kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

June 2004

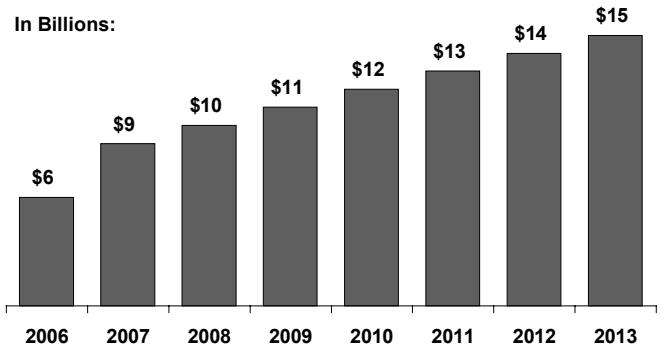
The "Clawback:" State Financing of Medicare Drug Coverage

by Andy Schneider

On January 1, 2006, a new chapter in federal-state fiscal relations will begin. For the first time since the enactment of the Medicare and Medicaid programs in 1965, a specific Medicare benefit will be financed in significant part by state payments. The benefit is the prescription drug coverage offered under the new Medicare Part D. January 1, 2006 is the date on which Part D is scheduled to start and on which the states will begin helping to pay for it. The Congressional Budget Office (CBO) estimates that over the first five years, states will pay $48 billion toward Part D coverage (Figure 1); this represents about 13 percent of the estimated $362 billion cost of the coverage and low-income subsidy over that period. These payments will constitute the largest single flow of funds from states to the federal government from 2006 onward.[1]

Figure 1

Projected State "Clawback" Payments, FY 2006-2013



SOURCE: CBO Estimate of the Effect of Federal Direct Spending and Revenues of Title I of the Conference Agreement for H.R. 1 (11/20/2003)

KAISER COMMISSION ON Medicaid and the Uninsured

The mechanism through which the states will help finance the new Medicare drug benefit is popularly known as the "clawback" (the statutory term is "phased-down State contribution"). In brief, the clawback is a monthly payment made by each state to the federal Medicare program beginning in January 2006. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles – i.e., low-income elderly or disabled individuals who are enrolled in both Medicare and Medicaid. As shown in Figure 1, state clawback payments are projected to increase from $6 billion in 2006 to $15 billion in 2013.

This Issue Brief will describe the origins of the clawback, the formula by which each state's clawback amount is calculated, and the clawback's implications for states and for low-income Medicare beneficiaries.

Origins of the Clawback

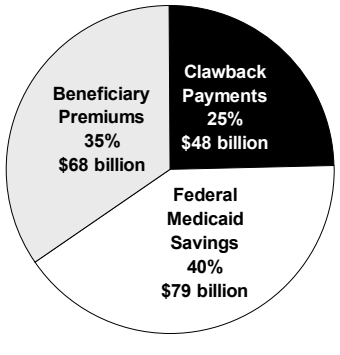
Currently, outpatient prescription drug coverage is provided to dual eligibles through Medicaid; states pay a share of the cost of this coverage. The state share varies from state to state, ranging from 50 percent to 23 percent (on average, 43 percent). An estimated 6.1 million low-income Medicare beneficiaries were enrolled in Medicaid in 2002 for full coverage, including nursing home care and outpatient prescription drugs.[2] States spent an estimated $5.6 billion of their own funds that year on prescription drug coverage for dual eligibles (total federal and state spending was $13.2 billion). The $5.6 billion in state spending represented about 6 percent of all state dollars spent on Medicaid [3] and about half of all state dollars spent on drug coverage for all Medicaid beneficiaries.[4]

Effective January 2006, Medicare Part D, not Medicaid, will offer outpatient prescription drug coverage to dual eligibles. As of that date, federal Medicaid matching funds will no longer be available for the costs of outpatient prescription drugs for low-income Medicare beneficiaries. The state share of these costs – i.e., what $5.6 billion in 2002 would grow to be in 2006 – is the subject of the clawback. Rather than allowing states to keep their entire share of these costs and apply them to other purposes, the clawback provision requires that they pay most of their estimated savings to the Medicare program to help pay for Part D coverage for low-income beneficiaries. States are required to pay the federal government 90 percent of their estimated savings in calendar year 2006; over the following 9 years, this proportion is reduced to 75 percent. Thereafter, the proportion remains at 75 percent.

