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Overview of Medicare Part D

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Introduction

The Medicare Modernization Act of 2003¹ (“MMA”) represents one of the largest expansions in a public benefits program since the 1960’s. While the legislation has numerous provisions, the most significant for people with disabilities is the creation of a new prescription drug program called Medicare Part D. Prior to this legislation, Medicare only provided drug coverage in limited circumstances. These circumstances included its Part B coverage for individuals with end stage renal disease or that offered by certain Medicare Advantage Plans. Beginning in 2006 however, Medicare will provide prescription drug coverage in several different forms to all individuals who are entitled to Medicare Part A and/or enrolled in Part B.

Unlike other health care entitlement programs, Medicare Part D provides varying levels of prescription drug assistance, depending on an individual’s income level and eligibility for other programs.² For example, an individual who is enrolled in both Medicare and Medicaid will generally pay only a small co-payment for his or her medications. In contrast, an individual with a larger Social Security Disability Insurance (SSDI) check of \$1400 may be responsible for 100% of his or her drug costs during certain periods of the year.

In addition to the varying levels of coverage, Medicare Part D does not utilize one standard drug formulary with one set of rules for accessing medications. Rather, Medicare Part D includes a variety of competing Prescription Drug Plans (PDPs) provided by private insurance companies.³ As such, Medicare Part D offers eligible Medicare beneficiaries many plans to choose from, each with a different drug formulary and different rules. Individuals are asked to choose a plan, or in some cases, a plan is chosen for them. As explained below, individuals should carefully consider several different factors before enrolling a particular drug plan.

For those Medicare beneficiaries considering employment, earned income’s impact on Medicare Part D becomes yet another factor to consider in making an informed decision to return to work. Those Medicare beneficiaries already in the workforce should seek benefits management advice to ensure that they maximize their new Part D coverage. In all cases, Medicare Part D will become a permanent fixture on the landscape of both workforce development and benefits planning.

This brief will assist the BPAO and PABSS Project staff in gaining a working knowledge of these new benefits. It will also provide the framework for adding Medicare Part D implications into the counsel and advice provided to individuals making employment-related decisions. BPAO and PABSS must be able to provide counsel and advice in the following areas:

- Assisting the individual in understanding how his or her drug coverage has changed since Part D began (PART I);
- Assisting the individual in understanding what Part D financial assistance or “extra help” is currently available (PART II);
- Assisting the individual in understanding how employment income will impact the level of financial assistance or “extra help” available under Medicare Part D (Part III);

¹ Medicare Modernization Act of 2003, Pub. L. No. 108-173, § 1860D-14(a)(3)(C)-(D) (2003) [hereinafter MMA].

² 42 C.F.R. §§ 418.3105, 423.773(c), and 418.3001; et seq.

³ Each PDP has its own formulary, though regulations provide requirements and recommendations on the structure and content of formularies. 42 C.F.R. § 423.104.

- Assisting the individual in understanding the interaction of the SSA work incentives and Medicare Part D (Part IV);
- Assisting the individual in understanding how to manage his or her Part D benefits to ensure coverage of needed medications (PART V); and
- Assisting the individual in making an informed choice when enrolling in one of Medicare’s Prescription Drug Plans (Part VI).

PART I

Assisting in the Individual’s Transition from their Current Drug Coverage to a Part D Plan & Helping Him or Her Understand the Transition

Prior to implementation of Medicare Part D, Medicare beneficiaries used several different systems to pay for their prescription drugs. Many individuals, called “dual eligibles,”⁴ were enrolled in both Medicare and Medicaid, and as a result could access their drugs through the Medicaid system. Some individuals accessed medications through a retiree or employer health plan. Others accessed a state system such as a State Pharmaceutical Assistance Program⁵ or the AIDS Drug Assistance Program⁶ for drug coverage. Still others accessed various private discount cards or drug company patient assistance programs.⁷ Because prescription drug coverage was not generally available under Medicare, individuals had to find these other sources to cover their prescription drug costs.

One of the largest changes impacting BPAO and PABSS Medicare consumers is the impact that Medicare Part D has on these other sources of prescription drug coverage. Some of these programs have been eliminated or will be eliminated in 2006. Other programs will limit when or how a Medicare beneficiary can access the program. Still other programs will limit access based on the level of assistance the individual receives from Medicare Part D.

In the first months of 2006, BPAO and PABSS staff may spend a lot of time talking to current and former customers about how their coverage will or has changed. Listed below is a brief description of the changes made to these other sources of prescription coverage in 2006.

Medicaid: Commencing January 1, 2006, individuals entitled to enroll in Medicare Part D will NOT be able to access the full formulary of prescription drugs provided by the Medicaid program. Only those prescription drugs expressly prohibited from coverage by Medicare Part D can be available to Medicare beneficiaries under Medicaid.⁸ These prohibited Medicare Part D drugs include certain categories like barbiturates,⁹ benzodiazepines,¹⁰ and weight gain/loss drugs.¹¹ Each state Medicaid program can choose to cover some or all of the drugs in these excluded categories for Medicare beneficiaries. It is a good idea for BPAO and PABSS Projects to ask their state Medicaid agency which drugs will continue to be covered for Medicare Part D eligible beneficiaries. Medicaid will NOT cover a prescription drug that could be included in a Medicare Part D plan but happens to be missing from the formulary of the plan in which an individual is enrolled. The drug must be specifically excluded from Medicare coverage before Medicaid will pay for it.

⁴ Social Security Act § 1935(c)(6) available at http://www.ssa.gov/OP_Home/ssact/title19/1935.htm.

⁵ State Pharmaceutical Assistance Programs (SPAP) are authorized by state law to provide pharmaceutical coverage or assistance. To be qualified for purposes of the MMA, the program must meet the requirements of 42 C.F.R. § 423.464(e)(1). A list of CMS qualified programs is available at http://63.241.27.78/medicarereform/states/qual_spap_list.pdf as of November 8, 2005.

⁶ These are programs that are authorized under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 Pub.L. No. 101-381 (1990), as amended.

⁷ These are programs run by pharmaceutical companies to offer their medications to low-income individuals. U.S. Department of Health and Human Services, Office of Inspector General (OIG) Bulletin: *Patient Assistance Programs for Medicare Part D Enrollees*, 2005 available at <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2005/PAPAdvisoryBllletinFinal-Final.pdf>.

⁸ MMA, Pub.L. No. 108-173 § 1860D-2(c)(2) and (e)(2), which references Social Security Act, § 1927(d)(2) and 1927(d)(3) for what are excluded drugs available at http://www.ssa.gov/OP_Home/ssact/title19/1927.htm.

⁹ Social Security Act § 1927(d)(2)(I).

¹⁰ *Id.* at 1927(d)(2)(I).

¹¹ *Id.* at 1927(d)(2)(A).

Retiree/Employer Health Insurance: Many Medicare Part D beneficiaries rely on retiree or employer plans (either their own or their spouses) for drug coverage. The interaction of Medicare Part D with these plans is beyond the scope of this brief. However, BPAO and PABSS Projects should be aware that these plans were required to inform their participants of the status as a “creditable” or “non-creditable” plan.¹² If “creditable,” the plan is as good as or better than Medicare Part D coverage.¹³ Individuals in “creditable” plans may want to continue their private coverage and choose NOT to enroll in a Part D plan without being subjected to a late enrollment penalty, as long as they have not gone without that creditable coverage for 63 days or longer.¹⁴ Because some plans may drop individuals who enroll in a Part D plan, individuals who are covered by an employer or union plan should contact the plan to determine the impact enrollment in Part D might have.

State Pharmaceutical Assistance Programs (SPAP): Many states have provided drug coverage to seniors and people with disabilities under a State Pharmaceutical Assistance Program. Under the Medicare Modernization Act, states are given the opportunity to seek approval from the Centers for Medicare and Medicaid Services (CMS) to structure their programs to “wrap around” Part D.¹⁵ By doing this, program costs can be counted toward an individual’s True Out of Pocket Expenses or “TROOP” under Part D. Such a “wrap around” program is now referred to as a qualified SPAP.¹⁶ In response to this requirement, most states have used one of three approaches: created a qualified SPAP, continued their current program uninterrupted, or discontinued their existing SPAP altogether.

AIDS Drug Assistance Programs (ADAP): Every state has an AIDS Drug Assistance Program¹⁷, which provides antiretroviral and certain other medications to individuals living with HIV/AIDS. Like Medicaid, each state ADAP has its own formulary of drugs that it provides as well as its own set of income and other eligibility rules. States have a lot of flexibility in deciding how they will assist Medicare Part D eligible individuals and each state will make its own determination. However, every program must require Medicare Part D eligible individuals to enroll in a Part D plan in order to be eligible for any ADAP benefits. And, no ADAP expenditures can count toward “TROOP.”¹⁸ Some states are considering disenrolling some or all Medicare Part D eligible individuals and other states have decided to “wrap around” Part D benefits to assure continued, uninterrupted coverage.

