

**A NEW MEXICO ADVOCATES' GUIDE**

to the

**MEDICARE SAVINGS**

**PROGRAMS**

And

**EXTRA HELP**

**(Medicare Low-Income Prescription Drug Subsidy)**

*Including Information About  
Conditional Medicare Applications*

**(Revised, January 1, 2019)**

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## **TABLE of CONTENTS**

<u>WELCOME and INTRODUCTION</u> .....	1
<u>I. SUMMARY OVERVIEW</u> .....	4
<u>A. Medicare Savings Programs</u> .....	4
<u>B. Extra Help</u> .....	5
<u>C. Program Similarities and Differences</u> .....	6
<u>II. THE MEDICARE SAVINGS PROGRAMS</u> .....	8
<u>A. Overview</u> .....	8
<u>B. QMB</u> .....	8
<u>C. SLMB &amp; QI</u> .....	9
<u>D. “Countable” Income and Assets</u> .....	11
<u>E. Additional MSP Coverage Benefits</u> .....	11
<u>F. Applying for MSP Coverage</u> .....	11
<u>G. Implementation</u> .....	13
<u>III. EXTRA HELP (a/k/a “LIS”)</u> .....	14
<u>A. Background and Overview</u> .....	14
<u>B. How Extra Help Works</u> .....	15
<u>C. Applying For Extra Help</u> .....	16
<u>D. Benefits of Having Extra Help</u> .....	17
<u>E. Post-Eligibility Developments</u> .....	18
<u>IV. MSPs vs. EXTRA HELP --- SIMILARITIES and DIFFERENCES</u> .....	19
<u>A. Some Similarities</u> .....	19
<u>B. Some Differences</u> .....	19
<u>V. “CONDITIONAL” APPLICATIONS FOR MEDICARE</u> .....	21
<u>A. Purpose of the Conditional Application</u> .....	21
<u>B. How the Application Process Works</u> .....	21
<u>C. Complications or Problems that Can Arise</u> .....	22
<u>D. Citizenship</u> .....	22
<u>APPENDIX A --- MEDICARE: A BASIC INTRODUCTION</u> .....	24
<u>APPENDIX B --- MEDICARE’S PRESCRIPTION DRUG COVERAGE</u> .....	27

# WELCOME and INTRODUCTION

## WELCOME

The purpose of this Advocates' Guide is two-fold. First, it is intended to serve as a detailed source of information and guidance about the “**Medicare Savings Programs**” and “**Extra Help**” -- two programs that provide valuable coverage and financial benefits to lower income Medicare beneficiaries -- and how to qualify for the programs.

Second, it is intended to serve as a platform to facilitate exchanges of information, concerns, ideas, and strategies about these programs among individuals who are interested in such sharing. One of the reasons for our formatting the Guide with numerous headings and subheadings is to make references to particular points easier.

The Guide will be a continual work in progress, because we want to adjust it to accommodate the needs and suggestions of readers and the ideas they and our staff share. Feedback is always welcome.

For readers with little familiarity with Medicare, brief synopses of how the program works in general and how its drug coverage works in particular, are included at the end of this Guide as Appendix A and Appendix B.

**The preparation of the original 2016 version of this Advocates' Guide was supported with grant funding from the Con Alma Health Foundation, for which funding we remain deeply grateful.**

## HOW TO USE THE GUIDE

The first section of the Guide following this Welcome and Introduction -- entitled “Summary Overview” -- contains a condensed discussion of the Medicare Savings Programs and Extra Help. Readers unfamiliar with these programs may find that discussion sufficient, especially before they begin to work with clients who may benefit from these programs. The subsequent sections of the Guide have more detailed discussions of each program, as well as a discussion of the

little known but extremely valuable “Conditional” Application for Medicare process.

## INTRODUCTION

The “Medicare Savings Programs” (MSPs) and “Extra Help” are both programs that help lower income Medicare beneficiaries meet the often substantial out-of-pocket costs that Medicare beneficiaries face.

The three MSPs discussed are *Medicaid* eligibility categories. They cover at least a beneficiary’s Medicare Part B premiums and -- in the case of one of them (“**QMB**”) – the beneficiary’s Medicare Part A premiums;<sup>1</sup> and their Medicare deductibles, coinsurance, and co-pays, as well.

“**Extra Help**” (a/k/a “Low Income Subsidy” [LIS]) is a separate program that covers part of the costs of a beneficiary’s Medicare *prescription drug coverage* (Medicare “**Part D**”). There are different levels of Extra Help assistance, and **eligibility for a MSP program automatically qualifies a beneficiary for the most generous level.**

Both programs save beneficiaries -- and often the beneficiaries’ families -- a considerable amount of money. They help many beneficiaries retain (and for some, *obtain*) Medicare coverage, by making it more affordable.

Many people think Medicare is a program just for seniors. In fact **a large number of individuals under 65 have Medicare because they receive Social Security Disability (SSDI) benefits.** *These beneficiaries can also qualify for MSPs and/or Extra Help.*

The MSPs provide *limited-benefit* Medicaid coverage. They help Medicare beneficiaries whose income and/or resources are too high to qualify for a Medicaid eligibility category that *does* provide full Medicaid coverage.

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<sup>1</sup> Most Medicare beneficiaries do *not* have to pay the Part A premium, because Part A coverage is funded mainly by the FICA payroll deductions they or a spouse (and, in some cases, a parent) paid over the years. With respect to individuals who don’t qualify for premium-free Part A, see Section V.

