

VI. Help for Low-Income Beneficiaries

This section covers:

- *Eligibility*
- *Levels of the Low-Income Subsidy*
- *Redeterminations and redeeming*
- *Part D plan reassignment by CMS*
- *Applying for the Low-Income Subsidy*
- *Medicaid's role with non-Part D drugs*
- *Prescription Drug Assistance Programs and Medicare Part D*

A. Eligibility

There is substantial financial help available to Medicare beneficiaries with limited income and resources who are enrolled in a Part D plan. A program called the Low-income Subsidy (LIS), or “Extra Help Program,” provides this financial assistance to beneficiaries with limited financial means. The subsidy helps pay the costs charged by the Part D plan including the monthly premium, the annual deductible, and co-payments or co-insurance amounts for covered drugs. The MMA set forth several subsidy levels to help reduce these costs. The subsidy levels vary depending on the amount of a beneficiary’s income and resources (or assets).

Extra Help is available to Medicare beneficiaries whose:

- Income is **below** 150% of the federal poverty level (FPL)
 - In 2008, 150 percent of FPL for a single person is \$1,300 per month and \$1,750 per month for a married couple¹. (The new FPL is announced each year in February.)
- Resources (sometimes called assets) are **at or below** \$11,990 for an individual and \$23,970 for a married couple (2008).

Counseling Tip:
There are special rules for some low-income nursing home residents. Please see *Section B, “Levels of the Low-Income Subsidy.”*

Please note that not all sources of income and resources are counted when determining eligibility for the Low-Income Subsidy.

¹ These income amounts do not take into account any income exclusions or disregards. Federal Poverty Level figures change each year and are generally published in the *Federal Register* in late January or early February. They may be used as soon as they are published. The 2008 FPL figures are available at: <http://aspe.hhs.gov/poverty/08fedreg.htm>

Countable Income

The degree of help available to low-income beneficiaries depends in part on the amount of income they receive. In general, the Extra Help Program uses Supplemental Security Income (SSI) rules to calculate “countable income” in determining if beneficiaries meet the income limits for the low-income subsidies. Common sources of income that count are:

- Social Security benefits
- Railroad Retirement benefits
- pensions or annuities (including veterans' pensions)
- alimony
- rental income (net)
- workers compensation
- wages (gross) or earnings from self-employment (net)

If the beneficiary receives Social Security benefits for a disability or blindness and has work-related expenses that are not reimbursable by his employer, these expenses will be deducted before earned income is counted. Some sources of income do not count in Extra Help eligibility determinations. They include food stamps, home energy assistance, stipends paid to ACTION program volunteers (e.g., Senior Companion Program workers), some victim compensation payments (e.g., war reparations), and some tribal payments to Native Americans. For more details, see the Social Security booklet *A Guide to SSI for Groups and Organizations* at <http://www.ssa.gov/pubs/11015.html>

Countable and Excluded Resources

The amount of help available to low-income beneficiaries also depends on their resources or assets. Only certain resources count in determining eligibility for the Extra Help Program. These “countable resources” generally are those “liquid” resources that one can turn into cash within twenty (20) days. Some examples of countable resources are:

- Bank accounts (checking, savings or certificates of deposits or CDs)
- Stocks, bonds, savings bonds, mutual funds, individual retirement accounts (IRAs)
- Cash at any other financial institution or at home
- Life insurance policies (cash value: If you turned in your policy right now, how much money would it be worth?)
- Real estate other than the beneficiary's primary home

Other non-liquid resources that one cannot turn quickly into cash, such as the beneficiary's primary home or a car, do not count in determining one's eligibility for a Part D low-income subsidy. They are "excluded resources." Other excluded resources include:

- Up to \$1,500 (for single persons) or \$3,000 (for married couples) of the cash value of life insurance policies, often called "whole life" or "universal life" policies. Term life insurance policies and whole life or universal life policies with a face value (death benefit) of less than \$1,500 are excluded.
- Property one needs for self-support, such as rental property
- Jewelry and home furnishings
- Burial spaces owned by a beneficiary and spouse

Beneficiaries can exclude from their countable resources up to \$1,500 (for single persons) and \$3,000 (for married couples) that they designate for funeral and burial expenses. Added to the \$10,490 (\$20,970 for married couples) of countable resources that beneficiaries can have and still qualify for the Extra Help Program, this resource exclusion effectively lifts the resource limit to \$11,990 for an individual and \$23,970 for married couples.

B. Levels of the Low-Income Subsidy

There are several levels of subsidies available to beneficiaries depending on the amount of income and resources they have.