Drug Company Patient Assistance Programs: Most, if not all, drug manufacturers run Patient Assistance Programs. Eligible Medicare beneficiaries have relied on these programs to access needed medications. With the start of Medicare Part D, drug manufacturers are currently making decisions about eligibility criteria for Medicare Part D beneficiaries. Some drug companies are continuing coverage for Medicare Part D eligible individuals, some are only continuing coverage until May 15, 2005, and others will continue coverage if a person does not enroll in Part D. The U.S. Department of Health and Human Services’ Office of Inspector General has developed guidelines as to what a Patient Assistance Program can and cannot do in order to comply with federal anti-kickback statutes.¹⁹ Individuals will need to contact the program directly to inquire about their eligibility criteria for Medicare Part D beneficiaries.

¹² 42 C.F.R. § 423.56(f).

¹³ 42 C.F.R. § 423.56(a).

¹⁴ *Id.* at § 423.46(a).

¹⁵ *Id.* at § 423.464.

¹⁶ Qualified State Pharmaceutical Assistance Programs, *supra* note 5 and accompanying text.

¹⁷ Ryan White CARE Act, *supra* note 6 and accompanying text.

¹⁸ 70 Fed. Reg. 4240-4241 (2005). *New Medicare Drug Plan: Implications for People Living with HIV/AIDS*, available at <http://www.hab.hrsa.gov/publications/October2005/>.

¹⁹ U.S. Department of Health and Human Services, Office of the Inspector General (OIG) Bulletin: *Patient Assistance Programs for Medicare Part D Enrollees*, *supra* note 7.

²⁰ 20 C.F.R. 418.3101 - 3350.

PART II**Assisting the Individual in Understanding What Level of Part D Financial Assistance or “Extra Help” is Currently Available****The Five Categories of Part D Help**

Unlike Medicaid and many public health care programs, Medicare Part D is not just one standard program for every eligible individual. Rather, assistance with Medicare Part D offers varying levels of benefits depending on what Part D level a person falls into. For some, Medicare Part D will provide a formulary of prescription drugs requiring only a small co-payment for each drug. For others, Medicare Part D will provide a formulary of prescription drugs after payment of a premium, co-payments for each drug, and different levels of co-insurance. The cost of Medicare Part D often depends on a person’s assets and both the type and amount of their income as well as their annual drug expenditures.

Four assistance levels with Medicare Part D costs offer “extra help” to qualified individuals.²⁰ In these categories, individuals are given assistance in paying for Medicare Part D. A fifth category offers individuals the basic Part D coverage. Described more fully below, the five main categories of Medicare Part D eligibility include:

1. Dual Eligibles;²¹
2. Medicare Savings Program Enrollees (QMB, SLMB, QI) or SSI beneficiaries without Medicaid (“Other Deemed Eligibles”);²²
3. Individuals with low-incomes and limited assets who have applied and been determined eligible for the “extra help’s” full subsidy;²³
4. Individuals with low-incomes and limited assets who have applied and been determined eligible for the “extra help’s” partial subsidy;²⁴
5. Individuals that do not qualify for an “extra help” subsidy but are entitled to the basic Part D coverage.

As an initial step, BPAO and/or PABSS staff must determine the category an individual falls into or qualifies for. The BPAO and/or PABSS can then advise the individual on what his or her current Medicare Part D benefit looks like or should look like. In doing this, the BPAO and/or PABSS may be addressing a benefits management issue such as advising the individual on how to apply for “extra help” or a Medicare Savings Program, or how to confirm his or her dual eligibility status.

The determination process for assessing an individual’s assistance group is hierarchical. For purposes of determining the eligibility category, dual eligible status “trumps” all other categories and sits at the top of the selection pyramid. In addition, a Medicare Savings Programs Enrollee or SSI beneficiary without Medicaid status follows secondary and “trumps” all other categories except the dual eligible status. An individual may qualify for many different categories, but the relevant category is always the one that offers the most financial assistance and/or the highest level of automatic eligibility. For example, an individual may be enrolled in QMB and eligible for full extra help if he or she applies. But, if

²¹ Social Security Act, *supra* note 4; 42 C.F.R. § 423.773(c)(1).

²² 42 C.F.R. § 423.773(c)(1).

²³ *Id.* at § 423.773(b).

²⁴ 42 C.F.R. 423.773(d).

that person also meets spenddown and is Medicaid eligible, he or she is a dual eligible. Similarly, if a person applied for extra help and was determined eligible, but then subsequently enrolled in QMB, that person enjoys the QMB status for Medicare Part D purposes.

In advising individuals, BPAO and/or PABSS staff should explain the category that an individual qualifies for and the cost-sharing attributable to that category. The general categories and their benefits are set out in this chart and explained more fully below.²⁵

	Full Subsidy	Partial Subsidy
Dual Eligibles (eligible for both Medicare & Medicaid)	<ul style="list-style-type: none"> ▪ Deemed Eligible (No need to apply for extra help and will be automatically enrolled in Prescription Drug Plan (PDP) with opportunity to change monthly) ▪ No Deductible ▪ No Premium for Basic Plan ▪ No Doughnut Hole ▪ \$1-\$3 Co-Pay (\$2-\$5 Co-Pay if income is above 100% FPL or \$0 Co-Pay if living in an institution) ▪ No cost-sharing above out-of-pocket threshold* 	N/A
QMB, SLMB, QI, SSI without Medicaid QMB - 100% FPL SLMB - 120% FPL QI - 135% FPL (state variation in countable income and assets)	<ul style="list-style-type: none"> ▪ Deemed Eligible (No need to apply for extra help but should still choose to enroll in a PDP or be automatically enrolled in May 2006) ▪ No Deductible ▪ No Premium for Basic Plan ▪ No Doughnut Hole ▪ \$2-\$5 Co-Pay ▪ No cost-sharing above out-of-pocket threshold* 	N/A

²⁵ 42 C.F.R. 423.780(a)-(d) (premium subsidy); 42 C.F.R. § 423.782(a) - (b) (cost sharing subsidy).

<p>Countable Income up to 135% of Federal Poverty Level</p> <p>Assets \$6000 <Individual \$9000 <Couple</p>	<ul style="list-style-type: none"> ▪ Must Apply ▪ No Deductible ▪ No Premium for Basic Plan ▪ No Doughnut Hole ▪ \$2-\$5 Co-Pay ▪ No cost-sharing above out-of-pocket threshold* 	<p>N/A</p>
<p>Countable Income up to 150% of Federal Poverty Level</p> <p>Assets \$10,000 <Individual \$20,000 <Couple</p>	<p>N/A</p>	<ul style="list-style-type: none"> ▪ Sliding Scale Premium ▪ \$50 Deductible ▪ No Doughnut Hole ▪ 15% Co-Insurance ▪ \$2 -\$5 Co-Pay or 5% co-insurance above out of pocket threshold, whichever is higher*

*Costs used to meet out of pocket threshold include what the individual pays and what Medicare pays as the “extra help.”

Standard Medicare Part D Eligible

The Medicare Modernization Act outlines the parameters of the standard benefit.²⁶ Plans do not have to follow the exact parameters set up by the Act, but are required to provide at least the actuarial equivalent of these standard parameters.²⁷ Of course plans may also choose to provide more than the standard benefit.

The standard Medicare Part D coverage contains certain costs that must usually be borne by the individual. Individuals who were not Medicaid-enrolled at the relevant time or whose incomes and assets exceed the “extra help” limits are eligible for the standard benefit. Under the standard benefit in 2006, individual’s cost can include:

- A premium of any amount;
- A deductible of up to \$250;²⁸
- After meeting the deductible, up to a 25% cost-share until total drug costs reach \$2250;²⁹
- Up to a 100% cost share after spending \$2250 in total drug costs until the individual’s true out of pocket costs reach \$3600 (which, in many cases, will mean \$5100 in total drug costs);³⁰ and
- The greater of either a \$2 co-pay for generics and \$5 co-pay for brands or a 5% co-insurance, after the individual’s true out of pocket costs reach \$3600 (catastrophic coverage).³¹

The key to understanding when a person reaches any of these phases of cost sharing is to track the individual’s true out of pocket expenses, or TROOP. The TROOP is calculated by adding those expenses paid by: the individual, a relative or friend, a charity, a qualified State Pharmaceutical Assistance Program, or what Medicare pays as the “extra help.”³² A person does not reach catastrophic coverage, the final phase, until the TROOP expenses meet \$3600, no matter what the plan’s cost sharing is at any other point.³³

²⁶ 42 C.F.R. § 423.104(d).

²⁷ *Id.* at § 423.104(d)(5)(B)(ii).

²⁸ *Id.* at § 423.104(d)(1).