The MSPs and Extra Help do *not* use the “MAGI” method of income counting with which you may be familiar. Rather, financial eligibility for them is based on an applicant’s “countable” income and assets under the older methodology in which a variety of *disregards* are applied to gross income and assets. That methodology is based on Supplemental Security Income (SSI) income/assets counting rules.

# I. SUMMARY OVERVIEW

## A. MEDICARE SAVINGS PROGRAMS

1. There are four Medicare Savings Program (MSP) Medicaid eligibility categories, but three of them are the most frequently used: **QMB** (which stands for “Qualified Medicare Beneficiary”); **SLMB** (which stands for “Specified Low Income Beneficiary”); and **QI** (which stands for “Qualified Individual”).

2. The broadest coverage is provided by **QMB** -- it covers a beneficiary’s Medicare Part A and B premiums, *and* Part A and B deductibles, coinsurance, and co-pays. Most Medicare beneficiaries do not have to pay for Part A premiums (because of FICA contributions they, a spouse, or parent paid over the years). But for those who have to pay those premiums, QMB coverage is especially valuable because it will pay for their Part A premiums (*see Section V.*).

3. The benefit provided by **SLMB** and **QI** coverage is *identical*: coverage of the individual’s Medicare Part B premiums. The sole difference between SLMB and QI eligibility is that QI uses a higher *income* eligibility level. This is a result of the technical legislative history underlying the establishment of the MSPs.

4. The use of the terms “cover” and “coverage” is significant. While Medicaid *pays* for MSP beneficiaries’ monthly *premiums*; it usually does not *pay* for QMB beneficiaries’ deductibles, coinsurance, or co-pays. *Rather, providers are legally prohibited from charging QMB beneficiaries for them.*

5. QMB coverage begins the month *after* the month an applicant is found eligible. Conversely, SLMB and QI coverage can be *retroactive* for any or all of the three months prior to the month of application (if the applicant met the eligibility requirements in those months) [*NOTE: the eliminations of three-month retroactive coverage under Centennial Care does not apply to SLMB and QI*].

6. The state Medicaid agency’s payment of a beneficiary’s Medicare premiums is known as the “**Buy-In.**” Each state has a Buy-In agreement with the federal government which authorizes those payments.

7. Effectuation of any beneficiary's Buy-In can take up to two-three months after s/he is found eligible; however beneficiaries will receive reimbursement of premiums for those months (from Social Security if the premiums were deducted from their Social Security benefits). The reverse is true when an individual's eligibility is terminated.

8. Applications for the MSPs are processed by the Income Support Division (ISD) of New Mexico's Human Services Department (HSD). Applications can be initiated online, by FAX, by mail, or in-person at an ISD office. Applicants must normally use the same form that is used for any Medicaid application [*NOTE: an older, shorter application form for MSPs coverage is no longer published*].

## **B. EXTRA HELP**

1. "Extra Help" is the popular name that was adopted for a Congressionally-mandated "Low Income Subsidy" (LIS) program enacted when Part D prescription drug coverage was added to the Medicare program.

2. Medicare's drug coverage is complicated. It is available only from private Plans -- either drug-only Plans or HMO-like "Medicare Advantage" Plans that offer drug coverage (most do). While the Medicare law specifies a *standard* benefit structure, Plans can and do use alternative structures which can vary from Plan to Plan. See **Appendix B**.

3. The "standard" benefit structure includes: an initial annual deductible; followed by a specified dollar amount of coverage with 25% coinsurance charges; followed by a specified dollar amount of drug purchases with no coverage (the "**Donut hole**"); followed by an unlimited amount of coverage with an up to 5% coinsurance. Plans can also have monthly premiums. Plans use both co-pays and coinsurance<sup>2</sup> charges, although co-pays are more common.

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<sup>2</sup> "Coinsurance" usually refers to cost-sharing charges based on a percentage of the cost of particular goods or services. "Co-pays" usually refer to flat payment amounts charged for particular goods and services.

4. Extra Help has two general levels of coverage. The more generous level -- called "*Full LIS*" -- covers plans' premiums (up to a fixed amount), annual deductibles, and the Donut Hole, while dramatically reducing co-pays and coinsurance charges. The less generous level -- called "*Partial LIS*" -- is for 'higher income' beneficiaries, and provides smaller subsidies.

5. Individuals who qualify for any of the three MSPs *automatically* qualify for the more generous level of Extra Help. Nonetheless, applying for *both* a MSP *and* Extra Help at the same time is often helpful (see **Section IV.B.**).

6. Applications for Extra Help should be submitted to the Social Security Administration; online, by phone, in person, or by mail (using a special form). For practical reasons, *applying online is best*. Eligibility is retroactive to the month of application.

### **C. PROGRAM SIMILARITIES and DIFFERENCES**

1. The income eligibility levels for *both* the MSPs and Extra Help are based on various percentages of the Federal Poverty Level (FPL). However, while MSP eligibility is based only on the FPL levels for a family size of 1 or 2 (individual or married couple), Extra Help eligibility can be based on larger household sizes.

2. While the methodology for determining 'countable' income and assets for both MSP and Extra Help eligibility is based on SSI rules, some SSI rules that apply to MSP eligibility -- for example, counting as "income" certain housing and food assistance -- do not apply to Extra Help eligibility.

3. While MSP eligibility is lost promptly when a beneficiary's income or assets exceed financial eligibility levels, Extra Help coverage -- especially for widow(er)s -- can continue for considerably longer periods.

4. Online applications for both MSPs and Extra Help can be partially completed and then continued at a later time. Applying for Extra Help online expedites the eligibility-processing time; that is less likely to be the case with online applications for MSP coverage.



