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BEFORE THE CALIFORNIA SENATE HEALTH COMMITTEE
INFORMATIONAL HEARING ON
FEDERAL MEDICARE PRESCRIPTION DRUG ACT: STATE READINESS, IMPLEMENTATION, AND CONSUMER ISSUES

March 16, 2005

Good afternoon, Chairwoman Ortiz, Senator Alquist, Assemblywoman Chan, Assemblywoman Berg, and distinguished members of the Committees. Thank you for inviting me to provide the Federal perspective on the Medicare Modernization Act (MMA).

You have already heard about the background of the legislation. Let me focus areas of most interest to States – transitioning dual eligible beneficiaries' drug coverage from Medicaid to Medicare and beneficiary protections.

Planning the Transition from Medicaid to Medicare

CMS has put a comprehensive plan in place for full-benefit dual eligible beneficiaries to move from Medicaid to the new Medicare drug benefit on January 1, 2006. Along with our many partners in making sure that full-benefit dual eligibles get the most out of the new comprehensive Medicare benefit, we are implementing a comprehensive plan to assure there are no gaps in coverage for these beneficiaries. CMS is currently working with states to establish data exchanges that will identify full-benefit dual eligible beneficiaries whose coverage under Medicaid will end on December 31, 2005. After identifying these beneficiaries, CMS will contact them by mail this summer (mid-May) to inform them that they are deemed eligible for the low-income subsidy. Information will also be available through 1-800 MEDICARE, www.medicare.gov and through state Medicaid offices. And this fall, the full-benefit dual eligible beneficiaries will be notified of the plan in which they will be auto-enrolled if they do not choose a plan beforehand (October 27-November 10).

CMS is engaged in multiple meetings and coordination efforts with the states to ensure a smooth transition process. We are currently drafting a "State Legislators' Checklist" in conjunction with state associations, which includes questions pertaining to the role states have for accepting and processing low-income subsidy applications, retiree options, state contributions, state insurance laws and regulations, as well as general education and awareness. The checklist will also provide instruction on how the transition of full-benefit dual eligibles will be handled.

CMS will have multiple opportunities to disseminate the checklist to the states. The National Conference of State Legislatures, Council of State Governors, state committee chairpersons and state legislators will each receive mailings. I will send a copy of that Checklist directly to you once I receive it. In addition, CMS Regional Offices will serve as an additional resource for states. CMS also is working with the National Governors' Association to convene meetings with each state Medicaid director. Monthly conference calls with state Medicaid directors are scheduled to provide an opportunity to work through any issues and ensure as much information as possible is available. Furthermore, CMS will work with the State Issues Workgroup on further guidance on transition issues. My staff in San Francisco are participants on this Workgroup. In addition, my staff are holding biweekly calls with various agencies in the State to identify issues, and we are committed to getting answers to questions raised. State participants on these calls include representatives from the Department of Health Services, the Department of Developmental Services, and the Department of Aging.

Working in conjunction with the states and Social Security Administration (SSA), CMS also will conduct expansive outreach activities in the spring of this year (May) to educate Medicare beneficiaries about the new prescription drug plan and to encourage those who do not automatically qualify for the low-income subsidy to apply. To avoid confusion, CMS will notify full-benefit dual eligible beneficiaries, Medicare beneficiaries who receive SSI benefits, and those enrolled in an MSP that they automatically qualify for the subsidy and do not need to apply. To make the enrollment process as simple as possible for beneficiaries not deemed eligible for the low-income subsidy, CMS worked with SSA and many advocacy groups through an extensive public process to develop the application form and process to be used to verify a beneficiary's income and resources to qualify them for the low-income subsidy. SSA and state Medicaid agencies will be responsible for handling the low-income subsidy application process.

Beneficiaries may apply online, by phone, mail, or in person, and no financial documents will be required at the time of the application. Information listed on the application will be verified later, and beneficiaries will only be asked for follow-up documentation if the application cannot be verified through data matches.

