HB

374

OUSE COMMITTEE REPOF

(11)

Date Referred to Committee: January 14, 2004 FURTHER REFERRALS:

Date of Committee Action: 1/27/04

The FINANCE Committee considered: HB 374

HOUSE BILL NO. 374 SENIORCARE

"An Act establishing the SeniorCare program and relating to that program; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [✓] CS *for* HB 374 (FIN)

For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ [ ] Same Title [✓] New Title

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW FISCAL NOTES *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
HSS	✓			
HSS	✓			
HSS	✓			
HSS	✓			
HSS	✓			

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations		Printed Last Name	DP	DNP	NR	AM
	Meyer	Meyer	✓			
	Hawker	Hawker	✓			
	Stoltze				✓	
	Joule				✓	
	Moses	MOSES	✓			
	Fate	Fate	✓			
	Foster	FOSTER	X			
	Chenault	Chenault	✓			
Chair:	Harris	Harris	✓			
Chair:	Williams		✓			

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-HCS-01-28-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Health Care Services
Component: Health Purchasing Group

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 243

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual		50.0				
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	50.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
1189 Senior Care Fund		50.0				
TOTAL	0.0	50.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 85.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Care Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Care Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The Department of Health and Social Services Division of Health Care Services anticipates required FY04 start-up costs of $85.0 for the development of MMIS claims processing capability for payment of the state program's drug benefit plan.

Prepared by: Sherry Hill, Special Assistant — Phone 465-1618
Division: Office of the Commissioner — Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner — Date 01/28/2004
Agency: Department of Health and Social Services

STATE OF ALASKA
2004 LEGISLATIVE SESSION

BILL NO. HB374CS(FIN)-DHSS-HCS-01-28-04

ANALYSIS CONTINUATION

There are no additional anticipated costs during the course of FY05.

The department anticpates costs of $50.0 for MMIS system changes and documentation with the sunset of the program in FY06.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-DPA2-01-28-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Public Assistance
Component: SeniorCare

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 2760

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	14,649.6	7,690.9				
Miscellaneous						
TOTAL OPERATING	14,649.6	7,690.9	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
1189 Senior Care Fund	14,649.6	7,690.9				
TOTAL	14,649.6	7,690.9	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 554.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Care Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Care Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The proposed SeniorCare program provides a cash or drug benefit to eligible seniors age 65 or older. Program benefits will be disbursed through the SeniorCare program in the Division of Public Assistance budget. The program is proposed to operate during the last quarter of FY 04, the entire FY 05 and the first half of FY 06.

Prepared by: Sherry Hill, Special Assistant — Phone 465-1618
Division: Office of the Commissioner — Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner — Date 01/28/2004
Agency: Department of Health and Social Services

STATE OF ALASKA
2004 LEGISLATIVE SESSION

BILL NO. HB374CS(FIN)-DHSS-DPA2-01-28-04

ANALYSIS CONTINUATION
SeniorCare Caseload Projections, continued

FY 05

Cash benefit: 7,928 x $1,440 = **$11,415,600**

Drug benefit, below 135% poverty: 630 x $1,600 = **$1,008,000**

Drug benefit between 135% and 150% poverty: 2,226 x $1,000 = **$2,226,000**

TOTAL FY 05 COST: $11,415,600 + $1,008,000 + $2,226,000 = **$14,649,600**

FY 06

Cash benefit: 8,323 x $720 = **$5,992,830**

Drug benefit, below 135% poverty: 662 x $800 = **$529,600**

Drug benefit between 135% and 150% poverty: 2,337 x $500 = **$1,168,500**

TOTAL FY 06 COST:

$5,992,830 + $529,600 + $1,168,500 = **$7,690,930**

ANALYSIS CONTINUATION

SeniorCare benefit levels

Cash benefit: $360/yr. in FY04; $1,440/yr. in FY05; $720 in FY06
Drug benefit, below 135% poverty: $400/yr. in FY04; $1,600/yr. in FY05; $800/yr. in FY06
Drug benefit between 135% and 150% poverty: $250/yr. in FY04; $1,000/yr. in FY05; $500/yr. in FY06

SeniorCare Caseload Projections

FY 04

Cash benefit: 7,550
Drug benefit below 135% poverty: 600
Drug benefit between 135% and 150% poverty: 2,120

FY 05

Cash benefit: 7,928
Drug benefit, below 135% poverty: 630
Drug benefit between 135% and 150% poverty: 2,226

FY 06

Cash benefit: 8,323
Drug benefit, below 135% poverty: 662
Drug benefit between 135% and 150% poverty: 2,337

Cost Projections:

FY 04 (4th Qtr. only)

Cash benefit: 7,550 x $360 = $2,718,000
Drug benefit, below 135% poverty: 600 x $400 = $240,000
Drug benefit between 135% and 150% poverty: 2,120 x $250 = $530,000

TOTAL FY04 COST: $2,718,000 + $240,000 + $530,000 = $3,488,000 - $2,934,000 (FY 04 appropriation for Alaska Senior Assistance Program) = $554,000

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-DPA1-01-28-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Public Assistance
Component: Public Assistance Admin

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 233

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	40.0	20.0				
Travel	7.0	3.0				
Contractual	12.0	4.0				
Supplies	2.0	1.5				
Equipment	0.5					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	61.5	28.5	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
1189 Senior Care Fund	61.5	28.5				
TOTAL	61.5	28.5	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 25.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Care Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior CareFund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

Outreach for the proposed SeniorCare program will include the staffing and operation of a SeniorCare Information Office to provide full-time, telephone-based information on programs and services, advertising about the SeniorCare program and travel to provide information to seniors throughout the state.

Prepared by: Sherry Hill, Special Assistant
Phone 465-1618
Division: Office of the Commissioner
Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/28/2004
Agency: Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-HCS-01-23-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Health Care Services
Component: Health Purchasing Group

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 243

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual		50.0				
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	50.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1189 Senior Services Fund		50.0				
TOTAL	0.0	50.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 85.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Services Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Services Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The Department of Health and Social Services Division of Health Care Services anticipates required FY04 start-up costs of $85.0 for the development of MMIS claims processing capability for payment of the state program's drug benefit plan.

Prepared by: Sherry Hill, Special Assistant
Phone 465-1618
Division: Office of the Commissioner
Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/23/2004
Agency: Department of Health and Social Services

STATE OF ALASKA
2004 LEGISLATIVE SESS'ON

BILL NO. HB374CS(FIN)-DHSS-HCS-01-23-04

ANALYSIS CONTINUATION

There are no additional anticipated costs during the course of FY05.

The department anticpates costs of $50.0 for MMIS system changes and documentation with the sunset of the program in FY06.

ATTACHMENT A: SENIOR CARE PROGRAM ESTIMATED COSTS

	FY 04 -- 4th Qtr	FY 05	FY 06
Caseload Projections	100%	105%	105%
Alaska Senior Assistance Program (AKSAP)	8,150	8,558	8,985
SeniorCare Below 135% of Poverty	2,000	2,100	2,205
SeniorCare Between 135% and 150% of Poverty	2,120	2,226	2,337
Participation Projections			
AKSAP caseload	7,550	7,928	8,323
30% SeniorCare Below 135%	600	630	662
100% SeniorCare Between 135% and 150%	2,120	2,226	2,337
Benefit Assumptions			
AKSAP	$ 360	$ 1,440	$ 720
SeniorCare Below 135%	$ 400	$ 1,600	$ 800
SeniorCare Between 135% and 150%	$ 250	$ 1,000	$ 500

Budget Forecast	FY 04 -- 4th Qtr	FY 05	FY 06
AKSAP	$ 2,718,000	$ 11,415,600	$ 5,992,830
SeniorCare Below 135% of Poverty	$ 240,000	$ 1,008,000	$ 529,600
SeniorCare Between 135% and 150% of Poverty	$ 530,000	$ 2,226,000	$ 1,168,500
Total Program Cost	$ 3,488,000	$ 14,649,600	$ 7,690,930
Less Current FY04 Funding for AKSAP *	$ (3,334,000)		
Net Total Program Cost	$ 154,000	$ 14,649,600	$ 7,690,930
Administrative Costs			
Eligibility	$ 52,800	$ 191,400	$ 17,600
Claims Processing	$ 85,000	$ -	$ 50,000
Outreach	$ 25,000	$ 61,500	$ 28,500
Total Administrative Costs	$ 162,800	$ 252,900	$ 96,100
Combined Program and Administrative Costs	$ 316,800	$ 14,902,500	$ 7,787,030
General Funds	$ 316,800	$ 2,902,500	$ 7,787,030
Federal Funds		$ 12,000,000	
TOTAL FUNDS			$ 26,340,330

* Assumes full FY 04 federal funding for AKSAP can be used for the combined SeniorCare program.

1/23/2004

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-DPA1-01-23-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Public Assistance
Component: Public Assistance Admin

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 233

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	40.0	20.0				
Travel	7.0	3.0				
Contractual	12.0	4.0				
Supplies	2.0	1.5				
Equipment	0.5					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	61.5	28.5	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1189 Senior Services Fund	61.5	28.5				
TOTAL	61.5	28.5	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 25.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Services Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Services Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

Outreach for the proposed SeniorCare program will include the staffing and operation of a SeniorCare Information Office to provide full-time, telephone-based infomation on programs and services, advertising about the SeniorCare program and travel to provide information to seniors throughout the state.

Prepared by: Sherry Hill, Special Assistant
Phone 465-1618
Division: Office of the Commissioner
Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/23/2004
Agency: Department of Health and Social Services

(Revised 6/2002 OMB)

ATTACHMENT A: SENIOR CARE PROGRAM ESTIMATED COSTS

	FY 04 -- 4th Qtr	FY 05	FY 06
Caseload Projections	100%	105%	105%
Alaska Senior Assistance Program (AKSAP)	8,150	8,558	8,985
SeniorCare Below 135% of Poverty	2,000	2,100	2,205
SeniorCare Between 135% and 150% of Poverty	2,120	2,226	2,337
Participation Projections			
AKSAP caseload	7,550	7,928	8,323
30% SeniorCare Below 135%	600	630	662
100% SeniorCare Between 135% and 150%	2,120	2,226	2,337
Benefit Assumptions			
AKSAP	$ 360	$ 1,440	$ 720
SeniorCare Below 135%	$ 400	$ 1,600	$ 800
SeniorCare Between 135% and 150%	$ 250	$ 1,000	$ 500

Budget Forecast	FY 04 -- 4th Qtr	FY 05	FY 06
AKSAP	$ 2,718,000	$ 11,415,600	$ 5,992,830
SeniorCare Below 135% of Poverty	$ 240,000	$ 1,008,000	$ 529,600
SeniorCare Between 135% and 150% of Poverty	$ 530,000	$ 2,226,000	$ 1,168,500
Total Program Cost	**$ 3,488,000**	**$ 14,649,600**	**$ 7,690,930**
Less Current FY04 Funding for AKSAP *	**$ (3,334,000)**		
Net Total Program Cost	**$ 154,000**	**$ 14,649,600**	**$ 7,690,930**
Administrative Costs			
Eligibility	$ 52,800	$ 191,400	$ 17,600
Claims Processing	$ 85,000	$ -	$ 50,000
Outreach	$ 25,000	$ 61,500	$ 28,500
Total Administrative Costs	**$ 162,800**	**$ 252,900**	**$ 96,100**
Combined Program and Administrative Costs	**$ 316,800**	**$ 14,902,500**	**$ 7,787,030**
General Funds	$ 316,800	$ 2,902,500	$ 7,787,030
Federal Funds		$ 12,000,000	
TOTAL FUNDS			**$ 26,340,330**

* Assumes full FY 04 federal funding for AKSAP can be used for the combined SeniorCare program.

1/23/2004

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-DAS-01-28-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Departmental Support Services
Component: Information Technology Services

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 2754

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies	7.1	7.5				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	7.1	7.5	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
1189 Senior Care Fund	7.1	7.5				
TOTAL	7.1	7.5	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 6.8
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Care Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Care Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The Public Assistance Systems Operations unit, under the departmental Information Technology Services component, will issue and mail SeniorCare drug benefit cards to approximately 2,720 recipients in FY 04, 2,856 recipients in FY 05, and 2,999 recipients in FY 06.

Prepared by: Sherry Hill, Special Assistant
Phone 465-1618
Division: Office of the Commissioner
Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/28/2004
Agency: Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-ALP-01-28-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Alaskan Pioneer Homes
Component: Alaska Pioneer Homes Management

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR
Requester: HOUSE (FIN)
Component No.: 2731

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	94.6	5.2				
Travel						
Contractual	74.0	4.0				
Supplies	15.7	0.9				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	184.3	10.1	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
1189 Senior Care Fund	184.3	10.1				
TOTAL	184.3	10.1	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 46.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal: [ ]

POSITIONS

Full-time	2	2				
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Care Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Care Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The Division of Alaska Pioneer Homes will process enrollment and determine program eligibility for the SeniorCare program. The division will also issue and mail checks for the cash benefit segment of the program. The SeniorCare program will operate for the last quarter of FY 04, the entirety of FY 05, and six months of FY 06.

Prepared by: Sherry Hill, Special Assistant — Phone 465-1613
Division: Office of the Commissioner — Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner — Date 01/28/2004
Agency: Department of Health and Social Services

STATE OF ALASKA
2004 LEGISLATIVE SESSION

BILL NO. HB374CS(FIN)-ALP-01-28-04

ANALYSIS CONTINUATION

Due to increasing costs, a 10% inflation factor was applied to FY 05 costs to determine FY 06 contractual services and supply costs.

The eligibility Tech I (range 13, step A) will provide or supervise the provision of accurate eligibility determinations and benefit authorizations for new and ongoing SeniorCare cash benefit or pharmacy benefit applicants/recipients. In accordance with regulations the position's work includes interviews, data collection, data review and analysis and investigations. The position will enroll pharmacy benefit recipients in the public assistance EIS system.

The Admin Clerk III, (range 10, step A) position will perform specialized clerical functions requiring knowledge of SeniorCare policies. The position will need to understand laws and regulations and vary procedures depending on different situations, and be able to explain the requirements to others. The position will need to recognize errors and discrepancies in information and take appropriate action. The Admin Clerk III will be the back up position for the ET I and will process "month-end" cash benefit checks in the absence of the ET I.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-DAS-01-23-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Departmental Support Services
Component: Information Technology Services

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 2754

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies	7.1	7.5				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	7.1	7.5	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1189 Senior Services Fund	7.1	7.5				
TOTAL	7.1	7.5	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 6.8
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Services Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Services Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The Public Assistance Systems Operations unit, under the departmental Information Technology Services component, will issue and mail SeniorCare drug benefit cards to approximately 2,720 recipients in FY 04, 2,856 recipients in FY 05, and 2,999 recipients in FY 06.

Prepared by: Sherry Hill, Special Assistant
Phone 465-1618
Division: Office of the Commissioner
Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/23/2004
Agency: Department of Health and Social Services

ATTACHMENT A: SENIOR CARE PROGRAM ESTIMATED COSTS

	FY 04 -- 4th Qtr	FY 05	FY 06
Caseload Projections	100%	105%	105%
Alaska Senior Assistance Program (AKSAP)	8,150	8,558	8,985
SeniorCare Below 135% of Poverty	2,000	2,100	2,205
SeniorCare Between 135% and 150% of Poverty	2,120	2,226	2,337
Participation Projections			
AKSAP caseload	7,550	7,928	8,323
30% SeniorCare Below 135%	600	630	662
100% SeniorCare Between 135% and 150%	2,120	2,226	2,337
Benefit Assumptions			
AKSAP	$ 360	$ 1,440	$ 720
SeniorCare Below 135%	$ 400	$ 1,600	$ 800
SeniorCare Between 135% and 150%	$ 250	$ 1,000	$ 500

Budget Forecast	FY 04 -- 4th Qtr	FY 05	FY 06
AKSAP	$ 2,718,000	$ 11,415,600	$ 5,992,830
SeniorCare Below 135% of Poverty	$ 240,000	$ 1,008,000	$ 529,600
SeniorCare Between 135% and 150% of Poverty	$ 530,000	$ 2,226,000	$ 1,168,500
Total Program Cost	$ 3,488,000	$ 14,649,600	$ 7,690,930
Less Current FY04 Funding for AKSAP *	$ (3,334,000)		
Net Total Program Cost	$ 154,000	$ 14,649,600	$ 7,690,930
Administrative Costs			
Eligibility	$ 52,800	$ 191,400	$ 17,600
Claims Processing	$ 85,000	$ -	$ 50,000
Outreach	$ 25,000	$ 61,500	$ 28,500
Total Administrative Costs	$ 162,800	$ 252,900	$ 96,100
Combined Program and Administrative Costs	$ 316,800	$ 14,902,500	$ 7,787,030
General Funds	$ 316,800	$ 2,902,500	$ 7,787,030
Federal Funds		$ 12,000,000	
TOTAL FUNDS			$ 26,340,330

* Assumes full FY 04 federal funding for AKSAP can be used for the combined SeniorCare program.

1/23/2004

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-DPA2-01-23-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Public Assistance
Component: SeniorCare

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 2760

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	14,649.6	7,690.9				
Miscellaneous						
TOTAL OPERATING	14,649.6	7,690.9	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1189 Senior Services Fund	14,649.6	7,690.9				
TOTAL	14,649.6	7,690.9	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 554.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Services Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Services Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The proposed SeniorCare program provides a cash or drug benefit to eligible seniors age 65 or older. Program benefits will be disbursed through the SeniorCare program in the Division of Public Assistance budget. The program is proposed to operate during the last quarter of FY 04, the entire FY 05 and the first half of FY 06.

Prepared by: Sherry Hill, Special Assistant
Phone 465-1618
Division: Office of the Commissioner
Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/23/2004
Agency: Department of Health and Social Services

ANALYSIS CONTINUATION
SeniorCare Caseload Projections, continued

FY 05

Cash benefit: 7,928 x $1,440 = **$11,415,600**

Drug benefit, below 135% poverty: 630 x $1,600 = **$1,008,000**

Drug benefit between 135% and 150% poverty: 2,226 x $1,000 = **$2,226,000**

TOTAL FY 05 COST: $11,415,600 + $1,008,000 + $2,226,000 = **$14,649,600**

FY 06

Cash benefit: 8,323 x $720 = **$5,992,830**

Drug benefit, below 135% poverty: 662 x $800 = **$529,600**

Drug benefit between 135% and 150% poverty: 2,337 x $500 = **$1,168,500**

TOTAL FY 06 COST:

$5,992,830 + $529,600 + $1,168,500 = **$7,690,930**

STATE OF ALASKA
2004 LEGISLATIVE SESSION

BILL NO. HB374CS(FIN)-DHSS-DPA2-01-23-04

ANALYSIS CONTINUATION

SeniorCare benefit levels

Cash benefit: $360/yr. in FY04; $1,440/yr. in FY05; $720 in FY06
Drug benefit, below 135% poverty: $400/yr. in FY04; $1,600/yr. in FY05; $800/yr. in FY06
Drug benefit between 135% and 150% poverty: $250/yr. in FY04; $1,000/yr. in FY05; $500/yr. in FY06

SeniorCare Caseload Projections

FY 04

Cash benefit: 7,550
Drug benefit below 135% poverty: 600
Drug benefit between 135% and 150% poverty: 2,120

FY 05

Cash benefit: 7,928
Drug benefit, below 135% poverty: 630
Drug benefit between 135% and 150% poverty: 2,226

FY 06

Cash benefit: 8,323
Drug benefit, below 135% poverty: 662
Drug benefit between 135% and 150% poverty: 2,337

Cost Projections:

FY 04 (4th Qtr. only)

Cash benefit: 7,550 x $360 = $2,718,000
Drug benefit, below 135% poverty: 600 x $400 = $240,000
Drug benefit between 135% and 150% poverty: 2,120 x $250 = $530,000

TOTAL FY04 COST: $2,718,000 + $240,000 + $530,000 = $3,488,000 - $2,934,000 (FY 04 appropriation for Alaska Senior Assistance Program) = $554,000

ATTACHMENT A: SENIOR CARE PROGRAM ESTIMATED COSTS

	FY 04 -- 4th Qtr	FY 05	FY 06
Caseload Projections	100%	105%	105%
Alaska Senior Assistance Program (AKSAP)	8,150	8,558	8,985
SeniorCare Below 135% of Poverty	2,000	2,100	2,205
SeniorCare Between 135% and 150% of Poverty	2,120	2,226	2,337
Participation Projections			
AKSAP caseload	7,550	7,928	8,323
30% SeniorCare Below 135%	600	630	662
100% SeniorCare Between 135% and 150%	2,120	2,226	2,337
Benefit Assumptions			
AKSAP	$ 360	$ 1,440	$ 720
SeniorCare Below 135%	$ 400	$ 1,600	$ 800
SeniorCare Between 135% and 150%	$ 250	$ 1,000	$ 500

Budget Forecast	FY 04 -- 4th Qtr	FY 05	FY 06
AKSAP	$ 2,718,000	$ 11,415,600	$ 5,992,830
SeniorCare Below 135% of Poverty	$ 240,000	$ 1,008,000	$ 529,600
SeniorCare Between 135% and 150% of Poverty	$ 530,000	$ 2,226,000	$ 1,168,500
Total Program Cost	**$ 3,488,000**	**$ 14,649,600**	**$ 7,690,930**
Less Current FY04 Funding for AKSAP *	**$ (3,334,000)**		
Net Total Program Cost	**$ 154,000**	**$ 14,649,600**	**$ 7,690,930**
Administrative Costs			
Eligibility	$ 52,800	$ 191,400	$ 17,600
Claims Processing	$ 85,000	$ -	$ 50,000
Outreach	$ 25,000	$ 61,500	$ 28,500
Total Administrative Costs	**$ 162,800**	**$ 252,900**	**$ 96,100**
Combined Program and Administrative Costs	**$ 316,800**	**$ 14,902,500**	**$ 7,787,030**
General Funds	$ 316,800	$ 2,902,500	$ 7,787,030
Federal Funds		$ 12,000,000	
TOTAL FUNDS			**$ 26,340,330**

* Assumes full FY 04 federal funding for AKSAP can be used for the combined SeniorCare program.

1/23/2004

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB374CS(FIN)-DHSS-ALP-01-23-04
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIOR CARE PROGRAM
RDU: Alaskan Pioneer Homes
Component: Alaska Pioneer Homes Management

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: HOUSE (FIN)
Component No.: 2731

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	94.6	5.2				
Travel						
Contractual	74.0	4.0				
Supplies	15.7	0.9				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	184.3	10.1	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1189 Senior Services Fund	184.3	10.1				
TOTAL	184.3	10.1	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 46.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time	2	2				
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The total cost of the Senior Care Program is $26,340,330 which includes $3,334,000 in funds already appropriated for the Alaska Senior Assistance Program in FY 04. This fiscal note assumes that the total amount of $26,340,330 will be appropriated or reappropriated to the Senior Services Fund created by Section 2 of HB 374 and therefore available for appropriation from the Senior Services Fund for program expenditures.

The program will span fiscal years FY 04-FY06. A detailed analysis of total program costs is attached.

The Division of Alaska Pioneer Homes will process enrollment and determine program eligibility for the SeniorCare program. The division will also issue and mail checks for the cash benefit segment of the program. The SeniorCare program will operate for the last quarter of FY 04, the entirety of FY 05, and six months of FY 06.(Continued on next page)

Prepared by: Sherry Hill, Special Assistant — Phone 465-1613
Division: Office of the Commissioner — Date/Time 01/23/2004
Approved by: Joel S. Gilbertson, Commissioner — Date 01/23/2004
Agency: Department of Health and Social Services

ANALYSIS CONTINUATION

Due to increasing costs, a 10% inflation factor was applied to FY 05 costs to determine FY 06 contractual services and supply costs.

The eligibility Tech I (range 13, step A) will provide or supervise the provision of accurate eligibility determinations and benefit authorizations for new and ongoing SeniorCare cash benefit or pharmacy benefit applicants/recipients. In accordance with regulations the position's work includes interviews, data collection, data review and analysis and investigations. The position will enroll pharmacy benefit recipients in the public assistance EIS system.

The Admin Clerk III, (range 10, step A) position will perform specialized clerical functions requiring knowledge of SeniorCare policies. The position will need to understand laws and regulations and vary procedures depending on different situations, and be able to explain the requirements to others. The position will need to recognize errors and discrepancies in information and take appropriate action. The Admin Clerk III will be the back up position for the ET I and will process "month-end" cash benefit checks in the absence of the ET I.

ATTACHMENT A: SENIOR CARE PROGRAM ESTIMATED COSTS

	FY 04 -- 4th Qtr	FY 05	FY 06
Caseload Projections	100%	105%	105%
Alaska Senior Assistance Program (AKSAP)	8,150	8,558	8,985
SeniorCare Below 135% of Poverty	2,000	2,100	2,205
SeniorCare Between 135% and 150% of Poverty	2,120	2,226	2,337
Participation Projections			
AKSAP caseload	7,550	7,928	8,323
30% SeniorCare Below 135%	600	630	662
100% SeniorCare Between 135% and 150%	2,120	2,226	2,337
Benefit Assumptions			
AKSAP	$ 360	$ 1,440	$ 720
SeniorCare Below 135%	$ 400	$ 1,600	$ 800
SeniorCare Between 135% and 150%	$ 250	$ 1,000	$ 500

Budget Forecast	FY 04 -- 4th Qtr	FY 05	FY 06
AKSAP	$ 2,718,000	$ 11,415,600	$ 5,992,830
SeniorCare Below 135% of Poverty	$ 240,000	$ 1,008,000	$ 529,600
SeniorCare Between 135% and 150% of Poverty	$ 530,000	$ 2,226,000	$ 1,168,500
Total Program Cost	$ 3,488,000	$ 14,649,600	$ 7,690,930
Less Current FY04 Funding for AKSAP *	$ (3,334,000)		
Net Total Program Cost	$ 154,000	$ 14,649,600	$ 7,690,930
Administrative Costs			
Eligibility	$ 52,800	$ 191,400	$ 17,600
Claims Processing	$ 85,000	$ -	$ 50,000
Outreach	$ 25,000	$ 61,500	$ 28,500
Total Administrative Costs	$ 162,800	$ 252,900	$ 96,100
Combined Program and Administrative Costs	$ 316,800	$ 14,902,500	$ 7,787,030
General Funds	$ 316,800	$ 2,902,500	$ 7,787,030
Federal Funds		$ 12,000,000	
TOTAL FUNDS			$ 26,340,330

* Assumes full FY 04 federal funding for AKSAP can be used for the combined SeniorCare program.

1/23/2004

23-GH2123\V
Mischel
1/26/04

adopted 1/27/04

CS FOR HOUSE BILL NO. 374(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY THE HOUSE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the senior care program and relating to that program; creating a new fund for the provision of senior services; relating to aid to senior citizens; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. The uncodified law of the State of Alaska is amended by adding a new section to read:

SENIOR CARE PROGRAM. (a) The senior care program is established in the Department of Health and Social Services. Under the program, the department may provide cash assistance and prescription drug benefits as specified in this section as far as practicable under appropriations provided by law.

(b) The department shall

(1) administer the program; and

(2) adopt regulations under AS 44.62 to carry out the purposes of the program.

(c) In order to be eligible for the program, an individual shall

(1) be 65 years of age or older;

(2) be a resident of the state;

(3) have household income

(A) that does not exceed 135 percent of the federal poverty guideline as defined by the federal Office of Management and Budget and revised under 42 U.S.C. 9902(2) to be eligible for cash assistance under (d) of this section or prescription drug benefits under (e) of this section; or

(B) that exceeds 135 percent, but not exceeding 150 percent, of the federal poverty guideline as defined by the federal Office of Management and Budget and revised under 42 U.S.C. 9902(2) for prescription drug benefits under (f) of this section;

(4) meet other eligibility requirements specified in this section and in regulations adopted under this section; and

(5) apply on a form provided by the department; the department may use an abbreviated form for individuals who received payments under an assistance program for seniors paying $120 a month and administered by the department on or before March 31, 2004.

(d) An eligible individual who meets the income standard of (c)(3)(A) of this section may receive cash assistance of $120 a month as far as practicable under appropriations available to the program. The department may prorate the amount of cash assistance paid under this subsection if the department estimates that appropriations for the program are not sufficient to meet the demands for the program in a fiscal year.

(e) In place of the cash assistance under (d) of this section, an eligible individual may once annually elect to receive prescription drug benefits, provided in the manner specified by the department in regulation. The total maximum prescription drug benefits an individual may receive under this subsection in a fiscal year is $1,600. An individual who has prescription drug coverage under AS 47.07 is not eligible to receive prescription drug benefits under this subsection.

(f) An eligible individual who meets the income standard of (c)(3)(B) of this section may receive only prescription drug benefits as provided in this subsection. The provisions of (e) of this section apply to prescription drug benefits provided under this subsection except

that the total maximum prescription drug benefits that an individual may receive under this subsection in a fiscal year is $1,000.

(g) To receive prescription drug benefits under (e) or (f) of this section, an eligible individual must assign to the department the individual's rights to payments under any other prescription drug program for a prescription drug benefit paid under this section. Payment may not be made under this section for an amount that would otherwise qualify for payment under another prescription drug benefit plan, except for prescription drug coverage received from health care facilities that operated under the authority of 25 U.S.C. 450 - 458 bbb-2 (P.L. 93-638).

(h) Except as otherwise provided in this subsection, the department may pay under (e) and (f) of this section only for a prescription drug, insulin, and insulin syringes. The department may not pay under (e) and (f) of this section for drugs used to treat obesity, baldness, infertility, or impotence; drugs that are prohibited from receiving funding under the medical assistance program in AS 47.07; smoking cessation products; drugs used for symptomatic relief of coughs and colds; oral vitamins; or brand-name multisource drugs if a therapeutically equivalent generic drug is on the market, except that the department shall pay for brand-name multisource drugs if the prescriber writes on the prescription "The brand-name drug is medically necessary" and the prescriber states the reason that the brand-name drug is medically necessary. The department may also restrict coverage of drugs under (e) and (f) of this section to be consistent with the preferred drug list implemented by the department for purposes of the medical assistance program under AS 47.07.

(i) For a fiscal year in which prescription drug benefits under (e) and (f) of this section are not available for a full 12 months, the commissioner may prorate the total maximum amounts available under (e) and (f) of this section according to the number of months for which those benefits are available.