**5.** Applicants for MSP coverage will be required to provide what some applicants often find to be burdensome information-verifying documentation. Applicants for Extra Help are able to self-declare some much (which SSA will attempt to verify through databases accessible to the agency).

## II. THE MEDICARE SAVINGS PROGRAMS

### A. OVERVIEW

1. The MSPs were designed to provide some relief to Medicare beneficiaries whose income and/or assets were “too high” to qualify for full-benefit Medicaid coverage, but too low to comfortably afford Medicare’s out-of-pocket costs.

2. For example, one of the most common ways a lower income Medicare beneficiary could qualify for full-benefit Medicaid – one benefit of which includes Medicare premium Buy-In -- was to qualify for SSI. But SSI financial eligibility levels are extremely low: countable income under \$771/month (in 2019),<sup>3</sup> which is only about 75% of FPL; and countable assets under \$2,000.

3. Implementation of MSP eligibility is *mandatory* for all state Medicaid programs.

4. Income eligibility levels for the MSPs are based on fixed percentages of current Federal Poverty Levels (FPLs). Those levels are recalculated annually, and usually made public between late January and February. *However, the new levels are not implemented by the state until April 1.*

NOTE: In any year when there is a cost-of-living (“COLA”) increase in Social Security benefits, the amount of an individual’s monthly COLA amount is disregarded until April 1.

5. Each of the three MSPs discussed here have 2-3 word titles; however they are commonly referred to by their acronyms.

### B. QMB

1. The initials stand for “Qualified Medicare Beneficiary.” QMB was the first of the MSPs to be required for state Medicaid programs.

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<sup>3</sup> The amount is effectively \$791 (for 2019) in most cases, since SSA disregards the first \$20/month of the applicant’s other income. Additional income disregards may apply to some types of income (*e.g.*, work income).

2. There is both an income *and* assets (resources) test for QMB. Applicants must have *countable* incomes under 100% of the FPL; and *countable* assets under set levels (*see Section II.F.2. for a chart of current financial eligibility levels*).

“Countable” refers to the fact that some of an applicant’s actual income and assets are disregarded (*i.e.*, not counted) in determining eligibility; such as the \$20 income disregard noted in footnote #3. **See Section II.D.**

3. There are only two income eligibility levels, one for an individual and the other for a married couple.

4. QMB covers a beneficiary’s Medicare Part B -- and, if necessary, Part A -- premiums as well as Part A and B cost-sharing (deductibles, coinsurance, and co-pays<sup>4</sup>).

**NOTE:** Regarding *premiums*, “covers” means that Medicaid actually pays them. Regarding cost-sharing, “covers” means that regardless of whether Medicaid makes any payment to a provider in addition to the amount paid by Medicare **QMB beneficiaries cannot lawfully be billed for the balance.**

QMB eligibility also results in automatic eligibility for a reduction in Medicare Part D prescription drug out-of-pocket costs. It does so by making the beneficiary **automatically eligible** for “**Extra Help**” (discussed in **Section III.**).

5. QMB coverage is only *prospective*; meaning that the coverage does not begin until the month *after* the month the applicant is found eligible.

### **C. SLMB and QI**

1. The initials stand for “Specified Low Income Medicare Beneficiary” and “Qualified Individual.”

2. There is both an income *and* assets (resources) test for both SLMB and QI coverage.

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<sup>4</sup> Regarding the difference between “Coinsurance” and “Co-pays,” see footnote #2.

a. SLMB applicants must have *countable* incomes *above* 100% of the FPL but under 120% of the FPL; and *countable* assets under the same levels applicable to QMB eligibility.

b. QI applicants must have *countable* incomes *at or above* 120% of the FPL, but under 135% of the FPL; and *countable* assets under the same levels applicable to QMB eligibility.

**Regarding the meaning of “countable,” see Section II.D.**

3. As with QMB, there are only two income eligibility levels -- one for an individual and the other for an eligible married couple (**see Section II.F.2. for a chart of current financial eligibility levels**).

4. SLMB and QI both cover only the beneficiary’s Medicare Part B premium. However, as with QMB, SLMB and QI eligibility also results in **automatic eligibility** for “**Extra Help**.”

**NOTE:** Since SLMB and QI both provide the exact same coverage, why are they two separate eligibility categories? The reason is based on legislative history. While federal law always required states to provide QMB and SLMB coverage, QI coverage was originally available only to the extent of federal appropriations for it. That restriction was eventually eliminated. As a result, it is OK to look at just the QI income eligibility level.

5. SLMB/QI coverage is *retroactive* up to three months prior to the month of application; if the applicant met the eligibility criteria (**see Section I.A.5.**).

**a. However, the state’s Medicaid application forms do not adequately alert applicants to their right to get the retroactive coverage.** Question #8 on the HSD 100 and MAD 100 application forms only ask if the applicant has “received *medical services*” in the previous three months.

**b. Until the forms are amended to alert SLMB/QI applicants to the possibility of retroactive coverage, we suggest applicants (1) answer yes to those questions, and add the words “Medicare premiums;” and (2) specifically discuss the matter with an ISD worker.**

## D. “COUNTABLE” INCOME AND ASSETS

1. “Countable” refers to the fact that not all of an applicant or beneficiary’s actual income or assets are counted in determining financial eligibility. There are some types and amounts that are *disregarded*.