²⁹ *Id.* at § 423.104(d)(2).

³⁰ *Id.* at § 423.104(d)(3).

³¹ *Id.* at § 423.104(d)(5).

³² *Id.* at § 423.100..

³³ This is defined as annual out-of-pocket threshold, 42 C.F.R. 104(b)(5)(iii).

For the most part, Medicare Part D PDPs in 2006 follow the standard format set out by the Medicare Modernization Act, with some variation. Nationally, premiums range from \$1.87 - \$104.89 per month. Deductibles range from \$0 to \$250. Cost sharing after the deductible is somewhere around 25% and is usually lower if the deductible is higher. During the 100% cost sharing phase, a few plans will cover generic drugs and even fewer offer coverage for both generics and brand name drugs. Plans generally follow the \$2/\$5 or 5% cost sharing at the catastrophic coverage phase.

Dual Eligible

I. Definition of a Dual Eligible³⁴

A dual eligible individual is a person who:

- A. At a relevant point in time, was enrolled in Medicaid and/or is currently enrolled in Medicaid; and
- B. Is currently entitled to Medicare Part A and/or enrolled in Part B.

Dual eligible individuals include those “enrolled in Medicaid” by meeting a spenddown or deductible, or those enrolled in Medicaid Buy-In Programs. It does not include those individuals who never met their spenddown or deductible within the relevant time period.³⁵

In order to determine an individual’s dual eligible status in 2006, the two most important factors are if and when he or she received Medicaid. Leading up to the commencement of Medicare Part D, individuals on Medicare were placed in dual eligible status if they were enrolled in Medicaid sometime in the period of May or June-December of 2005. So, an individual who met his or her spenddown or deductible once, in July 2005, would attain the dual eligible status for 2006.³⁶ In addition, Medicare Part D eligible individuals who enroll in Medicaid in 2006 will attain dual eligible status for the remainder of 2006 if they did not already have that status from Medicaid enrollment during the relevant time in 2005. Once an individual attains dual eligible status, that status remains for the entire year, regardless of any loss of Medicaid eligibility after the dual eligible status is attained.³⁷

In order to determine dual eligible status in 2007 and subsequent years, the Centers for Medicare and Medicaid Services (CMS) will request Medicaid enrollee information from the states at a certain point during the prior year. For 2007 dual eligible status determinations, CMS will use state data received from July 2006 through December 2006. So, in order to maintain or gain dual eligible status in 2007, an individual will have to be listed in this state data. Or, he or she can gain dual eligible status by enrollment in Medicaid sometime in 2007 and this dual eligible status will then continue from that point forward.³⁸

Because of the 24 month waiting period for Medicare eligibility,³⁹ some BPAO/PABSS customers will meet the requirements of (B) above some time in the future. In order for these individuals to be considered dual eligibles when they enroll in Medicare, they must be enrolled in Medicaid on the first day of the month the individual is eligible for Part D.⁴⁰

³⁴ Social Security Act, *supra* note 4.

³⁵ *Id.*

³⁶ Some states began sharing lists in May and others in June.

³⁷ 42 C.F.R. § 423.774(b).

³⁸ 70 Fed. Reg. 4376 (2005).

³⁹ 42 U.S.C. §§ 406.12(a) and 407.10(a)(1).

⁴⁰ 42 C.F.R. § 423.34(f)(2).

II. Assistance in Paying for Prescription Drugs for Dual Eligible Individuals

Dual eligible individuals receive full “extra help” in paying their cost sharing obligations under the Medicare Part D plans.⁴¹ In 2006, they will pay \$1 for generics and \$3 for brand name drugs on the PDP formulary if their income is 100% of the Federal Poverty Level (\$9800 per year in 2006 for a household of one) or below.⁴² If their income is above 100% of the Federal Poverty Level, they will pay \$2 for generics and \$5 for brand name drugs on the PDP formulary.⁴³ After reaching \$3,600 out-of-pocket threshold (2006), the individual will no longer need to make co-pays.⁴⁴

Dual eligible individuals are also eligible to receive assistance in paying their premiums.⁴⁵ This includes payment of the entire premium for any basic plan offered by a PDP, as long as that premium is below the benchmark premium for their region.⁴⁶ If a beneficiary chooses to enroll in a PDP’s enhanced plan, the individual will only receive assistance up to the amount of that PDP’s basic plan and up to the benchmark premium in that PDP region.⁴⁷ For example, a particular PDP offers three plans: Basic at \$14, Enhanced at \$29, and Premium at \$35. If a dual eligible signs up for the Enhanced plan at \$29, he or she will only receive \$14 in premium assistance and will need to pay the difference of \$15 each month.⁴⁸

Cautionary Note: Under current Medicaid rules, pharmacies are required to dispense a prescription drug even if the individual cannot pay the co-payment.⁴⁹ The Medicare Part D program does not follow this rule, but “pharmacies are permitted to waive or reduce cost-sharing amounts provided they do so in an unadvertised, non-routine manner after determining that the beneficiary is financially needy” or fails to pay the required copay.⁵⁰

III. Automatic Enrollment into Both “Extra Help” and a Part D PDP for Dual Eligibles

Dual Eligible individuals do not have to apply to receive full “extra help.”⁵¹ Rather, these individuals automatically qualify for this financial assistance. Each state Medicaid agency is required to maintain a list of individuals enrolled in their Medicaid program, including those enrolled in a Medicaid Buy-In program. This list is shared on an on-going basis with the Centers for Medicare and Medicaid Services (CMS). Those on this list are given “dual eligible” status for the relevant year, including its requisite cost sharing assistance, without any action on the part of the beneficiary.⁵²

Dual eligible individuals are also automatically enrolled into a PDP.⁵³ For those individuals who became dual eligibles as a result of Medicaid enrollment in 2005, the auto-enrollment into a PDP should have occurred starting in November of 2005, with an effective date of January 1, 2006. For individuals who are eligible for Medicare Part D first and later enrolled in Medicaid, the auto-enrollment into a plan will be effective on the first day of month after of Medicaid eligibility or January 1, 2006, whichever is later.⁵⁴ However, if the individual is already enrolled in a Medicare Part D plan, there will be no new PDP assignment.⁵⁵ The person will only be deemed eligible for the full “extra help” benefit. Finally, for those individuals who are Medicaid eligible first and then become Medicare Part D eligible, the auto-enrollment will be effective on the first day of Medicare Part D eligibility.⁵⁶ Auto-enrollment may be retroactive to the earliest date of dual status but not earlier than January 1, 2006.

⁴¹ *Id.* at § 423.782(a).

⁴² *Id.* at § 423.782(a)(2)(iii)(A).

⁴³ *Id.* at § 423.782(b)(3).

⁴⁴ *Id.* at § 423.782(a)(2)(iii)(B)(3).

⁴⁵ *Id.* at § 423.780(a).

⁴⁶ *Id.* at § 423.780(b)(ii).

⁴⁷ *Id.* This is a premium subsidy and therefore eligible individuals are entitled to this subsidy up to but not greater than the premium paid. *Id.*

⁴⁸ Centers for Medicare and Medicaid Services, *The Extra Help for the Basic Premium*, available at <http://www.cms.hhs.gov/states/downloads/BasicPremiumFactSheet.pdf>.

⁴⁹ 42 C.F.R. § 447.15.

⁵⁰ 70 Fed. Reg. 4240 (2005).

⁵¹ 20 C.F.R. § 418.3105.

⁵² The subsidy of all who meet the requirements of deemed eligible under 42 C.F.R. § 423.773(c) is effective with the first month they have deemed eligibility status. 20 C.F.R. § 418.3105.

⁵³ 42 C.F.R. § 423.34(d).

⁵⁴ Centers for Medicare and Medicaid Services, *Update Guidance-Changes to Effective Date and PDP Notice Requirements for Auto-Enrollment and Facilitated Enrollment*, (March 17, 2006) [hereinafter CMS Update Guidance].

⁵⁵ However, as a full benefit dual eligible he or she will have a special enrollment period enabling them to change plans each month. 42 C.F.R. § 423.38(c)(4).

⁵⁶ 42 C.F.R. § 423.34(f)(3); Centers for Medicare and Medicaid Services, *PDP Guidance Eligibility, Enrollment and Disenrollment*, Center for Medicare and Medicaid Services, http://www.cms.hhs.gov/pdps/PDP_enrollmentguidance+exhibit_final_8-29-05.pdf.

