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THE PROPOSED MEDICARE PRESCRIPTION DRUG BENEFIT: A DETAILED REVIEW OF IMPLICATIONS FOR DUAL ELIGIBLES AND OTHER LOW-INCOME MEDICARE BENEFICIARIES

Prepared by
JOCELYN GUYER
KAISER COMMISSION ON MEDICAID AND THE UNINSURED

September 2003

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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I. Overview

A prescription drug benefit could be added to Medicare within the next several months. The Senate and House of Representatives each approved legislation in June of 2003 that would establish outpatient prescription drug coverage for Medicare beneficiaries as part of Medicare program reform and a conference committee is now working to reconcile differences.[1] President Bush has made a number of public statements urging Congress to finalize the legislation and send it to him for his signature. Among the key differences in the House and Senate bills that still must be addressed is the treatment of Medicaid beneficiaries and the structure of low-income subsidy programs. The way in which these issues are resolved will have major implications for Medicaid beneficiaries, other low-income individuals, and state budgets, as well as potential cost implications for the federal government. As with all other provisions in the bill, these issues will be debated in the context of congressional budget constraints that generally limit the amount of resources available for a Medicare prescription drug benefit to $400 billion over the next 10 years. The major issues for low-income individuals and Medicaid in the bills are described below.

- **Treatment of Medicare and Medicaid Dual Eligibles**

  Currently, Medicaid plays a key role in filling in gaps in Medicare coverage, including the lack of a prescription drug benefit, for close to six million seniors and people with disabilities who rely on both Medicaid and Medicare for their health care coverage. The House and Senate Medicare bills differ dramatically in their treatment of these "dual eligibles" – the Senate bill excludes them from the Medicare prescription drug benefit, while the House bill makes them eligible for coverage.

  If adopted, the Senate provision would represent the first time in Medicare's history that a benefit would not be provided on a universal basis to all individuals eligible for Medicare. It also could result in some of the very poorest and sickest Medicare beneficiaries receiving more restricted drug coverage through Medicaid than their counterparts receive under the Medicare prescription drug benefit, particularly given that states increasingly are cutting back on prescription drug coverage in Medicaid in response to budget problems and rapidly rising prescription drug expenses.

- **Implications of Medicare Drug Coverage for States and Their Medicaid Budgets**

  States have long maintained that it is inappropriate to rely on Medicaid to fill gaps in Medicare coverage, including the lack of prescription drug coverage. Governors and other state leaders have pressed for a prescription drug benefit in Medicare as a means for shifting responsibility to the federal government for providing prescription drug coverage

[1] The Senate bill, S. 1, is known as the "Prescription Drug and Medicare Improvement Act of 2003" while the House bill, H.R. 1, is known as the "Medicare Prescription Drug and Modernization Act of 2003."

to dual eligibles. Since states pay for an average of 43 percent of the cost of financing the Medicaid program (but none of the cost of financing Medicare benefits), such a shift could provide significant fiscal relief to states. The effort to persuade the federal government to take responsibility for prescription drug coverage for Medicare beneficiaries has grown stronger in recent years in response to the state fiscal crisis and the pressure that rapidly rising prescription drug costs has placed on Medicaid budgets.

Under the Senate bill, states would continue to bear all of the responsibility for providing prescription drug coverage to dual eligibles with full Medicaid benefits. If adopted, the Senate treatment of these dual eligibles would mean states would experience little fiscal relief as a result of the Medicare prescription drug benefit (although the Senate bill includes some provisions designed to provide some fiscal relief to states through alternative means). The House bill includes dual eligibles in the Medicare prescription drug benefit, allowing state Medicaid programs to shift some of the responsibility for prescription drug costs for dual eligibles to the federal government. However, to offset the cost to the federal government of this shift, the House bill reduces federal Medicaid payments to the states over the next several years, effectively "recapturing" some of the state fiscal relief that otherwise would be generated by the House bill. Overall, the Congressional Budget Office (CBO) has estimated that the Senate bill would generate $20 billion in fiscal relief for states in Medicaid, while the House bill would generate $44 billion.

- **Treatment of Low-Income Individuals Not Enrolled in Medicaid**

  Medicare beneficiaries with low incomes face particular challenges in securing prescription drugs. Many of them are not eligible for assistance with prescription drug costs through Medicaid, state-funded programs, or retiree health plans, yet have very limited resources with which to pay for prescription drugs out of pocket. As a result, they spend a significant share of their income on prescription drugs and often forgo needed medications.

  Both the Senate and House prescription drug bills include subsidy programs that provide low-income Medicare beneficiaries assistance with their premium and cost-sharing obligations. The two bills, however, differ dramatically in the size and adequacy of their low-income subsidy programs, with the Senate offering assistance to individuals at higher income levels without requiring them to meet an asset test and providing a more extensive subsidy. The Senate bill also includes more provisions than the House to make it easier for Medicare beneficiaries to apply for the low-income subsidy program, as well as to coordinate the new Medicare low-income subsidy program with other Medicaid-based programs designed to help them with their premium and cost-sharing obligations under Parts A and B of Medicare.

  These, and additional issues of particular importance to low-income Medicare beneficiaries, are discussed in the remainder of this issue brief. The prescription drug sections of the House and the Senate bills also include numerous significant provisions not addressed in this issue brief. A detailed side-by-side comparison of these provisions

can be found at www.kff.org, while Box 1 below includes a brief summary of some of the key provisions. In addition, both bills include some related, non-Medicare provisions affecting Medicaid; prescription drug patent and reimportation policy modifications; and changes to the role of private health plans in the Medicare program not addressed in this issue brief.

Box 1
Summarized Comparison of Prescription Drug Proposals in the 108th Congress

	Senate-Passed Plan (S. 1)	House-Passed Plan (H.R. 1)
General Approach	Voluntary stand-alone drug benefit under Medicare Part D administered by new agency and delivered through private risk-bearing entities, effective January 1, 2006.	Voluntary stand-alone drug benefit under Medicare Part D administered by new agency and delivered through private risk-bearing entities, effective January 1, 2006. Establishes competitive government contribution system in 2010 that includes traditional Medicare.
Eligibility	Individuals entitled to Part A and enrolled in Part B may enroll, unless receiving full Medicaid benefits.	Individuals entitled to Part A or enrolled in Part B may enroll.
Monthly premium	CBO estimates $34 in 2006, increasing to $62 in 2013, based on enrollee's choice of plan.	CBO estimates $35.50 in 2006, increasing to $56 in 2013, based on enrollee's choice of plan.
Deductible	$275 (indexed)	$250 (indexed)
Cost-Sharing Applied to Total Drug Spending	50% to initial coverage limit of $4,500; 100% between initial limit and stop-loss (indexed); 10% above stop-loss.	20% to initial coverage limit of $2,000; 100% between initial limit and stop-loss (indexed); no coinsurance above stop-loss.
Stop-Loss Threshold Applied to Out-of-Pocket Spending	$3,700 (indexed). After reaching threshold, 90% reimbursement. Payments from qualified private sources, such as employer/retiree plans, do not count toward stop-loss.	$3,500 (indexed). After reaching threshold, 100% reimbursement. Payments from qualified, private sources such as employer/retiree plans, do not count toward stop-loss.
Role of Private Plans/Traditional Medicare	Benefits provided through private, risk-bearing plans. Government contracts with private non-risk-bearing entities to provide coverage in areas with fewer than two private stand-alone prescription drug plans.	Benefits provided through private, risk-bearing plans. Administrator authorized to increase government risk as necessary (but not assume full risk) to guarantee two plan options in each area.
CBO Estimate	$421 billion net change in direct spending (excluding section 133 of the bill relating to requirements that pharmacy benefit managers disclose certain information).	$405 billion net change in direct spending.

II. Implications for Medicaid Beneficiaries

Overview

Currently, Medicaid plays a key role in filling in gaps in Medicare coverage, including the lack of a prescription drug benefit for close to six million seniors and people with disabilities who rely on both Medicaid and Medicare for their health care coverage. The House and Senate Medicare bills differ dramatically in their treatment of these "dual eligibles" who are eligible for full Medicaid benefits – the Senate bill excludes them from the Medicare prescription drug benefit, while the House bill makes them eligible for coverage.

If adopted, the Senate exclusion provision would represent the first time in Medicare's history that a benefit would not be provided on a universal basis to all individuals eligible for Medicare. It also could result in some of the very poorest and sickest Medicare beneficiaries receiving more restrictive drug coverage through Medicaid in some cases than their counterparts receive under the Medicare prescription drug benefit, particularly given that states increasingly are cutting back on Medicaid prescription drug coverage in response to budget problems and rapidly rising costs.

By providing an alternative to prescription drug coverage through Medicaid, both Medicare prescription drug bills, but particularly the Senate bill with its exclusion of dual eligibles from the Medicare prescription drug benefit, may give states new incentives to reduce their optional Medicaid coverage of low-income seniors and people with disabilities.

The Current Environment

- **Close to six million seniors and disabled people – one in seven Medicare beneficiaries – rely on both Medicaid and Medicare for their health care coverage.** State Medicaid programs have a long history of filling gaps in Medicare to make the program work for low-income elderly and disabled beneficiaries. Medicaid "wraps around" Medicare to provide additional financial assistance and benefits to 6.8 million low-income elderly and disabled Medicare beneficiaries, often referred to as dual eligibles. Most dual eligibles qualify for full Medicaid assistance with Medicare premiums and cost-sharing, prescription drugs, long term care, and additional services, such as vision and hearing care. Other dual eligibles, however, receive more limited assistance with Medicare premiums and cost-sharing obligations under Medicare Savings Programs (Figure 1). Of the 6.8 million people who were dual eligibles, 5.8 million were eligible for full Medicaid benefits that included prescription drug coverage while one million qualified for the limited set of benefits. Overall, these "full" dual eligibles accounted for one in seven (15 percent) of Medicare beneficiaries (Figure 2).[2]

[2] Urban Institute estimates. See Appendix C for details. By 2006, when the prescription drug benefit goes into effect under both the House and the Senate bills, the number of individuals affected by the Senate exclusion provision would be higher.

- **Dual eligibles are much poorer, in worse health, and use more health care services than other Medicare beneficiaries.** Since seniors and people with disabilities generally must have income well below the poverty line and minimal assets to qualify for Medicaid, dual eligibles are much poorer than other Medicare beneficiaries – more than 70 percent of dual eligibles have annual incomes below $10,000 compared to 13 percent of all other Medicare beneficiaries. Dual eligibles also tend to be much sicker and to need more care than other Medicare beneficiaries – dual eligibles are more than twice as likely to be in fair or poor health as other Medicare beneficiaries (52 percent versus 24 percent) and nearly a quarter of dual eligibles are in nursing homes compared to two percent of other Medicare beneficiaries (Figure 3).