1. Full Dual-Eligible Beneficiaries (Medicare and Full Medicaid) with Incomes at or Below 100% of the FPL

In 2008, 100 percent of the FPL is \$867 per month for an individual and \$1,167 per month for a married couple. Full-duals who reside in the community and meet these income requirements receive the following subsidies:

- They do not pay the monthly premium if they choose a standard plan that has a premium at or below the benchmark premium for their region or a "de minimis plan" (*see subsection D "Part D Plan Reassignment" below*).
 - Beneficiaries who enroll in a standard plan with a premium above the "de minimis" amount must pay the balance out-of-pocket.
 - Beneficiaries who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits.
- They do not pay the annual deductible.
- They have co-payments of \$1.05 for each generic or preferred brand prescription drug or \$3.10 for each prescription for all other drugs that are on the plan's formulary (2008).
- After beneficiaries in this group reach the out-of-pocket threshold, all prescription drugs on the plan's formulary are free.

Counseling Tip: A "de minimis plan" is a Part D plan with a 2008 premium that exceeds the regional LIS benchmark premium by \$1.00 or less.

2. Full Dual-Eligible Beneficiaries (Medicare and Full Medicaid) with Incomes Above 100% of the FPL

In 2007, 100 percent of FPL is \$867 per month for an individual and \$1,167 per month for a married couple. Most beneficiaries in this group qualify for full Medicaid benefits through an income spend-down or through a Medicaid Home and Community-Based Services (HCBS) waiver. Full-duals who reside in the community and meet these income requirements receive the following subsidies:

- They do not pay the monthly premium if they choose a standard plan that has a premium at or below the benchmark premium for their region or a “de minimis plan” (*see subsection D “Part D Plan Reassignment” below*).
 - Beneficiaries who enroll in a standard plan with a premium above the “de minimis” amount must pay the balance out-of-pocket.
 - Beneficiaries who enroll in an enhanced plan must pay the portion of the plan’s premium that is attributed to the enhanced benefits.
- They do not pay the annual deductible.
- They have co-payments of \$2.25 for each generic or preferred brand prescription drug or \$5.60 for each prescription for all other drugs that are on the plan’s formulary (2008).
- After low-income beneficiaries in this group reach the out-of-pocket threshold, all prescription drugs on the formulary are free.

3. Medicare Beneficiaries with Income Between 100% and 135% of the FPL

In 2008, this income bracket includes those with incomes of more than \$867 but less than \$1,171 per month for a single person, and more than \$1,167 but less than \$1,576 per month for a married couple. This income group generally includes Medicare beneficiaries enrolled in the Medicare Savings Programs (MSPs), including Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs). These beneficiaries are sometimes referred to as partial dual-eligibles. This group also includes SSI recipients who automatically receive full Medicaid benefits.

There are two subsidy levels available for beneficiaries within this income range depending upon the amount of their countable resources.

a. Beneficiaries with Fewer Resources: Beneficiaries in this income group with countable resources (assets) of less than \$7,790 for an individual or less than \$12,440 for a married couple (2008):

- They do not pay the monthly premium if they choose a standard plan that has a premium at or below the benchmark premium for their region or a “de minimis plan” (*see subsection D “Part D Plan Reassignment” below*).
 - Beneficiaries who enroll in a standard plan with a premium above the “de minimis” amount must pay the balance out-of-pocket.

- Beneficiaries who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits.
- They do not pay the annual deductible.
- They have co-payments of \$2.25 for each generic or preferred brand prescription drug or \$5.60 for each prescription for all other drugs that are on the plan's formulary (2008).
- After low-income beneficiaries in this group reach the out-of-pocket threshold, all prescription drugs on the formulary are free.

b. Beneficiaries with More Resources: Beneficiaries in this income group with countable resources (assets) between \$7,790 and \$11,990 for an individual or between \$ 12,440 and \$23,970 for a married couple (2008):

- They do not pay the monthly premium if they choose a standard plan that has a premium at or below the benchmark premium for their region or a "de minimis plan" (*see subsection D "Part D Plan Reassignment" below*).
 - Beneficiaries who enroll in a standard plan with a premium above the "de minimis" amount must pay the balance out-of-pocket.
 - Beneficiaries who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits.
- They have a \$56 annual deductible (2008).
- They pay a co-insurance of 15 percent for each prescription drug that is on the plan's formulary.
- After low-income beneficiaries in this group reach the out-of-pocket threshold, generic and preferred brand prescription drugs on the formulary are \$2.25 and all other drugs are \$5.60 (2008).

4. Beneficiaries with Income Between 135% FPL and 150% of the FPL

Beneficiaries whose countable income is between 135 percent and 150 percent of FPL **and** who have countable resources (assets) of no more than \$11,990 for an individual or \$23,970 for a married couple are eligible for a subsidy (2008). In 2008, this income bracket includes those with income more than \$1,170 but less than \$1,300 per month for a single person and more than \$1,575 but less than \$1,750 per month for a married couple. Beneficiaries who meet these income and asset requirements receive the following subsidies:

- Medicare pays a portion of the monthly premium based on their income:
 - Individuals with incomes greater than 135 percent but at or below 140 percent of the FPL receive a premium subsidy of 75 percent of the benchmark premium (see the table below).
 - Individuals with incomes greater than 140 percent but at or below 145 percent of the FPL receive a premium subsidy of 50 percent of the benchmark premium (see the table below).

