



**JOINT**  
**OFA RESEARCH REPORT OLR**

**The New Federal Medicare  
Prescription Drug Improvement and  
Modernization  
Act of 2003  
And Its Impact on Connecticut:  
*A Preliminary Analysis***

***A Joint Report of  
The Office of Legislative Research and  
The Office of Fiscal Analysis***

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Office of Fiscal Analysis  
Room 5200, LOB  
Hartford, CT 06106-1591  
Phone (860) 240-0200  
<http://www.cga.state.ct.us/ofa>

Office of Legislative Research  
Room 5300, LOB  
Hartford, CT 06106-1591  
Phone (860) 240-8400  
<http://www.cga.state.ct.us/olr>

## **Executive Summary**

The federal Medicare Prescription Drug Improvement and Modernization Act of 2003 will have a major impact on Connecticut residents as well as programs operated by the state. Two of the most significant areas affected are the state's dually eligible (Medicare and Medicaid) clients and ConnPACE clients. The new federal law will also affect state and teacher retiree programs financially. While the state may obtain significant savings as a result of redefining its ConnPACE program, it could also be subject to substantial expenditures depending upon the implementation of drug benefits for the dually eligible clients. There are approximately 75,000 dually eligible clients having \$350 million in prescription drug costs. The ConnPACE program has \$66.8 million in drug costs for 52,200 clients. For both programs, the legislature will have to make extensive changes in state law to coordinate implementation with the new federal drug benefit.

### **Dually Eligible Clients**

The Medicare Part D prescription drug benefit will be provided to dually eligible clients on a voluntary basis. The state will no longer receive federal reimbursement for drug costs currently provided to these clients under Medicaid. How the program is ultimately administered will determine whether the state saves money or is subject to considerable additional budgetary expenditures. The estimated range, based upon assumptions made in this report, is from \$17.7 million in savings to \$337.2 million in additional expenditures. This latter figure assumes a highly unlikely scenario occurring but is provided to illustrate the uncertainty in program structure and administration. This part of the law becomes effective January 1, 2006.

### **ConnPACE**

The Medicare prescription discount card and Part D drug benefit programs could result in significant savings for ConnPACE to the extent that pharmaceutical costs for enrollees are transferred from the state to the federal government. The amount of savings will depend upon the extent to which ConnPACE enrollees choose to participate in these new programs. The federal law makes this choice voluntary.

Changes to ConnPACE statute will likely be informed by forthcoming recommendations by a State Pharmaceutical Assistance Transition Commission, which must report to the President and Congress by January 2005.

The drug discount card program, starting June 2004, provides a \$600 credit against drug purchases for certain low income persons. An estimated FY 05

ConnPACE savings of \$12.6 - \$13.8 million would result if all those estimated to be eligible for the credit enroll.

A more comprehensive Part D program starts January 2006. If full participation by eligible ConnPACE enrollees is achieved an FY 06 savings of \$22.1 - \$23.5 million and an FY 07 savings of \$49.7 - \$52.6 is projected.

## **INTRODUCTION**

This joint report by the Office of Legislative Research and the Office of Fiscal Analysis is an initial examination of the impact the new federal Medicare Prescription Drug Improvement and Modernization Act of 2003 will have on Connecticut. This report is preliminary and based upon the staff's current knowledge of the complex bill. And, at this time limited data was available from state agencies whose programs will be affected by the bill. As more information becomes available, including federal regulations designed to implement the numerous provisions, the offices intend to update the information contained in the report. In addition, a number of issues concerning implementation may require substantial changes in state law and program operations. Some of these issues will likely be addressed in the upcoming session of the General Assembly. OFA and OLR intend to update this analysis at the close of the 2004 General Assembly.

## **SUMMARY OF MEDICARE PRESCRIPTION DRUG LAW**

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (H. R. 1, P.L. 108-173), which was signed by the President on December 8, establishes a voluntary prescription drug benefit for seniors age 65 and over and younger disabled people who qualify for Medicare. The full benefit starts in January 2006, and a temporary prescription drug discount card program provides some help until that date. The new law also provides extra financial assistance for participants with low incomes and assets and those who are dually eligible for Medicare and Medicaid (see section on dually eligible below).

Before this law was enacted, Medicare paid only for part of beneficiaries' hospital (Part A) and doctor and other medical bills (Part B). It generally covered only prescription drugs administered in a hospital or doctor's office. It did not cover outpatient drugs other than a few cancer chemotherapy drugs. Most Medicare beneficiaries purchase Medicare supplement insurance known as "Medigap" to help cover what Medicare does not pay, but few of these policies provide prescription coverage and even then it is only limited coverage. Some Medicare HMOs, which people can choose as an alternative to the regular Medicare fee-for-service plan, cover prescriptions.

### **Discount Card Program**

The legislation requires a temporary prescription drug discount card program to start by June 2004 and end when the full program begins in 2006. The cards will be offered by private entities such as health insurers, retail pharmacies, pharmaceutical companies, or other organizations that meet

standards the Medicare program sets. The cards' benefits and their drug formularies can vary. People can choose a card anytime before January 1, 2006. If they choose one card for 2004, they can choose a different card for 2005. The annual enrollment fee can be no more than \$30. Administration officials say participants could save from 10% to 25%.

Seniors with incomes below 135% of the federal poverty level (FPL) (currently \$12,123 for one person and \$16,362 for two) who enroll in a card program will receive a \$600 credit against their drug purchases for each year the program is in operation; unused amounts carry over from the first to the second year. There is no asset test for the assistance. The federal government will pay the enrollment fee for people eligible for transitional assistance, and states may choose to pay the fee for others. But most people who have full dual eligibility for Medicare-Medicaid prescription benefits will not be eligible for a card; rather, their Medicaid coverage for prescriptions will continue.

### **Medicare Part D Prescription Drug Program**

In January 2006, the permanent prescription drug program (called Medicare Part D ) begins. People who wish to continue in the original Medicare fee-for-service plan will be able to sign up with one of several Medicare-approved, free-standing prescription-only plans offered by private insurers or other entities, which would assume some of the insurance risk. If beneficiaries are in a Medicare HMO (renamed Medicare Advantage Plans) or similar plan that already offers prescription coverage, they must receive their coverage through it. If their HMO does not offer prescription coverage, they can sign up for a prescription-only plan. The law requires that at least two plans operate in each region and arranges for "fall back" plans if this fails to occur. The secretary of Health and Human Services (HHS) will define the regions.

All approved plans must provide at least the following "standard" coverage:

1. 75% coverage of prescription costs up to \$2,250 with a \$250 annual deductible,
2. no coverage beyond the \$2,250 threshold until the beneficiary has spent a total of \$3,600 in out-of-pocket costs (\$5,100 in total consumer and Medicare expenditures), and then
3. "catastrophic coverage" of 95% of all prescription costs above \$5,100 (the beneficiary pays the greater of 5% of the cost per prescription or \$2 for generic and \$5 for brand names).

Medicare can adjust the deductible, threshold, and out-of-pocket amounts annually to reflect changes in prescription spending.

The plans may charge a monthly premium that can vary somewhat, but is expected to be about \$35 (for a total annual premium of \$420, which is excluded from the threshold and out-of-pocket cost calculations). Medicare

beneficiaries with incomes below 150% of the FPL (\$13,470 for one person, \$18,180 for two) and assets below \$10,000 (\$20,000 for couples) will receive varying levels of federal subsidies for their premiums, deductibles, and co-payments.