The clawback was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA was enacted under a budget constraint that allowed the expenditure of $400 billion over a 10-year period, net of offsetting savings and revenues. Neither the version of MMA passed by the House, nor that passed by the Senate, contained a clawback provision.[5] Instead, the clawback provision emerged from the House-Senate conference agreement.[6] To stay within the $400 billion constraint, the conferees relied, in part, on three offsets: (1) monthly premiums paid by beneficiaries opting to enroll in a Part D plan; (2) the federal share of the savings from terminating Medicaid drug coverage for dual eligibles; and (3) the state clawback payments. (The cost of the Part D program was also adjusted through the design of the coverage, the cost-sharing requirements, and the reach of the low-income subsidies, among other factors.) As shown in Figure 2, the clawback accounts for about one fourth of the estimated offsets over the first five years of implementation (2006-2010).

Figure 2

Offsets to Cost of Medicare Part D, 2006-2010



$195 Billion

SOURCE: CBO Estimate of the Effect of Federal Direct Spending and Revenues of Title I of the Conference Agreement for H.R. 1 (11/20/2003)

KAISER COMMISSION ON Medicaid and the Uninsured

Clawback Formula

Beginning in January 2006, each state participating in Medicaid is required to make a monthly payment to the federal government of a specified amount.[7] The monthly payment is to be deposited into the Medicare Prescription Drug Account in the Medicare Part B Trust Fund, from which the Part D and the low-income subsidy programs are funded. The manner in which the payment is made is to be specified by the Secretary of Health and Human Services (HHS).[8] The amount of each state's monthly payment is determined by the formula in Figure 3.

Figure 3: Formula for Determining Monthly State Clawback Payments

Monthly State Payment	=	1/12	X	Per Capita Expenditures (PCE)	X	Dual Eligibles (DE)	X	Phase-Down Percentage (PD%)
				State share of per capita Medicaid expenditures on prescription drugs covered under Part D for dual eligibles during 2003, trended forward		Number of dual eligibles enrolled in a Medicare Part D plan in the month for which payment is made		Phase-down percentage for the year specified in the statute (e.g., 90% in 2006)

For example, if, in January 2006, a state has 50,000 dual eligibles enrolled in Part D plans, and if its per capita Medicaid spending for prescription drugs for dual eligibles (2003 trended forward) is $1,000, then the state's payment amount for the month would be $3.75 million (Figure 4).

Figure 4: Hypothetical Example of Calculation of Monthly State Clawback Payment

$3.75 million	=	1/12	X	$1,000 (PCE)	X	50,000 (DE)	X	90% (PD%)

The statute specifies in some detail the method for computing each of these factors:

PCE: The per capita expenditure is the amount the state spends as its share of Medicaid per capita spending for covered Part D drugs for dual eligibles in calendar year 2003, increased by the average annual percent increase in per capita prescription drug spending nationally, for all populations, since 2003 (currently projected at 11.9% for 2003-2004, 11.3% for 2004-2005, and 11.1% for 2005-2006).[9] The state share is based on the state's federal matching rate for the month in which the payment is due. In calculating the state Medicaid per capita expenditures for prescription drugs for dual eligibles in calendar year 2003, the Secretary must include pharmacist dispensing fees, adjust for manufacturer rebates,[10] and exclude any expenditures for drugs not covered under Part D. In the case of states that enrolled dual eligibles in Medicaid managed care plans, the Secretary must estimate the actuarial value of prescription drug benefits provided to dual eligibles under such capitated arrangements.[11]

DE: The number of dual eligibles for the month is the number of Medicare beneficiaries who (1) are enrolled in a Part D plan or in an Medicare Advantage plan that offers prescription drug coverage (MA-PD) and (2) have been determined by the state to be eligible for full Medicaid benefits, not just subsidies for Medicare premiums and cost-sharing.[12]

PD%: The phase-down percentage for each year is set forth in the statute. It declines from 90 percent in calendar year 2006 to 75 percent in calendar year 2015 and thereafter (Table 1).[13]

Table 1:
Phase-Down Percentage (PD%)

CY 2006	90%
CY 2007	88 1/3%
CY 2008	86 2/3%
CY 2009	85%
CY 2010	83 1/3%
CY 2011	81 2/3%
CY 2012	80%
CY 2013	78 1/3%
CY 2014	76 2/3%
CY 2015 and thereafter	75%

To help states estimate their monthly payment amounts, the Secretary is required to notify each state of the state's PCE amount no later than October 15 prior to the start of the calendar year for which the PCE amount is to be used. (The states will then be able to apply their estimated monthly enrollment of dual eligibles and the phase-down percentage in order to estimate their monthly obligation.)

