THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

LOW-INCOME ASSISTANCE UNDER THE MEDICARE DRUG BENEFIT

December 2009

Medicare's 46 million elderly and disabled beneficiaries have access to the Part D drug benefit offered through private plans approved by the federal government (stand-alone prescription drug plans (PDPs) or Medicare Advantage drug plans). The drug benefit includes substantial premium and cost-sharing subsidies for Medicare beneficiaries with low incomes and modest resources, including beneficiaries eligible for full Medicaid benefits (dual eligibles). In 2009, 36 percent (9.6 million) of the nearly 27 million Medicare Part D enrollees are receiving low-income subsidies.

Low-income subsidies (LIS) are intended to reduce or eliminate enrollees' out-of-pocket expenses associated with the drug benefit, including premiums, deductibles, copayments, and costs in the coverage gap (also called the doughnut hole). Part D plans are required to offer a statutorily defined standard benefit or one that is actuarially equivalent, or in the case of MA-PD plans, an enhanced plan that is available for no additional premium. The standard benefit for 2010 has a $310 deductible, then coinsurance of 25 percent up to $2,830 in total drug costs, followed by a gap in coverage between $2.830 and $6,440 where enrollees pay 100 percent of the costs of their drugs. After enrollees have incurred $4,554 in out-of-pocket expenses, they qualify for catastrophic coverage, and pay 5 percent of drug costs.

WHO QUALIFIES FOR LOW-INCOME SUBSIDIES AND WHAT HELP DO THEY GET?

Dual eligibles who typically qualify for Medicaid based on their income and assets are automatically deemed eligible for Medicare prescription drug low-income subsidies. Those who receive premium and/or cost-sharing assistance from Medicaid through the Medicare Savings Programs, or MSP (QMB, SLMB, QI), and those only eligible for SSI cash assistance are also automatically deemed eligible for LIS and need not apply.

Dual eligibles and others deemed eligible for low-income subsidies pay no Part D plan premiums or deductibles, but pay $1.10 or $2.50 for generic drugs and $3.30 or $6.30 for brand-name drugs in 2010, depending on their income (Figure 1). Dual eligibles in nursing homes have no drug copayments under Part D plans.

Other low-income Medicare beneficiaries must meet an income and resource test and submit an application to determine if they qualify for low-income subsidies. Those with income below 150 percent of poverty ($16,245/individual; $21,855/couple in 2009) and limited resources (below $12,510/individual; $25,010/couple in 2009) are also eligible for premium and cost-sharing subsidies. These individuals must apply for subsidies through the Social Security Administration (SSA) or their state Medicaid program. In general, greater premium and cost-sharing assistance is targeted to those with lower incomes and resources.

Figure 1

Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2010

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Individuals with Medicare and Medicaid	$0	$0	$1.10-$2.50/generic $3.30-$6.30/brand-name; no copays after total drug spending reaches $6,440
Individuals with Medicare and Medicaid in nursing homes	$0	$0	No copays
Individuals with income <135% of poverty and resources <$8,100/individual; $12,910/couple	$0	$0	$2.50/generic $6.30/brand-name; no copays after total drug spending reaches $6,440
Individuals with income 135%-150% of poverty and resources <$12,510/individual; $25,010/couple	sliding scale up to $31.94*	$63	15% of total costs up to $6,440; $2.50/generic $6.30/brand-name thereafter

SOURCE: Kaiser Family Foundation summary of Medicare drug benefit low-income subsidies in 2010.
NOTES: 2009 poverty level is $10,830/individual and $14,570/couple. Resources include funeral or burial expenses of $1,500/individual and $3,000/couple. Poverty and resource levels will be updated in early 2010. *$31.94 is the 2010 national average monthly Part D beneficiary premium.

HOW IS ELIGIBILITY DETERMINED?

