THE HENRY J. KAISER FAMILY FOUNDATION

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Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), makes a fundamental change in federal policy affecting over 6 million impoverished seniors and people with disabilities who are enrolled in both Medicare and Medicaid (i.e, the "dual eligibles"). The law adds an outpatient prescription drug benefit to the Medicare program through Part D plans, effective January 1, 2006. On that same day, the new law terminates federally-funded Medicaid prescription drug coverage for all dual eligibles, regardless of whether they have obtained coverage through a Part D plan, and regardless of whether their Part D plan's coverage is as broad as their state's Medicaid coverage. The following questions and answers are designed to provide a more detailed explanation of this change in policy, as well as explore its implications for the individuals affected by it.

In preparing the following questions and answers, the Kaiser Commission on Medicaid and the Uninsured relied on a thorough review of the new Medicare law, as well as consultations with individuals who were active in framing the legislation. In some cases, however, the legislative language and its implications are unclear. The answers below represent the Commission's best judgment as to the meaning of the legislative language. The authoritative interpretation, however, will be that of the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS).

1. Who are the dual eligibles?

Medicaid plays a key role in filling in gaps in Medicare coverage for more than 7 million low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. For 6.1 million of these dual eligibles, Medicaid covers prescription drugs, nursing home and other long-term care services, and health care services not provided by Medicare, as well as paying for their Medicare premiums and cost-sharing. These "full-benefit" dual eligible individuals, as they are called by the new Medicare law, are the "dual eligibles" discussed in these questions and answers. Overall, dual eligibles account for one in seven (15 percent) of Medicare beneficiaries. By 2006, the Congressional Budget Office projects that there will be 6.4 million dual eligibles with full Medicaid coverage.

There are one million other low-income elderly or disabled Medicare beneficiaries who also receive assistance from Medicaid. They are not, however, entitled to Medicaid prescription drug, nursing home, and other benefits. Instead, they receive assistance only with their Medicare premium and cost-sharing obligations. In general, these dual eligible

individuals are not as poor as the "full benefit" dual eligibles.[i] This population is not discussed in these Qs & As because they are not currently entitled to Medicaid prescription drug coverage; the new Medicare law's termination of such coverage will therefore have no effect on them.

Since seniors and people with disabilities generally must have income well below the poverty line and minimal assets to qualify for Medicaid, dual eligibles are much poorer than other Medicare beneficiaries. They also tend to have far more extensive health care needs than other Medicare beneficiaries.

- More than 70 percent of dual eligibles have annual incomes below $10,000 compared to 13 percent of all other Medicare beneficiaries.
- Dual eligibles are more than twice as likely to be in fair or poor health as other Medicare beneficiaries (52 percent versus 24 percent).
- Nearly a quarter of dual eligibles are in long-term care facilities compared to two percent of other Medicare beneficiaries.
- Dual eligibles are more than twice as likely to have Alzheimer's (6 percent versus 3 percent), as well as substantially more likely to have diabetes (24 percent versus 17 percent) and to have suffered a stroke (14 percent versus 11 percent) than other Medicare beneficiaries.

2. How many dual eligibles are there in each state?

Table 1 provides information on the number of dual eligibles in each state. As it illustrates, the number of Medicare beneficiaries who also are covered by Medicaid ranges from 6,000 in Wyoming to more than 900,000 in California. The state-by-state variation in the number of Medicare beneficiaries also enrolled in Medicaid is due to obvious factors such as the size of the state's elderly population and the extent to which its Medicare beneficiaries are impoverished, as well as to wide variation across states in the degree to which they have expanded Medicaid eligibility for seniors and people with disabilities beyond federal minimum standards.

3. What kind of prescription drug coverage is currently available to dual eligibles in Medicaid?

The Medicaid prescription drug benefit is designed for the impoverished and often sickly population it serves, providing beneficiaries with the full range of drugs that they need with little or no co-payment.[ii] As a result, the prescription drug coverage provided to seniors through Medicaid has compared favorably to coverage provided through alternative sources, although there is significant variability across states. For example, a 2001 survey of seniors conducted in eight states found that low-income seniors with Medicaid prescription drug coverage reported lower out-of-pocket prescription costs than seniors with prescription drug coverage through employer-based coverage, Medi-gap policies, HMO plans with drug benefits, and state pharmacy assistance coverage.[iii] These low-income seniors also reported skipping medication at rates similar to those of seniors with employer coverage, but otherwise were less likely to skip medications than seniors

with coverage from other sources. The same study also found that there was tremendous variability by state in drug spending and cost-related skipping of medications among seniors with Medicaid.

