

The Medicare Low Income Drug Subsidy: Strategies to Maximize Participation

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Medicare Rights Center

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I. INTRODUCTION

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established a voluntary, outpatient prescription drug benefit in Medicare to begin on January 1, 2006. In recognition of the importance of prescription drugs to the health and well-being of Medicare beneficiaries, and the inability of many beneficiaries to afford them even under the new benefit, the law provides for substantial financial subsidies for poor and near-poor beneficiaries. For many beneficiaries, these subsidies can mean that their limited budgets are no longer strained between prescription drugs and other basic needs. The subsidies could go a long way in alleviating the human hardship and the lost lives caused by the unaffordability of prescription medicine. But, the record of enrolling eligible beneficiaries in existing Medicare-subsidy programs is poor -- less than one-third of eligible persons nationwide are enrolled.¹ The federal and state governments who administer the low-income drug subsidy program will need to take extraordinary efforts to assure that all those who can benefit from this new opportunity can take advantage of it. Given the critical importance of this benefit to poor beneficiaries, as well as the known barriers to participation in low-income health assistance programs, an unprecedented level of creativity, flexibility, collaboration, and dedication is needed by officials to design a program that is user-friendly and accessible. Fortunately, recent efforts to streamline eligibility and enrollment processes have helped to boost participation in low-income health assistance programs. Within existing law, government officials can employ and build upon these innovative strategies to spur enrollment in the low-income drug subsidy program. This issue brief identifies these promising measures to ease eligibility and enrollment procedures and explains their legal bases under current law. It does not address solutions that require legislation, although this will be required to promote the maximum participation in the low-income subsidy. These administrative strategies will not only prompt participation in the low-income drug subsidy program, but other Medicare subsidies as well.

II. BACKGROUND

In 2006, an estimated 14.2 million older persons and persons with disabilities -- that is 35 percent of the Medicare population -- will qualify for the low-income drug subsidy program (see Figure 1).² These estimates include three distinct groups of Medicare beneficiaries:

- *Beneficiaries with full Medicaid benefits, known as the “dual eligibles.”* Effective January 1, 2006, states will end drug benefits for the some 6.4 million dual eligibles, and they must obtain drug coverage through Medicare.
- *Beneficiaries eligible for Medicare cost-sharing assistance programs, known as the Medicare Savings Programs.* An estimated 1.1 million low-income beneficiaries who do not qualify for full Medicaid receive limited assistance through the Medicare Savings Programs to pay their Medicare premiums and cost-sharing.³ Fewer than one-third of eligible persons are enrolled in these programs.⁴
- *Near-poor beneficiaries.* These individuals have incomes or assets that exceed the limits for full Medicaid and the Medicare Savings Programs. As compared to beneficiaries with greater means, these individuals are less likely to have existing prescription drug coverage⁵ and are less likely able to afford Part D coverage.

As a group, these subsidy-eligible individuals tend to have poorer health and a greater need for medications than other beneficiaries.⁶ The low-income drug subsidy, which provides, on average, from \$1,300 to \$1,400 in assistance with drug costs,⁷ could substantially improve access to medically necessary medications for many of these individuals.

To receive assistance, potentially eligible individuals must both be:

- determined eligible for the subsidy and
- enrolled in a Part D drug plan or Medicare Advantage plan.

Full Medicaid benefit dual eligibles and individuals who are eligible for a Medicare Savings Program will be “deemed” eligible for and automatically enrolled in the low-income subsidy program, obviating the need to apply for benefits. All other individuals must affirmatively apply for the low-income subsidy and prove that their income and assets are low enough to qualify for benefits.

Figure 1: The New Low Income Subsidy Program

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 will subsidize Part D plan premiums and related costs for some low-income Medicare beneficiaries when it commences in 2006.

The low-income subsidy has two basic levels of assistance. Persons with incomes below 135 percent of the Federal Poverty Line (FPL) and assets below \$6,000 for individuals and \$9,000* for couples qualify for the “full subsidy,” paying no premium, no deductible and small co-payments.** Persons with incomes between below 150 percent FPL and assets valued less than \$10,000 for individuals and \$20,000* for couples qualify for a “reduced subsidy,” paying a sliding-scale premium, a \$50 deductible, 15 percent co-insurance up to \$5,100 in total drug spending and small co-payments*** for additional drug expenditures.

* Asset levels will be indexed to inflation.