The legislation prohibits companies that sell Medigap policies with drug coverage from selling or renewing them after January 1, 2006, except that people who choose not to participate in Medicare Part D can keep and renew their existing policies. Medicare beneficiaries who have medical savings accounts are also eligible for the Part D program.

The federal law provides a subsidy to employers' health plans that cover retirees' prescription drug costs. The 28% subsidy applies to costs above \$250 and up to \$5,000 per Medicare enrollee. State employee health plans would also be eligible for the subsidy. The subsidy is an incentive to employers to continue their current levels of coverage and not reduce or drop their retirees' prescription coverage.

## **Medicaid**

Medicare beneficiaries who are also fully eligible for Medicaid benefits can participate in the Medicare discount card and Part D programs. If they do, Medicare will be their primary payor. If people in this group do not choose a prescription plan, one will be randomly chosen for them, but they will have an option to change or leave the plan. States cannot require them to enroll in a prescription plan.

The legislation prohibits states from using federally reimbursable Medicaid money to provide "wrap around" coverage (coverage for things that Medicare does not pay for) for Part D beneficiaries, but they may choose to cover drugs excluded under the Medicare coverage for people who are not full dual-eligibles. It also requires states to give back some of their Medicaid savings to the federal government (the so-called "clawback" provision).

## **Coordination With State Pharmaceutical Assistance Programs**

The federal legislation makes the new Medicare pharmaceutical program the primary payer for people who are also enrolled in state programs, such as Connecticut's Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE), that help lower-income seniors and people with disabilities who do not qualify for Medicaid. It allows participants' Medicare prescription card to serve also as the state program's card. States' spending on drug costs for people participating in their programs count as out-of-pocket expenses toward Part D's spending thresholds. State programs can purchase additional benefits for Part D enrollees from the private drug plans or they can directly provide supplemental benefits.

The legislation creates a State Pharmaceutical Assistance Program (SPAP) commission, composed of federal and state officials and others, to develop a proposal for coordinating the new program's benefits and administration with state drug benefit plans. And it provides grants to states to help with their transition and coordination expenses.

### **Other Significant Provisions**

Other changes, which are likely to have an effect on states, include:

1. increasing the Medicare Part B deductible from \$100 to \$110 in 2005;
2. requiring people with annual incomes above \$80,000 (\$160,000 for couples) to pay higher Part B premiums starting in 2007;
3. prohibiting reimportation of drugs from Canada, except if the HHS secretary allows it and sets standards by regulation;
4. speeding up procedures for bringing generic drugs to market;
5. authorizing electronic prescriptions, first in a pilot project and then nationwide in 2008, and
6. providing Medicare coverage for more prevention, some checkups, more screening tests, and disease management.

The legislation also provides higher reimbursements for Medicare HMOs and similar entities (renaming the current Medicare+Choice Plans as Medicare Advantage plans); higher fees for doctors and hospitals, especially in rural areas; and more money for Medicaid disproportionate share hospital (DSH) payments. It also requires the HHS secretary to test a less restrictive definition of "homebound" for Medicare home health services eligibility and requires a demonstration for home health services delivered at adult day care centers. It also creates tax-free health savings accounts that people can establish to help pay for their medical needs and to which they or their employers can make annual limited contributions that can accumulate over a lifetime.

Starting in 2010, the legislation establishes six-year demonstration projects in six metropolitan areas to test competition between private health plans and the fee-for-service Medicare plan.

The legislation also makes numerous other changes, which are further discussed in the following summaries at:

<http://www.ncsl.org/statefed/health/presummcagre.pdf>

<http://waysandmeans.house.gov/media/pdf/healthdocs/confagreement.pdf>

[http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=21129](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=21129)

## **THE LAW'S EFFECT ON CONNECTICUT'S MEDICARE POPULATION**

### **Coverage Groups**

Medicare covers elderly and disabled residents. Connecticut had a total of 516,359 Medicare beneficiaries in 2001 representing 15% of the state's population. The majority of the beneficiaries are elderly, while 11% are individuals with disabilities. In terms of income, 9% of the Medicare population is under 100 % of the federal poverty level (FPL), 27% fall between 100 and 199% of FPL, and the remaining 64% of the population are at or over 200% of poverty.

In Connecticut, 114,000 Medicare beneficiaries fall below 135% of poverty and will receive the full low-income drug plan subsidy (see below). Almost half these individuals are enrolled in the ConnPACE program. Another 23,000 residents will receive a partial low-income subsidy because their income is between 135% and 150% of poverty. This assumes that the beneficiaries meet the asset tests for two categories of eligibility.

For much of the population, Medicare represents the first payer of health care services, but most residents have additional payers to fill the gap for non-covered health services. In Connecticut the following table illustrates those segments of the Medicare population covered by other payers.

<b>Medicare Beneficiaries by Type of Coverage: 1996 Data</b>	
Coverage	% of Population
Medicare HMO	11%
Medicare and Employer Sponsored Insurance	39%
Medicare and Medigap Policy	22%
Medicare, Medigap and Employer Sponsored	4%
Medicare Fee-For-Service Only	8%
Medicare and Medicaid (Dual Eligibles)	16%

The new Medicare law will affect each of the above coverage groups in different ways. The first coverage group, Medicare HMOs, have been in decline in Connecticut; only two continue to serve clients. As of 2003 only 6% of Medicare beneficiaries are enrolled in an HMO plan as compared to 11% in 1996. The new law changes these plans, enabling them to offer Medicare prescription drug plans (Part D coverage) along with their other benefits.

Nationwide the legislation allocates an additional \$14.2 billion over nine years to increase the premiums paid to these plans.

The next coverage group, Medicare and employer-sponsored insurance plans, are also affected by the addition of the prescription drug benefit. As an incentive for employer-sponsored plans to keep existing prescription drug benefits for retirees, the federal government intends to provide them with a 28% subsidy.

The next two categories include individuals who have purchased Medigap coverage to fill in for missing coverage. Some of the most expensive Medigap plans include prescription coverage, but the law now prohibits the sale of new Medigap policies that include such coverage. Consequently, people in these two coverage groups will have to decide whether to obtain drug coverage through Medicare or renew their existing Medigap policy.