Array of Drugs Covered in Medicaid

Under federal law, states that elect to provide prescription drugs in their Medicaid programs must cover all FDA-approved drugs of every manufacturer that has entered into an agreement with the Secretary of Health and Human Services to pay rebates to states for the products they purchase.[iv] States have a number of tools at their disposal to control the utilization of prescription drugs, including the option to impose prior authorization requirements, to charge nominal co-payments, and to limit (within reason) the number of prescriptions. However, states cannot simply deny coverage for a particular drug product of a participating manufacturer when that drug is medically necessary.

Cost-Sharing Requirements in Medicaid

When providing prescription drugs to Medicaid beneficiaries, states are limited to charging "nominal" co-payments (and some groups of beneficiaries, such as nursing home residents, are fully exempt from co-payments). A "nominal" co-payment has been defined in regulation as ranging from 50 cents to $3.00, depending upon the cost of the Medicaid item or service. Providers are not allowed to deny services to Medicaid beneficiaries if they are unable to make a co-payment. As a result, the imposition of co-payments on low-income Medicaid beneficiaries for prescription drugs is often the functional equivalent of a reduction in reimbursement to the pharmacist.

Recent Trends

In recent years, a number of states have been compelled by fiscal problems and rising prescription drug costs to cut back on the scope of prescription drug coverage in Medicaid. They have done so by requiring prior authorization before paying for a prescription and by increasing beneficiary co-payments (within the nominal limitations established by federal law).[v] Some states also impose limits on the number of prescriptions that Medicaid beneficiaries can fill each month, with the limits ranging from three to eight prescriptions per month depending on the state (e.g., Georgia, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, and Texas).[vi] As a result of these changes, there now is more variation than ever across states in the scope of the Medicaid prescription drug benefit. In many states, however, it remains relatively comprehensive.

4. What happens to the Medicaid prescription drug coverage of dual eligibles under the new Medicare law?

On January 1, 2006, dual eligibles, like other Medicare beneficiaries, will become entitled to receive coverage for outpatient prescription drugs by enrolling in a Medicare Part D plan. At the same time, these 6 million individuals will lose their Medicaid

prescription drug coverage. Specifically, as of that date, states will no longer be able to receive federal Medicaid matching funds to provide any drugs that could be covered by a Medicare Part D plan to dual eligibles with Medicaid benefits.[vii] Instead, dual eligibles are expected to secure prescription drug coverage through Medicare Part D plans. Note, however, that the bar on federal matching payments for Medicaid prescription drugs extends to all dual eligibles who *could* enroll in a Medicare Part D plan even if they have not yet done so. As a result, it is possible that some dual eligibles could end up with no prescription drug coverage for a period of time after losing their Medicaid-financed prescription drug coverage.

The bar on using federal matching funds to provide Medicaid prescription drug coverage extends to all "full benefit" dual eligibles, whether they are covered as a result of federal Medicaid requirements or at state option.[viii] Some examples of the groups of Medicaid beneficiaries who will no longer qualify for federally-financed prescription drug coverage if they are on Medicare include:

- Supplemental Security Income (SSI) recipients
- Beneficiaries covered under the state option to expand coverage for seniors and/or the disabled to100 percent of the poverty line
- Nursing home residents and others who qualify for Medicaid because their medical bills cause them to "spend down" to eligibility under a state's medically needy program
- Nursing home residents and others covered under the state option to extend Medicaid eligibility for institutionalized individuals up to 300% of the SSI payment standard
- Beneficiaries receiving home- and community-based services at state option

5. Do dual eligibles lose their Medicaid drug coverage even if they are not enrolled in a Medicare Part D plan?

As of January 1, 2006, states cannot provide federally-financed prescription drug coverage to dual eligibles even if those individuals are not yet enrolled in a Medicare Part D plan. By the same token, dual eligibles do not have the choice to remain with their current Medicaid coverage instead of signing up for a Medicare Part D plan. They do, however, have the choice of whether to enroll in a Part D plan and, if enrolled, can elect to drop out of or switch their Part D coverage.