** Full benefit dual eligibles with incomes below the poverty level will have copayments of \$1/generic;\$3 brand name. These co-payments are indexed to inflation. Other full subsidy recipients will have co-payments of \$2 generic;\$5 brand name. These co-payments are indexed to average per capita Part D spending.

*** Co-payments of \$2 generic/\$5 brand name will apply. These co-payments are indexed to average per capita Part D spending.

III. AUTOMATIC ENROLLMENT

The best way to maximize enrollment in health insurance programs is to automatically enroll as many persons as possible.⁸ Due to automatic enrollment, Medicare Part B has a 95.5 percent participation rate.⁹ Persons automatically receive Part B when they turn 65 and sign up for Social Security unless they decline Part B enrollment.¹⁰ The benefit is still voluntary because persons can opt out. In contrast, national participation in the Medicare Savings Programs is very low in part because persons must affirmatively apply for benefits.¹¹

The MMA and Centers for Medicare and Medicaid Services’ (CMS) proposed regulations deem all full Medicaid enrollees eligible for the low-income benefit, so they will be automatically enrolled in the subsidy program and do not need to apply for this benefit. Further, while most individuals must formally select a plan, full Medicaid benefit dual eligibles who fail to select a Part D plan or enroll in a Medicare Advantage plan with drug coverage on their own will be automatically assigned to a prescription drug plan in their region for which a premium subsidy is available.¹² Persons who have been auto-assigned to a Part D plan can subsequently change plans or opt out of Part D.¹³ As in Part B, the opt-out provision preserves the voluntary nature of the Part D benefit and the low income subsidy.

Experience with enrollment in the Medicare drug discount card program and Transitional Assistance (\$600 credit) demonstrates the value of automatic enrollment. CMS permitted certain states to act as authorized representatives for their state pharmacy assistance recipients and to automatically enroll them in drug discount cards and Transitional Assistance.¹⁴ As of July 2004, it appeared that the vast majority of the roughly million people enrolled in the Medicare drug discount card program and Transitional Assistance were automatically enrolled by their state.¹⁵ Given the success of these efforts, CMS has undertaken efforts to facilitate enrollment in the drug discount program and Transitional Assistance for Medicare Savings Programs enrollees. In October 2004, over one million individuals received a randomly assigned Medicare-approved discount drug card and a letter informing them that they likely qualify for Transitional Assistance and that they should call a toll-free number if they wish to activate the benefit and the card.¹⁶ (It must be noted that data have not yet been disclosed revealing the proportion of people automatically enrolled in Medicare-approved discount cards and Transitional Assistance who have used those benefits.)

Enrollees in Medicare Savings Programs and state pharmacy assistance programs have already been identified by CMS for special treatment. CMS’ proposed rules also deem all Medicare Savings Programs recipients

eligible for the full subsidy, thus eliminating the need for them to directly apply for benefits.¹⁷ Similarly, for eligible state pharmacy assistance recipients, the authority of states was already recognized to automatically qualify recipients for the prescription drug discount cards and Transitional Assistance.¹⁸

Recommendation: The same automatic procedures that pertain to full Medicaid “dual eligible” beneficiaries should be extended to individuals enrolled in the Medicare Savings Programs and state pharmacy assistance programs. As with full-benefit dual eligibles, Medicare Savings Programs and State Pharmacy Assistance beneficiaries who have been automatically assigned to a plan should have the ability to switch plans or opt out of Part D.

IV. TRANSITIONING FROM MEDICAID TO MEDICARE

While automatic enrollment measures are critical to ensure dual eligibles enroll in a Medicare drug plan, the transition from Medicaid to Medicare drug coverage still poses significant hazards for dual eligibles. Critical treatment regimens for vulnerable Medicare beneficiaries will likely be disrupted if persons do not realize their coverage has changed or do not understand the new benefit design, which may differ greatly from their Medicaid coverage. Minimizing harm during drug coverage transitions requires numerous interventions including: (1) repeated notice to enrollees through multiple channels about their change in coverage; (2) education and counseling about the new plan’s benefit formulary and how it will affect access to their medications and customary pharmacy; (3) massive data exchanges among several parties, including states, plans, and pharmacies of eligibility, refill, and prior authorization information; (4) and trouble-shooting help to consumers and pharmacists to resolve computer errors and unexpected system issues. According to MedPAC, an independent federal body that advises Congress on Medicare issues, accomplishing these tasks in private-sector plan transitions takes a minimum of six, and preferably nine months.¹⁹ Transition tasks for dual eligibles will be far more difficult and require more time given the number of persons involved and the increased information, education, and counseling needs of this vulnerable population. Dual eligibles are, on average, significantly poorer, sicker, and less educated; have higher drug utilization; and are far more likely to have cognitive impairments than other Medicare beneficiaries and individuals with employer-sponsored health insurance.²⁰ Yet, current law allows, at most, six weeks to transition 6.4 million dual eligibles from Medicaid to Medicare drug coverage.²¹