(j) The department may not make payment or authorize a benefit under this section to or on behalf of an individual residing in a public institution or nursing facility.

(k) An eligible individual who leaves the state may not receive cash assistance or prescription drug benefits under this section during the absence unless the individual temporarily leaves for one of the following reasons:

(1) medical treatment; or

(2) a vacation, business trip, or other absence of fewer than 30 consecutive days unless the individual has applied for and received a time extension from the department for special circumstances.

(*l*) An individual who receives a determination under this section from the department that denies, limits, or modifies prescription drug benefits or cash assistance under this section, other than a determination under (d) or (i) of this section to prorate the amount of benefits or assistance, may request a hearing before the department. The department shall adopt regulations for the conduct of hearings under this subsection. The hearing process under this subsection is not subject to AS 44.62.330 - 44.62.630. The decision of the department after a hearing under this subsection is a final administrative order subject to appeal to the superior court.

(m) An individual who receives assistance or benefits under this section when not entitled to them because the information provided by the individual was inaccurate or incomplete is liable to the department for the value of the assistance or benefits improperly provided to the individual. In a civil action brought by the state to recover from the individual the value of assistance or benefits improperly provided under this section, the state may recover from the individual the costs of investigation and prosecution of the civil action, including attorney fees as determined under court rules.

(n) Cash assistance provided under this section is inalienable by assignment or transfer and is exempt from garnishment, levy, or execution as provided in AS 09.38.

(o) In this section,

(1) "commissioner" means the commissioner of health and social services;

(2) "department" means the Department of Health and Social Services;

(3) "eligible individual" means an individual who meets the requirements of this section and regulations adopted under this section for eligibility for the program;

(4) "program" means the program established in this section;

(5) "public institution" means a governmentally owned establishment that furnishes food, shelter, and some additional treatment or services to 16 or more persons;

(6) "resident" has the meaning given in AS 47.25.430(a).

* Sec. 2. The uncodified law of the State of Alaska is amended by adding a new section to read:

SENIOR CARE FUND. A senior care fund is established as an account in the general fund. The fund shall be used by the commissioner of health and social services to pay for the costs incurred for the provision of senior services under sec. 1 of this Act. The fund consists of money appropriated to the fund by the legislature. The legislature may appropriate interest earned on money in the fund to the fund.

* Sec. 3. The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. To the extent the regulations are not inconsistent with this Act, regulations adopted by the Department of Health and Social Services in 2003 to provide cash assistance of $120 a month to seniors that are in effect on March 31, 2004, remain in effect as valid regulations until the department adopts regulations under this Act and those regulations take effect under AS 44.62. Upon the filing of regulations adopted under this Act, the commissioner of health and social services shall post the regulations on the department's Internet website.

* Sec. 4. (a) This Act is repealed on the date that the Medicare Part D benefit under P.L. 101-173 for prescription drugs for Medicare recipients is operational for recipients in this state, as communicated to the commissioner of health and social services by the United States Department of Health and Human Services.

(b) The commissioner of health and social services shall notify the revisor of statutes of the date described in (a) of this section.

(c) Money in the fund established in sec. 2 of this Act reverts to the unreserved general fund on June 30 in the fiscal year in which this Act is repealed under (a) of this section.

* Sec. 5. This Act takes effect April 1, 2004.

1-27-04

withdrawn

AMENDMENT 3

OFFERED IN THE HOUSE FINANCE COMMITTEE

BY REPRESENTATIVE CROFT

TO: CS HB 374 (FIN) Work Draft version 23-GH2123\V

Page 3, delete lines 22-25:

"(i) For any fiscal year in which prescription drug benefits under (e) and (f) of this section are not available for a full 12 months, the commissioner may prorate the total maximum amounts available under (e) and (f) of this section according to the number of months for which those benefits are available."

Renumber accordingly.

1-27-04

AMENDMENT 4

OFFERED IN THE HOUSE FINANCE COMMITTEE
BY REPRESENTATIVE JOULE

adopted as amended

TO: CS HB 374 (FIN) Work Draft version 23-GH2123\V

Page 3, line 31, after "treatment":

Insert "for the individual"

Delete: "or"

4a

Page 3, after line 31;

Hams amdt

Insert a new paragraph to read:

"(2) to accompany the individual's parent, spouse, sibling, grandchild, child, or stepchild who is receiving medical treatment outside the state; or"

Page 4, line 1:

Delete: "30"

Insert "60"

Renumber accordingly.

1-27-04

Failed 2-8

AMENDMENT 5

OFFERED IN THE HOUSE BY REP. JOULE

TO: CSHB 374 (FIN)

Page 1, Lines 5-6

Delete all material and insert

"***Section 1** AS 47.65 is amended by adding a new section"

Page 1, Line 7

Delete "SENIOR CARE PROGRAM'

Insert

"Article 4. Cash and Drug Benefit for Older Alaskans

Sec. 47.65.300 Senior care program."

Page 5 Lines 15-23

Delete all material

Renumber the following sections accordingly

Failed 2-8 1-27-04

AMENDMENT 6

Offered in House Finance Committee By: Rep. Joule

TO: CSHB 374 work draft 1/14/04

Delete Page 2, lines 18-22 (d)

Delete Page 3, lines 22-25 (i)

withdrawn

1-27-04

AMENDMENT 7

Offered in House Finance Committee

By: Rep. Joule

TO: CSHB 374 work draft 1/14/04

Page 4, line 27

After '"public institution" means a"
Insert "state" governmentally owned establishment

1-27-04

adopted

AMENDMENT 8

Offered in House Finance Committee By: Rep. Joule

TO: CSHB 374 work draft 1/14/04

Page 1, line 8

Delete "may"
Insert "shall"

Page 2, line 19

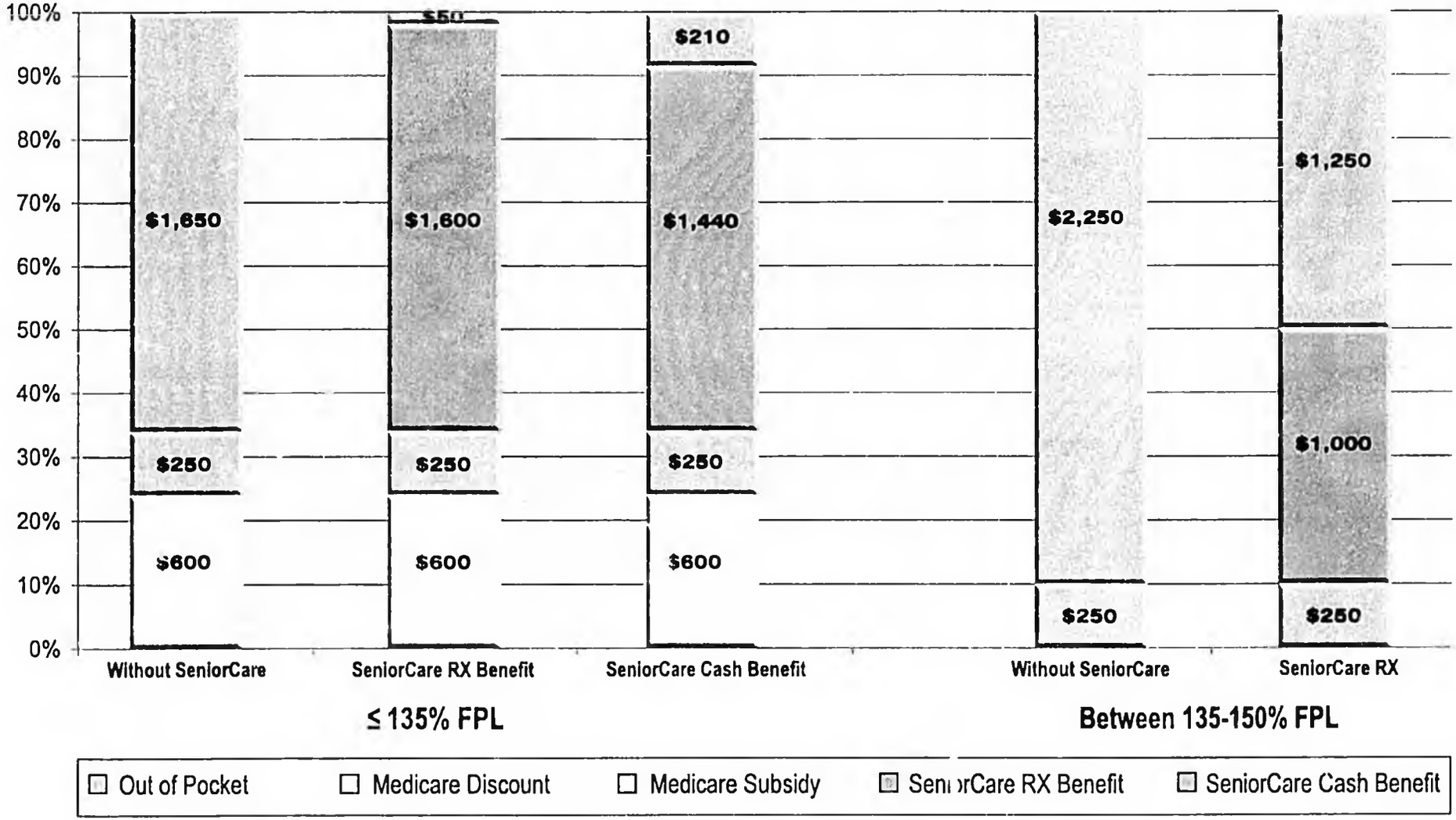
Delete "may"
Insert "shall"

Senior CARE

Bridging the Gap

Comparison of Benefits

$2,500 Annual Rx Cost



FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: HB 374
(H) Publish Date: 1/12/04

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIORCARE PROGRAM
RDU: Public Assistance
Component: SeniorCare

Sponsor: RULES COMMITTEE
Requester:

Component No.: 2760

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	14,649.6	7,690.9				
Miscellaneous						
TOTAL OPERATING	14,649.6	7,690.9	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	12,000.0					
1003 GF Match						
1004 GF	2,649.6	7,690.9				
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	14,649.6	7,690.9	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 554.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The proposed SeniorCare program provides a cash or drug benefit to eligible seniors age 65 or older. Program benefits will be disbursed through the SeniorCare program in the Division of Public Assistance budget. The program is proposed to operate during the last quarter of FY 04, the entire FY 05 and the first half of FY 06.

See assumptions, next page.

Prepared by: Angela Salerno
Phone: 465-6300
Division: Public Assistance
Date/Time: 01/09/2004
Approved by: Joel S. Gilbertson, Commissioner
Date: 01/09/2004
Agency: Department of Health and Social Services

STATE OF ALASKA
2004 LEGISLATIVE SESSION

BILL NO. HB 374

ANALYSIS CONTINUATION
SeniorCare benefit levels

Cash benefit: **$360/yr. in FY04; $1,440/yr. in FY05; $720 in FY06**
Drug benefit, below 135% poverty: **$400/yr. in FY04; $1,600/yr. in FY05; $800/yr. in FY06**
Drug benefit between 135% and 150% poverty: **$250/yr. in FY04; $1,000/yr. in FY05; $500/yr. in FY06**

SeniorCare Caseload Projections

FY 04

Cash benefit: **7,550**
Drug benefit below 135% poverty: **600**
Drug benefit between 135% and 150% poverty: **2,120**

FY 05

Cash benefit: **7,928**
Drug benefit, below 135% poverty: **630**
Drug benefit between 135% and 150% poverty: **2,226**

FY 06

Cash benefit: **8,323**
Drug benefit, below 135% poverty: **662**
Drug benefit between 135% and 150% poverty: **2,337**

Cost Projections:

FY 04 (4th Qtr. only)

Cash benefit: 7,550 x $360 = **$2,718,000**
Drug benefit, below 135% poverty: 600 x $400 = **$240,000**
Drug benefit between 135% and 150% poverty: 2,120 x $250 = **$530,000**

TOTAL FY04 COST: $2,718,000 + $240,000 + $530,000 = $3,488,000 - $2,934,000 (FY 04 appropriation for Alaska Senior Assistance Program) = **$554,000**

STATE OF ALASKA
2004 LEGISLATIVE SESSION

BILL NO. HB 374

ANALYSIS CONTINUATION
SeniorCare Caseload Projections, continued

FY 05

Cash benefit: 7,928 x $1,440 = **$11,415,600**

Drug benefit, below 135% poverty: 630 x $1,600 = **$1,008,000**

Drug benefit between 135% and 150% poverty: 2,226 x $1,000 = **$2,226,000**

TOTAL FY 05 COST: $11,415,600 + $1,008,000 + $2,226,000 = **$14,649,600**

FY 06

Cash benefit: 8,323 x $720 = **$5,992,830**

Drug benefit, below 135% poverty: 662 x $800 = **$529,600**

Drug benefit between 135% and 150% poverty: 2,337 x $500 = **$1,168,500**

TOTAL FY 06 COST:

$5,992,830 + $529,600 + $1,168,500 = **$7,690,930**

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 374
(H) Publish Date: 1/12/04
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: ESTABLISHING THE SENIORCARE PROGRAM
RDU: Public Assistance
Component: Public Assistance Admin

Sponsor: RULES COMMITTEE

Requester:

Component No.: 233

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	40.0	20.0				
Travel	7.0	3.0				
Contractual	12.0	4.0				
Supplies	2.0	1.5				
Equipment	0.5					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	61.5	28.5	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	61.5	28.5				
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	61.5	28.5	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 25.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Outreach for the proposed SeniorCare program will include the staffing and operation of a SeniorCare Information Office to provide full-time, telephone-based infomation on programs and services, advertising about the SeniorCare program and travel to provide information to seniors throughout the state.

Prepared by: Angela Salerno
Phone 465-3200
Division: Pulbic Assistance
Date/Time 01/06/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/07/2004
Agency: Department of Health and Social Services

(Revised 9/2002 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: HB 374
(H) Publish Date: 1/12/04

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIORCARE PROGRAM
RDU: Alaskan Pioneer Homes
Component: Alaska Pioneer Homes Management

Sponsor: RULES COMMITTEE

Requester:

Component No: 2731

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	94.6	5.2				
Travel						
Contractual	74.0	4.0				
Supplies	15.7	0.9				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	184.3	10.1	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF	184.3	10.1				
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	184.3	10.1	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 46.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time	2	2				
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The Division of Alaska Pioneer Homes will process enrollment and determine program eligibility for the SeniorCare program. The division will also issue and mail checks for the cash benefit segment of the program. The SeniorCare program will operate for the last quarter of FY 04, the entirety of FY 05, and six months of FY 06.

Due to increasing costs, a 10% inflation factor was applied to FY 05 costs to determine FY 06 contractual services and supply costs.

Continued next page.

Prepared by: Virginia Smiley
Phone 465-4422
Division: Alaskan Pioneer Homes
Date/Time 01/06/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/07/2004
Agency: Department of Health and Social Services

STATE OF ALASKA
2004 LEGISLATIVE SESSION

BILL NO. HB 374

ANALYSIS CONTINUATION

The eligibility Tech I (range 13, step A) will provide or supervise the provision of accurate eligibility determinations and benefit authorizations for new and ongoing SeniorCare cash benefit or pharmacy benefit applicants/recipients. In accordance with regulations the positionÃ?Â¢??s work includes interviews, data collection, data review and analysis and investigations. The position will enroll pharmacy benefit recipients in the public assistance EIS system.

The Admin Clerk III, (range 10, step A) position will perform specialized clerical functions requiring knowledge of SeniorCare policies. The position will need to understand laws and regulations and vary procedures depending on different situations, and be able to explain the requirements to others. The position will need to recognize errors and discrepancies in information and take appropriate action. The Admin Clerk III will be the back up position for the ET I and will process "month-end" cash benefit checks in the absence of the ET I.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: HB 374
(H) Publish Date: 1/12/04

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE SENIORCARE PROGRAM
RDU: Departmental Support Services
Component: Information Technology Services

Sponsor: RULES COMMITTEE
Requester:
Component No.: 2754

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies	7.1	7.5				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	7.1	7.5	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	7.1	7.5				
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	7.1	7.5	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 6.8
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The Public Assistance Systems Operations unit, under the departmental Information Technology Services component, will issue and mail SeniorCare drug benefit cards to approximately 2,720 recipients in FY 04, 2,856 recipients in FY 05, and 2,999 recipients in FY 06.

Prepared by: Janet Clarke, Director
Phone: 465-1630
Division: Administrative Services
Date/Time: 01/07/2004
Approved by: Joel S. Gilbertson, Commissioner
Date: 01/07/2004
Agency: Department of Health and Social Services

(Revised 9/2002 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 5
Bill Version: HB 374
(H) Publish Date: 1/12/04
Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title ESTABLISHING THE SENIORCARE PROGRAM
RDU Health Care Services
Component Health Purchasing Group
Sponsor RULES COMMITTEE
Requester
Component No. 243

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual		50.0				
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	50.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF		50.0				
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	50.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 85.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The Department of Health and Social Services Division of Health Care Services anticipates required FY04 start-up costs of $85.0 in general funds for the development of MMIS claims processing capability for payment of the state program's drug benefit plan.

There are no additional anticipated costs during the course of FY05.

The department anticpates general fund costs of $50.0 for MMIS system changes and documentation with the sunset of the program in FY06.

Prepared by: Nancy Burns
Phone 465-3356
Division Health Care Services
Date/Time
Approved by: Joel S. Gilbertson, Commissioner
Date 01/07/2004
Agency Department of Health and Social Services

(Revised 8/2002 OMB)

Adopted
Offered 1.20.04

AMENDMENT

OFFERED IN THE HOUSE FINANCE COMMITTEE
BY REPRESENTATIVE CROFT

TO: CS HB 374 Work Draft version 23-GH2123\D

Page 2, line 23:

Delete: "make an irrevocable election"

Insert: "semi-annually elect"

Croft "delete semi"

Delete "annually"

(1) Say "annually elect"

(2) Croft changed to "once annually elect"

new CS coming that incorporates new amendments (via Pete E)

Adopted
Offered 1-20-04

AMENDMENT 2

OFFERED IN THE HOUSE FINANCE COMMITTEE

BY REPRESENTATIVE CROFT

TO: CS HB 374 Work Draft version 23-GH2123\D

Page 3, line 15:

Delete: "may"

Insert: "shall"

23-GH2123\D
Mischel
1/14/04

CS FOR HOUSE BILL NO. 374( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the senior care program and relating to that program; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SENIOR CARE PROGRAM. (a) The senior care program is established in the Department of Health and Social Services. Under the program, the department may provide cash assistance and prescription drug benefits as specified in this section as far as practicable under appropriations provided by law.

(b) The department shall

(1) administer the program; and

(2) adopt regulations under AS 44.62 to carry out the purposes of the program.

(c) In order to be eligible for the program, an individual shall

(1) be 65 years of age or older;

(2) be a resident of the state;

(3) have household income

(A) that does not exceed 135 percent of the federal poverty guideline as defined by the federal Office of Management and Budget and revised under 42 U.S.C. 9902(2) to be eligible for cash assistance under (d) of this section or prescription drug benefits under (e) of this section; or

(B) that exceeds 135 percent, but not exceeding 150 percent, of the federal poverty guideline as defined by the federal Office of Management and Budget and revised under 42 U.S.C. 9902(2) for prescription drug benefits under (f) of this section;

(4) meet other eligibility requirements specified in this section and in regulations adopted under this section; and

(5) apply on a form provided by the department; the department may use an abbreviated form for individuals who received payments under an assistance program for seniors paying $120 a month and administered by the department on or before March 31, 2004.

(d) An eligible individual who meets the income standard of (c)(3)(A) of this section may receive cash assistance of $120 a month as far as practicable under appropriations available to the program. The department may prorate the amount of cash assistance paid under this subsection if the department estimates that appropriations for the program are not sufficient to meet the demands for the program in a fiscal year.

A #1

(e) In place of the cash assistance under (d) of this section, an eligible individual may ~~make an irrevocable election~~ once annually elect to receive prescription drug benefits annually, provided in the manner specified by the department in regulation. The total maximum prescription drug benefits an individual may receive under this subsection in a fiscal year is $1,600. An individual who has prescription drug coverage under AS 47.07 is not eligible to receive prescription drug benefits under this subsection.

(f) An eligible individual who meets the income standard of (c)(3)(B) of this section may receive only prescription drug benefits as provided in this subsection. The provisions of (e) of this section apply to prescription drug benefits provided under this subsection except that the total maximum prescription drug benefits that an individual may receive under this

subsection in a fiscal year is $1,000.

(g) To receive prescription drug benefits under (e) or (f) of this section, an eligible individual must assign to the department the individual's rights to payments under any other prescription drug program for a prescription drug benefit paid under this section. Payment may not be made under this section for an amount that would otherwise qualify for payment under another prescription drug benefit plan, except for prescription drug coverage received from health care facilities that operated under the authority of 25 U.S.C. 450 - 458 bbb-2 (P.L. 93-638).

(h) Except as otherwise provided in this subsection, the department may pay under (e) and (f) of this section only for a prescription drug, insulin, and insulin syringes. The department may not pay under (e) and (f) of this section for drugs used to treat obesity, baldness, infertility, or impotence; drugs that are prohibited from receiving funding under the medical assistance program in AS 47.07; smoking cessation products; drugs used for symptomatic relief of coughs and colds; oral vitamins; or brand-name multisource drugs if a therapeutically equivalent generic drug is on the market. However, the department may pay for brand-name multisource drugs if the prescriber writes on the prescription "The brand-name drug is medically necessary" and the prescriber states the reason that the brand-name drug is medically necessary. The department may also restrict coverage of drugs under (e) and (f) of this section to be consistent with the preferred drug list implemented by the department for purposes of the medical assistance program under AS 47.07.

(i) For a fiscal year in which prescription drug benefits under (e) and (f) of this section are not available for a full 12 months, the commissioner may prorate the total maximum amounts available under (e) and (f) of this section according to the number of months for which those benefits are available.

(j) The department may not make payment or authorize a benefit under this section to or on behalf of an individual residing in a public institution or nursing facility.

(k) An eligible individual who leaves the state may not receive cash assistance or prescription drug benefits under this section during the absence unless the individual temporarily leaves for one of the following reasons:

(1) medical treatment; or

(2) a vacation, business trip, or other absence of fewer than 30 consecutive

days, unless the individual has applied for and received a time extension from the department for special circumstances.

(*l*) An individual who receives a determination under this section from the department that denies, limits, or modifies prescription drug benefits or cash assistance under this section, other than a determination under (d) or (i) of this section to prorate the amount of benefits or assistance, may request a hearing before the department. The department shall adopt regulations for the conduct of hearings under this subsection. The hearing process under this subsection is not subject to AS 44.62.330 - 44.62.630. The decision of the department after a hearing under this subsection is a final administrative order subject to appeal to the superior court.

(m) An individual who receives assistance or benefits under this section when not entitled to them because the information provided by the individual was inaccurate or incomplete is liable to the department for the value of the assistance or benefits improperly provided to the individual. In a civil action brought by the state to recover from the individual the value of assistance or benefits improperly provided under this section, the state may recover from the individual the costs of investigation and prosecution of the civil action, including attorney fees as determined under court rules.

(n) Cash assistance provided under this section is inalienable by assignment or transfer and is exempt from garnishment, levy, or execution as provided in AS 09.38.

(o) In this section,

(1) "commissioner" means the commissioner of health and social services;

(2) "department" means the Department of Health and Social Services;

(3) "eligible individual" means an individual who meets the requirements of this section and regulations adopted under this section for eligibility for the program;

(4) "program" means the program established in this section;

(5) "public institution" means a governmentally owned establishment that furnishes food, shelter, and some additional treatment or services to 16 or more persons;

(6) "resident" has the meaning given in AS 47.25.430(a).

* Sec. 2. The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. To the extent the regulations are not inconsis

with this Act, regulations adopted by the Department of Health and Social Services in 2003 to provide cash assistance of $120 a month to seniors that are in effect on March 31, 2004, remain in effect as valid regulations until the department adopts regulations under this Act and those regulations take effect under AS 44.62. Upon the filing of regulations adopted under this Act, the commissioner of health and social services shall post the regulations on the department's Internet website.

* **Sec. 3.** (a) This Act is repealed on the date that the Medicare Part D benefit under P.L. 101-173 for prescription drugs for Medicare recipients is operational for recipients in this state, as communicated to the commissioner of health and social services by the United States Department of Health and Human Services.

(b) The commissioner of health and social services shall notify the revisor of statutes of the date described in (a) of this section.

* **Sec. 4.** This Act takes effect April 1, 2004.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 14, 2004

SUBJECT: Senior Care Program CS HB 374( );
(Work Order No. 23-GH2123\D)

TO: Representative Bill Williams
Attn: Pete Ecklund

FROM: Jean M. Mischel
Legislative Counsel

Enclosed is a blank committee substitute for HB 374 that makes technical and stylistic changes consistent with the Manual of Legislative Drafting (2003) and clarifies provisions that may be ambiguous or otherwise unclear.

The following is a detailed list of those changes.

Page 1, Title and subsection 1(a):

The term "SeniorCare" was rewritten as "senior care." The department will be free to promote the program as "SeniorCare" in the same way the department promotes Denali KidCare, but the proper statutory form is "senior care."

Page 1, line 7:

The sentence beginning with "The SeniorCare program is authorized to provide..." was rewritten as "Under the program, the department may provide..." "Program" is defined later in the bill to mean the senior care program.

Page 1, line 11:

Subsection (b)(1) was changed from "administer the SeniorCare program established under (a) of this section" to "administer the program."

Page 1, line 14:

The word "must" was changed to "shall."

Page 2, line 2:

The phrase "State of Alaska" was changed to "state."

Page 2, line 3:

Following "have" the word "household" was inserted to modify "income."

Page 2, line 4:

The phrase "of not more than" was changed to "that does not exceed."

Page 2, lines 4-5 and line 8:

The phrase "poverty level for this state" was changed to "poverty guideline as defined by the federal office of management and budget and revised under 42 U.S.C. 9902 (2)."

Page 2, line 7:

The phrases "of more" and "of more than" were changed to "exceeding" and "that exceeds," respectively.

Page 2, line 17:

The phrase "is authorized" was changed to "may" and "per month" was changed to "a month."

Page 2, line 19:

The phrase "authorized to be" was deleted and the word "section" was changed to "subsection."

Page 2, line 22:

The phrase "authorized in (d)" was changed to "under (d)."

Page 2, line 29:

The phrase "is authorized to" was changed to "may" and the comma following "benefits" was deleted.

Page 3, lines 4, 5 and 21:

The word "any" was changed to "a" or "an", as appropriate.

Page 3, line 6:

The phrase "any other" was changed to "another."

Page 3, line 7:

The citation to 25 U.S.C. 450-458 was changed to 25 U.S.C. 450-458bbb-2 for accuracy.

Page 3, line 9:

The phrase "is authorized" was changed to "may."

Page 3, lines 12-13 and line 20:

The word "Medicaid" was deleted and replaced with "the medical assistance program in."

Page 3, lines 14-16:

The word "brand name" was rewritten as "brand-name" and "multi-source" as "multisource."

Page 3, line 28:

The comma following "absence" was removed.

Page 3, line 29:

The word "reasons" was added after the word "following."

Page 3, line 31:

An extra space was removed after the word "absence", the word "less" was replaced with "fewer" and the word "consecutive" was inserted between the words "30 days."

Page 4, line 8:

The phrase "after a hearing under this subsection" was added after the word "department."

Page 4, lines 20-21:

The phrase "the Department of Health and Social Services" was changed to "health and social services."

Page 4, line 25:

The word "SeniorCare" was deleted.

Page 4, line 28:

The second use of the word "resident" was deleted.

Page 5, line 2:

The phrase "per month" was changed to "a month" and the phrase "before the effective date of this Act" was changed to "that are in effect on March 31, 2004."

Page 5, line 3:

The phrase "implementing this Act" was deleted.

Page 5, lines 5-6:

The phrase "the Department of Health and Social Services" was changed to "health and social services."

Page 5, line 6:

The phrase "shall notify the revisor of statutes of the effective date of the regulations and" was changed and moved to Section 3 as described below.

Page 5, lines 8-12, Section 3:

This section was split into subsections (a) and (b), the phrase "the commissioner of the Department of Health and Social Services certifies to the revisor of statutes that the commissioner received notification from the United States Department of Health and Human Services that" was moved to the end of the section and changed to ", as communicated to the commissioner of health and social services by the United States Department of Health and Human Services." The new subsection (b) incorporates language deleted in Section 2 as described above and reads: "(b) The commissioner of health and social services shall notify the revisor of statutes of the date described in (a) of this section." These changes were made in order to clarify the date on which the senior care program will be repealed. This clarification pinpoints the Medicare operational date as the repeal date. The problem with the original bill's language is that the notification by the federal authorities might occur before the starting date of the Medicare program, giving Alaska lead time. The CS version assumes that the legislature wouldn't want the state's program to be repealed until the federal program actually starts, not when the notification was received.

Please let me know if you have any questions or if any of the changes in the CS have substantive effects that are not in accord with your wishes.

JMM:med
04-029.med

Enclosure

DISABILITY LAW CENTER OF ALASKA

JUNEAU
230 South Franklin #206
Juneau, AK 99801
(907) 586-1627
FAX (907) 586-1066

January 25, 2004

By hand delivery

Representative John Harris, co-chair
Senate Finance Committee
State Capitol, Room 507
Juneau, Alaska

Representative Bill Williams, co-chair
Senate Finance Committee
State Capitol, Room 515
Juneau, Alaska

Re: **HB 374: SeniorCare and Prescription Drug Coverage for Alaska's Medicare population**

Dear Representatives Harris and Williams:

I include some additional background on the issue of prescription drug coverage for Medicare-only eligibles (whether elderly or under 65).

One facet of the conversation is coverage for new, more effective oral medications for cancer. Previous cancer treatments had been covered by Medicare as injectable medications (chemotherapy) administered by physicians, hospitals or clinics on an outpatient basis. **The need for assistance in prescription coverage** for these new oral cancer drugs – which offer the promise of directly saving lives – **is no less urgent for Alaskans with cancer under 65** as it is for Alaskans with cancer who are over 65 years of age.