The new Medicare law directs the Secretary of HHS to develop procedures for enrolling dual eligibles in a Part D plan for which a full premium subsidy is available if they do not do so on their own. In areas where there is more than one Part D plan for which a full subsidy is available, the Secretary is directed to randomly assign dual eligibles among such plans. The legislation does not provide any timeframe by which the Secretary's procedures must provide for the enrollment of dual eligibles in Part D plans. Nor does it provide any mechanism to enable the Secretary to identify the dual eligibles in need of such coverage. The legislation does not give states any direct authority to ensure that dual eligibles are enrolled in Part D plans. As a result, it is possible that some dual eligibles will end up without any drug coverage, at least for a temporary period of time.

6. What kind of drug coverage will be available to dual eligibles through Medicare Part D plans?

Like other Medicare beneficiaries, dual eligibles have a choice of receiving their drug coverage through private stand-alone drug-only plans or through "Medicare Advantage" plans that offer a comprehensive array of Medicare benefits, including prescription drug coverage. (For purposes of these Qs and As, the term "Part D plans" is used to refer to both the stand-alone drug plans and Medicare Advantage plans.)

Array of Drugs Covered. The array of drugs covered by a dual eligible's Part D plan will depend on the policies of the plan in which he or she happens to enroll. Although they must follow some rules if they want to establish formularies, Part D plans have broad flexibility under the new law to determine the array of drugs that they want to cover. They are explicitly authorized to limit to two the number of drugs that they cover in any given therapeutic class. Each Part D plan – rather than the Secretary or an external private organization – may define what constitutes a therapeutic class for purposes of complying with this requirement.

Right to Appeal for Coverage of a Non-Covered Drug. All Part D plan enrollees, including dual eligibles, will have the right to ask their Part D plans to reconsider a decision to deny a prescription drug that is on the plan's formulary. In the case of "tiered" formularies – i.e. where a Part D plan charges lower cost-sharing for preferred drugs and higher cost-sharing for non-preferred drugs – plan enrollees may request an exception in certain circumstances. Finally, plan enrollees will also be able to appeal the denial of payment for a drug that is not on the plan's formulary if the prescribing physician determines that none of the drugs on the formulary would be as effective for the individual as the nonformulary drug or would have adverse side effects. In some circumstances, enrollees may be able to appeal the plan's decision to the Secretary and ultimately to the federal courts. However, it is not clear how well these appeals procedures will work for dual eligibles.

The Secretary is directed by the law to develop such procedures to operate in a manner similar to Medicare + Choice appeals procedures. Under Medicare + Choice procedures, the right to a hearing before the Secretary is available only to Part D plan enrollees with disputed claims of $100 or more, while the right to judicial review is limited to claims involving $1,000 or more. The Medicare + Choice appeals process also includes provisions for expedited appeal decisions in cases of emergency that generally call for emergency appeals to be decided within 72 hours. It is unclear whether individuals who appeal a denial of a drug that is not on the Part D plan's formulary have a right to an expedited decision, no matter how urgent the situation. In contrast to the current Medicare + Choice procedures, the new legislation specifically bars doctors from pursuing appeals before the Secretary or the courts on behalf of their patients. Given their limited financial resources and (in many cases) physical and cognitive impairments, dual eligibles may find it particularly difficult to navigate the appeals process by themselves.

7. How much will dual eligibles have to pay for covered prescriptions under Medicare Part D?

As discussed above, dual eligibles that require a drug that is not covered by the Part D plan in which they enroll will have to pay the entire cost of the drug themselves. With respect to drugs that are covered by the Part D plan, however, the new legislation will offer substantial assistance with cost-sharing obligations to dual eligibles and other qualified low-income Medicare beneficiaries. More specifically, the new law establishes a low-income subsidy program that will make cost-sharing assistance available to dual eligibles is as follows:

- **No deductible and no premium for enrolling in an average or low-cost plan.** Medicare will pay the Part D deductible on behalf of all dual eligibles, as well as their premiums if they enroll in an average or low-cost Part D plan. (If a dual eligible wants to enroll in a Part D plan that charges a premium in excess of the average for a region, the dual eligible must pay the difference in premium costs out of his or her own pocket.) The deductible and premium subsidy are available to *all* "full-benefit" dual eligibles, not just those who would otherwise be eligible for the new law's low-income subsidy program due to their income or assets. For example, individuals who "spend down" to Medicaid eligibility after their medical bills are taken into account are eligible for the new low-income subsidy program even if their income exceeds the eligibility threshold applied under the subsidy program to Medicare beneficiaries who are not dual eligibles.