2. An applicant’s **gross** income is determined before any disregards are applied. Thus, for example, the monthly Social Security payment a beneficiary receives is commonly their gross benefit amount *minus* a deduction for their Medicare Part B premium. But their “gross income” could be even *higher*:

a. Applicants and others are commonly astonished to learn that there is some gross “income” that is counted against them that they *don’t even have!* For example, income deducted from Social Security or SSI benefits to collect on Overpayments *is* counted for eligibility determination purposes;

b. More insidiously, individuals who are determined to have their shelter or food costs ‘subsidized’ by others -- what SSI calls “In-Kind Support & Maintenance” -- can have substantial amounts of ‘income’ attributed to them.

## E. ADDITIONAL BENEFITS OF MSP COVERAGE

1. Coverage under any of these MSPs eliminate any “late enrollment” premium penalties beneficiaries might otherwise have to pay out-of-pocket.

2. By automatically qualifying eligible beneficiaries for “Extra Help” with Medicare prescription drug costs, each of these programs makes beneficiaries eligible for the other advantages of that coverage (**see Section III.D.**).

3. *QMB* coverage can also help certain low income individuals *obtain* Medicare coverage, where it would be otherwise unaffordable (**see Section V**).

## F. APPLYING for MEDICARE SAVINGS PROGRAM COVERAGE

1. Applications are submitted to the state Human Services Department’s Income Support Division (“ISD”).

a. Online through the state’s “Yes New Mexico” ‘portal’ ([www.Yes.state.nm.us/](http://www.Yes.state.nm.us/)) ; by Faxing (1-855-804-8960) or mailing a paper application (to: Central Aspen Scanning Area (CASA), PO Box 830, Bernalillo, NM 87004); or in person, at an ISD office serving the area where you live.

2. As with any Medicaid coverage, applicants must also satisfy a number of other requirements; *e.g.*, residency, citizenship (including LPR status, etc.), providing documents verifying financial and other eligibility requirements.

**The Current\* Countable Income and Resources Limits for the Medicare Savings Programs Are:**

Category	INCOME**	RESOURCES
<b>QMB</b>		
Individual	\$1,032/month	\$7,573
Couple	\$1,392/month	\$11,360
<b>SLMB</b>		
Individual	\$1,234/month	\$7,573
Couple	\$1,666/month	\$11,360
<b>QI</b>		
Individual	\$1,386/month	\$7,573
Couple	\$1,872/month	\$11,360

\* The *income* eligibility figures increase annually, on April 1; the resources eligibility figures increase annually on January 1.

\*\* These income figures *include* the \$20 disregard.

## G. IMPLEMENTATION

1. Implementation of any beneficiary's premium Buy-In involves electronic communications among the state Medicaid agency, the federal Medicare agency ("CMS"), and the Social Security Administration (SSA).

2. Traditionally it could take 2-3 months for the agencies' computers to "talk" with one another to start (or stop) premium deductions from the beneficiary's Social Security benefits; causing retroactive payments (or debits) of applicants' benefits. This time lag has been markedly shortened by the ASPEN system, but there can still be problems when the identifying information the agencies have about particular individuals differs.

a. If implementation *is* delayed, SSA will send the beneficiary a refund for the months when Buy-In coverage should have been in effect.

b. The situation is reversed when a beneficiary is *terminated* from MSP coverage; the beneficiary's Social Security benefits will be docked for any non-coverage month.

3. The lag time in implementing the Buy-In can *increase* where a beneficiary's name or SSN are not listed exactly the same in each agency's data system.

4. The federal Office of Personnel Management ("**OPM**") is also able to arrange for Medicare premiums to be deducted from federal retirees' *monthly annuity payments*, but that is separate from the above-described Buy-In process.

### III. EXTRA HELP (a/k/a “LIS”)

#### A. BACKGROUND and OVERVIEW

1. Medicare implemented comprehensive coverage of prescription drugs in 2006. A limited amount of drug coverage existed before then --under Part B -- and that coverage continues to exist under Part B.

a. The comprehensive coverage is commonly referred to as Medicare “**Part D**” (named after the section of the Medicare law that authorizes the coverage).

**NOTE: Medicare beneficiaries who *also* have *full-benefit Medicaid coverage* must use Medicare’s drug coverage for most of their medications.**

2. Unlike Part A and B coverage, which beneficiaries can choose to use on a fee-for-service basis (*i.e.*, seeing any provider who accepts them as a Medicare patient), Part D coverage is available *only* from private *Plans*.

a. There are both statewide drug-only Plans (“**PDPs**”), and Medicare Advantage Plans serving particular geographic areas that include drug coverage (“**MA-PDs**”)

3. Medicare drug coverage is complicated because of the way it is structured and because the scope and cost of coverage can vary from plan to plan. Each Plan can adopt its own *formulary* -- a list of the specific drugs it covers and the manner in which it covers them. **Appendix B** has a summary description of how the coverage works.

4. Moreover, the coverage can involve a substantial amount of out-of-pocket “*cost-sharing*,” co-pays and coinsurance<sup>5</sup>); possible premiums and deductibles; and a coverage gap (k/a the “**Donut Hole**”); which can be a great burden for low income beneficiaries.

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<sup>5</sup> Regarding the difference between “Coinsurance” and “Co-Pays,” see footnote #2 on p.5.



5. Recognizing the potential financial burden, the law authorizing Part D included a program of financial assistance for low-income beneficiaries to cover some of those costs.

a. The Medicare *law* originally called this program “Low Income Subsidy” (“**LIS**”); a term you will still often see.

b. Early on however, the Medicare and Social Security agencies began to refer to the program as “**Extra Help.**”

## **B. How Extra Help Works**

1. Extra Help pays all or part of an enrolled beneficiary’s:

- a. Part D premiums and deductibles, if any;
- b. Part D coinsurance/co-pays; and
- c. Part D costs during the “donut hole”

HOWEVER, there are several levels of coverage, based on income and resource levels.

