

Figure 3

Overview of Low-Income Part D Benefits, 2006

Low-Income Subsidy Levels	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligible; Income up to 100% FPL (\$9,570/individual in 2005)	\$0	\$0	\$1/generic \$3/brand-name; no copays after total drug costs reach \$5,100
Full-benefit dual eligible; Income greater than 100% FPL	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug costs reach \$5,100
Income less than 135% FPL (\$12,920/individual in 2005) and assets <\$6,000/individual; \$9,000/couple	\$0	\$0	\$2/generic \$5/brand-name after total drug costs reach \$5,100
Income 135%–150% FPL (\$12,920–\$14,355/individual in 2005 and assets <\$10,000/indiv; \$20,000/couple	sliding scale up to \$35	\$50	15% of total costs up to \$5,100 catastrophic limit; \$2/generic \$5/brand-name thereafter
All others (non-subsidy eligible)	\$35	\$250	25% up to initial coverage limit; 100% up to \$3,600 out-of-pocket spending

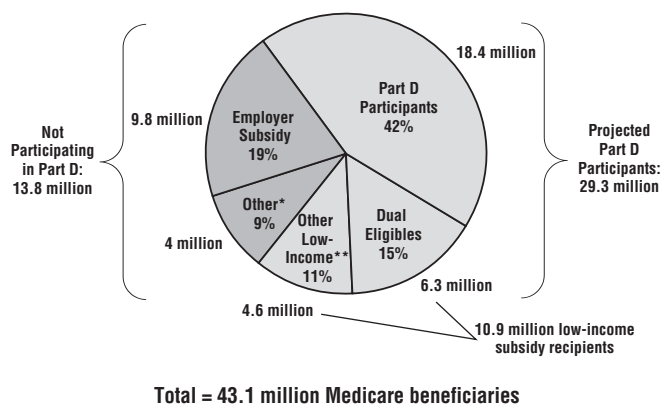
SOURCE: Kaiser Family Foundation summary of Part D low-income subsidies in 2006.

PARTICIPATION

Of the estimated 43.1 million Medicare beneficiaries, 29.3 million are expected to enroll in Part D plans in 2006 (Figure 4). Of 14.5 million beneficiaries eligible for low-income subsidies in 2006, HHS expects 10.9 million to receive them. Another 9.8 million are expected to receive drug coverage comparable to Part D under an employer plan.

Figure 4

Estimates of Medicare Part D Participation, 2006



*"Other" non-participants includes federal retirees with drug coverage through FEHBP or TRICARE, and those who lack drug coverage. **"Other Low-Income" includes non-dual eligibles with incomes <150% FPL. SOURCE: HHS OACT, MMA Final Rule, January 2005.

Enrollment in Medicare Part D plans is voluntary, however, individuals who delay enrollment after their initial eligibility enrollment period will pay a lifetime premium penalty equal to 1% of the base premium for each month they delay enrollment.

INTERACTION WITH OTHER COVERAGE

Employer-sponsored plans currently cover drugs for more than 11 million beneficiaries. To encourage employers to maintain these benefits, Medicare will provide tax-free subsidies equal to 28% of costs between \$250 and \$5,000 in drug expenses per retiree to employers providing drug benefits that are at least comparable to the standard Part D benefit.

Medicaid provides drug coverage for 6.3 million Medicare beneficiaries, known as "dual eligibles." As of January 1, 2006, dual eligibles will get drug coverage from Medicare Part D plans, rather than Medicaid. The HHS Secretary is responsible for automatically enrolling individuals into Part D plans if they do not sign up on their own.

Medicare Advantage plans are a source of coverage for nearly 5 million beneficiaries in 2004 and will be required to offer standard drug coverage in 2006 (except private FFS and Medicare Savings Account plans).

Medigap plans provide drug coverage to less than 10% of the Medicare population. Beginning in 2006, Medigap insurers may not issue new policies that include drug coverage or supplement Part D.

State Pharmaceutical Assistance Programs can continue to provide coverage and can supplement Part D coverage for eligible enrollees.

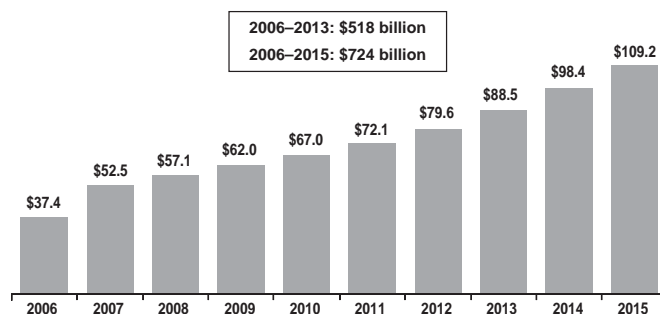
EXPENDITURES AND FINANCING

The net federal cost of the new Medicare drug benefit is estimated to be \$724 billion between 2006 and 2015 (Figure 5). Financing for the Medicare drug benefit will come from several sources, including premiums paid by beneficiaries, receipts from states (known as the "clawback"), Medicaid savings, and general revenues.

FUTURE CHALLENGES

Figure 5

Net Federal Cost of the Medicare Prescription Drug Benefit (HHS 2005 Projections) (in billions)



SOURCE: Administration's FY 2006 Budget.

The Medicare drug benefit offers help to beneficiaries with rising out-of-pocket drug costs, especially those with low incomes, but implementation poses significant challenges for CMS, drug plans, and beneficiaries. Successful implementation will depend on whether new drug plans emerge throughout the country and provide beneficiaries with access to needed medications and a stable, affordable source of drug coverage over time, while controlling rising drug costs. Beneficiary education and counseling will be critical to promote informed decision-making and a smooth transition as the new drug benefit is implemented.

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