To ensure that states make the monthly payments, the statute requires that states pay interest on any unpaid amount. Any unpaid amount, plus interest, is to be offset "immediately" against the federal Medicaid matching funds the state would otherwise receive in the quarter in which the payment is due.[14]

While much of the formula is specified by statute, there remain important issues that must be clarified administratively by CMS, such as which drugs are covered under Part D. CMS has begun the process of collecting the enrollment and expenditure data necessary to calculate the 2003 PCE for each state and to revise current reporting systems to generate the monthly DE data needed starting in 2006.[15]

Implications for States

The clawback is only one of a number of provisions in MMA that affect states, ranging from new administrative responsibilities for the Part D low-income subsidy program to additional federal matching funds for disproportionate share hospital (DSH) payments to subsidies for state employee retirement benefits programs.[16] Of all these provisions, however, the clawback has the most significant fiscal and policy implications.

States are responsible for a portion of the cost of prescription drug coverage for dual eligibles, even though these beneficiaries are entitled to drug coverage through Medicare. The clawback establishes a watershed national policy precedent regarding responsibility for the health care costs of low-income Medicare beneficiaries. To the extent that those beneficiaries are eligible for and enrolled in a state's Medicaid program, the state is responsible for a portion of the cost of their prescription drug coverage, even though they are not receiving the coverage

through Medicaid but are instead entitled to that coverage through Medicare Part D. While the proportion for which the states are responsible declines somewhat over time, it does not phase out entirely, remaining at 75 percent after 2014. States can reduce the amount of their clawback payment in any given year by reducing the number of "optional" categories of dual eligibles they cover, but they must still make payments based on the number of beneficiaries in the "mandatory" categories of dual eligibles.[17] In short, the only way that states can completely absolve themselves of the responsibility for contributing toward the costs of Medicare prescription drug coverage for dual eligibles (other than persuading Congress to change the law) is to withdraw from the Medicaid program altogether – a highly unlikely occurrence.[18]

Under current law, states already make some payments on behalf of dual eligibles—states are required to pay their monthly Medicare Part B premiums. Rather than deducting the monthly Part B premium ($66.60 in 2004) from the Social Security check of a low-income, dually eligible Medicare beneficiary, the Medicare program relies on states to pay the premiums. States send these premium payments to the Medicare Part B Trust Fund; they receive federal Medicaid matching funds on these "Medicare buy-in" payments at their regular federal matching rate. This is a substantial state expenditure; in FY 2004, the state share of Medicare premiums for dual eligibles is estimated to be $2.8 billion.[19]

These state "buy-in" payments differ fundamentally from the clawback. First, the "buy-in" payment is designed to ensure that dual eligibles remain enrolled in Medicare Part B so that when Medicare and Medicaid cover the same service, such as a physician visit, Medicare pays first. (Enrollment in Part B is voluntary, and many low-income elderly or disabled individuals might well prefer to use the $66.60 per month for rent or food or other necessities.) The clawback payment, in contrast, has no effect on a Medicaid beneficiary's enrollment in Medicare generally or Medicare Part D in particular. In addition, the Medicare Part B premium that states pay on behalf of dual eligibles is set at 25 percent of the costs of the Part B program; as program costs rise, so does the Part B premium amount. In contrast, the clawback payment amount is determined by factors other than the growth in Medicare spending.

