

The Medicare Drug Program Fails to Reach Low-Income Seniors More Than Three out of Every Four Low-Income Seniors Eligible for Special Subsidies Are Still Without Drug Coverage

“Seniors in the greatest need will have the greatest help under the modernized Medicare system.”

– President Bush at the signing of the Medicare drug legislation, December 8, 2003

*“. . . the plan for low-income seniors is a really good deal. I mean,
it’s a good deal for everybody, but it’s a really good deal for low-income seniors.”*

– President Bush in a “Conversation on Medicare,” Maple Grove Community Center, MN, June 17, 2005

“After this legislation goes into effect, low-income seniors will never be confronted with the choice of putting food on the table or paying for life-saving prescription drugs. Low-income seniors will finally have the benefit that will take care of their drug costs, and this will save the government money in the long run.”

– House Speaker Dennis Hastert urging the House to vote for the Medicare drug bill, November 22, 2003

Introduction

In their glowing assessments of the Medicare drug law, President Bush and congressional leaders promised that the new program would substantially improve drug coverage for low-income seniors and people with disabilities. The legislation, after all, did provide significant subsidies for this vulnerable group. However, now that the program is into its fourth month, it is all too clear that the promise to low-income seniors has been broken.

Out of approximately 7.2 million low-income seniors who are eligible for the low-income subsidies (also known as “Extra Help”) that were designed to help make medicines affordable, only about 1.7 million—24 percent—are actually receiving those subsidies. As the state-by-state data in this report show, in 17 states,¹ at least four out of five low-income seniors eligible for these special subsidies are not receiving them.

To make matters worse, the poorest of the poor—those very low-income Medicare beneficiaries who also qualify for Medicaid—have *worse* drug coverage today than they had before the new Medicare Part D program began in January. These co-called “dual eligibles,” approximately 6.3 million needy seniors, had good drug coverage *through Medicaid* before Part D began. As described more fully on page 4, this group now has drug coverage through private Medicare plans that, in several respects, *is not as good as* the Medicaid coverage they used to have.

The bottom line is this: The Bush Administration’s claims that Medicare Part D is a success are, at best, highly misleading. So is the Administration’s claim that 29.7 million people have enrolled in Medicare Part D. In point of fact, only 8.6 million—29 percent—of those 29.7 million lacked drug coverage before Part D began. The remaining 21.1 million “enrollees” already had drug coverage before January 2006.

Disappointing Enrollment of Low-Income Beneficiaries

The low-income provisions of the Medicare Part D benefit represent a rare area of agreement among all sides in the debate over Medicare prescription drugs. Part D's low-income subsidy was intended to be a genuine step forward in helping needy beneficiaries afford prescription drugs. The subsidy offers significant help for those whose low incomes and limited financial assets qualify them for the program.

These beneficiaries do not have to pay a premium, deductible, or co-insurance, and they are protected during the coverage gap (known colloquially as the "doughnut hole"). Instead, *most* beneficiaries who qualify for the low-income subsidy merely have to make modest copayments when they purchase drugs. Those with slightly higher incomes or assets pay somewhat more, but their cost-sharing is limited to 15 percent of their drug costs—far from a minimal amount, but still substantially less than the normal share Part D beneficiaries must pay.

In order to receive this benefit, however, most beneficiaries must affirmatively apply for the subsidy.² This is a separate process from applying for Part D. Beneficiaries typically apply first for a subsidy through the Social Security Administration (SSA),³ and then, if approved, select a Part D plan. In effect, low-income seniors and people with disabilities must navigate two separate enrollment processes.⁴

To date, enrollment in the low-income subsidy has been a deep disappointment. Table 1 provides an estimate of the number of low-income beneficiaries in each state who are eligible for the subsidy and the number who have enrolled. According to the most recent data available from SSA, only 1.7 million of these 7.2 million beneficiaries—fewer than one out of four—had been approved as of the end of April. For the vast

majority of needy Medicare beneficiaries, then, the promise of help with prescription drug costs remains unfulfilled.

As shown in Table 1, in 17 states, at least four out of five low-income seniors eligible for Extra Help are not getting it. In only five states (Arkansas, Kentucky, North Carolina, Texas, and Vermont) and the District of Columbia has enrollment in the low-income subsidy exceeded one-third of those eligible.

