

HELP FOR LOW-INCOME BENEFICIARIES

This section covers:

- Eligibility
- Levels of Low-Income Subsidy
- Applying for the Low-Income Subsidy
- Eligible for Low-Income Subsidy: What Happens Next
- Medicaid's Role with Non-Part D Drugs
- Redeterminations and Redeeming
- Part D Plan Reassignment by CMS
- Prescription Drug Assistance Programs and Medicare Part D

ELIGIBILITY

Medicare beneficiaries with limited income and resources have access to substantial financial help with the costs of Part D. A program called the low-income subsidy (LIS), or “Extra Help,” provides this assistance to beneficiaries with limited means. The subsidy helps to pay a portion of Part D plans’ costs – including the monthly premium, the annual deductible, and copayments or coinsurance amounts for covered drugs. The MMA sets forth several subsidy levels that differ based on the amount of a beneficiary’s income and resources (or assets).

The Social Security Administration (SSA) manages the following processes related to the low-income subsidy:

- Provides general information to the public about LIS
- Supplies applications for LIS
- Makes LIS eligibility determinations for Medicare beneficiaries who apply for LIS

SSA works in conjunction with CMS on the LIS program. In short, CMS is responsible for administering the program, while SSA makes determinations about who is eligible for the program.

In general, LIS is available to Medicare beneficiaries whose:

- Income is **below** 150% of the federal poverty level (FPL)
 - In 2009, 150 percent of FPL for a single person is \$1,354 per month and \$1,821 per month for a married couple living in the 48 contiguous states or the District of Columbia. Income amounts are higher for those living in Hawaii and Alaska. (The new FPL is announced each year in the first few months of the year.)
- Resources (sometimes called assets) are at or below \$12,510 for an individual and \$25,010 for a married couple (2010).

Please note these income amounts do not take into account any income exclusions or disregards. Federal poverty levels for 2009 are available at <http://aspe.hhs.gov/poverty/09poverty.shtml>. Also note that SSA does not count all sources of income and resources when determining eligibility for LIS. Federal poverty levels become available each year in January. These figures will be updated upon receipt of 2010 information.

SSA and CMS also work with state Medicaid agencies to determine LIS eligibility for another group of Medicare beneficiaries – individuals who qualify for Medicaid or for a Medicare Savings Program (MSP). These beneficiaries are considered “deemed eligible” and will automatically receive the subsidy. All other individuals must apply in order to receive the subsidy (see Appendix C). Except in limited circumstances, those who are eligible for LIS receive the subsidy at least throughout the calendar year.

Note: There are special rules for some low-income nursing home residents. See the section on Levels of the Low-Income Subsidy on page 40.

Countable and Excluded Income

The degree of help available to low-income beneficiaries depends in part on the amount of income they receive. In general, SSA 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 countable income 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 beneficiaries receive Social Security benefits for a disability or blindness and have work-related expenses that are not reimbursable by their employers, these expenses will be deducted before earned income is counted. Some sources of income do not count in LIS 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. More details about countable income are available in the Social Security booklet, *A Guide to SSI for Groups and Organizations* (see Appendix D).

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.

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 a primary home

Other resources, such as the beneficiary's primary home or a car, do not count in determining one's eligibility for LIS. These 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.
- Cash value of a life insurance policy, beginning in 2010
- Property one needs for self-support, such as rental property
- Jewelry and home furnishings
- Burial spaces owned by a beneficiary and spouse

Note: Beginning in 2010, SSA will no longer use the cash value of life insurance when calculating eligibility for LIS. This change is due to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

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 \$11,010 (\$22,010 for married couples) of countable resources that beneficiaries can have and still qualify for the LIS, this resource exclusion effectively lifts the resource limit to \$12,510 for an individual and \$25,010 for couples (2010).