The clawback links state fiscal liability for Medicare Part D financing directly to federal budget policy. The second significant policy implication of the clawback for states is that these payments are now part of the Medicare Part D baseline for federal budget purposes.[20] This means that if Medicare Part D expenditures are higher than projected and Congress wishes to address the overrun, one of its options would be to increase state clawback payments (other options would include increasing beneficiary premiums or reducing the scope of Part D coverage). Conversely, if the states want Congress to change federal law to reduce or eliminate their clawback payments, this change would be treated as reducing revenues to the federal government and increasing the cost of Medicare Part D to the federal government. Should Congress decide to make this change, it would also have to decide whether to offset the loss of state clawback payments with other policy changes (e.g., increasing beneficiary premiums or reducing the scope of Part D coverage), or to simply allow the federal deficit to increase by the amount of the clawback payments foregone. State clawback payments are also a "dedicated Medicare financing source" for purposes of the annual Medicare Funding Warning, which provides for expedited Congressional consideration of legislation in the event general revenue funding for Medicare exceeds 45 percent of program outlays.[21] Should these procedures be

triggered, one option for reducing the share of federal general revenue contributions would be to increase state clawback payments.

The clawback formula may lead to inaccurate calculations of state savings. A third implication has to do with the potential inaccuracy of the clawback formula as a proxy for state savings resulting from the substitution of Medicare Part D for Medicaid drug coverage. As discussed above, the formula relies heavily on a per capita expenditure (PCE) amount that is determined largely by each state's Medicaid spending for outpatient prescription drugs for dual eligibles in calendar year 2003. Available state-by-state data for 2002 shows a wide variation in prescription drug spending per dual eligible, ranging from $375 in Tennessee to $1,371 in New Hampshire (Table 2).[22]

States that, for whatever reason, had high per capita drug spending on dual eligibles in calendar year 2003 would have their clawback amounts calculated each year using this high amount. The statute does not permit CMS to rebase the PCE amount for 2004 or 2005. Thus, a state that implemented prescription drug cost containment measures in 2003 or subsequent years could not reduce its PCE amount in 2006, even if it succeeded in reducing its per capita spending on Medicaid drugs for dual eligibles during 2004 or 2005. As a result, a state with high per capita drug spending in 2003 would be at a permanent disadvantage vis-à-vis a state that had a low per capita expenditure on prescription drugs for dual eligibles in that year. Moreover, this disadvantage would grow each year as the trend factor – the annual rate of increase in per capita national prescription drug spending on all populations – is applied.

The application of a uniform national trend factor creates another problem, regardless of whether a state's PCE amount for 2003 is high or low. If the rate of increase in a state's Medicaid drug spending on dual eligibles is less than the annual rate of increase in prescription drug spending nationally for all populations (currently compounding at 11 percent per year), then the clawback formula will eventually produce a payment amount that exceeds a state's actual savings from no longer covering prescription drugs for duals through its Medicaid program. In short, the more effective a state is in managing the costs of its prescription drug benefit in the future, the more likely it is that the state's clawback payments will exceed its savings from Medicare Part D coverage. Although the fiscal burden of this potential mismatch is somewhat mitigated by the application of the phase-down percentage (e.g., 90 percent in 2006, declining over time to 75 percent), the formula could nonetheless result in a monthly state payment obligation in excess of actual state savings. This could, in turn, present cash flow difficulties for some states, particularly in 2006, when a number of states will experience an increase in their state Medicaid matching percentage as a result of the normal updating of the federal matching formula.[23]