2. Beneficiaries with “countable” income up to 150% of the Federal Poverty level can get some assistance. However, beneficiaries with countable income under 135% of FPL -- which is the Medicaid QI eligibility level -- and “countable” resources under the MSP levels (*see Section II.F.2.* ) get the most generous help. In fact, **beneficiaries who receive Medicaid – including any MSP coverage – automatically qualify for Extra Help.**

3. Beneficiaries with “countable” incomes under 135% of FPL and “countable” resources under the MSP level get:

- a. Coverage of monthly premiums, if any, but only up to a “**benchmark**” amount;
- b. Coverage of their Plan’s deductible, if any;
- c. Coverage through the donut hole; and
- d. Substantially reduced coinsurance/co-pay charges

**NOTE:** Within the above “group,” beneficiaries receiving Medicaid-covered nursing home or home and community based “waiver” services have coinsurance/co-pays waived.

4. Beneficiaries with monthly “countable” income *at or above* 135% of FPL, but below 150% of FPL [\$1,538 for individuals; \$2,078 for married couples, in **2019**]; and “countable” resources up to \$13,390 (\$25,720 for couples) [**in 2019**] receive less generous assistance (**but see Section IV.B.2.d.**).

a. There are four differing levels of help for that group, based on whether the individual’s or couple’s countable income is:  
up to 135% of FPL;  
from 135% to 140% of FPL;  
from 140% to 145% of FPL; or  
from 145% to 150% of FPL.

**NOTE:** While 135% of FPL is also the *income* eligibility maximum for MSP coverage, the above-noted 135% figure is for Extra Help eligibles whose *assets* levels exceed the MSP levels.

### **C. Applying For Extra Help**

1. Applications are usually made to the Social Security Administration (SSA), and can be made in three ways:

- a. By submission of a special paper application form;
- b. Online at [www.ssa/prescription](http://www.ssa/prescription) help; or
- c. By phone, to 1-800-772-1213.

**Online applications are preferred.**

**NOTE:** Paper applications can only be made on special forms available from SSA. Photocopies or downloads of the form *cannot* be used.

2. Online applications must be completely filled out; SSA will make follow-up calls to individuals submitting incomplete paper forms.

3. You *can* also apply through state ISD offices, but applying through SSA is decidedly preferable.

4. Coverage is *retroactive* to the first day of the month in which the application is submitted.

5. Applicants *can* apply for *both* Extra Help with SSA; and MSP coverage through state ISD offices, even at the same time. There are some advantages to doing that (see **Section IV.B.**).

**NOTE:** You must be enrolled in a Medicare drug plan (including Medicare Advantage plans with drug coverage) before the Extra Help assistance can take effect.

#### **D. Benefits of Having Extra Help**

1. The coverage eliminates responsibility for any Part D late enrollment penalties.

2. Beneficiaries are able to apply for Extra Help throughout the year. If they are not enrolled with a Part D plan when found eligible, the Medicare agency will enroll them in a plan within about two months. In the interim, the beneficiaries can obtain drugs (with the subsidies) through a special program called “**LI NET.**”

3. Beneficiaries have the right to “switch” to other Part D plans (including Medicare Advantage plans with drug coverage) one time *during each of the first three calendar quarters of the year*. “**Switching**” is **not encouraged**, unless your current coverage proves to be unsatisfactory.

4. If the beneficiary has not enrolled with a drug plan, s/he will *automatically be assigned to one (but see point 3)*.

**NOTE:** All these consequences occur whether the beneficiary gets Extra Help by applying for it, or by automatically getting it as a result of obtaining Medicare Savings Plan coverage.

## E. Post-Eligibility Developments

1. The federal Medicare agency (CMS) will automatically enroll Extra Help eligibles in a PDP if the beneficiary has not chosen a different Plan.
2. CMS first notifies these eligibles in writing that they should enroll with a Plan or opt out of the coverage.
3. Each year, in August, CMS selects a number of beneficiaries for re-determination of eligibility. They are selected from among those who became eligible between May of the previous year and April of the current year.
  - a. Eligible individuals who were deemed eligible because, for example, they have MSP coverage, are excluded from that process. Their eligibility continues through the end of the following year regardless of changes in their deemed status.
  - b. In the case of an eligible *couple*, if one spouse dies during the year, the widow(er)'s coverage lasts for an *additional* year.
  - c. Eligible individuals can also report changes in circumstances that would affect their eligibility and/or amount of help. *However, there does not seem to be any penalty for failing to do so.*
4. The actions noted above generate a large number of written Notices for eligible individuals, which come on different colored paper.

## IV. MSPs vs. EXTRA HELP --- SIMILARITIES AND DIFFERENCES

### A. Some Similarities

1. Obtaining coverage under a Medicare Savings Program automatically qualifies a beneficiary for the more generous level of Extra Help assistance.
2. Each benefit requires an application, and the applicant must satisfy countable income and resources tests.

### B. Some Differences

1. Extra Help pertains solely to Medicare's drug coverage
2. MSP eligibility can terminate any time a beneficiary's monthly countable income and resources exceed eligibility levels; Extra Help for those individuals lasts at least until the end of the year.

In addition, where both members of a married couple were found eligible for Extra Help and one spouse dies, the Extra Help coverage for the widow(er) continues for an *additional* year.