Another facet is the cheaper cost of prescription medications in Canada and other foreign countries. This is a very complex issue, with several conflicting interests at stake, and numerous suggested approaches to the issue. But the bottom line is: Alaskans under 65 with disabilities are driven by high prescription drug costs to seek discounts out of state in the same way that Alaska's Medicare-only seniors are driven across the border or out-of-state, at a loss of in-state revenues for Alaska's pharmacies and retailers. **The SeniorCare bill, if expanded to include Alaska's under-65, Medicare-only eligibles, will keep additional revenues in-state, and piggy back on the Administration's plans for cost-saving for public-funded prescription drug benefit programs for seniors, Medicaid-eligibles, and others in this area.**

Both the Council on State Governments[1] and the Alaska Prescription Drug Task Force[2] expressed the view that a prescription drug benefit for Medicare-only recipients should cover *both* seniors and persons with disabilities under age 65. Congress recognized the wisdom of this in the Medicare Prescription Drug, Improvement and

[1] CSG, Governing Board/Executive Committee, *Resolution on Prescription Drug Coverage Under Medicare* (Dec. 8, 2002) reprinted at: http://www.csg.org/CSG/Policy/CSG+policy+positions/default.htm (under "2002 Annual Meeting Policy Resolutions," click on "Prescription Drug Coverage Under Medicare")(copy enclosed).

[2] Alaska Prescription Drug Task Force: Recommendations to Governor Tony Knowles (Oct. 1, 2002), at page 25 ("Alaska should establish a state-funded direct benefit prescription drug program. . . . The eligible population should be those over 65 and eligible for Medicare *and those under 65 who receive Medicare benefits due to disability*"), reprinted at: http://hss.state.ak.us/dsds/ (excerpt enclosed).

Modernization Act of 2003, which applies to seniors and under-65 Medicare-only eligibles alike. We think the prescription drug "bridge" bill (HB 374) could be easily be amended to include Alaskans under 65, and have drafted an amendment to do just that (copy enclosed).

However, if the committee decides that more information is needed before it can act to include this subpopulation, we urge instead the immediate passage of HB 374 out of the Finance committee. We do not want to slow the bill, and will continue our advocacy on this subject with the Administration and its advisory councils serving Alaskans with disabilities. We hope that if the committee cannot revise HB 374, another bill may be introduced that will address the prescription drug coverage needs of Alaska's under-65, Medicare-only recipients.

I understand that I may be permitted to make some verbal remarks to the House Finance Committee on January 27, after 1:30 p.m. I have been called away to Sitka on some urgent business relating to my clients, and will testify by telephone from the Sitka LIO on January 27.

Very truly yours,

Bob Briggs

Robert B. Briggs, staff attorney

CC: (w/ encls.)

House Finance Committee
Joel Gilbertson, Commissioner, DHSS
Dennis DeWitt, Office of the Governor
Alaska Commission on Aging (Banarsi Lal, chairperson)
Alaska State Independent Living Council (Erma Perry, chairperson)
Governor's Committee on Employment and Rehabilitation of People with Disabilities
Pat Luby, AARP
Dave Fleurant, exec. dir., DLC-Anchorage

AMENDMENT TO

HOUSE BILL NO. 374

AMENDMENT NO. _____ OFFERED BY: _____

At page 1, line 1, delete "SeniorCare" and insert "Alaska Rx Care"

At page 1, line 6, delete "SENIORCARE" and insert "Alaska Rx Care"; delete "SeniorCare" and insert "Alaska Rx Care";

At page 1, lines 7 and 11, delete "SeniorCare";

At page 2, line 1, delete "65" and insert "18";

At page 2, line 3, before "have income" insert: "be eligible for Medicare Part A, Part B or both;" and renumber succeeding subsections

At page 4, line 25, delete "SeniorCare" and insert "Alaska Rx Care"

At page 5, line 2, delete "seniors" and insert "eligible individuals"

CSG GOVERNING BOARD/EXECUTIVE COMMITTEE

RESOLUTION ON

PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

WHEREAS, 40 million seniors and 5 million disabled Americans do not have outpatient prescription drug coverage under Medicare although Medicare is their primary source of insurance coverage;

WHEREAS, 38 percent of America's seniors and individuals with disabilities do not have any outpatient prescription drug coverage at all;

WHEREAS, The majority of Medicare beneficiaries must rely on other public and private health care programs to provide prescription drug coverage;

WHEREAS, Drug coverage can make a significant difference in the financial and physical health of Medicare beneficiaries because research indicates that those without coverage pay higher out-of-pocket costs for medications and also fill fewer prescriptions;

WHEREAS, Among all Medicare beneficiaries the average out-of pocket costs for prescription drugs is more than $1,000 per year;

WHEREAS, Prescription drug coverage options for seniors have diminished in recent years due to the decrease in prescription drug coverage offered by Medicare+Choice plans and by employers for retirees;

WHEREAS, The under-65 disabled population enrolled in Medicare also faces daunting challenges with access to and the affordability of prescription drugs due to low incomes, high medication use, poor health and few options for prescription drug coverage; and

WHEREAS, Prescription drugs are an integral part of modern medical care, making it possible for more Americans to lead longer, healthier and more productive lives; and

NOW THERFORE BE IT RESOLVED that The Council of State Governments strongly urges the President and Congress to pass legislation providing an outpatient prescription drug benefit under Medicare for America's seniors and individuals with disabilities who demonstrate an economic need.

source: http://www.csg.org/CSG/Policy/CSG+policy+positions/default.htm

Adopted on the 8th Day of December, 2002, at the
CSG Annual State Trends and Leadership Forum
In Richmond, Virginia

Governor Michael Huckabee
2003 CSG President

Representative Daniel Bosley
2003 CSG Chair

ALASKA PRESCRIPTION DRUG TASK FORCE

RECOMMENDATIONS TO GOVERNOR TONY KNOWLES

October 1, 2002

source: http://hss.state.ak.us/dsds

Introduction:

When Medicare was signed into law in 1965, little thought was given to providing a prescription drug benefit. Few prescriptions were regularly used as "preventive medicine" and those that were available were not that expensive. In today's medical world, prescription drugs are considered "smart medicine." Research has created thousands of new medications that are routinely used to avoid expensive surgery and maintain optimum health. Most employers routinely provide prescription drug coverage to their enrolled employees and dependents because it is an effective, economical tool in the health care resource box. Thirty-seven years after enactment, however, Medicare still does not provide a prescription drug benefit to Alaskans over 65 and younger persons with disabilities who are also covered under Medicare. Medicaid, on the other hand, recognizes that prescription coverage is an essential part of a health care plan.

In the absence of a federal plan, 34 states have established some type of program to provide pharmaceutical coverage or assistance to older persons or younger persons with disabilities who are not eligible for Medicaid. The programs vary in their approaches, their target population, and in the amount of assistance they provide. However, each shares a common element: it is designed to reduce the burden of prescription drug costs for a selected group in the population. In addition, some require a drug regimen review that usually results in lower costs as well as healthier residents.

The Task Force has reviewed the programs of each state, conferenced with staff experts at the National Conference of State Legislatures, solicited comments in writing and through a public hearing, and reviewed a variety of changes that might have some impact on reducing the cost of prescription drugs to Alaska's seniors. Current pharmaceutical costs were reviewed and projections are included for growth of Alaska's senior population. Baring Congress enacting a significant prescription drug program under Medicare, Alaska can expect increasing pharmaceutical costs for our older population and increasing costs to the Medicaid program. In 2001, pharmaceutical costs for all Alaskans went up over 25% and 27% for the Medicaid program. As Governor Knowles said on August 2, 2002..."we can't wait any longer--it's time to take action."

Task Force Members:
Robert Albertson, Chief Pharmacist, Alaska Pioneers' Home
Steven Ashman, Director, Alaska Division of Senior Services
Marie Darlin, Alaska Resident over age 50
Jeff Davis, Vice President and General Manager, Premera Blue Cross/Blue Shield of Alaska
Bob Lohr, Director, Alaska Division of Insurance
John Patrick Luby, Alaska Resident over age 50
Jonathan Sherwood, Manager, Alaska Division of Medical Assistance

Task Force Assignment # 6: Develop Recommendations For Regulations, Waiver Applications, and Legislation That This State Should Pursue In Assisting Alaskans With The Costs Of Their Prescription Drugs, And Project A Cost To The State For Each Recommendation

The task force considers it important to recognize that these recommendations do not focus solely on reducing the cost of prescription medications. It is equally important to consider improving the health status as an overall and appropriate goal. We have only to look to the experience of the Alaska Pioneer Homes to see this.

When the Pioneer Home staff pharmacists began to perform drug regimen reviews, the typical Pioneer (average age 89) was taking 14 medications. By a simple review of all medications and discussion with the resident and his/her physician, drug usage was cut by 50%. With only 7 medications, the overall health status of the residents improved and prescription drug expenses were significantly reduced.

1. **Establish a direct benefit pharmaceutical program**

It is the consensus of the task force that Alaska should establish a state-funded direct benefit prescription drug program for residents who meet age or disability and income requirements whose needs cannot be met by the other recommendations.

These programs, similar to programs adopted in many other states that have proven successful and have provided the greatest benefit to those most in need due to high and hard-to-control pharmaceutical costs.

The eligible population should be those over 65 and eligible for Medicare and those under 65 who receive Medicare benefits due to disability. The Legislature should determine the most appropriate income level. However, the income level should be above that for Medicaid eligibility and most states have selected a limit determined by the federal poverty level, e.g. 150% ($16,620 single, $22,395 couple) or 200% ($22,160 single, $29,860 couple) of the Federal Poverty Level.

One of the benefits of a state-funded direct benefit program would be that it qualifies for the Medicaid best price exemption and that it will help in negotiating the highest rebates.

Develop and implement formularies, preferred drug lists and/or prior authorization requirements as cost control tools, for negotiating manufacturer rebates, and for selecting the best therapeutic medication of "fail first" triaging of drug choices.

To reduce the state's share of the cost of a direct benefit pharmaceutical program, and to promote maintenance of individual and family responsibility, consideration should be given to requiring participant co-pays on a sliding scale basis. Sliding scales will allow the state to benefit those Alaskans with the greatest financial need. Other cost control techniques may include deductibles and maximum benefit limits.

The State should also consider including some or all of its direct benefit pharmaceutical program under a Medicaid waiver. This would allow some federal funds to be used to subsidize the costs of the program, although federal cost neutrality requirements for waivers may limit the amount available.

The State should consider adding a catastrophic benefit for those with higher incomes but extremely high prescription costs.

The State should consider a variety of delivery mechanisms but should maximize the opportunity for drug regimen reviews by pharmacists. The task force believes, based on the Alaska Pioneer Home experience, any drug regimen review process will result in reduced costs and reduced inappropriate usage.

In marketing a new state-funded direct assistance program, the State should look to the experience of the Denali KidCare program as a successful model of outreach and enrollment.

2. Establish a clearinghouse/education program on prescription drugs.

The task force recommends that Alaska establish a clearinghouse for information on prescription drugs and an educational outreach program.

Some private pharmaceutical companies have, individually or in collaboration with other companies, established free or deeply discounted prescription drugs to low-income individuals. It is difficult for individuals, physicians and pharmacists to stay up to date on the variety of available programs and the changes that the marketplace continues to create in regard to existing and new programs. The task force believes that the Department of Administration, Division of Senior Services, is a logical location for such a clearinghouse. The Division already performs extensive outreach throughout the State and houses a successful Medicare/Medicaid information program that acts as a clearinghouse on these topics. Likewise, DOA staff pharmacists of the Pioneer Homes already do outreach and education to older persons as well as to physicians and community and institutional pharmacists and other health care professionals. Funding for the Pioneer Home's outreach is temporary and should be made permanent.

A clearinghouse on available prescription drug programs can be developed with or without a direct benefit program. With a minimal investment, Alaska can greatly increase the utilization of free pharmaceutical programs from private companies by older and disabled Alaskans who meet the income parameters, as well as significantly enhance the knowledge of physicians and pharmacists about appropriate therapeutic substitutions, available generic substitutes, etc.

An educational component targeted toward consumers can include information on use of generics, therapeutic substitution as well as a drug regimen review that can act to counter the effects of direct to consumer prescription drug advertising.

An educational component targeted toward prescribing physicians should include cost information on brand name drugs, availability of less expensive generics, therapeutic substitution as well as information on conducting drug regimen reviews with patients. It will help balance the information currently provided by pharmaceutical companies encouraging the use and sale of their latest product.

3. Expand the use of the 340B program.

There are currently 34 facilities in Alaska that use the 340B program. Approximately 70 more sites are eligible. Under the 340B program, drug manufacturers must enter into agreements with the United States Department of Health and Human Services to provide covered outpatient drugs to participating entities at discounted prices. Federally Qualified Health Centers (FQHC) exist throughout Alaska. If all the entities eligible actually participated in the 340B program, discounts averaging 25-40% would be offered on most drugs and could be made available to financially needy older and younger disabled Alaskans from sites near them. The task force recommends that Alaska increase the use of safety net providers and expand the 340B drug pricing availability to more citizens throughout the State. Current and future 340B entities should be encouraged to apply to HHS as demonstration projects allowing them to expand access to more affordable medications to greater numbers of local citizens.

4. Use a preferred drug list or formulary and drug regimen review in the Medicaid program.

The task force recommends that the Alaska Medicaid program develop a preferred drug list or formulary that designates less expensive but therapeutically appropriate drugs. The Alaska Pioneer Homes already uses an approved formulary. Likewise, the task force recommends that the Medicaid program develop a drug regimen review similar to the successful reviews conducted by the Alaska Pioneer Homes.

Therapeutic substitution is the practice of dispensing an alternate chemical entity from the same therapeutic class for the drug that was ordered. In institutions like the Pioneer Homes, this is worked out prospectively as much as possible. In the event that a substitute has not been agreed upon up front, the pharmacist makes recommendations for alternate available choices to the ordering physician or other prescriber. This is different from generic substitution that is the substitution of exactly the same chemical entity and bio-equivalent drug product form for one of a different brand name.

Currently Alaska Medicaid recipients have a $2 co-payment for each prescription. The task force recommends that the Medicaid program consider changing the co-payments to a reduced amount for medications that are generic or on a preferred drug list and a higher amount for medications that are brand name, e.g. $1 or $2 for preferred drugs/generics and $3 or $4 for brand name medications.

5. **Seek possible funding from private sources.**The task force recommends that the State seek possible funding opportunities from private foundations interested in health issues. Many foundations are willing to collaborate with state government to develop models that reduce inappropriate prescription drug usage and costs.

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

Get Mad

Medicare Non-Coverage of New Oral Cancer Treatments: A Hard Pill To Swallow

Other Fall 2001 Articles
- Feature Article
- Science in the Spotlight
- Living Legend
- Alliance View
- 15 Year Forecast

Promising new drugs are revolutionizing the treatment of cancer. But as so often happens, the federal bureaucracy has yet to catch up with scientific advances. As a result, millions of Americans may be denied potentially life-saving cancer drugs.

The reason? As bizarre as it sounds, it's because some of the new the cancer treatments are in the form of ***pills***. That's right - pills that patients would swallow in the comfort and convenience of their own homes. Under current law, Medicare will not pay for ***oral*** cancer medications, only ***injectable*** medications given by physicians.

Until recently, traditional cancer treatments like chemotherapy were administered intravenously, done in hospitals or doctors' offices. Unfortunately, while the treatments kill cancer cells, they also kill healthy cells. That's what causes the devastating side effects like hair loss, nausea, and fatigue. But coming on the market is a new generation of "oral cancer therapies." These pills' more targeted approach is far less toxic, and produces fewer nasty side effects, than injections. These drugs have shown great promise in treating leukemia, breast and prostate cancer.

But these new drugs aren't cheap. A one-month supply of a typical new drug can cost up to $2,500. And because the drugs do not cure cancer, the drugs must be taken for life to keep the cancer at bay. Because cancer is predominantly a disease associated with aging, Medicare coverage for these cancer medications is essential. Medicare now covers more than 90 percent of current, injectable cancer treatments, but pays for only a fraction of the oral medications.

"This doesn't make any sense, and it needs to change," says Dwayne Howell, president and CEO of the Leukemia and Lymphoma Society.

Judy Orem, 57, is living proof of the new drugs' effectiveness. In December 1995, she was diagnosed with chronic myeloid leukemia, an aggressive bone marrow cancer. After enduring three years of debilitating Interferon treatments, she thought she'd come to the end of the line. "The doctors told me there was nothing more they could do,"

she says. But then she heard about clinical trials of a new cancer drug. She enrolled in the trial, made a remarkable recovery, and remains on the medication.

"If I were depending on Medicare to cover me, I wouldn't be alive today," Orem says. "I'd have died long ago."

While the 40 oral anti-cancer drugs currently on the market make up just five percent of available cancer treatments, researchers predict that figure will grow to at least 25 percent within a decade.

Sen. Olympia Snowe (R-Maine) says this disparity must be corrected. "As cancer therapy moves more toward reliance on oral drugs, Medicare coverage policy must be updated to cover the new therapies." In May, she joined forces with Sen. Jay Rockefeller (D-WV) to co-sponsor the "Access to Cancer Therapies Act of 2001."

Rockefeller says, "The bill will help ensure that seniors and the disabled will have access to oral cancer drugs as a part of their Medicare benefit." To date, 23 senators have signed on as co-sponsors in support of the bill. Similar legislation has been introduced in the House by Rep. Deborah Pryce (R-Ohio). At last count, 207 members have agreed to be co-sponsors of that bill.

Some House and Senate leaders would prefer that the legislation be part of a comprehensive Medicare drug benefits package. However, most Hill watchers say it would be 2004 at the earliest before a comprehensive drug benefits plan could take effect.

Judy Orem says cancer patients can't afford to wait that long. "People are dying because they're not able to get these new drugs. They've used the ones Medicare covered, and they don't work. The longer they wait to approve this, the more people will die."

Email a Friend

Printer-Friendly

Feedback

WHAT YOU CAN DO:

The Alliance along with some 40 patient advocacy organizations representing millions of American families and many more scientific and academic groups support Secretary Thompson's endorsement of this lifesaving research, and will urge Mr. Bush to be "pro-life" and allow federal funding for embryonic stem cell research to continue. We urge you to:

- Write your local paper and encourage more news coverage on this discriminatory provision in Medicare and the chilling effects it has on patients. Draft up your own opinion and send it as a letter to the editor.
- Call, write, or E-mail your Senators and Representative, and urge them to support the Access to Cancer Therapies Act of 2001.
- Write or E-mail the White House to urge President Bush to sign legislation when it arrives on his desk.

LETTER TO HOUSE COMMERCE COMMITTEE AND SENATE FINANCE COMMITTEE ADVOCATING PART B COVERAGE FOR ORAL ANTI-CANCER AGENTS (September 19, 2000)

September 19, 2000

The Honorable .....
Washington, D.C. 20510

Dear Senator .....:

The ongoing debate over prescription drugs has highlighted for the cancer community a major shortfall in coverage for life-extending therapies for beneficiaries diagnosed with cancer. While most anti-cancer drugs are currently covered by the program because they are "incident to" physician services, some important drugs remain unreimbursed—notably hormonal agents for breast and prostate cancer—because they are available only in oral dosage.

In addition, the drug discovery pipeline is about to release significant new oral anti-cancer compounds that are not covered under current Medicare law. Offering great potential for enhanced survival, these new agents are based on a variety of cellular mechanisms that inhibit proliferation of cancer cells. Yet without amendment to the Medicare statute, beneficiaries will not have access to these life-extending anti-proliferative cancer drugs.

Cancer is a disease of the elderly, and Medicare beneficiaries are disproportionately affected. Beneficiaries with cancer rely on Medicare to fund their often costly drug therapy, and special coverage rules have been adopted by Congress to meet the unique needs of cancer patients. Most importantly, because cancer therapy frequently employs drugs "off-label"—i.e., for disease indications not specifically approved by the Food and Drug Administration—the statute requires coverage of medically appropriate off-label drug usage in treating cancer patients.

These protections are absolutely essential for patients with cancer, and the cancer community strongly supports coverage for all anti-cancer agents, including oral drugs, in Medicare Part B. Only by expanding Part B coverage to include oral anti-cancer drugs can the program continue to provide comprehensive quality cancer care under the

supervision of a trained oncologist or other cancer specialist.

As the Presidential candidates debate prescription drug coverage for the elderly and this Congress considers end-of-session legislation, we believe now is the best time to add oral anti-cancer drug coverage to Part B. Coverage now will represent an impressive down payment on an overall Medicare drug benefit and will address concerns of cancer patients about their continuity and quality of care.

As representatives of people with cancer, cancer caregivers and cancer research organizations, we strongly urge your support for this urgently needed initiative.

Cancer Leadership Council

Alliance for Lung Cancer Advocacy, Support, and Education
American Society of Clinical Oncology
Cancer Care, Inc.
Cancer Research Foundation of America
The Children's Cause, Inc.
Coalition of National Cancer Cooperative Groups
Colorectal Cancer Network
Cure For Lymphoma Foundation
International Myeloma Foundation
Kidney Cancer Association
The Leukemia & Lymphoma Society
Multiple Myeloma Research Foundation
National Alliance of Breast Cancer Organizations
National Coalition for Cancer Survivorship
National Patient Advocate Foundation
National Prostate Cancer Coalition
North American Brain Tumor Coalition
Oncology Nursing Society
Ovarian Cancer National Alliance
Pancreatic Cancer Action Network
The Susan G. Komen Breast Cancer Foundation
US-TOO International, Inc.
Y-ME National Breast Cancer Organization

Back to Medicare Payment Index

About CLC | What's New | Policy Issues | Participants' Login
Home | Sitemap | Contact Info

Alliance for Retired Americans

source : http://www.retiredamericans.org/fridayalerts/2002/0524.htm

Friday

May 24, 2002

Rx Express Rolls North

Friday Alert PDF
May 24th PDF
About PDF Files
In order to view PDF files, you will need the Adobe Acrobat Reader®, a free software utility

Starting today, May 24, the Rx Express, organized by the Alliance for Retired Americans, will take busloads of senior citizens from states across the northern border to Canada to buy prescription drugs at costs far lower than in the United States. Today's bus will originate in Farmington, Connecticut, and will include a stop in Hartford to pick up additional passengers. Over the next month, hundreds of retired activists will make the trip to Canada. In many cases, the seniors will be joined on the bus by their Congressional Representatives

Search:
Go

"The lengths that these senior citizens must go to get affordable prescription drugs underlines the importance of Congressional action on an affordable Medicare prescription drug benefit," notes Alliance Executive Director Edward F. Coyle. "Unfortunately, there are tens of millions of seniors who cannot easily travel to Canada and must continue to pay exorbitant prices to fill their prescriptions."

These trips represent the largest ever coordinated effort to send seniors to Canada for the purpose of buying prescription drugs. A news conference will be held in Washington, D. C. in June to report on the trips' successes and to renew pressure on Congress to act on a prescription drug benefit under Medicare.
In the next month, Rx Express trips will depart from the following cities:

May 29-Philadelphia, Pennsylvania, with stops in Allentown, Hazelton and Scranton/Wilkes-Barre; and Mercer County, Pennsylvania.
May 30-Portland, Oregon; and Seattle, Washington.
May 31-Cleveland, Ohio.
June 10-Detroit, Michigan; Grand Forks, North Dakota; Pittsburgh, Pennsylvania; Grand Forks, Minnesota; Boston, Massachusetts; Manchester, New Hampshire; and Burlington, Vermont.
June 12-Milwaukee, Wisconsin.
June 14-Indianapolis, Indiana, with stops in Anderson and Fort Wayne.
June 18-Wilmer/Mankato, Minnesota.
Additional Rx Express trips in the planning stages for June include New York, Maine, Idaho, Alaska and Montana.

Drug Industry Scores Again

Last week, Friday Alert reported on the latest outrage by the Pharmaceutical Research and Manufacturers Association (PhRMA), the trade association for the drug industry, involving the spending of $3 million on a national television campaign using a front group, the United Seniors Association. The bogus ads promote a Republican prescription drug benefit under which the drug industry would benefit. Yet, despite a complaint filed with the Federal Trade Commission by a coalition of senior, consumer and labor groups, including the Alliance for Retired Americans, nothing happened to stop the ads. But when AARP, a major senior organization, launched a TV ad campaign aimed at urging seniors to save money by switching from brand-name drugs to generics, the big drugmakers demanded that the TV networks make AARP tone down its ads - which it did. "So, why, is it fair for the drug industry to use front groups to advance its agenda but a senior group is forced to moderate its message to keep the drug companies happy?" asks George J. Kourpias, Alliance President. "Can it be that the pharmaceutical industry spends a lot of its exorbitant profits on TV ads and the networks don't dare risk affending such a big advertiser?"

Alliance Participates In Two Capitol Hill Events

The Alliance for Retired Americans continued its high visibility on Capitol Hill again this week with appearances at two events. On Monday, Edward F. Coyle, Executive Director, joined Sen. Mark Dayton (D-MN) and key community activists at a news conference to discuss how President Bush's plan to make his massive tax cut permanent would jeopardize the future of Social Security. Coyle told participants, "The Alliance is prepared to be visible and vocal both in Congress and in public against any plan that threatens or undermines the financial stability of the Social Security system. We will keep pressure on our elected officials to ensure that they do not adopt any proposals that would cut or effectively reduce Social Security benefits, or would weaken, diminish or otherwise dismantle Social Security as it exists today." According to Coyle, "Social Security cannot be privatized without gigantic cuts in benefits and massive borrowing from other Federal funds - funds that are now in deficit as a result of the Republican tax cuts of 2002."

At a second event, on Thursday, Viola Quirion, an Alliance member from Waterville, Maine, told the Subcommittee on Oversight and Investiagations of the U.S. House Energy and Commerce Committee, "Prescription drugs should be one of the benefits of the Medicare program. Despite all the hopes placed in the Medicare+Choice program, it is not a solution. The share of Medicare+Choice enrollees with prescription drug coverage declined from 84 percent in 1999 to 67 percent in 2001. At the same time, premiums and co-payments are more costly. In half of the 33 states with Medicare+Choice plans with drug coverage, the average premium rose more than 100 percent in the past three years. Sadly for Maine residents, even if some were able to afford these increases, it doesn't make any difference-there is no Medicare+Choice plan in Maine. So trying to add preventive services coverage would be not help either."

Quirion, who suffers from ovarian cancer, said she has taken seven bus trips

to Canada over the past few years. "I estimate that I saved $1,000 every trip. Unfortunately, it took me a week to recover from the last trip because of my knees. I probably won't be able to make any more trips. But I am not alone, there are so many people that could benefit from these trips but are physically unable to board a bus. The real point, however, is that we should not have to make these trips at all." According to Quirion, "The real solution is within the power of Congress and that is to add a prescription drug benefit to the Medicare program as well as increase access to preventive services."

GOP Targets Seniors in 2002

Republican strategists have targeted seniors, Independents and women in the 2002 election campaign, saying their votes are key to victory. These strategists have gone so far as to issue specific recommendations for how GOP candidates should frame the debate on Social Security. For example, candidates are told to "attack the Democrats on some element of their Social Security plan . . . either they don't have a plan so they are willing to let it go bankrupt, they want to raise taxes, or they want to raise the retirement age." Another recommendation is "don't say 'privatization.' Instead say 'personal retirement accounts.'" So, much for truth in campaigning.

Friday Alert Archives

The Alliance for Retired Americans is a nationwide organization of three million un ...ces and other older and retired Americans working together to make their voices heard ... the laws, policies, politics and institutions that shape our lives.

---

888 16th Street, NW Washington, DC 20006
Privacy Policy | Site Index
tel: 1-888-373-6497
email: webadmin

DISABILITY LAW CENTER OF ALASKA

JUNEAU
230 Soulh Franklin #206
Juneau, AK 99801
(907) 586-1627
FAX (907) 586-1066

January 21, 2004

By hand delivery

Representative John Harris, co-chair
Senate Finance Committee
State Capitol, Room 507
Juneau, Alaska

Representative Bill Williams, co-chair
Senate Finance Committee
State Capitol, Room 515
Juneau, Alaska

Re: **HB 374: SeniorCare and Prescription Drug Coverage for Alaska's Medicare population**

Dear Representatives Harris and Williams:

We are enthused with the Governor's proposal in HB 374 to provide a "bridge" prescription drug benefit for Alaskans over age 65. Many elder Alaskans have only Medicare as their health insurance, and Medicare currently provides no prescription drug coverage. HB 374 is a very important step in the right direction.

I enclose a summary, provided late yesterday as well to the Senate Finance Committee, of the impact of Public Law 101-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003.[1] Many of the benefits of this federal law do not take effect until 2006. SB 259 promises to provide a "bridge" for Alaska's elderly population until 2006.

It is worthwhile in the consideration of HB 374 to remember that a significant portion of Alaska's Medicare-eligible population is *under age 65*, and are essentially **barred from the HB 374 bridge**. Of these, we estimate approximately 225 Alaskans, with an annual estimated drug expense of $288,900, who could equally benefit from a program like HB 374.[2] We quote from a nationally published report on this subject: "**As policymakers co sider measures to improve drug coverage for the Medicare population, the unique and substantial needs of non-elderly beneficiaries with disabilities should not be forgotten.**"[3]

Many of the people barred from the bridge of HB 374 are lifelong Alaskans with significant work histories, who now are totally and permanently disabled. Due to their unique circumstances, some face dauntingly high prescription drug expenses, but their income makes them ineligible for the most common benefit program, Medicaid. We pledge to work with the Administration and the Legislature to seek creative solutions to serve the needs of all Alaskans with disabilities.

Very truly yours,

Bob Briggs

Robert B. Briggs, staff attorney

CC: (w/ encls.)
House Finance Committee
Joel Gilbertson, Commissioner, DHSS
Dennis DeWitt, Office of the Governor

[1] Source: Kaiser Family Foundation. Website address:http://www.kff.org/medicaid/4162.cfm.
[2] See attached analysis and reports that form the basis of these estimates.
[3] B. Briesacher, et al., *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits* (Sept. 2002)(copy enclosed). Website address: http://www.kff.org/medicare/6054.cfm.