LEVELS OF LOW-INCOME SUBSIDY

There are different levels of subsidies that depend on eligible beneficiaries' income and resources. The descriptions below use the standard federal poverty level (FPL) for individuals living in the 48 contiguous states and the District of Columbia. Income amounts are slightly higher for those living in Alaska and Hawaii. Income charts are available at <http://aspe.hhs.gov/poverty/09poverty.shtml>. Federal poverty levels become available each year in January. These figures will be updated upon receipt of 2010 information.

The descriptions below refer to the benchmark premium. CMS calculates the benchmark premium each year using premium and enrollment information for all plans with enrollment in the past year. CMS uses the following premium amounts for plans:

- The total monthly premium for standard plans
- The portion of enhanced plans' premiums attributed to standard Part D coverage
- The monthly prescription drug beneficiary premiums for MA-PD plans

CMS calculates the average of these amounts and uses actual enrollment information to weight the average. This weighted average is called the "benchmark subsidy." Each year, CMS calculates the benchmark for each plan region. Those with the full premium subsidy do not have to pay a monthly premium if they enroll in standard plans with premiums below this benchmark amount.

Note: The following information is available as a chart. See Appendix E, *Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2010)*.

Full Dual-Eligible (Medicare and Full Medicaid) with Income up to 100% FPL

In 2009, 100 percent of the FPL equals \$902.50 per month for an individual and \$1,214.17 per month for a married couple. These beneficiaries do not have to apply for LIS because they are deemed eligible for the program. Full dual-eligible beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark amount must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay any annual deductible
- Pay \$1.10 for generic and preferred brand prescription drugs and \$3.30 for all other drugs on the plan's formulary (2010)
- After beneficiaries in this group reach the out-of-pocket threshold, all prescription drugs on the plan's formulary are free

Full Dual-Eligible (Medicare and Full Medicaid) with Income above 100% FPL

In 2009, 100 percent of FPL equals \$902.50 per month for an individual and \$1,214.17 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. These beneficiaries do not have to apply for LIS because they are deemed eligible for the program. Full dual-eligible beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark amount must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay any annual deductible
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan's formulary (2010)
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold

Income up to 135% FPL

In 2009, this income bracket includes those with monthly income up to \$1,218.38 for a single person and below \$1,639.13 for a married couple. This group generally includes beneficiaries enrolled in the Medicare Savings Programs (MSPs)—including Qualified Medicare Beneficiaries (QMBs), Specified Low-income Beneficiaries (SLMBs), and Qualifying Individuals (QIs). Those in MSPs sometimes are known as partial dual-eligibles. Many of these beneficiaries do not have to apply for LIS because they are deemed eligible for the program. 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.

• Fewer Resources

Beneficiaries in this income group with resources assets less than \$8,100 for an individual or less than \$12,910 for a married couple (2010):

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark amount must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits

- Do not pay any annual deductible
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan's formulary (2010)
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold
- **More Resources**

Beneficiaries in this income group with countable resources (assets) between \$8,100 and \$12,510 for an individual or between \$12,910 and \$25,010 for a married couple (2010):

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Have a \$63 annual deductible (2010), unless their plan has a deductible less than \$63. In that case, they would pay the plan's deductible, which could be as low as \$0
- Pay a coinsurance of 15 percent for each prescription drug on the plan's formulary
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan's formulary, after reaching the out-of-pocket threshold (2010)

Income between 135% FPL and 150% FPL

Beneficiaries whose countable income is between 135 percent and 150 percent of FPL (see chart below) and who have countable resources (assets) of no more than \$12,510 for an individual or \$25,010 for a married couple are eligible for a subsidy (2009). In 2009, this income bracket includes those with monthly income between \$1,218.38 and \$1,353.75 for a single person and between \$1,639.13 and \$1,821.25 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:
 - Those with income between 135 percent and 140 percent FPL receive a premium subsidy of 75 percent of the benchmark premium (see the table on page 43)
 - Those with income between 140 percent and 145 percent FPL receive a premium subsidy of 50 percent of the benchmark premium (see the table on page 43)
 - Those with income between 145 percent and 150 percent FPL receive a premium subsidy of 25 percent of the benchmark premium (see the table on page 43)
- Have a \$63 annual deductible (2010), unless their plan has a deductible less than \$63. They would pay the plan's lower deductible, or \$0 in plans with no deductible