- **Special assistance with cost-sharing obligations (i.e., no "doughnut hole" for dual eligibles)**. The low-income subsidy program also will provide extensive assistance with all of the dual eligibles' prescription drug costs, but only as long as they use drugs covered by their particular Part D plan. Unlike Medicare beneficiaries who are ineligible for the subsidy program, dual eligibles (and others who qualify for the low-income subsidy program) will not have to pay for 100 percent of their drug costs once they exceed an initial limit of $2,250 until their out-of-pocket spending reaches a catastrophic level. In other words, dual eligibles do not face a "doughnut hole." Instead, the co-payment obligations faced by dual eligibles are limited to the following:

    - *Dual eligibles residing in nursing homes or other institutions*: Since they already must dedicate all but a small share of their income each month to the cost of their nursing home care, dual eligibles residing in institutions are fully exempt from Part D cost-sharing obligations.[ix]

    - *Dual eligibles with income up to 100 percent of poverty not residing in institutions*: For dual eligibles with income at or below 100 percent of the federal poverty level ($8,980 per individual or $12,120 per couple in 2003), Part D co-payments are set at no more than $1 per generic drug and

$3 per brand name drug in 2006.[x] These co-payment obligations will increase over time with inflation, as measured by the Consumer Price Index. The majority of dual eligibles are likely to fall into this category and to face these co-payment obligations.

- *Dual eligibles with income above 100 percent of poverty (not residing in institutions)*: Dual eligibles with income above 100 percent of the poverty level not residing in institutions will pay up to $2 per generic drug and $5 per brand name drug in 2006.[xi] These co-payment amounts will be indexed over time to growth in per capita Part D drug costs. The individuals subject to these cost-sharing requirements are likely to include seniors or individuals with disabilities living in the community with high medical bills that qualify them for Medicaid eligibility.

The current Medicaid rule that prohibits providers from denying prescriptions to individuals who cannot meet a co-payment requirement will not apply to dual eligibles enrolled in Part D plans. Thus, if a dual eligible is unable to meet a Part D co-payment, he or she can be denied the prescription until the co-payment requirement is met.

8. Can states supplement the Medicare Part D benefit for dual eligibles if it turns out to be narrower than Medicaid prescription drug coverage?

Under current law, Medicare is primary payor to Medicaid. That is, if a dual eligible receives a service that is covered by both Medicare and Medicaid, Medicare will pay first; once Medicare coverage ends, then Medicaid coverage begins. For example, currently Medicare Part B covers some drugs, like chemotherapy and immunosuppressants, that are administered directly by physicians. In the case of dual eligibles, Medicare pays first, Medicaid pays some or all of the 20 percent co-insurance, and Medicaid pays for all covered outpatient drugs that are not physician administered and for which Medicare does not now pay.

The new Medicare law fundamentally alters this relationship. With one narrow exception, it bars states from using federal Medicaid matching funds to supplement the prescription drug benefit offered by Part D plans, whether by filling in cost-sharing or paying for uncovered drugs.[xii] A state could elect to use state general revenue funds to supplement the Part D benefit for dual eligibles. However, it is not obligated to do so and may be reluctant to take on this cost in the absence of federal Medicaid matching funds.

9. How will dual eligibles be informed of the choices they will face under the new Medicare law?

Under the new law, the Secretary of HHS is responsible for establishing a process for the enrollment of Medicare beneficiaries, including dual eligibles, in Part D plans. This process is to include broad dissemination to beneficiaries by the Secretary of comparative information about different Part D plans, including premiums charged, benefits covered,

and quality and performance. The process also contemplates the use of marketing materials by Part D plans; these materials are subject to prior review by the Secretary to ensure that they are not materially inaccurate or misleading. The Secretary is authorized (but not required) to provide information to Part D plans about eligible beneficiaries in order to facilitate marketing by the plans and enrollment of individuals into the plans. And, as discussed above, the Secretary is required to establish a default enrollment mechanism for dual eligibles who do not enroll in a Part D plan.