CMS also has made significant strides to minimize the impact of the administrative functions associated with eligibility determinations and enrollment procedures. First, along with the SSA, CMS is encouraging beneficiaries to apply for the low-income subsidy with SSA. Individuals will not even have to leave home to make such applications. We will provide guidance to states that also encourages them to use the SSA eligibility determination process. In addition, when an individual asks to enroll at a state office, the costs associated with this application will be matched by the Federal government.

CMS has worked to be sure that the process for applying for the low-income subsidy has been as automated as possible to minimize the burden to states in making low-income subsidy eligibility decisions. Furthermore, we have made sure that the process for such determinations through the SSA is available to the states; so that they all have a uniform, electronic method available to them should they choose to use it. It is our understanding that the State will be forwarding incoming low income subsidy requests to SSA for processing unless the applicant specifically asks that the State process the application.

As I mentioned, in June CMS will notify full-benefit dual eligible beneficiaries that their Medicaid prescription drug coverage is ending and that they have the right to choose a new Medicare prescription drug plan. Full-benefit dual eligible beneficiaries will be automatically enrolled in a plan in the fall of 2005, once the plans become available (October). Beneficiaries will still have an opportunity to select and enroll in a plan on their own, but if they take no action, their enrollment in the CMS-selected plan will become effective January 1, 2006. This will ensure there is no gap in their prescription drug coverage. For those beneficiaries who do not enroll in a plan, a notification will provide the opportunity for them to choose another plan.

Auto-enrollment will begin monthly after the new Medicare prescription drug plans become available this fall for full-benefit dual eligible beneficiaries. These beneficiaries may switch to a

different plan than the one in which they were auto-enrolled. And full-benefit dual eligible beneficiaries may switch plans at any time. This process ensures that all full-benefit dual eligible beneficiaries maintain a continuity of care with their prescription drug coverage when Medicaid prescription drug coverage ends, while retaining the right to select a plan that best meets their needs. Full-benefit dual eligible beneficiaries also may switch plans after the program begins January 1, 2006.

CMS will facilitate the enrollment for other low-income beneficiaries who receive the low-income subsidy, whether they apply or are deemed eligible. These beneficiaries will receive a letter notifying them they have until May 15, 2006, the end of the open enrollment period, to select a plan. If the beneficiaries do not select a plan, they will be enrolled in a plan effective June 1, 2006. Once enrolled, beneficiaries will have the opportunity to switch plans during a special enrollment period, which runs until the end of 2006.

Extensive Outreach and Education Planned

CMS is aware that education and outreach to beneficiaries about the new drug benefit is critical to its success. CMS will work with a broad array of partners including the Administration on Aging (AoA), our sister agency at HHS, to educate beneficiaries, their caregivers, and others who can help them make decisions about the new Medicare prescription drug benefit and other new Medicare benefits and options. SSA, other Federal agencies, states, employers, unions, and national and community-based organizations will all participate in this effort. Successfully reaching beneficiaries will provide them with the opportunity to select a plan that meets their needs. CMS welcome any assistance the Committee members can provide. Participating in Town Hall meetings and including information in newsletters would complement CMS' outreach activities.

CMS is working on an integrated and multi-pronged education effort that will include media advertising, simple language fact sheets, detailed publications including the annual "*Medicare & You*" handbook, direct mail, and community-based grassroots efforts to target specific populations with messages directed to their specific needs, including low-income beneficiaries. CMS has enhanced its partnership with the State Health Insurance Assistance Programs (SHIPs). CMS increased SHIP funding in 2004 and will provide $31.7 million to SHIPs in 2005,

reflecting the increased emphasis on one-on-one advice and counseling for Medicare beneficiaries. The SHIPs are among the most effective resources in helping beneficiaries learn about the changes to Medicare and will use the additional funds to equip their local organizations with the tools needed to answer beneficiaries' questions.