- **Many dual eligibles are covered by Medicaid at state option.** Federal law requires states to extend Medicaid to some very low-income seniors and disabled people, but states also have broad flexibility to expand Medicaid beyond these minimum federal requirements. The primary group to whom states must extend full Medicaid benefits are seniors and disabled people who qualify for cash assistance through Supplemental Security Income (SSI), a program that generally covers individuals up to 74 percent of the poverty line with minimal assets. States, however, also can extend coverage to "optional" groups of seniors and disabled people, including individuals with high medical expenses (36 states cover these "medically needy" individuals) and individuals with incomes up to 100 percent of poverty. As of 2001, 19 states provided full Medicaid benefits, including prescription drugs, to elderly individuals and persons with disabilities with incomes up to 100 percent of poverty (Figure 4).[3]

- **All states provide prescription drug coverage to dual eligibles, but the quality of coverage is at risk of eroding in many states due to fiscal pressures.** States are not required by federal law to provide prescription drug coverage to Medicaid beneficiaries, but all of them have chosen to do so. Historically, the prescription drug benefit in Medicaid has been closely tailored to the impoverished and often sickly population it serves, providing beneficiaries with the full range of drugs that they need with little or no copayment. Increasingly, however, states have been compelled by fiscal problems and rising prescription drug costs to cut back on the scope of prescription drug coverage in Medicaid. Forty-five states reported earlier this year that they had already acted or planned to act to implement prescription drug cost-containment strategies. These strategies range from developing formularies and requiring prior authorization to increasing beneficiary copayments and limiting the number of prescriptions beneficiaries can fill each month (Figure 5).[4] For example, states such as Georgia, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, and Texas now impose limits on the number of prescriptions that Medicaid beneficiaries can fill each month, with the limits ranging from three to eight prescriptions per month depending on the state.[5]

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[3] National Association of State Medicaid Directors, the Center for Workers with Disabilities and the American Public Human Services Association, *Aged, Blind and Disabled Medicaid Eligibility Survey*, June 27, 2002.
[4] Vern Smith et al., *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003*, KCMU, January 2003.
[5] KCMU Medicaid Drug Benefit Survey, prepared by Jeff Crowley with the Georgetown Institute for Health Policy Research for KCMU, forthcoming.

Legislative Proposals

The House and Senate bills adopt fundamentally different strategies for the treatment of low-income seniors and disabled people on Medicare and Medicaid. The Senate bill excludes dual eligibles with "full" Medicaid coverage that includes prescription drugs and other services, such as long-term care, from the new Medicare prescription drug benefit.[6] Instead, these individuals are expected to continue to rely on Medicaid for their prescription drug coverage.

In comparison, the House bill makes all Medicare beneficiaries eligible for the new prescription drug benefit, including those enrolled in Medicaid. Under the House bill, Medicare would become the primary payor of prescription drug coverage for dual eligibles and Medicaid would serve as the secondary payor. As the secondary payor, Medicaid would supplement the prescription drug coverage available through Medicare as needed to raise it to the state's Medicaid standards. For example, it appears Medicaid would pay the cost-sharing obligations of dual eligibles under the Medicare drug benefit if they exceed levels allowed in Medicaid. If a Medicare drug plan's formulary excludes a drug that is covered by Medicaid, it appears the Medicaid program would be expected to provide the drug as needed to dual eligibles. The House bill requires the new Medicare Administrator to implement a plan to coordinate Medicare and Medicaid prescription drug coverage for dual eligibles, but does not provide specific details regarding how coordination would work.

Box 2

Treatment of Medicaid Beneficiaries Under Medicare Bills

	Senate Bill	House Bill
Medicaid Beneficiaries' Eligibility for Part D	✓ "Full" dual eligibles (i.e., those with full Medicaid coverage that includes prescription drugs) are ineligible for Part D ✓Exclusion applies only to individuals enrolled in full Medicaid coverage, not those simply eligible for coverage ✓"Partial" dual eligibles and Medicare beneficiaries with prescription drug coverage under Medicaid drug-only waivers are eligible for Part D	✓ All Medicaid beneficiaries are eligible for Part D ✓Medicare becomes the primary payor for prescription drug coverage for dual eligibles ✓Medicaid serves as the secondary payor for prescription drug coverage for dual eligibles, supplementing Part D coverage as needed to raise it to state Medicaid standards
Coordination between Medicare and Medicaid prescription drug benefit	✓No provision	✓The Medicare Administrator will implement a plan to coordinate Medicare and Medicaid drug coverage

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[6] The Senate bill specifically excludes dual enrollees with full Medicaid coverage (i.e., coverage that includes long-term care services, prescription drugs, etc.). The exclusion does not apply to dual enrollees who receive assistance only with their Medicare premium and cost-sharing obligations, nor does it apply to Medicaid beneficiaries who receive drug only coverage under Medicaid waivers. Currently, four states provide drug-only coverage to low-income seniors under Medicaid waivers known as "Pharmacy Plus" waivers.

Implications and Issues

- **The Senate bill's exclusion of Medicaid beneficiaries marks a major departure from the principle of a universal Medicare program.** If adopted, the Senate exclusion provision would represent the first time in Medicare's history that Medicare benefits would not be provided on universal basis. The bar on dual eligibles with prescription drug coverage through Medicaid enrolling in Medicare Part D would exclude close to six million Medicare beneficiaries – one in seven Medicare beneficiaries – from the new prescription drug benefit.

- **Some dual eligibles may end up with more restrictive prescription drug coverage than other Medicare beneficiaries if excluded from Medicare's prescription drug benefit.** Historically, the Medicaid drug benefit has been closely tailored to the impoverished and frail population that it serves, providing all necessary prescription drugs to beneficiaries with minimal or no cost-sharing. However, as noted above, the quality of the drug coverage available through Medicaid is increasingly at risk as states turn to cutbacks in Medicaid prescription drug coverage to address fiscal problems. By the time the Medicare drug benefit is implemented in 2006, it is possible a significant number of dual eligibles will find that the prescription drug coverage available to them through Medicaid is more restrictive in some respects than the drug coverage provided to other low-income Medicare beneficiaries under Part D. Since states have broad discretion to determine the adequacy of their prescription drug benefit in Medicaid, the magnitude of any disparity in benefits will likely depend heavily on the state in which a dual eligible happens to reside.

- **Under the Senate bill, Medicare beneficiaries will be more likely to be excluded from the new drug benefit in some states than others.** The Senate provision would have a widely disparate impact on Medicare beneficiaries across the country. A larger share of Medicare beneficiaries would be ineligible for the Medicare prescription drug benefit in states that have elected to expand Medicaid coverage beyond federal minimum standards or that have a disproportionately large low-income elderly population that is more likely to qualify for Medicaid. As shown in Table 1, in 2000, the percent of Medicare beneficiaries with full Medicaid benefits – and who, thus, would be ineligible for the Medicare prescription drug benefit under the Senate bill – ranges from a low of six percent of Medicare beneficiaries in Idaho to 30 percent of Medicare beneficiaries in Mississippi.[7]

- **A Medicare prescription drug benefit could create incentives for states to rollback optional Medicaid expansions for seniors and the disabled.** In light of a new prescription drug benefit in Medicare, states may determine it is no longer as important for them to provide optional Medicaid coverage to seniors and the disabled. Many of these people will be able to secure some prescription drug coverage through Medicare, reducing the imperative to offer them coverage through Medicaid. The incentive for states to rollback optional eligibility expansions is likely to be particularly strong if the

[7] Urban Institute estimates. See Appendix C for details.

Senate exclusion provision is adopted. In effect, the Senate bill allows states to make more of their low-income seniors eligible for the Medicare drug benefit – and to shift the cost of providing them with prescription drugs from Medicaid to Medicare – only by dropping them from full Medicaid coverage. The potential for rollbacks under such a system may be significant – over half (56 percent) of elderly Medicaid beneficiaries and nearly a quarter (23 percent) of all Medicaid beneficiaries with disabilities qualify for Medicaid as a result of optional state expansions.[8] If states rollback optional eligibility expansions, all of the Medicaid services provided to the affected seniors and disabled people would be eliminated, not just their Medicaid prescription drug coverage.

- **Under the House bill, a lack of coordination between a new Medicare prescription drug program and Medicaid could result in low-income Medicare beneficiaries missing out on coverage.** If the House strategy of including Medicaid beneficiaries in the Medicare drug benefit is adopted, there is a risk that dual eligibles will miss out on some prescription drug coverage for which they are eligible unless there is strong coordination between the Medicare and Medicaid programs. The House bill calls for the Medicare Administrator to implement a plan to promote coordination, but does not address any of the specific issues likely to arise if close to six million low-income individuals rely on both Medicaid and Medicare to secure their prescription drug coverage. These issues include whether dual eligibles will be informed of the steps that they should take – and, in particular, whether they should turn to Medicaid versus Medicare – if they encounter problems securing a drug that they need or face higher cost-sharing than is appropriate. Similarly, the House bill does not address whether states will be given detailed, up-to-date information on the formularies used by Medicare prescription drug plans to enable them to serve as effective secondary payors for drug coverage for dual eligibles.

III. Implications for State Budgets

Overview

States have long maintained that it is inappropriate to rely on Medicaid to fill gaps in Medicare coverage, including the lack of prescription drug coverage. Governors and other state leaders have pressed for a prescription drug benefit in Medicare as a means for shifting responsibility to the federal government for providing prescription drug coverage to dual eligibles. Since states pay for an average of 43 percent of the cost of financing the Medicaid program (but none of the cost of financing Medicare benefits), such a shift could provide significant fiscal relief to states.[9] The states' efforts to persuade the federal government to take responsibility for prescription drug coverage for Medicare beneficiaries have grown stronger in recent years in response to the state fiscal crisis and the pressure that rapidly rising prescription drug costs has placed on Medicaid budgets.

[8] Urban Institute analysis of fiscal year 1998 HCFA 2082 and HCFA 64 data as presented in KCMU, *Medicaid "Mandatory" and "Optional" Eligibility and Benefits*, July 2001.

[9] In any given state, the share of most Medicaid costs paid for by the state can vary from a low of 17 percent to a high of 50 percent depending on the state's federal Medicaid matching rate. In addition, selected Medicaid expenses, such as administrative costs, are reimbursed at a different matching rate.

Under the Senate bill, states would continue to be responsible for providing prescription drug coverage to dual eligibles with full Medicaid benefits. If adopted, the Senate treatment of these dual eligibles would mean states would experience little fiscal relief as a result of the Medicare prescription drug benefit (although the Senate bill includes some provisions designed to provide modest fiscal relief to states through alternative means).[10] The House bill includes dual eligibles in the Medicare prescription drug benefit, allowing state Medicaid programs to shift some of the responsibility for prescription drug costs for dual eligibles to the federal government. However, to offset the cost to the federal government of this shift, the House bill reduces federal Medicaid payments to the states over the next several years, effectively "recapturing" some of the state fiscal relief that otherwise would be generated by the House bill.

In addition, both bills include a number of provisions that would affect state budgets in other ways, including new requirements that states play a central role in administering the low-income subsidy program for Medicare. As a result, they are expected to face new administrative expenses, as well as to experience an increase in Medicaid enrollment as people applying for the low-income prescription drug subsidy in Medicare discover they are eligible for Medicaid and enroll in coverage. On the other hand, states are expected to be able to reduce their own spending on State Pharmacy Assistance Programs (SPAP) if a Medicare prescription drug benefit is adopted, generating fiscal relief for those states that operate such programs.

Overall, the CBO estimates that the House bill will provide states with $44 billion in fiscal relief under Medicaid over the next 10 years, while the Senate will provide $20 billion. The primary reason the House bill provides states with more than twice as much fiscal relief is because it includes dual eligibles in the Part D benefit. In addition, CBO estimates that under both bills states will secure at least $450 million a year in fiscal relief as a result of subsidies and cost-sharing payments that they receive on behalf of individuals enrolled in SPAPs.

