10 percent copayment.) This assistance can be extremely helpful to low-income Medicare beneficiaries who do not have other prescription drug coverage. Beneficiaries can apply for transitional assistance on the same application that they use to apply for a discount card. Those who have prescription drug coverage through Medicaid, Tricare, or the Department of Veterans Affairs are not eligible for transitional assistance. However, receiving the $600 subsidy should not prevent someone from later becoming eligible for Medicaid.

There are currently about 70 Medicare-approved cards available around the country, although many serve only limited geographic areas. Each card offers a different combination of discounts on different drugs.

Helping Beneficiaries Choose a Card

Beneficiaries who want a drug discount card must apply directly to the sponsoring company. Beneficiaries can only change cards once, from November 15 to December 31, 2004. It is therefore very important that they chose their card carefully. They should consider what cards their pharmacy accepts, which cards cover the drugs they need, and which cards offer the best savings. In some cases, beneficiaries may be better off using other discount cards than those approved by Medicare.

Medicare's Web site, www.medicare.gov, is a good place to start looking for which cards are available, which drugs they cover, and the discounts they offer. The same information is available by telephone at 1-800-MEDICARE. Because the information available from Medicare is not always current or 100 percent correct, however, applicants should verify information with the card vendor and their local pharmacy. Beneficiaries who want additional help may want to contact their local State Health Insurance Assistance Program (SHIP).

Prescription Drug Discount Card: Issues for States

Although the Medicare discount card program has been running since June 2004, there are several issues states still need to address, including the following:

1. Coordinating State Pharmacy Assistance Programs and the Discount Card

States need to decide whether and how to coordinate their existing State Pharmacy Assistance Programs (SPAPs) with the new Medicare-approved discount cards. Several states are encouraging their pharmacy assistance beneficiaries to enroll in both a discount card and transitional assistance, and at least seven states (Connecticut, Maine, Massachusetts, Michigan, New Jersey, New York, and Pennsylvania) are enrolling beneficiaries automatically.[5] By giving beneficiaries access to the $600 transitional assistance, states may be able to reduce expenses in their own pharmacy assistance programs. Other states, however, have determined that their program will work better without coordination with the Medicare-approved discount card and are not coordinating benefits.

2. Reaching out to Partial Dual Eligibles

Because partial dual eligibles have incomes below 135 percent of the federal poverty level, they qualify for transitional assistance. And since automatic enrollment would be a quick and efficient way of helping low-income Medicare beneficiaries, many advocates have encouraged CMS to enroll these beneficiaries automatically. As of July 2004, however, CMS had not opted to automatically enroll partial dual eligibles. If CMS decides against automatic enrollment, there are other strategies states can use to reach this population. For example, states can call or write to partial dual eligibles and explain the advantages of signing up for a card and transitional assistance.

Phase Two: Medicare Part D benefit for low-income beneficiaries

Starting in January 2006, Medicare will offer a new Part D prescription drug benefit. Participation in the benefit will be optional for all Medicare beneficiaries, but low-income beneficiaries will almost certainly want to join. Dual eligibles, in particular, will have to enroll in order to maintain prescription drug coverage since they will be losing their Medicaid drug coverage.

Part D will have two components—a basic benefit and an additional subsidy for low-income beneficiaries.

- All Medicaid beneficiaries and other low-income beneficiaries will need to enroll in both components, meaning that enrollment for them will be a two-step process. They will have some cost-sharing requirements (discussed below).
- Medicare beneficiaries who do not qualify for the low-income subsidy will enroll only in the basic benefit. They will have sizeable cost-sharing obligations under the basic Part D benefit, including premiums, deductibles, and coinsurance. Some of these beneficiaries may find that their costs will outweigh any advantages the program confers. The structure of this basic benefit is explained in the Appendix.

All Part D beneficiaries will receive their prescription drug coverage from private plans. Each private Part D prescription drug plan will only cover the drugs on its formulary, unlike state Medicaid programs, which currently cover all medically necessary drugs.

A. What Part D and the low-income subsidy cover

The amount of help beneficiaries will get from the low-income subsidy will depend on several factors. Dual eligibles will receive a more generous subsidy than other beneficiaries, and dual eligibles in institutions will receive the most help (see table below). For all beneficiaries, the size of the subsidy will depend on beneficiaries' incomes and assets (see also table on page 7).