To minimize harm to individuals during the transition period, the law permits the adoption of certain safety-net procedures. For example, plans could be required to treat dual eligible individuals as a special population entitled to access an open formulary including all Part D covered drugs. Alternatively, plans could be obligated to “grandfather in” the formularies, prior authorization requirements, and pharmacy-network agreements of Medicaid programs for a period of six months to one year. Further, Medicaid drug coverage could be temporarily extended during the transition period for those individuals whose enrollment in a Part D plan cannot be verified at the point of sale. Ultimately, legislation may be needed to forestall widespread, harmful disruptions in care for dual eligibles.

Recommendation: During the transition from Medicaid to Medicare drug coverage, CMS should adopt stop-gap measures that enable persons to temporarily maintain access to their current medications and customary pharmacy. To minimize catastrophic disruptions in treatment for dual eligibles, plans should be required to offer open formularies to all dual eligibles or to honor Medicaid program formularies and pharmacy networks agreements for a period of six months to one year. Additionally, Medicaid should temporarily continue for individuals whose Part D plan enrollment cannot be verified at the point of sale.

V. COORDINATION ACROSS GOVERNMENT AGENCIES

Under the MMA, the Social Security Administration (SSA) and state Medicaid programs have parallel responsibility for administering the low-income subsidy program.²² This means that SSA and states, with oversight from CMS, have simultaneous authority to develop financial eligibility requirements, application procedures, and renewal and appeals rules for the low income subsidy. The overlapping responsibility for the low-income drug subsidy could lead to unacceptable inequities and confusion within the same state if SSA and Medicaid field offices apply different eligibility rules and application procedures. Inconsistent standards could cause the same individual to be found eligible for benefits at one office but not at another.

Intensive coordination and uniform policies across the various government agencies could help minimize bureaucratic barriers. The law promotes such efforts by SSA and CMS. Notably, the law directs the Secretary of the U.S. Department of Health and Human Services (“the Secretary”) and SSA to “jointly” devise and provide to the states a model, uniform application form and rules for certifying the value of applicant resources.²³ Second, as discussed below, the Secretary has authority to determine how frequently and in which manner states and SSA must renew subsidy determinations.²⁴ Third, the law permits SSA and CMS to jointly devise other uniform policies, including those for financial eligibility and appeals. Finally, standardizing program rules is consistent with Congressional intent to promote participation in the subsidy. The law envisions a simple application process and created multiple application avenues to apply to make enrollment easier.²⁵

Recommendation: SSA and CMS should adopt uniform federal policies governing eligibility, applications, enrollment, renewals, and appeals in a given state.

V. LIBERALIZING THE RULES FOR ASSETS

Income and asset determinations for the low-income subsidy eligibility determinations are based on methods employed by the Supplemental Security Income (SSI) program. But certain liberalizations of these rules are allowed to enable more persons to qualify for the subsidy. In its draft regulations, CMS has already increased the amount of income a person may have to qualify for benefits by considering all related household dependants in income determinations, rather than just the spouse and applicant as required under SSI.²⁶ Similarly, the agency has taken some steps to loosen SSI rules for counting assets. CMS applies a streamlined definition of countable resources, which only considers liquid resources and real property that is not the applicant’s primary residence.²⁷ CMS also eases asset rules by deeming all persons determined eligible for the Medicare Savings Programs eligible for the subsidy, regardless of their income or assets.²⁸ This policy effectively adopts the more liberal Medicare Savings Programs asset rules in some states into the low-income subsidy determinations.²⁹ CMS has not extended this policy, however, to persons with incomes between 135 percent and 150 percent of the federal poverty level who will be eligible for partial subsidies, although the MMA gives CMS this authority, if this policy would not result in “significant differences in persons” who qualify for benefits.³⁰

