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THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

April 2007

The Impact of Part D on Dual Eligibles who Spend-Down to Medicaid

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Executive Summary

Individuals with incomes exceeding thresholds for regular Medicaid eligibility may qualify under state medically needy programs by spending down excess income on healthcare services. In 2005, nearly three-quarters of states offered such programs for persons who are elderly or have disabilities. For the vulnerable population of Medicare beneficiaries who spend down to Medicaid, the Part D transition has added additional complexities that may result in disruptions in pharmacy coverage and add financial burdens. One consequence of Medicare Part D coverage is that medically needy individuals who are also enrolled in Medicare may not be able to spend down to Medicaid eligibility as quickly as they did before Part D because they no longer have significant out-of-pocket expenses for prescription drugs. As such, they may experience lapses in Medicaid eligibility and be unable to obtain other needed healthcare services.

Part D Implications for Spend-Down Dual Eligibles

Documenting the impact of Part D on Medicaid spend-down populations is difficult. While states report enrollment in medically needy programs to CMS, they do not uniformly report the portion with Medicare eligibility. Despite the lack of data, it seems reasonable to conclude that the interface of Part D with the medically needy and other spend-down programs may explain some of the challenges faced by CMS as Part D reached the end of its first full year of operation. Key observations include the following.

Lapses in Medicaid Eligibility – Medically needy individuals enrolled in Medicare may not be able to spend down to Medicaid eligibility as quickly as they did before Part D because they no longer incur significant out-of-pocket costs for prescription drugs. As such, they may experience lapses in Medicaid eligibility, impeding their access to other needed healthcare services, including drugs not covered by Part D (e.g., benzodiazepines), and non-Medicare covered services that are often covered by Medicaid, such as extended mental health services and Medicare cost-sharing programs.

Delays in Part D Enrollment – Another implication for spend-down eligibles centers on Part D enrollment procedures when Medicaid eligibility is attained the first time during a calendar year. Spend-down Medicare beneficiaries often do not attain Medicaid eligibility until late in the month and may miss the cut-off date for CMS auto-enrollment into a Part D plan. This postpones their Medicare prescription drug coverage and deemed LIS status. CMS has developed safeguards to recognize Part D coverage for dual eligibles that experience problems because of the timing of auto-

enrollment, but these may not be effective for spend-down beneficiaries just attaining Medicaid eligibility for the first time and who may lose Medicaid eligibility the next month.

Issues with Re-Deeming and Part D Plan Re-Procurement in 2007 – The CMS re-deeming and re-procurement procedures also impact spend-down individuals. Medicare beneficiaries who spent down to Medicaid eligibility during July 2006 were deemed LIS eligible for the entire calendar year 2007. However, those who were not Medicaid eligible during July and who did not complete their required spend down before the end of calendar year 2006 were not deemed LIS eligible – even if they did not experience a change in household composition or income.

CMS advised individuals who lost their deemed LIS status for 2007 to submit applications to the Social Security Administration or the state Medicaid eligibility agency for LIS eligibility determination. Some, however, may not understand the potential benefits and may not submit applications – losing access to Part D premium subsidies, discounted cost sharing, and coverage during the donut hole. Those not acting will receive monthly Part D premium bills in 2007. Even if individuals who lost deemed LIS status do pay the Part D premiums, they face increased Medicare cost sharing in January 2007 and will have no coverage if they reach the donut hole. Ironically, they may find themselves once again incurring pharmacy costs that trigger Medicaid spend-down eligibility later in 2007.

Those who lose deemed LIS also will lose the transition protections afforded to the dual eligibles. As a result, these individuals who were auto-enrolled by CMS in 2006 may now find themselves enrolled in a plan that is no longer "low cost" or in a plan leaving the Part D market. While CMS has established a Special Enrollment Period to allow these individuals to choose an alternative plan after the first of the year, they will not benefit from other protective policies adopted by CMS, compounding the challenges noted above.

The medically needy and spend-down programs under Medicaid have always been fairly complicated for individuals to navigate and for states to administer, but these programs have provided an important safety net for many people whose medical costs overwhelm their income. Under Part D, those who spent down to Medicaid eligibility were treated as LIS eligible for the entire calendar year 2006 – regardless of the impact that obtaining Part D coverage may have had on future spend-down Medicaid eligibility.