Low-Income Part D Benefits for Full Dual Eligibles

Beneficiaries do not pay an annual premium and are not subject to an assets test.[6] Coverage is arranged in the following tiers:

Beneficiary Status or Income	Coverage
Beneficiaries in nursing homes or other institutions	• Premium: none • All drugs in plan are free • No copayments
Families with incomes up to 100% of the federal poverty level	• Premium: none • Copayments: $1 for generics, $3 for brand-name drugs • No copayments after total drug costs reach $5,100 for the year
Families with incomes over 100% of the federal poverty level	• Premium: none • Copayments: $2 for generics, $5 for brand-name drugs • No copayments after total drug costs reach $5,100 for the year
After 2006, $1 and $3 copayments will increase with the consumer price index. After 2006, $2 and $5 copayments will increase based on increases in Medicare's drug spending. After 2006, the catastrophic limit of $5,100 will increase based on increases in Medicare's drug spending.	

Low-Income Part D Benefits for Other Low-Income Beneficiaries

Beneficiaries are subject to an assets test. The amount of subsidy provided varies according to beneficiaries' income and assets. Coverage is arranged in the following tiers:

Income and Assets		Coverage
Income below 135% of the federal poverty level . . .		
. . . and	Assets below $6,000 for an individual or $9,000 for a couple	• Premium: none • Copayments: $2 for generics, $5 for brand-name drugs • No copayments after total drug costs reach $5,100 for the year
. . . and	Assets between $6,000-$10,000 for an individual or $9,000-$20,000 for a couple	• Premium: premium on sliding scale from $0-$35/month; premiums will increase annually • Beneficiaries must pay a $50 annual deductible • Beneficiaries must pay 15% coinsurance of drug costs up to $5,100 • After total drug costs reach $5,100 for a year, beneficiaries pay copayments of $2 for generics and $5 for brand-name drugs for the rest of the year
Income between 135%-150% poverty; assets less than $10,000 for individual or $20,000 for couple		• Premium: premium on sliding scale from $0-$35/month; premiums will increase annually • Beneficiaries must pay a $50 annual deductible • Beneficiaries must pay 15% coinsurance of drug costs up to $5,100 • After total drug costs reach $5,100, beneficiaries pay copayments of $2 for generics and $5 for brand-name prescriptions for the rest of the year
After 2006, asset limits will increase with the consumer price index. After 2006, copayments and the catastrophic limit of $5,100 will increase based on increases in Medicare's drug spending.		

Limits on premium subsidies: For both dual eligibles and other low-income beneficiaries, the low-income subsidy only covers plan premiums where they are equal to the "low-income benchmark premium." The low-income benchmark premium is the weighted average of premiums for basic prescription drug coverage among plans in the beneficiary's geographic area.[7] Beneficiaries who wish to choose a higher-cost plan will have to pay the difference (between the low-income benchmark premium and the higher-cost premium) themselves.[8]

B. Enrollment

As of this writing, enrollment procedures for the low-income subsidy are still unclear. The MMA assigns both the Social Security Administration and state Medicaid agencies with joint responsibility for administering enrollment and periodic redetermination for the low-income subsidy. CMS's draft regulations provide some preliminary guidance as to how these responsibilities will be divided, but many details will need to be resolved during 2004 and 2005.

Enrollment will be a two-part process for low-income beneficiaries. They will need to be enrolled both in the low-income subsidy and in a prescription drug plan, and they may find going through two enrollment processes to be cumbersome and discouraging. Well-thought-out state outreach and enrollment policies can make an important difference in reducing burdens on beneficiaries and increasing enrollment.

Under the proposed regulations, full dual eligibles will be automatically enrolled in the low-income subsidy. As to enrollment in a prescription drug plan, ideally, full dual eligibles should select a Part D plan themselves—this would help ensure that their plan serves their medical needs. However, because many full dual eligibles will be unable to select a plan themselves (for example, because of physical or cognitive impairments), those who do not choose a plan will also be automatically enrolled in a prescription drug plan. Automatic enrollment will be vital in ensuring that full dual eligibles do not experience a gap in coverage when they switch from Medicaid drug coverage to Medicare Part D coverage. Full dual eligibles who are automatically enrolled in a Part D plan will be able to change plans for any reason[9]—for example, if a plan's formulary does not cover all a beneficiary's necessary drugs.