Eligibility for Part D low-income subsidies is based on income and resources. Social Security benefits, Veterans benefits, pensions, and annuities are counted as income. Eligibility is based solely on the income of the applicant (and spouse, if applicable), regardless of other household members with income. Resource levels used to determine LIS eligibility are higher (more generous) than those used for SSI and Medicaid. Resources are defined as assets that can typically be converted to cash within 20 days, such as stocks, bonds, and checking, savings, and retirement accounts. An applicant's principal home, car, and life insurance policies do not count toward the resource limit. Savings for funeral or burial expenses are permitted ($1,500/individual and $3,000/couple).

HOW MANY ARE RECEIVING LOW-INCOME SUBSIDIES?

According to CMS, 12.5 million Medicare beneficiaries are eligible for low-income assistance under Part D in 2009, of whom 8.1 million (65 percent) are receiving subsidies because they automatically qualify as full dual eligibles or recipients of MSP or SSI (Figure 2). Another 1.5 million beneficiaries (12 percent) receive LIS because they applied and were determined eligible, and 0.5 million are estimated to be eligible but not receiving LIS because they have drug coverage other than Part D (e.g., VA or from a former employer).

According to CMS estimates, 2.3 million low-income Medicare beneficiaries (19 percent) are eligible for low-income subsidies, but not receiving them. A recent survey of seniors found that half of those potentially eligible for low-income subsidies (based on income) but not receiving them were enrolled in a Part D plan (Neuman et. al, 2007). Because eligibility is based on income and resources, some beneficiaries with incomes below 150 percent of poverty do not qualify for additional assistance. According to the SSA, nearly 30 percent of LIS application denials in 2007 were due in part to excess assets.

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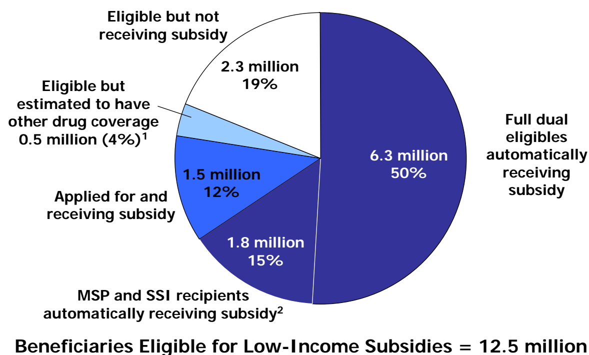
Figure 2

Medicare Drug Benefit Low-Income Subsidy Eligibility and Participation, 2009



Beneficiaries Eligible for Low-Income Subsidies = 12.5 million

SOURCE: Centers for Medicare & Medicaid Services, 2009 Enrollment Information (as of February 1, 2009).
NOTES: [1]Includes Veterans Affairs, Indian Health Service, and Retiree Drug Subsidy (RDS) coverage. [2]MSP is Medicare Savings Program; SSI is Supplemental Security Income.

How Do Beneficiaries Apply for Subsidies?

Beneficiaries who are not automatically eligible for LIS must apply through SSA or their state Medicaid programs. Applications may be submitted in person, by mail or phone, or online through the SSA website. Documenting income or resources is not required. LIS recipients retain eligibility throughout the calendar year in which they qualify.

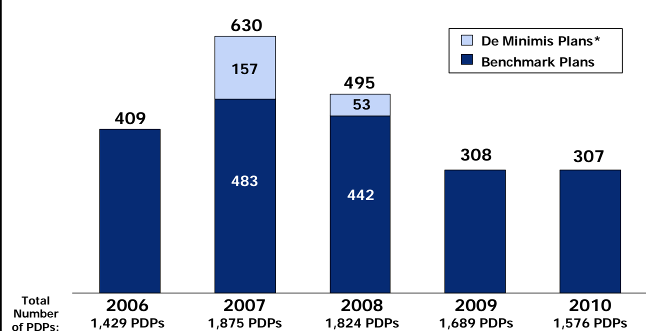
If beneficiaries apply for Part D low-income subsidies through their state Medicaid program, Medicaid must also screen for eligibility for benefits under the Medicare Savings Programs (MSP). Beginning in 2010, SSA will send LIS applicants' information to their state Medicaid program for screening. CMS shares SSA information monthly with state Medicaid agencies on who qualifies for LIS to assist states' efforts screening individuals for Medicaid or MSP benefits.