Additionally, CMS is supporting non-profit community-based organizations to help educate and assist low-income beneficiaries who may otherwise be hard to reach. CMS is working with the Access to Benefits Coalition (ABC), a coalition of almost 100 beneficiary and patient support organizations to target this hard-to-reach population. CMS is gaining valuable experience working with these organizations on the Medicare-approved drug discount card program that will be useful for outreach and education and providing enrollment assistance, especially with the low-income population.

[FYI, ABC Grantees in CA:

- in Los Angeles, Rav Tov Committee to Aid New Immigrants, Inc. and the City of Los Angeles, Department of Aging;
- in San Diego, Aging and Independence Services;
- in San Francisco, Self-Help for the Elderly, the Bernal Heights Neighborhood Center, and Network for Elders;
- in Watsonville, Salud Para La Gente, Inc.;
- in San Jose, the Council on Aging of Silicon Valley;
- in San Bernardino, the County of San Bernardino;
- in Lakeport, Sutter Lakeside Hospital; and
- in Eureka, the Area 1 Agency on Aging.]

CMS also is conducting the Regional Education About Choices in Health (REACH) Campaign, a nationally coordinated educational and publicity effort implemented on the local level by CMS' 10 Regional Offices through their partners. The campaign will work with community organizations and ensure that low-income Medicare beneficiaries, including full-benefit dual eligible beneficiaries, who may not have learned about the new benefit and subsidy program because of barriers of location or literacy, know how and where to get their questions answered,

receive culturally and linguistically appropriate information, and receive accurate and reliable information tailored to meet community needs.

CMS also will work with providers in the nursing home arena, pharmacies and other health professions to let them know how to further assist beneficiaries who they care for and interact with as well as those who can benefit from this important new Medicare resource. CMS is also working with Medicare Today, a partnership of nearly 100 major health care organizations, including providers, advocacy entities, plans and employers to inform beneficiaries about the new drug benefit. Medicare Today will be a coast-to-coast grassroots effort utilizing the capacities of its various member organizations.

The goal is to leverage resources in such a way that all organizations and agencies that potentially interact with Medicare beneficiaries will provide either education materials themselves, or an avenue through which beneficiaries can learn more.

Protections for Beneficiaries

In addition to ensuring a smooth transition for full-benefit dual eligible beneficiaries, the new Medicare prescription drug benefit includes a number of protections. To ensure that drug plans provide access to medically necessary treatments for all beneficiaries and do not discriminate against any beneficiaries, these protections include use of appropriate formularies; provisions for beneficiaries who reside in long term care facilities; coverage determination, exceptions, and appeals processes; privacy protections; customer service provisions; and enforcement actions. CMS will rely on widely recognized best practices for existing drug benefits that serve millions of seniors and people with disabilities in order to ensure uninterrupted access for Medicare beneficiaries. In addition, a Medicare Beneficiary Ombudsman will serve as a beneficiary advocate to ensure people with Medicare receive the benefits and right to which they are entitled. The Ombudsman will closely track all issues related to drug benefit access. CMS is nearing the end of its search process to fill the position.

Formularies Address Special Needs

The MMA requires each formulary to include at least two drugs in each approved category and class, unless only one drug is available for a particular category or class. This requirement,

however, should be viewed as a minimum and plans are encouraged to include more in their formularies. CMS may require formularies to include more than two drugs per category or class in cases in which additional drugs offer unique and important therapeutic advantages and where their exclusion may substantially discourage beneficiaries with certain diseases from selecting the plan. This will ensure plans and formularies do not discriminate against a particular type of patient.

All plan formularies must be developed and reviewed by a pharmacy and therapeutics committee (P&T). A majority of the committee members must be practicing physicians or pharmacists and at least two members – one practicing physician and one practicing pharmacist – must have expertise in geriatric and disabled care. Plans' benefit management tools, such as prior authorization, will be compared to existing national drug benefit management standards and guidelines to ensure they are used in a clinically appropriate manner. The goal of this process is to make sure beneficiaries have access to medically necessary prescription drugs and to allow plans to design and manage their formularies to provide the most affordable benefit possible.

