



Medicare Part D Frequently Asked Questions: Eligibility & Enrollment

This list of "Frequently Asked Questions" regarding eligibility and enrollment issues in the new Medicare Part D prescription drug benefit is designed to both inform advocates and be used as a tool to educate consumers. It is one document in a series that address four different categories: Eligibility & Enrollment, Benefit Design, Exceptions & Appeals, and Administrative Issues. This document will continue to evolve as new questions arise. If you have a question that is not addressed here, please contact NMHA's Advocacy Resource Center at shcrinfo@nmha.org.

Who is eligible for the Medicare drug benefit (Part D)?

(1) Individuals with Medicare Part A or Medicare Part B; (2) Dual eligibles, those who qualify for both Medicare and Medicaid.

Who are "dual eligibles?"

Dual eligibles are low-income seniors and people with disabilities (including people with mental health disorders), who are enrolled in both Medicare and Medicaid. Most dual eligibles are very low-income individuals (with incomes at or below 73 percent of FPL) with substantial health needs.¹ 38 percent of dual eligibles have mental or cognitive impairments.² Dual eligibles, numbering 6.4 million, are to be automatically enrolled in the Medicare Part D prescription drug benefit.³

How will full dual eligibles be affected by the Medicare prescription drug benefit?

The most significant change is that dual eligibles will receive their prescription drug coverage through Medicare rather than Medicaid when Part D goes into effect. State Medicaid programs will no longer provide coverage for prescription drugs for dual eligible individuals except that states may choose to cover certain drugs that will not be covered by Medicare. Dual eligibles will no longer have access to all FDA approved medications per Medicare rules (see Benefit Design section). However, dual eligibles will not be subject to a gap in prescription coverage which will occur at higher income levels under the Medicare prescription drug benefit.

Because of their low-income status, dual eligibles will automatically receive premium and cost-sharing subsidies. Dual eligibles will have nominal co-payment requirements up to the catastrophic coverage limit (\$5,100), which may be different from the state Medicaid requirements. In many states, Medicaid co-pay requirements for dual eligibles currently fall below the levels that most dual eligibles will face when they are enrolled in Part D plans. Unlike Medicaid, Medicare Part D does not require pharmacies to provide

¹ For more information on dual eligibles, see *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries*, Kaiser Commission on Medicaid and the Uninsured, Jan. 2005, available at

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51187>.

² MedPAC, *Report to Congress: New Approaches in Medicare*, June 2004, p. 72.

³ *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries*, Kaiser Commission on Medicaid and the Uninsured, Jan. 2005, available at

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51187>.

medications to low income enrollees regardless of ability to pay. Dual eligibles will also have to pay 100 percent of the costs of drugs that are not covered by their Part D plans.

Who are partial dual eligibles?

Partial dual eligibles consist of three categories of individuals: (1) Qualified Medicare Beneficiaries (“QMBs”); (2) Specified Low-Income Medicare Beneficiaries (“SLMBs”); and (3) Qualifying Individuals (“QI-1”). They generally have slightly higher incomes than full dual eligibles, and Medicaid only pays for cost-sharing associated with Medicare, including premiums. The amount of assistance with prescription drug cost-sharing under Part D for these individuals varies according to income, but all partial dual eligibles have incomes below 135 percent FPL (see chart on p. 1 of FAQ regarding Benefit Design).

How will partial dual eligibles be affected by the Medicare Part D benefit?

Partial dual eligibles do not currently receive prescription drug coverage through Medicaid; some receive drug coverage through state-funded programs, and some have no coverage at all. The Part D program will allow partial dual eligibles to receive drug coverage through Medicare, and they will also automatically qualify for the low-income subsidy (see questions on the subsidy for more information about enrolling). CMS will conduct “facilitated enrollment” into Part D plans for partial dual eligibles. What this enrollment process entails is not yet clear.

When can I sign up for Medicare drug coverage?

