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# *TARGETED HELP TO THOSE WHO NEED IT MOST: THOSE WITH LOW-INCOMES AND THOSE WITH HIGH DRUG COSTS*

Starting in 2006, the new Medicare drug benefit makes prescription drug coverage available to all 43 million Medicare beneficiaries, providing them with substantial federal help in paying for their prescription drugs and improving their quality of life. For the first time in Medicare, additional, targeted help will be available to those who need it most – people with very high prescription drug costs and people with low incomes. Millions of low-income beneficiaries will receive comprehensive coverage at little or no cost. And those eligible for low-income assistance will have no gap in their drug coverage.

**Medicare will provide protections to all beneficiaries with high drug costs.**

All beneficiaries, regardless of income, will receive protection from high drug costs under the new Medicare prescription drug program. The standard drug benefit will pick up about 95 percent of all drug costs once a beneficiary spends $3,600 out-of-pocket in a year. This coverage will ensure that beneficiaries with very high drug needs are protected. There is no plan maximum, and the coverage will never run out.

The addition of coverage for high drug costs through Medicare is a major improvement on plans available in the market today. Currently, the Medigap H, I, and J plans that do provide some prescription drug coverage, have no catastrophic coverage. Once a beneficiary spends the maximum, he or she is liable for the entire remaining cost. Similarly, current Medicare+Choice plans (now called Medicare Advantage) often have yearly maximums that can leave beneficiaries uncovered. The new drug benefit in 2006 will make drugs affordable for all beneficiaries.

**Illustrative Savings for a Beneficiary with High Drug Costs**

| Beneficiary Group | Annual Spending (Unmanaged, Full Retail) | Out-of-pocket Spending Under Medicare | Percentage Savings After Premium | Dollar Savings After Premium |
|---|---|---|---|---|
| Beneficiary with standard coverage | $10,000 | $3,770.00 | 58% | $5,802 |
| Beneficiary with income under 150% FPL and low assets | $10,000 | $990.58 | 88% | $8795.42 |
| Beneficiary dually eligible above 100% FPL regardless of assets and beneficiary with income below 135% FPL and low assets | $10,000 | $274.62 | 97% | $9725.38 |
| Beneficiary dually eligible for Medicaid with income below 100% FPL | $10,000 | $156.92 | 98% | $9843.08 |
| Beneficiary who is dually eligible for Medicaid and a nursing home resident | $10,000 | $0 | 100% | $10,000 |

Explanatory Notes: Beneficiary out-of-pocket costs and percentage savings assume 15% cost management by Part D plans, through price discounts and utilization management. Premium for the 150% FPL group is assumed to be in the middle of the sliding scale between $0 and $428. The out-of-pocket calculation for the 135% FPL and 100% groups assumes an average prescription price of $65 and an average co-pay of $3.50 and $2, respectively.

**Medicare will provide extra help to those with low incomes and limited resources.**

Of the 14.5 million low-income Medicare beneficiaries eligible to participate in the new drug benefit's low-income subsidy program, nearly 11 million are estimated to actually enroll in 2006. The 14.5 million people are about a third of the estimated 43 million Medicare beneficiaries in 2006.

- About 6.4 million "dual eligible" low-income beneficiaries will have no premium or deductible and nominal co-pays of as little as $1 or $3 per prescription. For these beneficiaries, the Medicare benefit will pay, on average, 97 percent of their drug costs. Of the "dual eligible" beneficiaries, about 1.5 million who are institutionalized are totally exempt from cost sharing. They pay no premiums, no deductibles, no coinsurance, and no co-payments.
- About 3 million Medicare beneficiaries who are not full-benefit dual eligibles, but whose incomes are less than 135 percent of the federal poverty level ($12,568 for an individual and $16,861 for a couple in 2004) and who have limited assets, will also

pay only a few dollars per prescription, with no premium or deductible. Medicare will cover 95 percent of their drug costs on average.

- For about 1.5 million beneficiaries with incomes less than 150 percent of the federal poverty level and assets up to $10,000 (or $20,000 if married) in 2006, the Medicare benefit will provide 15 percent co-pays with a sliding-scale premium, covering 85 percent of their drug costs on average.
- The new comprehensive drug benefit is expected to attract more than 1 million beneficiaries with limited means who have been eligible for Medicaid benefits (including SLMB, QMB, and QI benefits) but were not previously enrolled, as a result of the high value of the drug benefit and Medicare's unprecedented outreach activities.

In determining income under the proposed rule, CMS will take into consideration the size of the applicant's family, which means more individuals will qualify for low-income assistance. For purposes of determining eligibility, family size means the applicant, their spouse living in the same household, and the number of related individuals also living in the same household and who are dependent on the applicant or the applicant's spouse for at least one-half of their financial support. This may include children, grandchildren or other relatives, some of whom may be disabled.