CMS intends to encourage and approve formularies that provide drug lists and benefit management approaches that are already in widespread use. In addition to determining that the categories, classes and the formulary list are not discriminatory, CMS intends to check the plan design, using clear benchmarks that plans can utilize as a guide in building formularies and structuring their bids.

It is important to note that CMS will ensure when plans develop their formularies the plans recognize the special needs of particular types of beneficiaries, such as mental health patients, those with HIV/AIDS, those living in nursing homes, people with disabilities and other beneficiaries who are stabilized on certain drug regimens. CMS regulations require each plan to submit a transition plan for moving enrollees currently taking a Part D drug that is not on their formulary to a medication that is on the list. The process must address situations where a beneficiary seeks to fill a prescription that is not on a formulary, but is unaware of what is covered by the plan or what is included in the exception process. CMS will review these plans as part of the approval process and a plan will not be approved unless its transition plan is adequate to protect Medicare beneficiaries.

Medicare prescription drug plans must arrange with their pharmacy network to provide notices of beneficiary rights under Medicare coverage determination processes. The beneficiary may always pay in full for any prescription and initiate an exceptions request. If a beneficiary requests an exception, plans must make their decisions within 24 hours for expedited requests or sooner if the patient's health requires it. Should the exceptions request be upheld, the beneficiary may submit the receipt for the purchase and the plan will later reimburse the beneficiary for any plan liability. If the beneficiary cannot afford to purchase the entire prescription, pharmacies typically have procedures for dispensing a few doses of a prescribed drug (for which the beneficiary pays). The Medicare prescription drug plans must comply with the provisions of the Federal notice and guidelines, but they may establish additional contractual procedures with their pharmacy network to address such a situation. CMS currently is investigating what additional guidance may be provided to the prescription drug plans and the pharmacies.

Addressing the Needs of Long-Term Care Residents

CMS is working to make the transition from Medicaid to Medicare smooth for all full benefit dual eligible beneficiaries, and there will be specific protections for beneficiaries who live in long-term care facilities and get their prescriptions from long-term care pharmacies. As a condition of providing the new benefit, every plan must provide coverage to all its enrollees who live in any nursing home in its region. To help facilitate the transition, the Medicare prescription drug plans will be notified as to which of their enrollees live in a long-term care setting. This will help the plans and the facilities prepare for any potential changes to a beneficiary's drug regimen. Simultaneously changing a number of prescriptions could adversely affect the health of the patient. Because a large number of long-term care residents may be auto-enrolled, it is important for the transition process to account for filling the first prescription. Medicare prescription drug plans will need to ensure that long-term care pharmacies in their network work with long-term care facilities before enrollment begins to ensure a smooth transition. Also, plans may need to provide a temporary "fill first" supply order for a limited amount of prescribed medications. CMS expects plans' applications for participation in the Medicare prescription drug program to explain their proposed procedures and timeframes to transition beneficiaries who live in long-term care facilities to the new benefit.

Beneficiaries residing in long-term care facilities are more likely to have prescriptions for multiple medications. Fortunately, the MMA includes a new Medication Therapy Management benefit. As an additional clinical support service that will improve the quality of care delivered, beneficiaries enrolled in a new Medicare prescription drug plan that are considered "at risk" (those with costs exceeding $4,000 annually, those with multiple co-morbidities, and those with taking multiple medications) will receive this service to optimize therapeutic outcomes through improved medication use.