An individual can sign up for prescription drug coverage under Medicare Part D beginning Nov. 15, 2005, although drug coverage will begin no earlier than Jan. 1, 2006. The initial enrollment period runs for six months, from Nov. 15, 2005 until May 15, 2006. In October 2005, dual eligibles will be assigned a plan into which they will be automatically enrolled on Jan. 1, 2006 unless they choose a different plan.

Do I have to enroll?

No, enrollment in Part D is voluntary except for individuals who are dual eligibles. CMS expects that many people with employer- or union-sponsored coverage will remain with their retiree plans and decline Medicare’s drug benefit. This coverage is considered “creditable coverage” if it is of equal or greater value than Part D standard coverage. An employer will notify employees and retirees whether their coverage is creditable.

If an individual does not have creditable coverage and does not enroll in a Part D plan at the first opportunity and then later chooses to join, they will be subject to a higher premium based on a late enrollment penalty. CMS will set this penalty for the first few years of the program at one percent of the average drug premium per uncovered month. In subsequent years, the amount of the penalty would increase with the growth in the base Part D premium. Individuals would be subject to the penalty for as long as they remain enrolled in Part D.

How do I enroll in a Part D plan?

You can enroll in the Part D program by submitting an application to an approved Part D plan. Eligible individuals will receive information from Medicare in Fall 2005 about plan options in their area. The plan will enroll you and let Medicare know that you have enrolled. Dual eligibles will be automatically enrolled into a plan in their area unless they choose a different plan before the deadline of Jan. 1, 2006 when their Medicaid prescription drug coverage ends.

What if a dual eligible is unhappy with the plan into which they were auto-enrolled?

Dual eligibles will have six weeks (starting Nov. 15, 2005) to choose their Medicare drug plan by January 1, 2006. During this time, they will be able to change plans if they do not like the plan to which they were

assigned for auto-enrollment. In addition, after Jan. 1, 2006, dual eligibles will also be able to change plans whenever they want (at least once a month). It is important to note that the low-income subsidy for which all dual eligibles qualify will only cover the premium for lowest cost plan in their area. If a plan selected by the individual has a higher premium, they are responsible for the difference in cost.

How often can dual eligibles switch plans?

Dual eligibles will be able to switch plans up to once a month.

Can I keep a Medicare drug discount card after the Medicare Part D program goes into effect?

No, the Medicare discount card program will phase out when the drug benefit begins. The card program was only intended to be temporary assistance to Medicare enrollees while the drug benefit was being implemented. Participation in the Medicare discount card program will end either: 1) when you begin receiving drug coverage under a Medicare prescription drug plan, which will occur beginning January 1, 2006, for enrollments in 2005; or 2) at the end of the initial enrollment period for Part D, which is May 15, 2006; whichever comes first.

Will I be able to compare prices beforehand similar to the drug discount card?

CMS plans to extend the internet price comparison functions that were developed for the drug discount card to the Part D program. Enrollees should be able to compare prices they would pay under different Part D plans. This is particularly important, since the standard coverage features a coverage gap between the initial coverage limit and the catastrophic coverage. While in this gap, enrollees will pay 100 percent of their drug costs (unless they have help from supplemental coverage or the low-income subsidy), so it will be important for them to be able to compare prices in advance.

Will I be able to compare formularies beforehand?

Yes. Formulary information will be available from plans most likely in October 2005 and certainly during the open enrollment period, which begins Nov. 15, 2005, allowing people to compare formularies as they choose drug plans.

I have a very low income. Will I receive any additional assistance to access the Medicare Part D prescription drug benefit?