In addition to income, an applicant's resources will also be considered. However, under the proposed rule only certain resources will be counted, including checking and savings accounts, stocks, bonds, and other resources that can be readily converted to cash within 20 days. In addition, the value of real estate other than the family home is counted. The family home, the land on which it is built, personal belongings including the family car, the value of burial plots, and a wedding ring, for example, will not count.

*Full-benefit dual eligible beneficiaries will receive generous subsidies for their drug costs.*

The largest group of low-income assistance beneficiaries – full-benefit dual eligible individuals – will now receive their drug coverage through Medicare. State Medicaid programs will no longer provide coverage for prescription drugs for dual eligible individuals except that states may choose to cover certain drugs that will not be covered by Medicare. Low-income beneficiaries will now have the same benefits as other Medicare recipients – including a uniform, comprehensive drug benefit that is available in every state and provides a choice of drug plans.

About 6.4 million full-benefit dual eligible individuals will automatically qualify for subsidies of their Medicare prescription drug program premiums and cost sharing. Full-benefit dual eligible beneficiaries who don't select a drug plan will be assigned to one. They will be able to opt out of a plan to which they are assigned, although they would then be responsible for paying for prescription drugs that could be covered under the Medicare prescription drug program if they don't elect another plan. "Deeming" – or automatically qualifying – full-benefit duals as eligible for the new drug benefit and enrolling them in a drug plan ensures that this population,

**Mrs. Smith is an 80-year-old widow. She has an annual income of $9,000 and no countable assets. She is a full-benefit dual eligible and her annual drug costs are $750.**

**In 2006, she will be eligible for the new Medicare prescription drug benefit's low–income subsidies. She will pay no premium, no deductible and will have no gap in coverage. She will pay either $1 or $3 for each prescription depending on whether she uses generic or non-preferred drugs. Under the Medicare prescription drug program, Mrs. Smith will only pay about $20 a year for her drug costs.**

which is often much sicker than those with higher incomes, receives comprehensive benefits without a break in coverage.

Depending on their income, subsidy amounts vary slightly for full-benefit dual eligibles. Full-benefit dual eligibles with incomes lower than 100 percent of federal poverty level will not pay a premium or deductible and will have nominal cost sharing of $1 for generic drugs or preferred multiple source drugs or $3 for any other drug. Once their total drug spending reaches $5100 (for 2006), they will have full coverage with no co-pays at all. The nominal co-payments will go up slightly each year to reflect increases in inflation.

Other full-benefit dual eligibles with incomes above 100 percent of federal poverty level will not pay a premium or deductible, will pay co-payments of $2 for each generic drug or multiple source preferred drug and a $5 co-payment for any other drug. Again, once their total drug spending reaches $5100 (for 2006) they will have full coverage. Similarly, these co-payments will go up slightly each year to reflect increases in inflation.

Institutionalized, full-benefit dual eligibles pay no cost-sharing whatsoever. For example, full-benefit dual eligible beneficiaries in nursing homes and ICFs-MR will have no cost sharing at all and can retain their limited personal needs allowances for their personal expenses rather than having to spend them on drug costs.

**Mr. and Mrs. Jones are retired Medicare beneficiaries. As a married couple they have an annual income of $16,000 with countable assets valued at less than $9,000. Mr. Jones has annual drug spending of $1,250 while Mrs. Jones spends $750. Currently they have no drug coverage.**

**In 2006, the Joneses will be eligible for the new Medicare prescription drug benefit. They will pay no premium, no deductible and will have no gap in coverage. They will pay co-pays of $2 or $5 for each prescription.**

**Under the Medicare prescription drug program, Mr. Jones will pay about $57 a year for his drug costs and Mrs. Jones will pay about $34. Both will save about 95% savings on their current drug spending.**

*Other low-income beneficiaries also receive significant subsidies.*

Medicare beneficiaries who are not full-benefit dual eligibles, but who have incomes less than 135 percent of the federal poverty level and assets up to $6,000 (or $9,000 for a couple) in 2006, will pay no premium or deductible and have nominal cost sharing of $2 and $5. They will have no coverage gap and no co-payments for drug costs once their total drug spending reaches $5100 (for 2006).