Medicare Part D has added a layer of complexity for the vulnerable Medicaid spend-down population that may result in disruptions of pharmacy coverage and/or add financial burdens. It is difficult to identify (or quantify) this population, so states and advocates may not be adequately prepared to assist in the transitions to 2007 and beyond. However, these "former" spend-down Medicaid enrollees deserve a special focus and enhanced LIS outreach, since their loss of Medicaid – and therefore deemed LIS status – does not reflect a change in their underlying financial condition. Rather, their loss of deemed LIS in 2007 may be solely due to the presence of a Part D benefit that was made affordable only by deemed eligibility for LIS in 2006.

INTRODUCTION

The Medicare Modernization Act (MMA)[1] of 2003 added the prescription drug coverage known as Part D to the Medicare program. For low-income seniors and individuals with disabilities enrolled in both Medicare and Medicaid (the dual eligibles), most prescription drug coverage transitioned from Medicaid to Medicare when Part D became effective January 1, 2006. The MMA authorized the Centers for Medicare and Medicaid Services (CMS) to auto-enroll dual eligibles into Medicare prescription drug plans starting November 2005. By June 2006, approximately 6.6 million dual eligibles were enrolled in Part D.[2]

State Medicaid directors predicted that ongoing Part D challenges were likely for selected dual eligible populations – especially for Medicare beneficiaries who *spend down* to Medicaid eligibility.[3] Individuals eligible for Medicaid under state medically needy criteria have incomes that exceed thresholds for Medicaid coverage, but they also have high healthcare expenses that may be used to offset the excess income. They are permitted to spend down to Medicaid eligibility by subtracting incurred healthcare expenses, including the cost of prescription drugs, from countable income.[4]

One consequence of Medicare Part D coverage is that medically needy individuals who are also enrolled in Medicare may not be able to spend down to Medicaid eligibility as quickly as they did before Part D because they no longer have significant out-of-pocket expenses for prescription drugs. As such, they may experience lapses in Medicaid eligibility and be unable to obtain other needed healthcare services.

To explore the inter-relationship of Medicare prescription drug coverage and Medicaid spend-down for the medically needy, the Kaiser Commission on Medicaid and the Uninsured asked Health Management Associates to describe Part D impacts for spend-down individuals and the resulting effects on their eligibility both for Medicaid and the Medicare Low-Income Subsidy (LIS) assistance.

DUAL ELIGIBLES WHO SPEND-DOWN: THE MEDICALLY NEEDY

To become eligible for Medicaid, an individual must fall into a defined eligibility category, e.g., pregnant women, children, aged, blind, or disabled. Then the individual's financial status is reviewed. The determination involves exemptions and deductions to derive countable income and resources. If the countable income and resources are equal to or less than the limits set by a state, the individual qualifies for Medicaid.

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[1] Formally called *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Pub. L. No. 108-173

[2] Of the 6.6 million, 478,000 are enrolled in Medicare Advantage plans offering prescription drug coverage. Centers for Medicare & Medicaid Services, *State Enrollment in Prescription Drug Plans Data Nov. 15, 2005 – June 11*, available at www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp under "State Enrollment Data (v06.11.06)"

[3] V. Smith, K. Gifford, S. Kramer and L. Elam, *Observations on the Initial Implementation of the Medicare Prescription Drug Program: Perspectives of State Medicaid Directors Through a Focus Group Discussion*, May 2006, available at http://www.kff.org/medicaid/7520.cfm

[4] National Association of State Medicaid Directors, *Aged, Blind and Disabled Medicaid Eligibility Survey*, 2003, available at www.nasmd.org/eligibility/default.asp under "Optional Groups"

Federal law generally requires that states offer Medicaid coverage to individuals who are aged, blind or disabled and who receive cash assistance under the federal Supplemental Security Income (SSI) program. States also may offer Medicaid coverage to several other populations. One option is the medically needy group – individuals with high healthcare expenses but too much income to qualify for Medicaid under any other category. Individuals eligible through the medically needy process may also have coverage under Medicare. Almost three-quarters of the states operated medically needy programs for the aged and disabled in 2005. These programs allow healthcare expenses to be deducted from excess income to qualify for Medicaid coverage, i.e., an individual may spend down to eligibility. Depending on the state, this process may occur over a period of one to six months. If, after deducting healthcare expenses, the individual's income is below the state's established income threshold, the individual qualifies for Medicaid coverage for the remainder of the period. Table 1 shows an example of how the spend-down amount is calculated.[5] The actual income thresholds used in medically needy programs vary widely across the states. While states are permitted to offer a more limited benefit package to this group, most states offer the full Medicaid benefit package to medically needy individuals.