ALASKA'S DISABLED MEDICARE BENEFICIARIES & THE DEBATE OVER DRUG BENEFITS: A FORGOTTEN POPULATION?

by Robert B. Briggs[1]
Disability Law Center of Alaska, Inc.
(January 20, 2004)

- 7,648 disabled Alaskans under age 65 receive Medicare

Most recent estimates we could find suggest that approximately 17% (7,648 out of a total 43,815) of Alaska's Medicare beneficiaries are under age 65.[2] By definition, these under-65 individuals are totally and permanently disabled. Most if not all of them receive Medicare as an adjunct to receiving Title II benefits based on a history of contributing 40 or more quarters into the Social Security trust fund. I.e., they have worked and paid Social Security taxes for ten or more years.

- 3,812 disabled Alaskans under age 65 receive Medicare who are not eligible for Medicaid

Many Medicare beneficiaries also are eligible for and receive Medicaid. Such so-called "dually eligible" persons already receive prescription drug benefits through Medicaid. The Kaiser Family Foundation reported 9,500 Alaskans[3] are so-called "*dual-eligibles.*" Subtracted from the total Medicare population (43,815), we estimate a total population of "*non-dual eligible*" Alaskans totaling *34,315.*

How many if these "non-dual eligibles" are under age 65? We could find no state-specific statistics. We did find a recent CMMS report published in June 2002 using 2000 data reporting that nationally 9% of the "non-dual eligible" population is under age 65.[4] If this national percentage also holds in Alaska, then 9% of Alaska's "non-dual-eligible" population are under age 65. I.e., we believe there are at least *3,812 former Alaskan workers with disabilities, under age 65, who are eligible for Medicare, but not Medicaid.*

- 1,606 disabled Alaskans under age 65 receive Medicare who are not eligible for Medicaid, and have no other prescription drug coverage

Some people on Medicare are quite wealthy, because entitlement to Title II Social Security benefits is established by age or disability, not income or resources. This contrasts with Supplemental Security Income (SSI) benefits, for which an individual must have income less than $545 per month and resources of under $2,000, or Alaska's Adult Public Assistant (APA) program, which pays out a cash benefit to bring individual income up roughly to $1,000 (with the same income and resource limits as SSI). This would be one reason for classifying a

---

[1] Research assistance by Lynn Armstrong, Disability Law Center of Alaska, Inc., Juneau.
[2] Source: Kaiser Family Foundation, State Health Facts Online: Alaska:Medicare (data as of July 1, 2001). Website address: http://www.statehealthfacts.kff.org.
[3] Id.
[4] CMMS, *Program Information on Medicare, Medicaid, SCHIP and other programs of the Centers for Medicare & Medicaid Services* (June 2002), at page 3. Website address: http://www.cms.hhs.gov/charts/series/sec3-b3.pdf

Medicare recipient as a "non-dual-eligible" – the individual's income or resources are too high to be eligible for the very low eligibility limits of Medicaid or APA.

Some people have access to private health care through spouses, former employment, or can afford private health insurance. So not all the "non-dual eligibles" can be said to actually "need" a State general-fund funded prescription drug benefit. HB 374 wisely recognizes this by establishing income thresholds of eligibility of 135 and 150% of the federal poverty line.

How many "non-dual-eligible" Alaskans under age 65 need prescription drug benefits? While we have found no exact numerical estimates, a national report found that *21% of all Medicare beneficiaries under age 65 with disabilities had no prescription drug coverage, including Medicaid.*[5] If this percentage holds in Alaska, then 21% of Alaska's 7,648 under-65 Medicare beneficiaries – **1,606 individuals** – have no prescription drug benefits of any kind. The actual number may be higher, since the national report on the prescription drug coverage needs of the 2002 Medicare Disabled Beneficiaries report (Briesacher, et al.) included some health insurance options which may not be available in Alaska.

- 707 disabled Alaskans under age 65 receive Medicare who are not eligible for Medicaid, have no other prescription drug coverage, and are "medically indigent"

In one very real way, "gross income" is not an accurate measure of "need" in this context, because prescription drug costs can be so high. Briesacher et al. reported that the average annual drug spending for under-65 Medicare beneficiaries was nearly twice as high as for the elderly.[6] This is not because the population is profligate, but instead because the under-65 Medicare population is, on average, *more medically fragile* than the elder population. As such their medication needs are higher than average, and the costs of those medications is greater. Breischer, et al., at 17.

How many of Alaska's under-65, Medicare-only recipients are "medically indigent?" Briesacher et al. report (at page 6 and page 7, Fig. 3) that 19% of those with full-year prescription drug coverage spend more than 5% of their income on drug expenditures alone; 36% of those with part-year drug coverage spend more than 5% of their income on drugs; and *44% of Medicare beneficiaries under age 65 who lack drug coverage spend more than 5% of their income on prescription medications.drug expenditures alone.* So at the very least, there are approximately 707 Alaskan Medicare beneficiaries who have no source of prescription drug coverage, and who spend more than 5% of their income on medications. That is 707 individuals made "medically indigent" by drug costs alone.

- Roughly $726,400 to solve the problem for Alaskans "medically indigent" under-age-65 Medicare-only beneficiaries

---

[5] This compares with 24% of Medicare beneficiaries age 65 and older. B. Briesacher, et al., *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits* (Sept. 2002). Website address: http://www.kff.org/medicare/6054.cfm.

[6] Id. at page 5.

Using 1998 figures, Briesacher et al. (at page 6) documented that Medicare beneficiaries under age 65 have higher average medication costs ($1,284 versus $841 per year for those over 65). With a standard Medicare-like co-pay of 20%, this would result in a total estimated cost of $726,400 per year to provide coverage to this medically indigent population ($1,284 x 707 x 0.80). This figure, however, is likely low, since these "medically indigent" Medicare beneficiaries by definition have prescription medication expenses that are even higher than the average Medicare beneficiary's expenses.

- Roughly $288,900 to help Alaska's under-age-65 Medicare-only beneficiaries with incomes under 200% of the federal poverty line

While we have not found exact figures, it is possible to project the number of Alaskans under age 65 who receive only Medicare and no other drug benefits, whose income is under 200% of the federal poverty line (FPL). The Kaiser Family Foundation, using CMMS statistics, estimates 7,680 of Alaska's Medicare beneficiaries have incomes between 100 and 199% of the FPL.[7] Applying the same percentages as above, then 14% (1,075 individuals) of this subpopulation is likely under age 65. As discussed above, if the national percentages reported in Briesacher, et al. are applicable to Alaska, 21% of this sub-subpopulation may be estimated to have no prescription drug coverage of any kind. Thus, if a benefit program were designed to serve Alaska's under-age-65, Medicare-only beneficiaries who receive no other prescription drug benefits, we estimate approximately **225 individuals** would be served. Using average statistics for drug expenditures from Briesacher, total cost per annum would be **$288,900** without any co-pay. This figure is probably low, due to old drug expenditure data, and more current data may yield a different estimated per capita drug expenditure.

[7] Source: Kaiser Family Foundation, State Health Facts Online: Alaska:Medicare (data as of July 1, 2001). Website address: http://www.statehealthfacts.kff.org.

KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Implications of the New Medicare Prescription Drug Benefit for State Medicaid Budgets

For a number of years, Governors and other state policymakers have maintained that Medicare – rather than state Medicaid programs – should play the key role in providing prescription drug coverage to Medicare beneficiaries, including those who also qualify for Medicaid (i.e, the "dual eligibles").[i] The Medicare prescription drug bill signed into law by President Bush on December 8, 2003 includes dual eligibles in the new Medicare drug benefit as of January 1, 2006.[ii] Although the new law shifts drug coverage for dual eligibles from Medicaid to Medicare, it does not provide full fiscal relief to states or guarantee equivalent coverage to dual eligibles. A number of provisions in the law may actually adversely affect state Medicaid budgets and offset much of the Medicaid fiscal relief that state policymakers had long expected would accompany the adoption of a prescription drug benefit in Medicare.

This issue brief describes the key provisions of the new Medicare prescription drug benefit in terms of the potential impact on state Medicaid programs and budgets; reviews the Congressional Budget Office estimates available at this time on the effect of these provisions on state Medicaid expenditures; and discusses why the fiscal impact of the new Medicare prescription drug benefit on Medicaid budgets can be expected to vary widely across states. It does not address other provisions of the new Medicare law with a potential impact on states, many of which are not related to the creation of a new prescription drug benefit in Medicare (e.g., the law contains new Medicaid funds for payments to hospitals that serve a disproportionately large number of uninsured and Medicaid patients). Information on the overall effect of the law on states is not currently available from the Congressional Budget Office or other sources.

I. Key Provisions of the New Medicare Prescription Drug Benefit Affecting State Medicaid Budgets

Some of the most significant changes in the new law affecting state Medicaid spending include the following:

- **Dual eligibles are expected to secure drug coverage through Medicare; Medicaid no longer will finance drug coverage for this population.** As of January 1, 2006, dual eligibles are expected to secure their prescription drug coverage through Medicare under the new "Part D" of the program. On that date, states no longer can secure federal Medicaid matching funds for the cost of providing prescription drug benefits to dual eligibles who are eligible to enroll in Part D.[iii] As a result, states no longer will have to expend state Medicaid matching funds on providing prescription drug coverage to dual eligibiles. If dual eligibles do not enroll in a Part D plan or if they need more drug coverage than is

provided by their Part D plans, states can provide it to them using 100 percent state funds. The federal government, however, will not provide states with Medicaid matching funds for such expenditures.

- **Continued state financing of much of the prescription drug costs for dual eligibles through "clawback payments".** States are required to continue to finance much of the cost of providing the new Medicare Part D benefit to dual eligibles on an ongoing basis through monthly maintenance-of-effort or "clawback" payments to the federal government. The payments are designed to return to the federal government a significant share of the amount states would have spent on dual eligibles' prescription drug coverage under Medicaid if the new Medicare law had not been enacted. The share of such expenditures, described as the "takeback" share, is set at 90 percent in 2006 and tapered down to 75 percent for 2015 and later years. The size of the clawback payments for any given state in any given month will be determined by a complex formula, primarily based on the state's per capita expenditures on Medicaid prescription drugs for dual eligibiles in 2003 trended forward by per capita growth in prescription drug spending nationwide since 2003[iv]; the number of dual eligibles in the state who are enrolled in the new Part D program in the month in question; and the "takeback" share for the month in question.

- **Significant new responsibilities for administering Medicare's low-income subsidy program.** The law requires state Medicaid agencies and Social Security Offices to accept and evaluate the applications of Medicare beneficiaries seeking assistance under Medicare's Part D low-income subsidy program. The new Part D program will provide assistance with the Part D premium, deductible and cost-sharing obligations to Medicare beneficiaries with income below 150 percent of the poverty line who can meet an asset test. Over 14 million seniors are expected to be eligible for the new subsidy program in 2006, although not all of them are expected to participate.[v] Among those who do participate, a significant share may apply for coverage through Social Security Offices.[vi] However, even if a small share of eligible Medicare beneficiaries apply for assistance at state Medicaid agencies, states will incur new Medicaid administrative expenses as they hire staff and modify their computer systems to accommodate the applicants. Moreover, states are required to screen the Medicare beneficiaries seeking low-income subsidies for eligibility for selected categories of Medicaid eligibility that provide assistance with Medicare premium and/or cost-sharing obligations (i.e., the "Medicare Savings Programs"). If states find someone who is eligible for such assistance, they must offer the individual the chance to enroll in Medicaid. As a result, the new Part D low-income subsidy program is expected to have a "woodwork" effect that increases state Medicaid expenditures.

II. Overall Impact on State Medicaid Expenditures

In a November 20, 2003 letter to Senator Don Nickles, the Congressional Budget Office provided estimates of the effect on state Medicaid expenditures of the three provisions

described above. According to CBO, the elimination of Medicaid-financed prescription drug coverage for dual eligibles will reduce state Medicaid spending by some $115 billion between federal fiscal year 2004 and 2013. Over the next ten years, however, CBO estimates suggest that states will see 85 percent of this $115 billion in Medicaid fiscal relief disappear due to the mandatory clawback payments ($88.5 billion), higher enrollment in Medicaid when people come into Medicaid offices to apply for the Part D low-income subsidy program ($5.8 billion), and new administrative responsibilities ($3.1 billion). The net fiscal relief to state Medicaid programs over the next ten years is expected to total $17.2 billion. Nearly 80 percent of this fiscal relief is expected to occur in the last four years (2010 – 2013) of the 10-year period evaluated by CBO.

In the short-term, the Congressional Budget Office estimates suggest that the new law will actually increase state Medicaid spending. Between fiscal year 2004 and 2006, new state Medicaid costs due to the Medicare bill are expected to exceed Medicaid fiscal relief by $1.2 billion. The primary reason for the net expense to state Medicaid budgets in the short-term appears to be that states' clawback payments to the federal government in 2006 are expected to exceed the amount of fiscal relief states will secure as a result of no longer providing Medicaid-financed prescription drug coverage to dual eligibles.

While the CBO estimates assess the impact of some of the major changes in the Medicare law related to the new prescription drug benefit, they are not designed to represent a comprehensive assessment of the law on state finances. They do not take into account provisions unrelated to prescription drug coverage that may benefit states, such as an increase in federal funds available for disproportionate share hospital (DSH) payments; an extension of funding for a Medicaid program that pays the Medicare Part B premiums of selected beneficiaries with income up to 135 percent of poverty (i.e., the "QI-1 program"); and new funds for providing health care services to undocumented immigrants. They also do not take into account states' savings on the cost of drug coverage for retired state employees or State Pharmacy Assistance Programs, or new Medicaid costs for dual eligibles that states are expected to incur due to the increase in Part B deductibles.

III. State-by-State Variation in the Impact of the Medicare Law on Medicaid Budgets

The CBO estimates of the impact on state Medicaid budgets of key provisions of the new Medicare law suggest that nationwide states may retain roughly 15 percent of the fiscal relief they otherwise would secure as a result of no longer providing prescription drug coverage to dual eligibles. For any given state, however, the impact could vary significantly from this nationwide figure. Given the complexity of the law, it is likely to be some time before state-by-state estimates of its impact are available, but the following factors are likely to play a key role in determining how states fare:

- **The trajectory of state Medicaid spending on prescription drugs for dual eligibles in the absence of the Medicare law.** The clawback payments that states must make each month to offset the cost to the federal government of

providing Part D drug coverage to dual eligibles are based in part on national growth over time in per capita prescription drug expenditures. Under their Medicaid programs, however, some states likely would have seen the per capita cost of providing prescription drug expenditures to dual eligibles rise more rapidly than a nationwide average, while other states would have experienced relatively modest growth. The states that would have experienced relatively modest growth, however, still must make payments to the federal government based on a nationwide trend.

- **State Medicaid expenditures on prescription drugs for dual eligibles in 2003.** A second key factor in determining the size of each state's clawback payments to the federal government for Part D benefits is its per capita state Medicaid expenditures on prescription drugs for dual eligibles in 2003. This figure varies widely across states because some states offer more comprehensive prescription drug benefits and/or are currently more aggressive about adopting cost-control measures than others. The clawback formula effectively freezes these state-by-state variations in place, requiring states that offered relatively expensive benefits to pay the federal government more than their counterparts with narrower benefits or more aggressive cost controls. (Table 1 provides state-by-state information on per capita state Medicaid expenditures for prescription drugs for dual eligibles in 2002, the latest year for which data are available. These figures vary for the reasons noted above, and because states have different federal Medicaid matching rates. The clawback formula takes into account changes over time in states' Medicaid matching rates).

- **The number of dual eligibiles in each state who enroll in the new Part D benefit.** The cost of the new Medicare law in any given state will depend on the number of dual eligibles who enroll in the new Part D benefit. In 2006, the size of states' clawback payments to the federal government is expected to increase by an average of $1,260 for each dual eligible who enrolls in Medicare Part D coverage.[vii] (The fiscal cost to an individual state associated with the enrollment of a dual eligible in Part D will vary widely because it is based on each state's expenditures on prescription drugs for dual eligibles in 2003 trended forward at a national growth rate.) Since states' clawback payments are determined in part based on the number of dual eligibles who enroll in Part D coverage, the new law actually creates an incentive for states to reduce the size of their dual eligible populations with Part D benefits to reduce the burden of their clawback payments.

- **Whether a state decides to supplement the Part D benefit in any way.** The impact of the Medicare law on state Medicaid budgets also will depend on whether a state elects to use its own funds without federal Medicaid matching to address gaps for dual eligibles if Part D plans do not cover the full array of drugs that are needed due to restrictive formularies or if the Part D cost-sharing obligations exceed the amount a state deems reasonable for dual eligibles. Given that states are facing ongoing fiscal problems, many states may not elect to use state-only funds to fill gaps in Part D coverage or may elect to to fill some of the

gaps only for selected groups, such as the mentally ill or HIV-positive individuals who may be particularly vulnerable if they experience a deterioration in coverage.

While it is impossible at this time to assess how these, as well as other factors, will affect individual states, some states undoubtedly will fare better than others. States with relatively comprehensive Medicaid prescription drug benefits are likely to fare less well than their counterparts with more limited coverage because they are likely to face large maintenance-of-effort payments to the federal government due to their per capita expenditures on prescription drugs for dual eligibles in 2003. At the same time, the tradition of providing comprehensive prescription drug coverage to dual eligibles may lead policymakers in these states to feel particularly compelled to use state funds to address some of the gaps that could emerge in the scope of the Part D coverage available to dual eligibles.

Conclusion

It will likely be some time before individual states are able to fully evaluate the effect of the new Medicare prescription drug benefit on their Medicaid budgets and dual eligible populations. For now, however, it seems clear that the law provides substantially less Medicaid fiscal relief than states had long expected would accompany the addition of a prescription drug benefit to Medicare, as well as raises a number of questions regarding how dual eligibles will fare under the new Medicare law. Because of the diversity in states' situations and policies, wide variation in the impact on states and their budgets can be expected.

This issue brief was prepared by Jocelyn Guyer with the Kaiser Commission on Medicaid and the Uninsured. She was assisted by many of her colleagues at KCMU, as well as by Andy Schneider of Medicaid Policy, LLC.

[i] Unless otherwise noted, "dual eligible" is used throughout this issue brief to refer to individuals with both Medicaid and Medicare coverage who are entitled to full Medicaid benefits. It does not include individuals, often known as "partial dual eligibles," who are eligible for assistance from Medicaid only with their Medicare cost-sharing obligations.

[ii] H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The law does not simply add a prescription drug benefit to Medicare, but also makes a number of other changes to the Medicare program Medicaid, prescription drug policy, and other areas. This issue brief, however, addresses primarily only those provisions of H.R. 1 related to the new Medicare prescription drug benefit that affect Medicaid.

[iii] The bar on receiving federal Medicaid matching funds for prescription drug coverage extends to all dual eligibiles with full Medicaid benefits covered under state plan amendments, including dual eligibles covered at state option. One exception is that states can secure Medicaid matching funds for providing drugs to dual eligibiles that Part D plans are not allowed to cover. The classes of drugs that fall under this exemption 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; and 7) benzodiazepines. The law does not clearly address the issue of whether states can continue to receive federal Medicaid matching funds for the cost of providing prescription drug benefits to seniors and people with disabilities covered under Medicaid Section 1115 waivers.

[iv] The measure of national growth in per capita prescription drug expenditures will be based on National Health Expenditure Survey estimates of per capita prescription drug spending growth through 2006 and on the growth in per capita Part D spending in 2007 and later years. The law provides more detail on the formula than is presented here, but also leaves a number of issues unresolved. For example, the law is ambiguous as to whether the per capita expenditure figure that is used in the clawback formula will be based on total Medicaid prescription drug spending in 2003 divided by the number of dual eligibles or the total Medicaid prescription drug spending in 2003 on dual eligibles divided by the number of dual eligibles.

[v] Congressional Budget Office, letter to Senator Don Nickles, Chairman, Committee on the Budget, November 20, 2003.

[vi] Even if subsidy-eligible individuals apply for assistance through Social Security Offices, states may have a role to play in their eligibility determinations because the level of subsidy that someone receives depends on whether he or she is a dual eligible. Thus, depending on how the option to apply for coverage through Social Security Offices is implemented, states may need to provide or verify information on the Medicaid status of dual eligibiles when they seek to enroll in the new low-income subsidy program through a Social Security Office.

[vii] KCMU estimates based on trending forward the average per capita state expenditure on prescription drug coverage for dual eligibles in fiscal year 2002 by national projected growth in per capita prescription drug spending through 2006. The resultant figure was multiplied by 90 percent to approximate the average amount by which states' clawback payments will increase in 2006 per additional dual eligible enrolled in Part D. The data on average state expenditures per dual eligible in 2002 were provided by the Urban Institute and projections of per capita growth in prescription drug expenditures through 2006 were taken from National Health Expenditure Survey Projections prepared by CMS, Office of the Actuary, February 2003.

Source: http://www.cms.hhs.gov/charts/series/sec3-b3.pdf

Program Information

on Medicare, Medicaid, SCHIP, and other programs of the

Centers for Medicare & Medicaid Services

ORDI
Office of Research, Development and Information

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

June 2002 Edition

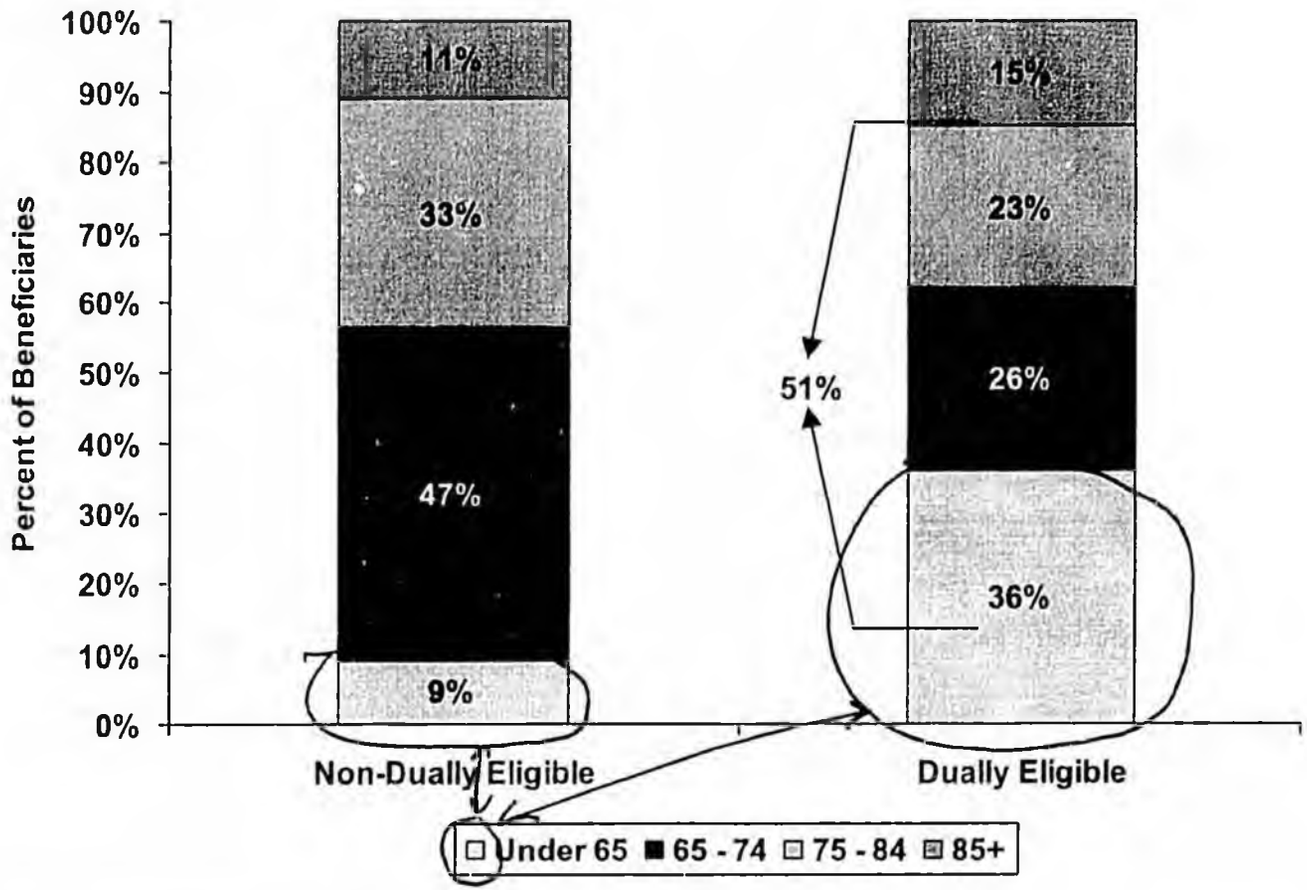
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

3. Dually Eligible Beneficiaries

Proportion of Medicare Dually Eligible and Non-Dually Eligible Beneficiaries, by Age, 2000

Over half of the dually eligible population are under age 65 or over 85.

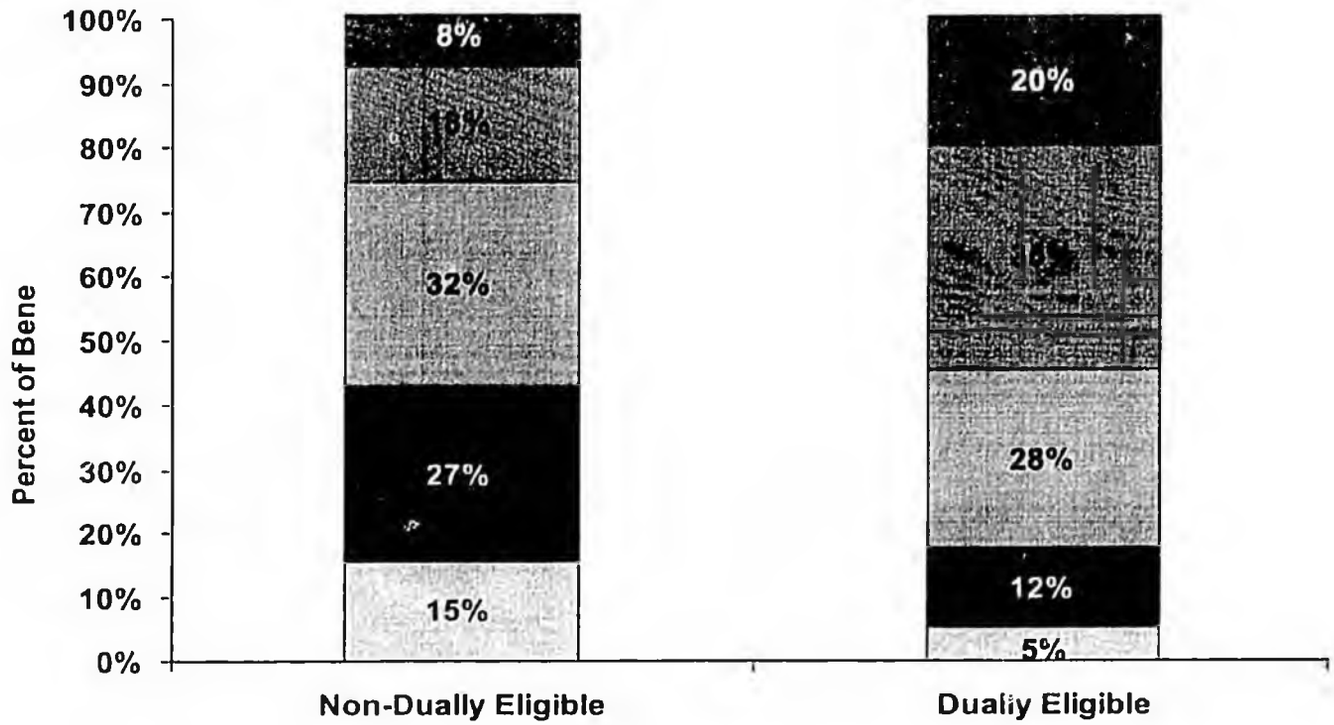


Note: Dually eligible beneficiaries are Medicare beneficiaries that also receive Medicaid coverage.

Source: CMS, Office of Research, Development, Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

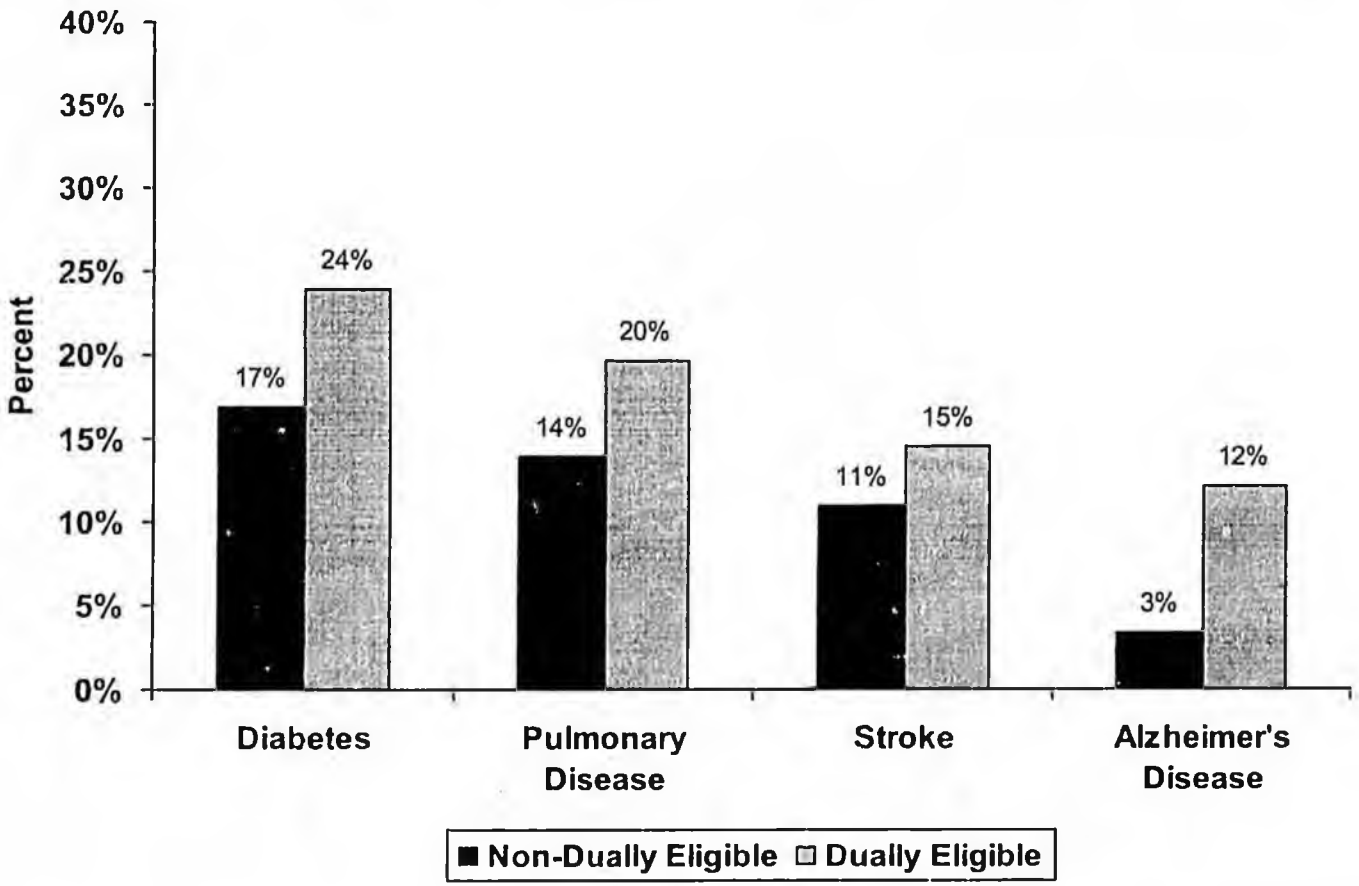
Self-Reported Health Status of Dually Eligible and Non-Dually Eligible Beneficiaries, 2000

Over half of the dually eligible population is in poor or fair health.



