THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Enrolling Low-Income Medicare Beneficiaries in Subsidized Part D Drug Coverage

The MMA includes a number of provisions aimed at making it possible for low-income Medicare beneficiaries to take advantage of the new Medicare prescription drug benefit, including a major new low-income subsidy program. Once enrolled in a Part D plan, people with income below 150 percent of the poverty line with limited assets are eligible for assistance with their Part D cost-sharing obligations. The level of assistance the low-income subsidy program provides will vary depending on an individual's circumstances, but it is particularly generous for people with income below 135 percent of the poverty with limited assets.

For low-income people with both Medicare and Medicaid coverage ("dual eligibles"), the MMA transfers responsibility for their prescription drug coverage from Medicaid to Medicare. To make the Part D coverage more affordable for dual eligibles, they are deemed automatically eligible for a Part D low-income subsidy and, in most cases, provided with lower cost-sharing obligations than other low-income subsidy participants. Since low-income subsidies cannot be used by beneficiaries unless they are enrolled in a Part D plan, the law also calls for autoenrolling dual eligibles in prescription drug plans if they do not sign up on their own.

This handout describes the major statutory and regulatory elements of the MMA related to:

1) Signing dual eligibles up for a Part D plan;

2) Signing other low-income Medicare beneficiaries up for the Part D low-income subsidy program.

1. Enrolling Dual Eligibles in Part D Plans

The MMA transfers responsibility for prescription drug coverage for full benefit dual eligibles from Medicaid to Medicare, ending all Medicaid-financed prescription drug coverage for this group as of January 1, 2006. Since they otherwise are likely to be without coverage, the MMA calls for autoenrolling dual eligibles in Part D plans if they do not sign up on their own. Dual eligibles also are deemed automatically eligible for the new Part D low-income subsidy program. The key provisions of the statute and proposed MMA regulation related to enrolling dual eligibles in Part D plans include the following:

Basic Background on Statute

- Medicaid prescription drug coverage of full benefit dual eligibles ends January 1, 2006.
- Dual eligibles instead are expected to secure Rx coverage through Part D plans.
- For dual eligibles, initial enrollment in Part D is effectively not voluntary. If they do not sign up for on their own, the Secretary of Health and Human Services is required to autoenroll them on a random basis into an average or low-cost plan for which a full premium subsidy is available.
- A dual eligible has the option of disenrolling from a Part D plan once autoassigned or of switching plans.

Key Provisions in Proposed MMA Regulation

- Allows dual eligibles to begin enrolling in Part D plans on November 15, 2005 (the first day of the initial Part D enrollment period that applies to all Medicare beneficiaries)
- Requires autoenrollment of dual eligibles at the end of the initial Part D enrollment period (May 15, 2006) if they have not signed up on their own. (However, discussion is underway about autenrolling dual eligibles earlier to prevent a coverage gap.)
- The preamble raises the possibility that HHS may turn to states to conduct autoenrollment; solicits comments on whether states or the federal government is the appropriate entity for this responsibility
- Otherwise, provides limited information on how autoenrollment will occur
- Establish special enrollment periods for dual eligibles, allowing them to switch Part D plans at any time

Key Questions

1. How long will dual eligibles have to enroll in Part D plans on their own before facing random assignment? What is the risk that they will face gaps in coverage?

Under the proposed regulation, dual eligibles (like other Medicare beneficiaries) will be able to get some information about the Part D plans available to them no later than October 15, 2005. They will be able to actually enroll beginning on November 15, 2005.

The proposed regulations say that dual eligibles will then have until the end of their initial enrollment period -- May 15, 2005 for current Medicare beneficiaries -- to sign up on their own before facing random assignment. However, due to concerns that dual eligibles will be without any drug coverage as of January 1, 2006 unless enrolled in a Part D plan, discussion is underway about autoenrolling dual eligibles earlier.

2. How will dual eligibles find out about the need to enroll in Part D coverage? Will they have enough information to make informed voluntary enrollment choices?

The regulation requires states to send a notice to dual eligibles about the need to voluntarily enroll in a Part D plan or face random assignment, but it is not clear when this notice must be sent or what kind of information it must provide. The preamble also says "a widespread education and information campaign" will provide dual eligibles with information about their options. As with other Medicare beneficiaries, it is unclear exactly what information will be available to help people make enrollment decisions on November 15, 2005 when people can first begin signing up for Part D plans. The preamble indicates that further operational guidance is forthcoming on this topic. It also indicates that CMS plans to rely heavily on an expanded version of its discount card web site to provide people with information on their Part D choices.