- Individuals with incomes greater than 145 percent but below 150 percent of the FPL receive a premium subsidy of 25 percent of the benchmark premium (see the table below).
- They pay a \$56 annual deductible (2008).
- They pay a co-insurance of 15 percent for each prescription drug on the plan’s formulary.
- After beneficiaries in this group reach the out-of-pocket threshold, generic and preferred brand prescription drugs on the formulary are \$2.25 and all other drugs are \$5.60 (2008).

Monthly Income Amounts by Percent of the 2007 FPL

	Single Person	Married Couple
Greater than 135% but at or below 140% of the FPL	\$1,170.01-\$1,2131.33	\$1,575.01-\$1,633.33
Greater than 140% but at or below 145% of the FPL	\$1,213.34-\$1,256.67	\$1,633.34-\$1,691.67
Greater than 145% but below 150% of the FPL	\$1,256.68-\$1,300.00	\$1,691.68-\$1,750.00

For more information on the levels of the Low-Income Subsidy, please see the chart, *“Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2008).”*

Special rules apply to the low-income subsidy for full-duals who reside in certain long-term care (LTC) facilities including: skilled nursing facilities, nursing facilities, inpatient psychiatric hospitals, and intermediate care facilities that are residential facilities for developmentally disabled adults (called "ICF/MRs"). Regardless of their income, Medicare beneficiaries who receive full Medicaid benefits and reside in these LTC facilities receive the maximum subsidies, and therefore do not incur any out-of-pocket costs for prescription drugs that are on the plan’s formulary. They do not pay any monthly premiums, an annual deductible, or co-payments for their prescriptions.

Residents of assisted living facilities, group homes, and board and care homes may qualify for the Low-Income Subsidy, but are subject to some cost-sharing in line with their income and resources.

Counseling Tip: If a LTC stay is covered by the Medicare Part A skilled nursing facility benefit, Part A covers the prescription drugs.

Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2008)

ELIGIBILITY GROUP		COST-SHARING			
Monthly Income Limit	Resource Limit	Annual Deductible	Monthly Premium	Costs Until TrOOP Totals \$4,050²	Catastrophic Benefit After TrOOP Totals \$4,050
Deemed Eligible for Extra Help: Medicare and Medicaid*, Medicare Savings Programs**, and SSI-only					
Full dual-eligible beneficiaries with income less than 100% FPL: <ul style="list-style-type: none"> • Single: ≤ \$866.67 • Married: ≤ \$1,166.67 	Resource limits differ by state. Check with your state Medicaid agency.	\$0	\$0 ¹	\$1.05 for generics and preferred brand drugs or \$3.10 for all other drugs	\$0
All deemed beneficiaries with income between 100% and 135% FPL: <ul style="list-style-type: none"> • Single: \$866.68 to \$1,170 • Married: \$1,166.68 to \$1,575 	Resource limits differ by state. Check with your state Medicaid agency.	\$0	\$0 ¹	\$2.25 for generics and preferred brand drugs or \$5.60 for all other drugs	\$0
Must Apply for Extra Help: Other Low-Income Beneficiaries					
Below 135% FPL: <ul style="list-style-type: none"> • Single: ≤ \$1,170 • Married: ≤ \$1,575 	<ul style="list-style-type: none"> • Single: < \$7,790³ • Married: < \$12,440³ 	\$0	\$0 ¹	\$2.25 for generics and preferred brand drugs or \$5.60 for all other drugs	\$0
Below 135% FPL: <ul style="list-style-type: none"> • Single: ≤ \$1,170 • Married: ≤ \$1,575 	<ul style="list-style-type: none"> • Single: \$7,790 - \$11,990³ • Married: \$12,440 - \$23,970³ 	\$56	\$0 ¹	15% co-insurance	\$2.25 for generics and preferred brand drugs or \$5.60 for all other drugs
Between 135% and 150% FPL: <ul style="list-style-type: none"> • Single: \$1,170 to \$1,300 • Married: \$1,575 to \$1,750 	<ul style="list-style-type: none"> • Single: \$7,790 - \$11,990³ • Married: \$12,440 - \$23,970³ 	\$56	Premium based on income: <ul style="list-style-type: none"> • 135% to 140% FPL - 25% of the monthly premium • 140% to 145% FPL - 50% of the monthly premium • 145% to 150% FPL - 75% of the monthly premium 	15% co-insurance	\$2.25 for generics and preferred brand drugs or \$5.60 for all other drugs

Notes

FPL = Federal Poverty Level. In 2008, 100% of the FPL is \$10,400 for an individual (or \$866.67 per month) and \$14,000 for a married couple (or \$1,166.67 per month) in the 48 contiguous states and the District of Columbia. Income limits are higher in Alaska and Hawaii and for beneficiaries living with dependents. Federal Poverty Guidelines for 2008 are located at: <http://www.hapnetwork.org/medicaid/fpl-2008.html>.