Table 2

"Full" Dual Eligible Enrollment and Prescription Drug Spending, by State, 2002

State	Enrollment: Full Dual Eligibles	Spending on "Full" Duals (millions): Total	Spending on "Full" Duals (millions): Prescribed Drugs	Prescribed Drugs as % of Total	State Per-Capita Spending on Prescribed Drugs for Full Duals
United States	6,126,000	$91,056	$13,177	14%	$918
Alabama	121,000	$1,349	$193	14%	$470
Alaska	9,000	$144	$24	17%	$1,122
Arizona	57,000	$765	$91	12%	$562
Arkansas	98,000	$1,010	$151	15%	$422
California	904,000	$8,290	$1,652	20%	$888
Colorado	59,000	$1,014	$137	14%	$1,162
Connecticut	76,000	$2,252	$201	9%	$1,322
Delaware	9,000	$236	$24	10%	$1,313
District of Columbia	17,000	$287	$29	10%	$504
Florida	354,000	$3,933	$937	24%	$1,153
Georgia	129,000	$1,622	$298	18%	$947
Hawaii	26,000	$250	$32	13%	$529
Idaho	10,000	$163	$28	17%	$799
Illinois	171,000	$2,976	$423	14%	$1,237
Indiana	103,000	$1,828	$301	16%	$1,110
Iowa	55,000	$911	$124	14%	$838
Kansas	39,000	$792	$109	14%	$1,110
Kentucky	172,000	$1,961	$418	21%	$730
Louisiana	109,000	$1,300	$252	19%	$687
Maine	42,000	$645	$106	16%	$843
Maryland	71,000	$1,368	$182	13%	$1,282
Massachusetts	193,000	$3,638	$408	11%	$1,058
Michigan	190,000	$1,891	$358	19%	$822
Minnesota	92,000	$2,194	$232	11%	$1,258
Mississippi	133,000	$1,092	$258	24%	$463
Missouri	138,000	$1,983	$408	21%	$1,152
Montana	15,000	$207	$33	16%	$591
Nebraska	35,000	$533	$82	15%	$949
Nevada	18,000	$208	$33	16%	$910
New Hampshire	19,000	$455	$52	11%	$1,371
New Jersey	140,000	$2,684	$381	14%	$1,359
New Mexico	27,000	$405	$47	12%	$466
New York	537,000	$15,217	$1,200	8%	$1,117
North Carolina	225,000	$2,824	$527	19%	$903
North Dakota	13,000	$272	$28	10%	$656
Ohio	179,000	$4,401	$496	11%	$1,142
Oklahoma	77,000	$869	$123	14%	$471
Oregon	56,000	$766	$156	20%	$1,134
Pennsylvania	306,000	$3,339	$554	17%	$822
Rhode Island	27,000	$715	$63	9%	$1,114
South Carolina	117,000	$1,199	$192	16%	$503
South Dakota	14,000	$240	$29	12%	$707
Tennessee	191,000	$2,058	$197	10%	$375
Texas	363,000	$4,956	$654	13%	$717
Utah	17,000	$263	$52	20%	$913
Vermont	22,000	$248	$58	23%	$977
Virginia	101,000	$1,450	$243	17%	$1,166
Washington	93,000	$1,007	$239	24%	$1,275
West Virginia	36,000	$634	$77	12%	$529
Wisconsin	115,000	$2,082	$274	13%	$988
Wyoming	6,000	$128	$15	12%	$956

Source: Kaiser Commission on Medicaid and the Uninsured estimates based on Urban Institute analysis of MSIS and Medicaid Financial Management Reports, as presented in Bruen and Holahan, *Shifting the Cost of Dual Eligibiles: Implications for States and the Federal Government* , The Kaiser Commission on Medicaid and the Uninsured, November 2003, available at http://www.kff.org/kcmu.

Implications for Low-income Medicare Beneficiaries

As noted by others, the substitution of Medicare Part D coverage for Medicaid prescription drug coverage will have major implications for the 7 million dual eligibles who will be affected when the law is implemented in 2006. There are issues relating to the ability of dual eligibles to navigate the complexity of Part D coverage, the adequacy of drug coverage under Part D in relation to Medicaid drug coverage, and the adequacy of the low-income subsidy program in protecting dual eligibles from excessive cost-sharing obligations.[24] The clawback poses issues for these beneficiaries as well.

States may have some funds available to expand or improve their Medicaid coverage for dual eligibles and other Medicaid beneficiaries. To the extent that the clawback leaves states with some savings, these state funds will be available (at state option) to purchase additional Medicaid services, upgrade Medicaid reimbursement, or otherwise improve Medicaid coverage for dual eligibles and other Medicaid beneficiaries. States are not, however, required to use any of their state fund savings remaining after the application of the clawback to fund their Medicaid programs.

Dual eligibles may face tightened Medicaid eligibility standards and/or more difficult enrollment or reenrollment procedures. The incentive inherent in the clawback formula is for states to limit or reduce the number of dual eligibles. Under the formula, the lower the number of dual eligibles in any month (i.e., the lower the DE value), the lower the monthly clawback amount the state owes. While Medicaid eligibility for some groups of low-income Medicare beneficiaries is mandatory for the states, in the case of others it is optional.[25] Not all states currently cover all of these optional eligibility groups.[26] States can reduce the value of DE – and therefore their monthly clawback payment amount – by foregoing expansions in eligibility, by slowing enrollment in existing eligibility groups, or by reducing the number of optional eligibility groups they now cover. On the other hand, reductions in the numbers of dual eligibles will also result in the loss of a state's federal Medicaid matching payments for the cost of Medicaid-covered nursing facility, personal care, and other long-term care services for these individuals.