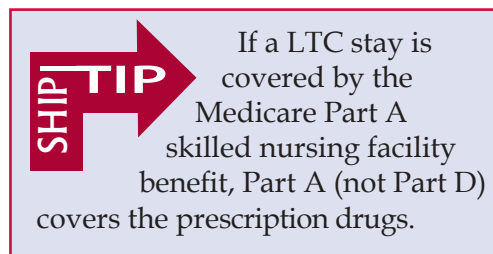
- Pay a coinsurance of 15 percent for each prescription drug on the plan’s formulary
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan’s formulary, after reaching the out-of-pocket threshold (2010)

Monthly Income by Percent of the 2009 FPL

Federal Poverty Level (FPL)	Single	Married
135% to 140% FPL	\$1,218.38 to \$1,263.50	\$1,639.13 to \$1,699.83
140% to 145% FPL	\$1,263.50 to \$1,308.63	\$1,699.83 to \$1,760.54
145% to 150% FPL	\$1,308.63 to \$1,353.75	\$1,760.54 to \$1,821.25

For more information on the levels of the low-income subsidy, see Appendix E, *Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2010)*.

Special LIS rules apply 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 maximum subsidies, and therefore do not incur any out-of-pocket costs for prescription drugs on their plans’ formularies. They do not pay monthly premiums, annual deductibles, or copayments for their prescriptions.



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

APPLYING FOR LOW-INCOME SUBSIDY: WHO NEEDS TO APPLY AND WHO DOES NOT?

Some low-income beneficiaries do not need to apply for LIS (Extra Help) because they are “deemed eligible.” Other low-income beneficiaries **must apply**.

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. 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.

Medicare beneficiaries who are enrolled in one of three Medicare Savings Programs (MSPs) sometimes 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 programs, the state also covers Medicare’s deductibles and coinsurance costs.

SHIP TIP Generally, those who need to apply for the subsidy have incomes above 135 percent of the FPL. Those with incomes below 135 percent are often eligible for a Medicare Savings Program, and therefore are deemed eligible for LIS and do not need to apply.

Medicare beneficiaries who must apply for the extra help are those with limited financial means but who are not a full or partial dual. All beneficiaries who think they may be eligible for the extra help can apply, but only those who meet the income and resource limits will be found eligible.

EXAMPLE *Mary, a retired widow, has an annual income of \$10,000 and resources that amount to \$13,000. Although her resources are just over the limit for the subsidy, her income is 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 Do Beneficiaries Apply?

Those beneficiaries who are not deemed eligible and want to apply for Extra Help must complete an application in order for SSA to make an eligibility determination. Beneficiaries can access the SSA application in four ways:

- Go to the SSA website at <http://www.ssa.gov> and complete the application **online**
- 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 ask a customer service representative to help them complete the application over the phone
- Go to a local SSA office and pick up an application form SSA Form 1020 (see Appendix C)

Once paper applications are complete, they must be mailed to the Social Security Administration. The application comes with a self-addressed, postage-paid envelope.

SSA verifies elements of eligibility (e.g., 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 asks applicants to submit proof of income or resources in limited circumstances. Two examples of such instances are if there are discrepancies between the information on the application and the government records or if applicants report ownership of non-home real property.

Beneficiaries also can go their local Medicaid offices and speak with an eligibility specialist. These offices are required to help beneficiaries complete the SSA application for extra help. The Medicaid office can send the applications in to SSA, or the beneficiaries can mail the application on his own. (The applications come with self-addressed, postage paid envelopes.) While Medicaid offices are required to provide this assistance for beneficiaries, reports indicate most beneficiaries receive help applying for LIS elsewhere.