CMS has recognized that this auto-enrollment process may not always work as intended. As with implementation of any large-scale changes, individuals who should be auto-enrolled because of dual eligible status may be missed. In order to correct this, CMS has created a “stop gap” system for 2006.⁵⁷ If a dual eligible arrives at a pharmacy and has not been auto-enrolled into a plan, the pharmacist does have the ability to enroll them into a national Wellpoint PDP plan in order to disburse their needed medications at that time.⁵⁸ In order to qualify for this special procedure, some proof of Medicaid and Medicare eligibility must be shown.⁵⁹ This includes a current Medicaid card or a history of accessing prescription drugs at that pharmacy through Medicaid. If it is later discovered that the person was not a dual eligible, they will be responsible for paying back any co-payment or cost sharing amounts that were not charged.⁶⁰

Medicare Savings Enrollees (QMB, SLMB, QI) and SSI Beneficiaries Without Medicaid (“Other Deemed Eligibles”)

I. Medicare Savings Programs Enrollees⁶¹

State Medicaid agencies provide assistance with the cost sharing under Medicare Part A and B to some individuals. These programs are known as Medicare Savings Programs. There are three Medicare Savings Programs: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual QI. QMB pays for the Medicare premiums, co-payments and deductibles for Medicare Parts A and B. SLMB and QI pay for the Medicare Part B premium only. The asset eligibility for the three programs varies from state to state, but most states require asset limits of up to \$4000 for an individual and \$6000 for a couple. The income limits for each program are: 100% of the Federal Poverty Level for QMB, 125% of the Federal Poverty Level for SLMB, and 135% of the Federal Poverty Level and not eligible for Medicaid for QI.

II. SSI Beneficiaries Without Medicaid⁶²

In most states, eligibility for SSI automatically qualifies and enrolls the individual in Medicaid. However, this is not the case in 209(b) states. In these states, individuals receiving SSI are not automatically enrolled into Medicaid and may have eligibility requirements different than those of SSI. Therefore, some beneficiaries in these states may be receiving SSI and Medicare but no Medicaid. SSI recipients without Medicaid are reported to CMS by SSA.

III. Assistance in Paying for Drugs Under Part D for Other Deemed Enrollees

Like dual eligibles, QMB, SLMB, QI and SSI beneficiaries without Medicaid receive the full “extra help” subsidy in paying for the prescription drugs on a Medicare Part D plan’s formulary.⁶³ This means that they do not have to pay the plan’s basic cost sharing and receive the same premium assistance as dual eligibles. They do not pay a deductible, and for a \$2 generic and \$5 co-pay, they can purchase the prescription drugs included in the formulary of their PDP.⁶⁴ After reaching \$3600 in true out-of-pocket threshold (in 2006), the individual can access prescription drugs on the PDP formulary for \$0.

⁵⁷ Centers for Medicare and Medicaid Services, *Point-of-Sale Facilitated Enrollment of Dual Beneficiaries: Process Center Outline*, available at <http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/POSFacilitatedEnrollmentWeb.pdf>.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ 20 C.F.R. § 418.3105; 42 C.F.R. § 423.773(c).

⁶² *Id.*

⁶³ *Id.*

⁶⁴ The same rule for collection of co-payments applies to other deemed eligibles. See *supra* text accompanying note 50. 70 Fed. Reg. 4240 (2005).

IV. Automatic Enrollment into “Extra Help” and Facilitated Enrollment into a Part D PDP

Individuals in this category are automatically qualified for the full “extra help” benefits and are enrolled through a process similar to the one used for dual eligibles. These individuals will also be assigned to a PDP, but that assignment occurs only if the individual has not enrolled into a PDP by April 30, 2006. Individuals will begin to receive notice of their automatic assignment, effective May 1, 2006 in late March or early April of 2006. This is called a “facilitated enrollment.”

Low-Income Beneficiaries Who Must Apply for “Extra Help”

Individuals with low-income and assets who do not automatically qualify for “extra help” can still apply for the assistance. For those who must apply, there are two levels of “extra help” available: full “extra help” and partial “extra help.” The level of assistance the individual receives depends on their countable income and assets.⁶⁵

The Social Security Administration is charged with accepting and processing these applications.⁶⁶ Applications can also be submitted to state Medicaid offices, completed on-line, or mailed into the Social Security Administration.⁶⁷ Individuals who need assistance completing the application may call 1-800-Medicare (1-800-772-1213) or watch for one of several community events held by the Social Security Administration where applications are being accepted. So far, application processing varies. Experiences in the field indicate that the decision process is faster if the application is submitted on-line or through one of the community events.

I. Low-Income Beneficiaries with Full “Extra Help”

Individuals are entitled to full “extra help” if their countable income is less than 135% of the Federal Poverty Level and their assets are below \$6000 for an individual and \$9000 for a couple.⁶⁸ In determining countable income and resources, most SSI rules are utilized; these rules are explained more fully below.⁶⁹ Therefore, individuals with earned income can have a total income much higher than 135% of the Federal Poverty Level because over half of their earned income will not count. Since most widely distributed materials on Medicare Part D do not fully explain how earned income is treated, the BPAO/PABSS Projects have a particularly important role in explaining this distinction to working individuals

Full “extra help” individuals enjoy the same cost sharing arrangement as the QMB, SLMB, QI and SSI beneficiaries without Medicaid. These individuals receive the full premium assistance for basic plans and some premium assistance for enhanced plans.⁷⁰ They do not pay a deductible, and they pay \$2 or \$5 co-payments for prescription drugs on their PDP’s formulary. After reaching the \$3600 out-of-pocket threshold (in 2006), the co-payment reverts to \$0.

Individuals with full “extra help” will be enrolled into a PDP plan effective May 1, 2006 if they do not voluntarily enroll in a plan by April 30, 2006.⁷¹

⁶⁵ 20 C.F.R. § 418.3101.

⁶⁶ *Id.* at § 418.3005; Social Security Administration, *Program Operating System Section HI 03001.001* [hereinafter POMS].

⁶⁷ See Centers for Medicare and Medicaid Services, *Guidance to States on the Low-Income Subsidy*, Sec. 10.3.1, (May 25, 2005) available at <http://www.new.cms.hhs.gov/States/Downloads/GuidanceToStateonLimited-IncomeSubsidy.pdf>.

⁶⁸ POMS Section HI 03001.001(D); 42 C.F.R. § 423.773(b).

⁶⁹ MMA 1860D-14(a)(3)(C)-(D).

⁷⁰ 42 C.F.R. § 423.780(d).

⁷¹ CMS Update Guidance, *supra* note 54.

II. Low-Income Beneficiaries with Partial “Extra Help”

Individuals will be determined eligible for the partial “extra help” subsidy if their countable income is less than 150% of the Federal Poverty Level and their assets are less than \$10,000 for an individual and \$20,000 for a couple.⁷² As the name suggests, individuals in this category have greater cost sharing under Medicare Part D than the other “extra help” categories. Again, it is important to remember that not all of a person’s actual income is counted in determining eligibility and over one-half of earned income will be excluded.

Partial “extra help” individuals will receive some assistance in paying for the Part D benefit. Individuals will receive sliding scale assistance with premiums, which means that they may be responsible for at least a portion of the premium payment.⁷³ They will pay a reduced deductible of up to \$50. Then, individuals pay a 15% co-insurance until reaching the \$3600 out-of-pocket threshold (in 2006). After this, the individual pays the greater of a \$2 co-payment for generics and a \$5 co-payment for brand names, or 5% in co-insurance.⁷⁴

Individuals with partial “extra help” will be enrolled into a PDP plan effective May 1, 2006 if they do not voluntarily enroll in a plan during the initial enrollment period ending April 30, 2006.⁷⁵

III. Countable Income

In general, the income determination for “extra help” eligibility follows the income rules for counting income in the SSI program. So, in analyzing an individual’s eligibility for “extra help,” BPAO/ PABSS staff will be utilizing familiar SSI income rules to determine countable income for SSDI individuals. There are some differences however, so it is always important to refer to the Program Operating Manual Section pertaining to Medicare Part D (HI 030: Eligibility for Medicare Prescription Drug Coverage) and not those of the SSI Program.

A. Determining Family Size and Whose Income Counts

One of the main differences between the SSI program and the Medicare Part D program is that Medicare Part D does NOT use Social Security’s deeming rules. This means that all of the income of the spouse is included. A parent’s income would not be included in the calculation unless the contributions of a parent were applicable under the Medicare Part D in-kind support and maintenance rule. How this works in practice is explained more fully below.

Because SSA bases eligibility on percentages of the Federal Poverty Level, it is important to determine who is included as a member of a household and whose income is counted in the household’s total. Under Medicare Part D rules, a household consists of the individual, his or her spouse if living together, and any persons who are related by blood, marriage or adoption, who are living with the applicant and his or her spouse and who are dependent on the applicant or their spouse for at least one half of their financial support.⁷⁶ Therefore, if an individual is married with one child living at home who is in school, eligibility for “extra help” is determined as a three person household. However, only the income of the individual and spouse are considered. Income of a dependent is not factored into the eligibility analysis.⁷⁷ Neither is the income of an individual with whom the individual is “holding out” as a spouse.⁷⁸

⁷² POMS Section HI 03001.001; 42 C.F.R. § 423.773(d).