In 2003, 3.5 million individuals became eligible for Medicaid through medically needy spend-down programs. Thirty-five percent were aged or had disabling conditions and accounted for 85 percent of total Medicaid spending on the medically needy. [Many in this spend-down group also are eligible for Medicare.]

Table 1: Spend-Down Example for the Medically Needy

State's Medically Needy Monthly Income Limit:	$450	
Individual's Countable Monthly Income:	$650	
Income Over State Limit:	$200	
State Spend-Down Period:	6 months	The period varies by state from 1 to 6 months.
Individual's Spend-Down Amount:	$1,200	Income over state's limit times spend-down period ($200 times 6 months)

Eleven 209(b) states, which use a definition of disability or an income requirement that is more restrictive than used for the federal Supplemental Security Income program (SSI), are required to offer spend-down options to the aged who live in nursing facilities and to children and adults with disabilities who live in the community. Two of these states (Ohio and Oklahoma) offered the required spend-down program but no medically needy program. Therefore, a total of 36 states had a spend-down program for the elderly and people with disabilities in 2005 (Appendix A).

PART D IMPACTS FOR THE SPEND-DOWN DUAL ELIGIBLES

General Issues

If a Medicare beneficiary spends down to Medicaid eligibility for even one day of a month, the individual is considered to be dually eligible for purposes of Medicare Part D. Dual eligibles are deemed eligible for LIS assistance, which CMS calls *Extra Help*. LIS for the dual eligibles provides a 100 percent federal subsidy on Part D premiums – up to the low-income subsidy benchmark; eliminates deductibles and the Medicare coverage gap known as the *donut hole*; and provides

[5] *Ibid.*

discounted cost sharing available from all Medicare prescription drug plans. (See Appendix B for a comparison of Part D cost sharing parameters for 2006 and 2007). LIS status, once attained, continues at the same level until the end of the calendar year for dual eligibles – even if Medicaid eligibility periodically lapses or is lost entirely.[6]

For dual eligibles who fail to sign up for a Medicare prescription drug plan, CMS auto-enrolls them randomly in Part D stand-alone plans meeting a LIS benchmark premium.[7]At the end of each year, the MMA requires that CMS re-evaluate the LIS status of enrolled Medicare beneficiaries (including dual eligibles) and determine whether individuals still qualify to be deemed eligible for the federal subsidies on premiums and cost sharing.[8] Challenges for spend-down individuals under the Part D auto-enrollment process follow.

Early Impacts on Spend-Down Dual Eligibles

In February 2006 CMS issued various tip sheets for its partners to use in educating Medicare beneficiaries. In its tip sheet *Information Partners Can Use on Medicaid Spend Down*,[9] CMS advised dual eligibles with spend-downs:

> "… if you 'spend down' to Medicaid because you have high drug costs, you may find that Medicare covers your drug spending and you no longer 'spend down' as quickly to become Medicaid-eligible... Once you start receiving Medicare prescription drug coverage and, if you qualify, the extra help paying for it, your out-of-pocket expenses for prescription drugs will be reduced, leaving you with more available income. Your reduced payments for prescription drugs will in turn reduce the amount of medical expenses you can have deducted from your income. This means your need for Medicaid may be reduced. However, you don't lose your ability to rely on Medicaid in months when you have greater medical expenses… [CMS] doesn't expect extra help eligibility to affect Medicaid coverage for people in nursing homes, because they will continue to have nursing home costs and will therefore have high medical expenses each month, even if Medicare is paying for their prescription drugs."