Percent of Non-Dually Eligible and Dually Eligible Beneficiaries with Selected Diseases and Chronic Conditions, 2000

The dually eligible population has higher rates of debilitating diseases and conditions such as pulmonary disorders and Alzheimer's disease.

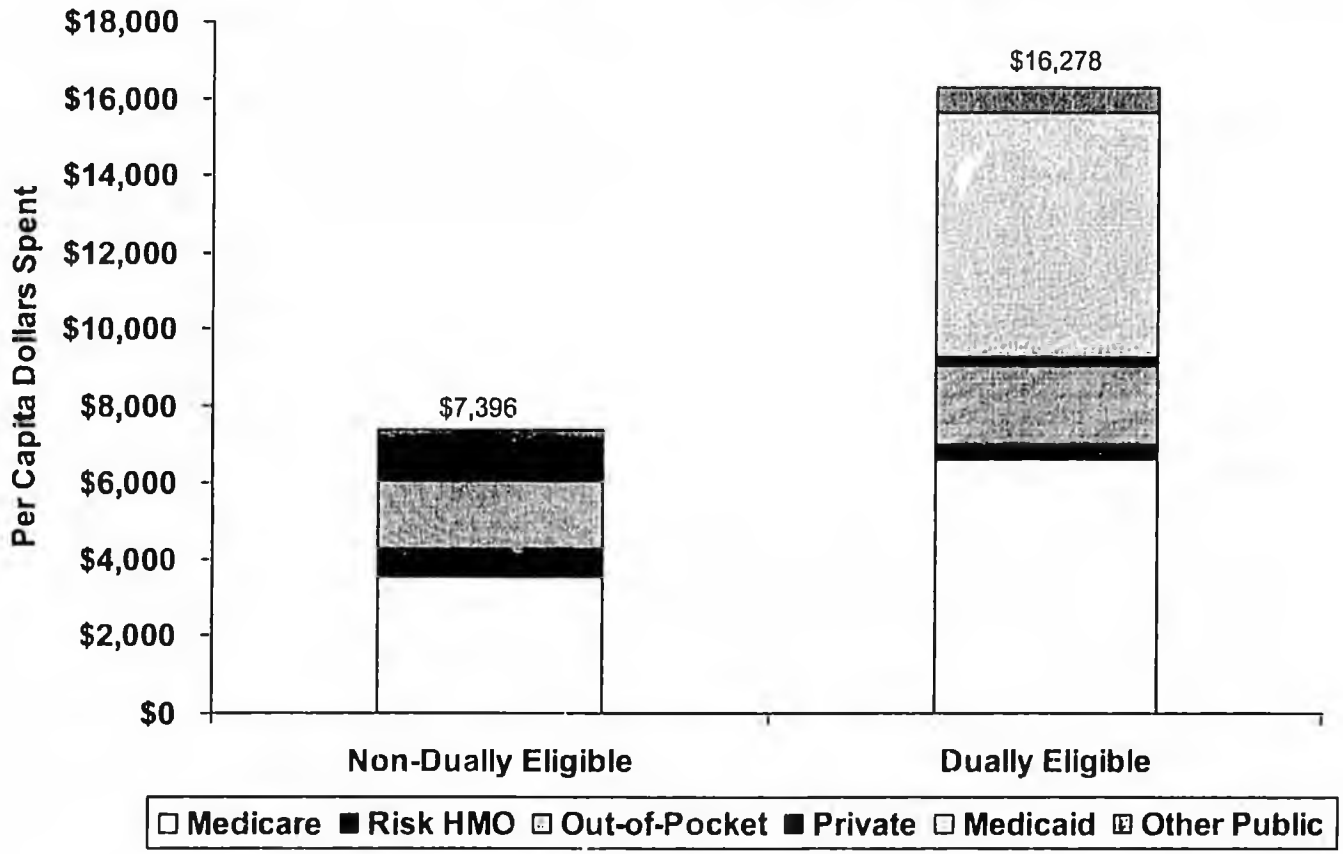


Note: Dually eligible beneficiaries are Medicare beneficiaries that also receive Medicaid coverage.

Source: CMS, Office of Research, Development, Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Total Health Expenditures by Payer for Dually Eligible and Non-Dually Eligible Beneficiaries, 1999

Health expenditures for the dually eligible population were more than double that of the non-dually eligible.



Note: Out-of-Pocket does not include premium payments. Payers will not sum to total due to some small categories being omitted. "Other Public" includes VA, DOD, and state-based pharmaceutical assistance programs.

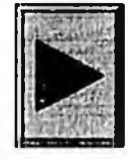
Source. CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and UseFile.

End of Chapter

Return to Main Menu

WWW.CMS.HHS.GOV/CHARTS/SERIES

Next Chapter



TOPICS:

Health Coverage & the Uninsured

Health Insurance/Costs

HIV/AIDS

Medicaid/SCHIP

Medicare

> Main Page
> Elderly
> Medicare + Choice
> Medicare/Medicaid Dual Enrollees
> People with Disabilities
> Prescription Drugs
> Retiree Benefits

Minority Health

Prescription Drugs

South Africa

State Health Policy

Study of Entertainment Media

Women's Health Policy

Youth & HIV/STDs

EMAIL ALERT SIGN-UP:
Email ENTER
Update My Profile

SPECIAL FEATURES

Kaiser Commission on Medicaid and the Uninsured

Kaiser Polls

Media Fellowships

News Media Partnerships

Entertainment Media Partnerships

Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate Over Drug Benefits

About 5 million Americans under age 65 qualify for Medicare coverage because they are totally and permanently disabled. They are more likely than the elderly to live in poverty, to be in poor health, and to experience difficulties living independently and performing basic daily tasks. A new study from The Commonwealth Fund and the Henry J. Kaiser Family Foundation, reports that the disabled have few options other than Medicaid for obtaining prescription coverage. In Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate Over Drug Benefits, Becky Briesacher, Bruce Stuart, Jalpa Doshi, and Sachin Kamal-Bahl of the University of Maryland, and Dennis Shea of the Pennsylvania State University, conclude that a Medicare drug benefit designed for the elderly will not suffice for the disabled unless their particular needs are assessed and addressed.

- Report

Information provided by the Medicare Policy Project
Publication Number: 6054

SEARCH:
Search GO
ADVANCED SEARCH | HELP

Why Log In?
Make kff.org work best for you with personalized saved links, email notification of the newest publications, and online ordering.

ADD TO MY SAVED LINKS
PRINTER-FRIENDLY PAGE
EMAIL THIS PAGE
ORDER THIS PUBLICATION
LINK TO US

GET ACROBAT READER

MEDICARE'S DISABLED BENEFICIARIES: THE FORGOTTEN POPULATION IN THE DEBATE OVER DRUG BENEFITS

Becky Briesacher, Bruce Stuart, Jalpa Doshi, and Sachin Kamal-Bahl
University of Maryland School of Pharmacy

and

Dennis Shea
The Pennsylvania State University

September 2002

Support for this research was provided by The Commonwealth Fund and The Henry J. Kaiser Family Foundation. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund, The Henry J. Kaiser Family Foundation, or their directors, officers, or staff.

Copies of this report are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering publication number **573.** The report can also be found on the Fund's website at **www.cmwf.org.** Copies are also available from the Henry J. Kaiser Family Foundation website at **www.kff.org** (publication number **6054**) or by calling **1-800-656-4533.**

CONTENTS

LIST OF FIGURES AND TABLES

ABOUT THE AUTHORS

Becky Briesacher, Ph.D., is the director of research at the Peter Lamy Center on Drug Therapy and Aging at the University of Maryland School of Pharmacy. Formerly, she was director of the Institute for Pharmaceutical Economics at the University of the Sciences in Philadelphia. Among her current projects are a study of hip fracture in residents of long-term care facilities for Omnicare, Inc; profiles of drug use and expenditure patterns of disabled and institutionalized Medicare beneficiaries for the assistant secretary of planning and evaluation; and analyses of quality indicators for drug benefits for The Commonwealth Fund. Dr. Briesacher received her Ph.D. from the University of Maryland, Baltimore. Her dissertation examined unfilled prescription behavior among the Medicare population.

Bruce Stuart, Ph.D., is executive director of the Peter Lamy Center on Drug Therapy and Aging. Dr. Stuart began his career in health services research as an economic analyst and later director of the Health Research Division in the Michigan Medicaid program. Dr. Stuart taught health economics, finance, and research methods at the University of Massachusetts and The Pennsylvania State University. In 1997 he joined the faculty of the University of Maryland School of Pharmacy as the Parke-Davis endowed chair in geriatric pharmacotherapy and was selected as a Maryland Eminent Scholar for his work in geriatric drug use. Among his current projects are a study of disease management, formulary design, and other managed care policies on Medicaid beneficiaries with asthma funded by the Agency for Healthcare Research and Quality; an analysis of drug use and expenditure patterns for disabled and institutionalized Medicare beneficiaries for the Office of Disability, Aging and Long-Term Care; and an analysis of quality indicators for prescription coverage of the elderly for The Commonwealth Fund. He received his economics training at Whitman College and Washington State University.

Jalpa Doshi is a doctoral candidate in the Pharmaceutical Health Services Research program at the University of Maryland, Baltimore. Her current projects include analyses of drug use and expenditure patterns for disabled Medicare beneficiaries, analyses of drug use by institutionalized Medicare beneficiaries across different long-term care settings, and studies of costs and quality of prescription coverage for community-dwelling elderly Medicare beneficiaries. She received her master's degree in pharmaceutical health services research at the University of Maryland, Baltimore.

Sachin Kamal-Bahl is a predoctoral fellow in the Pharmaceutical Health Services Research program at the University of Maryland, Baltimore. He has worked on projects

ranging from prescription drug access among rural seniors to inappropriate drug use among elderly Medicare beneficiaries. His dissertation examines the prevalence, predictors, and adverse consequences of a commonly used inappropriate drug in the elderly population. He is currently working on projects assessing the impact of prescription benefit design characteristics, such as tiered-copayment structures on prescription drug expenditures and selection.

Dennis Shea, Ph.D., is a professor of health policy and administration in the College of Health and Human Development at the Pennsylvania State University and faculty affiliate of the Center for Health Care and Policy Research, Social Science Research Institute, and Gerontology Center. At Penn State he directs the undergraduate program and teaches and researches health economics and health care finance. Dr. Shea's primary areas of research are in the impact of health policy, insurance, income, and other economic and financial factors on health services cost and use of older persons, particularly in the areas of physician services, mental health, and prescription drugs. Dr. Shea is a graduate of the College of William and Mary, Cambridge University, and Rutgers University.

EXECUTIVE SUMMARY

The ongoing debate over the addition of a prescription drug benefit to Medicare's benefit package has focused primarily on the needs of the elderly. The needs of Medicare's nonelderly, disabled beneficiaries have received considerably less attention. There are around 5 million Medicare enrollees who are under age 65 but qualify for Medicare because they are totally and permanently disabled. Prescription drug coverage is critical for this population, which is more likely than the elderly to live in poverty, be in poor health, and experience difficulties living independently and performing basic daily tasks.

This analysis draws upon the 1998 Medicare Current Beneficiary Survey Access to Care and Cost and Use Files to describe the prescription drug experiences of Medicare beneficiaries under 65 who are living with disabilities. The key findings are:

- The disabled are heavy users of medications, filling more prescriptions than the elderly in 1998 (34 vs. 25, respectively) and spending more on drugs annually ($1,284 vs. $841).
- Overall rates of drug coverage throughout 1998 were comparable for under-65 disabled and elderly beneficiaries (79% and 76%, respectively). Medicaid was the primary source of drug coverage for the under-65 disabled, assisting one of three such beneficiaries, but was the source for only one of 11 seniors. Elderly beneficiaries, on the other hand, were more likely to have prescription coverage through an employer-sponsored health plan.
- Out-of-pocket drug spending varies by source and stability of coverage. Under-65 disabled beneficiaries who lacked drug coverage for the entire year in 1998 had significantly higher out-of-pocket spending ($499) than did those with full-year coverage ($314).
- Out-of-pocket drug spending also varies widely by type of coverage. For disabled beneficiaries under age 65 who had drug coverage through Medigap, out-of-pocket costs averaged $601 in 1998—more than was paid by those without Medigap coverage ($499). Disabled beneficiaries with employer-sponsored drug coverage and those enrolled in Medicaid had average out-of-pocket drug costs of $375 and $199, respectively.
- Disabled beneficiaries' high drug costs and low incomes make paying for prescription medications particularly burdensome. More than a quarter (27%) of all under-65 disabled beneficiaries spent 5 percent or more of their annual incomes on

prescription drugs in 1998, with the proportion rising dramatically for those with coverage for only part of the year (36%) or no coverage at all (44%).

- Access problems are exacerbated for those with unstable or no drug coverage, particularly among the disabled. Compared with those with full-year coverage, disabled beneficiaries without prescription benefits were nearly three times more likely not to fill all of their prescriptions and more than twice as likely to delay care because of costs.
- The types of medications typically used by the disabled differ considerably from those used by the elderly. Psychotherapeutics, for example, are the prescriptions most commonly filled by the disabled (57% use this group of drugs), but they rank only 10th among drugs used by the elderly (23%). The disabled are also far heavier users of analgesics and central nervous system drugs, whereas the elderly are most apt to use heart medications.

The under-65 disabled Medicare population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills. Yet with the exception of Medicaid, disabled Medicare beneficiaries have few options for obtaining stable and comprehensive prescription drug coverage. All of these factors place the disabled at special risk.

Some policymakers have proposed linking a Medicare drug benefit to the medications most often used by the elderly. If that were to happen, the findings presented here suggest that the disabled would be systematically disadvantaged. If the drug benefit consists mainly of government subsidies to private insurers, few disabled beneficiaries are likely to receive assistance. While most recent Medicare prescription drug benefit proposals do not consider restricting the benefit to those medications most often used by the elderly, as some earlier proposals did, this does not mean that access to medications for disabled Medicare beneficiaries would not be difficult. Formulary restrictions, drug utilization review, and other administrative mechanisms can and have been used by public and private payers to restrict access to certain drugs, especially newer, more effective, yet more expensive, psychotherapeutics.[1] As policymakers consider measures to improve drug coverage for the Medicare population, the unique and substantial needs of nonelderly beneficiaries with disabilities should not be forgotten.

[1] L. Gorman. "Treatment Denied: Colorado Health Care 'Reform' and the Mentally Ill." Independence Institute Issue Paper, July 31, 2001.

MEDICARE'S DISABLED BENEFICIARIES: THE FORGOTTEN POPULATION IN THE DEBATE OVER DRUG BENEFITS

INTRODUCTION

Despite concerns about aging baby boomers swamping the Medicare program, beneficiaries under age 65 who are entitled through the Social Security Disability Insurance (SSDI) program represent the fastest-growing segment of the Medicare population. There are around 5 million people who are under age 65 and qualify for Medicare on the basis of disability, representing nearly 14 percent of all Medicare beneficiaries. By 2010, this group is expected to number 7.6 million, or almost 17 percent of the Medicare population.[2] The needs of the under-65 disabled population on Medicare have gone largely unnoticed in the debate over improving prescription drug coverage for Medicare enrollees. Typically, policy proposals extend drug coverage to all Medicare beneficiaries, including the under-65 disabled, but design features and need assessments have still focused almost exclusively on the elderly. The prevailing wisdom seems to be that a benefit designed for the elderly will also work for the disabled. Policies based upon that assumption could prove problematic for a population as vulnerable—and as poorly researched—as Medicare's disabled.

This analysis was conducted to provide policymakers with better information on disabled beneficiaries' need for prescription coverage. It uses 1998 data from the Medicare Current Beneficiary Survey to: (1) compare disabled and elderly Medicare beneficiaries on various dimensions, including demographic characteristics, prescription drug coverage, patterns of drug use and spending, and reported problems with access to care; and (2) compare the characteristics and prescription drug use patterns of disabled Medicare beneficiaries with drug coverage across a range of sources, both for the full year and for only part of the year, and those without it. It also evaluates the impact of specific drug benefit programs available to the disabled in certain states and counties.

Finally, to determine whether the needs of the SSDI population differ according to type of disability, sub-analyses were performed for people with mental and physical impairments; results are presented in detail in the Appendix.

---

[2] Qualifications for Medicare disability entitlement are strict: workers can receive Social Security Disability Insurance (SSDI) assistance only after being diagnosed with qualifying medical conditions that are expected to last at least 12 months or result in death. Except for persons diagnosed with end-stage renal disease or amyotrophic lateral sclerosis, SSDI beneficiaries must complete a 24-month waiting period before Medicare benefits commence. National Economic Council, Domestic Policy Council, *Disability, Medicare, and Prescription Drugs*. The White House, July 31, 2000.

Study Methods

Data for this study were obtained from the 1998 Medicare Current Beneficiary Survey (MCBS) Cost and Use and Access to Care files. The MCBS is a longitudinal survey, conducted in the home, of a representative national sample of the Medicare population.[3] The MCBS oversamples beneficiaries under the age of 65, making it one of the best data sources for studying the disabled population. The population for this study consisted of all elderly and disabled Medicare beneficiaries living in the community (e.g., not in an institution) for at least part of the year in 1998.[4] All analyses applied sampling weights to provide nationally representative population estimates.[5] State and county residence codes in the MCBS were used to assess the effects of policies intended to improve access to prescription drug coverage for disabled beneficiaries. The availability of Medicare+Choice plans varies by county and was determined from plan listings obtained from the Centers for Medicare & Medicaid Services (CMS).

---

[3] The MCBS is conducted under the auspices of the Centers for Medicare & Medicaid Services (CMS). Begun in the fall of 1991, the MCBS includes interviews with over 12,000 Medicare beneficiaries three times a year using computer-assisted personal interviewing. MCBS interviewers collect extensive information on individuals' use and expenditures for health services, including prescription drugs, source of payment, type of health insurance, access to care, and health and functional status. The interviewers also collect information on socioeconomic status and demographic characteristics.

[4] To distinguish beneficiaries by disabled or elderly entitlement status, the authors used the Medicare administrative designation given as of December 31, 1998. This designation limits the disabled population to only those under the age of 65, since the status effectively disappears once disabled beneficiaries become Medicare-eligible by age. Excluded from the sample are beneficiaries institutionalized year-round and a small group of beneficiaries entitled only through end-stage renal disease.

[5] All analyses used sampling weights supplied for each individual in the MCBS and clustering corrections using survey software in *Stata 7.0*. The authors computed mean values and standard errors around each estimation. Rather than report the standard errors, they followed the practice recommended in the MCBS guidelines of identifying values with standard errors exceeding 30 percent of the estimate. Estimates with a relative standard error greater than 30 percent are designated as potentially unreliable in the tabled findings.

FINDINGS

Beneficiary Characteristics

In 1998, Medicare beneficiaries included approximately 4.8 million community-dwelling disabled and 33 million elderly. The typical disabled beneficiary is a middle-aged (mean age=49.9), unmarried man. At least one of four is nonwhite or Hispanic (Table 1). By contrast, most elderly beneficiaries fall between the ages of 65 and 74 (mean age=74.9), a majority is female, and most are married. Fewer than 15 percent are minorities. Disabled Medicare beneficiaries are at significant economic disadvantage compared with elderly beneficiaries. Medicare's disabled are twice as likely as seniors to live under the federal poverty level (45% vs. 20%), and nearly 80 percent live on modest incomes under 200 percent of the poverty level, compared with just over 50 percent of seniors.[6] Disabled beneficiaries with mental impairments are especially likely to have incomes below the poverty level (Appendix Table A1).

Measures of health status indicate that disabled beneficiaries have much poorer physical, mental, and functional levels than do the elderly. The disabled are twice as likely to report being in fair or poor health (59% vs. 23%) and twice as likely to have trouble performing at least one "activity of daily living" (44% vs. 26%) or one "instrumental activity of daily living" (36% vs. 16%). (Activities of daily living include getting out of bed and being able to feed yourself, while instrumental activities of daily living include using a phone, going shopping, or preparing meals.) The disabled also bear a heavy disease burden compared with nondisabled individuals of the same age. Furthermore, despite being considerably younger than the elderly, disabled beneficiaries are as likely to report having three or more chronic conditions.

Opportunities for Obtaining Prescription Drug Coverage

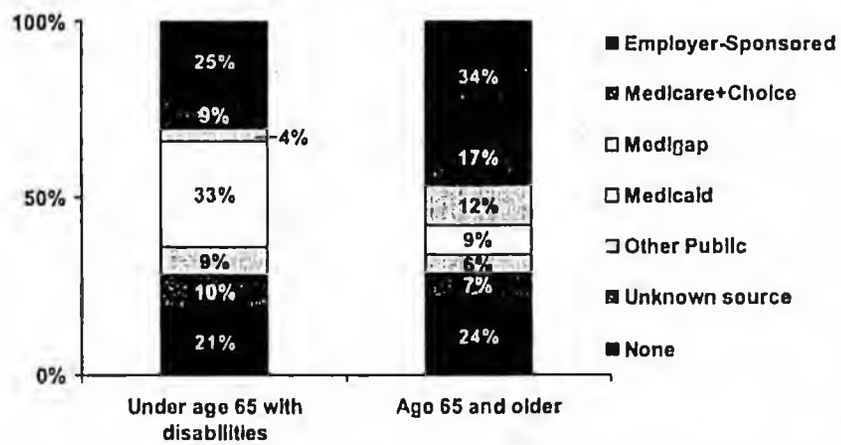
More than three-quarters of all elderly and disabled Medicare beneficiaries maintained some form of prescription drug coverage in 1998. While rates of continuous and part-year drug coverage were about the same among both elderly and disabled beneficiaries, there were substantial differences in the sources and generosity of coverage (Figure 1). In general, the disabled rely far more heavily than the elderly on public programs for protection from prescription drug costs and, among those with private coverage, their benefits tend to be less generous.[7]

---

[6] These estimates are higher than those reported from the Current Population Survey (CPS). The major reason for this discrepancy is that the CPS counts all sources of household income while the MCBS counts only income received by the beneficiary or spouse.

[7] Medicaid provides a substantial portion of drug coverage for the disabled with mental impairments (45%) (Appendix Table A1). For those with only physical impairments, drug coverage comes most often through employer-based insurance (30%), although Medicaid is a close second source (25%). Both disabled groups show lower than average enrollment in Medicare managed care plans with drug benefits.

Figure 1. Sources of Prescription Drug Coverage Among Medicare Beneficiaries Throughout 1998, by Entitlement Status



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

In 1998, one of three disabled beneficiaries received drug benefits from Medicaid—through either traditional Medicaid or the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs—compared with only one of 11 of the elderly (9%).[8] More than one of 12 disabled beneficiaries (9%) obtained drug coverage through other public sources such as the Veterans Administration and state-funded pharmacy assistance programs, compared with one of 16 elderly beneficiaries (6%). Public coverage is particularly prevalent among those with mental impairments (Appendix Table A1).

Private sources of drug coverage are less commonly used by the disabled. For instance, one of four disabled beneficiaries obtained drug coverage from employer-based insurance, compared with one of three elderly beneficiaries. Fewer than 9 percent (8.8%) of the disabled had drug coverage from Medicare HMOs and less than 4 percent received any drug benefits from Medigap plans. The elderly have coverage at rates two and three times higher, respectively, from these sources of coverage.

Differences in sources of coverage among elderly and disabled beneficiaries are due in large part to differences in access to benefits. In 1998, for example, only seven of the 13 states with a state-funded pharmacy assistance program offered eligibility to disabled

[8] National Economic Council, Domestic Policy Council. *Disability, Medicare, and Prescription Drugs.* The White House, July 31, 2000. Twenty-eight percent of the disabled had no prescription coverage in 1996, 22 percent had drug benefits from employer-based coverage, 3 percent from Medigap plans, 4 percent from Medicare managed care plans, and 43 percent from Medicaid.

persons under age 65.[9] While 11 states and the District of Columbia provided full Medicaid benefits—including drug coverage—to all Medicare beneficiaries enrolled in their QMB program and, in some cases, their SLMB+ program, the lack of such coverage in the majority of states creates particular challenges for beneficiaries with disabilities.[10]

In terms of private-sector coverage opportunities, access to individually purchased Medigap policies is guaranteed to the disabled in only nine states. Six states have guaranteed-offer laws that ensure the disabled access to standardized Medigap policies (Plans A through J), although only three of these plans (H, I, and J) include drug coverage. Three states guarantee Medicare beneficiaries with disabilities access to Medigap policies with drug coverage that existed before the standardized Medigap policies were developed.

Among all the public and private sources of drug coverage, only one—the Medicare+Choice program—provides widespread opportunities to the disabled population (Table 2). In 1998, nearly 72 percent of disabled beneficiaries lived in counties served by at least one Medicare+Choice plan, even though these plans are not available in all counties. By contrast, only 14 percent of Medicare's disabled resided in states with Medigap guaranteed-offer laws and about 20 percent in states that granted access to drug coverage through QMB/SLMB+ or state-funded pharmacy assistance programs.

Not surprisingly, drug coverage rates among disabled beneficiaries living in these states and counties appear to be higher than average, suggesting that these policies might be providing some assistance. Nearly 40 percent of the disabled living in QMB/SLMB+ states received drug benefits from Medicaid in 1998, a rate that is a third higher than that among beneficiaries living in states without such programs. State pharmacy assistance programs are one of several other public sources of prescription drug coverage for the disabled. While the MCBS does not identify the other public sources, this study's results show that, in states that have pharmaceutical assistance programs, more than 15 percent of the disabled have prescription drug coverage, compared with just 7.5 percent in states without such programs. This indicates that the programs can work to obtain coverage for the disabled. Likewise, living in counties served by Medicare+Choice plans appears consistent with having higher rates of prescription coverage, especially private coverage

---

[9] According to the National Economic Council report, as of 2001, 24 states had some form of pharmacy assistance program, but only nine states offered eligibility to disabled beneficiaries. K. Fox, T. Trail, S. Crystal. *State Pharmacy Assistance Programs: Approaches to Program Design*. The Commonwealth Fund, May 2002. In 1998, the seven states with drug programs that offered eligibility to the under-65 disabled were Connecticut, Illinois, Maine, Maryland, New Jersey, Vermont, and Wyoming.

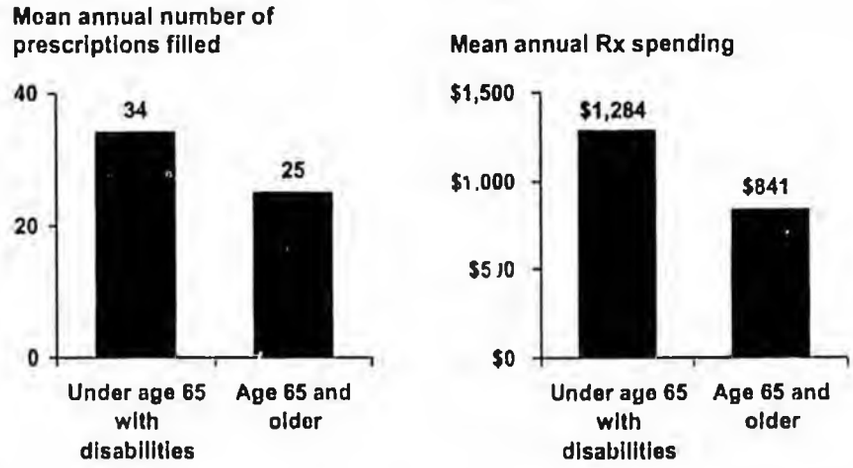
[10] P. B. Nemore. *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*. The Henry J. Kaiser Family Foundation, December 1999. The 11 states were Florida, Hawaii, Maine, Massachusetts, Mississippi, Nebraska, New Jersey, Pennsylvania, South Carolina, Utah, and Vermont.

(39.9% vs. 27.8%). On the other hand, living in a state that guarantees access to a Medigap plan appears to entail far less advantage. Whether any of these programs actually generated additional prescription coverage for the disabled population is difficult to assess without further analysis. However, the magnitude of differences associated with QMB/SLMB+ and Medicare+Choice programs strongly implies that at least these two programs have had that effect.