3. Extra Help uses more liberal income and resources-counting rules than the Medicare Savings Programs. For example, under Extra Help (but not under the Medicare Savings Programs):
  - a. Family size (for determining the FPL amount) includes other dependent relatives living in the household (MSPs use only family sizes one or two);
  - b. "In-kind support and maintenance" is not considered;
  - c. The value of life insurance policies is not counted;
  - d. A \$1,500 per applicant burial fund resource disregard is available based simply on *declared intent* to use assets for burial expenses.

**3.** There are even different *colors* of the notices applicants and beneficiaries receive under both programs.

**a.** Under the MSPs, the notices -- which are sent by the state Human Services Department's Income Support Division -- are almost all on *white* paper;

**b.** Under Extra Help, notices – which are sent by the Social Security Administration and/or the federal Medicare agency (CMS) -- come in a variety of colors depending on which of many diverse situations is involved (*see Section III.E.*).

## V. “CONDITIONAL” APPLICATIONS FOR MEDICARE

### A. Purpose of the Conditional Application

1. A “Conditional” application for Medicare is an application an individual *aged 65 or older* can submit, under which Medicare coverage will not take effect should the applicant fail to qualify for full benefit Medicaid coverage or QMB.

2. Such applications are helpful primarily for people who do not qualify for premium-free Medicare “Part A.” -- typically, people who lack enough lifetime work in Social Security covered employment to get Social Security benefits.

3. If an individual needs to purchase Medicare, it is very expensive. In 2019, the premiums alone cost up to \$437/month for Part A; and at least \$135/month for Part B. Such individuals are unlikely to be able to afford the premiums.

4. If an applicant qualifies for Medicaid QMB, the QMB coverage will pay for his/her Part A and B premiums, cover their Medicare cost-sharing (*e.g.*, deductibles and co-pays), and automatically qualify the individual for “Extra Help” (financial assistance with Medicare drug costs).

### B. How the Application Process Works

1. To use the “conditional” application process, the individual must first apply for Medicare Parts A and B with the Social Security Administration (SSA), *stating s/he is doing so on a “conditional basis.”* **Unfortunately, the application can only be submitted in the first three months of any year** (known as the “General Enrollment Period” [GEP]).

2. Then, once the applicant receives written confirmation from SSA that s/he qualifies for Medicare, s/he should apply for QMB coverage with the state Human Services Department’s Income Support Division (ISD).

3. If the applicant is found eligible for QMB, the Medicare coverage will start automatically, effective July 1<sup>st</sup>. If the QMB application is denied, SSA will not start the Medicare coverage.

### C. Complications or Problems that Can Arise

1. As noted in B.1., the Medicare application must be submitted during the first three months of the year; ideally, as early as possible, to allow for possible application processing problems.

2. The Medicare coverage will not start until July, and it is not retroactive.

3. It is advisable to submit the QMB application by the beginning of *May* at the latest, because QMB does not take effect until the month *after* the month during which you are *found eligible*.

4. For several years, workers with both SSA and ISD were not sufficiently aware of the process; and, accordingly, failed to provide information about it to affected individuals and/or provided misinformation.

Recognizing the problem, in June 2018 SSA revised a provision in its “**POMS Manual**” that describes the process, and publicized the revision to its workforce nationwide. The POMS Manual is a compilation of rules on which SSA workers rely. The provision is “**POMS Section HI 00801.140.**”

### D. Citizenship

1. Applicants do not have to be U.S. Citizens to qualify for *Medicare*; but if not they do have to be a Lawfully Permanent Resident (LPR) who has resided in the United States during the five years immediately before the month the Medicare application is submitted.

2. QMB applicants do not have to be U.S. Citizens either, but *Medicaid's* rules for non-Citizen eligibility can add additional complications.



3. Non-U.S. citizens are advised to consult with an experienced advisor before submitting applications for QMB and conditional applications for Medicare.

**For more detailed information, the Senior Citizens' Law Office has a Fact Sheet on "Conditional Applications for Medicare" on the "Information Center" of its web site, [www.sclonm.org](http://www.sclonm.org). (Search "Healthcare," then "Medicare").**

# APPENDIX A

## MEDICARE: A BASIC INTRODUCTION

Medicare is a nationwide health insurance program. Enacted by Congress in 1965, Medicare was intended to pay for health care services to ensure a basic level of health care for the nation's elders (and later, persons with disabilities). Just as with most private health insurance, Medicare coverage includes cost-sharing in the form of premiums, deductibles, co-pays, and coinsurance.

### **1. Who Can Get Medicare?**

Individuals age 65 or older and who are eligible for Social Security; individuals receiving Social Security Disability benefits for 24 months; certain individuals receiving Railroad Retirement benefits; individuals who worked for governmental agencies and paid into Medicare; and individuals with end-stage renal disease (ESRD). Individuals 65 or older, but not otherwise eligible for Medicare, can purchase the coverage.

### **2. What Is the Difference Between Medicare and *Medicaid***

Medicare is run by federal agencies, and its rules are the same throughout the country. Eligibility is *not* "means tested." Medicaid eligibility always depends on whether you meet financial eligibility tests. Each state runs its own Medicaid program, and eligibility and coverage rules can vary from state to state.

### **3. How Does Medicare Coverage Work?**

Coverage is divided into three "parts;" A, B, and D. Almost all beneficiaries take Parts A and B; most also take Part D.

**Part A** covers hospital, skilled nursing home, home health, and hospice services. Most people do not have to pay a premium for Part A, because they or a spouse paid into Medicare from their past earnings. There are large cost sharing charges for hospital stays, and skilled nursing home stays after the 20th day.