Documenting the impact of Part D on Medicaid spend-down populations is difficult. While states report enrollment in medically needy programs to CMS, they do not uniformly report what portion of the medically needy group is also Medicare eligible. Despite the lack of data, it seems reasonable to conclude that the interface of Part D with the medically needy and other spend-down programs may explain some of the challenges faced by CMS as Part D reached the end of its first full year of operation. Key implications for those individuals who spent down to dual eligibility in the first year of Part D operation include:

- **Once auto-enrolled into a Part D plan with deemed LIS assistance, an individual may no longer be able to spend down to Medicaid or may spend down more slowly.**

  Before Medicare offered prescription drug coverage under Part D, monthly prescription drug costs often led to Medicare beneficiaries spending down to Medicaid eligibility in states with medically needy or 209(b) spend-down programs. Acute or catastrophic episodes may

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[6] Kaiser Family Foundation, *Medicare Fact Sheet: Low-Income Assistance Under the Medicare Drug Benefit*, May 2006, available at http://www.kff.org/medicare/7327.cfm

[7] There are several instances when CMS does not auto-enroll dual eligibles into stand-alone Part D prescription drug plans meeting the LIS benchmark. One is when a dual eligible is enrolled in a Medicare Advantage plan and the individual will be assigned to a prescription drug option offered by that plan (regardless of its premium's amount). Another is when a dual eligible chooses a stand-alone Part D plan not meeting the LIS benchmark.

[8] Letter from Center for State and Medicaid Operations, Centers for Medicare & Medicaid Services to State Medicaid Directors (July 6, 2006).

[9] Centers for Medicare & Medicaid Services, Tip Sheet, *Information Partners Can Use On: Medicaid Spend Down*, as of February 21, 2006, available at www.cms.hhs.gov/partnerships/downloads/medicaidspenddown.pdf.

allow an individual, whose income is too high to qualify for Medicaid under a state's regular eligibility standards, to become Medicaid eligible for at least a period of time under a spend-down program. However, it was common for individuals with chronic or disabling conditions to spend down regularly as a result of having to purchase multiple, often high-cost medications.

- **If a Medicare beneficiary does not meet the Medicaid spend-down amount, she will not receive Medicaid coverage for other health care benefits.**

  While CMS suggests there is an even tradeoff for the spend-down beneficiaries once they are enrolled in Part D, others disagree. It is certainly true that individuals may experience Medicare pharmacy coverage as a real improvement and convenience, since they no longer are required to incur and document pharmacy or other medical expenses to the state before receiving prescription drug coverage from Medicaid. However, the loss (or delay) of Medicaid eligibility for many of these individuals precludes coverage for other healthcare services, e.g., Medicare cost sharing, mental health treatment services, vision and dental services.

  Depending on an individual's relationship with healthcare providers, some Medicare spend-down beneficiaries may only have had to *incur* costs without actually paying out-of-pocket expenses to their pharmacies. The extent (or absence) of such cost sharing arrangements for drugs under the previous Medicaid coverage and the extent to which a Medicare beneficiary continues to obtain (or instead avoids obtaining) services with the loss of Medicaid coverage will all impact a specific individual's experience.

- **If a Medicare beneficiary does not meet his Medicaid spend-down amount, the individual will not receive coverage for the drugs covered by Medicaid programs**.

  Medicare prescription plans are prohibited from covering certain products including Part B drugs, benzodiazepines, barbiturates, agents used to promote smoking cessation, prescription vitamins/mineral products, prescription cough/cold preparations and over-the-counter drugs. Medicaid programs frequently cover many of the Part D excluded drugs. Mental health providers have said that Medicare beneficiaries who have lost their Medicaid eligibility are confused when they have to pay 100 percent for benzodiazepines and barbiturates even though they have drug coverage through Part D.

- **Spend-down Medicare beneficiaries often do not attain Medicaid eligibility until late in the month and miss the cut-off for CMS auto-enrollment into a Part D plan.**

  The auto-enrollment process relies on batch files prone to built-in time lags.[10] State data on the dual eligibles (referred to as the State MMA file) is submitted to CMS between the 15th and 25th day of each month.[11] When an individual spends down into Medicaid eligibility for the first time, this eligibility may occur after the state's file is sent to CMS. The result is a delay in the individual's auto-enrollment to a plan and/or a gap in the electronic files available to pharmacies trying to document Part D eligibility. Before their transition to Medicare prescription drug coverage, the spend-down dual eligibles had more immediate coverage under Medicaid.