In addition, existing law permits federal officials to alleviate other rules for considering and counting assets that can be barriers to enrollment and a source of increased determination delays and administrative costs.³¹ Currently the MSP and SSI rules count all but \$1,500 worth of life insurance and burial funds as assets. Most low-income persons have burial funds or life insurance policies below \$10,000.³² An independent analysis concluded that Louisiana saved \$1.5 million per year in administrative costs by raising the amount of life insurance and burial funds excluded – or “disregarded” – from eligibility determination to \$10,000.³³

Recommendations:

- ***The asset definition should specifically exclude the cash value of life insurance policies and burial funds or, at a minimum, be increased to a reasonable amount not less than \$10,000.***
- ***CMS should extend the policy permitting use of a state’s MSP asset rules to apply to persons with incomes between 135-150 percent of poverty.***

VI. STREAMLINING APPLICATION FORMS, ENROLLMENT POLICIES, AND RENEWAL PROCESSES

A. Application Forms and Enrollment Policies

Low-income persons who do not qualify for full Medicaid or the Medicare Savings Programs must first apply for the low-income subsidy and prove that their incomes and assets are sufficiently low to qualify for benefits. However, onerous application and enrollment processes represent a leading barrier to participation in low-income assistance programs.³⁴ In particular, requirements for face-to-face interviews at Medicaid offices and documentation of income and assets can discourage and sometimes prevent eligible Medicare

beneficiaries, especially those with low literacy, limited English-speaking skills, and cognitive impairments, from applying for benefits.³⁵ The need to provide documentation of income and assets is one of the most significant barriers to enrollment in the Medicare Savings Programs.³⁶ Cumbersome application processes also represent administrative challenges by increasing eligibility staff workloads and the cost of processing applications.³⁷ The SSA's draft of the low-income subsidy application form allows individuals to declare their income and assets, without submitting copies of financial statements, but the proposed CMS rules allow states to request these documents from applicants.³⁸

Congress clearly intended that low-income subsidy applications be simplified and the application process be streamlined to maximize enrollment in the benefit. The MMA directs CMS and SSA to create a model "simplified application form and process" that allows for self-certification of income and assets and limits documentation requirements to "copies of recent statements (if any) from financial institutions. . . ."³⁹ Congress also promoted mail-in and electronic applications and discouraged in-person interviews "except when necessary. . . ."⁴⁰ In addition, the MMA requires that low-income subsidy applicants be screened for Medicare Savings Programs eligibility and offered enrollment in these programs.⁴¹ Combining these eligibility processes would increase the efficiency of applying for the Part D subsidy, since applicants can be informed that completing the application may result in drug assistance, cost-sharing assistance for Medicare Parts A and B, and – depending on income and assets – wrap-around services through Medicaid.

Recommendations:

- ***All low-income subsidy applicants, no matter where they apply, should be screened for Medicare Savings Program eligibility and given the opportunity to apply for full Medicaid benefits. To that end, the model low-income subsidy application should be designed to screen applicants for the Medicare Savings Programs as well, while also notifying applicants that they could apply for full Medicaid coverage.***
- ***States should consider all low-income subsidy applicants for Medicare Savings Program eligibility and immediately enroll eligible individuals in the Medicare Savings Program unless the applicant affirmatively opts out of Medicare cost-sharing assistance.***
- ***Persons should only be required to submit income and asset information one time to be considered for and enrolled in all programs for which they may qualify, eliminating the need for persons to complete multiple application processes or to apply at multiple sites. SSA and states should share information, and states should have access to SSA's automated verification system, without the risk of being cited for eligibility error rates if they rely on this verification system instead of requesting documentation from participants.***
- ***The model low-income subsidy application should reflect CMS's proposed streamlined definition of countable assets and be at least as simple as the model MSP application form adopted by CMS and states.⁴² This form is two-pages (double-sided), uses fourteen point font, includes adequate white space to enhance readability, and only asks questions relevant to the eligibility determination .⁴³***
- ***The model application form should be translated into Spanish and other prevalent languages to accommodate persons with limited English proficiency and be available in alternative formats for persons with disabilities .***
- ***The federal government should allow applicants to self-certify the veracity of their financial information on their application forms and should prohibit in-person interview requirements.***