**Part B** covers outpatient services, including doctor visits, lab and X-rays, medical equipment and ambulance trips. Unlike Part A, everyone is responsible for paying a monthly premium for Part B (others, including Medicaid if you're eligible, can pay it for you). The standard amount in 2019 is \$135/month. Your premium might be higher depending on your income. There are cost sharing charges for most services, except for many preventive services.

**Part D** covers prescription drugs. Coverage is available only from private plans, and each plan's coverage rules can differ. There can be a monthly premium, a deductible, and a gap in coverage known as the "donut hole" when the plan pays nothing; and there are usually co-pays for each prescription. By law, charges for drugs in the "donut hole" are decreasing; in 2019 they are 25% of cost for name brand drugs, and 37% of cost for generics.

#### **4. What Is Medicare "Part C"?**

Part C refers to the part of the Medicare law that authorizes private, mostly HMO-like, health plans to provide Medicare services to beneficiaries willing to sign up with them. They are technically known as "Medicare Advantage" (MA) plans.

#### **5. How Do You Sign Up For Medicare?**

A few months before your 65th birthday, or the 24th month of Social Security disability benefits, you will get a mailing that includes a Medicare card showing you will soon have Part A and B. Everyone else has to apply, usually with the Social Security Administration. You will have the chance to decline Part B, but unless you or your spouse is working and has health coverage you will face higher premiums and delayed coverage when you try to take it later.

#### **6. What Are Your Basic Medicare Choices?**

When you first get Medicare, it is on a fee-for-service basis ("Original Medicare"); you can use any willing medical provider. You can buy "Medigap" insurance, which mainly covers some Part A and B cost sharing. You can choose to sign up with a Part D plan (if you don't have other drug coverage, you may pay higher premiums if you choose to sign up later). You can choose to sign up with a MA

plan -- which often includes Part D coverage -- but must get all or most of your Medicare services through the Plan's providers. Any Medigap, MA or Part D Plan premiums are in addition to your Part B premium

Medigap insurance does not work with MA plan coverage. Medigap insurers cannot reject you for health reasons during the first six months you have Medicare. MA and Drug plans must usually accept you regardless of your health status whenever you choose to sign up with them.

You can also sign up with MA or Part D plans when you first sign up *for Medicare*. You can also sign up with, drop, or switch MA and drug plans during an annual October 15 – December 7 “Open Enrollment” period; and, starting in 2019 you can also *drop or switch* MA plans during the first three months of the year.

### **7. Can You Appeal Medicare Decisions?**

Yes, you can appeal most decisions about your eligibility, premium charges, and services coverage. In most cases you will get written notices that tell you how to appeal.

### **8. Is There Help With Paying for Medicare Costs?**

There are programs that assist lower income seniors in paying some of the Medicare cost sharing. For example, there are programs that help with Medicare premiums and cost-sharing. Contact the Senior Citizens' Law Office for more information.

## APPENDIX B

### MEDICARE'S PRESCRIPTION DRUG COVERAGE

Medicare's prescription drug coverage is codified as "Part D" of the Medicare Act. It was adopted by legislation in 2003, and implemented in 2006. Unlike Part A and B coverage -- which beneficiaries can choose to use on a fee-for-service basis -- Part D coverage is available *only* from private plans. The coverage rules under Plans can vary considerably.

#### **1. What Types of Plans Are Available?**

There are two types:

- a. **PDPs**, drug-only Plans that operate statewide; and
- b. **MA-PDs**, "Medicare Advantage" Plans that include drug coverage. They are available to residents of limited geographical areas within the state.

#### **2. What Drugs Are Covered?**

All Medicare drug Plans have their own *formulary* --- a list of the drugs they cover. Each Plan must cover at least two drugs in a large number of drug classifications (more in certain classes). It is possible for beneficiaries to get "*exceptions*" to their Plan's formulary (and/or cost-sharing amounts) based on medical need, but it is not always easy.

#### **3. How Does the Coverage Work?**

The structure of coverage is complicated (and can well be called zany) because: (1) while the law creates a "standard" benefit, Plans can and do use alternative coverage structures so long as they are "actuarially equivalent" to the standard benefit; (2) Plans can have differing formularies and cost-sharing arrangements; and (3) Plans can also have monthly premiums, which are not part of the standard benefit. (*see #6*)

#### 4. What Is the “Standard” Benefit?

a. The standard benefit in 2019 consists of:

- i. An annual deductible, of up to \$415, followed by;
- ii. An “initial coverage period”, with 25% coinsurance, which lasts until the total amount of the beneficiary’s and plan’s drug costs total \$3,782, followed by;
- iii. A coverage gap, widely known as the “Donut Hole,” when the Plan provides *no coverage* until the total amount of the beneficiary’s and (certain) plan’s drug costs (*see “b” below*) reach \$7,653.75, followed by;
- iv. A “Catastrophic” coverage period, with cost-sharing for each drug of either 5%, or \$3.40 for generics and \$8.50 for brand names, whichever is greater.

b. As a result of a provision in the *Affordable Care Act* the prices that beneficiaries have to pay for most drugs during the Donut Hole are discounted significantly, but they are credited with their Plan’s full cost.

i. During 2019, beneficiaries pay only 35% of the cost for brand name and “biologic” drugs, and 37% for generics.

ii. Those percentages were both scheduled to ultimately decrease to 25%. A provision in recent federal legislation accelerated the time when the *brand name* drug percentage applies, to this year (2019).

#### 5. Do Plans Charge Premiums?

All stand-alone drug Plans (PDPs ) have monthly premiums. Most Medicare Advantage Plans with drug coverage (MA-PDs) offer a zero-premium Plan option.

