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THE BENEFITS PLANNER

KEYS TO EFFECTIVE BENEFITS PLANNING, ASSISTANCE AND OUTREACH

THE MEDICARE PART D PRESCRIPTION DRUG PROGRAM

Special Issues Facing Younger Individuals Who are Dually Eligible for Medicaid and Medicare and The Interaction of Part D with the SSI, SSDI, Medicaid, and Medicare Work Incentives

The new Medicare Part D prescription drug program, which goes into effect on January 1, 2006, is one of the hottest topics of conversation among seniors. It is also a hot topic among younger individuals with disabilities who receive both Medicare and Medicaid.

Individuals who have been classified as "dually eligible" for both Medicare and Medicaid do not have a choice about whether to enroll or not. Under federal law, those individuals are required, effective January 1, 2006, to use Medicare Part D rather than Medicaid to pay for their prescription drugs. In fact, the federal Centers for Medicare and Medicaid Services will "auto enroll" into Part D any individual who has been identified as dually eligible for Medicare and Medicaid. With some exceptions for drugs not available through a Part D prescription drug plan, New

York's Medicaid program will no longer pay for prescription costs for those who are dually eligible after January 1, 2006.

This article will provide an overview of the Medicare Part D program as it applies to younger individuals with disabilities, with two special areas of focus. We will focus on the special issues facing individuals who are dually eligible for Medicare and Medicaid. We will also focus on the interaction of Part D with the range of work incentives under the Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare and Medicaid programs. Although the majority of Part D recipients will be individuals over age 65, we will not focus on the issues that are unique to the over 65 population including the interaction of Medicare Part D with New York's EPIC drug program.

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Medicare, the Basics

To understand how Part D will affect younger individuals with disabilities, it is important to understand what Medicare is, how an individual becomes eligible, and what happens to eligibility when an individual with a disability works. This section will discuss eligibility, premiums, and deductibles; the special issues facing Medicare recipients who work are discussed later.

What is Medicare?

Medicare is a federal health insurance program for persons over 65 and younger persons with disabilities. Medicare Part A covers a range of inpatient care. Medicare Part B covers outpatient services, including physician services, durable medical equipment, prosthetic devices, and home health services. Medicare Part C, formerly known as Medicare+Choice, is now called Medicare Advantage. Part C, commonly referred to as the managed care option, authorizes a variety of alternative private medical insurance and delivery systems.

Medicare Part D authorizes prescription drug insurance that will be voluntary for Medicare beneficiaries starting in 2006. Even though Part D is optional, for Medicaid recipients who are dually eligible for Medicare, enrollment is mandatory if the individual wants prescription drug coverage.

Medicare Eligibility

Medicare is almost universal for U.S. residents age 65 and older. It also covers individuals under age 65 who:

- Have received 24 months of SSDI benefits, or 24 months of Railroad Retirement disability benefits; or,
- Have End-Stage Renal Disease, a kidney impairment that requires regular dialysis or kidney transplantation to maintain life.

Persons diagnosed with amyotrophic lateral sclerosis (ALS) are exempt from the 24-month waiting period.

Unlike Medicaid, Medicare recipients need not have limited income and resources to establish eligibility. However, in the Part D low-income subsidy program, there is an income test for determining eligibility. As explained below, individuals who are eligible for both Medicare and Medicaid (dually eligible individuals) are automatically eligible for the full low-income subsidy without regard to their income.

Medicare Premiums, Deductibles, and Co-Payments. Medicare Part A coverage is generally automatic and not subject to a premium payment. Part B is optional and requires a premium payment (\$88.50 in 2006). Local Medicaid programs may pay these premiums for low-income individuals through the Qualified Medicare Beneficiaries (QMB) program, the Selected Low-Income Medicare Beneficiaries (SLMB) program, or Qualified Individual (QI-1) program. The QMB program allows state Medicaid programs to pay Part B premiums as well as copayments and deductibles, while the SLMB and QI-1 programs cover Part B premiums only.

This chart shows 2005 monthly eligibility figures for the QMB, SLMB, and QI-1 programs.

Family/ household size	QMB (poverty x 100%)	SLMB (poverty x 120%)	QI - 1 (poverty x 135%)
1	\$838	\$1,005	\$1,131
2	\$1,113	\$1,335	\$1,502
Resource Limits	\$4,000 individual \$6,000 couple	\$4,000 individual \$6,000 couple	no resource limit

In determining countable income for QMB, SLMB and QI-1 purposes, the SSI formula for calculating countable income (i.e., the same formula as used for determining countable income in the Medicaid spend down program) is used.

Medicare Part D planning tip. Although QMB, SLMB, and QI-1 recipients may not be Medicaid recipients, they are considered “dually eligible” for Medicare and Medicaid under Part D. This makes them automatically eligible for the full low-income subsidy, meaning they will face limited copayments, no deductibles, no cost sharing, no “donut hole,” and either no monthly premium or a reduced premium. Taking steps to ensure QMB, SLMB, or QI-1 eligibility guarantees dual eligibility status and, with it, eligibility for the full low-income subsidy.