Partial dual eligibles (those who are already enrolled in a Medicare Savings Program) will be automatically enrolled in the appropriate low-income subsidy but not in a prescription drug plan. These beneficiaries will still have to choose a Part D plan in order to obtain drugs. Advocates and state agencies will need to develop effective outreach efforts to educate these beneficiaries about the new benefits available to them.

Because state Medicaid agencies have records of their current dual eligibles, these agencies will play a leading role in ensuring that dual eligibles are properly enrolled in Part D and the low-income subsidy. These agencies will need to be sure that their records are accurate and will have to keep beneficiaries informed about the changes in their drug coverage.

State Medicaid agencies will also have to develop enrollment procedures for other low-income Medicare beneficiaries who apply for the low-income subsidy through a Medicaid agency. CMS and SSA are developing a simplified model application that they are to share with the states.[10] In addition, Medicaid agencies are required by the MMA to screen all applicants for eligibility for Medicare Savings Programs and to offer enrollment to all eligible applicants.[11] State agencies will need to develop the technical expertise and technological systems to carry out these new responsibilities.

4. Challenges for States:

What Advocates and Policy Makers Need to Know Now

State policy makers and advocates will have to consider a substantial number of issues in anticipation of implementing Medicare Part D. Even though the program does not begin until January 2006, many budget and policy decisions must be made during 2004 and early 2005 so that the necessary systems are in place by January 2006. In order to ensure the greatest possible coverage of low-income seniors and people with disabilities, advocates and policy makers should be thinking now about how their states can best make these changes. Among the main challenges and opportunities for states are the following:

- **Enrolling current full dual eligibles in Part D and in the low-income subsidy**

  OPPORTUNITY: Starting in 2006, states will no longer receive federal Medicaid matching funds to provide prescription drug coverage for full dual eligibles. The MMA anticipates that full dual eligibles will instead be enrolled in Part D and the low-income subsidy. According to the proposed regulations, the Secretary of Health and Human Services will automatically enroll full dual eligibles in the low-income subsidy and will also enroll them in a Medicare Part D plan if the beneficiaries do not enroll themselves in a plan. States will play a vital role in this process because they will decide who will need to be enrolled in the new program. Medicaid agencies will have to develop policies to ensure that full dual eligibles do not experience a gap in prescription drug coverage when the new program begins. Beneficiaries will need help choosing a new plan and understanding the changes to their prescription drug coverage.

  CHALLENGES

  - Ensuring that all beneficiaries are well informed and have no gaps in coverage.
  - Changing Medicaid systems' technology to keep up with the new rules and policies.

- **Processing applications for the low-income subsidy**

  OPPORTUNITY: States and the Social Security Administration (SSA) have joint responsibility for enrolling and periodically recertifying low-income seniors and people with disabilities in the new low-income subsidy. SSA will develop a model application and share it with the states. CMS's proposed regulations do not provide much guidance on how recertification rules will be affected. Advocates and policy makers should make sure that the application and recertification procedures that their state adopts are as simple as possible, including requiring minimal documentation. States' experiences with the State Children's Health Insurance Program (SCHIP) should be helpful in this regard. States may need new systems to accept and process applications or they may be able to partner with SSA. In addition, as new dual eligibles enter the Medicaid system, state agencies will need to ensure that they are enrolled in the Part D and low-income benefits.

  CHALLENGE: Developing simple application and renewal procedures that serve beneficiaries.

- **Screening and enrolling in Medicare Savings Programs**

  OPPORTUNITY: States are required by the MMA to screen all low-income subsidy applicants for Medicare Savings Programs (QMB, SLMB, and QI-1) and offer them enrollment if they are found to be eligible. Because states already process applications for these programs through their Medicaid offices, this should not require development of entirely new systems. But enrollment in these programs has historically been low in many states, so states should plan to make additional efforts in this area. States may wish to build on their experiences with screening SCHIP applicants for Medicaid eligibility.

  CHALLENGES

  - Adapting enrollment procedures to screen and enroll applicants for Medicare Savings Programs simply and easily.
  - Educating beneficiaries about how these programs can help them.
  - Preparing for the impact on Medicaid budgets of the new Medicare Savings Program beneficiaries.