**NOTE:** Any plan premiums are *in addition* to beneficiaries’ Medicare Part A and B premiums. Also, as with Part B, higher income beneficiaries must pay a higher Part D premium (if any).

## **6. Why And How Do Plans' Coverage Differ so much?**

As mentioned in #4, while there is a “standard” benefit structure set forth in the Medicare law, Plans can and do adopt varying alternative benefit structures so long as the structures are “actuarially equivalent” to the standard benefit. In addition, some Plans have premiums. Here are ways in which Plans' coverage can vary:

- a. They can have monthly premiums in varying amounts;
- b. They can have their own list of covered drugs (“formulary”);
- c. They can reduce, or eliminate any deductible;
- d. They can have varying co-pay and/or coinsurance amounts for drugs;
- e. They can assign drugs to different “tiers,” with each tier requiring a different amount of co-pay or coinsurance;
- f. They can provide some coverage in the Donut Hole;
- g. They can apply ‘administrative controls’ over access to particular drugs such as prior authorization, quantity limits, and “step-therapy;”
- h. They can have Plan offerings with higher premiums, which can offer broader coverage.

Plans can have a restricted “network” of the pharmacies you can use, and within that network designate some as “preferred” (where cost-sharing is usually lowest). In addition, Plans can make some changes to their formularies annually, and even during the year (subject to advance notice).

## **7. When Can You Select Prescription Drug Plans?**

Beneficiaries can enroll with a PDP or MA-PD during the same seven-month period they use to sign up for Medicare initially, or within two months after they lose other public or private prescription drug coverage

They can also enroll with, drop, or switch between Plans during an annual October 15-December 7 “Open Enrollment” period [technically named the “ACEP”]. Starting this year (2019) beneficiaries *who are enrolled in MA plans* can drop their MA plan, and enroll with a Part D plan, during the first three months of the year.

In addition, there are several *special enrollment periods* (SEPs) applicable to diverse situations, and beneficiaries who get “Extra Help” subsidies (see #10) can switch their Part D coverage one time during each of the first three calendar quarters of the year..

### **8. Is There A Penalty For Enrolling With a Prescription Drug Plan Late?**

Yes. If a beneficiary chooses to enroll in a Part D Plan outside the periods noted in #7, they will be penalized in the form of permanently higher premiums *unless* they had “creditable” drug coverage up to two months before their enrollment. “Creditable” coverage means coverage as good as Medicare’s, and most major sources of drug coverage satisfy that standard. The penalty amount is based on the number of months the beneficiary lacked creditable coverage, and is comparably modest.

### **8. How Can You Determine What Plan Is Best For You?**

The Medicare program has a “Plan Finder” tool. You can access it on the program’s [www.medicare.gov](http://www.medicare.gov) web site; or by phone call to the program’s 1-800-MEDICARE toll-free phone line. You can also get help from New Mexico’s “Aging & Disability Resource Center” (**ADRC**) (toll-free 1-800-432-2080; TTY 476-4937) and from numerous other public and private organizations and insurance agents, all of whom likely utilize the website-based tool.

Although the tool enables beneficiaries to compare Medicare Advantage plan coverage as well as Plans’ prescription drug coverage, it is set up to first ask about the beneficiary’s prescription drug usage. You input the name, strength, and dosage of each drug you use, and the pharmacies you use; and choose to review PDP and/or MA-PD options.

The results will show each plan that supposedly covers your drugs, ranked from the lowest overall costs to you (including any premiums) to the highest. You can access more detailed information about each covered drug, and, for example, about your costs through the year. If you take multiple drugs, making a Plan choice can be difficult because of the



differing coverage structures of plans. In addition, it is recommended that you contact the Plan(s) you are considering to confirm the information. It is not an easy task to use the tool and make decisions if you use multiple prescription drugs.

### **9. Can You Appeal Coverage Decisions By Your Part D Plan?**

Yes. You can appeal any coverage decision, but two types of appeals are most noteworthy: appeals from “exception” requests, and “tier” assignments. An exception request seeks coverage of a drug that’s not on the Plan’s formulary, but which is medically needed for the beneficiary. A tier exception appeal seeks to have a lower tier’s co-pay or coinsurance charge applied to your drug. The written support of your provider is indispensable to these appeals. Denials of exceptions can be appealed.

There are a few levels of appeals that can be pursued, and no fees or charges for them. A major problem is that you usually do not know that coverage has been denied until you go to get your prescription at the pharmacy counter. Even then, beneficiaries must ask their Plan for an actual *coverage determination* in order to appeal. This oddly bureaucratic requirement discourages many beneficiaries from appealing.

### **10. Is There Financial Assistance Available to Help Meet Part D Out-Of-Pocket Costs?**

Yes. The same law that authorized Medicare’s Part D coverage established a program of assistance for lower-income beneficiaries to help defray the out-of-pocket costs that arise under Part D coverage. Originally called “Low Income Subsidy” (LIS, a term you will still often see), it became known as “**Extra Help.**” There are several levels of Extra Help, which defray various portions of any Plan’s premium (if any), deductible (if any), Donut Hole costs, and co-pays and coinsurance amounts.

The most generous assistance is provided to individuals who have SSI, full-benefit Medicaid, *Medicaid* “Medicare Savings Program” (QMB, SLMB, and QI) coverage, or meet the financial eligibility tests for SMB, SLMB, or QI.

Beneficiaries with SSI, Medicaid, or Medicare Savings Program eligibility are *automatically deemed eligible* for Extra Help. All others must apply with the Social Security Administration --- online, in person, or through SSA's national toll-free service (1-800-772-1213; TTY 1-800-325-0778).