Current Environment

- **More than 40 percent of Medicaid spending is due to the cost of serving dual eligibles.** Dual eligibles account for a disproportionately large share of Medicaid spending because they tend to have extensive health care needs and use a significant amount of health care services. In federal fiscal year 2002, Medicaid spending on benefits for dual eligibles reached $96.1 billion (state and federal), accounting for more than 40 percent of total Medicaid spending on benefits. The cost of prescription drugs alone for dual eligibles was $13.4 billion (Figure 6).[11] Over the next 10 years, states

[10] Under the Senate bill, a small group of Medicaid beneficiaries who secure drug-only coverage under Medicaid demonstration projects will be eligible for the Medicare prescription drug benefit, creating some fiscal relief for states that provide this drug-only coverage.
[11] Urban Institute estimates. See Appendix C for details.

alone are expected to spend more than $700 billion providing Medicaid services to dual eligibles.[12]

- **The rising cost of prescription drugs has placed a particular strain on Medicaid budgets.** Prescription drug expenditures have been the fastest growing component of Medicaid spending growth in recent times, rising 20 percent annually for the last several years (Figure 7). In fiscal year 2002, Medicaid spending on prescription drugs reached a total of more than $20 billion, and roughly half of this amount was attributable to the cost of prescription drugs for people who were also enrolled in Medicare.[13] States alone spent $5.8 billion on prescription drugs for dual eligibles in federal fiscal year 2002, or some six percent of their total Medicaid spending.[14] In some states, the share of Medicaid expenditures attributable to the cost of providing prescription drugs to dual eligibles is even higher, reaching 10 percent or more in Florida, Kentucky, and Mississippi (Table 2).

- **States are struggling to fund prescription drug coverage through Medicaid for low-income Medicare beneficiaries.** As states have sought to balance their budgets in the face of sharp declines in revenue, the vast majority are taking action to reduce their Medicaid spending growth, including their Medicaid prescription drug spending. As noted in Section II, 45 states reported earlier this year that they had either already acted or planned to act to implement prescription drug cost-containment strategies. These strategies range from developing formularies and requiring prior authorization to increasing beneficiary copayments and limiting the number of prescriptions beneficiaries can fill each month (see Figure 5).

- **States have long maintained that Medicaid should not be required to fill gaps in Medicare coverage.** States have long advocated increasing the federal government's financial responsibility for dual eligibles on the grounds that Medicaid should not be required to fill gaps in Medicare's coverage, including the lack of a prescription drug benefit. With the state fiscal crisis in its third year and projections suggesting that the growth in Medicaid spending will outstrip state revenue growth for the indefinite future, states are searching for short and long-term strategies for managing their Medicaid budgets. The fiscal relief that Congress provided in the tax cut law enacted earlier this year offered them temporary assistance, but was not designed to address the long-term challenges confronting the program. In light of these trends, the National Governors' Association and other state organizations continue to advocate strongly for the federal government to take over responsibility for the cost of providing prescription drugs and other services to dual eligibles.

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[12] KCMU estimates based on assuming the share of state Medicaid spending on benefits attributable to dual enrollees will remain constant over the next 10 years. The data on the share of state Medicaid spending on benefits attributable to dual eligibles are from Urban Institute estimates (see Appendix C for details). To estimate growth in overall state Medicaid spending on benefits between fiscal year 2004 and 2013, KCMU used the Medicaid baseline issued by CBO in March of 2003. If anything, spending on dual eligibles is likely to rise as a share of Medicaid spending over the next 10 years, making these estimates conservative.

[13] Urban Institute estimates. See Appendix C for details.

[14] Urban Institute estimates. See Appendix C for details.

- **Some states operate SPAPs to provide prescription drug coverage to more moderate income Medicare beneficiaries.** Many states have sought to address the lack of prescription drug coverage for low and moderate income Medicare beneficiaries who do not qualify for Medicaid by establishing state pharmacy assistance programs. As of the beginning of 2003, 26 states had laws providing for the subsidy of prescription drug purchases for at least some states residents.[15] Although many of these programs offer only small subsidies or help a narrow group of individuals, a handful of states such as New Jersey, New York, and Pennsyvlania operate expansive state pharmacy assistance programs. Overall, states spend more than $1.5 billion on state-funded pharmacy programs, with much of the spending concentrated in the states with expansive programs.[16]

Legislative Proposals

The House and the Senate have adopted distinctly different approaches to how they treat Medicaid beneficiaries under their Medicare drug plans, and these approaches have significant fiscal implications for state Medicaid budgets. Both bills also include a number of other provisions that would affect state budgets.

Box 3

Treatment of States Under Medicare Bills

	Senate Bill	House Bill
State fiscal relief	✓No Medicare coverage of prescription drug benefits for dual eligibles ✓Instead, 100% FMAP is provided for dual eligibles with incomes up to 100% FPL in states with Medicaid drug coverage that meets minimum standards	✓ Medicare pays for Part D prescription drug benefits for dual eligibles (including low-income subsidies, as appropriate) ✓Federal government "recaptures" some of the state fiscal relief, with the share declining each year until 2021 when states retain all fiscal relief
Incentives for States to Maintain Optional Expansions	✓In states that maintain optional expansions for dual eligibles, 100% FMAP is provided for Medicare Part A deductible and coinsurance costs	✓No provision
Treatment of State Pharmacy Assistance Program	✓Allows qualified state pharmaceutical assistance programs to receive Medicare drug subsidies (in a manner similar to qualified retiree plans)	✓A commission is established to study coordination between Medicare Part D and state pharmacy assistance programs
Responsibility for Administering Low-Income Subsidy	✓States must determine eligibility for the low-income subsidy program. ✓Enhanced matching funds are available (details in Box 4)	✓States (along with SSA) must determine eligibility for the low-income subsidy program. ✓Enhanced matching funds are available (details in Box 4)

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The Senate Medicare bill excludes dual eligibles from the Medicare drug benefit. As a result, Medicaid continues to pay the full cost of providing drug coverage to dual eligibles. However, the bill does provides some fiscal relief to states by having the federal government take over the cost of paying Medicare Part B premiums for dual eligibles with incomes

[15] National Conference of State Legislatures, *2003 Prescription Drug Legislation*, updated August 8, 2003.
[16] Kimberly Fox et al., *State Pharmacy Assistance Programs*: *Approaches to Program Design*, The Commonwealth Fund, May 2002**.** The $1.5 billion figure reflects states' appropriations for state pharmacy assistance programs in fiscal year 2001. It is likely that state expenditures for these programs now exceed $1.5 billion.

between the SSI income cutoff and 100 percent of the federal poverty level.[17] This relief will be available only to states that meet standards the bill sets for Medicaid prescription drug coverage, such as not imposing a per month limit on the number of prescriptions a Medicaid beneficiary can fill. In addition, the Senate bill would provide full federal funding of Part A deductibles and coinsurance for states that continue to provide some expanded Medicaid coverage to seniors and disabled individuals with income up to 100 percent of the poverty level.

In contrast, the House bill would include dual Medicaid and Medicare enrollees in the prescription drug benefit. As a result, Medicaid programs would no longer bear full responsibility for the cost of providing prescription drugs to dual eligibles beginning in fiscal year 2006 when the Part D benefit goes into effect, creating the possibility of significant fiscal relief for the states. States would still, however, "wrap around" Medicare drug coverage for dual eligibles, filling in the gaps in Medicare drug coverage and ensuring that dual eligibles continue to receive drug coverage that meets a state's Medicaid standards. Until 2021, the federal government also will reduce states' federal Medicaid payments to offset a share of the state fiscal relief generated by the Medicare prescription drug benefit. In 2006, the first year of the drug benefit, the federal government will "take back" 93.33 percent of the state savings associated with providing low-income premium and cost-sharing subsidies for the Medicare drug benefit to dual eligibles. Over 15 years, the share of state savings recaptured by the federal government would gradually phase out, so that in 2021 states would begin to realize the full financial benefit of the federal government providing prescription drug coverage through Medicare.

Both bills also include a number of other provisions expected to affect state budgets. Some of these provisions, such as new requirements that states determine who is eligible for the low-income subsidy program in Medicare, would increase state expenditures. On the other hand, both bills are expected to make it easier for states that operate state pharmacy assistance programs for seniors and/or disabled people to reduce their expenditures on these programs. The Senate bill includes a specific provision that would allow state pharmacy assistance programs meeting certain standards to receive government subsidies for their Medicare enrollees equivalent to what their Medicare subsidies would be if they were enrolled in Part D. The House bill does not offer such subsidies, but states with SPAPs may elect to discontinue these programs given the new prescription drug benefit in Medicare, generating some state fiscal relief.

Implications and Issues

- **The Senate bill leaves states with full responsibility for the cost of providing prescription drug coverage to dual eligibles.** States have long expected that a Medicare prescription drug benefit would relieve them of the financial responsibility for providing prescription drug coverage to dual eligibles through Medicaid. Since the

[17] The Senate provision applies to all dual enrollees with income between the SSI income cutoff and 100 percent of the federal poverty level, including those with full Medicaid coverage and those who receive assistance only with their Medicare cost-sharing obligations (i.e., QMBs).

Senate excludes people with "full" Medicaid benefits from the Medicare drug benefit, it offers states little of the fiscal relief they had expected. The fiscal relief the Senate bill does provide appears relatively modest compared to the cost of providing prescription drug coverage to dual eligibles – estimates from the CBO suggest the Senate bill will provide states with $20 billion in fiscal relief in Medicaid over the next 10 years while they are expected to spend far more than $100 billion on prescription drugs for dual eligibles.[18,19]

- **Under the House bill, Medicare eventually takes on much of the responsibility for providing prescription drug coverage to dual eligibles, but provides less fiscal relief than states may have anticipated.** Under the House bill, the federal government eventually assumes much of the cost of providing prescription drugs to dual eligibles, but it also includes limitations. States still must supplement the Medicare coverage provided to dual eligibles and they must return a share of the fiscal relief they gain under the House bill through 2021. (Last year, the House's Medicare prescription drug bill also retained some of the state fiscal relief associated with including dual eligibles in the Medicare prescription drug benefit, but only through 2013.) The Congressional Budget Office has estimated that the amount of state fiscal relief available under the House bill would total a net of $44 billion between 2004 and 2013.[20]

- **Some states may secure fiscal relief as a result of new flexibility to scale back state pharmacy assistance programs.** If a Medicare drug benefit is enacted, many states with state-funded pharmacy programs will be able to scale back or eliminate these programs in the knowledge that seniors have an alternative means to secure prescription drugs. In most states, the size of the fiscal relief will be modest, but the handful of states that operate expansive SPAPs may experience substantial fiscal relief. CBO estimates that under both bills states will secure at least $450 million a year in fiscal relief as a result of subsidies and cost-sharing payments that they receive on behalf of individuals enrolled in state pharmaceutical assistance programs.

- **Other provisions of the bills may increase state spending**. Both bills contain a number of additional provisions that are expected to increase state spending, such as requiring

[18] The $100 billion figure is a conservative estimate based on assuming that state spending on prescription drugs for dual enrollees over the next 10 years will remain constant as a share of Medicaid spending on benefits. Information on the share of Medicaid spending on prescription drugs for dual enrollees in fiscal year 2002 were provided by the Urban Institute and projections of state Medicaid spending over the next 10 years are from the CBO Medicaid baseline, March 2003. If anything, the share of Medicaid spending attributable to prescription drug coverage for dual enrollees is likely to rise rapidly over the next 10 years.

[19] CBO's $20 billion estimate is a net figure that takes into account all of the provisions in the Senate bill that directly or indirectly affect state Medicaid spending. It includes, for example, the positive effect on state budgets of the Medicare Part B buyout, the Medicare Part A buyout, the movement of Pharmacy Plus enrollees into the Medicare prescription drug benefit, and a host of other small provisions. At the same time, it includes all of the provisions with a negative effect on state budgets, such as the cost to states of administering the low-income subsidy program and increases in Medicaid enrollment generated by the Medicare prescription drug low-income subsidy program. Congressional Budget Office Cost Estimate, *H.R. 1, Medicare Prescription Drug and Modernization Act of 2003 and S. 1, Prescription Drug and Medicare Improvement Act of 2003*, July 22, 2003.