Who Can Help Beneficiaries Complete the Application?

Three categories of helpers, called personal representatives, may act on behalf of beneficiaries for the purpose of applying for LIS. These include:

- Those asked to help (such as a family member or friend)
- Those authorized by state or other law
- Someone acting responsibly on behalf of an “incapacitated” beneficiary

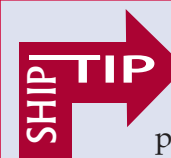
CMS expressly declined to limit “acting responsibly” in any way, stating that it assumes the good intentions of everyone who wants to help get people into the LIS program. Also, SHIP counselors are able to help beneficiaries complete applications.

How Long Does SSA 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.



Beneficiaries need to complete the SSA paper application using a black pen or a No. 2 pencil, or the SSA scanning system is not able to process the application. Also, advise beneficiaries not to write additional information on the application – the automatic system that processes the applications cannot detect it.



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

What Rights Do Beneficiaries Have if Their Subsidy Applications Are 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 LIS. 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* (see Appendix F).

ELIGIBLE FOR LOW-INCOME SUBSIDY: WHAT HAPPENS NEXT

Beneficiaries who qualify for LIS must be enrolled into Part D plans to receive the subsidy. An automatic system processes enrollments for all beneficiaries with LIS (those who are deemed and those who apply) into Part D plans if they do not enroll in plans on their own. This system turns a two-step process (LIS application and Part D enrollment) into one step for those who apply and automatic eligibility and enrollment for those who are deemed. While these systems may not operate flawlessly, they are critical to the success of Part D and LIS. If all beneficiaries had to apply for LIS and subsequently enroll in Part D, it is quite likely that enrollment would be far lower than it is.

Most beneficiaries who are deemed eligible are automatically enrolled into a Part D plan if they do not enroll on their own. They receive a yellow letter (see Appendix G) from CMS notifying them of the auto-enrollment process, unless they have creditable coverage through a retiree plan. If they do have creditable coverage through a retiree plan that is receiving a credit from CMS for their enrollment, these beneficiaries will not be automatically enrolled in a Part D plan. They will receive a white letter explaining this process (see Appendix H).

Note: Remember that CMS enrolls nearly all beneficiaries with LIS into random Part D plans. It is still a good idea to help those with LIS find the most appropriate plans for them. While costs will not vary much from plan to plan, formularies and pharmacy networks will differ. These distinctions may make the assigned plan worth far less than a chosen plan.

Limited Income Newly Eligible Transition (LI NET) Program

The Limited Income Newly Eligible Transition (LI NET) program is administered by Humana and offers those with the low-income subsidy (LIS) immediate, but temporary, access to prescription drug coverage. LI NET provides this coverage for beneficiaries who qualify for Extra Help and go to a pharmacy to have a prescription filled, but are not enrolled in Medicare drug plans.

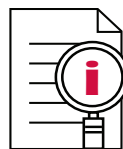
The LI NET program serves three functions:

1. When full dual-eligible beneficiaries have some period of retroactive eligibility with no Part D plan, the LI NET plan through Humana provides retroactive coverage of their prescription drugs. The LI NET program then auto-enrolls these beneficiaries prospectively into a standard Part D plan with a premium below the regional benchmark. Keep in mind that the LI NET auto-enrollment process applies to full benefit dual-eligible

bles and to Medicare beneficiaries and people with SSI who do not have Medicaid but who are entitled to retroactive Part D coverage.

2. All beneficiaries with the low-income subsidy (LIS) who are not enrolled in a Part D plan are eligible to use the LI NET plan for immediate coverage of their prescription drugs at the pharmacy. Beneficiaries must provide evidence of their eligibility for the LIS. Other than the group eligible for LI NET auto-enrollment, all other beneficiaries with LIS will still have access to the existing facilitated enrollment process.