Low-income beneficiaries who do not receive the extra help will almost certainly not enroll in a Part D plan, as they cannot afford the premiums and substantial cost-sharing associated with the basic Part D benefit. Most of them will have to continue to pay full out-of-pocket prices for drugs, and many will have to choose between their medications and other necessities.

During the first year of the program, most beneficiaries who do not join a Part D plan by May 15 must wait until the fall to enroll. Their coverage would not start until January 1, 2007. Those who sign up after May 15 must also pay a financial penalty as long as they are in Medicare. In recognition of the particularly dire needs of low-income beneficiaries, however, as well as the slow pace of enrollment, the Centers for Medicare and Medicaid Services (CMS) has recently announced that beneficiaries who qualify for the low-income subsidy will be able to enroll in a Part D plan after May 15 rather than having to wait until the next enrollment period.⁵ This is a positive step for low-income seniors and people with disabilities. And because there is no deadline for enrolling in the low-income subsidy itself, it is therefore even more important to inform these beneficiaries about their options and enroll them in the subsidy program and then a Part D plan.

Table 1:

Enrollment in the Low-Income Subsidy through April 28, 2006

State	Number Estimated Eligible	Number Approved as of 4/28/06	Percent Approved
Alabama	181,000	44,033	24%
Alaska	8,000	2,158	27%
Arizona	159,000	19,265	12%
Arkansas	89,000	34,146	38%
California	421,000	88,096	21%
Colorado	80,000	21,176	26%
Connecticut	62,000	14,276	23%
Delaware	20,000	2,623	13%
District of Columbia	14,000	6,539	47%
Florida	542,000	103,291	19%
Georgia	244,000	63,181	26%
Hawaii	28,000	7,957	28%
Idaho	50,000	7,863	16%
Illinois	296,000	62,117	21%
Indiana	164,000	45,421	28%
Iowa	88,000	17,422	20%
Kansas	80,000	16,763	21%
Kentucky	118,000	48,147	41%
Louisiana	165,000	35,992	22%
Maine	45,000	7,056	16%
Maryland	110,000	32,207	29%
Massachusetts	113,000	29,423	26%
Michigan	256,000	55,117	22%
Minnesota	114,000	18,174	16%
Mississippi	98,000	26,053	27%
Missouri	170,000	38,155	22%
Montana	35,000	6,661	19%
Nebraska	46,000	10,276	22%
Nevada	52,000	11,196	22%
New Hampshire	36,000	8,078	22%
New Jersey	180,000	54,501	30%
New Mexico	64,000	13,082	20%
New York	435,000	91,857	21%
North Carolina	245,000	82,160	34%
North Dakota	25,000	6,510	26%
Ohio	340,000	67,246	20%
Oklahoma	117,000	28,852	25%
Oregon	96,000	18,564	19%
Pennsylvania	397,000	68,808	17%
Rhode Island	33,000	6,765	21%
South Carolina	150,000	41,082	27%
South Dakota	29,000	5,543	19%
Tennessee	143,000	38,157	27%
Texas	485,000	164,341	34%
Utah	37,000	7,430	20%
Vermont	- -	4,715	~100%
Virginia	177,000	53,371	30%
Washington	124,000	24,463	20%
West Virginia	102,000	21,398	21%
Wisconsin	131,000	17,838	14%
Wyoming	16,000	2,880	18%
Total/Average	7,218,000	1,719,273*	24%

* There are 16,848 people who have been approved for the low-income benefit but have not been identified by state.

Sources: Estimate of number eligible from Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes* (Washington: National Council on Aging, 2005). Number approved from the Social Security Administration, "SSA Completed Decisions by State" (Data as of 4/28/06), available online at www.ssa.gov/legislation/statealphasmallfont.html.

As of this writing, however, the late enrollment penalty for low-income beneficiaries who join a Part D plan after May 15 remains in effect, although there are indications that CMS may change it. Although the penalty for most of those in the low-income subsidy is smaller than the penalty

for other seniors,⁶ it nevertheless would impose an additional financial burden on those with the least ability to pay and a significant administrative burden on Part D plans. Additionally, it would likely further discourage needy beneficiaries from signing up.