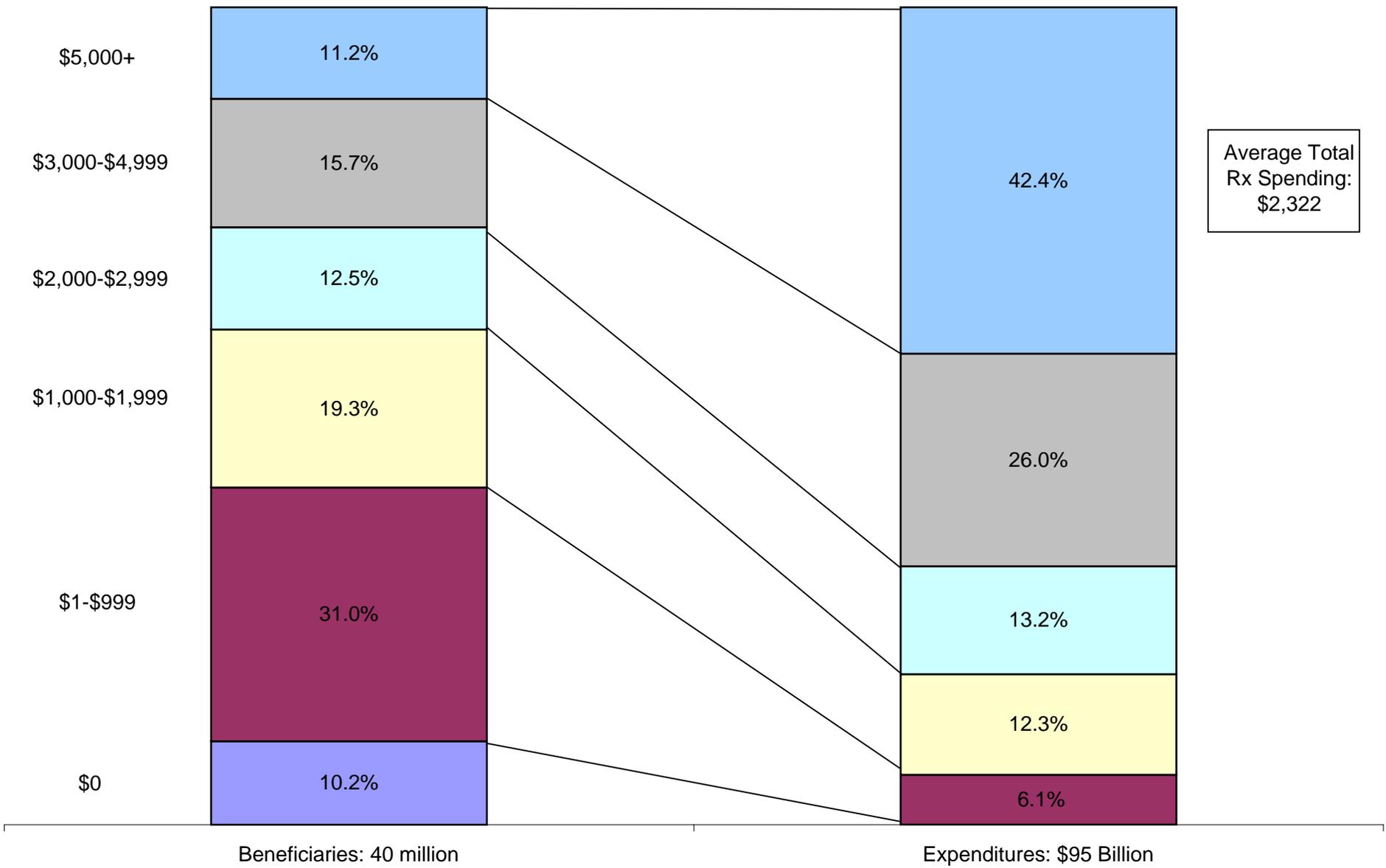
Medicare fee-for-service only clients either did not have prescription coverage or are enrolled in the state's ConnPACE program. Both groups of clients will be affected by the addition of Part D Medicare drug coverage. They may also be offered additional incentives to move into private Medicare HMOs (the new Medicare Advantage Plans) if they expand into the Connecticut insurance market. Such incentives could include lower premiums, deductibles, and co-pays for drug coverage.

Finally, the last coverage group comprises those residents who qualify for both Medicare and Medicaid coverage, the so-called dual eligibles. The effects on this group are treated more thoroughly in the section dealing with the law's long-term effects on the state.

### **Medicare Beneficiaries and Drug Expenditures.**

Chart 1 illustrates the distribution of drug costs and their relationship to beneficiaries. It shows that more than 40% of the Medicare population spends less than \$1,000 annually on drugs. For those falling into this group who do not receive a low-income subsidy, the federal benefit will be worth less than \$120. Twenty percent of the population spends between \$1,000 and \$2,000 annually. Those spending near the \$2,000 limit will receive about a \$1,000 benefit from Medicare Part D drug coverage. The chart also shows that those clients falling into the catastrophic coverage – over \$5,100 – account for 11% of the population but 42% of total drug expenditures. In terms of total dollars spent, this group receives the largest benefit from the new drug program, next to those beneficiaries who fall into the low-income subsidy group.

**Chart 1: Distribution of Medicare Beneficiaries and Total Drug Expenditures, 2003**



Source: Actuarial Research Corporation analysis for the Kaiser Family Foundation, June 2003

## **Effects on Beneficiaries**

Medicare Part D offers a prescription drug benefit for Medicare beneficiaries that was not previously available. Part D coverage will be offered through either private plans or as part of the new Medicare Advantage plans, which will be private HMOs similar to the currently available Medicare Choice plans. The plans are intended to be full risk bearing health plans; they must meet certain solvency requirements of the state in which they operate in or be approved by the HHS secretary. If private sector plans do not emerge in the market place, the law does provide for federal reinsurance that would allow the government to assume some or all of the risk involved in offering a prescription drug benefit to the Medicare population. Part D-covered drugs are generally all drugs approved by the Federal Drug Administration as allowed by law.

All Medicare beneficiaries are eligible for Part D drug coverage, but their income and assets affect their out-of-pocket expenses. Chart 2 illustrates how an individual is impacted by the new coverage.

If an individual's income exceeds 150% of the federal poverty level -- \$13,470 a year --he faces the premiums, co-payment, and deductibles outlined in Chart 1. The client pays an initial monthly premium of \$35, for an annual expense of \$420. The client must pay the first \$250 of drug expenditures before the Medicare drug plan coverage begins. He then pays 25% of costs between the next \$250 and \$2,250; the plan covers 75 %. Therefore if the client has additional costs of \$2,000, over the \$250 deductible, the plan will contribute \$1,500 while the client pays \$500.

If a client's drug costs exceed a total of \$2,250, he must pay for any additional costs until they reach \$5,100, including the initial deductible and 25 % co-payment. This amounts to an additional out-of-pocket consumer expenditure of \$2,850. Once the client's drug costs exceed the \$5,100 level, Medicare would pay 95% of all costs of drugs purchased, except for nominal co-pays of \$2 for generic drugs and \$5 for brand name drugs.

To illustrate the cash value of the benefit, if we assume a client's drug costs for the year are \$2,250, then the Medicare plan would pay \$1,080 and the client would have out-of-pocket expenses (including premiums) of \$1,170. The national average for prescription drug spending in 2003 was \$2,322 for Medicare beneficiaries.

Individuals with incomes at or below 150% of poverty receive various subsidies, depending in part on their assets, which are outlined below. This low-income subsidy program will have a direct impact on Connecticut's ConnPACE and Medicaid drug programs. These effects are detailed in the next section.