Three kinds of Medicare enrollees are eligible to get a low-income subsidy:

- Full-benefit dual eligible enrollees, those who are eligible for both Medicare and Medicaid. (About 6.3 million individuals.)
- Other enrollees who have incomes that are lower than 135 percent of the Federal Poverty Level (FPL) and who have resources up to \$6,000 (or \$9000 for a couple).⁴ About 3 million of the 5.7 million eligible individuals in this category are expected to enroll in the low-income subsidy program in 2006.
- Enrollees who have incomes over 135 percent FPL but less than 150 percent of FPL and who have resources up to \$10,000 (or \$20,000 for a couple).⁵ About 1.6 million of the 2.4 million eligible individuals in this category are expected to enroll in this low-income subsidy program in 2006.

⁴ In 2005, 135% of poverty represents income of \$12,920 a year for individuals and \$17,321 a year for couples. In 2006, when the drug benefit is scheduled to go into effect, these income limits will be higher reflecting inflation.

⁵ In 2005, 150% of poverty represents income of \$14,355 a year for individuals and \$19,245 a year for couples. In 2006, when the drug benefit is scheduled to go into effect, these income limits will be higher reflecting inflation.

How do I find out whether I qualify for the low-income subsidy?

To find out whether you qualify, go to the nearest Social Security Administration (SSA) field office or the appropriate state office that administers Medicaid. These offices will provide individuals with information on income and asset requirements for qualifying. They also will assist you in completing a low-income subsidy application. CMS and SSA will send notices to beneficiaries deemed eligible or potentially eligible for the low-income subsidy (also referred to as "extra help") between May and August of this year. SSA and states will begin accepting applications in May and processing them in July 1, 2005.

How do I apply for the low-income subsidy?

You can apply for the low-income subsidy at either your state Medicaid or social services agency or your local SSA field office.

SSA is developing a model, simplified application form for the low income subsidy and process for determination and verification of an eligible enrollee's income and resources (assets).

The SSA application form will consist of an attestation regarding an enrollee's level of resources and income. The goal of the application process is to eliminate the need for excess documentation. Whether applicants apply online or in person, it is unlikely that financial documents will be necessary at the time of application. CMS expects that the Social Security Administration will be able to verify most information through data matches with existing Social Security Administration, Medicare and Internal Review Service files. However, states and the SSA may need to request some follow up documentation to verify resources if data matches do not provide the needed verification.

States may choose to create their own application, but will have to follow the same set of rules for counting income and resources as the SSA. CMS is working with states and is encouraging them to use the SSA application process.

If you apply through a state agency, the state is required to screen your application for eligibility for other helpful Medicaid benefits but this screening will not take place if you apply through the local SSA office.

Under what circumstances may a Part D plan involuntarily disenroll an enrollee?

You may be involuntarily disenrolled for disruptive behavior and for nonpayment of a premium in a timely manner. To be involuntarily disenrolled, an enrollee's behavior must "substantially" impair the plan's ability to provide services. Behavior is not considered disruptive if it is related to use of medical services or compliance (or non-compliance) with medical advice. The plan must make a serious effort to resolve the problem, and must provide reasonable accommodations for individuals with mental or cognitive conditions. The plan must also inform the enrollee of their right to file a grievance and submit information. The enrollee's behavior must be documented by the plan.

In order to be disenrolled for nonpayment of a premium, your plan must first demonstrate that they have given you timely notice (including why you are being disenrolled and your right to a grievance hearing) and that they have taken reasonable efforts to collect the premium payment from you. The plan can refuse to reenroll you until all past premiums have been paid.

What recourse do I have after I am involuntarily disenrolled?

If you are disenrolled for nonpayment of a premium or disruptive behavior, you must be given timely notice including the reason for your disenrollment, as well as the notice of the right to a grievance hearing. If you are a dual eligible and are involuntarily disenrolled for disruptive behavior, you are still entitled to the special enrollment period.

The Special Enrollment Period allows full benefit dual eligible enrollees to switch from one Medicare Advantage Prescription Drug (MA-PD) plan to another, from one prescription drug plan (PDP) to another, or from original Medicare and a PDP into an MA-PD plan and vice versa.