6.3 Million—the Poorest of the Poor—Are Worse Off

In addition to the low-income beneficiaries who are not receiving the Extra Help to which they are entitled, an even larger group of low-income seniors and people with disabilities has reason to be disappointed with the new program. This group—the poorest of the poor—are worse off today than they were prior to January 2006.

These so-called dual eligibles are Medicare's most vulnerable beneficiaries. They are, on average, poorer and have more physical and mental impairments than others in Medicare. They are also the only beneficiaries whose drug coverage was disrupted directly as a result of the Part D program. Prior to January 1, 2006, they had prescription drug coverage from their state Medicaid programs. Under the Medicare law, their drug coverage was supposed to switch automatically to a Medicare Part D plan. Table 2 shows the distribution of the approximately 6.3 million dual eligibles in each state, as reported by CMS.

Unfortunately, the transition of dual eligibles from Medicaid into Medicare Part D was far from seamless. Most beneficiaries were automatically enrolled in Part D plans without regard for their specific needs. Moreover, well-documented problems with incompatible computer systems, lags in data transfers, and Part D plans that were unable or unwilling to communicate with pharmacists or patients left thousands of ben-

eficiaries without access to vital medications during the first months of the year.⁷ Nearly all states eventually stepped in to ensure that their dual eligibles would not go without life-sustaining drugs.

It now appears that some of the most egregious short-term problems—such as incompatible or delayed data exchanges—are easing and that most states are winding down their emergency support programs. But the fundamental structure of Part D will continue to create difficulties for dual eligibles. For more than half of all dual eligibles, copayments for drugs will be higher than they were under Medicaid, and copayments will increase for *all* dual eligibles in future years.

Dual eligibles have also lost the protection of the Medicaid program, which covered all medically necessary drugs. They are now in a system with a confusing array of private plan formularies and utilization management rules. It is likely that dual eligibles will continue to have difficulty obtaining medications. The Inspector General of the Department of Health and Human Services found that three out of every 10 dual eligibles were assigned to plans that covered less than 85 percent of the most commonly used drugs.⁸ Sicker beneficiaries are particularly at risk, as they have complex drug needs and cannot easily substitute one drug or dosage for another.

Table 2

Dual Eligibles Enrolled in Part D, by State

State	Number Enrolled in Stand-Alone Part D Plans	Number Enrolled in Medicare Advantage Plans (est.)	Total
Alabama	89,407	7,270	96,677
Alaska	11,567	10	11,577
Arizona	57,998	22,690	80,688
Arkansas	65,400	990	66,390
California	899,858	117,010	1,016,868
Colorado	43,616	12,290	55,906
Connecticut	67,833	2,930	70,763
Delaware	10,262	60	10,322
District of Columbia	15,601	460	16,061
Florida	351,277	56,760	408,037
Georgia	145,793	3,910	149,703
Hawaii	23,955	4,310	28,265
Idaho	18,793	1,390	20,183
Illinois	255,050	6,930	261,980
Indiana	99,067	1,380	100,447
Iowa	56,803	1,660	58,463
Kansas	40,415	1,540	41,955
Kentucky	85,745	2,890	88,635
Louisiana	101,747	6,440	108,187
Maine	46,470	90	46,560
Maryland	58,809	2,850	61,659
Massachusetts	186,290	12,950	199,240
Michigan	196,041	4,410	200,451
Minnesota	63,215	10,660	73,875
Mississippi	129,920	640	130,560
Missouri	146,852	10,700	157,552
Montana	15,274	390	15,664
Nebraska	32,173	1,130	33,303
Nevada	18,491	7,720	26,211
New Hampshire	19,815	140	19,955
New Jersey	140,012	6,300	146,312
New Mexico	33,980	4,390	38,370
New York	519,403	39,470	558,873
North Carolina	222,245	8,990	231,235
North Dakota	10,947	150	11,097
Ohio	181,348	20,910	202,258
Oklahoma	75,629	3,910	79,539
Oregon	36,064	11,190	47,254
Pennsylvania	157,885	44,580	202,465
Rhode Island	26,578	4,770	31,348
South Carolina	116,280	2,260	118,540
South Dakota	12,200	160	12,360
Tennessee	218,296	8,880	227,176
Texas	315,925	22,490	338,415
Utah	21,328	1,810	23,138
Vermont	16,384	10	16,394
Virginia	107,440	3,370	110,810
Washington	98,660	7,200	105,860
West Virginia	43,544	1,080	44,624
Wisconsin	110,644	5,390	116,034
Wyoming	5,771	90	5,861
Total Number Enrolled, U.S.	5,824,100	500,000	6,324,100

Source: Families USA calculations based on "Enrollment in Prescription Drug Plans by State Nov. 15, 2005-Apr. 18, 2006," available online at www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage, released on April 20, 2006. See the Methodology on page 10.