**Mr. Washington is a retired Medicare beneficiary. He has an annual income of $13,965 and annual drug spending of $1,750. Currently he has no drug coverage.**

**In 2006, Mr. Washington will be eligible for the new Medicare prescription drug benefit. Mr. Washington will pay a monthly premium of approximately $35, a $50 deductible, 15% coinsurance on each prescription up to the out-of-pocket threshold and will have no gap in coverage. Once his out-of-pocket spending reaches $807.50 (which corresponds to $5100 in total spending in 2006), he will pay just $2 or $5 co-pays for each subsequent prescription.**

**Under the Medicare prescription drug program, Mr. Washington will pay $265.63 a year for his drug costs, a 73% savings after the premium over his current drug spending.**

Medicare beneficiaries who are not full-benefit dual eligibles, but who have incomes less than 135 percent of the federal poverty level and assets between $6,000 and $10,000 (or $9,000 and $20,00 for a couple) in 2006, will pay no premium, a $50 deductible and have nominal cost sharing of 15 percent. They will have no coverage gap and co-payments of $2 and $5 for drug costs once their total drug spending reaches $5,100 (for 2006).

Finally, for beneficiaries with incomes less than 150 percent of federal poverty level and assets up to $10,000 (or $20,000 for a couple) in 2006, there is a sliding scale premium

that is based on income, a reduced deductible of $50, and cost-sharing of 15 percent for costs up to the out-of-pocket threshold. Once these beneficiaries spend $807.50 out-of-pocket for the year (which corresponds to $5,100 in total spending in 2006), they will pay only nominal cost-sharing with $2 and $5 co-pays.

*Beneficiaries will have an easy time applying for these new subsidies.*

Low-income Medicare beneficiaries will have choices about where they want to apply for their new coverage and will have a streamlined process available to them to determine which plan best meets their needs, and whether they are eligible for low-income subsidies.

Medicare Savings Program beneficiaries – Qualified Medicare Beneficiaries (QMBs), those entitled to Medicaid coverage of the Part B premium and all Medicare cost-sharing; Specified Low-income Medicare Beneficiaries (SLMBs), those entitled to Medicaid payment of their Part B premium (but not Medicare cost-sharing); and "qualifying individuals" (QIs), for whom states receive a 100% federally matched grant to pay the Part B premium -- will be deemed eligible for low-income subsidies. In limited circumstances, some recipients of supplemental security income (SSI) benefits don't receive Medicaid but are still deemed eligible for the subsidy. All of these beneficiaries will have to select a prescription drug plan in order to receive benefits.

Eligibility for low-income subsidies will be determined by state Medicaid agencies or by the Social Security Administration. Individuals will be able to go to either agency to apply for benefits. A determination will be effective beginning with the month that a beneficiary applies for subsidies and the determination will remain effective for up to one year. The agency that processes the determinations will determine the manner and frequency for re-determinations and the process for appeals.

A model, simplified application form and process for determination and verification of an eligible beneficiary's income and resources (assets) is being developed by the Social Security Administration (SSA) and will be available for Internet and phone filing. The application form will consist of an attestation regarding a beneficiary's level of assets or resources and their valuation. This means that beneficiaries will not have to gather together and bring volumes of files with them when they apply. In fact, the goal of the application process is to eliminate the need for excess documentation. Whether applicants apply online, by phone or in person, no financial documents will be necessary at the time of application. The SSA and the states will be able to verify most information through data matches with existing SSA, Medicare, and Internal Revenue Service files. States and SSA may need to request some follow up documentation to verify resources if data matches do not provide the needed verification.

**All low-income beneficiaries, including the dual eligible population, will get uniform benefits nationwide.**

Unlike Medicaid, which differs from state to state and is subject to budget pressures within states, the new Medicare prescription drug benefit is national, uniform, comprehensive, and provides beneficiaries the same protections they have come to expect from Medicare.

In order to control costs in their budgets, many Medicaid State Plans limit the number of prescriptions filled in a specified time period, limit the maximum daily dosage, or limit the frequency of dispensing a drug. Others have pharmacy lock-in programs, which require beneficiaries to fill their prescriptions in one designated pharmacy. Some states also limit the number of refills. These actions cannot occur under the new benefit.

Specifically, the Medicaid drug benefit remains a state option with benefits and limitations that vary from state-to-state while the new Medicare drug benefit provides for a more uniform drug benefit. Medicare drug plans will not be allowed to impose caps on the number of brand name drugs a beneficiary can receive, the number of refills, or the number or quantity of total prescriptions.

This is not the case today in Medicaid. Approximately nine Medicaid State Plans have strict limits on the number of brand name prescriptions that can be filled, and approximately 37 Medicaid State Plans employ refill and/or monthly or annual prescription limits.

Medicare drug plans will not be able to impose supply limits. With the exception of Tennessee, all states' Medicaid State Plans include supply limits.

The new Medicare prescription drug program also includes extensive beneficiary protections that will ensure that an appropriate range of drugs is conveniently available to all beneficiaries.

- Access: Medicare drug plans and Medicare Advantage plans must have a sufficient network to guarantee convenient access to retail pharmacies.