Deemed eligible beneficiaries do not need to apply for Extra Help. State Medicaid offices send a monthly file to CMS containing information about beneficiaries in all of the deemed eligible groups—including dual eligible beneficiaries, Medicare beneficiaries with a Medicare Savings Program, and SSI-only beneficiaries.

Footnotes

* This group is also called full dual eligible beneficiaries.

** This group includes Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB), and Qualifying Individuals (QI).

¹ Beneficiaries in this group receive the maximum premium subsidy amount. Beneficiaries enrolled in a plan that charges a higher monthly premium than the maximum subsidy amount (or in an enhanced Medicare drug plan) must pay the difference in cost with no help from the low-income subsidy.

² Total out-of-pocket drug costs include amounts paid by the extra help (or low-income subsidy) and true out-of-pocket (TrOOP) costs paid by the beneficiary. TrOOP costs include amounts paid by the beneficiary, friends, relatives, certain charities, qualified State Pharmacy Assistance Programs (SPAPs), and the low-income subsidy toward the annual plan deductible, co-payments or co-insurance amounts. Catastrophic coverage begins once the beneficiary's TrOOP reaches \$4,050 on drugs covered by the Medicare drug plan.

³ These resource limits include \$1,500 per person for burial expenses.

C. Redeterminations and Redeeming

The MMA requires that eligibility for the low-income subsidy (LIS) be reassessed each year, a process that involves three agencies: the Social Security Administration (SSA), the Centers for Medicare and Medicaid Services (CMS), and state Medicaid agencies. The agency that initially determines a beneficiary's eligibility for the LIS is responsible for reassessing his eligibility for the following calendar year.

- The Social Security Administration (SSA) has implemented a process called “redetermination” for LIS recipients who applied for and were found eligible for the LIS through the SSA.
- CMS reviews the LIS eligibility status of all beneficiaries who were deemed eligible for “extra help” (in the previous calendar year) because they receive Medicaid benefits (full or partial) or Supplemental Security Income (SSI) benefits. (Medicare beneficiaries who have “spent down” their “surplus income” in order to obtain Medicaid and/or receive Medicaid services through a Home and Community-Based Services (HCBS) waiver program are considered full-duals.) The process of determining if a beneficiary will continue to be deemed eligible for the LIS in the following year is called “redeeming.”
- State Medicaid agencies must redetermine eligibility for any beneficiary who applied for and was found eligible for the LIS through his state Medicaid agency.

SSA Redeterminations

The Social Security Administration (SSA) conducts three types of redeterminations: initial, cyclical, and subsidy changing events (SCE). These processes *only* pertain to beneficiaries who applied for the LIS (or extra help) through the SSA.

Initial redeterminations

To redetermine eligibility for 2008, the SSA has selected a group of beneficiaries who applied and were found eligible for extra help between May 2006 and April 2007 **and** whom the SSA believes have experienced a change in their circumstances that may have affected their eligibility for extra help. A total of 69,126 beneficiaries were selected. These beneficiaries should have received a redetermination form (<http://www.ssa.gov/prescriptionhelp/SSA-1026B-OCR-SM-INST.pdf>) in the mail between September 10 and September 25, 2007. The form, “Social Security Administration Review of Your Eligibility for Extra Help,” must be completed and returned within 30 days of receipt, **even if nothing has changed**. Please note that this is different from the redetermination process used for 2007. If a beneficiary does not complete and return the form, eligibility for extra help may be terminated, effective January 1, 2008.

Cyclical redeterminations

Each year the SSA will select a random group of extra help recipients for redetermination. To redetermine eligibility for 2008, SSA has selected 430,874 beneficiaries in their second year of eligibility. These beneficiaries should have received a redetermination form (<http://www.ssa.gov/prescriptionhelp/SSA-1026B-OCR-SM-INST.pdf>) in the mail between September 10 and September 25, 2007. (The form is the same form sent to those selected for the initial redetermination.) Beneficiaries must respond to the form within 30 days of receipt, **even if nothing has changed**. Please note that this is different from the redetermination process used for 2007. If a beneficiary does not complete and return the form, eligibility for extra help may be terminated, effective January 1, 2008.