[20] As with the $20 billion estimate of fiscal relief under the Senate bill, CBO's $44 billion estimate is a net figure that takes into account a range of House provisions that are expected to affect state Medicaid expenditures.

states to determine eligibility for the Medicare prescription drug subsidy program available to low-income individuals. Although the bills anticipate providing additional federal assistance for this new activity, the assistance will not cover the full costs for states over the next 10 years. States also are expected to face higher Medicaid costs as a result of people applying for Medicare's low-income subsidy program finding out about and enrolling in other low-income subsidy programs operated through Medicaid. (The CBO figures presented above on state fiscal relief take into account the cost to states of these other provisions.)

IV. Implications for Low-Income Individuals Not on Medicaid

Medicare beneficiaries with low incomes face particular challenges in securing prescription drugs. Many of them are not eligible for assistance with prescription drug costs through Medicaid, state-funded programs, or retiree health plans, yet have very limited resources with which to pay for prescription drugs out of pocket. As a result, they spend a significant share of their income on prescription drugs and often forgo needed medications.

Both the Senate and House prescription drug bills include subsidy programs that provide low-income Medicare beneficiaries assistance with their premium and cost-sharing obligations. The two bills, however, differ dramatically in the size and adequacy of their low-income subsidy programs, with the Senate program offering assistance at higher income and asset levels and providing a more extensive subsidy. They also vary in the extent to which they seek to ensure that the application process for the low-income subsidy program is easy for Medicare beneficiaries to navigate, as well as coordinated with the application process for other low-income subsidy programs, such as the Medicare Savings programs in Medicaid that help low-income individuals with their premium and cost-sharing obligations under Parts A and B of Medicare.

The Current Environment

- **Half of Medicare beneficiaries are low-income individuals.** A large share of seniors and disabled people live on modest, fixed incomes. In 2001, more than half of Medicare beneficiaries had income below 200 percent of the poverty line ($14,400 for an individual or $19,400 for a couple in 2003). These low-income individuals represented more than 19 million Medicare beneficiaries.[21]

- **A significant share of low-income Medicare beneficiaries lack prescription drug coverage.** A substantial number of low-income Medicare beneficiaries do not have access to private sources of coverage and yet do not qualify for Medicaid due to that program's restrictive income and asset eligibility rules. In many states, a senior or disabled person must have income below 74 percent of the poverty line and minimal assets to qualify for Medicaid. Many states also have application procedures that make it difficult for eligible individuals to enroll in Medicaid. While state-funded pharmacy programs help ease the coverage gap in a handful of states, they often provide only

[21] KCMU tabulations based on the March 2002 Current Population Survey.

minimal benefits; limit enrollment to a select number of individuals; or, in roughly half of all states, simply are not in operation.

- In 1998, more than a quarter of Medicare beneficiaries with income below the poverty line lacked drug coverage, even though many of these beneficiaries are eligible for prescription drug coverage through Medicaid (Figure 8).[22]

- A significant number of low-income individuals with incomes above 100 percent of poverty lacked prescription drug coverage in 1998 (Figure 8).[23] These "near poor" individuals are more likely than beneficiaries in any other income range to be without prescription drug coverage because they are largely ineligible for Medicaid, and yet often lack access to private sources of coverage.

- **Low-income Medicare beneficiaries often lack the resources to pay for prescription drugs.** With average out-of-pocket spending for prescription medications reaching about $1,000 per year for Medicare beneficiaries in 2003, many beneficiaries struggle with the high cost of prescription drugs.[24] For low-income beneficiaries, who have fewer resources with which to pay for prescription drugs, out-of-pocket costs can be particularly burdensome and impede access to needed prescriptions.

    - A recent eight-state survey found that more than two in five (42 percent) low-income Medicare beneficiaries without drug coverage spend *more* than $100 per month on their medication, which for an elderly person living at the poverty level represents one-seventh or more of his or her income.[25]

    - Low-income individuals – particularly those without drug coverage – are more likely to forgo medication or skip doses than higher income individuals (Figure 9).[26]

- **Many low-income Medicare beneficiaries are missing out on existing subsidy programs for which they are already eligible.** Since 1988, the federal government has required state Medicaid program to provide many low-income Medicare beneficiaries with assistance in meeting their Medicare Part A and Part B premium and cost-sharing obligations. These Medicaid-based subsidy programs for Medicare beneficiaries, often known as Medicare Savings Programs, generally offer assistance to Medicare beneficiaries with income below 135 percent of the poverty line and minimal assets who do not qualify for full Medicaid coverage. (Figure 1 provides details on the income and asset rules used in the Medicare Savings Programs.) Even though most of the Medicare Savings Programs have been in existence for a long time, a lack of awareness about their existence and cumbersome application procedures have kept a significant share of eligible Medicare beneficiaries from

[22] Source: Poisal, J.A., and L. Murray, *Health Affairs,* March/April 2001.
[23] Ibid.
[24] Actuarial Research Corporation analysis for the Kaiser Family Foundation, June 2003.
[25] Kaiser/Commonwealth/Tufts-New England Medical Center 2001 Survey of Seniors in Eight States, July 2002.
[26] Ibid.

enrolling.[27] In many states, Medicare beneficiaries must fill out lengthy forms and provide extensive paperwork documenting their income and assets to secure assistance under Medicare Savings Programs. The asset test has proven to be a particularly significant barrier.[28] Although it makes relatively few low-income Medicare beneficiaries ineligible for coverage – over eight in 10 Medicare beneficiaries below 135 percent of poverty have minimal assets – it complicates the application process by lengthening application forms and increasing documentation requirements. [29,30]

Legislative Proposals

The Senate and House bills each establish low-income subsidy programs that are designed to help low-income individuals take advantage of the prescription drug coverage available under the Part D benefit. The programs would subsidize the cost of low-income beneficiaries' premiums, deductibles, and co-insurance obligations for Part D benefits. Both bills would significantly expand assistance for low-income individuals, providing the most help to individuals below 135 percent of the poverty line who can meet an asset test. These individuals would not have to pay premiums or meet the deductible for Part D under the Senate or House bills, and they also would be eligible for help with their Part D co-insurance payments to varying degrees.

However, the low-income subsidy programs in the House and the Senate also vary in key ways that affect the number of people they serve and the level of subsidy that they provide. The Senate bill extends coverage to individuals at higher income and asset levels and provides a more extensive subsidy, but also excludes Medicaid enrollees from the Part D benefit and low-income subsidy program. Appendix B provides a detailed comparison of the subsidy structure under the Senate and the House bill and the key differences are summarized below.

[27] See, for example, Glaun, Kim, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings,* The Kaiser Commission on Medicaid and the Uninsured, December 2002.
[28] States have the discretion to eliminate the asset test for Medicare Savings Programs using less restrictive methodologies for determining what counts as an asset.
[29] Congressional Budget Office, Medicare beneficiaries, by Medicaid eligibility and asset eligibility, CY2006, June 2003.
[30] Glaun, Kim, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Finding* The Kaiser Commission on Medicaid and the Uninsured, December 2002.

Box 4

Low-Income Subsidy Programs Under Senate v. House Bills		
	Senate Bill	**House Bill**
Eligibility Rules	• Cost-sharing and premium assistance for Part D beneficiaries with income below 160% of poverty (3 tiers of subsidy) • Do not need to meet an asset test to qualify for assistance, but more generous assistance is provided to those who do meet one	• Cost-sharing and premium assistance for Part D beneficiaries with income below 135% of poverty • Sliding-scale premium assistance for those between 135% and 160% of poverty • Must meet an asset test to qualify for any assistance
Level of Cost-sharing Assistance	• Substantial help is provided with all of low-income individuals' drug expenditures, including expenditures above the initial limit of $4,500 (i.e., there is no "donut hole" for low-income beneficiaries)	• Substantial help is provided until drug expenditures reach an initial limit of $2,000 • No help with cost-sharing is provided above the initial limit until out-of-pocket expenses reach $3,500
Administration of Low-Income Subsidies		
	Senate Bill	**House Bill**
Eligibility Determinations for Low-Income Subsidy Program	• State Medicaid agencies must evaluate eligibility for low-income subsidies	• State Medicaid agencies must evaluate eligibility for low-income subsidies • SSA also will evaluate eligibility for low-income subsidies
Enhanced Matching Rate for States	• States initially provided with a 75% matching rate for most eligibility determinations, phasing down to 60% in 2008. Eligibility determinations for individuals ineligible for a Medicare Savings Programs set at 100%	• Set at 55% in 2005, and increases each year until it reaches 100% in 2019
Application Procedures	• States must use presumptive eligibility procedures when evaluating eligibility • States must conduct eligibility determinations at all Social Security field offices • Beginning in 2009, states must allow for self-declaration of assets	• No provision
Coordination Between Programs	• States must determine if low-income subsidy applicants also are eligible for selected Medicaid eligibility categories and, if eligible, enroll them	• No provision

The Senate bill would extend eligibility for subsidies to 160 percent of the poverty line, as well as offer assistance to all beneficiaries in this income range even if they do not meet an asset test, although the *level* of subsidy that an individual receives may depend on whether he or she can meet an asset test.[31] One notable exception is that since the Senate bill excludes Medicaid beneficiaries with prescription drug coverage from Part D, dual eligibles are ineligible for the low-income subsidy program regardless of their income and assets. In comparison, the House extends coverage under its low-income subsidy program to individuals below 135 percent of the poverty line who can meet an asset test. (The House also provides premium-only assistances to individuals between 135 percent and 150 percent of poverty who meet an asset test.) Beginning in 2009, the asset test in the Senate (used to determine the level of subsidy that someone receives) is set at $10,000 per individual and $20,000 per couple.[32] In the House, the asset test (used to determine whether someone is eligible for the low-income subsidy program) is set at $7,000 per individual and $9,000 per couple.

The Senate and the House bills also vary dramatically in the extent to which they help low-income individuals with their co-insurance obligations which, as explained in detail in Box 1 on page 3, are substantial under the basic structure of the benefits in the House and Senate bills. Both bills heavily subsidize the cost-sharing obligations low-income people face until their total drug costs reach an "initial limit," set at $4,500 in the Senate and $2,000 in the House. The Senate bill continues to pay for 80 percent to 95 percent of the cost of prescription drugs above its $4,500 initial limit until an individual incurs $3,700 in out-of-pocket costs. It then picks up an even larger share of a low-income person's drug costs. In comparison, the House pays for none of a low-income person's drug costs above $2,000 until he or she has spent a total of $3,500 out-of-pocket on prescription drugs.[33]

Both bills require states to determine who is eligible for the Medicare low-income subsidy program. (The House bill also requires the Social Security Administration to conduct such eligibility determinations.) To ease the fiscal burden on states of this requirement, the bills provide them with enhanced matching funds for the costs they incur. The Senate bill, however, never fully finances the cost of these eligibility determinations and the House does so only in 2019. The Senate bill also requires states to allow applicants to "self-declare" their assets; to allow individuals to enroll on a presumptive eligibility basis; to allow individuals to enroll at Social Security field offices; and to determine whether applicants for the low-income subsidy program also are eligible for a Medicare Savings Program and, if so, to enroll them in such coverage.