Responsibility for determining the eligibility of Medicare beneficiaries for premium and cost-sharing subsidies is assigned jointly to the states and the Social Security Administration (SSA). SSA is also directed to conduct outreach efforts to identify Medicare beneficiaries who may be eligible for the low-income subsidy program and to notify them of the program. However, no agency at the federal or state level is specifically charged with the responsibility for educating dual eligibles about the choices they face and assisting them in making those choices in an informed manner. Whether dual eligibles are effectively informed of the choices they have will depend on whether the Secretary of HHS, the Commissioner of Social Security, and the individual states work to achieve this objective and coordinate their efforts to do so.

10. Will dual eligibles be better or worse off as a result of the new Medicare law?

Even more than other Medicare beneficiaries, dual eligibles are likely to struggle with the implications of the new Medicare law and, perhaps, to be overwhelmed by the array of complex choices before them. As a result, the decision to eliminate federal financing for Medicaid prescription drug coverage of dual enrollees on January 1, 2006 – whether or not they are successfully enrolled in a Part D plan – could create some significant hardship for dual eligibles as they seek to navigate the new system.

Assuming that most dual eligibles do eventually enroll in Part D plans, whether they will be better or worse off with Part D will depend heavily on the response of the state in which they happen to reside, the array of drugs that are covered under the Part D plan in which they can afford to enroll, and their individual circumstances. More specifically, there are two aspects to the prescription drug coverage provided by Medicare Part D plans that are likely to determine whether dual eligibles have prescription drug coverage adequate to their needs:

- **Array of drugs covered:** In many circumstances, the array of drugs covered by Part D plans may fall short of those covered under Medicaid. This is likely to be particularly true of the Part D plans in which dual eligibles can afford to enroll given that they receive a premium subsidy only for the cost of enrolling in plans with average or below-average premiums. While Medicaid programs generally are required to cover all medically necessary drugs, Part D plans have far more flexibility to limit the array of drugs that they will cover. Although beneficiaries can appeal a decision by their Part D plan to deny coverage of a particular drug, it

is not yet clear how well these appeals procedures will work, particularly for dual eligibles with limited financial resources and, in many cases, physical or cognitive impairments.

- **Cost-sharing:** Medicaid co-payment requirements for dual eligibles in many states fall somewhat below the levels that most dual eligibles will face in 2006 when enrolled in a Medicare Part D plan. Currently, some 11 states do not impose any co-payment requirements on elderly and disabled Medicaid beneficiaries in need of prescription drugs and many others require co-payments that are more modest than will apply to dual eligibles under Part D. (Table 2 provides state-by-state information on the co-payment requirements that dual eligibles currently face under Medicaid versus the $1 per generic / $3 per brand name drug that will apply to most dual eligibles under Part D plans in 2006.) As a result, many dual eligibles are likely to find that their out-of-pocket costs for covered drugs increase when they enroll in Part D. Moreover, dual eligibles will have to pay for 100 percent of the cost of drugs that are not covered by their Part D plans. They also will no longer be protected by the Medicaid provision that requires pharmacists to fill the prescription of a beneficiary even if he or she cannot make a co-payment.

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[i] For an explanation of the categories of dual eligibles, see *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002, pp. 33-40.
[ii] This description of the Medicaid prescription drug benefit is taken from Andy Schneider and Linda Elam, *Medicaid: Purchasing Prescription Drugs*, Kaiser Commission on Medicaid and the Uninsured, January 2002.
[iii] Chart Pack issued by The Henry J. Kaiser Family Foundation, the Commonwealth Fund, and Tufts-New England Medical Center, *Seniors and Prescription Drugs, Findings from a 2001 Survey of Seniors in Eight States*, July 2002.
[iv] There are a limited number of classes of drugs that state Medicaid agencies can decide not to cover. These are: 1) anorexia, weight loss, or weight gain drugs; 2) fertility drugs; 3) drugs used for cosmetic purposes or to promote hair growth; 4) medicines used for the symptomatic relief of cough and colds; prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations); 5) over-the-counter drugs; 6) barbiturates; 7) benzodiazepines; and 8) tobacco cessation products.
[v] Vern Smith et al., *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003*, KCMU, January 2003.
[vi] KCMU Medicaid Drug Benefit Survey, prepared by Jeff Crowley with the Georgetown Institute for Health Policy Research for KCMU, forthcoming.

