



## Medicare Rx Drug Benefit: Navigating Low-Income Assistance

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### Introduction

Under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, all Medicare beneficiaries who have Medicare Part A (Hospital Insurance) or Part B (Medical Insurance for doctor services and outpatient care) will have access to prescription drug benefits. Most individuals will obtain drug coverage through private plans, either a stand-alone prescription drug plan (PDP) offered by an insurance company or through a Medicare Advantage plan with prescription drug coverage (MA-PD) (See Glossary, page 6.)

This report provides basic information for low-income beneficiaries, their families and their advocates about the application process for assistance and enrollment.<sup>1</sup> The May 2005 issue brief from the Alliance for Retired Americans Educational Fund (ARAEF), *Medicare Prescription Drug Benefit: A Guide Through the Maze*, offers guidance for other Medicare beneficiaries eligible for the drug benefit but not the subsidized help.

### Applying for Assistance

The Centers for Medicare & Medicaid Services (CMS), the agency responsible for implementation of MMA, will provide many low-income Medicare recipients with subsidy assistance for their prescription drug costs when the Medicare drug benefit begins on January 1, 2006. The amount of assistance will depend on factors such as their Medicaid status, income and assets, and living arrangement. The classification breakdown and extent of assistance with drug costs are summarized in the chart on page 3.

The low-income subsidy (LIS) helps pay the premiums, deductible, and co-payments for the new drug benefit. It also closes the coverage gap for low-income individuals.<sup>2</sup> Many low-income individuals will have to apply and qualify for the assistance first, then enroll in a plan at a later date. Others will automatically qualify for assistance and will be automatically enrolled. All eligible low-income beneficiaries will receive the subsidy only after enrollment.

<sup>1</sup> The Centers for Medicare & Medicaid Services officials estimate 11 million of the nearly 14 million Medicare beneficiaries eligible for the low-income subsidy will enroll in 2006. The Congressional Budget Office projects 8.7 million.

<sup>2</sup> The “coverage gap” or “doughnut hole” refers to the break in prescription drug coverage when total costs (both the individual’s out-of-pocket drug costs and the costs paid by the drug plan) fall between \$2,251 and \$5,100. It is between these amounts that most beneficiaries have to pay for 100 percent of their drug costs. It is only after reaching \$3,600 in total out-of-pocket expenditures, including the deductible or the \$5,100 catastrophic threshold, that coverage resumes.

## I. Automatic Eligibility and Enrollment

The following beneficiaries do not have to apply for the subsidy because they are “deemed eligible” or automatically entitled (see Glossary).

### Dual Eligibles

Approximately 6.4 million Medicare beneficiaries are termed “dual eligibles,” meaning they have both Medicare and full Medicaid benefits. This group is in a vulnerable position since they will lose the prescription drug coverage that Medicaid currently provides for them. They could pay more in cost-sharing when the Medicare benefit takes effect. Under the MMA, they will pay \$1-2 for a generic and \$3-\$5 for a brand-name drug, depending on their income. Cost-sharing<sup>3</sup> is projected to increase in subsequent years due to drug price inflation.

Dual eligibles will automatically qualify for the assistance; they do not have to apply for it. However, in order to receive the benefit they must enroll in a private plan, either a stand-alone prescription drug plan offered by an insurance company or a Medicare Advantage plan that offers both prescription drug and health coverage. If they do not choose a plan, the CMS will assign them to a prescription drug plan beginning in October 2005. They can switch to another plan at any time even after the benefit takes effect January 1, 2006.

Many nursing home residents fall within the dual eligible category—one in four dual eligibles lives in a nursing home or other long-term care facility.<sup>4</sup> This population is exempt from any cost-sharing. They will pay no premiums, no deductibles, no coinsurance, and no co-payments.

There are special concerns with the “dual” population because they tend to be poorer and sicker than other Medicare recipients. Seven in 10 dual eligibles have incomes below \$10,000. They have higher rates of Alzheimer’s disease, diabetes, pulmonary disease and stroke. Forty percent have disabilities, and nearly four in 10 have a mental or cognitive impairment.<sup>5</sup>

Plans must cover at least two drugs in each therapeutic category and class, but they do not have to cover every drug. Thus, beneficiaries may not have coverage for all of the drugs they require.<sup>6</sup> They will need help determining the best plan to cover most of their drugs and also to find a pharmacy that is part of the plan’s network.