How Do LIS Recipients Enroll in Part D Plans?

Beneficiaries who apply and are found eligible for low-income subsidies must also enroll in a Medicare drug plan for the subsidies to take effect. CMS facilitates enrollment in stand-alone PDPs for beneficiaries who qualify for LIS but do not sign up for a plan on their own. Although LIS recipients can enroll in any PDP or MA plan, they are only auto-assigned to PDPs.

Figure 3

Number of Medicare Stand-Alone Prescription Drug Plans Available Without a Premium to Low-Income Subsidy Recipients, 2006-2010

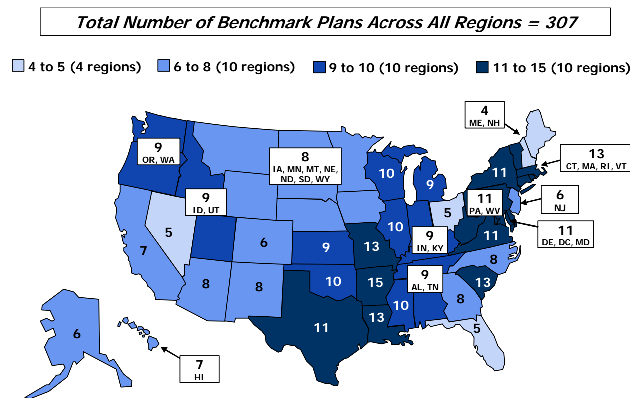


SOURCE: Kaiser Family Foundation analysis of CMS PDP Landscape Source Files, 2006-2010.
NOTE: Excludes PDPs in the territories. *Under a Medicare demonstration, de minimis plans were eligible to retain LIS beneficiaries despite exceeding the benchmark premium by $2 in 2007 and $1 in 2008.

Nineteen percent of all PDPs in 2010 (307 plans) qualify for automatic or facilitated enrollment of low-income subsidy recipients, the lowest number since the inception of the Part D benefit (Figure 3). These "benchmark" plans have monthly premiums below a benchmark amount calculated for each region, enabling LIS beneficiaries to enroll and pay no monthly premium. The number of benchmark plans available in 2010 varies by region, from 4 benchmark PDPs in the Maine/New Hampshire region (out of 43 PDPs) to 15 benchmark PDPs in the Arkansas region (out of 49 PDPs) (Figure 4).

Figure 4

Number of Benchmark Plans, by Region, 2010



SOURCE: Kaiser Family Foundation analysis of CMS PDP Landscape Source Files, 2010.

Because CMS subsidizes up to a specific premium amount for LIS-eligibles, and plan premiums may change each year, CMS reassigns some LIS recipients to different benchmark plans so they can continue to receive drug benefits with no or low premiums, while other LIS recipients must switch on their own or face monthly premiums. In 2010, 1.2 million low-income beneficiaries will be reassigned to a new plan by CMS and 2.2 million must choose a new plan or pay a monthly premium.

Beneficiaries receiving low-income subsidies, including dual eligibles and nursing home residents, are permitted to switch plans throughout the year, unlike other Part D enrollees who generally may switch plans only during the six-week annual coordinated enrollment period at the end of each year (November 15 to December 31).

Future Challenges

The Medicare drug benefit offers substantial help to low-income Medicare beneficiaries, who tend to be sicker than higher-income beneficiaries and therefore use more health care services and prescription medications. Yet nearly one in five low-income Medicare beneficiaries is eligible but not receiving this assistance, and many individuals with low incomes do not qualify because their resources are above the allowable threshold. Identifying eligible beneficiaries and implementing policies that guard against churning from plan to plan are critical to the success of the program.

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