State Savings and Wrap-Around Options

States will realize significant savings under the reforms made by the MMA, even after refunding some of their current Medicaid drug outlays to the Federal government and these savings can be used to provide further protections for Medicaid beneficiaries. Each state will see fiscal relief when all facets of the Medicare reforms are considered. For example, states will pay a declining portion of prescription drug costs for full-benefit dual eligible beneficiaries. [CMS and Administrator McClellan are open to meeting with States that have ongoing concerns about their phased-down contribution.] In addition, states will receive assistance with their retiree prescription drug costs, further reducing their spending on prescription drugs. CMS also is prepared to assist states in implementing the new law to ensure they save the maximum amount possible. As part of this effort, CMS has established a number of state workgroups to provide detailed guidance on the transition and administrative issues facing the states, such as determining eligibility for the low-income subsidy and moving full-benefit dual eligible beneficiaries to the new Medicare drug benefit.

Under the MMA, states can use their savings to "wraparound" the Medicare program by continuing to cover certain excluded drugs that the Medicare prescription drug benefit will not cover. States also will receive Federal match for those drug costs. Under the law, states that cover excluded drugs for their non full-benefit dual eligible Medicaid population must provide this same coverage to those who are full-benefit dual eligible beneficiaries. This provision of the law is fair and equitable and is in the best interest of full-benefit dual eligible beneficiaries and Medicaid programs. States make reasonable decisions on coverage of these drugs that provide good health care and are economical to the programs. This decision making process should not

be any different for the disabled and elderly than it is for families and children. And Medicaid programs that cover the excluded drugs, or provide a wraparound, will receive the Federal match as well.

CMS is currently drafting a letter to state Medicaid Directors to provide them with information regarding the Federal match. The letter reminds the states that Federal match will not be available for Part D drugs in the Medicaid program for dual eligibles participating in the Medicare prescription drug program as of January 1, 2006. In addition, the letter informs the states that one option they may want to consider for Medicaid coverage is allowing dual eligibles to receive an extended supply (e.g., 60 or 90 days) of their prescriptions near the end of this calendar year, provided an extended supply is allowed in their approved state plan. (California's State plan allows 100 days extended supply.) To do so would give beneficiaries access to the medication they need to carry them into the first several weeks of the program without violating the Federal match provisions in the MMA.

The wraparound provisions will further protect beneficiaries. The Medicare prescription drug plans will cover drugs in categories that address serious medical conditions and will not deny coverage simply because a state covers a less expensive alternative. Medicare prescription drug plans also may choose to cover some excluded drugs and in such cases, the state Medicaid program would be secondary to the Medicare prescription drug plan. As you know, states will make contributions on a monthly basis to the Federal government for the cost of providing the drug benefit. This amount will decline over time. Drugs excluded from the new prescription drug program are specifically excluded from the contribution each state makes. As a result, states are not double charged if they cover such drugs for full-benefit dual eligible beneficiaries.

Conclusion

Members of the Senate and Assembly Health Committees and the Senate and Assembly Subcommittees on Aging and Long Term Care, thank you for this opportunity to discuss the new Medicare prescription drug benefit and the transition process and protections for full-benefit dual eligible beneficiaries. The new benefit provides a substantial subsidy for low-income beneficiaries, while maintaining their ability to select a plan that best address their needs. At the

same time, CMS and its partners are working to ensure full benefit dual-eligibles do not experience any gaps in their coverage during the transition.

Important Dates:

- March – Social Security Administration (SSA) to mail low income subsidy application to two test zip codes in CA – Laguna Niguel and San Francisco
- April 18 – Potential drug plans submit formularies to CMS
- Mid-May – CMS mailing to deemed eligibles
- May 31 – SSA to begin mailing application packets to potential low income subsidy eligibles
- July 1 – SSA field offices and States begin to accept low income subsidy applications
- Mid-August – CMS begins to auto-enroll dual eligibles
- September 14 – (Tentative) CMS approval of plan submissions
- October 1-15 – CMS mails 2006 Medicare & You Handbook
- October 1 – Marketing of Medicare prescription drug coverage plans begins
- October 13 – Plan Compare and Medicare Personal Plan Finder live on Web
- October 27-November 10 – Auto-enrollment mailing to dual eligibles
- November 15-May 15, 2006 – Open Enrollment Period
- Late December – Assign full dual eligibles to plan of choice or assigned plan
- January 1, 2006 – Medicare prescription drug coverage begins

Here are some key messages about the new Medicare prescription drug benefit:

- This is drug coverage that helps beneficiaries pay for the prescriptions they need.
- Medicare prescription drug coverage is available to all people with Medicare.
- There is additional help for those who need it most.
- The Medicare prescription drug coverage pays for brand name as well as generic drugs.
- A beneficiary can choose between at least two Medicare prescription drug plans and pick a plan that is right for them.