⁷³ Level of premium assistance listed in POMS Section HI 03030.025.

⁷⁴ 42 C.F.R. § 423.782(b).

⁷⁵ CMS Update Guidance, *supra* note 54.

⁷⁶ POMS Section HI 03020.055(C); 42 C.F.R. § 423.772.

⁷⁷ *Id.*

⁷⁸ POMS Section HI 03030.005(B)(2) (a “holding out” couple is not considered married for purposes of determining subsidy eligibility).

Under Medicare Part D, any food or shelter that is given to an individual or his/her spouse or received because someone else pays for it is considered in-kind support and maintenance.⁷⁹ This includes but is not limited to room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. In-kind support and maintenance is added to the income calculation as unearned income at a maximum of one third of the monthly SSI rate for an individual (or the couple rate if a spouse is part of the household) or the market value of the support, whichever is lower.⁸⁰

B. Countable Unearned Income

Unearned income is counted the earliest of either when it is received, when it is credited to an individual's account, or when it is set aside for his or her use.⁸¹ Not all unearned income is counted and with a few exceptions, the unearned income exclusions are the same as the exclusions for the SSI program.⁸² These unearned income exclusions include: the \$20 per month unearned income exclusion, the \$60 per quarter irregular or infrequent unearned income exclusion, the housing assistance exclusions, the 1/3 child support exclusion for a child applicant, and the other SSI exclusions listed in the Program Operating Manual.⁸³ There are exceptions to the SSI exclusions. A Plan for Achieving Self Support ("PASS") will not be approved solely for the purposes of excluding income and resources to enable an individual to qualify for the subsidy. However, an individual with an approved PASS will be deemed eligible for the "extra help" because he or she is an SSI recipient. All interest and dividends, regardless of the source, are excluded from income for purposes of determining eligibility for the subsidy. And, the \$20 per month general income exclusion applies to all unearned income including income based on need.⁸⁴

C. Countable Earned Income

For Medicare Part D "extra help" purposes, earned income shares the SSI definition. It includes wages, net earnings from self-employment, payments for services preformed in a sheltered workshop, and/or royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered. Earned income is counted when the individual receives it, when it is credited to his or her account, or when it is set aside for the individual's use.⁸⁵

SSA will not count the following as earned income, in the order listed:⁸⁶

- Any refund of Federal Income taxes received under section 32 of the IRS Code (earned income tax credit) and any payment received from an employer under section 3507 of the IRS Code related to advance payments of the earned income tax credit;
- The first \$30 per calendar quarter of infrequent or irregular earned income;
- Any portion of the \$20 per month general income exclusion not excluded from the unearned income of the individual and/or the living-with spouse;

⁷⁹ POMS Section HI 03020.045(B); 20 C.F.R. § 418.3345.

⁸⁰ POMS Section HI 03010.035(B).

⁸¹ *Id.* at Section HI 03020.040; 20 C.F.R. § 418.3340(a).

⁸² POMS Section HI 03020.035 and Section 03020.050; 20 C.F.R. 418.3335.

⁸³ POMS Section HI 03020.035, referencing Section SI 00830.001 through Section SI 00830.880.

⁸⁴ POMS Section HI 03020.050; 20 C.F.R. § 418.3350.

⁸⁵ POMS Section HI 03020.025.

⁸⁶ POMS Section HI 03020.030; 20 C.F.R. § 418.3325.

- \$65 per month of the earned income of the individual and/or the living-with spouse;
- Impairment Related Work Expenses (“IRWE”) for individuals receiving Title II benefits that are not based on blindness and who are under age 65;
- One-half of the remaining earned income of the individual and/or the living-with spouse; and
- Blind Work Expenses (“BWE”) for individuals receiving Title II benefits based on blindness and who are under age 65.

Special Note about IRWE and BWE Calculations: Under Medicare Part D regulations, the definition of an IRWE or BWE is the same as the definitions under the SSI Program. However, the calculation is a little different. Rather than requiring an individual to submit evidence on their IRWE, in 2006 SSA will assume that the IRWE amount is 16.3% of the individual’s total earned income.⁸⁷ Similarly, in 2006 SSA will assume that the BWE amount is 25% of the individual’s total earned income.⁸⁸ The Regulations and POMS do not allow an individual to allege that their IRWEs or BWEs exceed this amount. If an individual does this, SSA representatives are directed to calculate the actual IRWE or BWE and use this to determine countable income. Under no circumstances is SSA to do this if the actual IRWE or BWE is below the percentage calculations.⁸⁹

IV. Countable Resources

An individual must have resources no more than the limits listed above in order to receive “extra help.”⁹⁰ In general, resources include cash and other assets that an individual owns and could convert to cash which can be used for his or her support and maintenance.⁹¹ All vehicles, household goods and personal effects are NOT counted as resources.⁹² In determining countable resources under Medicare Part D, SSA will not consider non-liquid resources, other than non-home real property. A non-liquid resource is defined as cash or other property that cannot be converted to cash within 20 days.⁹³

An individual’s countable resources are determined as of the first moment of the month that an application for “extra help” is filed.⁹⁴ Unlike SSI or Medicaid, there is consideration no transfer of resources rule.⁹⁵ If an individual is unmarried, only the individual’s resources are considered. SSA never considers the resources of relatives who live with the individual and receive one-half support from the individual, even though that relative is counted in the household size. Nor does SSA ever consider the resources of a non-relative. If the individual is married and living with his or her spouse, the spouse’s resources will be counted. Unlike SSI, “holding out” as a married couple does not result in treatment as a married couple for purposes of determining eligibility.⁹⁶

In general, Medicare Part D “extra help” uses the SSI resource exclusion rules, with some differences. Therefore, resource determinations exclude the individual’s principle place of residence, property essential to self-support, the SSI life insurance exclusion, and burial spaces. In addition, Medicare Part D allows individuals to exclude \$1500 from countable resources (\$3000 for a couple) if the individual alleges that he or she expects to use some resources for funeral or burial expenses. This exclusion is allowed regardless of ownership of a burial contract or burial space or use of the \$1500 life insurance exclusion.⁹⁷

⁸⁷ 20 C.F.R. § 418.3325(b)(5).

⁸⁸ *Id.* at § 418.3325(b)(7).

⁸⁹ POMS Section HI 0302.030; 20 C.F.R. § 418.3325(b)(5)-(b)(7).

⁹⁰ POMS Section HI 03030.025.

⁹¹ *Id.* at Section HI 03030.001.

⁹² *Id.*; 70 Fed. Reg. 77672 (2005).

⁹³ 70 Fed. Reg. 77672 (2005); POMS Section HI 03030.020.

⁹⁴ POMS Section HI 03030.010; 20 C.F.R. § 418.3415.

⁹⁵ See POMS *supra* note 66. POMS Section HI 03030.001.

⁹⁶ *Id.* at Section HI 03030.005.

⁹⁷ *Id.* at Section HI 03030.020.

V. Appealing a “Extra Help” Application Denial

If an individual’s application for “extra help” is denied or the individual disagrees with the level of “extra help” granted, he or she has a right to file an appeal of this determination within 60 days of receiving notice (or later, with good cause).⁹⁸ This appeal request can be made in person at the local SSA office, by phone, by mail, or by fax. Individuals can also access form SSA-1021, Appeal of Determination for Help with Medicare Prescription Drug Plan Costs, on the internet and use this form to file the appeal.⁹⁹ The individual is entitled to a telephone hearing unless he or she indicates otherwise. In that case, the individual can have a case review.¹⁰⁰ If this appeal is denied, the only recourse is to file a lawsuit with the federal district court within 60 days of the appeal denial.¹⁰¹

PART III

Assisting the Individual in Understanding How Employment Income will Impact the Level of Financial Assistance or “Extra Help” Available Under Medicare Part D

“Extra help” eligibility is determined by an individual’s income and resources or eligibility for other needs based programs. Unlike other public benefits programs like SSDI or SSI, “extra help” eligibility is not necessarily determined on a month by month basis. Only certain “changes” will trigger an immediate change in “extra help” eligibility for individuals already receiving some level of “extra help” assistance.¹⁰² Increases or decreases in income are NOT one of these changes. Rather, income changes are only considered during the time of a redetermination.¹⁰³ Therefore, in order to assess a person’s eligibility for “extra help” assistance and any change that earned income will have on a person’s eligibility for “extra help” assistance, accurately estimating the individual’s annual income is key. What matters is when and what the change in income is during the relevant window when a redetermination occurs.