- Comprehensive Formularies: Plans will be required to include at least two drugs in every therapeutic category and class on their formularies (unless the category only has one drug in it), and beneficiaries will be able to check the coverage status of specific drugs when selecting plans.

- Formulary Development: Plans must use a pharmacy and therapeutic committee that includes practicing doctors and pharmacists to establish their formularies, relying on the latest scientific evidence about drugs' efficacy, safety and cost effectiveness. US Pharmacopeia will develop a model formulary classification schema that plans may use. If plans choose a different classification, then CMS will review it to make sure that it is not designed to discourage enrollment by certain groups of beneficiaries.

- Coverage Determinations and Appeals: In cases where a doctor believes that a non-formulary drug is required, or that the available preferred tier drugs will not be as effective as a non-preferred drug, the beneficiary can challenge the plans' formulary and/or tiers. If successful, they can receive the drug on the more favorable tier's terms, and if unsuccessful, the beneficiary has several levels of external appeals. The physician and the beneficiary's authorized representative (such as a family member) can assist with this process. In addition, plans must have procedures to expedite these determinations and render decisions within 72 hours, and must authorize emergency supplies of the drug while the decision is

pending. If the plan fails to make a timely decision, it must continue coverage of the drug until such a decision is made.

- Counseling and information: Plans will also have drug utilization review programs and medication therapy management programs to make sure beneficiaries receive the appropriate drugs and to reduce adverse drug interactions. Plans will be required to supply a range of useful information to beneficiaries, including a clear explanation of the benefits detailing their drug spending; a description of the function of any formulary; how the plan's medication management program works; and information on grievance and appeals processes. In addition, plans are required to work with pharmacists to tell beneficiaries how much they could save with generic drugs.

- Privacy and confidentiality: Plans must also maintain beneficiary privacy and confidentiality, and conduct surveys on customer satisfaction.

Comments on the proposed regulations will be accepted until October 4, 2004. Comments should be submitted to the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/regulations/ecomments

**SUBSIDIES FOR FULL-BENEFIT DUAL ELIGIBLES**

| Benefit | Full-benefit Dual Eligible Beneficiaries with Income Below 100% FPL | Other Full-benefit Dual Eligible Beneficiaries with Income Above 100% FPL |
|---|---|---|
| **Deductible** | $0 | $0 |
| **Initial Drug Benefit ($0-$5,100†)** | $1/$3* | $2/$5** |
| **"Donut hole" or coverage gap** | None | None |
| **Catastrophic Benefit** | Full coverage | Full coverage |
| **Premium††** | $0 | $0 |

**Note: Institutionalized full-benefit dual eligible beneficiaries have no cost sharing.**
*Co-payments are $1 for each generic or multiple source preferred drug and $3 for any other drug and are indexed to the CPI-U.
**Co-payments are $2 for each generic or multiple source preferred drug and $5 for any other drug and are indexed to the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs.
† In 2006, $5,100 means a $250 deductible, 25% enrollee cost-sharing for drug costs above the deductible up to an initial coverage limit of $2,250, and catastrophic drug coverage once the enrollee has reached $3,600 in out-of-pocket costs.
††For low-income beneficiaries, the subsidy is based on the benchmark premium.

**SUBSIDIES FOR NON-DUAL LOW-INCOME ELIGIBLES**

| Benefit | Beneficiaries with Incomes Below 135% FPL* | Beneficiaries with Incomes Below 135% FPL and Higher Resources ** | Beneficiaries with Incomes Below 150% FPL*** |
|---|---|---|---|
| **Deductible** | $0 | $50 | $50 |
| **Initial Drug Benefit ($0-$5,100†)** | **($0-$5,100)**<br>$2/$5**** | **($51 - $5,100)**<br>15% copay | **($51 - $5,100)**<br>15% copay |
| **"Donut hole" or coverage gap** | None | None | None |
| **Catastrophic Benefit (Above $5,100)** | Full coverage | $2/$5**** | $2/$5**** |
| **Premium††** | $0 | $0 | 0%-100% sliding scale of a benchmark premium plan |

*Resource test in 2006 is 3 X SSI ($6,000/single or $9,000 couple).
**Resource test in 2006 is greater than $6,000/single but below $10,000 single (greater than $9,000/couple but below $20,000/couple).
***Alternative resource test of $10,000/single or $20,000 couple applies.
****Copayments are $2 for each generic or multiple source preferred drug and $5 for any other drug and are indexed to the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs.
† In 2006, $5,100 means a $250 deductible, 25% enrollee cost-sharing for drug costs above the deductible up to an initial coverage limit of $2,250, and catastrophic drug coverage once the enrollee has reached $3,600 in out-of-pocket costs.
††For low income beneficiaries, the subsidy is based on a benchmark premium