Medicare Part D: Issues Faced by SSDI and SSI Beneficiaries

What is Part D?

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) added a new prescription drug benefit to the Medicare program. This benefit, known as Medicare Part D, will

affect both Medicare beneficiaries, and beneficiaries who are eligible for both Medicare and Medicaid (dual eligible beneficiaries). The Center for Medicare and Medicaid Services (CMS) is responsible for the overall implementation of Medicare Part D.

Opting for Coverage and Auto Enrollment

Enrollment in Medicare Part D is voluntary for individuals who receive Medicare only (i.e., those who do not also receive Medicaid). However, enrollment is essentially mandatory for dual eligible beneficiaries who wish to receive prescription drug coverage because Medicaid will no longer cover prescription drugs for those eligible for both Medicaid and Medicare as of January 1, 2006. Not surprisingly, the Medicare Part D enrollment process will differ for Medicare only individuals and dual eligible recipients.

Medicare only individuals must actively enroll in a Part D plan if they wish to have prescription drug coverage through Part D. Medicare only individuals who are eligible or become eligible for Medicare during or after January 2006 should enroll in a Medicare Part D plan during the initial enrollment period or no later than May 15, 2006 to avoid premium penalties of one percent of their premium cost for every month of delayed enrollment. Late penalties apply to all Medicare beneficiaries and last for as long as the individual is enrolled in Medicare Part D.

If a Medicare only beneficiary is receiving drug benefits through another health insurance program and receiving creditable coverage (prescription drug benefits that are at least as good as the Medicare drug benefit), then he or she does not have to enroll in the new Medicare drug plan. These individuals should receive a letter from the insurance company indicating if their plan is creditable. Medicare only beneficiaries who do not have an existing drug benefit plan should consider enrolling during the initial enrollment period (i.e., before May 15, 2006) to avoid premium penalties.

Dual eligible beneficiaries cannot choose whether to enroll or not enroll into Medicare Part D; they will be auto-enrolled into the program. CMS will auto-enroll a dual eligible beneficiary into one of the lowest premium prescription drug plans offered in their state. Initial auto enrollment will occur between November 15, 2005 and December 31, 2005.

Keep in mind that the plan that a dual eligible beneficiary is auto-enrolled into may not be the best

for his or her individual needs. Dual eligible beneficiaries will have the option to switch from their assigned plan into another plan should they choose but should do so before December 31, 2005 to avoid lapses in drug coverage. Individuals who do not elect another plan will automatically be enrolled in the plan to which they were pre-assigned. Since Medicare Part D will replace Medicaid's prescription drug coverage for dual eligible beneficiaries as of January 1, 2006, dual eligibles should ensure that they are enrolled in a plan that best fits their individual needs.

Effective January 1, 2006, the existing prescription drug coverage for dual eligibles will end. The change in drug coverage from Medicaid to Medicare will affect dual eligible beneficiaries in a number of ways. First, dual eligibles will be responsible for a prescription drug copayment. Second, some Medicaid-covered drugs may not be covered under the new Medicare prescription drug program. Third, an assigned drug plan may not provide all the drugs an enrollee needs. Fourth, an assigned drug plan may not be accepted by that individual's usual pharmacy. While the latter two potential problems may also affect Medicare only recipients, we focus on dual eligible beneficiaries as they are more likely to be sick and poor yet likely to require more frequent use of prescriptions.

Benefit specialists should be ready to advise dual eligible beneficiaries of the following:

- Medicaid will continue to pay for other health care costs so recipients should not discard their Medicaid cards.
- If a Medicaid recipient is paying a spend down, they must continue paying the spend down or Medicaid will not pay for other health care costs.
- They will automatically be assigned to a Medicare Part D plan, but can immediately switch to a plan that better suits their needs.
- Their Medicaid card will no longer work at the drugstore as of January 1, 2006.
- If they have not been auto enrolled in a plan by January 1, 2006, they should bring their Medicaid and Medicare cards with them to their drugstore. They will be auto enrolled in a national plan, Welcare, on the spot.
- Only certain pharmacies will be able to fill their prescriptions depending on the Medi-

care Part D plan in which they are enrolled.

- They should ask their favorite pharmacy, especially if it is an independent pharmacy (not a chain), which drug plans will be accessible through them.
- A prescription drug plan's formulary (list of drugs covered) may not cover all prescribed drugs.
- In the past, if they told their pharmacy that they could not afford the Medicaid copayment, a pharmacy could not refuse them the medication. This has changed under Part D. They must pay the copayment or they may not be able to get their medication.
- They may need to take special action in situations in which their prescribed drugs are not on the drug plan's formulary.

What Will Part D Coverage Cost Beneficiaries?