Subsidy changing event (SCE) redeterminations

Subsidy changing events, including marriage, divorce, separation, annulment, and death of spouse, must be reported immediately. The SSA will send a special SCE redetermination form. Beneficiaries are required to complete and submit the form within 90 days of receipt. Beneficiaries who do not respond will no longer receive extra help; for those that do respond, their extra help status will change the month after SSA receives the completed form. More information about SCEs is available from the SSA Program Operations Manual System or POMS (<https://s044a90.ssa.gov/apps10/poms.nsf/lrx/0603050011!opendocument>).

Beneficiaries may appeal a reduction or termination of their subsidy. According to SSA, "It may be more advantageous to the individual to file an appeal than to file a new application. This is because the individual may lose one or more months of Part D subsidy by filing a new application. An appeal would preserve the retroactivity of the subsidy while a new application would not" (20 CFR 418.3605 - 418.3680). Beneficiaries should use the SSA appeals form available at: <http://www.ssa.gov/online/ssa-1021.pdf>.

More information on the Social Security Administration's updated redetermination processes and procedures can be found in the POMS at: <https://s044a90.ssa.gov/apps10/poms.nsf/lrx/0603050011!opendocument>. SSA has also prepared a 1-page sheet, "Review of Your Eligibility for Extra Help With Medicare Prescription Drug Plan Costs: Some Things You Should Know," in both English and Spanish (<http://www.ssa.gov/pubs/10111.pdf>).

Redeeming

Based on data that state Medicaid Agencies send to CMS, individuals with Medicare and Medicaid are deemed eligible for the LIS. Those who are deemed-eligible automatically qualify for the LIS, and therefore, do not need to complete an application. All individuals who were full or partial duals in July 2007 or any subsequent month in 2007 are redeemed eligible for LIS for calendar year 2008. Starting in July 2007, state Medicaid agencies, began sending monthly transmissions to CMS containing data on all dual-eligible beneficiaries. Individuals whose data was transmitted to CMS will be automatically redeemed eligible for LIS for 2008. If their LIS status has not changed, they will *not* receive a notice informing them that they will continue to receive extra help in 2008. If they remain LIS eligible, but a change in their income requires a change to their subsidy amount, they will receive an orange letter from CMS. The letter (<http://www.cms.hhs.gov/partnerships/downloads/11199.pdf>) explains that although they still qualify for the extra help in 2008, their co-pays will change as of January 1, 2008.

Some people who were deemed eligible for LIS in 2007 will not be deemed eligible for 2008 because they no longer qualify for Medicaid. These beneficiaries (more than 447,000) should have received a grey letter from CMS in September 2007 (<http://www.cms.hhs.gov/partnerships/downloads/11198.pdf>). The letter explains that effective January 1, 2008, they will not automatically receive extra help to pay for their Part D costs. The letter also explains that they can apply for the LIS through the SSA or their state Medicaid agency. An application for the LIS with a postage-paid envelope was included with the letter.

Counseling Tip: State Medicaid agencies are required to screen individuals for eligibility for the Medicare Savings Programs (MSP). Anyone found eligible for a MSP would be deemed eligible for the LIS.

Individuals who received this letter include Medicare beneficiaries who:

- no longer qualify for full Medicaid benefits;
- are no longer eligible for a Medicare Savings Program; or
- no longer receive Supplemental Security Income (SSI) and do not qualify for Medicaid.

Information on the number of beneficiaries who received the grey letter because they lost their deemed status is available by state, zip code, and county from the HAP website (<http://www.hapnetwork.org>).

Counseling Tip: Someone who inadvertently receives a grey letter, but should still in fact be considered a full or partial dual should call their Medicaid directly.

Anyone who receives the grey letter and subsequently re-qualifies for Medicaid would thereupon be redeemed for the LIS for 2008.

More information on the redeeming process is available from CMS at: <http://www.cms.hhs.gov/limitedincomeandresources>.

For Example: Clive had Medicaid for most of 2007 until he received a small sum of money through a judgment in a successful law suit. Therefore, he will not be deemed eligible for the LIS for 2008. However, he might be eligible for the Qualified Individual (QI) program. With the help of a caseworker at his local Medicaid office, Clive completes the QI application. A month later he is informed that he is in fact eligible for the QI program, and therefore, he will qualify for the LIS in 2008.

D. Part D Plan Reassignment by CMS

In the fall of each year, CMS reassigns certain groups of Medicare beneficiaries who are eligible for the LIS into Part D plans for the coming year. For 2008, CMS is reassigning two groups of Medicare beneficiaries who were deemed eligible for the extra help in 2007 and will continue to be deemed eligible in 2008:

- Medicare beneficiaries with the full subsidy who stayed in the plan that they were auto-assigned to by CMS for 2007, **and** their plan premium in 2008 is more than \$1.00 above the regional low-income premium subsidy benchmark or “de minimis”² (<http://www.hapnetwork.org/assets/pdfs/2008-lis-amounts.pdf>); and
- Medicare beneficiaries with the full subsidy whose plans are leaving the Medicare program in 2008.