## **Low-Income Subsidy Program for Medicare Beneficiaries**

### **1) Low-Income Subsidy Program: Dual Eligibles with Full Medicaid Benefits**

- No deductible and no premium;
- Cost-sharing up to catastrophic limit:
- For institutionalized dual eligibles: No cost-sharing requirements
- For dual eligibles at or below 100% of poverty (non-institutionalized):  
\$1 per generic or preferred multiple source drug /  
\$3 per brand name (indexed to CPI)
- For dual eligibles above 100% of poverty (non-institutionalized): \$2  
per generic / \$5 per brand name (indexed to per capita growth in  
Part D expenditures)
- No cost-sharing above the catastrophic limit

### **2) Other Low-Income Individuals with Income Below 135% of Poverty and Assets Below \$6,000 Per Individual / \$9,000 Per Couple**

- No deductible and no premium (if select average or lower cost plan)
- Cost-sharing of \$2 per generic or preferred multiple source drug and \$5  
per brand name drug (indexed to growth in per capita Part D spending)  
up  
to catastrophic limit
- Above catastrophic limit, no cost-sharing required

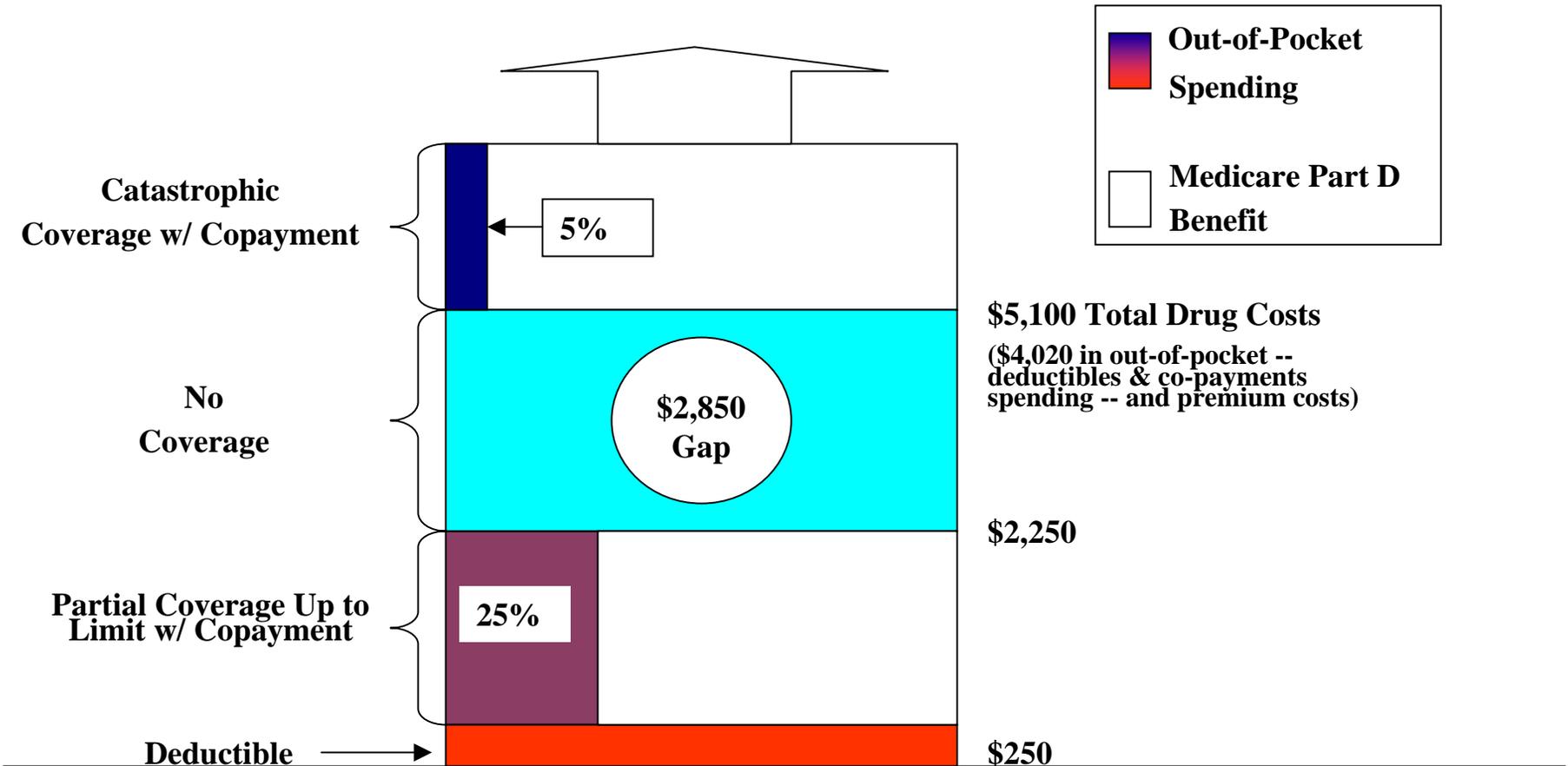
### **3) Other Low-Income Individuals with Income 135% to 150% of Poverty and Assets Below \$10,000 Per Individual / \$20,000 Per Couple \***

- Sliding scale premium assistance
- \$50 deductible
- 15% co-insurance up to catastrophic limit
- Above catastrophic limit, cost-sharing of \$2 per generic or preferred  
multiple source drug and \$5 per brand name drug (indexed to growth in  
per capita Part D spending)

\*Also included in this group are individuals with income below 135% of poverty and assets in excess of \$6,000 per individual / \$9,000 per couple

*Prepared by the Kaiser Commission on Medicaid and the Uninsured based on "The Medicare Prescription Drug, Improvement, and Modernization Act of 2003."*

## Chart 2: Out-of-Pocket Drug Spending in 2006 for Medicare Beneficiaries Under New Medicare Legislation



**New Medicare Legislation**  
+~\$420 in annual premiums

Note: Benefit levels are indexed to growth in per capita expenditures for covered Part D drugs. As a result the Part D deductible is projected to increase from \$250 in 2006 to \$445 in 2013; the catastrophic threshold is projected to increase from \$5,100 in 2006 to \$9,066 in 2013.

## **MEDICARE PRESCRIPTION DRUG COVERAGE---SHORT AND LONG-TERM IMPACTS ON CONNECTICUT PROGRAMS**

The passage of PL 108-173 will have a significant impact on Connecticut residents and dramatically alter the way the state provides drug benefits to clients under several programs. Those programs include Medicaid, ConnPACE, and retired state employee and retired teacher health plans. This section will outline that impact based upon data currently available and the staff's understanding of the law at this time.

### **Assumptions**

It is important to note that certain data needed to accurately reflect the law's impact is not yet available, and extensive federal rules will be promulgated over the next two years that will further clarify the operation of the new Medicare program. These factors require the staff to make certain assumptions about how the program will operate. When the data become available and the regulations are adopted, this may alter our analysis. On the state level, changes in law will also be required to fully integrate various portions of the new Medicare drug benefit with our state-funded programs. Staff will identify those assumptions where we find it necessary to make them in order to arrive at an accurate reflection of the law's impact.

### **Short-Term: Medicare Drug Discount Card And Transitional Assistance**

The new law establishes a voluntary Medicare Prescription Drug Discount Card and Transitional Assistance Program in which three groups of individuals may participate. The program will operate from June 1, 2004 to December 31, 2005. These groups are:

1. Medicare eligible individuals who are not enrolled in a Medicaid program that covers outpatient prescription drugs.

People in this group will be subject to an annual enrollment fee of up to \$30, payable to the card sponsor entity. The state may pay the annual enrollment fee.

2. Transitional assistance eligible individuals - those with incomes between 100% and 135% of poverty (currently \$12,123 single/\$16,362 married).

These individuals' annual enrollment fee will be paid by the Centers for Medicare & Medicaid Services (CMS). They will be eligible for federal payment of up to \$600 in FY 04 and FY 05, with a 10% coinsurance requirement.

3. Special transitional assistance eligible individuals - those with incomes below 100% of poverty (currently \$8,980 single, \$12,120 married).

These individuals' annual enrollment fee will also be paid by CMS. They will be eligible for federal payment of up to \$600 in FY 04 and FY 05, with a 5% coinsurance requirement.<sup>1</sup>

People with prescription drug benefits under a group health plan, federal employees' health benefits plan or through coverage extended to members of the uniformed services are not eligible to participate in the discount card program.