[31] As reviewed in detail in Appendix B, the Senate proposal includes a three-tier subsidy structure with the level of subsidy that an individual receives determined by his or her income and assets. In devising its subsidy structure, the Senate borrowed the eligibility rules used under existing Medicare Savings Programs (see Figure 1 for details) to establish the tiers of its subsidy structure, offering the highest level of subsidies to individuals who meet a state's QMB standards, a lower level of subsidy to individuals who meet a state's SLMB and QI-1 standards, and a third level for individuals with income below 160 percent of poverty not otherwise eligible for a low-income subsidy.
[32] For fiscal years 2006 and 2007, the Senate asset test is set at $4,000 for an individual and $6,000 for a couple.
[33] When defining "out-of-pocket" expenses, the House bill includes both payments made by low-income individuals and payments made on their behalf by the low-income subsidy program.

Implications and Issues

- **Both bills extend eligibility for prescription drug subsidies to millions of low-income Medicare beneficiaries.** The CBO estimates that the Senate bill would make about 12 million Medicare beneficiaries eligible for its low-income subsidy program by 2013, while the House bill would extend eligibility to about 15 million people, 7 million of whom are dual eligibles. In practice, not everyone who is eligible for the Medicare low-income subsidy program is expected to sign up due to lack of awareness about the program, application barriers, and/or a limited interest in the benefit it provides. As shown in Figure 10, CBO estimates that about 5 million people would enroll in the Senate's low-income subsidy program, while 2.5 million people would enroll in the House low-income subsidy program along with 7 million dual eligibles. (CBO assumes that all dual eligibles would enroll in the House's Medicare low-income subsidy program because states have a strong fiscal incentive to ensure that they do.)

- **The proposed asset rules, particularly in the Senate's low-income subsidy program, are less restrictive than those currently used in Medicaid.** The asset rules used in Medicaid often are quite restrictive and are not indexed over time. To qualify for full Medicaid coverage, seniors and people with disabilities generally must have fewer than $2,000 in assets per individual or $3,000 per couple. As a result, roughly three in 10 Medicare beneficiaries living below the poverty line cannot qualify for Medicaid due to their assets.[34] The House bill, which sets its asset limit at roughly three times this level for its low-income subsidy program, will help some of these individuals. The Senate bill will help an even greater number of low-income Medicare beneficiaries excluded from Medicaid due to their assets. It provides some assistance to all Part D Medicare beneficiaries with income below 160 percent of poverty even if they do not meet an asset test.[35]

- **The Senate's low-income subsidy program provides significantly more protection against prescription drug costs than the House bill.** For low-income people with more than $2,000 in drug costs, the Senate bill provides far more extensive assistance than the House bill. For example, an elderly woman living just below the poverty line with $3,000 in prescription drug costs would have to spend $150 of her own money on drugs under the Senate plan. In comparison, her out-of-pocket costs would be some $1,100 under the House bill, or more than 10 percent of her income.[36] The reason out-of-pocket

[34] Marilyn Moon et al, *Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs,* prepared for the Kaiser Family Foundation, June 2002.

[35] However, for individuals below 135 percent of poverty, the Senate provides a higher level of subsidy to those who meet an asset test.

[36] KCMU estimates. Under the House bill, Medicare pays for all of a subsidy-eligible individual's drug costs up to $2,000 except for a $2 co-payment requirement for generic drugs and a $5 co-payment requirement for brand name drugs. As a result, it is necessary to make assumptions about the average cost of drugs and co-payments for someone's drug spending up to $2,000 when estimating out-of-pocket costs under the House bill. For purposes of this example, KCMU assumed the beneficiary's cost-sharing obligations would equal five percent of the total cost of drugs. The estimate, however, is not highly sensitive to this assumption. For example, if the beneficiary's out-of-pocket costs were equal to 10 percent of their total drug spending, she would be required to spend $1,200 under the House bill instead of $1,100.

expenses would be relatively high under the House bill is that it does not offer any subsidies for drug expenses in excess of $2,000 a year until a beneficiary's out-of-pocket expenses reach $3,500. In contrast, the Senate does not have any such "coverage gap" for low-income individuals, although the level at which it subsidizes drug costs decreases modestly after someone's total drug costs reach $4,500 a year. Figure 11 displays the difference in the out-of-pocket expenses a poor Medicare beneficiary would experience under the Senate and House bills given a range of total drug costs. In large part as a result of the more extensive subsidy structure under the Senate bill, the CBO has estimated that the Senate's low-income subsidy program would cost nearly 40 percent more than the House's. If the cost of serving dual eligibles under the low-income subsidy programs is excluded, CBO estimates the Senate will spend nearly four times the amount as the House providing subsidies to low-income Medicare beneficiaries.[37]

- **The application process in the Senate promotes coordination between existing Medicare Savings Programs and the new low-income subsidy program.** The Senate "screen and enroll" provision requires states to screen individuals who apply for Medicare's low-income subsidy program for eligibility for the Medicare Savings Programs and, if they are found eligible, to enroll them in coverage.[38] The provision is likely to help boost enrollment in Medicare Savings Programs. In the House, states might choose to implement screen and enroll procedures, but they are not obligated to do so. Given their budget problems, states may be reluctant to implement such procedures voluntarily due to concerns about the cost of boosting enrollment in Medicare Savings Programs.

[37] CBO estimates the House's low-income subsidy program would cost $69 billion, with $49 billion of this cost attributable to dual enrollees and $20 billion to other low-income beneficiaries. The Senate's low-income subsidy program is estimated to cost $96 billion with $18 billion attributable to dual enrollees with drug only coverage and $78 billion to other low-income Medicare beneficiaries. The difference in cost is due primarily to the relative generosity of the House versus Senate subsidy structure, but also to some extent to a provision in the House bill that counts low-income subsidy payments made on behalf of beneficiaries as "out-of-pocket" costs for purposes of determining whether someone has reached the catastrophic limit. After reaching the catastrophic limit, a low-income person's drug costs are paid for by the Part D benefit rather than the low-income subsidy program.

[38] It, however, does not require states to evaluate whether an applicant for the low-income subsidy program would be eligible for full Medicaid coverage, just cost-sharing assistance under Medicare savings programs.

V. Conclusion

In the weeks and months ahead as Congress debates the final shape of a prescription drug benefit in Medicare, a number of issues with major implications for dual eligibles, other low-income Medicare beneficiaries, and Medicaid budgets will be debated. The outcome of these debates is of critical importance to low-income Medicare beneficiaries, particularly dual eligible individuals who typically are deeply impoverished and far more reliant than other Medicare beneficiaries on publicly-funded programs for prescription drugs and other health care services. States also have much at stake in the outcome of these debates, including potentially their ability to finance care for the more than 50 million children, parents, seniors, and people with disabilities who rely on Medicaid for health coverage. The key issues that will be debated include:

- **Treatment of Dual Eligibles**. Determining whether to include the 5.8 million full dual eligibles in the Part D prescription drug benefit or leave them reliant exclusively on Medicaid for their prescription drug coverage is a critical consideration. Depending on the fiscal fortunes and political priorities of the state in which they happen to reside, dual eligibles if excluded from the Medicare prescription drug benefit may end up with more restrictive prescription drug coverage than other Medicare beneficiaries – even though their need for assistance is far greater.

- **Treatment of States.** The decision on dual eligibles will also have significant fiscal implications for states. In the absence of a fundamental shift in the role of the federal government versus states in financing prescription drug coverage for dual eligibles, many states are expected to find that they cannot sustain current rates of growth in their Medicaid programs without cutting coverage for low-income people deeply.

- **Adequacy of Low-Income Subsidy Program.** Finally, Congress must determine the size and scope of its low-income subsidy program for low-income Medicare beneficiaries not on Medicaid. Most fundamentally, it must decide how many low-income Medicare beneficiaries it will cover; how easy it will be for beneficiaries to enroll in the subsidy program; and whether it will provide low-income individuals with a subsidy that is adequate enough to enable them to use needed prescription drugs.

This background paper was prepared by Jocelyn Guyer of the Kaiser Commission on Medicaid and the Uninsured with assistance from colleagues on the Commission and others on the staff of the Kaiser Family Foundation. KCMU would like to acknowledge the invaluable contributions of Brian Bruen and John Holahan of the Urban Institute who provided the data in this background paper on the number of dual enrollees and the cost of providing them with services.

Figure 1

Medicaid Eligibility for Medicare Beneficiaries, 2003

	Mandatory/Optional Eligibility Group	Income Eligibility	Asset Limit
Coverage That Includes Prescription Drug Benefits*			
SSI Cash Assistance [1]	Mandatory	SSI income eligibility (≤74% FPL for ind.)	$2,000 (individual), or $3,000 (couple)
Poverty-Level	Optional	≤100% FPL	$2,000 (individual), or $3,000 (couple)
Medically Needy [2]	Optional	Individuals who spend their income down to a specific level	$2,000 (individual), or $3,000 (couple)
Coverage Provides Help with Medicare Premiums and/or Cost-sharing, but No Prescription Drug Coverage ("Medicare Savings Programs")			
Qualified Medicare Beneficiary (QMB)	Mandatory	≤100% FPL	$4,000 (individual), or $6,000 (couple)
Specified Low-Income Beneficiary (SLMB)	Mandatory	100-120% FPL	$4,000 (individual), or $6,000 (couple)
Qualifying Individuals (QI 1's)	Mandatory	120-135% FPL (Enrollment is capped)	$4,000 (individual), or $6,000 (couple)

*Prescription drugs are covered at state option, but all states offer this benefit to categorically eligible Medicaid beneficiaries.
1. States that elect the so-called "(209b)" option can set lower levels.
2. Most but not all states provide prescription drug coverage to the medically needy.

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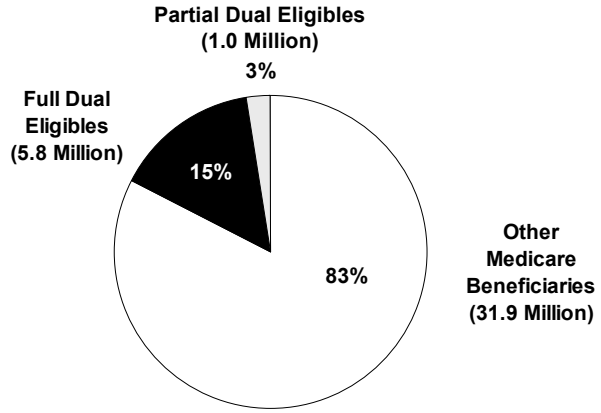
Figure 2

Medicaid Status of Medicare Beneficiaries, 2000



Medicare Beneficiaries = 38.8 Million

SOURCE: Medicare data are from the CMS Office of the Actuary. Medicaid data were prepared by the Urban Institute based on the 2000 MSIS. Note that full dual eligibles are eligible for prescription drug coverage through Medicaid while "partial" dual eligibles receive assistance with Medicare premium and/or cost-sharing obligations. Due to rounding, percentages do not total 100% and data do not sum to 38.8 million.