By early November, these Medicare beneficiaries should have received a blue letter from CMS with information about their reassignment. For more information about the letter, please go to: <http://www.hapnetwork.org/assets/pdfs/links-to-cms-mailings.pdf>.

CMS will *not* reassign some Medicare beneficiaries who were deemed eligible for the extra help in 2007 and will continue to be deemed-eligible in 2008 including:

- Medicare beneficiaries with the full subsidy who were assigned to a plan for 2007 but switched to a new plan, and the 2008 plan is more than \$1.00 above the regional low-income premium subsidy benchmark or “de minimis” (<http://www.hapnetwork.org/assets/pdfs/2008-lis-amounts.pdf>).

These beneficiaries should have received a tan letter from CMS by early November informing them that they will owe a portion of the premium if they remain in their plans. For more information about the letter, please go to:

<http://www.hapnetwork.org/assets/pdfs/links-to-cms-mailings.pdf>

Information from CMS on plan reassignment is available at:

<http://www.cms.hhs.gov/limitedincomeandresources>.

² Some Part D plans that were LIS benchmark plans in 2007 raised their premium above the 2008 regional LIS benchmarks. As a result, full LIS recipients would have to pay a portion of the plan premium if they remain in such a plan. Therefore, CMS is reassigning certain LIS-eligible individuals to different Part D plans with premiums that are at or below the regional LIS benchmark for their area.

E. Applying for the Low-Income Subsidy

Who Needs to Apply?

Some low-income beneficiaries do *not* need to apply for the low-income subsidy (extra help) because they are "deemed-eligible." Other low-income beneficiaries *must* apply.

1. Individuals who are "deemed-eligible" for the extra help and do *not* need to apply are those Medicare beneficiaries who receive Medicaid benefits, including full and partial benefits.
 - a. Individuals with Medicare and full Medicaid benefits are referred to as "full-duals," in that they are enrolled in both programs and are eligible for Medicaid's full set of benefits. Full-duals also include residents of nursing facilities who are on Medicare and Medicaid and Medicare beneficiaries who reside in the community and are enrolled in a Medicaid Home and Community-Based Services (HCBS) waiver program.
 - b. Medicare beneficiaries who are enrolled in one of three "Medicare Savings Programs" (MSP) are referred to as "partial-duals." The State, through its Medicaid program, pays at least the Part B premiums for beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB), and Qualified Individuals (QI) programs. For those in the QMB program, the State also covers Medicare's deductibles and coinsurance costs.
2. Medicare beneficiaries who *must* apply for the extra help are those with limited financial means, but who are not a full or partial dual. Anyone who thinks they may be eligible for the extra help can apply, but only those who meet the income and resource limits will be found eligible (*see subsection B, "Levels of the Low-Income Subsidy"*).

Counseling Tip: Generally, those who need to apply for the subsidy have incomes above 135% of the FPL. Those with incomes below 135% are likely eligible for a Medicare Savings Program, and therefore are deemed-eligible for the extra help and do not need to apply separately for it.

For Example: Mary, a retired widow, has an annual income of \$10,000 and resources that amount to \$12,000. Although her resources are just over the limit for the subsidy, her income is well below the maximum. She thinks it is worthwhile to apply for the subsidy, and completes an application. She is thrilled to find out that she is indeed eligible because some of her resources, including the \$600 cash value accumulated in a whole life insurance policy with a \$2,000 death benefit, along with \$1,500 that she can earmark for burial expenses, are excluded from the eligibility decision.

How Does a Beneficiary Apply?

Beneficiaries who believe they may be eligible for the low-income subsidy must complete an application. A beneficiary can choose to complete the standard Social Security Administration (SSA) application form (SSA Form 1020), or they can apply at their local Medicaid office.

A beneficiary can access the SSA application in four ways:

- go to the SSA website (www.ssa.gov) and complete the application on-line;
- call SSA at 1-800-772-1213 and ask a Customer Service representative to send an application through the mail;
- call SSA at 1-800-772-1213 and asking a Customer Service representative to help him/her complete the application over the phone; or
- go to a local SSA office and pick up an application.

Once the application is complete, it must be mailed to the Social Security Administration. The application comes with a self-addressed, postage paid envelope. SSA will verify elements of eligibility (i.e., income, resources, residency, and Medicare entitlement) by comparing the information on the application form to Social Security records and records from other federal agencies, including CMS. SSA will ask applicants to submit proof, such as banking statements, only if there are discrepancies between the information on the application and the government records, or if applicants report ownership of non-home real property.