A drug discount card sponsor must be a non-governmental entity with at least three years of CMS-approved private sector experience in the United States. When it applies for CMS approval, a sponsor must operate a drug benefit, drug discount card or low-income drug assistance program, or similar program that serves at least 1 million covered lives.

### **Medicare Discount Card and ConnPACE**

The ConnPACE program assists lower income elderly and disabled residents in buying pharmaceutical products. Eligibility is restricted to persons who have resided in Connecticut for at least six months; are either 65 years of age or older or between ages 18 and 64 and receiving disability benefits under the Social Security Disability Program or the Supplemental Security Income Program; have an annual adjusted gross income of less than \$20,800 if single or \$28,100 if married; and have liquid assets of less than \$100,000 if single or \$125,000 if married. People cannot be enrolled in Medicaid, have drug coverage that pays a portion or all of each prescription purchased, or have prescription drug coverage after a deductible has been met. Enrollees pay a \$30 annual application fee and are subject to a \$16.25 co-payment per prescription.

The 2003-05 Biennial Budget Act appropriates \$66,799,130 for FY 04 and \$73,542,896 for FY 05 to support ConnPACE. Due to continuing enrollment growth and delays in implementing cost containment initiatives, deficiencies of \$6.1 million and \$7.3 million, respectively, are anticipated.

Average monthly ConnPACE enrollment for FY 05 is projected to be 52,400 (44,850 elderly, 7,550 disabled). For purposes of this estimate it is assumed that 90% of the population (roughly 47,150 persons) will be eligible for

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<sup>1</sup> An enrollee's unused portion of the 2004 credit may be carried forward into 2005.

Medicare.<sup>2</sup> Of these, an estimated 13.5% will have incomes below 100% of poverty, while another 30.9% will have incomes between 100% and 135% of poverty. The anticipated distribution of ConnPACE enrollees by discount card classification is as follows:

- 6,400 eligible for special transitional assistance,
- 14,600 eligible for transitional assistance,
- 26,150 eligible to participate in the discount card program, without federal assistance, and
- 5,250 ineligible for the discount card program.

Savings would accrue to the state to the extent that participation in the drug discount card program reduces the number of DSS-paid prescriptions. An estimated maximum of \$12.6 - \$13.8 million in drug cost savings would result in FY 05<sup>3</sup>. FY 04 savings would equate to about \$450,000-\$500,000<sup>4</sup>.

Achieving these savings will depend upon full enrollment of ConnPACE participants having special transitional/transitional assistance eligibility into the discount card program by June 2004. Since program participation is voluntary, however, this may not be feasible without legislative action. While applicants over 135% of poverty may apply to drug discount card sponsors in writing, by telephone, or by Internet, all transitional assistance enrollments require a signed form<sup>5</sup>. This may present a challenge for DSS, as will other efforts it undertakes to coordinate ConnPACE benefits with those of the discount cards and conduct consumer education and outreach activities. Unanticipated expenses may also be incurred to compensate the program's financial intermediary for systems changes. The savings estimate above does not reflect these potential costs.<sup>6</sup>

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<sup>2</sup> OFA is awaiting a response from DSS regarding the Medicare eligibility status of ConnPACE enrollees. It is anticipated that the eligibility percentage for the disabled will be less than that for the elderly. However, lacking population specific data, an assumption of 90% eligibility in both groups is made.

<sup>3</sup> It is assumed that: The average price per prescription under the discount cards will range from roughly equivalent to ConnPACE's gross average prescription price (before manufacturers' rebate) to 10% greater; 85% of ConnPACE enrollees will have sufficient annual drug utilization to exhaust the \$600 credit; coinsurance charges are paid by the beneficiary; and participants do not disenroll during the year (in which case the balance of the \$600 remaining would be forfeit).

<sup>4</sup> Based on nineteen ConnPACE processing days in June 2004.

<sup>5</sup> Centers for Medicare & Medicaid Services. Materials for Pre-Application Conference for the Medicare Prescription Drug Discount Card and Transitional Assistance Program, December 18 & 19, 2003.

<sup>6</sup> OFA is awaiting a response from DSS regarding potential administrative burdens and associated expenses.

## **Long-Term: Medicare Prescription Drug Program (Part D)**

Part D will have significant impact on the state's Medicaid expenditures on behalf of people who are eligible for both Medicare and Medicaid (so-called dual eligibles) and ConnPACE.

### **Dual Eligibles**

While Medicare is provided to all those who qualify as a result of their work status, Medicaid is a means-tested benefit provided generally to those individuals who fall below the federal poverty limit. Historically, Medicaid has provided broader health care coverage than Medicare.<sup>7</sup> It has also provided prescription drug benefits while Medicare has not. States have made significant expenditures for this drug benefit, and the new legislation has a substantial impact on the future of this program. A more detailed description of the dually eligible population and the various categories of eligibility is presented in the appendix of the report.

In Connecticut, Medicare and Medicaid jointly cover approximately 84,000 individuals. Around 9,000 of these clients are "partial" dual eligibles in that the state assists in the purchase of Medicare Part B coverage but does not provide full Medicaid coverage. The remaining 75,00 clients are "full" dual eligibles whose prescription drugs are provided by Medicaid. The total cost to provide drugs to this group is estimated to be \$355 million with half the amount (\$177.5 million) provided through federal funds reimbursement. This represents one of the largest and fastest growing categories of Medicaid expenditures.

The new Medicare law eliminates federally reimbursable Medicaid drug coverage for the dual eligible population and extends the Part D drug benefit to them. This will have a significant effect on state expenditures as well as on clients, depending on how the new program operates.

Certain provisions in the federal law do not allow states to take full advantage of the savings that would have occurred if the new Medicare benefit simply supplanted the current Medicaid benefit. Congress recognized the potential windfall states would have received – estimated at \$177.5 million for Connecticut for FY06 –and added "clawback" requirements to recoup much of the savings.

For 2006, the law requires that 90% of state savings be returned to ("clawed back" by) the federal government. The savings are based on the number of clients enrolled and the amount of drug expenditures for 2003. In addition,

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<sup>7</sup> For instance, Medicare pays for the first 20 days of nursing home care and all but the first \$109 of each day for the next 79 days. After that Medicaid pays the rest assuming the patient qualifies for the benefit.

the states will no longer be reimbursed for drugs provided to dual eligibles under the Medicaid program. To further complicate program operations, while dual eligibles will be initially enrolled whether they choose to or not, the law allows them to decline coverage if they so desire. Under the law, each dual eligible client will be placed in a drug plan if he or she does not make an initial choice, however nothing in the law “**shall prevent such an individual from declining or changing such an enrollment.**”<sup>8</sup> This provision may pose a serious challenge for states seeking to maximize savings under the new law.

Under current state law, Connecticut would continue to provide benefits to those not enrolled in Medicare Part D, but it would be responsible for the full cost of drugs. It would no longer receive any federal reimbursement for drugs provided to dual eligible clients outside of the Medicare Part D benefit. The table below, *Federal Law Impact on Dual Eligible Pharmacy Expenditures*, outlines the potential savings and costs under the new federal Medicare benefit. It shows the impact that declining enrollment in the program would have if the state continued providing a drug benefit under the newly non-federally reimbursable program.