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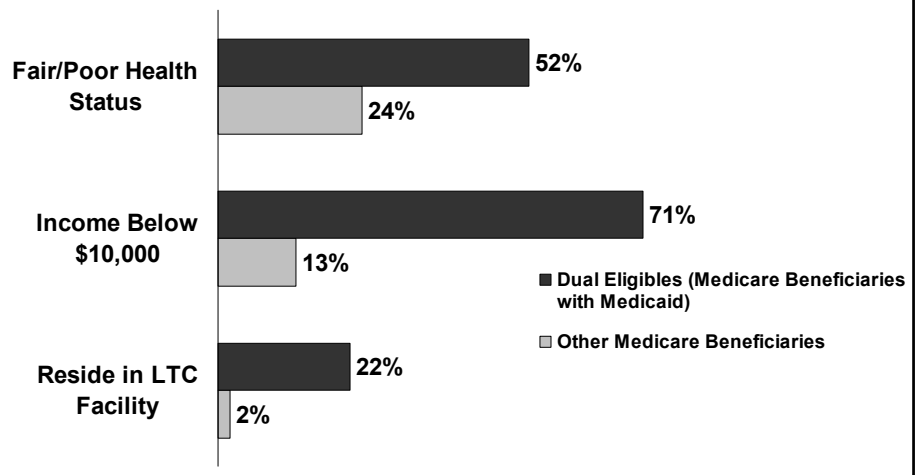
Figure 3

Characteristics of Dual Eligibles Compared to Other Medicare Beneficiaries, 2000



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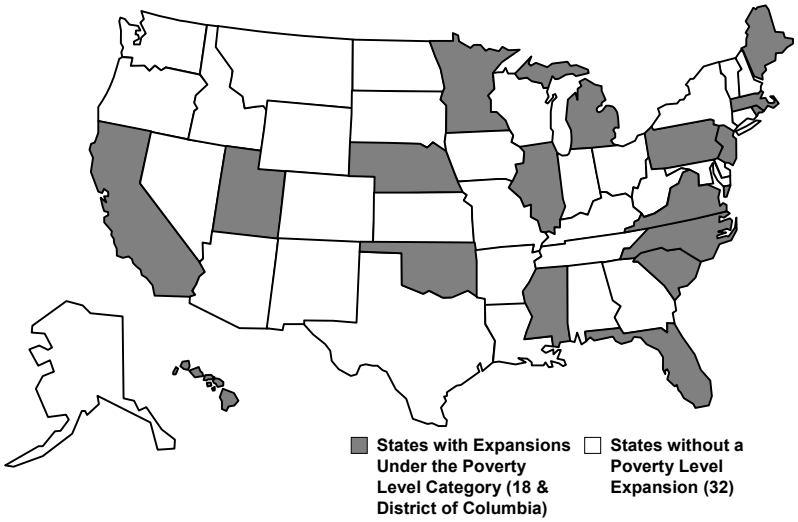
SOURCE: KCMU estimates based on analysis of MCBS Cost & Use 2000.

Figure 4

States with Expanded Medicaid Coverage for the Elderly and Disabled Under the Poverty Level Category, 2001



NOTE: Among states with poverty level expansions, 1 expanded to 135% FPL; 13 and the District of Columbia expanded to 100% FPL; and 4 expanded to a level below 100% FPL.
SOURCE: NASMD, Aged, Blind and Disabled Eligibility Survey, 2001.

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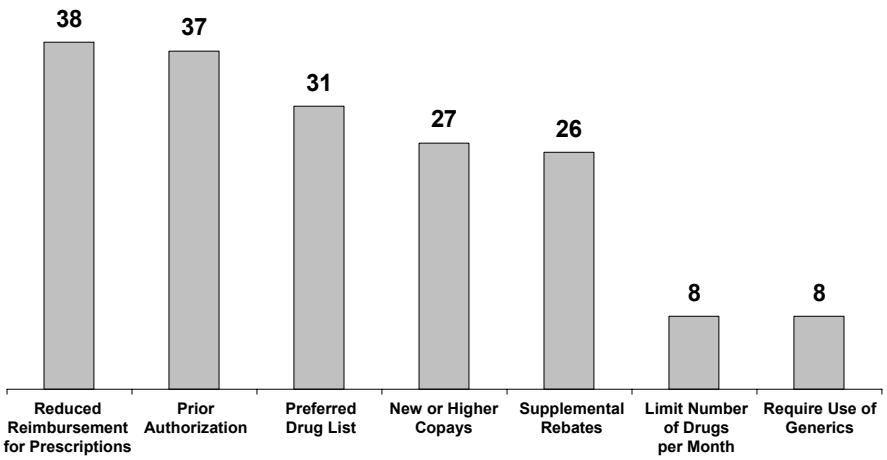
Figure 5

Recent Action by States to Reduce Growth in Medicaid Prescription Drug Spending, 2003-2004



NOTE: Data reflect the number of states adopting new strategies (or expanding their use of existing strategies) to reduce prescription drug spending growth in their fiscal year 2003 or 2004 budgets. States that had these strategies in place prior to fiscal year 2003, but did not modify them in their 2003 or 2004 budgets, are not reflected in this figure.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and forthcoming September 2003.

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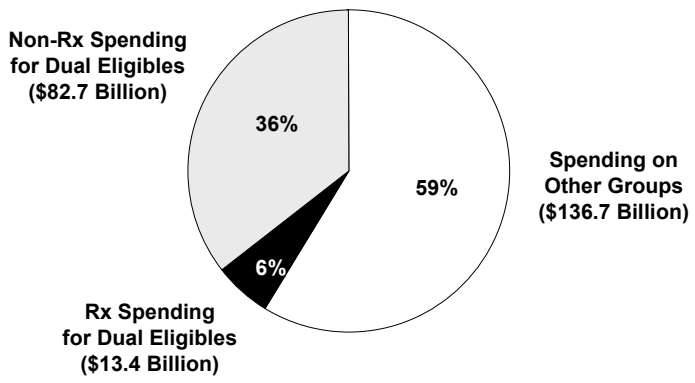
Figure 6

Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FFY2002



Total Spending on Benefits = $232.8 Billion

NOTE: Due to rounding, percentages do not total 100%.
SOURCE: Urban Institute estimates prepared for KCMU based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.

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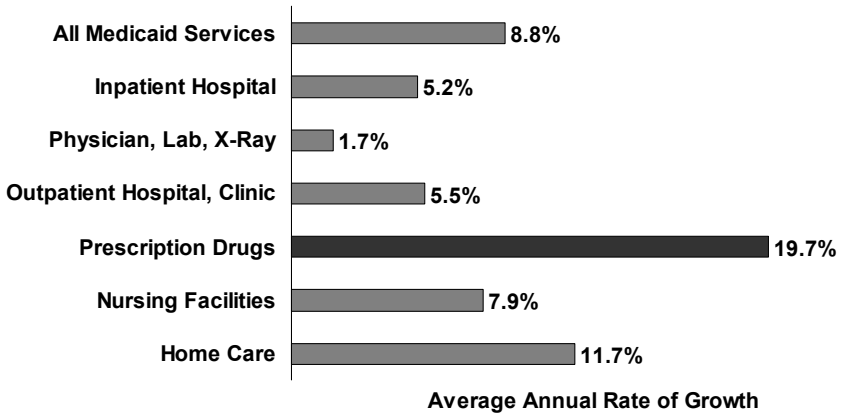
Figure 7

Average Annual Rate of Growth in Selected Medicaid Expenditures, 1998-2000



NOTE: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed.
SOURCE: Kaiser Commission on Medicaid and the Uninsured / Urban Institute analysis of HCFA-64 data.

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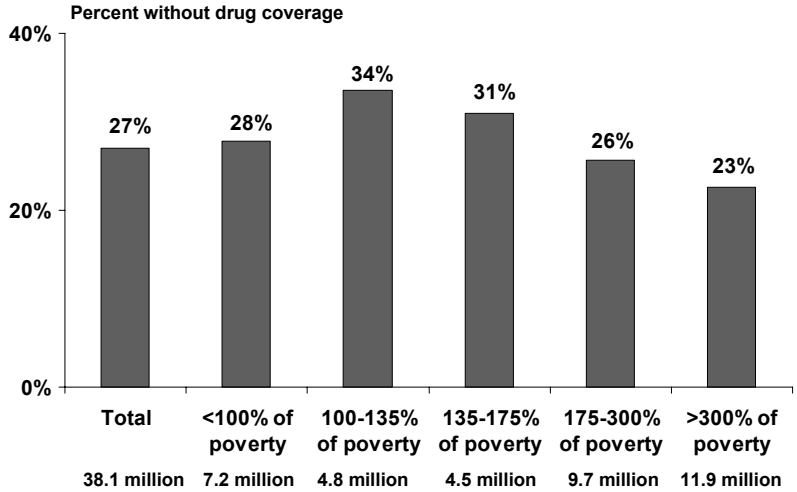
Figure 8

Medicare Beneficiaries Without Drug Coverage by Income Level, 1998



NOTE: 1998 federal poverty level was $8,050 for individuals; $10,850 for couples.
SOURCE: Poisal, J.A., and L. Murray, *Health Affairs,* March/April 2001.

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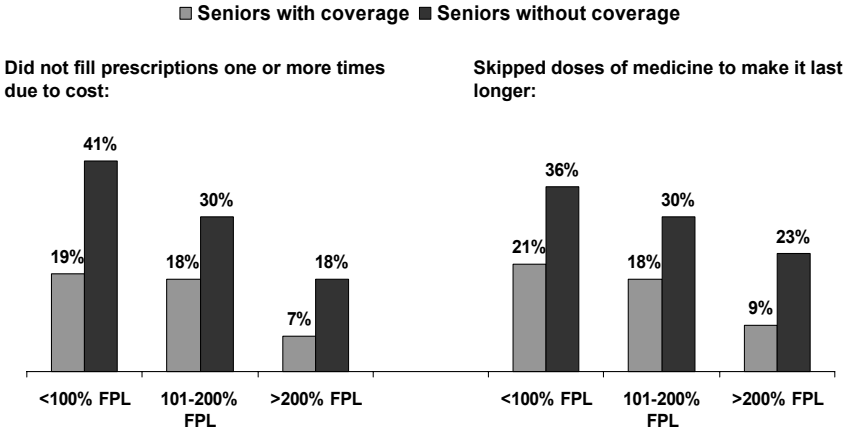
Figure 9

Percent of Seniors in Eight States Forgoing Needed Medicines, by Poverty Level and Prescription Drug Coverage, 2001



NOTE: Includes noninstitutionalized individuals over age 65 with incomes below 200% of poverty.
SOURCE: Kaiser/Commonwealth/Tufts-New England Medical Center 2001 Survey of Seniors in Eight States.

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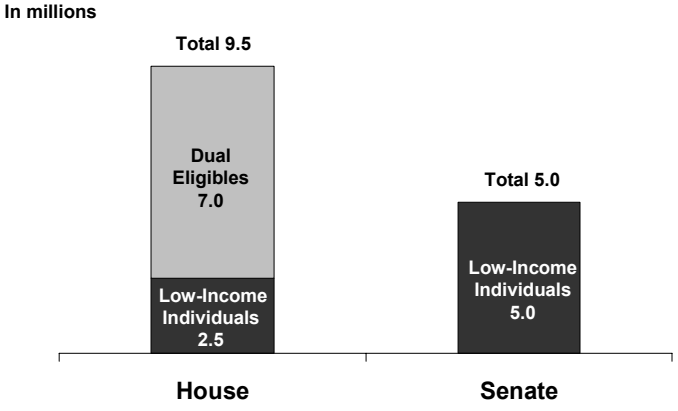
Figure 10

Estimated Enrollment of Medicare Beneficiaries in House v. Senate Low-Income Subsidy Program, 2013



SOURCE: CBO cost estimate of H.R. 1 and S. 1, July 22, 2003. All estimates are approximate.