*Example: Ms. Smith is a nursing home resident who is enrolled in both Medicare and Medicaid. Medicaid currently pays for most of her care as well as her prescription drugs. Under the MMA, she is automatically eligible for low-income assistance and will not have to pay anything for her prescription drugs. Medicaid will continue to pay for her other long-term care services but not her prescription drugs. Her sister, Ms. Jones, is also on Medicaid as well as Medicare but lives at home. She will be automatically eligible for the subsidy and automatically enrolled in a prescription drug plan, but she will pay between \$1-2 per prescription for a generic drug and \$3-5 for a brand-name drug. Both may find they do not have coverage for all of the medications they need.*

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<sup>3</sup>Cost-sharing means consumers pay a portion or percentage of the price. Co-payments are a consumer’s payments of a fixed cost per prescription (for example, \$2); co-insurance is payment of a proportion of costs (for example, 25 percent).

<sup>4</sup>Medicare Rights Center. Disenrollment Problems Foreshadow Catastrophic Transition Problems for Medicare Drug Benefit. May 5, 2005.

<sup>5</sup>Medicare Rights Center. Eliminate Asset Tests for the Low-Income Subsidy and Medicare Savings Program. May 19, 2005.

<sup>6</sup>The auto-enrollment by CMS will be random and not based on prescription needs.

## SSI and Medicare Savings Program

Current Supplemental Security Income (SSI) and Medicare Savings Program (MSP) beneficiaries—Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI) – who do not have full Medicaid are also considered “deemed eligible.” (See Glossary). CMS will auto-enroll SSI and MSP beneficiaries who do not choose a plan by May 2006.

*Example: Mr. Johnson is a Medicare beneficiary. He is not on Medicaid but because his annual income is \$9,000, and he has limited resources, his state Medicaid agency pays for his Medicare cost-sharing expenses through the Qualified Medicare Beneficiary Program. He does not have to apply for the subsidy but he should enroll in a plan. If he does not choose a plan, CMS will put him in a plan automatically in May 2006. In 2006, he will pay no premium or deductible for his drug benefit and will have no gap in coverage. He will pay \$2 for a generic drug or \$5 for a brand-name prescription drug.*

**Table 1. Medicare Drug Benefit for Eligible Low-Income Individuals**

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Cost-Sharing	Coverage Gap
<b>Dual Eligibles</b> living in nursing home	None	None	None	None
<b>Other Dual Eligibles</b>	None	None	\$1-2/generic \$3-5/brand no co-pays after \$5,100 total drug costs	None
<b>SSI, MSP and those with income</b> less than 135% federal poverty level (\$12,920/individual in 2005) and <b>assets</b> less than \$6,000/individual; \$9,000/couple	None	None	\$2/generic, \$5/brand no co-pays after \$5,100 total drug costs	None
<b>Income</b> 135%-150% federal poverty level (\$12,920-\$14,355/individual in 2005) and <b>assets</b> less than \$10,000/individual; \$20,000 couple	Sliding scale up to \$35	\$50	15% of total costs up to \$5,100 threshold; \$2/generic, \$5/brand thereafter	None

## II. Eligibility for Other Low-Income Individuals

Low-income individuals who are not deemed eligible may qualify for the low-income subsidy if their incomes are less than 150 percent of the federal poverty level (FPL). Their assets must not be more than \$10,000 for an individual and \$20,000 for a couple. From May through mid-August 2005, they will receive a notice of possible eligibility from the Social Security Administration (SSA).<sup>7</sup> The SSA and state Medicaid offices are responsible for processing eligibility determinations and began taking applications starting in June 2005.