The table sets out a number of participation rate assumptions, calculates the clawback provision based upon estimated pharmacy expenditures for 2006, and estimates the cost of providing a non-reimbursable drug program for those clients choosing not to participate in the Medicare benefit. The table also examines two separate clawback scenarios. The first shows the impact of establishing a clawback provision based upon 2003 client data. The second allows for an adjustment or relief from the clawback provision based upon the actual number of clients enrolled in Part D for 2006. At this point it is not clear which will be allowed under the federal law. The first scenario has a significantly greater impact on the state expenditures.

***Impact on Expenditures.*** If 100% of the dual eligibles enroll in Medicare Part D, the state would save the 10% it would not have to return the federal government as a result of the clawback provision: an estimated \$17.75 million in 2006. However, because Congress made enrollment in Medicare Part D voluntary for the dual eligible population, any reduction in the participation rate would have a serious budgetary impact if the state continues to provide a drug benefit as required by current law.

As the table shows, any drop-off in the participation rate will decrease the amount of savings the state could expect. In fact, under the no-relief clawback provision, if 20% of the clients decline enrollment and the state continues to provide a Medicaid drug benefit, an additional \$53 million over current

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<sup>8</sup> Medicare Prescription Drug Improvement and Modernization Act of 2003, Section 101 (section 1860D-1(b)(1)(C)).

## Federal Law Impact on Dual Eligible Pharmacy Expenditures

**Full Pharmacy Benefits Continued**  
*No Clawback Relief    Clawback Relief*

Assumptions	2006	2006
Dual Eligibles	75,000	75,000
Estimated Gross Prescription Cost	\$ 355,000,000	\$ 355,000,000
Estimated Net State Cost (less federal match)	\$ 177,500,000	\$ 177,500,000
Clawback % by Federal Law	90%	90%
Clawback Cost - Paid to the Feds by State	\$ 159,750,000	\$ 159,750,000
<b>Potential State Impact Based Upon Participation Rate</b>		
	<b>2006</b>	<b>2006</b>
<b>100%</b>		
State Savings for Part D Enrollees	\$ (177,500,000)	\$ (177,500,000)
Clawback Cost	\$ 159,750,000	\$ 159,750,000
Additional Cost to Continue Benefits	\$ -	\$ -
<b>Net Impact</b>	<b>\$ (17,750,000)</b>	<b>\$ (17,750,000)</b>
<b>95%</b>		
State Savings for Part D Enrollees	\$ (168,625,000)	\$ (168,625,000)
Clawback Cost	\$ 159,750,000	\$ 151,762,500
Additional Cost to Continue Benefits	\$ 8,875,000	\$ 8,875,000
<b>Net Impact</b>	<b>\$ -</b>	<b>\$ (7,987,500)</b>
<b>90%</b>		
State Savings for Part D Enrollees	\$ (159,750,000)	\$ (159,750,000)
Clawback Cost	\$ 159,750,000	\$ 143,775,000
Additional Cost to Continue Benefits	\$ 17,750,000	\$ 17,750,000
<b>Net Impact</b>	<b>\$ 17,750,000</b>	<b>\$ 1,775,000</b>
<b>80%</b>		
State Savings for Part D Enrollees	\$ (142,000,000)	\$ (142,000,000)
Clawback Cost	\$ 159,750,000	\$ 127,800,000
Additional Cost to Continue Benefits	\$ 35,500,000	\$ 35,500,000
<b>Net Impact</b>	<b>\$ 53,250,000</b>	<b>\$ 21,300,000</b>
<b>50%</b>		
State Savings for Part D Enrollees	\$ (88,750,000)	\$ (88,750,000)
Clawback Cost	\$ 159,750,000	\$ 79,875,000
Additional Cost to Continue Benefits	\$ 88,750,000	\$ 88,750,000
<b>Net Impact</b>	<b>\$ 159,750,000</b>	<b>\$ 79,875,000</b>
<b>0%</b>		
State Savings for Part D Enrollees	\$ -	\$ -
Clawback Cost	\$ 159,750,000	\$ -
Additional Cost to Continue Benefits	\$ 177,500,000	\$ 177,500,000
<b>Net Impact</b>	<b>\$ 337,250,000</b>	<b>\$ 177,500,000</b>

expenditures would be required. Even at 95% enrollment, the state will have to pay \$8.9 million for drugs costs as a result of the loss of federal reimbursement and would not receive another \$8.9 million in savings it would have otherwise expected under the Part D benefit provided to dual eligible clients, thus eliminating the \$17.75 million in expected savings. The table further displays other net impacts on expenditures based upon varying rates of participation.

If the clawback provisions were limited to actual enrollment rates, then the impact upon the state would be lessened. However, even under the latter scenario, the state would incur an additional \$21.3 million in expenditures at an 80% enrollment rate.

***A Potential Option.*** The state could change current law to (1) not provide a drug benefit for dual eligibles and (2) requiring ConnPACE participants to enroll in Part D. On its face this first change would be very difficult to do since dual eligibles are usually some of the state's most medically involved clients, including nursing home clients who would be at great risk if the state did not provide prescription drugs.

Under this option, the state would encourage those clients who do not enroll in the Part D benefit to participate in the ConnPACE program for which they would all be eligible. In an analysis presented elsewhere in this report, the staff project savings in the ConnPACE program if participation in Medicare Part D is made a condition of eligibility and ConnPACE is restructured for 2006 to act as a wrap-around benefit program that will fill the gap in Medicare coverage for current clients.

While dual eligible clients would not be required to join ConnPACE, this option would make it the only drug benefit available to them. If they entered the ConnPACE program, they would be required), to participate in the Medicare drug program. So, even though the federal law makes enrollment voluntary, the benefit provided by the state under the ConnPACE program can make enrollment mandatory, which would thus place these clients back into the Medicare Part D drug program.

### **Medicare Part D: Impact on ConnPACE in FY 06 and Beyond**

Beginning January 1, 2006, eligible ConnPACE enrollees may elect to receive pharmaceutical coverage under Part D plans. Substantial federal subsidies will be provided to individuals having both incomes up to 150% of poverty and low assets. For others, Part D will provide a 75% federal subsidy of drug costs between \$250 and \$2,250. A beneficiary's obligation for the cost of drugs at catastrophic levels (over \$5,100) will also be greatly diminished. The new Medicare benefit will afford Connecticut the opportunity to achieve significant General Fund savings, commencing in FY 06. An estimated 42% of Medicare

eligible ConnPACE enrollees will be eligible for low income/asset subsidies, while the remaining 58% will be eligible for regular Part D benefits.

### **State Pharmacy Assistance Programs: Integration with Part D Plans**

In passing the new Medicare changes, Congress recognized the unique challenges of integrating Part D<sup>9</sup> benefits with preexisting state pharmaceutical assistance programs (SPAPs) like ConnPACE. It instructed the HHS secretary, by July 1, 2005, to create guidelines for the coordination of payments, coverage, and supplemental drug benefits.

It also required the secretary to establish a method by which a Part D plan could receive capitated payments from a SPAP in order to provide supplemental prescription drug benefits to enrollees. A state with a SPAP that chooses to supplement Part D coverage may do so either directly or by purchase from a Part D plan. However, the law appears to prohibit a SPAP from developing an exclusive agreement with one or more Part D plans.<sup>10</sup>

Congress appropriated \$62.5 million for FFYs 05 and 06 to support a Transitional Grant Program under which approved states may receive funding to educate eligible SPAP enrollees about available prescription drug coverage under Part D plans. States may also use this funding to (1) provide technical assistance, phone support, and counseling to individuals regarding plan selection and enrollment and (2) “promote the effective coordination of enrollment, coverage and payment” between the SPAP and Part D plans. A state’s grant award will be proportional to the number of its enrollees relative to other states with approved SPAPs as of October 1, 2003. Connecticut’s share of this funding is unknown at this time.