3. Finally, the LI NET program also provides retroactive reimbursement for out-of-pocket expenses paid by beneficiaries with LIS who were not enrolled in a Part D plan at the time of the expenses.



For more information about the LI NET program, see the following publications:

Limited Income Newly Eligible Transition (LI NET) Program, Four Steps for Pharmacy Providers at <http://apps.humana.com/marketing/documents.asp?file=1285050>

Limited Income NET for People at the Pharmacy Counter at <http://www.cms.hhs.gov/partnerships/downloads/11328-P.pdf>

Limited Income NET Program for People with Retroactive Medicaid & SSI Eligibility at <http://www.cms.hhs.gov/partnerships/downloads/11401-P.pdf>

Humana has established a toll-free number for assistance with the LI NET program. This number is 1-800-783-1307.

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 some chemotherapy drugs. Other drugs that are generally excluded from Part D coverage are listed in the section on formularies. Some Part D plans with enhanced benefit designs, however, may provide coverage for some of the drugs in these categories.

A state's Medicaid program may cover some of these excluded drugs or Part D drugs that are not on Medicare drug plan formularies. Some Medicaid programs provide this coverage for full dual-eligible 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 at <http://www.cms.hhs.gov/States/EDC/list.asp>, or check with your state Medicaid agency.

EXAMPLE *Edna is a full dual-eligible 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. The formulary of her PDP does not cover that drug. However, her state's Medicaid program does provide coverage for the drug. Through Medicaid, Edna is able to get the drug she needs and will pay a minimal copayment for it.*

REDETERMINATIONS AND REDEEMING

Agencies reassess eligibility for the LIS on a regular basis. This process involves three agencies: the SSA, CMS, and state Medicaid agencies. The agency that initially determined a beneficiary's eligibility for the LIS is responsible for reassessing her eligibility for the following calendar year.

- **Redetermination:** SSA uses a process called "redetermination" to assess the continued eligibility of LIS recipients who applied for and were found eligible for LIS through the SSA.
- **Redeeming:** CMS reviews the eligibility status of all beneficiaries who were deemed eligible for LIS (in the previous calendar year) because they receive Medicaid benefits (full or partial) or Supplemental Security Income (SSI) benefits.
- **State Medicaid agencies** must redetermine eligibility for any beneficiary who applied for and was found eligible for the LIS through his state Medicaid agency. Note that this, however, is not a common method for LIS eligibility.

SSA Redeterminations

The Social Security Administration (SSA) conducts three types of redeterminations:

- Initial
- Cyclical
- Subsidy changing events (SCE)

The following SSA redetermination processes only pertain to beneficiaries who applied for the LIS (or Extra Help) through the SSA.

- **Initial Redeterminations**

To redetermine eligibility for 2010, the SSA selected a group of beneficiaries who were eligible for Extra Help in 2009 **and** who the SSA believes have experienced a change in their circumstances that may have affected their eligibility for extra help. These beneficiaries receive a redetermination form (see Appendix I) in the mail in September. The form, *Social Security Administration Review of Your Eligibility for Extra Help* (SSA-1026), must be completed and returned within 30 days of receipt, even if nothing has changed. If a beneficiary does not complete and return the form, SSA may terminate his eligibility for Extra Help, effective January 1 of the following year.

- **Cyclical Redeterminations**

Each year the SSA also will select a random group of Extra Help recipients for redetermination to redetermine their eligibility for 2010. These beneficiaries receive a redetermination form in the mail in September. The form is the same form sent to those selected for the initial redetermination (see Appendix I). Beneficiaries must respond to

the form within 30 days of receipt, **even if nothing has changed**. If a beneficiary does not complete and return the form, SSA may terminate their eligibility for Extra Help, effective January 1 of the following year.