I. Changes in Dual Eligible Status

Once dual eligible status has been confirmed, this eligibility will not change for the relevant year.¹⁰⁴ No subsequent change in income, eligibility for Medicaid, change in household size, marriage or divorce should change this.¹⁰⁵ For example, if an individual met Medicaid spenddown in October of 2005 and attained dual eligible status, but never met spenddown in any month thereafter, he or she would still keep dual eligible status for the entire year of 2006.¹⁰⁶ Similarly, if an individual enrolled in Medicaid in February of 2006, he or she would attain dual eligible status for the rest of 2006 no matter how the financial situation changes throughout 2006.¹⁰⁷

Dual eligible status must be re-established every year. For 2006, CMS and the states shared Medicaid enrollment lists throughout the entire second half of 2005. Anyone enrolled in Medicaid in this relevant period became a dual eligible. For 2007 and beyond, CMS will again seek information from the states on their Medicaid enrollees to make the dual eligible determinations during the prior year.

⁹⁸ POMS Section HI 03040.001; 20 C.F.R. 418.3630.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ POMS Section HI 03040.300; 20 C.F.R. § 418.3650.

¹⁰² 20 C.F.R. § 418.3120.

¹⁰³ POMS Section HI 03050.010; 20 C.F.R. § 418.3123.

¹⁰⁴ *Id.* 42 C.F.R. § 423.773.

¹⁰⁵ 20 C.F.R. § 418.3115, 418.3120, and 418.3123.

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

For purposes of determining the impact of employment income on Medicare Part D benefits, BPAO/PABSS staff will need to analyze how employment income impacts Medicaid eligibility at the relevant time. In some cases, employment income will establish Medicaid Buy-In eligibility during the relevant month and, therefore, dual eligible status. In other cases, employment income could cause an individual to lose Medicaid eligibility during the relevant time frame, and, therefore, lose dual eligible status. In any case, BPAO/PABSS consumers must understand how employment income will impact current and subsequent dual eligibility determinations.

II. Changes to QMB, SLMB, QI or SSI Beneficiaries Without Medicaid Status

BPAO/PABSS staff have always advised individuals as to the impact of employment income on eligibility for the Medicare Savings Programs (or its impact on the SSI check for those with Medicare and without Medicaid). Now, the impact of employment income on these programs as it relates Medicare Part D “extra help” eligibility must also be factored into the analysis. The analysis is the same as that of the dual eligible, explained above. For example, if employment income causes a loss of QI status, the individual may also see a loss of automatic eligibility for “extra help” provided to QI’s in the subsequent year. (Of course, the person can still apply for “extra help” through SSA.)

III. Redeterminations of Other “Extra Help” Eligibility

For those who apply for “extra help” and are determined eligible, redeterminations for “extra help” are not necessarily made or effective on a month-by-month basis. Instead, there are 6 “subsidy changing events:” marriage, divorce, death of a living-with spouse, annulment, separation, and separated spouses resuming cohabitation.¹⁰⁸ If one of these 6 events is reported to SSA, a subsidy redetermination is conducted and the change is effective the month after the month of the report. All other changes, including an increase or decrease in income or resources or change in household composition, are not effective until the following year.

Every year, SSA will conduct a certain number of scheduled redeterminations.¹⁰⁹ In every case, SSA must schedule a redetermination about a year after eligibility for “extra help” began.¹¹⁰

In addition to the above scheduled redeterminations, SSA will also conduct a redetermination on any individual who reports a change in income in August through December.¹¹¹ Because working individuals have an obligation to report income monthly for SSDI and SSI purposes, this redetermination process should pick up any reported changes in income at this time and make the adjustment in “extra help” eligibility for the following year.

Important Note: Individuals may apply for extra help or attain dual eligible and other deemed eligible status at any time.¹¹² Eligibility is effective as of the date of application or the effective date of eligibility for Medicaid or Medicare Savings Programs.¹¹³ None of these changes require the individual to wait until the following January to become effective. The only changes that are not effective until the following January are the loss of a subsidy altogether or movement from partial “extra help” to full “extra help” and visa versa for individuals who must apply.¹¹⁴

¹⁰⁸ 20 C.F.R. § 418.3120(b); POMS Section HI 03050.010.

¹⁰⁹ 20 C.F.R. § 418.3125; POMS Section HI 03050.010.

¹¹⁰ 20 C.F.R. § 418.3125(b)(1); POMS Section HI 03050.010.

¹¹¹ *Supra* note 109.

¹¹² 20 C.F.R. § 418.3110 and 3201; POMS Section HI 03050.010.

¹¹³ See *supra* note 52 and accompanying text. 42 C.F.R. §§ 423.772, and 418.3101; POMS Section HI 03020.015.

¹¹⁴ 20 C.F.R. § 418.3123; POMS Section HI 03050.010.

Part IV

Assisting the Individual in Understanding the Interaction of the SSA Work Incentives with Medicare Part D

I. The Impact of Medicare Part D on Drug-Related IRWEs

Prior to implementation of Medicare Part D, some SSDI beneficiaries who work did not have access to any public prescription drug program. These individuals paid for their prescription drugs on their own. In many instances, those drug expenses were established as an Impairment Related Work Expense or “IRWE” and excluded from countable income for SSDI purposes.¹¹⁵ Utilization of Medicare Part D may have an impact on this IRWE and eligibility for an SSDI check.

For example, prior to implementation of Part D, Julie works and earns \$1000 per month in gross income. She spends approximately \$200 per month on prescription drugs. Working with her benefits planner, SSA agreed that this \$200 per month is an IRWE. Therefore, her countable income is below the Substantial Gainful Activity (SGA)¹¹⁶ amount and she is allowed to keep her SSDI check of \$600 per month.

Under Medicare Part D, her income and assets make her eligible for full “extra help.” If she accesses her medications through Part D, she will no longer pay \$200 per month for her prescriptions. Her monthly drug bill will dramatically decrease to only \$2 and \$5 co-payments as long as her drugs are included on the formulary of the drug plan that she chooses. In turn, her IRWE will no longer be calculated at \$200 per month. Therefore, Julie must make an important choice about how she will access her medications under Medicare Part D, if at all.

II. Subsidy or Special Conditions and Unincurred Business Expenses

Countable income for Medicare Part D purposes will include any income that SSA has determined is a subsidy, special condition, or unincurred business expense just as it would under SSI rules.¹¹⁷ Because of this, individuals utilizing these work incentives will now have two countable incomes, one for SSDI purposes and one for Medicare Part D “extra help” purposes. As a result, establishment of a subsidy, special condition, or unincurred business expense should now be analyzed for its impact on Medicare Part D “extra help” purposes.

For example, prior to implementation of Part D, Jim works and earns \$1000 per month. Working with the benefits planner, he established with SSA that he works at 70% of the productivity of the rest of the workers in his position. Therefore, his countable income for SSDI purposes is \$700. His SSDI check is \$800 and he continues to receive a check because his countable income is below SGA.

In this situation, Jim does not qualify for “extra help” because his countable income is too high. Without the subsidy, he would lose his SSDI check at some point and would qualify for “extra help.” The BPAO/PABSS staff should now provide Jim with information on how the subsidy impacts his “extra help” eligibility. By doing this, Jim can make an informed choice on whether to continue to utilize the subsidy work incentive.

¹¹⁵ POMS Section DI 10520.000; 20 C.F.R. § 404.1576.

¹¹⁶ POMS Section DI 24001.001; 20 C.F.R. § 404.1572.

¹¹⁷ POMS Section DI 10505.010 (subsidy); 20 C.F.R. § 404.1574 (subsidy); POMS Section DI 55055.001 (unincurred business expense); 20 C.F.R. § 404.1575 (unincurred business expense).

III. The Trial Work Period and Grace Period

Earned income is counted in making an “extra help” determination even if the person is in their Trial Work Period or Grace Period. Because timing is so important in “extra help” determinations, when the Trial Work Period and Grace Period begin and end become important in determining current or future “extra help” eligibility.¹¹⁸ In some cases, an individual may lose eligibility for “extra help” at some point during the Trial Work Period and regain eligibility after the Grace Period has ended and the SSDI check is no longer received. Benefits advice analysis should now include an explanation on how the Trial Work Period and Grace Period interact with Part D “extra help” eligibility in order to give the customer a full picture of the various changes that may occur during this time.

IV. Medicaid Buy-In Programs

Enrollment in a Medicaid Buy-In program confers dual eligible status on an individual.¹¹⁹ Therefore, Medicaid Buy-In programs play an even more important role in the work incentive landscape. For some individuals, employment income will now allow them to access a level of Medicare Part D “extra help” that they would otherwise not receive. For example, an individual with an SSDI check of \$1300 per month and no other income or assets will not receive any “extra help” in paying Part D drug expenses. However, if this individual began working and qualified for the state Medicaid Buy-In program, he would qualify for the dual eligible’s extra help even though he now has an even higher monthly income.