[10] V. Smith, et al, *supra note 3*

[11] The cutoff date may be extended to the end of the month to allow for resubmissions when CMS detects transmission or data specification issues with a state's file.

- **CMS has built in safeguards to recognize Part D coverage for dual eligibles who experience a coverage gap due to the timing of the batched data exchanges, but these may not be effective for spend-down beneficiaries just attaining Medicaid eligibility.**

  CMS has made ongoing efforts to address problems associated with the Part D enrollment procedures for dual eligibles. For example, CMS began in August 2006 to prospectively auto-enroll Medicaid enrollees identified by states as approaching Medicare eligibility.[12] These so-called *prospective* dual eligibles include (1) Medicaid eligibles who are age 64 years and 7 months or older and (2) Medicaid eligibles that are likely to reach the end of the Medicare 24-month disability waiting period. This solution does not, however, address the challenge of a Medicare beneficiary who spends down to Medicaid for the first time after the middle of a month and who may lose eligibility the next month.

IMPACT OF THE SECOND YEAR OF PART D, STARTING JANUARY 1, 2007

Background

CMS has completed its re-deeming process to determine which Medicare beneficiaries will continue LIS assistance as dual eligibles for 2007. Medicare beneficiaries who were Medicaid eligible on the July 2006 State MMA files provided to CMS were deemed LIS eligible for the entire next calendar year. Others previously dually eligible were sent a letter in September 2006 advising them that they no longer automatically qualify for the LIS beginning in 2007.[13]

CMS reported that 623,000 individuals across the nation received these notices. CMS believes that many of these individuals may still qualify financially for other Part D subsidies, so the notification letters included an application for Low Income Subsidy, and encouraged individuals to apply through their Social Security Administration or state Medicaid eligibility agency.[14] CMS granted a one-time Special Enrollment Period beginning January 1, 2007 through March 31, 2007 to allow any beneficiary who no longer qualifies for LIS to make a one-time switch in Part D enrollment.[15] As subsequent state file transmissions identify other dual eligibles, they will receive deemed LIS status. Those identified before the end of January 2007 will have LIS assistance for all of 2007. Others will qualify for partial year coverage contingent on the date in 2007 that they become dual eligibles.

Coupled with the re-deeming process, CMS conducted its required annual re-procurement of Medicare prescription drug plans for calendar year 2007. The new contracts resulted in changes in the number of Part D benefit plans offered in a state and in their premium levels.[16] This process altered which plans meet a state's LIS benchmark. State Medicaid directors predicted coverage

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[12] States do not pay the phased-down state contribution (clawback) for the prospective full-benefit dual eligibles.
[13] Centers for Medicare & Medicaid Services, Tip Sheet, *Changes in Qualifying for Extra Help in 2007*, as of September 2006, available at http://www.cms.hhs.gov/partnerships/downloads/07LISchanges.pdf
[14] Centers for Medicare & Medicaid Services website, Limited Income and Resources, available http://www.cms.hhs.gov/limitedincomeandresources/.
[15] Centers for Medicare & Medicaid Services, *Extra Help – Changes in Low-Income Subsidy Status and Plan Assignment for 2007*, available at http://www.cms.hhs.gov/limitedincomeandresources/ under "Low-Income Subsidy (LIS) Redetermination and Re-assignment Background Information"
[16] Part D plan and premium changes are available at www.medicare.gov.

disruptions could occur when the new contracts take effect.[17] To protect dual eligibles, CMS implemented a *de minimis benchmark premium* that reduces the number of individuals who would have had to switch Part D plans to maintain the LIS 100 percent premium subsidy. The new procedure stipulates that Part D plans "are required to charge full-premium subsidy eligible beneficiaries [including the dual eligibles] a monthly beneficiary premium equal to the applicable low-income premium subsidy amount, if the plan's beneficiary premium … exceeds the low income premium subsidy amount by $2 or less."[18]