The clawback formula, in and of itself, is unlikely to determine state Medicaid eligibility policy for dual eligibles. States are concerned about the access of their low-income elderly and disabled residents to needed health and long-term care services. However, the formula does increase the incentive for fiscally-strapped states to cut back on coverage for optional groups of costly dual eligibles. To the extent states respond to the formula's incentive, Medicare beneficiaries who now qualify for Medicaid through optional eligibility pathways may find that enrollment and reenrollment in Medicaid becomes more difficult after January 1, 2006, when the clawback begins. In some instances, beneficiaries may find that the state has discontinued their eligibility category, and, if they are unable to establish eligibility on some other basis, they no longer have Medicaid coverage.

Conclusion

The launch of the new Medicare Part D program is just 18 months away, but many questions remain to be answered about the operation of the program, particularly as it relates to dual eligibles. Implementation of the clawback requirement is one of the important new operational challenges that the federal government, the states, and beneficiaries will face. As of this writing, no written guidance is available from the Centers for Medicare & Medicaid Services regarding the calculation of the clawback amounts or the manner in which states will be required to make the clawback payments. What is clear at this point, however, is that the clawback has established new ground in federal-state fiscal relations, with major implications for the states and low-income Medicare beneficiaries.

This research brief was prepared by Andy Schneider, Principal, Medicaid Policy, LLC. Research assistance was provided by Samantha Artiga and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured.

Endnotes

[1] The next most significant dollar flow is the payments that states make for Medicare Part B and Part A premiums on behalf of certain categories of Medicaid beneficiaries. Based on CBO projections, in FY 2006, state Medicare premium payments will total $3.5 billion, while state clawback payments will total $6 billion.

[2] B. Bruen and J. Holahan, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government,* Kaiser Commission on Medicaid and the Uninsured (November 2003), Table 2, www.kff.org.

[3] B. Bruen and A. Ghosh, *Medicaid Prescription Drug Spending and Use*, Kaiser Commission on Medicaid and the Uninsured (June 2004), p. 11; Bruen and Holahan, *op. cit*., Table 3.

[4] Bruen and Ghosh, *op. cit*., p. 7, estimate that 52 percent of all Medicaid drug spending in 2000 was attributable to dual eligibles.

[5] The House-passed bill would have allowed dual eligibles to enroll in the new Medicare Part D and would have made Part D the first dollar payor for these beneficiaries. If a state's Medicaid drug coverage was broader than the Part D coverage, Medicaid would then "wrap around" the Part D coverage, with the federal and state governments sharing in the cost as under current law. Under the Senate version, in contrast, dual eligibles would not be eligible for drug coverage under Part D; instead, Medicaid would continue to provide outpatient drug coverage to this population, with the federal government and the states sharing in the costs as under current law. States that offered a Medicaid drug benefit meeting a federal minimum standard would no longer be required to pay their share of the cost of monthly Part B premiums for certain dual eligibles. See Health Policy Alternatives*, Prescription Drug Coverage for Medicare Beneficiaries: A Side-by-Side Comparison of S. 1 and H.R. 1and the Conference Agreement (H.R. 1*) (November 26, 2003), pp. 4-5, www.kff.org/medicare/6111.cfm

[6] To stay within the $400 billion budget constraint, the House and Senate conferees decided to resurrect a financing mechanism that had been developed by the House in 2002. That year, in its Medicare prescription drug bill, the House provided for the assumption of the costs of prescription drug coverage for dual eligibles by Medicare, but it reduced the $58 billion in resulting savings to the states over 10 years by $12 billion. Congressional Budget Office, *Cost Estimate H.R. 4954, Medicare Modernization and Prescription Drug Act of 2002* (June 24, 2002), p. 13, www.cbo.gov. The mechanism for capturing some of these state savings for the federal government was to reduce the federal Medicaid matching payments that would otherwise be made to a state each quarter by a specified amount. This offset, which came to be known as the "clawback" (a term coined by the CBO cost estimators), was phased out entirely over a 10-year period. In contrast, the clawback finally enacted in the MMA is permanent.

[7] This requirement also applies to the District of Columbia but not to Puerto Rico or the territories.