- **Subsidy Changing Event (SCE) Redeterminations**

Beneficiaries with LIS who experience subsidy-changing events — including marriage, divorce, separation, annulment, and death of spouse — must report the event to SSA. Upon notification, SSA sends these beneficiaries 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 reflect the change the month after SSA receives the completed form. More information about SCEs is available from the SSA *Program Operations Manual System* or *POMS* at <http://policy.ssa.gov/poms.nsf/links/0603050011>.

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 (see Appendix F) for this process.

More information on the Social Security Administration’s updated redetermination processes and procedures are detailed in the *POMS* at <http://policy.ssa.gov/poms.nsf/links/0603050011>. SSA has also prepared a beneficiary fact sheet with more information, available online at <http://www.ssa.gov/pubs/10111.pdf> (see Appendix J).

Redeeming

Based on data that state Medicaid agencies send to CMS, individuals with Medicare and Medicaid are deemed eligible for the LIS. These beneficiaries automatically qualify for LIS, and therefore, do not need to complete an application. CMS redeems for the following year all individuals who were full or partial duals in or after July of the current year.

Starting each year in July, state Medicaid agencies begin sending transmissions to CMS containing data on all dual-eligible beneficiaries. Individuals whose data is transmitted to CMS automatically are redeemed eligible for LIS for the following year.

If their LIS status has not changed, they will not receive any notice informing them that they will continue to receive Extra Help in the following year. If they remain LIS eligible, but a change in their finances requires a change to their subsidy amount, they will receive an orange letter (see Appendix K) from CMS. The letter explains that although they still qualify for the Extra Help in 2010, their costs will change as of January 1.

Some people who were deemed eligible for LIS in the current year will not be deemed eligible for the following year because they no longer qualify for Medicaid. These beneficiaries receive a grey letter (see Appendix L) from CMS in September. The letter explains that they will not automatically receive Extra Help to pay for their Part D costs effective January 1. The letter explains they can apply for the LIS through the SSA. It also contains an application for the LIS with a postage-paid envelope.

SHIP TIP State Medicaid agencies are required to screen individuals for eligibility for the Medicare Savings Programs (MSPs). Anyone found eligible for a MSP would be deemed eligible for the LIS. The recent MIPPA law requires SSA and states to work together to screen and identify those who might be eligible for MSPs.

Individuals who receive this letter include Medicare beneficiaries who:

- No longer qualify for full Medicaid benefits
- Are no longer eligible for a Medicare Savings Program (MSP)
- No longer receive Supplemental Security Income (SSI) and do not qualify for Medicaid

Anyone who receives the grey letter and subsequently re-qualifies for Medicaid would thereupon be redeemed for the LIS for the following year. More information on the redeeming process is available from CMS at <http://www.cms.hhs.gov/limitedincomeandresources>.

SHIP TIP Beneficiaries who receive grey letters in error but are still full or partial dual-eligible should call their Medicaid offices to correct the mistake as soon as possible.

PART D PLAN REASSIGNMENT BY CMS

In the fall of each year, CMS reassigns certain groups of Medicare beneficiaries who are eligible for LIS into Part D plans for the coming year. Typically, CMS reassigns two groups of Medicare beneficiaries who were deemed eligible for the Extra Help in the past year and will continue to be deemed eligible in the following year:

- Medicare beneficiaries with the full subsidy who stayed in the plan into which they were auto-assigned by CMS, **and** their plan premium for the following year is more than the regional low-income premium subsidy benchmark.
- Medicare beneficiaries with the full subsidy whose plans are leaving the Medicare program in the following year.

Some Part D plans that were LIS benchmark plans in the past year will have a premium above the following year's regional LIS benchmark. As a result, full LIS recipients would be responsible to pay a portion of the plan premium if they remain in such plans. Therefore, CMS reassigns certain LIS-eligible individuals to different Part D plans with premiums that are at or below the regional LIS benchmark for their area. Specifically, CMS reassigns only those full subsidy LIS beneficiaries who accepted their auto-assigned plans.