Prescription Use and Spending

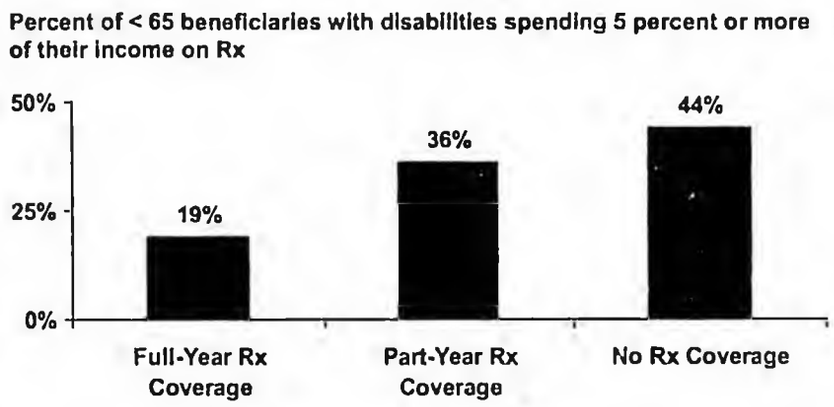
Having reliable prescription coverage is arguably more important for the disabled than it is for the elderly, given the much higher drug utilization and expenditure rates among disabled beneficiaries. While both the disabled and elderly were about equally likely to fill at least one prescription in 1998, the average number of prescriptions filled by disabled users (34) was much higher than for elderly prescription users (25) (Table 3 and Figure 2). Mean annual prescription spending for the disabled was almost 50 percent above that for the elderly ($1,284 vs. $841). With high prescription costs and low incomes, the disabled are particularly hurt by gaps in coverage or loss of benefits. A greater number of disabled beneficiaries than seniors spent 5 percent or more of their annual income on drugs (27% vs. 22%); the proportion who spent 5 percent or more of their income was even greater among the disabled with gaps in coverage (36%) or no coverage at all (44%) (Figure 3). Of course, these disparities reflect differences in baseline income levels, as well as in drug-related health care needs.

Figure 2. Prescription Drug Use and Spending Among Medicare Beneficiaries, by Entitlement Status, 1998



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

Figure 3. Out-of-Pocket Spending on Prescription Drugs as a Share of Income Among Beneficiaries Under Age 65 with Disabilities, by Drug Coverage Status

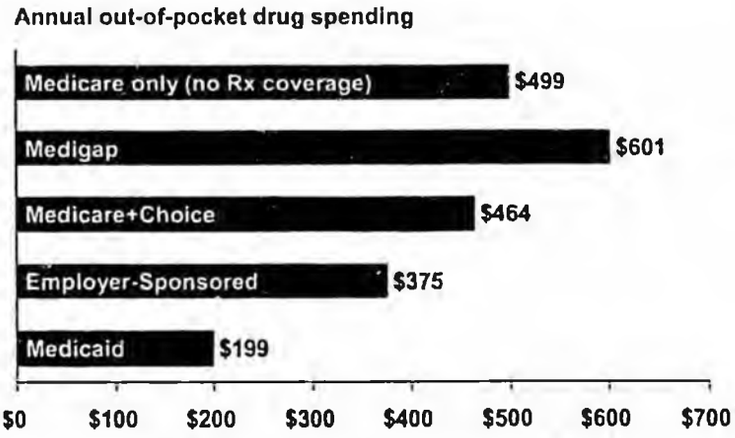


Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

As Table 3 clearly demonstrates, prescription drug coverage has a strong influence on average drug use and spending by disabled beneficiaries. While 75 percent of disabled beneficiaries without drug coverage filled at least one prescription during the year, over 90 percent of those with at least some drug coverage did so. Disabled beneficiaries without drug benefits filled 10 to 13 fewer prescriptions, on average, than those with drug benefits. As a result, mean annual prescription expenditures for the noncovered disabled are 60 to 70 percent below expenditures for those with some drug coverage. Although this may be partially attributable to the higher likelihood of disabled beneficiaries with greater prescription drug needs opting for coverage, the differences are striking and much larger than those found among elderly beneficiaries with and without drug coverage.

While prescription drug utilization among the disabled did not vary substantially by source of drug coverage, there were notable differences in out-of-pocket spending across sources of coverage (Figure 4). For instance, out-of-pocket costs for disabled beneficiaries under age 65 who had drug coverage through Medigap averaged $601—more than was paid out-of-pocket by those without coverage altogether ($499). Those with employer-sponsored drug coverage and those enrolled in the Medicaid program had average out-of-pocket drug costs of $375 and $199, respectively.

Figure 4. Out-of-Pocket Spending on Prescription Drugs Among Beneficiaries Under Age 65 with Disabilities, by Source of Drug Coverage



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

Tracing spending to the source of coverage reveals that, while the elderly pay a higher percentage of their total drug costs out-of-pocket, disabled beneficiaries actually have higher out-of-pocket costs (Table 4). Among those with drug benefits from Medicare managed care plans, disabled beneficiaries paid nearly double the amount paid out-of-pocket for medications by the elderly. Indeed, except for Medicaid beneficiaries, the disabled spent 19 to 42 percent more out-of-pocket for their prescriptions than the elderly when covered by the same types of insurance plans.

The disabled also tend to pay more, as a share of their incomes, toward drug expenses, regardless of type of coverage. Twice as many disabled as elderly beneficiaries with employer-sponsored plans or Medicare+Choice coverage spent at least 5 percent of their incomes on prescription expenses.[11] Only Medicaid offered substantial relief to the disabled in terms of keeping out-of-pocket costs low relative to income.

Because of the number and types of prescription drugs they use, as well as their lower likelihood of having generous employer-sponsored coverage, Medicare's disabled

[11] The relationship between drug coverage and drug use patterns is generally similar for mentally and physically impaired disabled beneficiaries, except for people with gaps in coverage. For the mentally impaired, those with part-year drug benefits used far fewer medications on average (29) than those with continuous full-year coverage (36) (Appendix Table A2). By contrast, disabled beneficiaries with part-year benefits and only physical impairments filled about the same number of prescriptions as those with coverage for the entire year (36 vs. 37). These patterns are difficult to explain since the generosity of part-year coverage is about the same for both groups.

beneficiaries receive considerably less protection through private sources of drug coverage than do the elderly.

Access Problems and the Need for Prescription Coverage

The disadvantages faced by the disabled described thus far translate into difficulty gaining access to needed medical care and prescription drugs. Compared with 17 percent of the elderly, over a third of the disabled population experienced at least one access problem, including: failure to fill prescribed drugs, trouble getting health care, delays in care because of cost, failure to see a physician for a health problem, and having no usual place of care (Table 5). The disabled are three to four times more likely than seniors to experience difficulties in filling prescriptions, getting care, affording timely treatment, and seeing physicians when sick. Only one measure, having a usual place of care, affects both groups similarly. Two areas are particularly problematic for the disabled: delays in medical attention because of costs and failure to see a doctor when necessary. While 18 percent of disabled beneficiaries identified each of these problems in 1998, only 4 percent of elderly beneficiaries reported delaying care because of cost and only 6 percent went without seeing a doctor even when they were experiencing a health problem.

Access problems are exacerbated for those with unstable drug coverage or no coverage at all, particularly the disabled. Disabled beneficiaries without prescription benefits are nearly three times more likely to fail to fill all of their prescriptions and more than twice as likely to delay care because of cost compared with those with full-year coverage. While about a quarter (24%) of the disabled with gaps in prescription coverage did not see a doctor when they had health problems, only 14 percent of those with continuous coverage did so. The disabled with prescription drug coverage may also have more comprehensive supplemental coverage for other benefits such as physician services, cost-sharing, and billing in excess of Medicare allowed charges. Prescription drug coverage, therefore, may be a proxy for comprehensive supplemental coverage that removes access barriers not just to prescription drugs but to other services as well. For the disabled population as a whole, the only access measure that appears to be unaffected by prescription coverage is "trouble getting health care." As with the other measures, however, the disabled on the whole experience far greater problems on this dimension than do the elderly.[12]

Commonly Used Prescriptions

Another potential issue for the disabled lies in the types of medications they typically use, which differ considerably from those used by the elderly. Table 6 presents the 10 therapeutic drug classes most commonly taken by each entitlement group.

---

[12] The disabled with mental and physical impairments were quite similar in their vulnerability to access barriers (Appendix Table A4).

Psychotherapeutics rank as the most-filled drug category among the disabled (filled by 57% of this group) but rank only 10th for the elderly (23%). The disabled are also far heavier users of analgesics and central nervous system drugs than are the elderly, who are most apt to use heart medications.[13] Some policymakers have suggested tying a Medicare drug benefit to the medications most often used by seniors. If that were to happen, the data presented here suggest that the disabled would be systematically disadvantaged.

Table 1. Characteristics of Elderly and Disabled Community-Dwelling Medicare Beneficiaries, 1998

Beneficiary Characteristics	Under Age 65 Beneficiaries with Disabilities	Over Age 65 Beneficiaries
All beneficiaries	4.8 million	33.2 million
Gender		
Female	42.4%	57.5%
Male	57.6	42.5
Race		
White	74.1%	86.7%
Black	16.7	7.9
Other	9.2	5.4
Hispanic ethnicity		
Hispanic	11.3%	6.4%
Non-Hispanic	88.8	93.6
Marital status		
Married	43.9%	56.4%
Single	56.1	43.6
Income in relation to Federal Poverty Level (FPL)		
< 100% FPL	45.3%	20.0%
101%–200% FPL	31.7	32.8
> 200% FPL	23.0	47.2
Self-reported health[a]		
Excellent	4.0%	16.1%
Very good	10.7	28.8
Good	25.6	32.5
Fair	32.9	16.3
Poor	26.4	6.2

[13] Within the disabled population, cardiopulmonary medications are more commonly prescribed to those with only physical impairments, while central nervous system medications are more typical for those with mental impairments (Appendix Table A5). Psychotherapeutic use figures prominently in the medical care of both groups: eight in 10 disabled beneficiaries with mental impairments took a least one psychotherapeutic medication in 1998, compared with four in 10 with only physical disabilities. Both groups are heavy users of analgesics.

Beneficiary Characteristics	Under Age 65 Beneficiaries with Disabilities	Over Age 65 Beneficiaries
Activities of daily living[a]		
0	55.9%	74.2%
1–2	27.4	17.5
3–6	16.7	8.3
Instrumental activities of daily living[a]		
0	63.6%	84.5%
1–2	26.3	11.1
3–5	10.1	4.4
Self-reported chronic conditions[a]		
Mental disorder	36.0%	3.6%
Osteoporosis	9.9	13.4
Alzheimer's disease	1.3	2.4
Arthritis	52.3	59.7
Hypertension	46.4	55.6
Heart condition	34.8	41.3
Chronic lung disease	26.2	14.2
Cancer	19.6	31.6
Diabetes	19.1	15.9
Stroke	12.2	10.4
Number of chronic conditions[a]		
0	8.9%	9.4%
1–2	44.4	43.7
3–4	32.0	36.9
5 or more	14.7	10.0
Source(s) of drug coverage[b]		
Employer plan	24.9%	33.6%
Medicare HMO	8.8	17.2
Individual Medigap	3.8	11.6
Medicaid[c]	33.0	9.4
Other public plan[d]	8.5	6.2
Some coverage but not reported[e]	10.3	6.7
Duration of drug coverage[f]		
Full-year coverage	60.1%	58.5%
Part-year coverage	18.8	17.5
No drug coverage[f]	21.2%	24.0%

Activities of daily living include getting out of bed and being able to feed yourself; instrumental activities of daily living include using a phone, going shopping, or preparing meals.

[a] Calculated only for those beneficiaries who were interviewed on health status in the community setting.

[b] Categories are not mutually exclusive.

[c] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[d] Other public plans include such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[e] Comprises beneficiaries who reported no drug coverage yet had third-party payments for prescriptions.

[f] Calculated only for those beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table 2. Availability of Selected Drug Benefit Programs for Disabled Community-Dwelling Medicare Beneficiaries, by Payers and Duration of Drug Coverage, 1998

	Under Age 65 Beneficiaries with Disabilities							
	Lives in State with QMB/SLMB+ Entitlement[b]		Lives in State with Pharmacy Assistance Program[a]		Lives in State with Medigap Guaranteed-Offer Laws[c]		Lives in County with Medicare+Choice Plan(s)	
	Yes	No	Yes	No	Yes	No	Yes	No
All Beneficiaries	21.4%	78.6%	21.1%	87.9%	14.0%	86.0%	71.6%	28.4%
Third-party payers								
All private sources[d]	41.5%	35.0%	33.1%	36.9%	43.6%	35.3%	39.9%	27.8%
Employer	25.7	24.7	23.9	25.1	31.7	23.9	25.6	23.7
Medicare HMO	11.7	8.0	5.9*	9.2	8.5*	8.9	12.2	0.5*
Individual Medigap	5.1	3.5	3.8*	3.8	5.4	3.5	3.6	4.1
All public sources[d]	44.3	36.7	41.0	38.0	38.9	38.2	37.5	40.4
Medicaid	39.9	31.1	32.4	33.0	35.3	32.6	32.4	34.4
Other public[e]	7.9	8.6	15.5	7.5	8.6	8.4	8.3	9.0
Duration of drug coverage[f]								
Full-year	71.9%	56.9%	59.5%	60.2%	70.2%	58.4%	61.5%	56.8%
Part-year	13.6	20.2	19.0	18.7	13.4	19.7	19.8	15.8
No drug coverage[f]	14.5	22.9	21.5	21.7	16.4	22.0	18.7	27.4

* Relative standard error greater than 30 percent.

[a] Eligibility for program includes disabled beneficiaries under age 65 (CT, IL, ME, MD, NJ, VT, WY).

[b] Full Medicaid benefits, including drugs, are given to QMB/SLMB+ beneficiaries (DC, FL, HI, ME, MA, MS, NE, NJ, PA, SC, UT, VT).

[c] Includes beneficiaries under the age of 65 with disabilities in six states (KS, ME, MI, NH, OR, PA) with guaranteed-offer laws targeted to the disabled, ensuring them access to standardized Medigap policies that may include Plans H, I, and J, along with those in the three states (MA, MN, WI) that offer pre-standard Medigap policies with drug coverage to all beneficiaries.

[d] Categories are not mutually exclusive.

[e] Other public plans includes such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[f] Calculated for only those disabled beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Tabl **welling**

Medicare Beneficiaries. by Presence and Duration of Drug Coverage, 19[illegible] [a]

Prescription Use and Spending	U ies with Disabilities				Over Age 65 Beneficiaries			
	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage
Beneficiaries filling at least one prescription	91.1%	95.8%	94.4%	75.0%	90.0%	92.2%	90.6%	84.2%
Mean number of prescriptions filled per year by users	33.5	36.5	32.9	23.3	24.7	26.0	25.1	20.8
Mean annual prescription drug spending	$1,284	$1,560	$1,283	$499	$841	$974	$772	$568
Mean annual prescription drug spending out-of-pocket	$388	$314	$496	$499	$379	$278	$460	$568
Percent of drug spending paid out-of-pocket	43.7%	26.4%	49.6%	100.0%	56.0%	37.1%	64.3%	100.0%
Out-of-pocket prescription drug spending as percent of annual income[b]								
0–5%	73.1%	80.7%	64.3%	55.7%	77.7%	86.3%	71.4%	59.8%
5% or more	26.9%	19.3%	35.7%	44.3%	22.3%	13.7%	28.6%	40.2%

[a] Sample consists of beneficiaries who had full-year Medicare entitlement.

[b] Calculated for only thos[illegible] beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table 4. Pre[illegible]nity-Dwelling Medicare Beneficiaries, by Source of Drug Coverage, 1998

Prescription Use and Spending	Under Age 65 Beneficiaries with Disabilities					Over Age 65 Beneficiaries				
	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public
Beneficiaries with no prescriptions filled	7.1%	5.5%*	5.6%	5.9%*	4.3%*	8.3%	8.3%	10.2%	11.4%	5.3%
Mean annual number of prescriptions filled by users	34.7	37.5	33.4	34.0	37.6	32.0	22.5	23.8	25.5	29.6
Mean annual prescription drug spending	$1,352	$1,247	$1,566	$1,354	$1,629	$1,004	$646	$980	$858	$1,069
Mean annual prescription drug spending out-of-pocket	$199	$464	$375	$601	$484	$179	$255	$264	$507	$393
Percent of drug spending paid out-of-pocket	21.1%	46.2%	29.4%	52.1%	41.6%	24.4%	50.2%	33.7%	64.2%	46.4%
Out-of-pocket prescription drug spending as percent of annual income[b]										
0–5%	84.2%	67.7%	79.2%	61.9%	64.5%	82.8%	86.0%	90.2%	69.9%	70.3%
5% or more	15.8%	32.3%	20.8%	38.1%	35.5%	17.2%	14.0%	9.8%	30.1%	29.7%

* Relative standard error greater than 30 percent.

[a] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table 5. Acc[illegible] nunity-Dwelling Medicare Beneficiaries, by Presence and Duration of Drug Coverage, 19[illegible] [a]

Access to Care Measure	Under Age 65 Beneficiaries with Disabilities				Over Age 65 Beneficiaries			
	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-year Rx Coverage	No Rx Coverage
Failed to fill prescribed drugs	6.4%	4.2%	7.7%	11.6%	2.2%	1.9%	2.0%	3.1%
Had trouble getting health care	9.1	8.0	12.3	9.7	2.3	2.3	3.2	1.9
Delayed care because of cost	18.4	11.8	28.3	29.0	4.2	3.0	5.3	6.0
Had health problem but did not see MD	18.1	13.9	23.7	25.5	6.1	5.7	5.7	7.3
Has no usual place for care	7.4	5.0	6.6	15.5	5.9	4.1	6.7	9.6
Any of the above access measures	35.0	27.8	43.5	49.2	16.5	14.2	18.2	21 2

[a] Sample consists of beneficiaries answering Access to Care questions of the 1998 MCBS and who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table 6. Most Commonly Filled Prescriptions for Elderly and Disabled Community-Dwelling Medicare Beneficiaries, by Therapeutic Drug Class, 1998

Therapeutic Drug Class	Under Age 65 Beneficiaries with Disabilities % (Rank)	Over Age 65 Beneficiaries % (Rank)
Cardiovascular	38.3 (3)	46.4 (1)
Cardiac drugs	33.4 (6)	40.4 (2)
Diuretics	25.9 (9)	34.2 (3)
Antiinfectives	41.5 (2)	28.1 (4)
GI preps	34.9 (5)	26.8 (5)
Hormones	30.8 (8)	24.1 (6)
EENT preps	—	23.8 (7)
Antiarthritics	31.6 (7)	23.1 (8)
Autonomic drugs	—	23.0 (9)
Psychotherapeutics	57.4 (1)	22.9 (10)
Analgesics	36.1 (4)	—
CNS drugs	22.1 (10)	—

Source: Medicare Current Beneficiary Survey, 1998.

CONCLUSION

These findings show that the disabled population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills. Yet, they have few places to turn for relief. Except for Medicaid, which serves as the major source of drug coverage for this population, the avenues by which needy disabled individuals can gain prescription coverage are heavily constrained. Few SSDI disabled are employed, which makes access to employer-sponsored coverage impossible except for those fortunate enough to have it from a previous employer or through a spouse's employer. The availability of Medicare+Choice plans has declined steadily since 1999, and there is evidence that some managed care plans may be discouraging the disabled from enrolling or inadequately serving those with more severe medical needs.[14]

Medicaid plays a pivotal role in providing services to disabled beneficiaries who have high medical costs and heavy prescription drug needs, but recent budget pressures could compromise that coverage. In 1998, elderly and disabled beneficiaries accounted for more than two-thirds of all Medicaid spending and four of five Medicaid dollars spent on prescription drugs.[15] State approaches to restoring solvency to their Medicaid budgets feature strategies designed to contain rising prescription drug costs, such as limits on the number of prescriptions that Medicaid will cover, drug formularies based on prior authorization, and increased copayments. Unless carefully designed and monitored, these policies may undermine the safety net that Medicaid provides to low-income disabled beneficiaries.

Clearly, the most effective way to protect the disabled from the high costs of prescription drugs would be for Congress to enact a comprehensive Medicare drug benefit. However, not just any drug benefit will suffice: the special needs of the disabled require explicit attention. For example, if the Medicare drug benefit were tightly crafted around the medical conditions and prescription use patterns of the elderly population, the disabled—particularly those with mental impairments—would be placed at a severe disadvantage. Mental illness is the single most common qualifying disorder for SSDI, accounting for 25 percent of all new awards, but many disabled beneficiaries also have

---

[14] See M. Gold, L. Nelson, R. Brown et al. "Disabled Medicare Beneficiaries in HMOs." *Health Affairs* 16 (September/October 1997): 149–62; and M. A. Laschober, P. Neuman, M. Kitchman, et al. "Medicare HMO Withdrawals: What Happens to Beneficiaries?" *Health Affairs* 18 (November/December 1999): 150–57.

[15] J. Guyer, *The Role of Medicaid in State Budgets*, prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2001.

severe physical conditions such as seizures or paralysis that are relatively uncommon among the elderly.[16]

The high cost-sharing provisions included in most proposals for a Medicare drug benefit would also prove problematic for many disabled beneficiaries. One common provision in the last round of Medicare drug benefit proposals was 50 percent coinsurance for beneficiaries with incomes as low as 135 percent of the federal poverty level. Another feature was the so-called "hole in the donut," a corridor of unprotected coverage for mid-range prescription expenses. Such provisions would place elderly and disabled alike at risk for substantial out-of-pocket costs, but the risk is substantially greater for the disabled, who are less likely to have back-up coverage or incomes sufficient to support uncovered prescription drug purchases. In short, a Medicare drug benefit designed for the elderly will not suffice for the disabled unless their particular needs are assessed and addressed.

[16] M. H. Davis, E. O'Brien, "Profile of Persons with Disabilities in Medicare and Medicaid." *Health Care Financing Review* 17 (1995): 179–211.

APPENDIX

In addition to comparing elderly and SSDI disabled beneficiaries, this analysis profiled differences in drug coverage, use, and cost for disabled persons with and without mental impairments. These results are presented here in a set of tables that parallel those in the main report. Evidence of mental impairment was drawn from two main sources derived from protocols developed by Rosenbach (1995), including the primary or secondary cause of disability entitlement and self-reported health conditions.[17] During the health status section of the MCBS interview, disabled respondents are asked whether they have ever had any of 30 medical conditions (including three questions about mental impairments, mental disorder, mental retardation, and Alzheimer's disease) and if these conditions caused their disability entitlement. Both entitlement cause and self-reported conditions are necessary for identifying mental impairments, since approximately 25 percent of the disabled sample list "other reason" or no recorded cause of entitlement. Included in this group are beneficiaries who answered the facility version of the survey, which includes additional mental condition indicators: mental disorder, Alzheimer's disease, manic depression, depression, dementia, and schizophrenia. Using these criteria, the authors classified 1,887 disabled MCBS respondents into two groups: those with evidence of mental impairment (882) and those with other impairments (1,005).

Appendix Tables A1 through A5 present the findings from this analysis. Although those with mental impairments and those with physical impairments both depend heavily on medications, those with mental impairments are at a substantial economic disadvantage, making access to publicly funded drug coverage especially critical. The share of beneficiaries under the age of 65 with disabilities living in poverty rises to a majority (58%) for those with mental impairments (including those with physical impairments as well), compared with 37 percent of those with physical impairments only. There are surprising similarities between those with mental impairments and those with physical impairments in terms of burden of illness. Disabled beneficiaries with physical impairments only most commonly suffer from arthritis (59%), hypertension (50%), and heart conditions (39%). Nearly as many of those with mental impairments suffer from the same physical conditions (e.g., 42% have arthritis and 40% have hypertension).

The two groups did differ in their sources of prescription drug coverage, however. Only a quarter (24%) of disabled beneficiaries with mental impairments had their drug insurance from employers or Medicare HMOs, compared with 41 percent of those with

---

[17] M. Rosenbach. "Access and Satisfaction Within the Disabled Medicare Population." *Health Care Financing Review* 17 (1995): 147–67.

physical impairments only (Table A1). While mean drug use was about the same for both groups (33 vs. 34 prescriptions per year), out-of-pocket costs vary, with those with mental impairments having considerably lower out-of-pocket spending than those with physical impairments alone ($337 vs. $425) (Table A2). Finally, the vast majority of disabled beneficiaries with mental impairments take psychotherapeutic agents (80%), while the most commonly filled prescriptions among beneficiaries with physical impairments alone are cardiovascular medications (filled by 47% of this group) (Table A5).

Table A1. Characteristics of Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type, 1998

Beneficiary Characteristics	Disabled with Mental Impairment(s)*	Disabled with Physical Impairment(s) Only
All beneficiaries	1.1 million	3.7 million
Gender		
Female	42.4%	42.4%
Male	57.6	57.6
Race		
White	77.4%	72.0%
Black	13.1	19.2
Other	9.6	8.9
Hispanic ethnicity		
Hispanic	11.3%	11.2%
Non-Hispanic	88.7	88.8
Marital status		
Married	29.2%	54.0%
Single	70.8	46.0
Income in relation to Federal Poverty Level (FPL)		
< 100% FPL	57.9%	36.6%
101%–200% FPL	25.7	35.8
> 200% FPL	16.4	27.6
Self-reported health[a]		
Excellent	6.5%	2.4%
Very good	12.9	9.1
Good	27.7	24.2
Fair	30.1	34.8
Poor	22.6	28.9
Activities of daily living[a]		
0	64.4%	50.2%
1–2	21.4	31.4
3–6	14.2	18.4

Beneficiary Characteristics	Disabled with Mental Impairment(s)*	Disabled with Physical Impairment(s) Only
Instrumental activities of daily living[a]		
0	58.4%	67.1%
1–2	29.9	23.9
3–5	11.7	9.0
Self-reported chronic conditions[a]		
Mental disorder	89.4%	0.0%
Osteoporosis	8.4	10.9
Alzheimer's disease	3.2	0.0
Arthritis	42.1	59.2
Hypertension	40.3	50.4
Heart condition	29.1	38.7
Chronic lung disease	24.5	27.3
Cancer	16.6	21.6
Diabetes	14.3	22.3
Stroke	11.0	12.9
Number of chronic conditions[a]		
0	4.3%	12.0%
1–2	45.9	43.5
3–4	30.9	32.7
5 or more	19.0	11.9
Source(s) of drug coverage[b]		
Employer plan	17.0%	30.4%
Medicare HMO	6.6	10.4
Individual Medigap	4.0	3.7
Medicaid[c]	44.6	25.0
Other public plan[d]	11.0	6.7
Some coverage but not reported[e]	9.3	11.0
Duration of drug coverage[f]		
Full-year coverage	60.7%	59.6%
Part-year coverage	18.4	19.1
No drug coverage[f]	21.0%	21.3%

* Includes those with only mental impairments as well as those with both mental and physical impairments.

Activities of daily living include getting out of bed and being able to feed yourself; instrumental activities of daily living include using a phone, going shopping, or preparing meals.

[a] Calculated for only those beneficiaries who were interviewed on health status in the community setting.

[b] Categories are not mutually exclusive.

[c] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[d] Other public plans includes such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[e] Comprises beneficiaries who reported no drug coverage yet had third-party payments for prescriptions.

[f] Calculated for only those beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table A2. Prescription Drug Use and Spending for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Presence and Duration of Drug Coverage, 1998[a]

	Disabled with Mental Impairment(s)*				Disabled with Physical Impairment(s) Only			
Prescription Use and Spending	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage
Beneficiaries filling at least 1 prescription	89.5%	94.1%	94.1%*	71.8%	92.3%	97.1%	94.2%**	77.3%
Mean annual number of prescriptions filled by users	32.7	36.4	28.7	23.5	34.0	36.6	35.8	23.1
Mean annual prescription drug spending	$1,217	$1,481	$1,159	$506	$1,332	$1,619	$136	$495
Mean annual prescription drug spending out-of-pocket	$337	$244	$450	$506	$425	$367	$528	$495
Percent of drug spending paid out-of-pocket	40.8%	22.7%	48.7%	100.0%	45.8%	29.0%	50.3%	100.0%
Out-of-pocket prescription drug spending as percent of annual income[b]								
0–5%	74.1%	82.1%	66.8%	52.6%	72.5%	79.7%	62.5%	57.8%
5% or more	25.9%	17.9%	33.2%	47.4%	27.5%	20.3%	37.5%	42.2%

* Includes those with only mental impairments as well as those with both mental and physical impairments.

** Relative standard error greater than 30 percent.

[a] Sample consists of beneficiaries who had full-year Medicare entitlement.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table A3. Prescription Drug Use and Spending for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Source of Drug Coverage, 1998

Prescription Use and Spending	Disabled with Mental Impairment(s)*					Disabled with Physical Impairment(s) Only				
	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public
Beneficiaries with no prescriptions filled	7.3%	13.9%**	5.5%**	7.4%**	6.0%**	6.8%	1.8%**	5.7%**	4.8%**	2.4%**
Mean annual number of prescriptions filled by users	33.6	36.5	35.2	34.2	36.5	36.1	37.9	32.6	33.9	38.8
Mean annual prescription drug spending	$1,365	$1,216	$1,481	$1,526	$1,421	$1,337	$1,261	$1,598	$1,227	$1,861
Mean annual prescription drug spending out-of-pocket	$173	$477	$400	$407	$382	$231	$458	$365	$744	$597
Percent of drug spending paid out-of-pocket	20.0%	42.9%	33.3%	42.7%	42.8%	22.4%	47.5%	28.0%	58.8%	40.2%
Out-of-pocket prescription drug spending as percent of annual income[b]										
0–5%	84.0%	60.6%	79.5%	72.5%	60.3%	84.5%	70.4%	79.1%	54.4%	69.0%
5% or more	16.0%	39.4%	20.5%	27.5%	39.7%	15.5%	29.6%	20.9%	45.6%	31.0%

* Includes those with only mental impairments as well as those with both mental and physical impairments.

** Relative standard error greater than 30 percent.

[a] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Beneficiaries with Disabilities by Disability Type and Presence and Duration of Drug Coverage, 19[illegible] a

Access to Care Measure	Disabled with Mental Impairment(s)*				Disabled with Physical Impairment(s) Only			
	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage
Failed to fill prescribed drugs	6.5%	5.1%	8.1%	9.8%	6.2%	3.5%	7.4%	12.9%
Had trouble getting health care	11.9	10.9	12.7	14.3	7.0	5.7	11.[illegible]	6.5
Delayed care because of cost	19.7	15.8	22.8	29.5	17.4	8.7	32.3	28.7
Had health problem but did not see MD	18.8	17.2	20.6	22.6	17.5	11.4	26.0	27.4
Has no usual place for care	8.9	6.6	9.7	15.6	6.3	3.7	4.3	15.4
Any of the above access measures	37.0	33.7	38.8	46.1	33.6	23.1	46.9	51.4

[a] Sample consists of beneficiaries answering Access to Care questions of the 1998 Medicare Current Beneficiary Survey and who had full-year Medicare entitlement.