Prior to implementation of Part D, some individuals accessed Medicaid Buy-In programs because of their prescription drug coverage. Now, some of these individuals may believe Medicaid Buy-In enrollment is unnecessary for them because Medicare Part D provides prescription drug coverage. Before dis-enrolling from a Medicaid Buy-In program, the individual must consider two important factors. First, there are other services that state Medicaid programs cover that are not covered by Medicare. The individual will lose access to these services if he or she dis-enrolls from the Medicaid Buy-In program. Second, unless otherwise qualified for Medicaid, a person risks losing his or her dual eligible status under Medicare Part D in the subsequent year by dis-enrolling from the Medicaid Buy-In program.

Part V

Assisting the Individual in Understanding How to Manage His or Her Part D Benefit to Assure Coverage of Needed Medications

Medicare beneficiaries have the choice of many different PDPs, with the prescription drugs covered and their level of coverage varying. For many BPAO/PABSS consumers, uninterrupted access to prescription drugs is a very important component of their efforts to return to work. Therefore, BPAO/PABSS staff must have a working knowledge of how to navigate through this complex benefits system in order to assist their individuals in accessing needed medications to the greatest extent possible. In order to gain this working knowledge, BPAO/PABSS staff must understand the basic requirements that PDPs must follow, including the benefits management tool rules¹²⁰ and formulary requirements.¹²¹ This will allow BPAO/PABSS staff to explain to beneficiaries what they can expect from their PDPs. In addition, BPAO/PABSS staff should be able to advise beneficiaries on the most effective strategies for accessing needed prescription drugs through switching plans or filing an exception.

¹¹⁸ POMS Sections DI 24010.005 and I3010.050; 20 C.F.R. §§ 1592 and 1592(a).

¹¹⁹ 42 C.F.R. § 423.773(c).

¹²⁰ MMA 1860D-4(c).

¹²¹ *Id.* at 1860D-4(b)(3).

I. The PDP Benefits Management Tools

The PDPs are allowed to utilize benefit management tools, which attempt to steer participants into using certain medications.¹²² Benefit management tools are rules put in place by the PDPs that limit access to a particular drug. In choosing a drug plan, individuals must not only check to see if their drug is on a PDP's formulary, but they must also check to see what types of benefits management tools are attached to that drug.

Benefit management tools help PDPs control their costs by allowing them to maintain some measure of control over drug access. Authorized benefit management tools include: step therapy, tiered co-payments, prior authorization, or generic substitutions.

- **Step therapy** is a process under which the PDP requires an individual to prove that a preferred drug is not as effective before allowing the individual to access their requested drug.¹²³
- **Tiered co-payments** allow PDPs to attach higher co-payment prices to particular drugs.¹²⁴ In general, tiered co-payments will only impact those individuals without “extra help” in paying their drug costs.
- **Prior authorization** is a process under which the PDP requires that an individual secure approval from the PDP before the individual can access certain medications.¹²⁵
- **Generic substitution** allows a PDP to require that an individual access only the generic version of a particular drug.

CMS has placed some limits on how a PDP may utilize benefit management tools. In particular, CMS has identified six categories of drugs (described below), which PDPs must ensure reasonable access to for all Medicare Part D beneficiaries.

II. Basic Formulary Requirements

Overall, PDPs are required to carry two drugs in each of 203 identified therapeutic categories.¹²⁶ Formulary changes are allowed as long as enrollees are provided with 60 days notice of the change.¹²⁷ Changes can include things like moving a particular drug to a higher or lower co-payment tier, adding benefit management tools to a particular drug, or dropping the drug from the formulary altogether.

Every PDP is required to carry “all or substantially all” of the drugs in six specific categories:

1. Anticonvulsants;
2. Antiretrovirals (HIV/AIDS);
3. Immunosuppressants;
4. Antidepressants;
5. Antipsychotics; and
6. Antineoplastics.¹²⁸

¹²² *Id.* at 1860D-4(c).

¹²³ 70 Fed. Reg. 4299.

¹²⁴ 42 C.F.R. § 423.4.

¹²⁵ 70 Fed. Reg. 4233, 4277 and 4326.

¹²⁶ 42 C.F.R. § 423.120(b)(2).

¹²⁷ *Id.* at § 423.120(b)(5)(i)(A).

¹²⁸ See Guidance from CMS regarding this requirement available at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidanceAllorSubAll.pdf>.

“All or substantially all” includes those drugs approved by the FDA and available in January 2006. If a PDP chooses to leave one of the drugs in these classes off of its formulary, the burden is on the PDP to provide clinical documentation to justify this decision. CMS will provide further guidance in the future as to the inclusion requirements of drugs approved and available after January 1, 2006.¹²⁹

If an individual is stabilized on a drug in one of the categories listed above prior to enrollment in a plan, a PDP should not utilize benefit management tools like prior authorization or step therapy with that individual, absent extraordinary circumstances.¹³⁰ However, if the individual is a “new start” and is not stabilized on the drug, PDPs are free to utilize benefit management tools. For example, each drug plan may be required to carry a specific antidepressant. If the beneficiary is a “new start” on this antidepressant, the PDP may still require that an individual try the generic version of this antidepressant before he or she will be allowed access to the name brand antidepressant. In contrast, if the individual was stabilized on this particular antidepressant prior to enrollment, the PDP cannot utilize generic substitution.

CMS has distributed guidance that provides even further protection against benefit management tools for antiretroviral medications. For these drugs, CMS has stated that prior authorization and step therapy are not “employed in widely used, best practice formulary models” for even those individuals using the antiretroviral for the first time or without stabilization. Therefore, in approving PDP formularies, CMS has shown a propensity to reject formularies that do not allow unfettered access to antiretroviral medications.

CMS will approve certain exceptions to the benefit management restrictions explained above. In particular:

- Iressa is not required to be included on formularies.
- Fuzeon must be listed on formularies but may require prior authorization for new users.
- All formularies must include either escitalopram or citalopram.
- Fosphenytoin may be left off formularies.
- Formularies are not required to include: all medication dosages, extended release products, or multi-source brands of identical molecular structure.¹³¹

III. Changing Plans

While the PDP formularies will cover a wide variety of prescription drugs, it is possible that a beneficiary will enroll or be enrolled into a plan that is not meeting his or her needs. In addition, because plans can change so long as consumers are given 60 days notice, a PDP may provide notice of a change that results in the beneficiary not receiving a needed medication.¹³² In these cases, certain individuals will have the option to disenroll from the plan.

Dual eligibles and Medicare Savings enrollees are allowed to change PDPs every month. Additionally, all enrollees have the option to switch plans once before May 15, 2006. Therefore, in some cases, if a PDP is no longer working for an individual or is about to change its formulary in a way that will negatively impact the individual, he or she can simply switch to another plan that better meets his or her needs.

¹²⁹ *Id.*

¹³⁰ See CMS guidance on *All or Substantially All*, available at <http://new.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidanceAllorSubAll.pdf>.

¹³¹ *Id.*

¹³² 42 C.F.R. § 423.120.

IV. Exceptions Process

Every PDP is required to have a process under which beneficiaries can request “exceptions” to the formulary coverage provided by the PDP.¹³³ There will generally be two types of exceptions: a request to provide a particular drug that is not on the formulary or a request that the PDP waive certain requirements (benefits management tools, higher tier co-payments) in accessing a drug. An individual is only allowed one exception per drug. The PDP may not require the enrollee to request another exception during the remainder of the enrollment period. At its option, the PDP may choose to continue coverage into a subsequent plan year.¹³⁴

It is a good practice for individuals to review the bases for exceptions listed under their particular PDP.¹³⁵ In general, reasons for granting an exception could include proof that the non-preferred drug a beneficiary has been prescribed is medically necessary, or that the preferred drug equivalent would not be as effective for them or could cause them to have an adverse reaction. In each exceptions case, supporting documentation from a doctor is essential.

The exceptions process begins with the Request for a Coverage Determination. This Request should be submitted in writing, with supporting documentation from a doctor. Until this supporting documentation is received, no coverage determination is required. The decision time frames differ depending on whether the request is made under the standard process or an expedited process. Beneficiaries have the right to request an expedited process when necessary.