CMS also established a reassignment process for the dual eligibles whose current plans have premiums above the 2007 de minimis premium or will no longer be participating with Part D. In November 2006, dual eligibles in these plans were reassigned to another plan for 2007 which met the LIS premium benchmark. The first choice for reassignment was a benchmark plan offered by the same company. If no such plan existed, CMS reassigned dual eligibles randomly among other LIS plans. CMS alerted states that nearly 250,000 dual eligibles were reassigned across the nation.[19] To qualify for the de minimis benchmark policy or for automatic reassignment, individuals either had to be identified as a dual eligible in the July 2006 State MMA file or become dually eligible between July and the end of December 2006.[20]

Implications for Spend-Down Dual Eligibles in 2007 and Beyond

- **Lapses in Medicaid eligibility may result in the loss of deemed LIS status in a subsequent year.**

  Medicare beneficiaries who no longer spend down to Medicaid eligibility, or who did not complete their required spend-down before the end of calendar year 2006, were not deemed eligible for LIS in 2007, even if they did not experience a change in household composition or income.

  While states are generally unable to identify the number of individuals who lost Medicaid eligibility under the state's spend-down/medically needy program as a result of obtaining Medicare Part D coverage, it is reasonable to assume that the phenomenon of Part D delaying or preventing full spend-down can explain a substantial number of the 623,000 individuals who were no longer listed as Medicaid eligible during July 2006. North Dakota, for example, had identified a number of the approximately 2,700 individuals "missing" from that state's July 2006 file as spend-down individuals who were expected to meet their spend-down obligation before the end of 2006. Minnesota reported 1,000 fewer individuals meeting spend-down in June 2006 compared to December 2005 and was concerned that the loss of deemed LIS status would create a transition challenge for this group. For those who

[17] V. Smith, K. Gifford, S. Kramer and L. Elam, *The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation, Results from a 50-State Snapshot*, Kaiser Commission on Medicaid and the Uninsured, February 2006, available at http://www.kff.org/medicaid/7467.cfm.

[18] Memorandum from Tom Hutchinson, Centers for Medicare & Medicaid Services to All Part D Plan Sponsors, *Clarification on De Minimus Premium Policy for Low-Income Subsidy Eligible Beneficiaries*, October 27, 2006

[19] State Counts for Beneficiary Notification (LIS Re-Assignments by CMS as of Nov 2006) available at http://www.cms.hhs.gov/limitedincomeandresources/

[20] CMS will not reassign dual eligibles if they elected to enroll in a plan in 2006 other than the one originally assigned by CMS, regardless of changes in premiums or if the selected plans are no longer be available. The Social Security Administration is also determining which non-dual (non-deemed) beneficiaries will continue to be eligible for LIS during 2007. Their LIS status will continue automatically – unless the beneficiary indicates a change in household composition or income.

did not re-qualify as a dually eligible beneficiary before the year end, there are some disturbing implications.

- **Individuals who lost deemed LIS as a dual eligible for 2007 should file an application for LIS determination; however, some may not realize the benefits and may not complete the application process.**

  Even though these individuals received an application with their notice of lost deemed LIS status, there is concern that many will fail to apply (or to do so in a timely manner) to avoid having to pay full premiums and higher cost sharing in 2007. Experience in 2005 and 2006 continues to underscore the slow rate at which low income Medicare beneficiaries have elected to participate in Part D, both in applying for LIS and in enrolling in Part D.[21]

- **Individuals losing LIS status for 2007 may be unable to pay Part D premiums.**

  Medicare prescription drug plans will start billing full premiums to individuals who have lost their LIS status. Individuals may find the premiums too expensive, fail to pay these bills, and lose Part D coverage. Those who allow their Part D coverage to lapse also may find themselves facing a financial penalty, if they later want to reenroll in a plan.[22]

- **Even if able to pay Part D premiums, those losing their deemed LIS status will not qualify for discounted cost sharing starting January 2007. These individuals may find themselves once again with incurred pharmacy costs that trigger Medicaid spend-down eligibility later in 2007.**

  Even if some who lose their deemed LIS status for 2007 are able to pay Part D premiums, their Medicare prescription drug cost sharing will increase starting January 2007 (Appendix B). Most significantly, these individuals will no longer have prescriptions paid if they reach the donut hole. Ironically, they may find themselves once again incurring pharmacy costs and could begin to cycle back through the whole process again, even up to and including the loss of deemed LIS for 2008.