**To qualify for the low-income subsidy, beneficiaries will have to meet both an income and assets test.** Assets include checking and savings accounts, investments, and life insurance; applicants will need to supply this information. Not included are the value of a house, automobile, burial plot, nor household furnishings and possessions. Nearly 14 million non-institutionalized people with Medicare would qualify for the LIS drug benefits on income alone. However, an estimated 2.4 million will not qualify for the subsidy because of the assets test.<sup>8</sup>

**Once approved for the subsidy, individuals must choose and enroll in a plan—they will not be automatically enrolled.** Enrollment is a two-step process separated by several months. Many people may forget to enroll because of a four-month lag between signing up for the subsidy in July 2005 and enrolling in a plan in November.

### For Information and Help with Applying for Low-Income Subsidy

Beneficiaries who may be eligible for a subsidy must apply and provide information about their income and assets. The following agencies will be available to assist with applications. To find the nearest office, consult your local telephone book or go to the web sites listed below.

- Social Security Administration field offices. 1-800-772-1213 (TTY 1-800-325-0778) [www.socialsecurity.gov](http://www.socialsecurity.gov)
- State Medicaid offices. [www.cms.hhs.gov/medicaid/statemap.asp](http://www.cms.hhs.gov/medicaid/statemap.asp)
- State Health Insurance Counseling Programs (SHIPs). [www.shiptalk.org](http://www.shiptalk.org)
- Area Agencies on Aging (AAAs) and local community organizations. [www.shiptalk.org](http://www.shiptalk.org), click on “Find a Counselor,” select location.

*Example: Mr. Brown’s income is \$13,500. His checking and savings accounts about to less than \$10,000 and he has no investments nor life insurance. He receives a notice in May 2005 from the Social Security Administration informing him that he may be eligible for help paying his prescription drug costs. He applies for the subsidy at the local SSA office and learns in July that he is eligible. He doesn’t understand that he must enroll in a plan in mid-November*

<sup>7</sup> See ARAEF May 2005 issue brief, *Medicare Prescription Drug Benefit: A Guide Through the Maze*, for calendar showing the approximate timeline for continuing implementation of the benefit from May 2005 through the enrollment deadline of May 2006.

<sup>8</sup> Kaiser Family Foundation. *Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test*. April 2005.

*and does nothing. In January 2006, he finds out that he does not have drug coverage because he is not in a plan. He may still enroll before the end of the enrollment period on May 15, 2006. When he does, he will pay a monthly sliding scale premium of about \$18.50, an annual \$50 deductible, and 15 percent of his drug costs up to \$5,100.*

**There is an advantage to applying for the subsidy through the state Medicaid agency rather than the SSA office.** State Medicaid programs, unlike SSA offices, must also screen applicants for the Medicare Savings Program. Under MSP, beneficiaries receive help from their state which pays for their Medicare Part B premiums and, in some cases, their Medicare deductibles and co-insurance. Some states also have more generous MSP eligibility criteria than the subsidy criteria. For example, they may not count any resource or they may exclude more income. People who apply through the state Medicaid agency and are found eligible for MSP using the more generous MSP criteria will automatically be eligible for the subsidy, but if they had applied for the subsidy at SSA they might not have been found eligible.

### **Role of States**

Many states operate State Pharmaceutical Assistance Programs (SPAPs) to provide drug coverage to residents with limited income. For certain individuals, SPAPs may complement the new Medicare prescription drug coverage by paying their cost-sharing or providing coverage for some drugs that are not on a plan's formulary. **Those currently receiving assistance with their drug costs from their SPAP should inquire whether or how their state program intends to continue assistance.**

To ease the transition, states have the option to allow dual eligible beneficiaries to fill three months' worth of their prescriptions in December prior to losing their Medicaid coverage. States will also be primarily responsible for educating and counseling recipients.

### **Choosing and Enrolling in a Plan**

Those who are eligible for the subsidy must enroll in a plan to receive the benefit. CMS will auto-enroll those who are "deemed eligible," but others must choose a plan. At press time, there are many unknowns. The identity of plan sponsors and details of their plans such as the formulary or covered drugs, premiums, co-payments and their pharmacy network will not be available to beneficiaries until the fall of 2005.