[vii] One exception is that states will be allowed to use Medicaid matching funds to provide classes of drugs that Part D plans are not allowed to cover. These are the classes of drugs – now covered under Medicaid at state option – described in endnote iii with the exception of tobacco cessation products.
[viii] The law does not address whether Medicare beneficiaries who currently secure prescription drug coverage under a Medicaid 1115 waiver are subject to the bar or not. This issue will need to be resolved by the Department of Health and Human Services.
[ix] Medicaid beneficiaries residing in institutions are allowed to keep a minimum of $30 each month for personal expenses such as haircuts and laundry. The remainder of beneficiaries' income is applied to the costs of care at the facility.
[x] The statute also requires Part D plans to apply the generic co-payment levels described in this section to a preferred multiple source drug.
[xi] The statute requires that all subsidy-eligible beneficiaries meet a resource test of either $6,000 or $10,000 for an individual ($9,000 or $20,000 for a couple); these resource limits are significantly higher than those that individuals must meet in order to qualify for full Medicaid benefits.
[xii] The one exception is that states can use Medicaid matching funds to provide classes of drugs that Part D plans are not allowed to cover. These are the classes of drugs – now covered under Medicaid at state option – described in endnote iii with the exception of tobacco cessation products.

Table 1

Dual Eligibles Enrollment by State, 2002

State	Dual Eligibles	Duals as a Share of… All Medicaid Enrollees	Duals as a Share of… Aged and Disabled Enrollees	Full Dual Eligibles	Full Duals as a Share of All Dual Eligibles*
United States	**7,200,000**	**14%**	**58%**	**6,126,000**	**85%**
Alabama	162,000	22%	59%	121,000	75%
Alaska	9,000	7%	53%	9,000	98%
Arizona	65,000	8%	49%	57,000	87%
Arkansas	121,000	21%	75%	98,000	81%
California	932,000	10%	58%	904,000	97%
Colorado	71,000	16%	61%	59,000	84%
Connecticut	83,000	17%	71%	76,000	92%
Delaware	15,000	10%	55%	9,000	64%
District of Columbia	19,000	11%	44%	17,000	90%
Florida	406,000	16%	56%	354,000	87%
Georgia	180,000	13%	51%	129,000	72%
Hawaii	27,000	11%	63%	26,000	96%
Idaho	12,000	7%	33%	10,000	80%
Illinois	221,000	11%	51%	171,000	77%
Indiana	125,000	14%	65%	103,000	83%
Iowa	67,000	19%	66%	55,000	82%
Kansas	46,000	15%	55%	39,000	85%
Kentucky	209,000	25%	73%	172,000	82%
Louisiana	142,000	15%	50%	109,000	77%
Maine	49,000	21%	64%	42,000	85%
Maryland	92,000	11%	51%	71,000	78%
Massachusetts	216,000	17%	61%	193,000	89%
Michigan	216,000	14%	54%	190,000	88%
Minnesota	103,000	15%	67%	92,000	90%
Mississippi	136,000	20%	58%	133,000	98%
Missouri	161,000	14%	64%	138,000	86%
Montana	16,000	14%	56%	15,000	93%
Nebraska	37,000	14%	68%	35,000	93%
Nevada	29,000	16%	60%	18,000	63%
New Hampshire	20,000	16%	72%	19,000	93%
New Jersey	171,000	18%	59%	140,000	82%
New Mexico	39,000	8%	52%	27,000	69%
New York	605,000	16%	54%	537,000	89%
North Carolina	272,000	19%	66%	225,000	83%
North Dakota	15,000	21%	75%	13,000	86%
Ohio	219,000	13%	51%	179,000	82%
Oklahoma	94,000	14%	65%	77,000	82%
Oregon	68,000	10%	63%	56,000	82%
Pennsylvania	335,000	18%	54%	306,000	91%
Rhode Island	33,000	16%	59%	27,000	82%
South Carolina	120,000	13%	58%	117,000	97%
South Dakota	18,000	16%	65%	14,000	78%
Tennessee	248,000	14%	56%	191,000	77%
Texas	489,000	16%	66%	363,000	74%
Utah	19,000	8%	49%	17,000	89%
Vermont	28,000	17%	73%	22,000	77%
Virginia	149,000	19%	62%	101,000	68%
Washington	107,000	10%	53%	93,000	87%
West Virginia	51,000	13%	41%	36,000	72%
Wisconsin	123,000	17%	60%	115,000	93%
Wyoming	9,000	14%	62%	6,000	72%

Source: Urban Institute estimates based on data from MSIS.