- **Individuals who lose deemed LIS status will also lose transition protections.**

  Individuals who were auto-enrolled by CMS in 2006 and deemed LIS eligible may now find themselves enrolled in a plan that is no longer "low cost" or no longer participating with Part D. While CMS has established a Special Enrollment Period to allow these individuals to choose an alternative plan after the first of the year, they will not benefit from the de minimis premium policy or the automatic reassignment process adopted by CMS. This will compound the challenges noted above. Those for whom coverage under Part D has delayed or prevented spend down to Medicaid eligibility are in most cases still low income individuals and can be expected to be vulnerable to disruptions in coverage.

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[21] Analysis by the Kaiser Family Foundation estimates that 75% of the estimated 4.4 million beneficiaries who did not enroll in Part D by May 15, 2006 are likely to qualify for LIS benefits. Kaiser Family Foundation, *Data Update: Medicare Prescription Drug Coverage Among Medicare Beneficiaries*, June 2006, available at http://www.kff.org/medicare/7453.cfm.

[22] Beneficiaries who are not eligible for the LIS must pay enrollment penalties for gaps in Part D coverage. CMS waived this penalty for LIS-eligible beneficiaries for 2006 and 2007.

CONCLUSION

The medically needy and spend-down programs under Medicaid have always been fairly complicated for individuals to navigate and for states to administer, but these programs have provided an important safety net for many whose medical costs overwhelm their income. Under Part D, those who spent down to Medicaid eligibility were treated as LIS eligible for the entire calendar year 2006 – regardless of the impact that obtaining Part D coverage may have had on future spend-down Medicaid eligibility.

Medicare Part D has added an additional layer of complexity for the vulnerable Medicaid spend-down population that may result in disruptions of pharmacy coverage and/or add financial burdens. It is difficult to identify (or quantify) this population, so states and advocates may not be adequately prepared to assist in the transitions to 2007 and beyond. However, these "former" spend-down Medicaid enrollees deserve a special focus and LIS outreach, since their loss of Medicaid – and therefore deemed LIS status – does not reflect a change in their underlying financial condition. Rather, their loss of deemed LIS in 2007 may be solely due to the presence of a Part D benefit that was made affordable only by deemed eligibility for LIS in 2006.

Appendix A: State Enrollment in Prescription Drug Plans Nov. 15, 2005 - June 11, 2006

State	Medicare-Medicaid[23] (Auto-Enrolled Dual Eligibles)		Medically Needy Program?	209(b) State?
Alabama	96,550	1.6%		
Alaska	11,739	0.2%		
Arizona	61,809	1.0%		
Arkansas	70,790	1.2%	Yes	
California	924,354	15.2%	Yes	
Colorado	46,312	0.8%		
Connecticut	69,728	1.1%	Yes	209(b)
Delaware	10,912	0.2%		
DC	15,896	0.3%		
Florida	364,944	6.0%	Yes	
Georgia	155,670	2.6%	Yes	
Hawaii	24,554	0.4%	Yes	209(b)
Idaho	20,301	0.3%		
Illinois	261,519	4.3%	Yes	209(b)
Indiana	104,820	1.7%	Yes	209(b)
Iowa	59,349	1.0%	Yes	
Kansas	42,620	0.7%	Yes	
Kentucky	93,560	1.5%	Yes	
Louisiana	106,087	1.7%	Yes	
Maine	47,558	0.8%	Yes	
Maryland	62,047	1.0%	Yes	
Massachusetts	192,429	3.2%	Yes	
Michigan	203,052	3.3%	Yes	
Minnesota	68,436	1.1%	Yes	209(b)
Mississippi	132,331	2.2%		
Missouri	150,456	2.5%	Yes	209(b)
Montana	16,376	0.3%	Yes	
Nebraska	33,243	0.5%	Yes	
Nevada	19,892	0.3%		
New Hampshire	20,847	0.3%	Yes	209(b)
New Jersey	142,000	2.3%	Yes	
New Mexico	36,211	0.6%		
New York	531,820	8.8%	Yes	
North Carolina	230,050	3.8%	Yes	
North Dakota	11,708	0.2%	Yes	209(b)
Ohio	189,805	3.1%		209(b)
Oklahoma	78,846	1.3%		209(b)
Oregon	43,811	0.7%		
Pennsylvania	162,816	2.7%	Yes	
Rhode Island	27,152	0.4%	Yes	
South Carolina	120,440	2.0%		
South Dakota	13,128	0.2%		
Tennessee	222,731	3.7%	Yes	
Texas[24]	341,490	5.6%	Yes	
Utah	22,399	0.4%	Yes	
Vermont	16,615	0.3%	Yes	
Virginia	115,196	1.9%	Yes	209(b)
Washington	103,607	1.7%	Yes	
West Virginia	46,932	0.8%	Yes	
Wisconsin	112,648	1.9%	Yes	
Wyoming	6,217	0.1%		
Total	**6,063,803**	100%		