**When the information becomes available, beneficiaries will have to decide which plan best addresses their medication needs. If LIS beneficiaries cannot find a plan that includes every one of their drugs, they may be unable to pay all the costs for the uncovered drugs.**

### **Conclusion**

The MMA makes monumental changes to Medicare. Private insurers have a major role in providing drug benefits to Medicare beneficiaries, introducing an array of choices. Medicare beneficiaries may find that selecting one of several plans, each with a different formulary and pharmacy network, will be too overwhelming and do nothing.

Low-income beneficiaries are more vulnerable because they are generally more physically and cognitively impaired than other Medicare beneficiaries. Low-income individuals and their families will likely need extensive one-on-one counseling to understand their options for accessing the benefit.

## **Glossary of Key Terms**

**Centers for Medicare & Medicaid Services (CMS).** The federal agency that administers Medicare and Medicaid and is responsible for implementing MMA.

**Deemed Eligible.** CMS determination of those who already qualify for the low-income subsidy and do not need to apply for it.

**Dual Eligibles.** Individuals who are beneficiaries of both the Medicare and Medicaid programs. They receive full Medicaid benefits. Their prescription drugs have been provided through Medicaid.

**Formulary.** List of drugs approved for use or payment—in other words, covered or reimbursable drugs.

**Low-Income Subsidy (LIS) Program.** Assistance with drug costs provided to low-income beneficiaries under the MMA. LIS beneficiaries must meet income and asset criteria and enroll in a plan to receive the LIS benefit.

**Medicaid.** A jointly funded federal-state program providing health coverage for low-income individuals who meet income, asset and categorical eligibility criteria.

**Medicare Advantage (MA, formerly Medicare+Choice).** Part C in the Medicare program allows private companies to offer a managed care health plan to Medicare eligible beneficiaries. MA plans may offer prescription drug coverage through a Medicare Advantage Prescription Drug Plan (MA-PD).

**Medicare Savings Program (MSP).** A part of state Medicaid programs that pays Medicare premiums, and in some cases, Medicare deductibles and coinsurance for three categories of low-income Medicare beneficiaries: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI).

**Qualified Individual (QI).** Individual eligible for Medicare Part A who has income between 120 and 135 percent of poverty and whose resources do not exceed a certain level (twice the level allowed under SSI). With a 100 percent federally matched grant, state Medicaid agencies pay the cost of Medicare Part B premiums. In contrast to the SLMBs, this program is not an entitlement.

**Qualified Medicare Beneficiary (QMB).** An individual eligible for Medicare Part A who has income at or below the federal poverty level and whose resources do not exceed a certain level. States, through their Medicaid agencies, are required to pay the Medicare cost-sharing for these individuals including Medicare premiums, and some or all of the deductibles and co-insurance.

**Specified Low-Income Medicare Beneficiary (SLMB).** An individual eligible for Medicare Part A who has income between 100 and 120 percent of the federal poverty level and whose resources do not exceed a certain level. State Medicaid agencies are required to pay the cost of Medicare Part B premiums for these individuals.

**Supplemental Security Income (SSI).** A federal income support program for low-income disabled, aged, or blind individuals. The maximum federal benefit rate is 27.4 percent below the official poverty level. Eligibility for SSI usually makes a person automatically eligible for Medicaid.

**Stand Alone Prescription Drug Plan (PDP).** Private plans that offer just a drug benefit.

## Alliance for Retired Americans Position on MMA

The Alliance opposed passage of the 2003 Medicare prescription drug law for four major reasons:

- The benefit is not comprehensive—beneficiaries will have to pay high-out-of-pocket costs for the benefit which will increase nearly 80 percent over the first 8 years alone;
- The law does too much to dismantle traditional Medicare in favor of private health plans, which stand to gain billions in government subsidies;
- The law does nothing to control the escalating increases in drug prices and expressly prohibits Medicare from using its buying power to negotiate lower drug costs; and
- There is a possibility that employer-sponsored health benefits more generous than the Medicare drug benefit may end coverage.

*This is the fourth in a series of issue briefs from the Alliance for Retired Americans Educational Fund on issues and programs that should be considered at the White House Conference on Aging scheduled for December 11-14, 2005 in Washington, D.C.*

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