3. What if dual eligibles do not enroll voluntarily? How will autoenrollment occur? Will states or the federal government have this responsibility?

The proposed regulations do not clarify who will conduct autoenrollment or how it will occur. The preamble suggests that HHS may delegate this responsibility to the states. If states are given this responsibility, they might receive regular Medicaid administrative matching funds (i.e., 50 percent reimbursement) or be reimbursed through "contractual or other arrangements."

4. What happens if dual eligibles fall though the cracks and are not enrolled in a Part D plan on January 1, 2006?

Neither the statute nor the proposed regulations specifically address what will happen if some dual eligibles end up without any drug coverage during the transition from Medicaid Rx to Medicare Part D. This could occur if people don't enroll voluntarily and autoenrollment does not happen by January 1, 2006 or if people are confused and disenroll from a Part D plan without securing alternative coverage. What are the options for helping people if gaps in coverage occur? State-funded coverage? Other options?

5. What if a dual eligible wants to switch plans?

The regulation provides for special enrollment periods for all dual eligibles under which they can disenroll from one Part D plan and enroll in another one. There appear to be no limits on the number of times a dual eligible can take advantage of a special enrollment period, nor requirements that they do so within a specified time period. It is not clear

how dual eligibles will find out about their option to use special enrollment periods to switch plans.

6. What special provisions are in place to help dual eligibles residing in nursing homes sign up for Part D plans?

The regulation does not specifically address how dual eligibles residing in nursing homes will be helped to sign up for Part D plans. For purposes of applying for the low-income subsidy, nursing home residents can be assisted by an authorized representative, but this language does not currently apply to enrollment in a Part D plan.

2. Enrolling People in the Part D Low-Income Subsidy Program

The Medicare Modernization Act (MMA) establishes a major drug assistance subsidy program for an estimated 14.1 million low-income Medicare beneficiaries. It is designed to make the new prescription drug coverage available under Part D affordable for Medicare beneficiaries with limited income and assets. The level of assistance it provides will vary based on a person's income, assets, and Medicaid status, but for most participants it will dramatically reduce cost-sharing obligations. The MMA statute requires both state Medicaid agencies and Social Security Administration offices to accept applications for the Part D low-income subsidy program, but leaves many other details of the enrollment process unspecified.

The proposed MMA regulations issued on August 3, 2004 provide some information on how HHS is contemplating handling a number of issues raised by the low-income subsidy program. The Social Security Administration also is expected shortly to issue proposed regulations on its role in administering the low-income subsidy.

Basic Background on Statute

- Basic structure of subsidy (see Tables 1 and 2 for details):
    - "Full" subsidy is available to people enrolled in a Part D plan with income below 135% of poverty who can meet an asset test;
    - Reduced subsidy is available to those below 150% of poverty with somewhat higher assets;
    - Special eligibility rules and cost-sharing protections apply to full benefit dual eligibles; Full dual eligibles and SSI recipients are deemed eligible even if they otherwise would not meet the subsidy eligibility rules
    - To be eligible for a subsidy, Medicare beneficiaries must be enrolled in a Part D plan
- The Secretary of HHS has the option to deem all QMBs, SLMBs, and QI-1s eligible for the full low-income subsidy
- Both States and SSA must accept applications and conduct eligibility determinations and re-determinations for the low-income subsidy program
- HHS must develop with SSA a model, simplified application form (and related process) and share it with states
- When people apply for a low-income subsidy at a state Medicaid agency, the state must screen them for eligibility for QMB, SLMB, and QI-1 and, if they are found eligible, offer them enrollment

Key Provisions in Proposed MMA Regulations

- HHS adopted the option to deem all QMBs, SLMBs, and QI-1s as eligible for the full low-income subsidy
- Asset test will consider only "liquid assets" and non-primary residences

- Verification requirements vary based on whether you apply at SSA or a Medicaid agency; if you apply at SSA, the preamble suggests the agency will use automated data matches to verify assets and income, requiring individuals to provide documentation only when necessary
- States required to begin accepting low-income subsidy applications on July 1, 2005
- Allows "personal representatives" to apply for a subsidy on behalf of a beneficiary. "Personal representatives" include someone asked by a beneficiary to act on his or her behalf; someone "authorized" to act on behalf of the beneficiary; or, if the applicant is "incapacitated" or "incompetent," someone "acting responsibly on their behalf."

Also, although not discusses explicitly in the proposed regulation, CMS has indicated that it will encourage states to send low-income subsidy applications to SSA for processing, effectively giving SSA ownership of low-income subsidy applications, redeterminations, and appeal requests.