Sources:
State Enrollment Data available at: www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp
Medicaid at a Glance, 2005, available at www.cms.hhs.gov/MedicaidGenInfo and Aged, Blind and Disabled Medicaid Eligibility Survey, National Association of State Medicaid Directors, 2003 for medically needy and 209(b) status.

[23] There are 478,000 additional dual eligibles enrolled in Medicare Advantage prescription drug plans.
[24] Texas offers its Medically Needy option for children and pregnant women only.

Appendix B: Changes in Medicare Part D Cost-Sharing Parameters

Part D Benefit Parameters	2006	2007
Low-Income Subsidy: Full-Benefit Dual Eligible		
1. Copayments for Institutionalized Beneficiaries	$0	$0
2. Maximum Copayments for Non-Institutionalized Beneficiaries		
a) Income Up to or at 100% of the Federal Poverty Level		
Up to Out-of-Pocket Threshold		
Generic Drug	$1	$1
Brand Drug	$3	$3.10
Above Out-of-Pocket Threshold	$0	$0
b) Income Over 100% of the Federal Poverty Level		
Up to Out-of-Pocket Threshold		
Generic	$2	$2.15
Brand Drug	$5	$5.35
Above Out-of Pocket Threshold	$0	$0
Low-Income Subsidy: Non-Full-Benefit Dual Eligible – Full Subsidy*		
Resources ≤ $6,000 (individual) or $9,000 (couple)		
a) Maximum Copayments up to Out-of-Pocket Threshold		
Generic Drug	$2	$2.15
Brand Drug	$5	$5.35
b) Maximum Copayments above Out-of-Pocket Threshold	$0	$0
Resources between $6,000 to $10,000 (individual) or $9,000 to $20,000 (couple)		
a) Deductible	$50	$53
b) Coinsurance up to Out-of-Pocket Threshold	15%	15%
c) Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred multi-source drug	$2	$2.15
Other (Brand)	$5	$5.35
Low-Income Subsidy: Non-Full Benefit Dual Eligible – Partial Subsidy*		
a) Deductible	$50	$53
b) Coinsurance up to Out-of-Pocket Threshold	15%	15%
c) Maximum Copayments above Out-of-Pocket Threshold		
Generic Drug	$2	$2.15
Brand Drug	$5	$5.35
Part D Standard Benefit Design (*Many plans use actuarial equivalent designs.)*		
a) Deductible	$250	$265
b) Initial Coverage Limit	$2250	$2400
c) Out-of-Pocket Threshold	$3600	$3850
d) Total Covered Part D Drug Spend at Out of Pocket Threshold	$5100	$5451.25
e) Minimum Cost-Sharing in Catastrophic Coverage		
Generic Drug	$2	$2.15
Brand Drug	$5	$5.35

Source: Office of the Actuary, Centers for Medicare & Medicaid Services, *Medicare Part D Benefit Parameters for Standard Benefit: Annual Adjustments for 2007*, May 22, 2006, available at www.cms.hhs.gov/MedicareAdvtgSpecRateStats/07_PartDBenefitParameters.asp#TopOfPage, under 2007 Part D parameter updates.

* The allowable resources were also updated for calendar year 2007.

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