Table 3

New Drug Coverage under Medicare Part D as of April 18, 2006

State	Medicare Beneficiaries with Drug Coverage	Maximum Number with New Coverage (est.)	Percent New Coverage
Alabama	572,074	192,127	34%
Alaska	38,347	6,261	16%
Arizona	604,190	107,778	18%
Arkansas	322,436	154,226	48%
California	3,365,957	475,088	14%
Colorado	406,683	85,939	21%
Connecticut	337,371	103,600	31%
Delaware	95,839	40,721	42%
District of Columbia	55,045	8,090	15%
Florida	2,234,449	507,084	23%
Georgia	758,824	326,178	43%
Hawaii	148,446	9,536	6%
Idaho	121,611	48,879	40%
Illinois	1,179,498	440,548	37%
Indiana	601,054	251,033	42%
Iowa	316,912	176,011	56%
Kansas	244,793	120,180	49%
Kentucky	482,470	196,720	41%
Louisiana	439,498	130,810	30%
Maine	167,584	63,638	38%
Maryland	499,874	152,840	31%
Massachusetts	712,501	171,609	24%
Michigan	1,048,324	317,428	30%
Minnesota	480,070	216,708	45%
Mississippi	324,794	115,004	35%
Missouri	648,058	196,120	30%
Montana	89,809	43,905	49%
Nebraska	179,484	90,259	50%
Nevada	223,772	42,819	19%
New Hampshire	114,227	40,219	35%
New Jersey	843,292	303,208	36%
New Mexico	207,265	52,759	25%
New York	1,861,126	402,640	22%
North Carolina	962,850	316,066	33%
North Dakota	67,820	43,363	64%
Ohio	1,306,797	316,237	24%
Oklahoma	387,284	147,622	38%
Oregon	366,331	126,878	35%
Pennsylvania	1,357,133	285,279	21%
Rhode Island	127,020	22,330	18%
South Carolina	474,699	148,771	31%
South Dakota	80,959	49,023	61%
Tennessee	688,095	181,050	26%
Texas	1,887,826	630,657	33%
Utah	166,386	63,382	38%
Vermont	67,063	26,970	40%
Virginia	709,824	264,969	37%
Washington	548,395	161,517	29%
West Virginia	257,383	100,298	39%
Wisconsin	483,430	149,907	31%
Wyoming	45,101	23,387	52%
Total, U.S.	29,710,073	8,647,671	
Average			29%

Source: Families USA calculations based on "Enrollment in Prescription Drug Plans by State Nov. 15, 2005-Apr. 18, 2006," available online at www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage, released on April 20, 2006, and Kaiser Family Foundation, State Health Facts Online, "Medicare Prescription Drug Coverage, Beneficiaries by State, Data as of January 13, 2006," available online at www.statehealthfacts.org, accessed January 2005.

Overall, considering the initial startup problems and the inherent complexities of Part D, dual eligibles are likely to be worse off than they were before the start of the Medicare

drug program. Although some of the technical glitches that have plagued the first few months of the program should be resolved over time, the structural problems will remain.

New Coverage Reaches Relatively Few

The Administration has recently touted figures showing that Medicare drug coverage has been extended to 30 million beneficiaries.⁹ This figure is quite misleading because it does not distinguish between those who have obtained new coverage and those who had coverage before. Of these 30 million beneficiaries, some 6.3 million are dual eligibles who already had drug coverage under Medicaid. About 10 million are federal or military retirees or retirees who have coverage through their former employers. And another 4 million were enrolled in Medicare Advantage plans last year—most of them already had coverage through their Medicare Advantage plans.¹⁰ All told, more than two-thirds of the 30 million “covered” beneficiaries had drug coverage before the start of Part D.