Thank you, again, for this opportunity. I welcome any questions you may have.

Handouts:

- Timeline (as of March 1, 2005)
- Explanation of how drug coverage will continue January 1, 2006 for dual eligibles
- CMS Outreach Strategy
- Explanation of the Appeals Process

BACKGROUND (if no previous speaker has provided this information)

Beginning in 2006, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) makes prescription drug coverage available to all 43 million Medicare beneficiaries. This important new benefit will provide beneficiaries with substantial help in paying for their prescription drugs, greatly enhancing their quality of life. The law also gives Medicare the ability, for the first time in the program's 40-year history, to provide additional comprehensive help to those in greatest need – beneficiaries with very high prescription drug costs and people with low incomes. Under the MMA, millions will receive comprehensive prescription drug coverage at little or no cost.

All Medicare beneficiaries will have the opportunity to participate in the new prescription drug benefit, including the approximately six-million low-income beneficiaries who also are enrolled in Medicaid. Known as "full-benefit dual eligibles," these beneficiaries will qualify for Medicare (instead of Medicaid) prescription drug coverage with low or no premiums and co-payments of a few dollars. CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently with the State Medicaid Agencies and other partners to ensure the process for beneficiaries is as quick and efficient as possible. Most importantly, protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new Medicare prescription drug benefit starts on January 1, 2006. This is critically important, especially for beneficiaries with chronic conditions who take a number of prescriptions. In addition, CMS will pay particular attention to the formulary designs of the new drug plans to ensure they are not discriminatory and they meet the needs of all beneficiaries. CMS will ensure formularies recognize the special needs of beneficiaries, including those with disabilities, mental health illness, HIV/AIDS, and those who live in nursing homes.

Standard Benefit Includes Protection from High Drug Costs

The new Medicare prescription drug benefit will offer protection from high pharmaceutical costs for all beneficiaries, regardless of income. Under the standard drug benefit, Medicare will cover on average 75 percent of a beneficiary's drug expenses up to $2,250, after a $250 deductible. Once a beneficiary's out-of-pocket spending reaches $3,600 in a year, the drug benefit will cover

about 95 percent of any additional pharmaceutical expenses, effectively protecting the beneficiary from very high drug costs. There is no cap to the Medicare coverage so beneficiaries will be continuously covered after reaching the out-of-pocket spending limit.

Additional Benefits for Low-Income Beneficiaries

The new drug benefit provides even greater protection for low-income and full-benefit dual eligible beneficiaries through a low-income subsidy. Qualification for the low-income subsidies will vary based on the status of the beneficiary.

Full-Benefit Dual Eligible Beneficiaries

Full-benefit dual eligible beneficiaries - those who currently receive full Medicaid benefits - will automatically qualify for the low-income subsidy. For beneficiaries in this category with incomes of 100 percent or less of the Federal Poverty Level (FPL), the Federal government will pay for their premiums up to the benchmark amount, and their entire deductible. The beneficiaries will only be responsible for nominal co-payments of no more than $1 for generic or preferred drugs or $3 for other drugs and, should they select such a plan, any premium amount exceeding the benchmark premium until the out-of-pocket limit is reached. As a result, Medicare will pay on average 98 percent of these beneficiaries' drug costs.

Full-benefit dual eligible beneficiaries with incomes greater than 100 percent of the FPL will not pay premiums up to the benchmark amount or deductibles and will have co-payments of no more than $2 for generic or preferred drugs or $5 for other drugs.