Under the standard process, the PDP has 72 hours to make a determination.¹³⁶ If the initial determination is negative, the individual may file an appeal (the first level of appeal) within 60 days.¹³⁷ Once the first level of appeal is filed, the PDP must make a redetermination within 7 days.¹³⁸ If this redetermination is a denial, the individual has 60 days to file a reconsideration before an Independent Review Entity (the second level of appeal).¹³⁹ The Independent Review Entity must also make a decision within 7 days. If the reconsideration is denied, the individual can attempt a third level of appeal before an Administrative Law Judge (“ALJ”).¹⁴⁰ This appeal must also be filed within 60 days and the amount in controversy must be at least \$100 in 2006 (and adjusted annually by the Secretary of the Department of Health and Human Services).¹⁴¹ There is no statutory deadline for a decision from the ALJ. If the ALJ denies the exception, the next level of appeal must be filed within 60 days before the Medicare Appeals Council.¹⁴² If denied at this level, the individual has 60 days to file a case with the Federal District Court.¹⁴³ To file with the Federal District Court, the amount in controversy must be \$1050 in 2006 (and adjusted annually as described above).¹⁴⁴

Under the expedited process, the PDP has 24 hours to make a determination.¹⁴⁵ If this initial determination is negative, the individual may file an appeal (the first level of appeal) within 60 days.¹⁴⁶ This redetermination must be decided within 72 hours.¹⁴⁷ If this redetermination is a denial, the individual has 60 days to file a reconsideration before an Independent Review Entity (the second level of appeal). The Independent Review Entity must also make a decision within 72 hours.¹⁴⁸ Thereafter, the expedited process follows the same procedure as the standard process.

¹³³ *Id.* at § 423.562(a)(1)(ii).
¹³⁴ *Id.* at § 423.578(c)(4)(i)(C).
¹³⁵ PDPs are required to provide a detailed description of grievance procedures. 42 C.F.R. § 423.128(b)(7).
¹³⁶ 42 C.F.R. § 423.568(a).
¹³⁷ *Id.* at § 423.582.
¹³⁸ *Id.* at § 423.590(a).
¹³⁹ *Id.* at § 423.600.
¹⁴⁰ *Id.* at § 423.610.
¹⁴¹ *Id.*
¹⁴² *Id.* at § 423.620.
¹⁴³ *Id.* at § 423.630.
¹⁴⁴ *Id.* at § 423.630(a)(2).
¹⁴⁵ *Id.* at § 423.572(a).
¹⁴⁶ *Id.* at § 423.600.
¹⁴⁷ *Id.* at § 423.590(d)(1).
¹⁴⁸ *Id.* at §§ 423.590 and 600.

PART VI

Assisting the Individual in Making an Informed Choice About Picking a Prescription Drug Plan

I. Initial Enrollment Periods, Special Enrollment Periods, and the Annual Coordinated Election Period

Enrollment in Medicare Part D is optional. For those automatically enrolled into a PDP, there is always the option to disenroll. For everyone else, participation in this program is voluntary. However, absent “creditable” coverage (explained above), there is a premium penalty for choosing not to enroll in Medicare Part D during a person’s initial enrollment period or an applicable special enrollment period. That premium penalty is equal to 1% of the national benchmark premium amount in the current year for every month in which the person was not enrolled into Medicare Part D.¹⁴⁹ Over time, this premium penalty could add significant costs to Medicare Part D for a lifetime if or when the individual does decide to join. “Extra help” will pay 80% of the penalty for 60 months and then 100% of the penalty thereafter.¹⁵⁰

The initial enrollment period for individuals eligible for Part D as of January 2006 is November 15, 2005 through May 15, 2006.¹⁵¹ For those eligible for Part D as of February 2006, the enrollment is from November 15, 2005 to May 31, 2006. For anyone eligible in March 2006 or later, the initial enrollment period is the 7 month period surrounding their eligibility date, just as it is under Medicare Part B.¹⁵²

After this initial enrollment to start the Program, Medicare Part D will have an annual coordinated election period from November 15 to December 31 of each year.¹⁵³ Remember, those who are dual eligibles, Medicare Savings Program enrollees, or SSI beneficiaries without Medicaid can change plans monthly. Those without this status are only allowed to change plans during this annual coordinated election period or a special enrollment period, explained below.¹⁵⁴

In limited circumstances, individuals will be able to change plans or enroll into a Part D plan during a special enrollment period.¹⁵⁵ The time frames of this period vary, depending on the circumstances warranting a special enrollment period. Those circumstances include: change in residence, current dual eligibility or individuals who lose their dual eligible status, contract violations by the PDP, non-renewals or terminations of the PDP contract with CMS, involuntary loss of creditable coverage, not adequately informed of creditable coverage, an error by a federal employee, or other exceptional circumstances.¹⁵⁶

II. Factors to Consider in Choosing a Prescription Drug Plan

It is not the role of the BPAO/PABSS Projects to choose the “right” PDP for individuals. In fact, in many cases, there is no one “right” PDP. There may be several PDPs that will allow the individual to access needed medications. There may be no plan that covers all of the individual’s needed medications in the way that the individual wants. It depends on many factors and the preferences of individuals.

¹⁴⁹ 42 C.F.R. §§ 423.286(d)(3) and 423.46.

¹⁵⁰ *Id.* at 42 C.F.R. § 423.780(e). On phone conferences, CMS staff have indicated that the premium penalty assistance will be extended to those with partial “extra help.”

¹⁵¹ 42 C.F.R. § 423(a)(1). Extensive enrollment guidance is also available from the Centers for Medicare and Medicaid Services, *PDP Guidance Eligibility, Enrollment and Disenrollment*, http://www.cms.hhs.gov/pdps/PDP_enrollmentguidance+exhibit_final_8-29-05.pdf.

¹⁵² 42 C.F.R. § 423.38(a)(2) and (3).

¹⁵³ 42 C.F.R. § 423.38(b)(2).

¹⁵⁴ In 2006 only, individuals who are not dual eligibles, Medicare Savings Program enrollees, or SSI beneficiaries without Medicaid will be able to change plans once between January 2006 and May 15, 2006, the end of the initial enrollment period.

¹⁵⁵ 42 C.F.R. § 423.38(c).

¹⁵⁶ *Id.*

Although BPAO/PABSS Projects will not be choosing PDPs for customers, staff should be able to assist customers in making informed decisions on which PDP to choose. In order to do this, BPAO/PABSS staff can provide the individual with a better understanding of what considerations must be taken into account before choosing a PDP. The guidance will be very different depending on the level of “extra help” provided to the individual under Medicare Part D. For those with full “extra help,” the financial considerations may not be as important. For those with no “extra help,” financial considerations may be paramount.

Those who receive full “extra help” (dual eligibles, Medicare Savings Program recipients, SSI beneficiaries without Medicaid, and those who applied and were found eligible for full subsidy “extra help”), should consider the following questions in choosing a PDP:

- Are all of my drugs on the formulary?
- What benefit management tools are attached to my drugs?
- Do I want to consider a higher priced premium plan with better coverage?
- Is my pharmacy included or is this even important to me?
- Am I qualified for my state’s SPAP and is it coordinating with the plan? (for those with SPAPs that will cover non-formulary or Medicare Part D excluded drugs)

Those who receive partial or no “extra help” should consider the following questions in choosing a PDP:

- Are all of my prescription drugs included in the plan’s formulary?
- What are the benefit management tools used by the plan?
- What premium am I willing to pay?
- What is the deductible?
- What are the co-payments attached to my drugs?
- Is my pharmacy coordinating with the plan and if not, is that important to me?
- Am I qualified for my state’s SPAP and is it coordinating with the PDP?

III. How to Choose and Enroll in a Prescription Drug Plan

There are several resources available to assist individuals in choosing a drug plan. The most common method for accessing information on particular plans is through the plan finder system on the website www.medicare.gov. This system allows an individual to submit his or her particular medications to see how they are covered on the plans available in his or her area. For those not comfortable using a computer, the toll-free 1-800-MEDICARE (1-800-633-4227) phone operators will assist an individual in getting more information on plans by utilizing the plan finder system for the individual. In addition, individual plans may have websites with information on their particular plans and/or they have the formulary and its rules available in writing. Individual PDPs also have operators available to answer particular beneficiary questions, including information on the formulary and its rules.

To enroll in a PDP, individuals have several choices. Through CMS, individuals may sign up at www.medicare.gov or by calling 1-800 MEDICARE (1-800-633-4227). Individuals can also contact the company offering the PDP they want to enroll in and ask them to send a paper application. This would then need to be

faxed or mailed to the company for processing. Drug company sponsors also generally maintain websites where individuals can enroll on-line. When enrolling, individuals should be aware that enrollment is not immediate and it also takes time before a prescription drug card will reach them. If an individual needs to utilize the plan prior to receipt of the card, he or she should contact the plan to find out what information needs to be provided to the pharmacy.

Conclusion

With its implementation, Medicare Part D joins the list of the myriad of public benefits programs that may be impacted by employment. As such, it should be added the list of factors that must be considered to make an informed decision about employment. Because of Medicare Part D's complexity and newness, individuals eligible for this Program will be turning to BPAO and PABSS Projects for guidance and assistance. The role of the BPAO and PABSS Projects is always to inform individuals about this and other public benefits programs as they relate to employment. By assisting individuals in the 6 areas presented in this brief, the BPAO and PABSS Projects will continue their roles as benefits advisors and benefits management experts. This will help them ensure that individuals have all of the information they need to make informed decisions about work and navigating the public benefits systems.

My Notes on Translating this to Practice:

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