It is not possible to determine precisely how many current Part D enrollees were without drug coverage prior to the start of the program because beneficiaries are not asked about previous coverage when they sign up. However, this number may be estimated by combining those who have signed up for stand-alone Part

D plans with the net increase in Medicare Advantage enrollment since the Part D program started. Since some of these beneficiaries had drug coverage before enrolling (for example, through a state pharmaceutical assistance program or private plan), this estimate is almost certainly too high. Nevertheless, it is reasonable to assume that most of them did not have drug coverage prior to 2006, which is why they would have signed up for Part D coverage.

Table 3 compares the number of beneficiaries in each state counted by the Administration as having some sort of Part D drug coverage with the estimated number of those who have obtained *new* coverage. Nationwide, of the 29.7 million counted as having Part D coverage, only 8.6 million, or 29 percent, have new coverage. This share varies markedly from state to state: In some cases, it appears that the Part D benefit has generated a substantial increase in the share of beneficiaries with drug coverage. In others, there has been very little gain.

Discussion

The launch of the Medicare drug benefit has resulted in some gains and some losses. A generous estimate suggests that about 8.6 million beneficiaries now have drug coverage who did not have it before. Of course, the value of this new coverage depends on a beneficiary's situation. The meager nature of the Part D benefit means that most beneficiaries will typically pay \$3,600 of their first \$5,100 in annual drug costs out of

pocket, in addition to premiums. Nevertheless, for some, especially for those with very high drug costs and no previous coverage, the benefit is likely an improvement.

At the same time, however, for the most vulnerable Medicare beneficiaries—the 6.3 million dual eligibles—the new benefit has been a difficult, and often unwelcome, change. Many went

through a traumatic and chaotic transition during the first months of the year. Although the immediate technical implementation problems should abate over time, the fundamental structure of Part D, with its mandatory copayments, more restrictive formularies, and maze of utilization management rules, will likely continue to create barriers to access to drugs. As a result, a significant portion of the poorest of the poor are worse off than they were before the Medicare drug program began.

Finally, and perhaps most urgently, there are still millions who are eligible for Part D who have not yet signed up. Unless Congress and the Administration change current rules, all beneficiaries will be subject to financial penalties if they join the program after May 15. Moreover, those who do not qualify for the low-income subsidy and who fail to sign up by May 15 will be locked out of the program and unable to obtain coverage until January 2007.

Many of those who have still not signed up appear to be low-income and eligible for substantial assistance. Why enrollment in the low-income subsidy has lagged so badly is difficult to assess.

But, given CMS's decision to permit those receiving the subsidy to enroll in a Part D plan after May 15 (albeit with a penalty), it is clear that outreach and enrollment efforts must be redoubled. One-on-one counseling, for example, can be very effective, but it requires both time and a substantial investment of resources.

SSA's job would be made easier if Congress and the Administration eliminated the late enrollment penalty and extended the enrollment deadlines for the rest of this year for all beneficiaries. Doing so would acknowledge that the confusing and difficult start of the Part D benefit has likely discouraged many from enrolling. A recent survey found that 54 percent of beneficiaries who were still deciding about whether to join a plan were unaware that they would face a penalty if they did not sign up by the deadline.¹¹ An extended penalty-free enrollment period would reassure beneficiaries that they have the time to make an informed choice and would support additional outreach efforts to reach needy beneficiaries before they become subject to a penalty.

Conclusion

The first months of the Medicare Part D program have been chaotic. Although approximately 8.6 million beneficiaries have obtained drug coverage who didn't have it before, approximately 6.3 million of the poorest of the poor may actually be worse off. Moreover, millions of other seniors and people with disabilities risk being left without adequate drug coverage when enrollment closes for the year on May 15, 2006—or risk being penalized when they do enroll in coverage. While making major changes to the program will take time, there are some immediate steps Congress can take to assist beneficiaries. Congress should lift the May 15 deadline and waive the late enrollment penalty for all beneficiaries this year. Doing so would provide beneficiaries, especially those with low incomes, with the time they need as they attempt to navigate this new, complicated, and confusing program

Endnotes

¹ Arizona, California, the District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Michigan, Minnesota, Montana, Nevada, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wisconsin, and Wyoming

² Approximately 1.1 million beneficiaries in Medicare Savings Programs (Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals-1) are automatically eligible for the subsidy.