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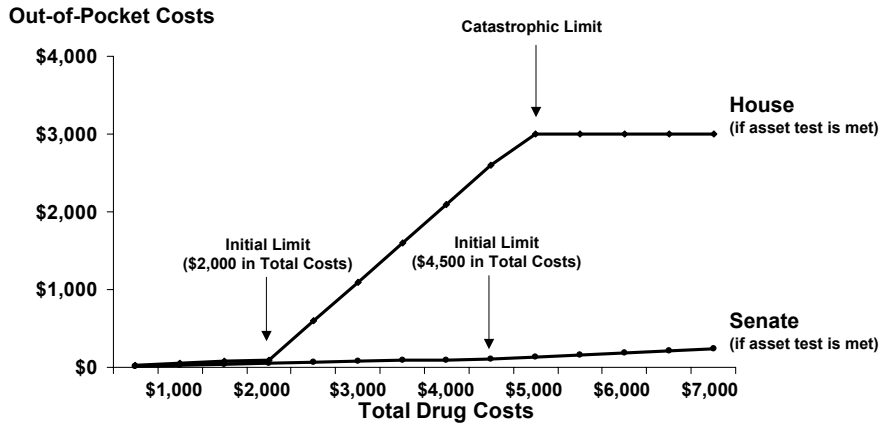
Figure 11

Out-of-Pocket Drug Costs for a Medicare Beneficiary Not on Medicaid with Income Below 100% of Poverty, House v. Senate Low-Income Subsidy Programs



SOURCE: KCMU calculations. For the House bill, out-of-pocket costs for co-payments are assumed to average 5 percent of drug costs up to $2,000. NOTES: In the House bill, Medicare low-income subsidy payments count as "out-of-pocket costs" applied toward the catastrophic limit of $3,500. In this example, the individual reaches the $3,500 catastrophic limit when out-of-pocket payments reach $3,000 because of a $500 low-income subsidy. To qualify for the low-income subsidies presented in this chart, beneficiaries also must meet an asset test.

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Table 1

"Full" Dual Eligibles as a Share of Medicare Beneficiaries by State , FFY 2000

	"Full" Dual Eligibles[1]	Medicare Beneficiaries[2]	"Full" Dual Eligibles as a Share of Medicare Beneficiaries
United States[3]	**5,840,000**	**38,762,000**	**15%**
Alabama	116,000	685,000	17%
Alaska	9,000	42,000	21%
Arizona	54,000	675,000	8%
Arkansas	93,000	439,000	21%
California	862,000	3,901,000	22%
Colorado	57,000	467,000	12%
Connecticut	73,000	515,000	14%
Delaware	9,000	112,000	8%
District of Columbia	16,000	75,000	21%
Florida	337,000	2,804,000	12%
Georgia	123,000	916,000	13%
Hawaii	25,000	165,000	15%
Idaho	9,000	165,000	6%
Illinois	163,000	1,635,000	10%
Indiana	98,000	852,000	12%
Iowa	52,000	477,000	11%
Kansas	37,000	390,000	10%
Kentucky	164,000	623,000	26%
Louisiana	104,000	602,000	17%
Maine	40,000	216,000	18%
Maryland	68,000	645,000	10%
Massachusetts	184,000	961,000	19%
Michigan	181,000	1,403,000	13%
Minnesota	88,000	654,000	13%
Mississippi	126,000	419,000	30%
Missouri	132,000	861,000	15%
Montana	14,000	137,000	10%
Nebraska	33,000	254,000	13%
Nevada	17,000	240,000	7%
New Hampshire	18,000	170,000	11%
New Jersey	134,000	1,203,000	11%
New Mexico	26,000	234,000	11%
New York	512,000	2,715,000	19%
North Carolina	215,000	1,133,000	19%
North Dakota	12,000	103,000	12%
Ohio	171,000	1,701,000	10%
Oklahoma	73,000	508,000	14%
Oregon	54,000	489,000	11%
Pennsylvania	293,000	2,095,000	14%
Rhode Island	26,000	172,000	15%
South Carolina	111,000	568,000	20%
South Dakota	13,000	119,000	11%
Tennessee	182,000	829,000	22%
Texas	346,000	2,265,000	15%
Utah	16,000	206,000	8%
Vermont	21,000	89,000	23%
Virginia	97,000	893,000	11%
Washington	88,000	736,000	12%
West Virginia	35,000	338,000	10%
Wisconsin	110,000	783,000	14%
Wyoming	6,000	65,000	9%

Source: Urban Institute estimates prepared for KCMU based on an analysis of data from CMS (MSIS and Medicare enrollment data).

1) "Full" dual eligibles are Medicare beneficiaries who also are enrolled in Medicaid and receive full Medicaid benefits.

2) "Medicare beneficiaries" defined as individuals enrolled in either Medicare Part A (HI), Part B (SMI), or both. Beneficiaries as of July 2000, as reported at http://cms.hhs.gov/statistics/enrollment/st00all.asp (Accessed August 25, 2003).

3) State figures will not sum to the national totals because of rounding. In addition, the United States' total for Medicare beneficiaries includes roughly 13,000 individuals that CMS listed as "residence unknown" who are not included in the state figures.

Table 2

Medicaid Expenditures for Dual Eligibles, FFY2000

	Total Expenditures on Services (federal and state combined, in millions)			State Expenditures on Services (state share only, in millions)			
	Expenditures for All Enrollees†	Expenditures for Dual Eligibles	Prescribed Drugs for Dual Eligibles	Expenditures for All Enrollees	Expenditures for Dual Eligibles	Prescribed Drugs for Dual Eligibles	Rx for Duals as a Share of Total Medicaid
United States	**$165,638**	**$68,396**	**$9,535**	**71,807**	**29,829**	**4,067**	6%
Alabama	2,330	1,012	139	689	299	41	6%
Alaska	460	108	17	196	46	7	4%
Arizona	2,112	577	66	740	202	23	3%
Arkansas	1,469	765	109	402	209	30	7%
California	16,498	5,822	1,196	8,018	2829	581	7%
Colorado	1,778	791	99	889	396	50	6%
Connecticut	2,790	1,788	145	1,395	894	73	5%
Delaware	515	183	17	257	91	9	3%
District of Columbia	783	220	21	235	66	6	3%
Florida	7,109	2,825	678	3,097	1231	295	10%
Georgia	3,531	1,202	216	1,448	493	88	6%
Hawaii *	528	179	23	231	78	10	4%
Idaho	580	121	20	168	35	6	3%
Illinois	7,657	2,304	306	3,828	1152	153	4%
Indiana	2,891	1,423	218	1,098	540	83	8%
Iowa	1,441	707	90	535	262	33	6%
Kansas	1,195	614	79	476	244	31	7%
Kentucky	2,827	1,493	302	850	449	91	11%
Louisiana	2,551	965	183	758	287	54	7%
Maine	1,276	501	77	427	168	26	6%
Maryland	3,510	1,046	132	1,755	523	66	4%
Massachusetts	5,262	2,785	295	2,631	1392	148	6%
Michigan	4,810	1,397	259	2,099	610	113	5%
Minnesota	3,236	1,721	167	1,618	860	84	5%
Mississippi	1,746	799	187	417	191	45	11%
Missouri	3,160	1,536	295	1,230	598	115	9%
Montana	423	158	24	115	43	6	6%
Nebraska	930	418	59	376	169	24	6%
Nevada	511	152	24	255	76	12	5%
New Hampshire	636	363	38	318	182	19	6%
New Jersey	4,604	2,066	275	2,302	1033	138	6%
New Mexico	1,238	307	34	334	83	9	3%
New York	25,710	12,142	868	12,855	6071	434	3%
North Carolina	4,693	2,112	381	1,809	814	147	8%
North Dakota	352	217	20	106	65	6	6%
Ohio	6,918	3,448	359	2,852	1421	148	5%
Oklahoma	1,563	653	89	462	193	26	6%
Oregon	1,678	579	113	685	236	46	7%
Pennsylvania **	6,259	2,516	402	2,838	1141	182	6%
Rhode Island	1,051	567	46	500	270	22	4%
South Carolina	2,695	902	139	826	276	43	5%
South Dakota	394	185	21	134	63	7	5%
Tennessee ***	4,509	1,550	142	1,640	563	52	3%
Texas	8,853	3,658	473	3,526	1457	189	5%
Utah	937	202	37	281	61	11	4%
Vermont	461	189	43	170	70	16	9%
Virginia	2,422	1,097	176	1,176	533	85	7%
Washington	2,364	720	173	1,173	357	86	7%
West Virginia	1,345	476	56	333	118	14	4%
Wisconsin	2,839	1,630	198	1,176	675	82	7%
Wyoming	209	100	11	80	38	4	5%

Source: Urban Institute estimates prepared for KCMU based on an analysis of data from CMS (MSIS and Medicaid Financial Management Reports).

† Total expenditures are as reported through MSIS. CMS-64 data for FFY 2000 indicate $182.6 billion in total spending on services.

* Estimates for Hawaii are based on MSIS data for FFY 1999, not FFY 2000 as in all other states.

** Pennsylvania did not report any dual eligibles in the FFY 2000 MSIS data. Estimates for dual eligible spending and enrollment in PA are based on the average distributions between dual enrollees and other groups of Medicaid enrollment and spending in 15 states that, like PA, use 100% of poverty (or higher) as the income eligibility standard for aged and disabled individuals. See Appendix C of the full report for more information on methodology.

*** Source data for Tennessee did not appear to include nursing facility expenditures. The Uban Institute estimated the amount of nursing home spending in the state using the FFY 2002 Medicaid FMR report for TN from CMS. The share of this total attributable to dual eligibles was estimated based on nationwide spending patterns.

APPENDIX A

Comparison of Key Medicaid and Low-Income Prescription Drug Provisions in S.1 and H.R. 1		
	Senate (S. 1)	**House (H.R. 1)**
Treatment of Medicaid Beneficiaries		
Eligibility for Part D	• "Full" dual enrollees (i.e., those with full Medicaid coverage that includes prescription drugs) are ineligible for Part D • Other Medicaid beneficiaries without full benefits are eligible for Medicare Part D, including individuals on Medicare Savings Programs and Pharmacy Plus enrollees	• All Medicaid beneficiaries are eligible for Part D • Medicare becomes the primary payor for prescription drug coverage for dual enrollees; Medicaid serves as the secondary payor, supplementing Part D coverage as needed to raise it to state Medicaid standards
Coordination between Medicare and Medicaid prescription drug benefit	• Not applicable since dual enrollees with full Medicaid coverage are ineligible for the Medicare prescription drug benefit	• The Medicare Administrator will implement a plan to coordinate Medicare and Medicaid drug coverage
Treatment of States		
State fiscal relief	• No Medicare coverage of prescription drug benefits for dual enrollees • Instead, 100% federal matching funds are provided for Part B premiums for dual enrollees with incomes between SSI level and 100% FPL	• Medicare pays for Part D prescription drug benefits for dual enrollees • Federal government "recaptures" some of the state fiscal relief, with the share declining each year until 2021 when states retain all fiscal relief
Incentives for States to Maintain Optional Expansions	• In states that maintain optional expansions for dual enrollees, 100% federal matching funds are provided for Medicare Part A deductible and coinsurance costs	• No provision
Treatment of State Pharmacy Assistance Programs	• Allows qualified state pharmaceutical assistance programs to receive Medicare drug subsidies (in a manner similar to qualified retiree plans)	• A commission is established to study coordination between Medicare Part D and state pharmacy assistance programs
Responsibility for Administering Low-Income Subsidy	• States must determine eligibility for the low-income subsidy program; enhanced matching funds provided	• States (along with SSA) must determine eligibility for the low-income subsidy program; enhanced matching funds provided
Low-Income Subsidy Program		
Eligibility Rules	• Cost-sharing and premium assistance provided to Part D beneficiaries with income below 160% of poverty • Do not need to meet an asset test to qualify for assistance, but more generous assistance is provided to those who can meet one	• Cost-sharing and premium assistance provided to Part D beneficiaries with income below 135% of poverty • Sliding-scale premium assistance for individuals with income between 135% and 160% of poverty • Must meet an asset test to qualify for any assistance
Level of cost-sharing assistance	• Substantial help is provided with all of low-income individuals' drug expenditures, including expenditures above the initial limit of $4,500 (i.e., there is no "donut hole" for low-income beneficiaries)	• Substantial help is provided until drug expenditures reach an initial limit of $2,000 • No help with cost-sharing is provided above the initial limit until out-of-pocket spending (including low-income subsidy payments) reaches $3,500
CBO Estimates of Medicaid and Low-Income Provisions		
State fiscal relief (2004 - 13)	• Net of $20 billion	• Net of $44 billion
Cost of low-income subsidy program (2006 - 2013)	• $96 billion ($18 billion for Pharmacy Plus enrollees and $78 billion for other low-income Medicare beneficiaries)	• $69 billion ($49 billion for dual enrollees and $20 billion for other low-income Medicare beneficiaries)
Average payments under low-income subsidy program (2013)	• $3,400 for those below 135% of poverty who meet asset test / $2,800 for all others	• $600
Estimated enrollment in low-income subsidy program (2013)	• 5 million low-income individuals	• 2.5 million low-income individuals and 7 million dual enrollees (9.5 million total)