Key Questions

- Will people know about and try to enroll in the low-income subsidy program? How easy will it be to complete and submit an application? What kind of assistance is available in completing applications, particularly for people with disabilities or other limitations?

- How will the requirement that someone be enrolled in a Part D plan in order to be eligible for a low-income subsidy affect enrollment procedures?

- How will the requirement that state Medicaid agencies screen low-income subsidy applicants for eligibility for the Medicare Savings programs (i.e., QMB, SLMB, and QI-1) be administered? Will beneficiaries have access to a single, unified application process for Part D and Medicare Savings programs? Or, will they have to provide the same information more than once?

- What are the implications of the federal government's plans to encourage states to forward low-income subsidy applications to SSA for processing? Advantages / disadvantages? What happens to the "screen and offer" requirement?

- To what extent will the low-income subsidy eligibility rules and application procedures vary based on whether a beneficiary applies at an SSA office or state Medicaid agency?

- How will the low-income subsidy actually be delivered? HHS will inform plans of who is eligible for the subsidy and plans, in turn, are supposed to reduce cost-sharing obligations. What implementation issues could arise?

Table 1

Additional Help with Prescription Drug Costs For Low-Income People on Medicare (For 2006 Benefits and Cost-Sharing)

Beginning in 2006, Medicare will help pay for outpatient prescription drugs. Medicare will provide additional help to beneficiaries who qualify based on low incomes and limited assets. The information below describes how people with low incomes can be helped in 2006 when the drug benefit goes into effect.

People on Medicare Who Also Have Full Medicaid Benefits (Dual Eligibles) will pay:

- No premium
- No deductible
- Copayments as follows:
    - Nursing home residents: No copayments
    - Individuals below poverty level: $1/generic; $3/brand name drug
    - Individuals above poverty level: $2 per generic; $5/brand name drug
- No copayments after individual spends $3,600 out-of-pocket on their prescription drugs

People on Medicare with Incomes Below 135% of Poverty (about $13,000/individual; 17,000/couple) and Assets Below $6,000 per individual/$9,000 per couple will pay:

- No premium
- No deductible
- Copayments of $2/generic and $5/brand name drug
- No copayments after individual spends $3,600 out-of-pocket on their prescription drugs

People on Medicare with Incomes Below 150% of Poverty (about $14,000/individual; $19,000/couple) and Assets Below $10,000 per individual/$20,000 per couple will pay:

- Sliding-scale premium
- $50 deductible
- 15% coinsurance up to $5,100 in total drug spending (= $3,600 out-of-pocket drug spending)
- Copayments of $2/generic; $5/brand name drug after individual spends $3,600 out-of-pocket on their prescription drugs

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Table 2
Key Elements of Application and Enrollment Procedures for the Low-Income Subsidy[1]

Treatment of Income and Assets

The following rules apply at both SSA offices and state Medicaid agencies

- **Asset test:** Based only on liquid assets (convertible to cash within 20 days) and non-primary residence.
- **Income test***:* SSI income methodologies will be used to determine countable income.
- **Family size/income***:* When determining family size for purposes of establishing the appropriate income threshold, SSA/states will consider the applicant, a spouse, and any dependents who are relatives residing with the family who are financially dependent on the applicant or the applicant's spouse for one-half of their support. The family's income, however, will include only the income of the Medicare beneficiary and, if relevant, a spouse.

Application and Verification Requirements

Application procedures and verification requirements will depend on whether a beneficiary applies at an SSA office or a state Medicaid agency

- **Face-to-face interview:**
  - SSA: According to the preamble, SSA will accept applications over the phone and via the Internet.
  - State Medicaid agency: Unclear. It appears states could require a face-to-face interview.

- **Verification:**
  - SSA: No specific documentation requirements in the regulation; the preamble indicates SSA will use automated data matches for verification of income and assets to the maximum extent possible, with more in-depth verification for a subset of applicants. According to the preamble, applicants generally will not have to document their assets.
  - State Medicaid agency: State discretion to determine verification requirements.

- **Redetermination procedures and appeals**
  - SSA: SSA will specify.
  - State Medicaid agency: Based on the rules that apply under the state's Medicaid program. (The regulation does not address what to do if the state's redetermination procedures vary across Medicaid eligibility categories.)

[1] Based on KCMU's review of the MMA statute and HHS's proposed rule issued on August 3, 2004. The Social Security Administration is expected shortly to issue a proposed rule on its role in administering the low-income subsidy program.