³ Under the Medicare law, state Medicaid agencies are also directed to accept applications for the low-income subsidy. In reality, however, few state Medicaid agencies have been active in enrolling beneficiaries, and the number of beneficiaries enrolled through these agencies is not available.

⁴ Those who enroll in the subsidy and do not select a Part D plan will have a Part D plan selected at random for them.

⁵ Centers for Medicare and Medicaid Services, *Limited-Income Subsidy (LIS) Enrollment Opportunity*, available online at <http://www.cms.hhs.gov/States/>, accessed on April 24, 2006.

⁶ 42 CFR § 423.780(e). Beneficiaries receiving the more generous low-income subsidy pay 20 percent of the full penalty. After five years, their penalty is waived entirely. Those with slightly higher incomes or assets (who pay 15 percent co-insurance for all prescriptions) must pay the full penalty as long as they are enrolled in Medicare.

⁷ Vernon Smith and Linda Elam, *The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation* (Washington: Kaiser Commission on Medicaid and the Uninsured, February 2006).

⁸ Office of the Inspector General, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090 (Washington: U.S. Department of Health and Human Services, January 2006).

⁹ U.S. Department of Health and Human Services, *30 Million Medicare Beneficiaries Now Receiving Prescription Drug Coverage* (Washington: U. S. Department of Health and Human Services, April 20, 2006).

¹⁰ A small share of Medicare Advantage beneficiaries did not have drug coverage in 2005.

¹¹ The Kaiser Family Foundation, *Seniors' Early Experience with the Medicare Prescription Drug Benefit – April 2006* (Washington: Kaiser Family Foundation, April 2006).

Note to Table 1: Estimates of those eligible for the low-income subsidy are rounded to the nearest thousand. For Vermont, the rounded estimate of eligibility is 4,000, and the state appears to have reached close to 100 percent enrollment.

Appendix: Methodology

Except where otherwise noted, the data used in this report are available directly from CMS's monthly update on state-by-state Medicare Part D enrollment, released most recently on April 20, 2006. There are several exceptions. First, total enrollment figures are slightly lower than the figures cited by CMS because this report does not include enrollment figures from Puerto Rico and the territories. Also, CMS does not provide state-level information about dual eligible enrollment in Medicare Advantage. Rather, it reports that, nationwide, approximately 500,000 dual eligibles are enrolled in Medicare Advantage. The state-by-state estimate in Table 2 is derived by distributing these 500,000 beneficiaries among the states in proportion to each state's share of overall Medicare Advantage enrollment. This method of estimation therefore does not reflect the substantial variation among states in the percentage of total Medicare beneficiaries enrolled in Medicare Advantage. It is not a perfect estimate, however, because it does not account for states where dual eligibles may be more or less likely than other Medicare beneficiaries to have enrolled in Medicare Advantage.

In addition, as discussed in the text, there is no precise measure of new coverage because beneficiaries are not asked if they had coverage prior to the start of the Part D program. The estimate in Table 3 is derived by first assuming that all enrollees in stand-alone Part D plans previously lacked prescription drug coverage. Second, any growth in Medicare Advantage enrollment in each state from January 2006 (when the first state-level data were made available) to April 2006 is assumed to represent new drug coverage. January enrollment figures were available in January and February from the Kaiser Family Foundation's State Health Facts Online service. These two assumptions likely overstate the number of beneficiaries who obtained new coverage because some of these enrollees likely had coverage from other sources prior to 2006. At the same time, some Medicare Advantage enrollees did not have prescription drug coverage during 2005 and gained coverage automatically on January 1, 2006. On balance, the combination of stand-alone Part D plan enrollment and new Medicare Advantage enrollment is the most reasonable and fairest approximation of new coverage given the limited information available.

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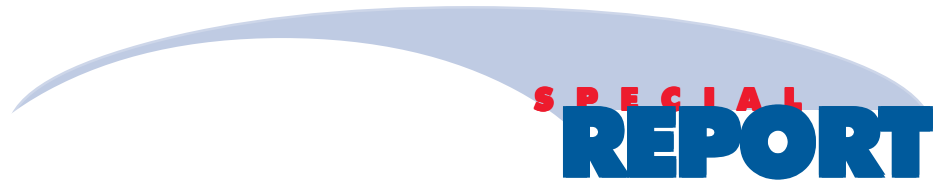
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Families USA Publication No. 06-103

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