VII. RENEWAL PROCEDURES

Experience with Medicaid and Medicare Savings Programs shows that reenrollment procedures could undermine stable participation in the low-income drug subsidy. If elderly individuals and persons with disabilities must complete quarterly or semi-annual reviews, fill out lengthy forms or even complete mail-in re-enrollment forms, many will not stay on the program.⁴⁴ Losing the subsidy will make Part D unaffordable for many low income Medicare consumers; even if they regain benefits, premium penalties resulting from gaps in creditable coverage may make re-enrolling in Part D too expensive. In any event, most persons with Medicare have fixed incomes and stay eligible for the programs from year to year.⁴⁵ Further, cumbersome

renewal processes increase workload and administrative costs for government agencies. Independent estimates predict that Louisiana will save more than \$1.5 million by streamlining their renewal process for the Medicare Savings Programs, while applying an *ex parte* process that entails an internal staff review would save the state \$2.4 million annually.⁴⁶

The law supports the adoption of uniform, consumer-friendly renewal standards by the federal government. First, the law specifically grants the Secretary the exclusive responsibility to determine the frequency of renewals as long as eligibility determinations do not last more than one year.⁴⁷ Thus, CMS could require that all renewals, whether conducted by states or SSA, be conducted annually. Second, the law permits SSA and CMS to agree upon common streamlined procedures for the renewal process.⁴⁸ At a minimum, simplified renewals should use a pre-printed renewal post card with instructions to return the card only if corrections about their eligibility status are needed.

Finally, although the law allows states and SSA to adopt their own procedures for fair hearings and appeals, these procedures must still adhere to federal case law governing terminations of public benefits. Decisions by a state or SSA to reduce or terminate a subsidy upon renewal must trigger continued coverage at pre-reduction levels pending an appeal. This right derives from U.S. Supreme Court precedent which established the absolute right to a pre-termination hearing pending the loss of welfare or Medicaid benefits.⁴⁹ Benefits must continue pending a hearing given the critical role the low- income subsidy will have in maintaining the recipient's health and well-being.

Recommendations:

- ***Renewals should occur no more frequently than annually, regardless of which entity, the state or SSA, made the initial eligibility determination.***
- ***SSA and CMS should adopt uniform simplified renewal procedures that, at a minimum, use a pre-printed renewal post card with instructions to return the card only if corrections about their eligibility status are needed.***
- ***Benefits must continue at pre-termination levels pending an appeal of an unfavorable renewal decision.***

IX. OUTREACH AND APPLICATION ASSISTANCE

Even if SSA and states adopt simplified application and renewal processes, many persons with Medicare are still likely to fail to apply or complete the low-income subsidy application process. It is critical that persons find out about and enroll in the low- income subsidy within their initial eligibility period (from November 15, 2005 to May 15, 2006 for current Medicare beneficiaries) so that they do not incur penalties when they try to enroll later. Even with low-income assistance, premium penalties may make drug assistance unaffordable for some persons. Persons with incomes from 135 to 150 percent of poverty must pay the full premium penalty for life, which may be one percent of the average premium amount per month. Persons with incomes under 135 percent of poverty must pay 20 percent of the premium penalty for five years.⁵⁰

The leading barrier to enrollment for the Medicare Savings Programs is the lack of knowledge that they exist.⁵¹ Further, even if persons do learn about the programs, many persons with Medicare, especially those who have limited educations, limited English proficiency, or physical or cognitive conditions, need personalized assistance to complete the application form. A recent study commissioned by CMS concludes that personalized assistance is a key factor in getting persons enrolled in the Medicare Savings Programs.⁵² As with the Medicare Savings Programs, a key issue for potential applicants for the low-income drug subsidy will be how the program will affect their eligibility for other public benefits, such as Medicaid eligibility based on a spend-down (e.g., Medically Needy), food stamps, and Section 8 rental assistance.⁵³ In addition, individuals will need personalized help to ensure that they actually receive benefits once they have applied because bureaucratic obstacles and snags tend to arise in Medicare subsidy enrollment processes.⁵⁴

One source of individual assistance that has been shown to be uniquely effective is the State Health Information Programs (SHIPs), providing individualized counseling and personal help to people with

Medicare.⁵⁵ Established community-based organizations and providers are also especially well-equipped to help underserved populations, including persons with limited English proficiency and persons with disabilities, to enroll in programs.⁵⁶ In enacting the MMA, Congress specifically underscored the importance of personalized application assistance by SHIPs and community groups.⁵⁷ Additionally, pharmacists and doctors are often in the position of providing advice and counseling to consumers about their drug coverage. In the private sector, despite education efforts by employers, employees often first learn of benefit changes when they visit their doctor or order a prescription at their pharmacy.⁵⁸ It is likely that pharmacists and physicians will be looked to by individuals to explain Part D options and benefits.