By early November, reassigned Medicare beneficiaries should receive blue letters from CMS with information about their reassignment. Those who are reassigned because their plan is leaving the Medicare program will receive Version 1 of the blue letter (see Appendix M). Those who are reassigned because their current, assigned plan's premium will be above the next year's regional LIS benchmark will receive Version 2 of the blue letter (see Appendix N).

Notably absent from those reassigned are all full subsidy LIS beneficiaries who enrolled in plans other than the one to which they were auto-assigned. CMS will not reassign these Medicare beneficiaries who were deemed eligible but switched plans. CMS refers to this group of beneficiaries as "choosers." CMS does not reassign one other group of LIS beneficiaries – those with partial LIS subsidy (which includes those with LIS who are charged a deductible).

These beneficiaries, the "choosers," should receive a tan letter (see Appendix O) from CMS by early November informing them that they will owe a portion of the premium if they remain in their plans.

Information from CMS on plan reassignment is available online at <http://www.cms.hhs.gov/limitedincomeandresources>.

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:

- State Pharmaceutical Assistance Programs (SPAPs)
- Private Pharmaceutical Assistance Programs (PAPs)

Beneficiaries must meet certain eligibility criteria to qualify for the benefits offered under these programs. These programs coordinate their benefits with Part D in different ways.

State Pharmaceutical Assistance Programs (SPAPs)

State Pharmaceutical Assistance Programs (SPAPs) provide assistance with prescription drug costs to some beneficiaries with limited financial resources. Eligibility criteria vary from program to program. The MMA allows SPAPs to wrap-around Medicare Part D coverage and fill in coverage gaps for medication that are either:



Tip 1: 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.

Tip 2: 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/07_SPAPs.asp.

Tip 3: An SPAP is always the payer of last resort. In the event of a coverage denial, beneficiaries need to pursue all avenues of getting coverage with the plan before asking the SPAP to pay.

- Not covered by an individual's PDP or MA-PD plan
- Excluded by law
- Cost prohibitive while someone is in the coverage gap ("doughnut hole")

Beneficiaries may still pay a portion of the cost for each of their medications even with Part D and SPAP coverage.

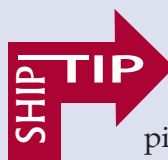
All other forms of drug coverage, including Part D, are primary to coverage provided by an SPAP. That is, an SPAP will only cover medications after any other drug coverage is applied to the cost of that drug. Additionally, payments made by some SPAPs to cover drugs that are on the plan's formulary, but are needed during the coverage gap, count towards TrOOP for the Part D plan. Only payments from qualified SPAPs count towards TrOOP.

The 24 states and territories that offer qualified SPAPs include: Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Massachusetts, Missouri, Montana, Nevada, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Texas, U.S. Virgin Islands, Vermont, Virginia, 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/QualifiedSPAP2.17.09.pdf>.

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 also have 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 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 medication. This process varies from company to company.

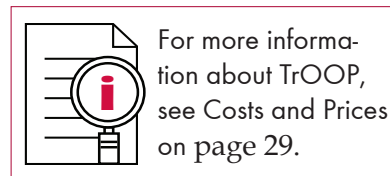
PAPs are not comprehensive insurance plans and therefore are not considered creditable coverage. Some programs may provide only one free sample or supply of a medication; others may provide ongoing assistance. The application process sometimes requires the participation of a physician who will receive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



To streamline the application process, CMS has 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 them free or at low cost. Go to <http://www.medicare.gov/pap/index.asp>.

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 copayment or coinsurance amount to receive a PAP-provided medication, the copayment or coinsurance amount counts towards TrOOP if the medication is on the plan's formulary.



EXAMPLE *Susanna takes Procrit, a very expensive cancer medication. Her Part D plan does cover this as a specialty drug; however, she is now in the coverage gap and cannot afford to pay \$986 for a 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 a \$125 copayment, which will count towards her TrOOP with the plan.*