Counseling Tip: The SSA application must be completed using a black pen or a No. 2 pencil, or the application cannot be processed. Also, information should not be written on the application—it will not be detected by the automatic system that processes the applications.

A beneficiary can also go a local Medicaid office and speak with an eligibility specialist. They are required to help a beneficiary complete the SSA application for extra help. The Medicaid office can send the application in to SSA, or the beneficiary can mail the application on his own. (The application comes with a self-addressed, postage paid envelope.)

Counseling Tip: Eligibility specialists at Medicaid offices are required to screen LIS applicants for the Medicare Savings Programs. Remember that MSP enrollees are deemed eligible for the Low-Income Subsidies and do not need to apply.

Who Can Help Complete the Application?

Under the MMA, three categories of helpers, called personal representatives, may act on behalf of beneficiaries for the purpose of applying for the Low-Income Subsidy. These are (a) those asked to help (such as a family member or friend), (b) those authorized by state or other law, and (c) someone acting responsibly on behalf of an "incapacitated" beneficiary. CMS expressly declined to limit "acting responsibly" in any way, stating that it assumes the good intentions of everyone who wants to help get people into the LIS program. SHIP counselors are also able to help a beneficiary complete an application.

For Example: Eloise received a subsidy application in the mail after calling SSA. She has asked her daughter, Sara, to help her complete the application. Sara helps her sort through her income and resources to provide the most accurate information. Together, they complete the application and mail it in the self-addressed, pre-paid envelope to SSA.

How Long Does it Take to Process an Application?

The law does not require the SSA to process applications and notify applicants about subsidy determinations in any particular time frame. The SSA states only that applications remain "in effect" until a decision is reached regarding subsidy eligibility, and has further indicated that it expects routine processing time to be two to three weeks.

What Rights Does a Beneficiary Have if a Subsidy Application Is Denied?

The SSA has an appeals process that low-income beneficiaries can use if they disagree with a decision to deny, reduce, or discontinue the low-income subsidy. Beneficiaries who wish to appeal a decision by SSA must complete a form called "Appeal of Determination for Help with Medicare Prescription Drug Plan Costs," which is available at: <http://www.hapnetwork.org/medicaid/lis.html> (please see "Other Resources").

F. Medicaid's role with non-Part D drugs

The MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs that are covered by Medicare Part A or Part B, such as chemotherapy drugs. Other drugs that are generally excluded from Part D coverage include:

- Drugs prescribed for weight-loss or weight-gain
- Drugs prescribed for the symptomatic relief of coughs and colds
- Prescription vitamins, with the exception of prenatal vitamins and fluoride
- Over-the-counter drugs, with the exception of insulin
- Prescription drugs to promote hair growth
- Fertility drugs
- Cosmetic drugs
- Drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications
- Barbiturates (drugs used to control seizures or used for sedation or anesthesia such as Phenobarbital or Nembutal®)
- Benzodiazepines, often referred to as minor tranquilizers, used to treat anxiety or insomnia (such as Xanax®, Valium® and Ativan®)
- Erectile dysfunction (ED) drugs, when prescribed for the treatment of sexual or erectile dysfunction³

Some Part D plans with enhanced benefit designs, however, may provide coverage for some of the drugs in these categories (*see Section II, "Types of Plans"*).

A state's Medicaid program may decide to cover some of these excluded drugs, along with Part D drugs that are not on Medicare drug plan formularies, for full-dual beneficiaries, including residents of nursing facilities and recipients of HCBS waivers. To access specific information about which non-Part D drugs state Medicaid programs are covering for full-dual beneficiaries, please check the CMS Website (<http://www.cms.hhs.gov/States/EDC/list.asp>) or check with your state Medicaid agency.

³ For Contract Year (CY) 2006 Erectile Dysfunction (ED) drugs met the definition of a Part D drug and were available on Plan Sponsor formularies. On October 26, 2005, Section 1860D-2(e)(2)(A) of the Social Security Act was amended to exclude ED drugs when prescribed for the treatment of sexual or erectile dysfunction for CY 2007 and beyond. Please see the CMS Q&A on ED drugs for more information: http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/QAEDDrugs_07.06.06.pdf.

For Example: Edna is a full-dual beneficiary who receives home and community-based services through a Medicaid waiver program. She is enrolled in a standard PDP. She was recently diagnosed with breast cancer, and has been prescribed a brand-name drug to help relieve the side effects of radiation. Because she is enrolled in a standard PDP, the drug is not on her plan's formulary. However, her state's Medicaid program covers the drug. Through Medicaid, Edna is able to get the drug she needs, and will pay a minimal co-pay or nothing at all per refill, depending on her state's Medicaid program.