Recommendations:

- ***CMS and SSA should invest in a targeted, language and culture-appropriate information and assistance campaign during summer 2005.***
- ***Substantial additional funding should be granted to SHIPs and community based groups so that they may provide individualized assistance. One-on-one counseling is crucial to ensure persons understand how the low income subsidy may affect their eligibility or benefits under other public benefits.***
- ***Education should be directed to pharmacists, physicians and other health care providers so they have the tools they need to efficiently and accurately advise patients about their drug coverage.***

X. CONCLUSION

The low-income drug subsidy promises much needed assistance with the cost of prescription drugs for low income men and women with Medicare. Nonetheless, the history of the Medicare Savings Programs indicates that the low-income drug subsidy may fail to attract significant participation unless the federal government employs key strategies in designing the program. To encourage widespread enrollment in this extremely valuable program, it is critical for SSA and CMS to work closely behind the scenes and take unprecedented steps to collaborate intensely to devise uniform policies that ensure simple application forms and streamlined enrollment and renewal protocols. Key measures include: simplifying the asset test; screening all low income subsidy applicants for the Medicare Savings Programs as well; requiring yearly renewals that promote multi-year enrollment; adequately funding individualized counseling and assistance and automatically enrolling participants of the Medicare Savings Programs and state pharmacy assistance programs in Part D plans. Finally, to minimize harm to dual eligibles during their transition from Medicaid to Medicare drug coverage, the federal government should apply stop-gap measures to allow them to maintain access to their medications and customary pharmacies during the transition period. Adopting these policies will demonstrate the federal government's ultimate commitment to assisting low income persons with Medicare afford their prescription medications.

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1. Congressional Budget Office (CBO), *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004. These estimates pertain to the Medicare Savings Programs, which subsidize Medicare costs for low-income Medicare consumers.
 2. *Id.*
 3. Brian Bruen and John Holahan, *Shifting the Costs of the Dual Eligibles: Implications for States and the Federal Government* (Washington, Kaiser Commission on Medicaid and the Uninsured, November 2003). The Medicare Savings Programs include the Qualified Medicare Beneficiary (QMB) program, which pays Medicare premiums and cost-sharing for persons with incomes below the poverty level; the Specified Low Income Beneficiary (SLMB) program, which pays Part B premiums for persons with incomes between 100-120 percent of the poverty level; and the Qualifying Individual Program (QI-1), which pays Part B premiums for persons with incomes between 120-135 percent of poverty. The federal asset level for the Medicare Savings Programs is \$4,000 for individuals and \$6,000 for couples.
 4. CBO, July 2004. These estimates exclude individuals who also qualify for full Medicaid benefits.
 5. CBO, *Issues in Designing a Prescription Drug Benefit for Medicare*, October 2002.
 6. See MedPAC, *Report to Congress New Approaches In Medicare*, Chapter Three, June 2004.
 7. CBO, July 2004.
 8. Dahlia K. Remler and Sherry A. Glied, *What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs*, *American Journal of Public Health*, January 2003. [Hereafter *Remler and Glied: What Other Programs Can Teach Us*].
 9. *Id.*
 10. Persons who qualify for Medicare based on a disability are automatically enrolled in Part B when they sign up for