[8] The statute indicates that the manner of payment should be "similar to the manner in which State payments are made" under the Medicare "buy-in." Section 1935(c)(1)(B) of the Social Security Act. Medicare "buy-in" refers to an agreement between a state and the federal government under section 1843 of the Social Security Act under which a state pays the Medicare Part B and Part A premiums on behalf of certain categories of Medicaid beneficiaries. The premium payments are subject to federal Medicaid matching payments at the state's regular matching rate. See *State Buy-In Manual*, HCFA Pub. 24, Transmittal No. 1 (Nov. 1, 1996).

[9] Heffler, S. et al, "Health Spending Projections through 2013," *Health Affairs*, Web Exclusive, February 11, 2004, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.79v1/DC1. These projections are recalculated annually and are subject to change.

[10] Section 1935(c)(3)(B)(ii)(III) of the Social Security Act. Medicaid payments to pharmacies for prescription drugs do not reflect manufacturer rebates to the state, which are collected on a quarterly basis after the prescription is paid for. To reflect the actual expenditure net of rebates, an adjustment to the gross expenditures must therefore be made. For a brief explanation of the Medicaid rebate program, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Purchasing Prescription Drugs* (January 2002), pp. 18-23, www.kff.org.

[11] Section 1935(c)(3)(A)(ii) of the Social Security Act.

[12] Section 1935(c)(6) of the Social Security Act. For a discussion of Medicaid eligibility categories for Medicare beneficiaries that do not entitle beneficiaries to full Medicaid benefits, see Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (July 2002), pp. 38-40, www.kff.org.

[13] Section 1935(c)(5) of the Social Security Act.

[14] Section 1935(c)(1)(C) of the Social Security Act. The interest rate is the average of the bond equivalent of the weekly 90-day Treasury Bill auction rates during the period, section 1903(d)(5) of the Social Security Act.

[15] Center for Medicaid and State Operations, Letter to State Medicaid Directors (May 6, 2004). According to the letter, "there are data reporting issues that must be addressed to allow for accurate state contribution calculations."

[16] See J. Guyer, *Implications of the New Medicare Prescription Drug Benefit for State Medicaid Budgets* (2004), Kaiser Commission on Medicaid and the Uninsured, www.kff.org.
[17] For a discussion of mandatory eligibility categories for elderly and disabled Medicare beneficiaries, see Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (July 2002), pp. 23-37, www.kff.org/medicaid
[18] For a discussion of the advantages to the states of participation in Medicaid, see V. Wachino, A. Schneider, and D. Rousseau, *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds* (January 2004), pp. 8-20, www.kff.org.
[19] The Congressional Budget Office projects that federal matching payments for Part B premium payments will total $3.7 billion in FY 2004. CBO, *Fact Sheet for CBO's March 2004 Baseline, Medicaid and the State Children's Health Insurance Program* (March 3, 2004).
[20] Under the Congressional budget rules, Medicare Part D represents mandatory or entitlement spending., and clawback payments represent offsetting receipts. See "Effects of the New Medicare Law on Mandatory Spending," Box 1-2, and "CBO's Baseline Projectws of Offsetting Receipts," Table 3-8, in Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2005 to 2014* (January 2004), www.cbo.gov
[21] Section 801(c)(3)(C) of P.L. 108-173.
[22] See also B. Bruen and J. Holahan, *Shifting the Costs of Dual Eligibles: Implications for States and the Federal Government* (November 2003), www.kff.org.
[23] Due to increases in per capita personal income in 2003, 30 states are projected to face increased state matching rates in FY 2006, while only 8 states are projected to experience reduced state matching rates. Of the 30 states with increased state shares, 21 are projected to see their shares increase by 0.5 percentage points or more. V. Miller, "FY 2006 FMAP Projections," *Federal Funds Information for States*, *Issue Brief 04-13* (April 27, 2004).
[24] Kaiser Commission on Medicaid and the Uninsured*, Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers* (January 9, 2004), www.kff.org.
[25] Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (July 2002), pp. 33-37, www.kff.org/medicaid.
[26] B. Bruen, J. Wiener, and S. Thomas, *Medicaid Eligibility Policy for Aged, Blind and Disabled Beneficiaries* (2003), www.aarp.org.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

Additional copies of this report (#7118) are available
on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.