A State Pharmaceutical Assistance Transition Commission is to be formed by March 1, 2004. The commission must report to the President and Congress (by January 1, 2005) regarding proposed legislative or administrative changes needed to facilitate the integration of SPAPs and Part D plans.

***State Budget Implications.*** The following analysis is undertaken in the absence of definitive guidance regarding how ConnPACE will function after Part D is implemented. Legislative action will likely be required to clarify program eligibility and benefits after December 31, 2005.<sup>11</sup> For simplicity’s sake, staff assumes that full participation in Part D plans by eligible ConnPACE enrollees

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<sup>9</sup> Including both prescription drug plans and Medicare Advantage-prescription drug plans.

<sup>10</sup> Section 1860D-23(b)(2) defines “State Pharmaceutical Assistance Program” to be a program providing supplemental assistance to part D eligibles “which...provides assistance to such individuals in *all part D plans and does not discriminate based upon the part D plan in which the individual is enrolled*” (italics added).

<sup>11</sup> For example, Section 17b-492 CGS may require modification, as it restricts ConnPACE eligibility to persons who are not “insured under a policy which provides full or partial coverage for prescription drugs once a deductible amount is met.”

is achieved as of that date. (Staff also assumes that ConnPACE coverage for those not eligible for Part D will remain as under current law.) However, as with the drug discount card program, participation in Part D is voluntary. The reader is therefore reminded that these projections should be considered to be maximum achievable savings.

Staff further assumes that DSS will supplement the new federal benefit in order to

- fill any resulting gaps in coverage due to formulary differences between traditional ConnPACE and Part D plans,
- pay premiums and deductibles for affected individuals, and
- limit an enrollee's co-payment (coinsurance) charges to a maximum of \$16.25.

Under current law, ConnPACE drug expenditures during the latter six months of FY 06 are anticipated to be \$49.5 million, based on a projected average monthly enrollment of 52,900, average net drug cost to the state of \$84.32 per prescription, and average monthly utilization per enrollee of 1.85 prescriptions. Given assumptions discussed above, these costs would be reduced by \$22.1 to \$23.5<sup>12</sup> million. Similarly, a projected \$49.7 to \$52.6 million in savings would result in FY 07, after adjusting for drug price inflation and annualizing.

It should be noted that these savings would be mitigated to the extent that sufficient Transitional Grant funding is not forthcoming to accommodate costs of systems changes required by DSS to administer the restructured benefit program. Additionally, some concern has been expressed by national commentators that pharmaceutical manufacturers' rebates (approximately 21.5% of current expenditures) paid to states like Connecticut may be jeopardized by the new Part D program<sup>13</sup>.

## **ADDITIONAL SIGNIFICANT IMPACT OF THE NEW FEDERAL MEDICARE LAW**

Two additional areas affected by the law are the state's (1) Disproportionate Share Hospital (DSH) program and (2) employee and teacher retirement programs.

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<sup>12</sup> The lesser savings amount is predicated upon 90% of ConnPACE covered drugs being picked up by part D plans. The greater amount assumes 95%.

<sup>13</sup> The analyses herein do not assume any enrollment changes in ConnPACE due to implementation of either the drug discount card program or Part D. However, the federal law requires enhanced outreach efforts surrounding pharmaceutical benefit programs at the federal and state level. This may increase program participation to an unknown extent. Alternatively, an unknown percentage of enrollees may drop ConnPACE enrollment and rely solely upon the federal program.

## **Disproportionate Share Hospitals**

The DSH program has two purposes. One is to compensate hospitals for the cost of providing inpatient care to clients not paying the full cost of services. Those clients include individuals insured by Medicaid, underinsured people, and those having no insurance coverage. The second purpose is to obtain federal reimbursement for that portion of the care that is not funded directly by Medicaid. This is achieved by creating a state payment to hospitals that can be claimed as Medicaid expenditures.

The new law provides a 16% increase in the DSH payment caps in FFY 04. This would increase Connecticut's available DSH limit from \$162 million to \$188 million. In order to draw down this additional revenue, Connecticut would have to increase its DSH related appropriations. In FY 03, Connecticut drew down approximately \$112.5 million in DSH-related revenue.

The federal government limits the amount of DSH revenue that can be derived from expenditures at state-operated mental health facilities. The new law apparently increases this limit. The state currently draws down \$42 million of the \$112.5 million total revenue from state mental health expenditures. With a 16% increase to the mental health DSH cap, the state would receive an additional \$6.7 million in DSH revenue. No additional appropriations would be necessary given current mental health funding levels.

## **State Retirement Programs**

The new law provides for a 28% subsidy payment to the sponsor of qualified retiree prescription drug plans. These payments are to be made on behalf of individuals who elect to continue their prescription drug coverage under the retirement plan rather than enroll in a Medicare sponsored plan. The subsidy to the sponsor will equal 28% of the gross covered retiree's prescription drug costs minus a \$250 deductible not to exceed a total drug cost of \$5,000. The state will receive this subsidy beginning in FY 06 based on the gross prescription costs it pays on behalf of retired teachers and state employees as long as it continues to provide this benefit. At this time those costs are not known but will be part of an updated report to be provided at the end of the 2004 session of the Connecticut General Assembly.

## **APPENDIX 1**

### **MEDICARE: GENERAL INFORMATION**

#### **Who is Eligible?**

Medicare helps seniors and younger disabled people pay for hospital stays and doctors' and other medical services. People become eligible for Medicare when they turn age 65 if they or their spouses worked for at least 40 quarters (10 years) and paid Social Security and Medicare payroll taxes while working or if they receive Railroad Retirement benefits. Younger disabled people who have received Social Security or Railroad Retirement disability payments for 24 months are eligible, as are people (as soon as they are diagnosed) with Lou Gehrig's disease or end-stage renal disease (permanent kidney failure that requires dialysis or a transplant).

Although people can choose early retirement and receive a lower Social Security monthly payment at age 62, Medicare coverage begins only at age 65 for those who are not disabled. People do not have to be citizens to qualify; legal immigrants who are permanent residents can qualify if they or their spouses have worked and paid payroll taxes for the required period.

The Medicare program has two parts: Part A (hospital insurance) and Part B (supplemental medical insurance, which pays for doctors' bills and other outpatient services). People who qualify can choose to participate in one or both parts. The vast majority choose both, but a small number of people are enrolled only in one part. Most people paid for Part A through their payroll taxes while they were working. People who did not pay Medicare taxes when they were working may under some circumstances be able to buy into Part A by paying premiums. Part B is paid for partly by a monthly premium that the subscriber pays after retirement and partly by general tax revenues. For 2004, the Part B premium is \$66.60 a month.

Eligibility does not depend on a person's income or assets, and benefits are the same for everyone, regardless of income or wealth. (Under the new federal prescription drug legislation, however, prescription benefits will vary depending on people's financial situation, and Part B premiums will increase for higher-income beneficiaries.)