- **Changes to State Pharmacy Assistance Programs (SPAPs)**

  OPPORTUNITY: More than 30 states currently administer pharmacy assistance programs that provide prescription drug coverage to low-income seniors and others who do not currently receive prescription drug coverage through Medicaid.[12] With the advent of Part D Medicare drug coverage, states should see the cost of their pharmacy assistance programs drop. They could use these savings to restructure their pharmacy assistance programs, perhaps by creating a wrap-around benefit for Part D. For example, states could cover drugs not covered in Part D or cover low-income beneficiaries' copayments. This would reduce state expenditures while providing a richer benefit for seniors and people with disabilities.

  CHALLENGES

  - Adjusting pharmacy assistance programs to maximize coverage.
  - Making sure that state budgetary savings remain available for health care.

- **Changes to state Medicaid prescription drug coverage**

  OPPORTUNITY: States will need to decide how to structure their remaining Medicaid prescription drug coverage. Although states will no longer receive federal matching funds to cover most drug costs for dual eligibles, states will still be able to use state funds to wrap around Part D benefits. They could also opt to cover Part D copayments, which in many states will be higher than Medicaid copayments. States will be able to receive federal Medicaid matching funds to cover drugs that are not covered in Part D. States will also continue to receive federal matching funds if they already cover over-the-counter drugs in their Medicaid programs.[13]

  The departure of dual eligibles from states' Medicaid programs will substantially shrink the size of Medicaid programs' drug purchases. States may face new challenges in obtaining good prices for prescription drugs to cover their remaining Medicaid beneficiaries. States whose Medicaid managed care contracts include prescription drugs will have to renegotiate their managed care rates. Multi-state purchasing pools may be a solution worth exploring. Finally, advocates should be sure that other state Medicaid services for dual eligibles, such as long-term care, remain unaffected.

CHALLENGES

- Adjusting Medicaid programs to maintain good prescription drug and other coverage for all beneficiaries.
- Protecting other Medicaid benefits, such as long-term care, for dual eligibles whose prescription drug coverage will change.

- **Maintaining drug coverage for beneficiaries in long-term care facilities and other institutions**

OPPORTUNITY: Dual eligibles in long-term care facilities have traditionally received their prescription drug coverage through Medicaid. Starting in 2006, they will be covered through Medicare Part D. States and institutions will have to renegotiate payment rates to reflect the change in benefits. In addition, managing beneficiaries' prescription drug needs may be become more complicated, because beneficiaries may belong to one of several prescription drug plans, each with its own formulary, rather than to one Medicaid formulary.

CHALLENGES

- Ensuring a smooth transition for beneficiaries in long-term care.
- Coping with a potentially large number of plan options that cover different drugs.
- Renegotiating payment rates for long-term facilities.

- **Challenges for state Medicaid budgets**

The MMA is a mixed bag for state Medicaid budgets. States will be relieved of their share of Medicaid spending on prescription drugs for dual eligibles. At the same time, however, they will have to take on the new administrative responsibilities discussed above. In addition, in order to help pay for the new benefit, the MMA requires that states pay back to the federal government a substantial portion of what they would have spent on Medicaid prescription drug coverage. Among Medicare wonks, this is called the "clawback payment." The amount of a state's clawback payment will depend on a number of factors, including primarily: 1) the amount it 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 each state; and 4) the year in which the payment is calculated. In 2006, states must pay 90 percent of their clawback amount to the federal government. This figure declines to 75 percent by 2013.[14] Overall, the Congressional Budget Office (CBO) estimates that states will save about $115 billion in Medicaid costs between 2004 and 2013—but about 85 percent of these savings will be offset by new costs and the clawback. CBO projects a modest net savings to states of $17.2 billion, most of which will occur in 2010-2013.[15]

CHALLENGES

- Being prepared for changes in Medicaid budgets.
- Making sure that states do not discourage dual eligibles' enrollment in Part D as a means of reducing clawback payments.

This is not an exhaustive list of issues, and most of these challenges have no single best solution. Nevertheless, the implementation of Part D and the low-income subsidy presents a unique opportunity for state policy makers and advocates to design policies that can ensure that low-income seniors and people with disabilities have easy access to prescription drug coverage. Advocates and policy makers should stay alert for developments at the federal level and plan for changes in their states. Please let us know about important issues in your state. As 2006 approaches, Families USA will publish a series of pieces explaining these issues, as well as others that arise.