Source: Prepared by KCMU. For a more detailed comparison of the two bills, see the side-by-side prepared for the Kaiser Family Foundation by Health Policy Alternatives at www.kff.org.

APPENDIX B

The Low-Income Subsidy Programs Under the Senate and House Medicare Bills	
Senate Bill	**House Bill**
Income under 100% of Poverty	
• No premium (no asset test) • No deductible • Cost-sharing of 2.5% up to $4,500 in drug costs ("initial coverage limit") • Cost-sharing of 5% between initial coverage limit and the point an individual spends $3,700 out-of-pocket on drugs ("stop-loss threshold") • Above stop-loss threshold, 2.5% cost-sharing • Must meet asset test * (except for premium assistance)	• No deductible and no premium • Cost-sharing of up to $2 per generic and $5 per brand name drug up to $2,000 in drug costs ("initial coverage limit") • After initial limit, no assistance until the individual has spent $3,500 out-of-pocket on drugs ("stop-loss threshold") • Above stop-loss threshold, no cost-sharing required • Must meet asset test **
Income 100% - 135% of Poverty	
• No premium (no asset test) • No deductible • Cost-sharing of 5% up to $4,500 in drug costs ("initial coverage limit") • Cost-sharing of 10% between initial coverage limit and the point an individual spends $3,700 out-of-pocket on drugs, the stop-loss threshold • Above the stop-loss threshold, 2.5% cost-sharing • Must meet asset test * (except for premium assistance)	• No deductible and no premium • Cost-sharing of up to $2 per generic and $5 per brand name drug up to $2,000 in drug costs ("initial coverage limit") • After initial limit, no assistance until the individual has spent $3,500 out-of-pocket on drugs, when catastrophic coverage begins • Above stop-loss threshold, no cost-sharing required • Must meet asset test **
135% - 160% of Poverty and Individuals < 135% of Poverty Not Meeting the Asset Test	**135% - 150% of Poverty**
• $50 deductible • Sliding scale premium based on income (expected to average $420 in 2006, the first year of the program, for someone without a subsidy) • Cost-sharing of 10% up to $4,500 in drug costs ("initial coverage limit") • Cost-sharing of 20% between initial coverage limit and the point an individual spends $3,700 out-of-pocket on drugs, the stop-loss threshold • After catastrophic coverage, 10% cost-sharing • No asset test *Note: People with income below 135% of poverty who do not meet the asset test receive the cost-sharing subsidies described in this section except they are fully exempt from premium obligations.*	• $250 deductible • Sliding scale premium based on income (expected to average $420 in 2006, the first year of the program, for someone without a subsidy) • Cost-sharing of 20% up to $2,000 in drug costs ("initial coverage limit") • After initial limit, no assistance until the individual has spent $3,500 out-of-pocket on drugs, the stop-loss threshold • Above stop-loss threshold, no cost-sharing required • Must meet asset test

* In the Senate, the asset test for 2006 – 2008 is $4,000 for a single person / $6,000 for a couple. Beginning in 2009, the asset test is $10,000 for a single person / $20,000 for a couple, indexed over time. ** In the House, the asset test is set at $6,000 for a single person and $9,000 for a couple, indexed over time.

Under the Senate and House bills, the deductible, initial coverage limit, stop-loss threshold, and asset limits are indexed. In addition, premium costs are expected to rise over time under both bills. Under the House bill, co-payment requirements are indexed to increases in per capita Medicare prescription drug spending.

SOURCE: Prepared by KCMU.

APPENDIX C
Methodology for Estimating the Number and Cost of Dual Eligibles

Unless otherwise noted, the data presented in this paper on the number of dual eligibles and the cost of providing them with prescription drugs and other services were estimated by Brian Bruen and John Holohan of the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured. The methodology used by Bruen and Holahan to derive their estimates is described below.

Estimates of the Number of Full and Partial Dual Eligibles

The Urban Institute estimated the number of full and partial dual eligibles using person-level data from the Medicaid Statistical Information System (MSIS) for federal fiscal year (FFY) 2000. To separate dual eligibles (full and partial) from other Medicaid enrollees, Bruen and Holahan generally relied on a data element that indicates whether an individual is entitled to Medicare (at least hospital insurance under Part A) and eligible for some category of Medicaid benefits. This flag also allows states to indicate whether the individual receives full Medicaid benefits or more limited assistance (e.g., only premium and/or cost-sharing assistance). However, about 30% of individuals identified as Medicare beneficiaries had values for this indicator that do not clearly identify whether they are enrolled as a full or partial dual eligible.

In cases where individuals were not explicitly identified as full or partial dual eligibles in MSIS, Bruen and Holahan assigned these individuals full or partial status. Their approach relied on establishing lower and upper bounds. First, if MSIS indicated the individual had received any of the following services, they were deemed a "full" dual eligible on the grounds that Medicaid would usually report spending for these services only for full dual eligibles: prescription drugs, ICF/MR services, dental care, HMO or prepaid health plan premium payments, personal care services, home health care services, or targeted case management. Generally, it was assumed that method established a lower bound for full dual eligibles in a state. It would identify full dual eligibles who used any of these services, but would miss individuals who either did not receive services at all or who used only services, such as inpatient hospital or physician services, where spending may simply reflect Medicaid payments of Medicare cost-sharing amounts and therefore is not a reliable indicator of receipt of full Medicaid benefits.

Secondly, Bruen and Holahan assigned individuals with an unknown basis of eligibility to full or partial status based on variables in MSIS that indicate for any given month whether a beneficiary is eligible for full benefits, limited benefits, or ineligible for Medicaid. Considering only months in which beneficiaries were listed as eligible for Medicaid, individuals were assigned "full" Medicaid eligibility if they were listed as receiving full benefits for more months than they were listed as receiving limited benefits over the course of FFY2000. Although this method seemed to be a more accurate means of identifying full dual eligibles, concerns about the reliability of the monthly enrollment variables, coupled with several instances where it appeared that this method assigned full

Medicaid benefits to too many people, led the researchers to think that this method led to something closer to an upper bound on the number of full dual eligibles in a state.

After estimating the number of full dual eligibles in each state using each of the two methods, Bruen and Holahan decided that the number of full dual eligibles likely fell somewhere in between these two estimates in most states, yet they lacked sufficient data to determine if either method was more accurate. Consequently, they took an average of the two estimates to generate the estimates in this background paper of the numbers of partial and full dual eligibles in each state and nationwide. The implicit assumption is that, if the two estimates indeed form lower and upper bounds, the number of full dual eligibles is more likely to be closer to a point half way between the two boundaries than either of the two boundaries.

To provide estimates of the share of Medicare beneficiaries who were dual eligibles in 2000, Bruen and Holahan used data on the number of Medicare beneficiaries in each state and the nation in 2000 taken from the CMS Web site, "CMS Statistics: Medicare Enrollment," accessed at http://cms.hhs.gov/statistics /enrollment/default.asp on August 22, 2003.

Estimates of the Cost of Providing Services to Dual Eligibles

Bruen and Holahan also used data from MSIS to estimate the cost of providing prescription drugs and other services to dual eligibles in 2000. In calculating fee-for-service expenditures on prescription drugs for dual eligibles, they adjusted the reported prescription drug expenditures to take into account that the federal government and states get rebates for outpatient prescribed drugs paid for by Medicaid. To account for the rebates, which reduce outpatient drug spending by an average of about 19 percent nationwide, the researchers calculated each state's average rebate using data from Medicaid Financial Management Reports (FMRs), which are annualized data from CMS Form 64, and applied this average rebate to all reported fee-for-service drug expenditures in the state.

Since some payments for prescription drugs and other services are incorporated into premium payments to managed care organizations, Bruen and Holahan also took payments to HMOs and distributed them to acute care service categories, including prescribed drugs (except in Arizona, as noted below). For most states, the share of managed care payments attributed to prescription drugs was based on fee-for-service spending for dual eligibles in the state. In states where payments to HMOs account for larger shares of total spending, the researchers allocated spending based on the combined spending patterns for all states with smaller shares of spending in payments to HMOs. The estimated drug spending from HMOs was not reduced to account for rebates, since the Medicaid drug rebate program does not apply to these expenditures.

State-Specific Notes

In four states, Arizona, Hawaii, Pennsylvania and Tennessee, Bruen and Holahan took additional measures to address data issues. For Arizona, payments to managed care were assigned to both long-term care and acute care services, based on data from the state and nationwide spending patterns. The estimates for Hawaii are based on FFY1999 MSIS data since the state's FFY2000 MSIS data were not available. Pennsylvania did not report any dual eligibles in the FFY2000 MSIS data. Estimates for dual eligible spending and enrollment in Pennsylvania are based on the average distributions between dual enrollees and other groups of Medicaid enrollment and spending in 15 states using 100% of poverty (or higher) as the income eligibility standard for aged and disabled individuals. These states were chosen as a proxy because Pennsylvania also uses 100% of poverty as its income standard for aged and disabled people, and thus presumably would exhibit similar trends. Lastly, Tennessee's expenditures for nursing facilities were inexplicably mostly negative. Tennessee's reported nursing facility expenditures were replaced with the amount reported on the state's FFY 2000 Medicaid FMR, and these payments were then allocated to various eligible groups (including dual eligibles) based on national spending patterns.

General Data Quality Notes

As with any large person-level data set, there are inconsistencies and errors in the MSIS data. Urban Institute researchers made several minor corrections to the source data, primarily assigning people to more age-appropriate categories and eliminating duplicate observations. In spite of these efforts, there were still inconsistencies and potential errors that the Urban Institute could not measure and/or make corrections for. For example, some states appeared to report too few or too many dual eligibles. Every state reported some spending for unknown services or unknown/ineligible persons. Some states also reported much higher/lower total spending in MSIS compared to the amounts reported on their Medicaid FMRs (CMS Form 64), even for comparably defined services. Therefore, readers may want to use particular caution when using the state-level data presented in Tables 1 and 2 since they are more subject to error-induced biases than the national estimates used in the background paper.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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