- Medicare after a two-year waiting period.
59. See *Remler and Glied: What Other Programs Can Teach Us*
 60. SSA §§1860D-14(a)(3)(B)(iv); 1860D-1(b)(1)(C); proposed 42 CFR § 423.773(c).
 61. SSA §1860D-1(b)(1)(C).
 62. In some states, the law confers the authority for the state to act as an individual's authorized representative. In the absence of such state laws, states can apply on an individual's behalf if the individual has signed an authorization form for this purpose. Alternatively, states can mail a completed application form to the individual and ask them to sign and return the form to apply. CMS, *Automatic Enrollment of State Pharmacy Assistance Enrollees*.
 63. Health Policy Alternatives, Inc., *Medicare Drug Discount Cards: A Work in Progress*, for the Henry J. Kaiser Family Foundation, July 2004. At the time of this report, neither updated enrollment numbers nor breakdowns on the number of persons who directly enrolled versus who automatically enrolled were available.
 64. See CMS, *Frequently Asked Questions: Medicare Approved-Discount Drug Card Program and Transitional Assistance Program: Assisted Enrollment for Medicare Savings Programs(MSP)Beneficiaries*.
 65. Proposed 42 CFR § 423.773(c).
 66. If the state pharmacy assistance program lacks an asset test, the state may need to review recipients' asset information to discern whether they are eligible for the subsidy.
 67. MedPAC, *Report to Congress: New Approaches in Medicare*, Chapter One, June 2004.
 68. *Id.*, Chapter Three
 69. Medicaid coverage ends on January 1, 2006, but November 15, 2006, the start of Medicare's initial open enrollment season, is the earliest date upon which individuals can be automatically assigned to a Part D.
 70. SSA § 1860-D14(a)(3)(B)(i).
 71. SSA § 1860D-14(a)(3)(E)(ii).
 72. See SSA § 1860D-14(3)(B).
 73. House of Representatives Report 108-391 at 472-73.
 74. Proposed 42 C.F.R. § 423.772. The MMA allows the federal government to define the size of the family unit for purposes of income calculations. Section 1860D-14(a) of the Social Security Act indicates that an applicant's income must be measured against the poverty level "applicable to a family of the size involved. . . ."
 75. Proposed 42 C.F.R. § 423.772. The MMA links the low-income subsidy to SSI law specifying what resources must be excluded in resource determinations. SSA § 1860D-14(a)(3)(D). In simplifying the asset rules, CMS acknowledges that it is not precluded from developing an affirmative list of countable assets for the subsidy that entails more exclusions than permitted under SSI. CMS also argues that narrowing the type of resources considered will ease the application process for consumers and eligibility workers as well as reduce administrative costs by reducing the time and effort required to verify certain kinds of assets. 69 Fed. Reg 46632 at 46726.
 76. Proposed 42 CFR § 423.773(c)(3).
 77. The Medicare Savings Programs employ the SSI methodology for counting resources, but federal law has permitted states to adopt more generous policies than those used by SSI. SSA § 1902(r)(2). Alabama, Arizona, Delaware and Mississippi have eliminated consideration of assets for the MSP altogether. Connecticut and New York disregard consideration of all assets for QI-1. Maine disregards the first \$10,000 of assets for individuals and \$12,000 for couples, while Minnesota excludes the first \$10,000 of assets for individuals and \$18,000 for couples.
 78. SSA § 1860D-14(a)(3)(E)(iv)
 79. Asset rules for low-income subsidy eligibility determinations can be more generous than SSI standards. See Footnote 27, *infra*.
 80. Laura Summer and Lee Thompson, *How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits*, the Commonwealth Fund, May 2004 [Hereafter *Summer Asset Tests*]
 81. Laura Summer, *Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs in Louisiana*, Prepared for State Solutions, August 12, 2004 [Hereafter *Summer Administrative Costs*].
 82. See Susan Haber, et. al, *Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs* (commissioned by the Centers for Medicare and Medicaid Services, October 2003) [Hereafter *Haber Evaluation of QMB*];
 83. Kim Glaun, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs: Case Study Findings* (Washington, Kaiser Commission on Medicaid and the Uninsured, December 2002) [Hereafter *Glaun Medicare Savings Programs*]; *Laura Summer Asset Tests*.
 84. *Haber Evaluation of QMB; Glaun Medicare Savings Program*].
 85. *Summer Asset Tests*
 86. 69 Fed. Reg. 67380 (Nov. 17, 2004) (November 17, 2004 draft SSA low-income application form); proposed 42 C.F.R. § 423.904(d)(3)(i).
 87. SSA §§ 1860 D-14(a)(E)(ii),(iii)
 88. House of Representatives Report 108-391 at 433.
 89. SSA § 1935(a)
 90. <http://www.cms.hhs.gov/dualeligibles/modelapp.pdf>.
 91. The draft SSA application form, issued November 17, 2004 includes questions regarding in-kind income that do not appear on the model MSP application form. 69 Fed. Reg. 67380 (Nov. 17, 2004).
 92. See *Glaun Medicare Savings Programs*; the Kaiser Commission on Medicaid and the Uninsured, *Barriers to Medicaid Enrollment for Low-Income Seniors: Focus Group Findings*, January 2002.
 93. See *Summer Asset Tests*; Susan Haber *Evaluation of QMB*.
 94. *Summer Administrative Costs*.
 95. This reading of section SSA §1860D-14(a)(3)(B)(ii) is compelled if the term "redetermination" as used elsewhere in that section is understood to mean "reconsideration" of an initial determination rather than as "renewal" or "reenrollment." There is precedent for the use of the term "redetermination" to mean "reconsideration" throughout