Endnotes

[1] Proposed regulations were published in the *Federal Register*, August 3, 2004.

[2] Brian Bruen and John Holahan, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government* (Washington: Kaiser Commission on Medicaid and the Uninsured, November 2003).

[3] *Ibid.*

[4] General Accounting Office, *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries* (Washington: General Accounting Office, March 2004).

[5] "Seven States to Enroll Low-Income Seniors Automatically in Drug Cards, CMS Says," *BNA Health Care Policy Report* 12, no. 24 (June 14, 2004): 800-801.

[6] For additional information on the low income benefit, see Families USA, *Extra Help for Your Drug Costs: Do You Qualify?*, available online at http://www.familiesusa.org/site/DocServer/Extra_help.pdf?docID=2764.

[7] Section 1860D-14(b)(2) of the Social Security Act, as added by the MMA (P.L. 108-173).

[8] Jeffrey S. Crowley, *The New Medicare Prescription Drug Law: Issues for Dual Eligibles with Disabilities and Serious Conditions* (Washington: Kaiser Commission on Medicaid and the Uninsured, June 2004).

[9] Proposed regulation 42 C.F.R. section 423.36(c)(4).

[10] Section 1860D-14(a)(3)(E)(ii) of the Social Security Act, as added by the MMA (P.L. 108-173).

[11] Section 103 of the MMA, establishing new Section 1935(a)(3) of the Social Security Act.

[12] National Conference of State Legislatures, *State Pharmaceutical Assistance Programs*, available online at http://ww.ncsl.org/programs/health/drugaid.htm, updated July 9, 2004.

[13] See proposed regulation, 42 C.F.R. section 423.906(c).

[14] Section 103(b) of the MMA, establishing new Section 1935(c) of the Social Security Act. See also Andy Schneider, *The "Clawback": State Financing of Medicare Drug Coverage* (Washington: Kaiser Commission on Medicaid and the Uninsured, June 2004).

[15] Letter from Douglas Holtz-Eakin, Director, Congressional Budget Office, to Senator Don Nickles, Chairman of Senate Budget Committee, November 20, 2003.

Appendix Table: The Basic Medicare Part D Prescription Drug Benefit

Under the new Part D, Medicare beneficiaries will be able to join a prescription drug plan. Beneficiaries will pay a monthly premium, estimated at $35 a month in 2006. The coverage they receive, shown in the tiers below, depends on the amount of a beneficiary's drug expenses:

Coverage	Drug Costs	Part D Pays	Beneficiary Pays	Beneficiary's Cumulative Total Out-of-Pocket Payment
Deductible	$0-$250	0	100%	$250
Initial Benefit	$251-$2,250	75%	25%	$750
"Doughnut Hole"— no coverage	$2,251-$5,100	0	100%	$3,600
Catastrophic Benefit	Over $5,100	95% of all remaining costs	5% of all remaining costs	$3,600 plus 5% of costs above $5,100
After 2006, the deductible, the point where the doughnut hole begins, and the point where catastrophic coverage begins will all increase based on increases in Medicare's drug spending.				

For more information on how the basic Part D benefit will work, visit the homepage and Medicare sections of the Families USA Web site at www.familiesusa.org. Other related materials can also be found in the "Medicare Road Show" section.

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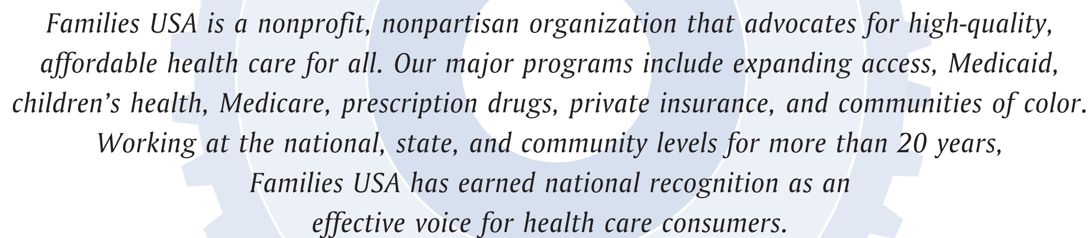

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