G. Prescription Drug Assistance Programs and Medicare Part D

Generally two types of prescription drug assistance programs are available to help Medicare beneficiaries with limited financial resources access their medications: 1.) State Pharmaceutical Assistance Programs (SPAP) and 2.) private pharmaceutical assistance programs (PAPs). Beneficiaries must meet certain eligibility criteria to qualify for the benefits offered under these programs. The ways in which these programs coordinate their benefits with Part D varies.

State Pharmaceutical Assistance Programs

State Pharmaceutical Assistance Programs (SPAPs) generally assist beneficiaries with limited financial resources with their prescription drug costs. Eligibility criteria vary from program to program. The MMA allows SPAPs to “wrap-around” the Medicare Part D benefit and fill in coverage gaps for medication that are either: 1.) not covered by an individual's PDP or MA-PD plan; 2.) excluded by law; or 3.) cost prohibitive while someone is in the coverage gap (“doughnut hole”).⁴ Beneficiaries still pay a portion of the cost for each of their medications even with Part D and SPAP coverage.

Counseling Tip: It is important for beneficiaries to show their pharmacist all of their drug benefit membership cards at the point-of-sale to ensure proper sequential billing.

All other forms of drug coverage, including Part D, are primary to coverage provided by a SPAP. That is, a SPAP will only cover medications after any other drug coverage is applied to the cost of that drug. Additionally, payments made by a SPAP to cover drugs that are on the plan's formulary, but are needed during the coverage gap (“doughnut hole”), count towards TrOOP for the Part D plan.⁵ As of July 2007, 25 states plus the Virgin Islands offer SPAPs that provide some level of coverage to SPAP enrollees who are also enrolled in a Part D plan.⁶

Counseling Tip: A SPAP is always payer of last resort. It is expected that when it is possible that a drug can be covered by a Part D plan, an exception or appeal should be filed first.

⁴ SPAPs that wrap-around Part D plans must meet certain criteria set forth under the MMA. These SPAPs are referred to as qualified SPAPs. More information on qualified SPAPs is available from CMS at:

<http://www.cms.hhs.gov/States/Downloads/QualifiedSPAPGuidelines.pdf>

⁵ Only payments from qualified SPAPs count towards TrOOP.

⁶ The 25 states that offer qualified SPAPs include: Alaska, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Massachusetts, Maine, Maryland, Missouri, Montana, North Carolina, New Jersey, Nevada, New York, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia,

Private Pharmaceutical Assistance Programs (PAPs)

Some private pharmaceutical companies offer their products to low-income individuals for free or reduced prices through pharmaceutical assistance programs (PAPs) and drug discount programs. These programs have also been called "indigent patient programs." Due to Medicare Part D coverage, many of these programs either no longer offer their services to Medicare beneficiaries who are eligible for or enrolled in a Medicare Part D plan, or they require some attempts to have the Part D plan pay for a medication before they will assist a beneficiary. There is a separate application process for each individual medication that varies between each company.

PAPs are not comprehensive insurance plans and therefore are not considered creditable coverage. Some programs may only provide one free sample or supply of a medication; others may provide ongoing assistance. The application process requires the participation of a physician who will receive and administer or deliver the drug to her patient.

It is important to know that the total cost of the drug that a PAP provides to a beneficiary in the coverage gap does not count towards True Out-Of-Pocket costs (TrOOP). Therefore, assistance from a PAP extends the time that a beneficiary spends in the coverage gap, and, hence, delays the Part D catastrophic benefit. However, if a beneficiary must pay a co-pay or co-insurance amount to receive a PAP-provided medication, the co-pay or co-insurance amount count towards TrOOP *if* the medication is on the plan's formulary.

For Example: Rafaella takes Procrit, a very expensive cancer medication. Her Part D plan does cover this as a tier five drug; however, she is now in the coverage gap and cannot afford to pay \$986 for a one-month's supply. She is also on a fixed income and also receives a partial in-kind stipend to pay her monthly rent. After speaking with her doctor, he applied for her to receive Procrit directly from the manufacturer where she will pay \$125 co-pay, which will count towards her TrOOP with the plan.

Other sources that count towards TrOOP include all payments made by the beneficiary, relatives, friends, or charitable foundation contributions, qualified SPAPs, and waivers or reductions by in-network pharmacists and formulary medications. *Please refer to Section V "Costs and Prices" for more information on TrOOP.*

Counseling Tip: To streamline the application process, CMS created a dedicated website that compiles detailed information about all of the PAPs available through every drug manufacturer. The site lists medications by name to find out whether the companies offer it free or at low cost: <http://www.medicare.gov/pap/>

Washington, and Wisconsin. Some states offer more than one qualified SPAP. A specific list of qualified SPAPs is available from CMS at: <http://www.cms.hhs.gov/States/Downloads/QualifiedSPAP7-5.pdf>