* Includes those with only mental impairments as well as those with both mental and physical impairments.

Source: Medicare Current Beneficiary Survey, 1998.

Table A5. Most Commonly Filled Prescriptions for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Therapeutic Drug Class, 1998

Therapeutic Drug Class	Disabled with Mental Impairment(s)* % (Rank)	Disabled with Physical Impairment(s) Only % (Rank)
Cardiovascular	27.0 (5)	46.8 (1)
Cardiac drugs	18.8 (10)	44.6 (3)
Diuretics	—	35.0 (9)
Antiinfectives	36.1 (2)	45.5 (2)
GI preps	26.1 (7)	41.5 (5)
Hormones	21.2 (8)	38.1 (7)
EENT preps	20.8 (9)	20.9 (10)
Antiarthritics	26.9 (6)	35.1 (8)
Autonomic drugs	—	—
Psychotherapeutics	79.6 (1)	39.6 (6)
Analgesics	28.8 (4)	41.7 (4)
CNS drugs	30.7 (3)	—

* Includes those with only mental impairments as well as those with both mental and physical impairments.

Source: Medicare Current Beneficiary Survey, 1998.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering by number. These items can also be found on the Fund's website at www.cmwf.org. Other items are available from the authors and/or publishers.

#544 *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources* (August 2002). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this policy brief, the authors suggest that a modest Medicare prescription drug benefit could be crafted that provides some coverage to all beneficiaries while protecting those with low-incomes and high out-of-pocket expenses.

Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap? (July 31, 2002). Dana Gelb Safran, Patricia Neuman, Cathy Schoen, Jana E. Montgomery, Wenjun Li, Ira B. Wilson, Michelle S. Kitchman, Andrea E. Bowen, and William H. Rogers. *Health Affairs* web exclusive. Article available online only at http://www.healthaffairs.org/WebExclusives/Safran_Web_Excl_073102.htm.

Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States (July 2002). Michelle Kitchman, Tricia Neuman, David Sandman, Cathy Schoen, Dana Gelb Safran, Jana Montgomery, and William Rogers. Copies of this report (#6049) are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533, http://www.kff.org.

#530 *State Pharmaceutical Assistance Programs: Approaches to Program Design* (May 2002). Kimberley Fox, Thomas Trail, and Stephen Crystal, Rutgers Center for State Health Policy. State pharmacy assistance programs for Medicare beneficiaries help only a small proportion of the Medicare population—just 3 percent, or 1.2 million beneficiaries out of 39 million nationwide. According to the authors, a federal program is needed to fill this gap in coverage, and it should coordinate with the 23 state programs currently in place.

#538 *A Medicare Prescription Drug Benefit: Focusing on Coverage and Cost* (April 2002). Juliette Cubanski and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, discusses the significant policy challenge of designing an effective and politically viable Medicare prescription drug benefit. Available online only at www.cmwf.org.

#537 *Medicare Managed Care: Medicare+Choice [illegible] Years* (April 2002). Colleen L. Barry and Janet Kline. This issue brief, prepared for the 20[illegible] Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, examines trends in enrollment, benefits and premiums, plan payments, and satisfaction and quality in Medicare+Choice. Available online only at www.cmwf.org.

#533 *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002* (March 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. In this report (available on the Fund's website only), the authors note that while increases in monthly premiums will affect all enrollees in 2002, sicker beneficiaries will bear the brunt of changes in the structure of prescription drug benefits and cost-sharing requirements as more plans restrict drug coverage to generics only and raise cost-sharing requirements for services such as inpatient and outpatient hospital care.

AARP Alaska

Testimony on Proposed SeniorCare Program
Marie Darlin, Coordinator
AARP Capital City Task Force

Alaska House of Representatives
Finance Committee
January 20, 2004

Good Afternoon, Co-Chairs and Committee Members. My name is Marie Darlin and I am a volunteer with AARP Alaska. I serve as the Coordinator of our Capital City Task Force. AARP has over 76,000 members in Alaska.

As you know, 2003 was a difficult year for many older Alaskans, particularly for those of us over age 72. We made our financial plans for retirement based on our Social Security, savings and investments, pensions for some of us, and the Alaska Longevity Bonus.

We have to plan our budgets and watch our expenses carefully. Most of us are not going to be able to return to the work force if we find we have not planned well financially. "What we have is what we've got".

When the Governor eliminated the Longevity Bonus, it hurt many of us in the pocketbook.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | 907-341-2277 | 907-341-2270 fax | 1-877-434-7598 TTY
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

In addition, as we age we also take more prescription drugs. ~~Unfortunately, those same prescription drugs that help us deal with chronic illnesses have also been increasing in costs at rates much higher than normal inflation.~~ According ~~to the Kaiser Family Foundation~~, some sources prescription drug increases in Alaska are higher than in any other state.

The loss of the Longevity Bonus compounded with the disproportionately high increases in prescription medications over the past few years have forced many older Alaskans to rethink how they can manage their retirement budgets.

Although the Senior Assistance Program did not replace the Longevity Bonus, it does help over 7,000 of our lowest income older Alaskans determine how to pay their day to day costs, especially for prescription drugs.

Congress has passed and the President has signed the federal Medicare prescription drug bill which will take effect on January 1, 2006. Although not perfect, this bill will significantly help an estimated 23,000 older Alaskans ~~who are below 150% of the federal poverty level~~. However, implementation is two years away.

The proposed SeniorCare program will help during ~~that~~ this two year period. Older Alaskans who are eligible will be able to choose between continuing to receive a monthly Senior Assistance Program check of $120 or, if they have high prescription drug costs, participating in the Alaska SeniorCare prescription program which will give them drug coverage equivalent to $133 monthly.

SeniorCare will also provide a maximum of $1,000 prescription drug coverage annually to older eligible Alaskans who fall between 135% and 150% of the federal poverty level. These

individuals have not been eligible for the Senior Assistance Program but many of them have high prescription drug costs. DHSS estimates that there are 2,200 older Alaskans in this category.

I want to emphasize that any financial assistance to help older Alaskans cope with escalating prescription drugs costs will be welcome.

We know there are still specific details to work out concerning enrollment, subsidy arrangements, etc. and we will be glad to work with you, our elected officials, and the administration to assure that the system is "user-friendly".

The SeniorCare proposal also includes two additional staff for a Senior Information Office. Access to information is critical for older citizens and family members who may be caregivers. AARP welcomes the two new staff positions but we also recognize that the Alaska senior population is growing...and growing...and growing. The number of families providing some type of assistance to older family members is also growing. I am sure many of you have this situation in your own families. It is a significant challenge to be able to render helpful information to an individual asking about help for an aging-related problem in Kake or Sutton, Clam Gulch or Kipnuk. Some of these questions are pretty hard to resolve in the middle of Anchorage and Fairbanks. Our only caution is that this is just a first step. Many people who will be calling for assistance will just need to know a local doctor that accepts Medicare or the location of the senior center. Others will be agonizing over a parent with worsening Alzheimer's or they have just been notified that their spouse is being discharged and they have no idea how to take care of him at home. These staff will need to know what services are available in Glennallen and Delta Junction. They will be asked if a particular assisted living facility in North Pole is "any good." Delivering quality

Delivering quality service for senior information is a tough job. This is an area that will only grow as our population continues to age.
AARP strongly supports the third part of the SeniorCare program: the Preferred Drug List, or PDL, for Medicaid.

Most countries, the Veteran's Administration, the Indian Health Service, more than half of the states, and many private employers utilize some form of a "preferred drug list." It doesn't make sense to pay for a more expensive drug when a less costly medication is available that is just as if not more effective. The prescription program under SeniorCare will also use the Preferred Drug List. We think this makes sense for consumers as well as for the State and will result in the use of the most effective therapeutic medications as well as those at the lowest cost.

I would offer one final comment. When we first heard about the SeniorCare proposal, our first question was "how will we pay for it?" AARP members are parents and grandparents. We want to be certain that we are not supporting a new benefit for older persons that will result in a decrease in funding for a neo-natal program. We are all in this together. We are all Alaskans, no matter what our age.

Thank you.

Marie Darlin
Coordinator, AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
907-586-3637

SITE: KETCHIKAN	SUBJECT OF MEETING: Workers Comp/HB374
COMMITTEE: HFIN	BILL #
DATE: 01/20/04	UPDATE #: Final

PRINT YOUR NAME	COMMUNITY	REPRESENTING/AFFILIATION	DO YOU WANT TESTIFY Y or N
Ed Zastrow	Ketchikan	AARP	No
PH 225-2814		3530 Denali Ave	

State of Alaska

Department of Health & Social Services

Frank H. Murkowski
Governor
P.O. Box 110001
Juneau, Alaska 99811-0001

NEWS RELEASE

Joel Gilbertson
Commissioner
907-465-3030
FAX: 907-465-3068
www.hss.state.ak.us

FOR IMMEDIATE RELEASE: Dec. 17, 2003

Governor announces SeniorCare, a new array of services for Alaska seniors

Prescription drug benefit, new services, better access to health care, information & resources to be offered

Juneau, Alaska – Governor Frank H. Murkowski today announced SeniorCare, a new proposed program to make prescription drugs more affordable for Alaska seniors. "SeniorCare will ıde qualified seniors with a prescription drug benefit to assist in the purchase of needed m. ications," Governor Murkowski said. SeniorCare will also include a new Senior Information Office and a Preferred Drug List to make prescription drugs more affordable. Seniors receiving the Alaska Senior Assistance Program can choose to continue receiving the cash assistance of $120 a month instead of the drug coverage.

"SeniorCare will provide a bridge for those seniors most in need of assistance until the full Medicare prescription drug benefit begins in January 2006," Governor Murkowski noted. "I will ask legislators to pass this legislation in January so that this benefit can begin in April 2004." The Senior Assistance Program cash benefit was only budgeted in the current fiscal year and would end June 30 if the legislature takes no action, but will continue as an option until January 2006 if passed.

"SeniorCare will help low income seniors who do not otherwise qualify for public assistance – the people with greatest needs," said Department of Health and Social Services Commissioner Joel Gilbertson. "However, we will provide a broader program that will help all seniors," Gilbertson said. The new SeniorCare program will provide a one-stop senior resource and referral service, help with prescription drugs and access to healthcare, and work to lower the cost of prescription drugs.

Seniors who qualify for the Senior Assistance Program (65 and older and 135 percent of the poverty level), and who are not receiving comprehensive Medicaid prescription drug coverage will be provided a choice – between the new SeniorCare prescription drug subsidy of $1,600 a year or to continue to receive the Senior Assistance Program cash assistance of $1,440 a year. Together with the $600 Medicare subsidy to begin this spring, these eligible seniors opting for the SeniorCare prescription drug benefit will have a combined drug subsidy of $2,200 a year.

-more-

Currently those seniors who qualify for the Senior Assistance Program earn less than $15,134 annually, or if living with a spouse, earn less than $20,439. To qualify, some assets are considered in the overall needs test.

Additionally, seniors between 135 percent and 150 percent of poverty level will receive a prescription drug benefit of $1,000 a year. The qualifying income level for these seniors would be those making below $16,815 for an individual or $22,710 for a couple. New federal poverty guidelines will be released early in 2004 and income level guidelines may change.

Other new offerings under the SeniorCare program include completion of a Preferred Drug List and opening a Senior Information Office.

"My commitment to Alaska seniors is to protect their access to prescription drugs, and to provide them better access to senior services," Governor Murkowski said. "Alaska seniors want to get necessary medical care as close to home and community as possible, and they want the opportunity to direct that care to the maximum extent. These are important because they promote independent living at the highest level possible, and that's what SeniorCare is all about."

The Medicaid Preferred Drug List, scheduled to be in place by early 2004, will contain costs for prescription drugs provided to those receiving Medicaid. The list will contain recommendations, selected by Alaska physicians and pharmacists, on drugs that are proven to be the most efficacious, cost-effective and safe. "The Preferred Drug List will also provide a valuable resource for all seniors to compare prescription drug costs, and will enable seniors to work with their physicians to identify cost-effective drugs that are right for them," Gilbertson said Once implemented next spring, seniors can get the list from the new Alaska Senior Information Office.

"By mid January, our new Senior Information Office is going to be the single stop Alaska seniors will have to make for all resources and referrals they need," Governor Murkowski said. "This is an essential thing we can do to give Alaska seniors better customer service." The Alaska Senior Information Office will provide a statewide toll-free telephone number and Web site for information on services available to seniors, including an up-to-date directory of local physicians who accept Medicaid and Medicare clients, available programs and services including SeniorCare, and prescription drug information and assistance for seniors. The Senior Information Office and the Preferred Drug List will not need legislative approval to be implemented.

The toll-free telephone number for the SeniorCare Senior Information Office is 1-800-478-6065 (Anchorage 907-269-3680) and the Web address is: http://www.seniorcare.alaska.gov

Current programs for seniors which will fall under SeniorCare include comprehensive Medicaid health insurance coverage and Medicare cost-sharing assistance for low-income seniors. About 7 000 eligible seniors receive prescription drugs, medical care, hospitalization and other services from the state at a cost of $119.6 million a year. In addition, DHSS will continue to work with the Denali Commission and others to ensure greater access to healthcare for Medicaid and Medicare patients.

-30-

For more information, please contact

Sherry Hill
Special Assistant to the Commissioner
Department of Health and Social Services
Juneau Office: 907-465-1618
Anchorage: 907-269-7800
Cell: 907-321-2838

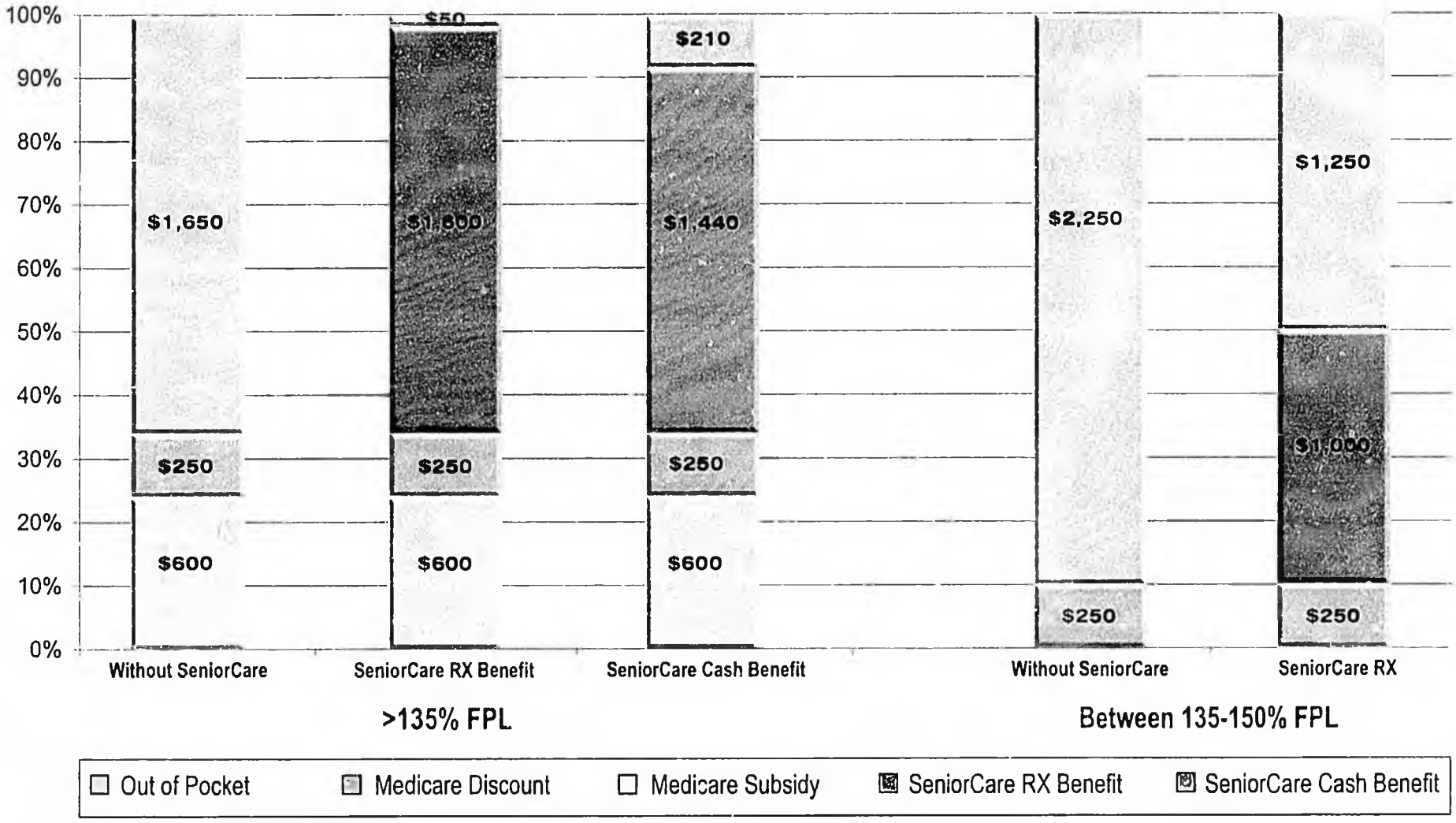
Ross Soboleff
Public Information Officer III
Department of Health and Social Services
(907) 465-1611

Senior CARE

Bridging the Gap

Comparison of Benefits

$2,500 Annual Rx Cost



A SPECIAL REPORT

A New Direction

Alaska's Benefits to Seniors Rank Among the Nation's Best

"We know Alaska's richest resource is our people."
- Governor Frank H. Murkowski

Governor Murkowski has charged Alaska's Department of Health and Social Services with setting new and higher standards for meeting the health care and social services needs of Alaskans. In the past year the department has made some of the most sweeping and innovative changes in Alaska's state government. DHSS Commissioner Joel Gilbertson undertook a major reorganization to better serve all Alaskans in need.

Self-Sufficiency, Safety Net and Access to Care

The work of the Department of Health and Social Services is guided by three core values: protecting each individual's right to live as self-sufficiently as possible; providing a safety net of services to those in the greatest need; and providing the broadest possible access to care. It is those core values that guide the department's work in serving seniors and in serving all Alaskans.

The Governor met with seniors at the State Fair

Division of Senior and Disabilities Services

One of the department's major initiatives in 2003 was to establish a new Division of Senior and Disabilities Services to care for seniors and the disabled in one agency. This division helps provide better access to a wide range of the services that seniors and people with disabilities need and deserve.

Making Hard Choices: Taking Care Of Those In Need

Governor Murkowski has said that one of the hardest decisions he had to make in 2003 was ending the Longevity Bonus program in order to redirect available financial resources to those seniors with the most serious needs. The Governor's commitment was to make sure seniors with the greatest need receive services. More than 1,100 elderly Alaskans who had been excluded from the Longevity Bonus program are among the 7,200 seniors now receiving needed assistance under the new Alaska Senior Assistance Program. The old program provided 18,000 of Alaska's 44,000 citizens over the age of 65 with monthly bonus checks, but deprived the other 26,000 of any such payment at all. And with eligibility for the old program based solely on date of birth – not on actual need – some of Alaska's most wealthy seniors got monthly checks, while others with significant needs got nothing. The new program provides funding for Alaskans in need who were not receiving any bonus payments. Of the 7,211 applicants qualifying for the new program, 6,072 had received the Longevity Bonus and 1,139 had not.

How We Compare To Other States

Alaska ranks near the top of the list of states in terms of services we provide to older residents. Alaska not only offers an array of services through the Department of Health and Social Services, but many other senior benefit programs as well. Property tax exemptions, sales tax exemptions, community service training and employment programs, hunting and fishing license exemptions, discounted ferry and Alaska Railroad

fares and driver's license discounts are all among the many ways the state shows respect and gratitude to older Alaskans who have helped make Alaska what it is today.

Introducing "SeniorCare" – A New Program For Alaska Seniors

Governor Murkowski believes that Alaskans should be provided the opportunity to direct and have access to necessary medical care as close to home and community as possible. The governor is committed to protecting access to prescription drugs for seniors, as well as providing better access to senior services. This commitment brought about some new services to help Alaska seniors in a program called "SeniorCare," which will provide help with prescription drugs, access to healthcare, and information about senior benefits, senior resources and referrals.

***NEW!* "SeniorCare"**
The Senior Assistance Program has been brought under a new program called "SeniorCare." Eligible seniors will soon be provided an option to receive a prescription drug benefit in lieu of cash assistance as provided under the Senior Assistance Program. A prescription drug benefit will be offered to an additional group of eligible seniors needing assistance. The "SeniorCare" prescription drug benefit is anticipated to be offered April 2004, pending legislative approval.

***NEW!* "SeniorCare" Prescription Drug Benefit:** Anticipated to start in April, this program will provide a bridge for seniors needing assistance until the new federal Medicare prescription drug program goes into effect in 2006. Seniors who qualify for the Senior Assistance Program (135 percent of the poverty level), and who do not receive Medicaid prescription drug coverage, will be provided a choice between the new "SeniorCare" prescription drug subsidy of $1,600 a year (prorated) or to continue with cash assistance. Together with the $600 Medicare subsidy to begin this spring, these eligible seniors opting for the "SeniorCare" prescription drug benefit will have a combined benefit of $2200 a year. Additionally, seniors between 135 percent and 150 percent of poverty level will receive a prescription drug benefit of $1000 a year.

"SeniorCare" Senior Assistance Program: Currently, Alaskans 65 and older at 135 percent of poverty level can receive cash assistance of $120 per month. By April, the seniors who qualify for this program will be offered a new option of receiving the "SeniorCare" prescription drug benefit in lieu of the cash benefit, for a total drug subsidy of $2,200. With a higher income eligibility level than Adult Public Assistance, the Senior Assistance Program now helps over 7,600 seniors – about 15 percent of whom had never received the Longevity Bonus. Alaska will spend more than $9 million on this program in the current fiscal year.

Total Medicaid Program Assistance: Prescriptions, medical care, hospitalization and other services are provided to more than 7,000 elderly eligible Alaskans at a cost of $119.6 million a year. Alaska spends almost $100 million on prescription drugs annually through Medicaid, with 25 percent annual cost increases expected in the future.

***NEW!* Medicaid Preferred Drug List:** The Preferred Drug List, scheduled to be in place by early 2004, will contain costs for prescription drugs provided to those receiving Medicaid. The Preferred Drug List will protect Alaska low-income seniors' access to prescription drugs, and will provide a valuable resource for all seniors to compare prescription drug costs. Once approved, the list will be made available through the Alaska Senior Information Office, allowing seniors to work with their physicians to identify cost effective drugs that are right for them.

***NEW!* Senior Information Office:** Find a one-stop resource and referral for benefits and services for seniors in the State of Alaska. Scheduled to be in place by mid-January, the Alaska Senior Information Office will provide a statewide toll-free telephone number for information on services available to seniors,

including: an up-to-date directory of local physicians who accept Medicaid and Medicare clients, available programs and services including "SeniorCare," prescription drug information and assistance for seniors.

Assistance with Medicare Costs for Low-Income Seniors: Premium, co-pay and deductible coverage is provided to those who qualify.

330 Clinics/Denali Commission: Federally funded clinics are being constructed in rural communities with assistance from the Denali Commission, to provide greater access for Medicaid and Medicare patients.

Other Programs for Alaska's Seniors

Please take a moment to learn about some of the other current programs that support Alaska's seniors.

Promoting self sufficiency and healthy behaviors

People should be provided the opportunity to be as independent and healthy as possible.

Long-Term Care Financial Assistance and Services

Home and Community-Based Programs: Seniors with dementia, those in rural areas, and other seniors in need are eligible for home- and community-based assistance programs. This program totals about $4.6 million annually in state funding.

IMPROVED! **Assisted Living Development Investment:** We are working with the Denali Commission to develop community-based assisted living services in rural communities.

Older Alaskans Waiver Services: More than 1,350 seniors who are eligible for nursing home care chose to receive care at home instead. This program provides assistance to seniors who meet income criteria at a cost of about $25.5 million each year.

Personal Care Attendant Program: People with functional impairments and who meet income eligibility requirements are served by this program, at a cost of $21.8 million for seniors.

IMPROVED! **Alaska Pioneers Homes**: Alaska's licensed assisted living facilities in Fairbanks, Palmer, Anchorage, Juneau, Sitka and Ketchikan provide more than 600 beds for Alaska's seniors. A person age 65 with one year Alaska residency can qualify for the Pioneers Homes. Rates are subsidized for low-income seniors. Alaska provides these services at a cost of about $35.7 million a year. Additionally, the state is proposing to invest more than $3 million to upgrade the Alaska Pioneers Homes in the next fiscal year.

Assisted Living Licensing: More than 1,700 assisted living beds are available in approximately 150 homes. There is no income criterion for this program.

Nursing Homes: The state of Alaska provides assistance to almost 950 people, largely seniors, in need of nursing home or home- and community-based waiver services. The state spent about $61.3 million in fiscal year ending June 30, 2003, on Medicaid nursing home services.

Transportation

Transportation services: Seniors and disabled residents get help in getting around town through local transportation services in communities statewide, such as AnchorRide in Anchorage, and Care-A-Van in Juneau. Alaska provides about $1.3 million annually for this program.

Employment Services

Senior Community Service Training and Employment: This program offers vocational training and job placement services to low-income Alaskans age 55. The state provides $1.6 million a year to support this effort.

Providing a safety net

Basic human needs should be met through a safety net of services in a safe and healthy community environment

Financial Assistance

Adult Public Assistance: This program can provide Alaskans age 65 and older with Medicaid coverage, and, for those meeting income eligibility guidelines, with monthly cash assistance to supplement SSI. The state pays about $18.6 million annually for this program.

Food Stamps: This program helps ensure that those Alaskans meeting certain eligibility guidelines receive adequate nutrition. Almost 1,100 Alaska seniors receive $2.4 million in food stamps each year.

Photo by Hall Anderson/Ketchikan Daily News

DHSS Commissioner Joel Gilbertson with seniors

Other financial assistance

Housing Assistance: The Alaska Housing Finance Corporation offers senior housing with rent limits for qualifying seniors.

Heating Assistance Program: This federally funded program helps low-income families, whether home owners or renters, meet the high costs of keeping their homes warm.

Assurance of Safety

***IMPROVED!* Adult Protective Services:** This program provides vulnerable adults with assistance and targets seniors in need. The demand for this service continues to grow, and the department is reviewing ways to have other departments, such as Public Safety, work collaboratively in this effort. Alaska provides this service for about $2 million a year.

Guardianships and Conservatorships: More than 850 adults take part in this program offered by the Office of Public Advocacy at a cost of $1.6 million per year to the state.

Long Term Care Ombudsman: This office investigates reports concerning the well being and rights of seniors who live in long-term care facilities. The office also works to resolve concerns that those over age 60 may have with other services. The state spent $208,000 on this service in the last fiscal year.

Services through Senior Centers

Senior Centers: State and federal grants help support 31 senior centers in Alaska.

Meal Transportation and Support: More than 100 Alaska communities receive help in providing nutritional services to those over age 60 at senior centers or similar centers, and through programs delivering meals to seniors' homes. Nutrition and health education is also provided. Alaska spends about $5.8 million a year on these programs through the Alaska Commission on Aging.

FOR INFORMATION CALL: ALASKA SENIOR INFORMATION OFFICE

Statewide: 1-800-478-6065

Anchorage: 907-269-3680

Alaska Department of Health & Social Services Division of Senior and Disabilities Services

Senior CARE

Comparison of Qualifications and Benefits

	SeniorCare Prescription Drug Subsidy	SeniorCare Cash Assistance Subsidy	SeniorCare Prescription Drug Subsidy
Qualifications	➧ 135% of Poverty Level ➧ Annual Income below $15,135 Single $20,439 Couple ➧ Liquid Assets below $4,000 Single $6,000 Couple	➧ 135% of Poverty Level ➧ Annual Income below $15,135 Single $20,439 Couple ➧ Liquid Assets below $4,000 Single $6,000 Couple	➧ 135% to 150% of Poverty Level ➧ Annual Income below $16,815 Single $22,710 Couple ➧ Liquid Assets below $4,000 Single $6,000 Couple
SeniorCare Benefit April 2004 - December 2005	➧ $1,600 Annual Prescription Drug Subsidy (prorated)	➧ $120 a month cash assistance (up to $1,440 annual)	➧ $1,000 Annual Prescription Drug Subsidy (prorated)
Medicare Benefit May 2004 - December 2005	➧ Annual Medicare Subsidy $600 ➧ Medicare drug discount	➧ Annual Medicare Subsidy $600 ➧ Medicare drug discount	➧ Medicare drug discount

HB 374

FRANK H. MURKOWSKI
GOVERNOR
GOVERNOR@GOV.STATE.AK.US

P.O. BOX 110001
JUNEAU, ALASKA 99811-0001
(907) 465-3500
FAX (907) 465-3532
WWW.GOV.STATE.AK.US

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 9, 2004

The Honorable Pete Kott
Speaker of the House
Alaska State Legislature
State Capitol, Room 208
Juneau, AK 99801-1182

Dear Speaker Kott:

Under the authority of article III, section 18 of the Alaska Constitution I am transmitting a bill establishing the "SeniorCare" program.

Prescription drug prices have spiraled upwards for years, placing a heavy financial burden on Alaska's seniors. This past year my administration has initiated a number of reforms to our Medicaid program that will help assure that seniors receive the safest and most clinically appropriate prescription drugs they need at a reasonable cost. Among these reforms is the development of a preferred drug list, requiring prior authorization for certain drugs, and expanding case management of high-cost clients; often persons with chronic conditions that require a large number of medications.

This fall, Congress approved a comprehensive package of Medicare prescription drug subsidies. However, these subsidies are not fully effective until 2006. This creates a gap for seniors who need immediate assistance. SeniorCare is an innovative program, which bridges that gap for Alaska's seniors. The Senior Assistance Program, which I established this year to help Alaska's neediest seniors, has been brought under SeniorCare.