* The percentages of full duals as a share of all duals are based on unrounded estimates of dual eligibles and "full" dual eligibles, and may differ somewhat from calculations that use the rounded estimates shown in this table.

Table 2: Medicaid Prescription Drug Co-Payment Policies for Dual Eligibles Compared to Co-Payments That Will Apply to Most Dual Eligibles Under Medicare Part D*

State	No Co-payments in Medicaid for dual eligibles	Medicaid co-payments always fall below Part D levels	Medicaid co-payments are the same or higher than Part D levels	Medicaid co-payments may be higher or lower than Part D levels depending on circumstances	Co-payment policy
Alabama**					
Alaska				●	$2 per Rx
Arkansas				●	$0.50 per Rx under $10; $1 per $10-$25 Rx; $2 per $25.01-$50 Rx; $3 per Rx over $50
Arizona	●				
California		●			Voluntary $1 per Rx
Colorado			●		$3 per Rx, excluding individuals exceeding maximum annual co-pay of $150
Connecticut		●			$1 per Rx, excludes persons in nursing facility/chronic disease hospital
Delaware	●				
District of Columbia		●			$1 per Rx
Florida	●				
Georgia				●	$0.50 per PDL Rx; $0.50-$3 per non-PDL Rx depending on cost
Hawaii	●				
Idaho	●				
Illinois			●		$1 per generic Rx; $3 per brand Rx
Indiana					
Iowa		●			$1 per Rx
Kansas				●	35% of enrollees have co-pay of $3 per Rx
Kentucky		●			$1 per Rx
Louisiana				●	$0.50-$3 per Rx depending on cost
Maine				●	$0.50-$3 per Rx depending on cost and brand/generic status
Maryland		●			$1 per generic Rx; $2 per brand Rx
Massachusetts				●	$2 per Rx
Michigan		●			$1 per Rx
Minnesota	●				
Mississippi			●		$1 per generic Rx; $3 per brand Rx
Missouri	●				
Montana				●	Up to $5 per Rx to a maximum of $25 per month
Nebraska				●	$2 per Rx
Nevada					
New Hampshire		●			$0.50 per generic Rx; $1 per brand Rx
New Jersey	●				
New Mexico	●				
New York		●			$0.50 per generic Rx and OTCs; $2 per brand Rx, excludes special needs (?)
North Carolina			●		$1 per generic Rx; $3 per brand Rx
North Dakota		●			$3 per brand Rx
Ohio					
Oklahoma				●	$1 per Rx under $30; $2 per Rx $30 and over
Oregon					
Pennsylvania		●			$1 per Rx
Rhode Island					
South Carolina				●	$2 per Rx
South Dakota				●	$2 per Rx unless in long-term care
Tennessee					
Texas	●				
Utah			●		$3 per Rx up to $15 per month
Vermont				●	$1 per Rx under $30; $2 per Rx $30-$50; $3 per Rx $50 and over
Virginia		●			$1 per generic Rx; $2 per brand Rx
Washington	●				
West Virginia				●	$0.50 per Rx under $10; $1 per $10-$25 Rx; $2 per Rx over $25
Wisconsin		●			$0.50 per OTC; $1 per legend (brand) Rx
Wyoming					
Column Totals	**11 states**	**13 states**	**5 states**	**14 states**	

Notes: *Under Part D, cost-sharing for dual eligibles will depend on their income and institutionalization status. For purposes of this table, KCMU compared the co-payment charges that currently apply under Medicaid to seniors and people with disabilities to those that will apply to noninstitutionalized dual eligibles with income below 100% of poverty under Part D in 2006 (i.e., $1 per generic prescription or preferred multiple source drug and $3 per brand name prescription. **Information not available for states shaded in gray.

SOURCE: Forthcoming KCMU report, *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003*.