- other parts of the Medicare program. See SSA §§ 1852 (5)(c)(2)(C); 1869(a)(3); 1893 (f) (2)(A). Furthermore, the language of the Conference Report accompanying the MMA strongly supports a reading of §1860D-14(a)(3)(B) that gives the Secretary the authority to determine the term of the eligibility determination and the Commissioner and the states the authority to determine the “manner” that “redeterminations or appeals” are made. House of Representatives Report 108-391 at 473. Alternatively, if “redetermination” is understood to mean “renewal,” or “reenrollment,” the subsections of §1860D-14(a)(3)(B) are inherently in conflict – giving the Secretary the exclusive authority to determine how long eligibility determinations will be effective in subsection (ii) and then permitting State plans to set the renewal timeframe in subsection (iii) and SSA to set the renewal timeframe in subsection (iv).
96. The law does not restrict SSA and CMS from devising common renewal procedures. The language in SSA § 1860D-14(a)(3)(B) requiring that “redeterminations” be conducted in a manner consistent with state Medicaid plan requirements and as determined by the Social Security Administration procedures most logically refers to fair hearings and appeals.
 97. See *Goldberg v. Kelley*, 397 U.S. 254 (1970); Sarah Rosenbaum, *Grievance and Appeals Procedures: An Analysis of MMA and Proposed Regulations* (Washington, D.C., the Henry J. Kaiser Family Foundation, September 2004).
 98. Individuals will pay the greater of one percent of the base premium amount for every month that they did not have creditable drug coverage for more than 62 days, or an amount set by the Secretary that is “actuarially sound.” SSA § 1860D-13(b). Full subsidy recipients will pay 20 percent of this penalty for five years. SSA § 1860D-14(a)(1)(A)(ii).
 99. See *Haber Evaluation of QMB*.
 100. *Id.*
 101. Other public benefit programs, such as food stamps, Section 8 rental assistance, and Medicaid spend-down programs, deduct for medical expenses when determining income eligibility. The receipt of the low- income subsidy will likely increase individuals’ monthly net income for these programs by reducing their medical expenses. The MMA specified that the receipt of Transitional Assistance would not affect eligibility or assistance under other federal benefits, SSA § 1860D-13(g)(6), but the law does have a similar provision for the low-income drug subsidy.
 102. See *Glaun Medicare Savings Programs; Haber Evaluation of QMB*.
 103. In a 2002 report on the effectiveness of SHIPs, the Health and Human Services Office of Inspector General (HHS OIG) wrote, “The SHIPs are uniquely positioned to provide personal locally-oriented counseling and assistance services with trained counselors who often have similar backgrounds, cultures, and experiences as the beneficiaries they serve.” HHS OIG, February 2002.
 104. For example, in Washington state, community-based organizations and providers have been called upon to provide Medicare Savings Program application assistance to Filipino elders. Local groups knew that Filipino elders needed specific advice about applying for the Medicare Savings Program if they lacked sufficient work history to qualify for premium-free Part A; how their immigration status affected their eligibility; and how Medicare Savings Program enrollment would affect their ability to sponsor over-seas relatives for immigration to the U.S. *Glaun Medicare Savings Programs*
 105. The Conference report states:

[HHS’s] public information campaign should include a program of outreach, information, appropriate mailings, enrollment assistance with and through appropriate state and federal agencies, including state health insurance counseling and assistance programs, in coordination with other federal programs of assistance to low-income individuals, to maximize enrollment of eligible individuals. In addition, special outreach efforts shall be made for disadvantaged and hard-to-reach populations, including targeted efforts in historically underserved populations, and working with low-income assistance sites and a broad array of public, voluntary, and private community organizations serving Medicare beneficiaries. . . .” House of Representatives Report 108-391 at 432-33.
 106. MedPAC, *Report to Congress: New Approaches in Medicare*, Chapter One, June 2004.

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