The new law offers even greater protection for the approximately 1.5 million full-benefit dual eligible beneficiaries who reside in institutions. They will pay no premiums, no deductibles, no coinsurance, no co-payments, and will not have to spend their personal needs allowance on prescription drugs.

Medicare Savings Program and Social Security Income Beneficiaries

Low-income Medicare beneficiaries who are enrolled in Medicare Savings Programs (QMB, SLMB, and QI programs) or who receive Supplemental Security Income (SSI), will automatically qualify for a low-income subsidy. The Federal government will pay for the entire

deductible and premiums up to the benchmark amount for beneficiaries enrolled in a Medicare Savings Program. These beneficiaries will have co-payments of $2 generic or preferred drugs or $5 for other drugs until the out-of-pocket limit is reached. If they select a plan with a premium that exceeds the benchmark amount, they will be responsible for the difference. Subsidies vary for SSI recipients depending on whether or not the beneficiary has Medicaid coverage. SSI recipients with Medicaid coverage will have no premiums or deductibles and will have co-payments of no more than $1 for generic or preferred drugs and $3 for other prescriptions until the out-of-pocket limit is reached. SSI recipients without Medicaid coverage will have no premiums or deductibles and will have co-payments of no more than $2 for generic or preferred drugs or $5 for other drugs until the out-of-pocket limit is reached.

Other Low-Income Beneficiaries

Subsidies also are available to other Medicare beneficiaries with incomes less than 150 percent of the FPL. These beneficiaries must apply for the low-income subsidy, which varies based on income. Those with incomes less than 135 percent of the FPL and assets up to $6,000 (or $9,000 for a couple) in 2006 will pay no premium up to the benchmark or deductible and will have cost sharing of up to $2 for generic drugs and preferred drugs $5 other prescriptions up to the out-of-pocket limit of $3,600, after which there will be no cost sharing.

Beneficiaries with incomes less than 135 percent of the FPL with assets between $6,000 and $10,000 ($9,000 and $20,000 for a couple) will have no premiums and a $50 deductible. Cost sharing for such beneficiaries will not exceed 15 percent up to the out-of-pocket limit. There will be no coverage gap and co-payments will be $2 for generic or preferred drugs and $5 for other drugs after the out-of-pocket limit has been reached. On average, Medicare will pay about 96 percent of the drug costs for beneficiaries with incomes below 135 percent of the FPL.

Subsidies also are available for beneficiaries with incomes greater than 135 percent, but less than 150 percent, of the FPL and assets up to $10,000 ($20,000 for couples) in 2006. Premiums for such beneficiaries will be based on a sliding income scale. The deductible will be $50 and cost sharing will not exceed 15 percent coinsurance for costs up to the out-of-pocket threshold. Once the out-of-pocket threshold has been reached, beneficiaries in this income group will also have co-payments of up to $2 generic and preferred drugs and $5 other drugs. For beneficiaries in this

income range, Medicare will cover an average of 85 percent of their drug costs. As mentioned above, beneficiaries who select a prescription drug plans with premiums that exceed the benchmark will be responsible for the difference.

The low-income subsidy available under the MMA will impact a large number of Medicare beneficiaries. In fact, in 2006, 14.4 million individuals will qualify to receive help at one level or another under the subsidy program, including:

- 6.3 million full-benefit dual eligible beneficiaries (900,000 in CA);
- 5.7 million beneficiaries with income under 135 percent of FPL who meet the lower asset tests (1.4M in CA) (which number includes 2 million Medicare Savings Program beneficiaries); and
- 2.4 million beneficiaries with incomes below 150 percent of FPL who meet the higher asset test (220,000 in CA).

This means that approximately one-third of the nearly 43 million Medicare beneficiaries will be receiving substantial assistance with their drug costs. The remaining two-thirds also will have significant assistance with their prescription drug costs.

* figures from CA State Profile, April 2004