## **Who is Not Eligible?**

Most, but not all, seniors participate in Medicare. But the following groups are generally not eligible :

1. people who have never worked or did not work long enough and do not have spouses who worked;
2. some older federal retirees with no other employment (those hired after January 1, 1983 must pay Medicare taxes and, when they retire and reach age 65, are eligible for Medicare benefits which are coordinated with the federal employees' health benefits);
3. teachers hired before March 31, 1986, who do not participate in Medicare unless they have had some other employment that required them to pay into Social Security or are eligible through their spouse's employment (teachers hired after that date must pay Medicare payroll taxes and are eligible for Medicare);
4. older state, municipal, and state college employees who retired before these groups became subject to Social Security and Medicare payroll taxes unless they or their spouses also had other qualifying employment; and
5. illegal immigrants.

## **What Medicare Pays For**

Medicare pays only part of hospital and medical bills after the patient meets a deductible. The benefits outlined below apply to the "original Medicare plan," also known as "fee-for-service," which permits the patient to go to any hospital or doctor who then bills Medicare for part of the Medicare-approved fee for the service performed. The patient is responsible for the rest.

*Part A.* Part A pays for hospital stays, inpatient mental health care, skilled nursing home care after a related three-day hospital stay (but not merely custodial care), part-time or intermittent home health care associated with an injury or illness, hospice care, and blood.

For each benefit period in 2004, patients must pay a deductible of \$876 for a hospital stay of one to 60 days. They must pay daily copayments for stays over 60 days, up to a total of \$219 per day for days 61-90 of a hospital stay and \$438 per day for days 91-150 of a hospital stay (Lifetime Reserve Days). Patients must pay all costs for each day beyond 150 days. A benefit period starts when the patient enters a hospital or nursing home and ends when he has been discharged for at least 60 days; the next time he enters the hospital or nursing home a new benefit period starts, requiring the same deductibles and co-pays.

For each benefit period in 2004, Medicare pays the full cost for the first 20 days in a skilled nursing home. Then the patient must pay \$109.50 per day for days 21 through 100, and the total cost after that. Medicare-approved home health care requires no copayment from the patient.

*Part B.* Part B pays for doctor's bills, outpatient hospital care, laboratory and diagnostic tests; physical therapy, occupational therapy, home health care, durable medical equipment, supplies, and other medical services not covered by Part A.

Besides the \$66.60 monthly premium, which is deducted from their Social Security benefits, Part B participants must pay a \$100 annual deductible and then 20% coinsurance on physician charges and most other Medicare-approved services.

Medicare does not cover some expenses at all or only minimally. While it covers prescription drugs that have to be administered in a hospital, nursing home, or doctor's office, until passage of H.R. 1 it did not generally cover outpatient prescription drugs (except for some limited outpatient cancer drugs). Medicare also does not cover physician charges above the amount Medicare approves, hospital stays over 150 days, and most long-term custodial care services. It does not cover dental care, eyeglasses, or hearing aids. It typically pays for only medically necessary procedures and not checkups or preventive care, although the program has added a number of screening tests in the last several years and H.R. 1 allows payment for certain checkups and more prevention and screening.

PL 108-173 increases the Part B premium for higher income participants phased in over five years starting in 2007. It also increases the Part B deductible from \$100 to \$110 in 2005 and starts indexing it to inflation in 2006.

## **APPENDIX 2**

### **DUALLY-ELIGIBLE**

#### **Who Are They?**

The new law provides assistance to individuals who are considered "dually eligible," meaning they are eligible for both Medicare and Medicaid. Once someone is deemed dually eligible, she is then determined to be eligible for either full Medicaid coverage (which essentially provides "wrap around" coverage for things that Medicare does not cover, such as prescriptions, as well as cost sharing assistance) or for limited assistance with meeting Medicare's cost sharing requirements, including premiums.

There are a number of different paths or Medicaid coverage groups through which individuals get this dual coverage, depending on their income and other circumstances. Table 1 depicts the most common Medicaid eligibility options that offer full Medicaid wrap around coverage. Table 2 lists the Medicaid coverage groups that provide more limited, cost sharing assistance (e.g., Medicare Part B premiums).

TABLE 1. FULL MEDICAID ELIGIBILITY FOR MEDICARE BENEFICIARIES

<b>Category</b>	<b>Mandatory or Optional</b>	<b>Income Limit</b>	<b>Asset Limit</b>	<b>Medicaid Coverage</b>
<b><i>SSI Cash Assistance Related (people age 65 and older only) [1]</i></b>	Mandatory	Generally 74% of the FPL for individuals and 82% for couple	\$2,000 for individual; \$3,000 for couple	Pays for services Medicare does not or “wrap-around” coverage, including prescription drugs and long term care, as well as Medicare Part A and B cost sharing
<b><i>State Supplement</i></b>	Mandatory	300% of maximum SSI benefit (\$1,692 for individual in 2004)	\$1,600 for individual; \$2,400 for couple	Same as above
<b><i>Poverty-Related [2]</i></b>	Optional	Up to 100% of FPL	\$2,000 and \$3,000	Same as above
<b><i>Medically Needy [1]</i></b>	Optional	Individuals who spend down their incomes to specific state levels	Same as limits in SSI program	Wrap around, but may be more limited than SSI group.
<b><i>Medicaid for Employed Disabled</i></b>	Optional	Up to \$75,000	Varies by state [3]	Same as above
<b><i>Special Income Rules for Nursing Home Residents</i></b>	Optional	Individuals living in institutions with incomes up to 300% of SSI limit	\$2,000 and \$3,000	Same as above

<b>Home- and Community-Based Service Waivers</b>	Optional	Individuals who would be eligible if they resided in an institution, unless they use special income rules	See income rules	Same as above, except cost sharing only if income is below threshold
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Source: Kaiser Commission on Medicaid and the Uninsured (2003)

[1] Federal law allows states to set financial eligibility criteria that are more restrictive than those set for the SSI program. In Connecticut, the income and asset limits are the same for individuals applying for Medicaid based on SSI or medical need.

The income limit, which does not change as it is tied to the cash assistance benefit in the Temporary Family Assistance (TFA) program, is \$476 for a single person living in the community. (These individuals can have income up to \$659 because the state disregards the first \$183 of unearned income.)

[2] At least 11 states have exercised this coverage option. Connecticut is not one of them.

[3] In Connecticut, the asset limit for eligibility is \$10,000 for individuals and \$15,000 for married couples.

TABLE 2. MEDICAID PAYS MEDICARE COST SHARING [1]

<b>Medicaid Coverage Group</b>	<b>Income Limits</b>	<b>Asset Limits</b>	<b>Medicaid Benefit</b>
<b>Qualified Medicare Beneficiary</b>	Up to 100% of FPL	\$4,000 for individuals, \$6,000 for couples	Medicaid pays Medicare premiums, deductibles, and co-payments [2]
<b>Specified Low-Income Medicare Beneficiaries</b>	Between 100% and 120% of FPL	Same as above	Medicaid pays Medicare Part B premiums.
<b>Qualified Working Disabled Individuals</b>	Working disabled individuals with incomes up to 200% of FPL	Same as above	Medicaid pays Medicare Part A premiums
<b>Qualifying Individual</b>	Between 120% and 135% of the FPL	Same as above	Medicaid pays Medicare Part B premium. (Federally funded, no state match.)

Source: Kaiser Commission on Medicaid and the Uninsured (2003)

[1] The state must cover the first three groups. The last group is optional.

[2] In Connecticut, Medicaid pays for premiums and deductibles. It generally does not pay the 20% co-payment for Part B services.

### **Appendix 3**

#### **Staff on this project:**

Spencer Cain, OFA  
Saul Spigel, OLR  
Joan Soulsby, OFA  
Robin Cohen, OLR  
Helga Niesz, OLR  
Neil Ayers, OFA