The SeniorCare program would provide two levels of subsidies, based on income. An individual who has an annual income of up to 135 percent of the federal poverty level for Alaska, and who is not already receiving a prescription drug benefit through Medicaid, may choose to receive up to $1,600 a year in prescription drug subsidies or to receive a monthly cash payment of $120. An individual who has an annual income of more than 135 percent but no more than 150 percent of the federal poverty level for Alaska may receive up to $1,000 a year in prescription drug subsidies, but

would not be eligible for the alternative cash payment. In addition, under federal law separate from this bill, the temporary Medicare prescription drug subsidy would add an extra $600 per year of prescription drug coverage to the first group.

Eligibility for the program would be limited to Alaska's most needy seniors. The program would not pay for prescription drug subsidies for seniors who already receive coverage under Medicaid or certain similar prescription drug subsidy programs. Eligibility for the program would be further defined by regulations developed by the Department of Health and Social Services under authority granted in this bill. Until those regulations are in effect, the eligibility requirements that govern the Alaska Senior Assistance Program (established by regulation in 2003) would govern the SeniorCare program. This would ensure that the SeniorCare program could go into operation without delay.

Prescription drug subsidies under the program would cover almost all prescription drugs, insulin and insulin syringes, and would require that, if available, cheaper and therapeutically equivalent generic drugs must be used unless a medical professional indicates that a brand name is medically necessary. This requirement would ensure that the subsidies would cover the maximum amount possible of each recipient's prescription drug costs.

The SeniorCare program is designed to help Alaska's seniors meet their financial and prescription drug needs. When the new Medicare prescription drug subsidy administered by the federal government begins, SeniorCare would be discontinued.

I urge your prompt and favorable action on this measure.

Sincerely yours,

Frank H. Murkowski
Governor

Enclosure

Senior CARE

Fact Sheet

SeniorCare is a proposed array of services for Alaska seniors. SeniorCare bridges a gap for low-income seniors until the full Medicare prescription drug coverage begins in January 2006, and provides a statewide senior information, resource and referral service for all Alaska seniors.

Seniors who qualify for this year's Senior Assistance Program (65 and older and 135 percent of the poverty level), and who are not receiving comprehensive Medicaid prescription drug coverage, will be provided a choice starting in April 2004 pending legislative approval. They will choose between receiving the new SeniorCare prescription drug subsidy of $1,600 a year or to continue to receive the Senior Assistance Program cash assistance of $120 a month, which totals $1,440 a year. Together with the $600 Medicare subsidy to begin this spring, these eligible seniors opting for the SeniorCare prescription drug benefit will have a combined benefit of $2,200 a year.

Additionally, seniors between 135 percent and 150 percent of poverty level will receive a prescription drug benefit of $1,000 a year.

Other services offered through SeniorCare include a new Senior Information Office through the Division of Senior and Disabilities Services. This office will be a one-stop resource for information seniors need. The Alaska Senior Information Office will provide a statewide toll-free telephone number and Web site for information on services available to seniors, including an up-to-date directory of local physicians who accept Medicaid and Medicare clients, available programs and services including SeniorCare, and prescription drug information and assistance.

The Medicaid Preferred Drug List, scheduled to be in place by early 2004, will contain costs for prescription drugs provided to those receiving Medicaid. The list will contain recommendations, selected by Alaska physicians and pharmacists, on drugs that are proven to be the most efficacious, cost-effective and safe. The Preferred Drug List will also provide a valuable resource for all seniors to compare prescription drug costs, and will enable seniors to work with their physicians to identify cost-effective drugs that are right for them. Once implemented next spring, seniors can get the list from the new Alaska Senior Information Office. The Senior Information Office and the Preferred Drug List will not need legislative approval to be implemented.

Current programs for seniors which will fall under SeniorCare include comprehensive Medicaid health insurance coverage and Medicare cost-sharing assistance for low-income seniors. About 7,000 eligible seniors receive prescription drugs, medical care, hospitalization and other services from the state at a cost of $119.6 million a year. In addition, DHSS will continue to work with the Denali Commission and others to ensure greater access to healthcare for Medicaid and Medicare patients.

To be eligible for the two levels of SeniorCare benefits, a senior age 65 or older must meet the following eligibility criteria:

First Level: Seniors eligible to receive the $1,600 Senior Care Prescription Drug Subsidy or $1,440 Senior Assistance Program cash assistance:

- Individuals may have an annual gross income of up to $15,134, couples a combined annual gross income of up to $20,439 (below 135 percent of the federal poverty level). Permanent Fund Dividend income is not counted.
- Participants receiving Medicaid prescription drug coverage are only eligible for cash assistance, and are not eligible for the SeniorCare prescription drug benefit.

Second Level: Seniors eligible to receive the $1,000 Senior Care Prescription Drug Subsidy only:

- Individuals may have an annual gross income of up to $16,815, couples a combined annual gross income of up to $22,710 (between 135 percent and 150 percent of the federal poverty level). Permanent Fund Dividend income is not counted.

Assets allowed:

- Individuals may have assets up to $4,000, couples combined assets up to $6000.
    - Assets not counted include a home, funds set aside for burial, automobiles, real estate and other real property.
    - Only liquid assets are counted such as cash and those assets easily converted to cash (e.g., stocks, bonds, IRAs, etc.).

For individuals, eligibility is based solely on their own income and assets. For married couples that are living together, eligibility is based on their combined income and assets regardless of whether one or both are 65 or older.

Other eligibility criteria:

- The senior must be a US citizen or legal alien, a resident of Alaska, and must intend to remain a resident of Alaska throughout the duration of the program.

- Only those seniors living independently (outside an institution such as a nursing home, Pioneer Home, API) are eligible.

Once they receive the benefit, recipients must report changes in residence, mailing address or the death of a spouse within 10 days.

The Benefit:
Seniors who qualify for this year's Senior Assistance Program, and who are not receiving Medicaid prescription drug coverage, will be provided a choice. They will choose between receiving the new SeniorCare prescription drug subsidy of $1,600 a year or to continue to receive the Senior Assistance Program cash assistance of $1,440 a year. Together with the $600 Medicare subsidy to begin this spring, these eligible seniors opting for the SeniorCare prescription drug benefit will have a combined benefit of $2,200 a year.

Additionally, seniors between 135 percent and 150 percent of poverty level will receive a prescription drug benefit of $1,000 a year.

How to Apply
Seniors who meet the eligibility criteria need apply only once by mail. The application asks for information about income and assets, and requires a signature to confirm the truthfulness of the statement given. No additional proof of income or assets is required.

If found eligible, the individual will receive written notice, and begin receiving the benefit following the month of application.

Applications for the current Senior Assistance Program are available at senior centers, libraries, offices of the Division of Public Assistance and at variety of other community agencies and at http://www.hss.state.ak.us/dpa/. Application forms for the new prescription drug benefit will be available spring 2004 at the same outlets.

The toll-free telephone number for the SeniorCare Senior Information Office is 1-800-478-6065 (Anchorage 907-269-3680) and the Web address is: http://www.seniorcare.alaska.gov

Alaska Department of Health & Social Services
Division of Senior and Disabilities Services
SeniorCare Senior Information Office
Statewide: 1-800-478-6065
Anchorage (907) 269-3680
www.seniorcare.alaska.gov

Senior CARE

Frequently Asked Questions

Q: What is SeniorCare?
SeniorCare is a proposed array of services for Alaska seniors. SeniorCare bridges a gap for low-income seniors until the full Medicare prescription drug coverage begins in January 2006, and provides a statewide senior information, resource and referral service available for all Alaska seniors.

In the current Senior Assistance Program, eligible seniors receive a cash benefit of $120 per month to help with basic needs such as food, housing and medication. Starting in April 2004, a prescription drug subsidy will be available to these same Alaska seniors, if approved by the Alaska Legislature. In the program, certain eligible seniors will have the option of selecting either the prescription drug subsidy or the cash benefit. A prescription drug benefit will also be offered to an additional group of eligible seniors needing assistance.

Seniors who qualify for this year's Senior Assistance Program (65 and older and 135 percent of the poverty level), and who are not receiving comprehensive Medicaid prescription drug coverage, will be provided a choice this spring. They will choose between receiving the new SeniorCare prescription drug subsidy of $1,600 a year or to continue to receive the Senior Assistance Program cash assistance of $1,440 a year. Together with the $600 Medicare subsidy to begin this spring, these eligible seniors opting for the SeniorCare prescription drug benefit will have a combined benefit of $2,200 a year.

Additionally, seniors between 135 percent and 150 percent of poverty level will receive a prescription drug benefit of $1,000 a year. The qualifying income level for these seniors would be those making below $16,815 for an individual or $22,710 for a couple.

Other services offered through SeniorCare include a new Senior Information Office through the Division of Senior and Disabilities Services. This office will be a one-stop resource for information seniors need. The Alaska Senior Information Office will provide a statewide toll-free telephone number and Web site for information on services available to seniors, including an up-to-date directory of local physicians who accept Medicaid and Medicare clients, available programs and services including SeniorCare, and prescription drug information and assistance for seniors.

The Medicaid Preferred Drug List, scheduled to be in place by early 2004, will contain costs for prescription drugs provided to those receiving Medicaid. The list will contain recommendations, selected by Alaska physicians and pharmacists, on drugs that are proven to be the most

efficacious, cost-effective and safe. The Preferred Drug List will also provide a valuable resource for all seniors to compare prescription drug costs, and will enable seniors to work with their physicians to identify cost-effective drugs that are right for them. Once implemented next spring, seniors can get the list from the new Alaska Senior Information Office.

The Senior Information Office and the Preferred Drug List will not need legislative approval to be implemented.

Current programs for seniors which will fall under SeniorCare includes comprehensive Medicaid health insurance coverage and Medicare cost-sharing assistance for low-income seniors. In addition, DHSS will continue to work with the Denali Commission and others to ensure greater access to healthcare for Medicaid and Medicare patients.

Q: When will the SeniorCare prescription drug benefit be made available?
It is anticipated that the prescription drug subsidy will begin April 1, pending legislative approval, and it will be available until the full Medicare prescription drug benefits begin in January 2006.

Q: Who is eligible for the SeniorCare prescription drug subsidy or cash benefit?
The individual must be age 65, a US citizen or legal alien, a resident of Alaska, and must plan to remain in Alaska for the duration of the program. Those seniors opting for the prescription drug subsidy must also have the Medicare Drug card, once it is available, about May 2004.

Seniors with income below 135 percent of the federal poverty level (annual income less than $15,134), and liquid assets of no more than $4,000 will qualify for the program. Couples living together who are married may have an annual income of no more than $20,439 and assets of no more than $6,000. Seniors who qualify for the SeniorCare program and who do not receive Medicaid prescription drug coverage, will be able to choose cash assistance or the new SeniorCare prescription drug subsidy of $1,600 a year (prorated).

Seniors with income between 135 percent and 150 percent of poverty level will also qualify for a prescription drug subsidy. The qualifying income level for these seniors would be those making below $16,815 for an individual or $22,710 for a couple. New federal poverty guidelines will be released early in 2004 and income level guidelines may change.

Q: Are all my income and assets counted for purposes of eligibility?
No. Permanent Fund Dividend income is not counted. Also, only liquid assets are counted. Liquid assets are cash or other resources that can easily be converted to cash. Liquid assets include cash, bank accounts, stocks, bonds, individual retirement accounts, money market certificates, cash value of life insurance, etc. A home, automobiles and other real property are not counted for purposes of eligibility.

Q: My spouse is over 65, but I'm not. Do we have to count my income and assets as well?
Yes. Eligibility is based on the combined income and assets of couples who are married and living together regardless of whether one or both is eligible to receive the benefit.

Q: I live in an assisted living home. Am I eligible for the Alaska SeniorCare Program?
Yes. Seniors living independently or in assisted living homes are eligible. You are not eligible if you are living in a nursing home or other institutional setting.

Q: Will SeniorCare prescription drug benefit cover all drugs?
No. The benefit will not cover over-the-counter drugs, vitamins, or any medical supplies currently not covered under Medicaid. This benefit will follow the current Medicaid formulary for seniors, so drugs normally not dispensed to seniors will not be covered under this program.

Q: How will SeniorCare prescription drug benefit work with Medicare and other insurance coverage?
SeniorCare will be the payer of last resort. Medicare and other insurance will be the first payer for prescription drugs, and the SeniorCare benefit will follow after the first benefits have been exhausted.

Q: Will I need to pay to sign up for the SeniorCare prescription drug benefit?
No. SeniorCare does not require an enrollment fee, co-payments for prescriptions or premium payments.

Q: Can I leave the state and still receive the benefit?
It depends. If you are only leaving temporarily and plan to remain an Alaska resident, you will remain eligible, though you may not be able to use your benefit while out of state.

However, if you intend to change your state of residence, the benefit will end. Other states are not offering the SeniorCare program.

Q: I receive Adult Public Assistance. Will I be eligible for the Alaska SeniorCare Program?
You are eligible for the cash assistance benefit, but if you are receiving Medicaid prescription drug coverage, you will not be eligible for the SeniorCare prescription drug subsidy.

Q: How can I apply for SeniorCare prescription drug or cash assistance?
Applications for the cash assistance Senior Assistance Program are currently available at Division of Public Assistance offices, at senior centers around the state, and at a variety of other community service agencies. Seniors who meet the eligibility criteria need apply only once by mail or online. The application asks for information about income and assets, and requires a signature to confirm the truthfulness of the statement given. No additional proof of income or assets will be required.

Application forms for the new prescription drug benefit will be available spring 2004 at the same outlets mentioned above and available on-line through the DHSS Web site.

Q: I am currently receiving the Senior Assistance Program cash benefit. How can I choose to receive the Alaska SeniorCare prescription drug benefit?
You will receive information on the new prescription drug option before the benefit is set to begin in April 2004. You will receive a form asking your preference. You will simply need to indicate your choice to switch to the new option and send it in.

Q: I have not yet applied for the Senior Assistance cash benefit. When I apply, how will I know if I've been found eligible for the program?
You will receive a written "notice of award" informing you that you are eligible, and when your benefit will begin.

Q: Once I begin receiving the Alaska SeniorCare prescription drug or cash benefit, is there anything I must do to maintain my eligibility for the benefit period?
You are required to report changes in mailing or residence address, the death of an individual receiving assistance, or admission or discharge from a nursing home or other institutional setting. We may periodically review eligibility.

Q: How long will SeniorCare benefits be offered?
Anticipated to being in April 2004 pending approval by the Alaska Legislature, SeniorCare will bridge a gap for low-income seniors until the full Medicare prescription drug coverage begins in January 2006. The SeniorCare prescription drug and cash benefit will end when the full Medicare prescription drug begins in January 2006.

Q: How many seniors does the state anticipate to participate in the SeniorCare prescription drug benefits?
Of the more than 47,000 seniors in Alaska, about 7,200 seniors are now receiving cash assistance under the Senior Assistance Program. A number of these seniors now receive prescription drugs, medical care, hospitalization and other services from the state. Seniors receiving Medicaid prescription drug coverage would not be able to receive SeniorCare prescription drug coverage, but would continue to qualify for the SeniorCare Senior Assistance Program cash assistance.

About 2,000 seniors who are enrolled in the Senior Assistance Program do not currently qualify for Medicaid services and would be able to choose to switch to the prescription drug benefit from the cash assistance. It is estimated that about 630 eligible seniors will choose to receive the SeniorCare prescription drug benefit.

Additionally, it is estimated that about 2200 seniors would fall within the 135 percent to 150 percent of the federal poverty level to qualify for the SeniorCare $1,000 prescription drug benefit. It is estimated that all if not most of these eligible seniors will choose to receive the SeniorCare prescription drug benefit.

Q: How do I contact the SeniorCare Senior Information Office?
The toll-free telephone number for the SeniorCare Senior Information Office is 1-800-478-6065 (Anchorage 907-269-3680) and the Web address is: http://www.seniorcare.alaska.gov

Alaska Department of Health & Social Services
Division of Senior and Disabilities Services
SeniorCare Senior Information Office
Statewide: 1-800-478-6065
Anchorage (907) 269-3680
www.seniorcare.alaska.gov

AARP Alaska

JAN 12 2004

January 12, 2004

The Honorable Peggy Wilson, Chair
House Committee on Health, Education and Social Services
Alaska State Capitol, Room 104
Juneau, Alaska 99801-1182

Dear Chair Wilson: RE: SeniorCare (Governor Murkowski) - Support

On behalf of the AARP members in Alaska, we encourage you and your colleagues on the House Committee on Health, Education, and Social Services to support Governor Murkowski's SeniorCare proposal.

As you know, many older Alaskans faced very difficult financial situations with the loss of the Longevity Bonus. I am sure you heard from your constituents, as we did from our members, that their retirement budgets were significantly impacted by this loss after they had already been retired.

The Senior Assistance Program does not replace the Longevity Bonus, but helps over 7,000 older Alaskans cope financially in their later years. This program was projected to end June 30, 2004.

The SeniorCare program will extend the Senior Assistance Program, for those who qualify and choose to participate, until January 1, 2006. On that date the new federal Medicare prescription drug benefits will begin. During the debate about the Governor's proposal to eliminate the Longevity Bonus, we indicated in our testimony that many older Alaskans told us that they used the Bonus to purchase prescription drugs that, as you know, have had disproportionately high increases every year. The Senior Assistance Program checks have helped to cover at least some of those same costs.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | 907-341-2277 | 907-341-2270 fax | 1-877-434-7598 TTY
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

The SeniorCare program offers older Alaskans a choice: to continue to receive the monthly Senior Assistance checks or to receive assistance with their out-of-pocket prescription drug costs until January 1, 2006, when the Medicare prescription drug benefit begins. Any assistance that will help eligible older Alaskans cope with the increasing costs of prescription medications will be welcome. As a nurse, you know better than most how important it is to be able to afford prescription drugs. It's just smart medicine and certainly older Alaskans will appreciate the financial support.

In addition, the SeniorCare program will have a new class of an estimated 2,200 older Alaskan beneficiaries who will be eligible for state prescription drug assistance of $1,000 annually. These citizens have incomes between 135% and 150% of the federal poverty level. They do not qualify for the Senior Assistance program and this is a group that also faced difficulties when the Longevity Bonus was eliminated. The SeniorCare program will help them with prescription drug costs until the Medicare program begins in two years.

The SeniorCare proposal also provides two additional staff for a Senior Information Office. In all our AARP surveys, access to helpful information is always cited as a critical need by older persons as well as younger family members who may be caring for older relatives. We anticipate that these new staff positions will help answer those questions for an ever-growing senior population and provide local contacts and guidance.

AARP particularly applauds the last part of the SeniorCare program: the Medicaid preferred drug list (PDL).

All of us, legislators and citizens alike, are frustrated by the rising costs of prescription drugs in the Medicaid program. "Whatever the market will bear" increases in prescription drug costs cannot continue without devastating our state budget.. Many states have already established preferred drug lists as a tactic to rein in prescription spending while still providing the most effective therapy available. States that have implemented Medicaid PDL's have generally saved at least 10% on prescription costs. It is just good common sense. Why should Alaska pay for a more expensive medication when a less expensive one is available, especially when it has been found scientifically to be equivalent or even more effective? AARP supports PDL's – with appropriate consumer protections – to avoid cuts in Medicaid eligibility or benefits and to expand access to affordable drugs. The Alaska preferred drug list that is currently being developed provides those consumer protections that AARP considers important.

PDL's also take advantage of pharmaceutical manufacturers' desires for market share. Anyone who watches 30 minutes of television understands how serious pharmacy companies are about direct-to-consumer marketing. With the companies spending more money on marketing than research, PDL's offer them an opportunity to expand the market share they obviously desire.

The Alaska program is being developed at a fortunate time. Federal funding for state efforts has resulted in unbiased information for therapeutic effectiveness comparisons

between drugs in the same class and making prudent purchasing decisions based on scientific evidence, not marketing claims.

In the past, we have not had a "Consumer Reports" for prescription drugs. All we had were the claims of the manufacturer or the television image of how much better life would be if we only took that particular brand name medicine. Now, however, PDL's are being developed using scientific evidence on effectiveness as well as cost.

Think about this. When a drug company seeks approval for a new drug from the FDA, they are only required to prove that their medication is more effective than a sugar pill. They are not required to prove that their product is more effective than drugs that are already on the market to treat a particular condition.

The Alaska Preferred Drug List will be our "Consumer Reports" for prescription drugs. It will be based on clinical evidence and standards of practice. Costs will be considered but only after safety and therapeutic efficacy.

When a physician determines it is medically necessary, he/she can prescribe a drug that is not on the PDL.

The comparative information on the PDL will be good consumer information for all of us, whether we are Medicaid beneficiaries or not. AARP believes the Alaska PDL will help us to be more prudent prescription drug consumers with information on costs as well as effectiveness. We applaud the steps already taken by Commissioner Gilbertson and the Alaska health professionals who are developing the PDL.

Although we have not seen any necessary or specific legislative language, "we like what we hear." We will be glad to comment further when the legislation and regulations are available.

When we survey our members about their prescription problems, their concerns generally come down to access and affordability. AARP anticipates the proposed SeniorCare program will help older Alaskans and all Medicaid beneficiaries with both these issues.

We encourage you and your Committee colleagues to support the SeniorCare program.

Should you have any questions about our position, please feel free to contact Marie Darlin, Coordinator of the AARP Capital City Task Force (907-586-3637); Patrick Luby, AARP Legislative Representative (907-762-3314); or me (907-245-5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
AARP State Coordinator for Advocacy
3009 Northwood Street
Anchorage, AK 99517-1871
907-245-5259 (voice)
907-245-5279 (fax)
ffmas@aurora.uaf.edu

cc: Vice-Chair Carl Gatto
Representative John Coghill
Representative Paul Seaton
Representative Kelly Wolf
Representative Sharon Cissna
Representative Mary Kapsner
Governor Frank Murkowski
Commissioner Joel Gilbertson
Marie Darlin
Patrick Luby

DISABILITY LAW CENTER OF ALASKA

230 South Franklin, #206
Juneau, Alaska 99801

(907) 586-1627 phone
(907) 586-1066 fax

TO: DISTRIBUTION (see below)

FROM: Bob Briggs

DATE: 1/16/04

FAX:

No. of pages, including cover sheet: (5)

Re: HB 374 / SB 259

Comments:

(yesterday) I started circulating the attached information about a little-discussed population of Medicare-only recipients who do not have prescription drug coverage -- disabled Alaskans under age 65. I am trying to communicate w/ all House & Senate Finance committee members that while HB 374 and SB 259 provide a bridge for Rx coverage for seniors on Medicare until federal benefits begin in 2006, there is a whole group of Alaskans with identical needs -- disabled Alaskans on Medicare only under age 65 -- so I pose the question, "Can we widen the bridge?"

I must work today on client-related matters, but please find the material I have been distributing. I will stop by your offices next week to discuss further & try to arrange meetings to further discuss this idea.

Distribution: Sen. Therriault, Sen. Ben Stevens, Sen. Hoffman, Sen. Stedman, Sen. Elton, Rep. Kott, Rep. Harris, Rep. Meyer, Rep. Foster, Rep. Williams, Rep. Chenault, Rep. Whitaker, Rep. Moses

PRESCRIPTION DRUGS AND YOUNGER MEDICARE BENEFICIARIES WITH DISABILITIES

The language used to discuss Medicare prescription drug coverage perpetuates the myth that Medicare beneficiaries are all over age 65. BNA's *Medicare Report* for February 2, 2001 proclaims, "Bush Unveils Prescription Drug Plan to Help *Seniors* Through State Grants." (Emphasis added.). The Congressional Progressive Caucus titles its more comprehensive prescription drug bill, "The Medicare Extension of Drugs to *Seniors* (MEDS) Plan." (Emphasis added.) But what about the over five million Medicare beneficiaries who are under 65 and who are eligible based on disability? No Medicare prescription drug benefit should be designed, intentionally or unintentionally, to exclude this population.

According to "Disability, Medicare, and Prescription Drugs," a report issued July 31, 2000 by the White House National Economic Council and Domestic Policy Council,

- About 75% of younger disabled Medicare beneficiaries, as compared with half of elderly beneficiaries, have incomes of less than 200% of poverty, about $17,000 per year for an individual;
- About 60% of younger, disabled Medicare beneficiaries with disabilities repo[illegible] fair to poor" health status as compared with about 22% of elderly beneficiaries. Moreover, 30% have functional limitations due to health problems, compared with 18% of the elderly.
- Beneficiaries with disabilities use an average of 28 prescriptions per year, compared with 20 for the overall Medicare population. Moreover, those with disabilities also use more expensive medications; as a result, beneficiaries with disabilities spend on average $1,016 per year for prescription drugs compared with $674 for all Medicare beneficiaries.
- Beneficiaries with disabilities are also less likely than older beneficiaries to have prescription drug coverage through retiree health plans, Medicare managed care plans, or Medigap insurance.

It would indeed be ironic if Congress's response to the lack of drug coverage for Medicare beneficiaries would exclude Medicare beneficiaries under 65 who are more vulnerable than most aged Medicare beneficiaries. Yet that is exactly what Congress has done by allowing Medigap insurers to medically underwrite Medicare beneficiaries under 65, while requiring that Medicare beneficiaries over 65 are treated as a community rated group. Moreover, many states have created state pharmaceutical assistance programs for low income Medicare beneficiaries that exclude Medicare beneficiaries under 65. It also appears that the Administration's proposed state block grant for pharmaceutical assistance for low income Medicare beneficiaries may have the unintended consequence of perpetuating these inequitable exclusions of Medicare beneficiaries under 65.

In crafting a Medicare prescription drug benefit, law-makers need to assure that all Medicare beneficiaries, regardless of income, age or basis for Medicare eligibility, have access to a uniform and affordable prescription drug benefit. In discussing the prescription drug issue law-makers and the press should also be careful to correct the mistaken impression that Medicare is a program only for older people.

MEDICARE'S DISABLED BENEFICIARIES: THE FORGOTTEN POPULATION IN THE DEBATE OVER DRUG BENEFITS

Becky Briesacher, Bruce Stuart. Jalpa Doshi, and Sachin Kamal-Bahl
University of Maryland School of Pharmacy

and

Dennis Shea
The Pennsylvania State University

September 2002

Support for this research was provided by The Commonwealth Fund and The Henry J. Kaiser Family Foundation. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund, The Henry J. Kaiser Family Foundation, or their directors, officers, or staff.

Copies of this report are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering publication number 573. The report can also be found on the Fund's website at www.cmwf.org. Copies are also available from the Henry J. Kaiser Family Foundation website at www.kff.org (publication number 6054) or by calling 1-800-656-4533.

EXECUTIVE SUMMARY

The ongoing debate over the addition of a prescription drug benefit to Medicare's benefit package has focused primarily on the needs of the elderly. The needs of Medicare's nonelderly, disabled beneficiaries have received considerably less attention. There are around 5 million Medicare enrollees who are under age 65 but qualify for Medicare because they are totally and permanently disabled. Prescription drug coverage is critical for this population, which is more likely than the elderly to live in poverty, be in poor health, and experience difficulties living independently and performing basic daily tasks.

This analysis draws upon the 1998 Medicare Current Beneficiary Survey Access to Care and Cost and Use Files to describe the prescription drug experiences of Medicare beneficiaries under 65 who are living with disabilities. The key findings are:

- The disabled are heavy users of medications, filling more prescriptions than the elderly in 1998 (34 vs. 25, respectively) and spending more on drugs annually ($1,284 vs. $841).
- Overall rates of drug coverage throughout 1998 were comparable for under-65 disabled and elderly beneficiaries (79% and 76%, respectively). Medicaid was the primary source of drug coverage for the under-65 disabled, assisting one of three such beneficiaries, but was the source for only one of 11 seniors. Elderly beneficiaries, on the other hand, were more likely to have prescription coverage through an employer-sponsored health plan.
- Out-of-pocket drug spending varies by source and stability of coverage. Under-65 disabled beneficiaries who lacked drug coverage for the entire year in 1998 had significantly higher out-of-pocket spending ($499) than did those with full-year coverage ($314).
- Out-of-pocket drug spending also varies widely by type of coverage. For disabled beneficiaries under age 65 who had drug coverage through Medigap, out-of-pocket costs averaged $601 in 1998—more than was paid by those without Medigap coverage ($499). Disabled beneficiaries with employer-sponsored drug coverage and those enrolled in Medicaid had average out-of-pocket drug costs of $375 and $199, respectively.
- Disabled beneficiaries' high drug costs and low incomes make paying for prescription medications particularly burdensome. More than a quarter (27%) of all under-65 disabled beneficiaries spent 5 percent or more of their annual incomes on

prescription drugs in 1998, with the proportion rising dramatically for those with coverage for only part of the year (36%) or no coverage at all (44%).

- Access problems are exacerbated for those with unstable or no drug coverage, particularly among the disabled. Compared with those with full-year coverage, disabled beneficiaries without prescription benefits were nearly three times more likely not to fill all of their prescriptions and more than twice as likely to delay care because of costs.
- The types of medications typically used by the disabled differ considerably from those used by the elderly. Psychotherapeutics, for example, are the prescriptions most commonly filled by the disabled (57% use this group of drugs), but they rank only 10 among drugs used by the elderly (23%). The disabled are also far heavier users of analgesics and central nervous system drugs, whereas the elderly are most apt to use heart medications.

The under-65 disabled Medicare population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills. Yet with the exception of Medicaid, disabled Medicare beneficiaries have few options for obtaining stable and comprehensive prescription drug coverage. All of these factors place the disabled at special risk.

Some policymakers have proposed linking a Medicare drug benefit to the medications most often used by the elderly. If that were to happen, the findings presented here suggest that the disabled would be systematically disadvantaged. If the drug benefit consists mainly of government subsidies to private insurers, few disabled beneficiaries are likely to receive assistance. While most recent Medicare prescription drug benefit proposals do not consider restricting the benefit to those medications most often used by the elderly, as some earlier proposals did, this does not mean that access to medications for disabled Medicare beneficiaries would not be difficult. Formulary restrictions, drug utilization review, and other administrative mechanisms can and have been used by public and private payers to restrict access to certain drugs, especially newer, more effective, yet more expensive, psychotherapeutics.[1] As policymakers consider measures to improve drug coverage for the Medicare population, the unique and substantial needs of nonelderly beneficiaries with disabilities should not be forgotten.

[1] L. Gorman. "Treatment Denied: Colorado Health Care 'Reform' and the Mentally Ill." Independence Institute Issue Paper, July 31, 2001.