As of January 1, 2006, Medicare will offer a standard drug benefit to all Medicare recipients. The recipient's share or out-of-pocket costs connected with this coverage will vary depending on whether the individual qualifies for a full or partial low-income subsidy, discussed in the next section.

Medicare beneficiaries, who enroll in Part D and are not eligible for a low-income subsidy (also called "extra help") will generally have to pay:

- The monthly premium which averages about \$29. Keep in mind, however, that most drug plans will have a smaller or larger monthly premium, with less or more drugs covered depending on the cost of the premium.
- A deductible of \$250 (the first \$250) (some plans may waive this, but charge more for certain drugs)
- 25 percent coinsurance for initial coverage costs from \$250 to \$2250 (total \$500) or a copay that reflects approximately that 25 percent
- 100 percent of drug costs between \$2250 and \$5100 (total \$2850)(referred to as the "donut hole")
- Depending on the prescription drug plan, 5 percent of drug costs above \$5100 or a copayment of \$5 for brand name drugs and \$2 for generic drugs. Individuals who reach this category are referred to as needing catastrophic coverage.

Medicare only beneficiaries will need to become familiar with the term true-out-of-pocket costs (TrOOP). A beneficiary's Medicare plan will keep track of a recipient's TrOOP costs and should send the beneficiary a monthly statement reflecting where he or she stands in connection with meeting the \$250 deductible through their TrOOP. Keep in mind that only payments made towards drugs on a plan's formulary count towards the out-of-pocket maximum. This means that drugs purchased from an out-of-network pharmacy or drugs that are explicitly excluded from Medicare coverage, like over the counter drugs, will not count toward the TrOOP.

The Low-Income Subsidy

Through the low-income subsidy, the federal government will provide "extra help" with the premium, deductible and copayments to needy eligible individuals if they enroll in a Medicare Part D plan. CMS estimates that about 40 percent of those eligible for Part D will be eligible for extra help. Individuals qualify for the low-income subsidy in one of two ways: automatically, if they are considered dually eligible for Medicaid and Medicare; or by separate application if they are eligible for Medicare only.

Dually eligible recipients include Medicare recipients who receive Medicaid of any kind or who are enrolled in one of the Medicare Savings Programs, QMB, SLMB, or QI-1, as discussed above. Full extra help will be provided to dual eligible beneficiaries, meaning they will owe no monthly premiums (or limited premiums if they select a more expensive plan), no deductibles, no co-insurance, no out-of-pocket money for the donut hole, and limited per prescription copays. For dual eligible beneficiaries with incomes above 100 percent of the federal poverty level, there will be copays of \$2 for generic/preferred drugs and \$5 for brand name/non-preferred drugs up to the out-of-pocket limit (\$3,600), after which there is no copay. For dual eligible beneficiaries with incomes below 100 percent of the federal poverty level, the out-of-pocket copayment is reduced to \$1 for generic/preferred drugs and \$3 for brand name/non-preferred drugs up to the out-of-pocket limit. For those dual eligible beneficiaries who are institutionalized, there will be no copays.

Medicare only beneficiaries can qualify for either full or partial assistance depending on their income and/or asset category. For Medicare only beneficiaries, there will be two categories of extra help: full

extra help for individuals under 135 percent of the federal poverty level and partial extra help for individuals with income between 135 percent and 150 percent of the federal poverty level.

Individuals who qualify for partial extra help will have a sliding scale monthly premium, an annual deductible of \$50, 15 percent copays through the \$3,600 out-of-pocket limit, and copayments of \$2 and \$5 through the catastrophic stage.

<i>This chart summarizes costs for the different categories of individuals eligible for the low-income subsidy.</i>			
<i>*FPL is the Federal Poverty Level</i>			
Category	Income b/w 135% & 150% of FPL* (\$1,078-1,196 per month) Assets less than \$6,000 for individual, \$9,000 for couple (Partial Help)	Income of less than 135% of FPL (up to \$1,077 per month) Asset less than \$10,000 for individual, \$20,000 for couple (Full Help)	Dual Eligible (Full Help)
Monthly Premium	sliding scale	\$0	\$0
Annual Deductible	\$50	\$0	\$0
Copayment (between \$251 & \$5,100)	pay 15% for drug costs between \$50 & \$5,100	Institutionalized = no copays \$2-\$5 copays up to drug costs of \$5,100	Dual Eligibles w/income of less than 100% of FPL = \$1-\$3 copays Dual eligibles w/income of more than 100% of FPL = \$2-\$5 copays ...up to drug cost of \$5,100
Catastrophic coverage for drug costs over \$5,100	\$2-\$5 copays	100% covered	100% covered

Individuals who receive Medicare only benefits will need to apply for the low-income subsidy at their local Social Security Administration (SSA) office.

Low-Income Subsidy Applications

Since SSA is handling applications for extra help, they must use federal SSI rules for counting of income and resources when making low-income subsidy determinations. Enrollment for the low-income subsidy starts as of the first day of the month of application, if the individual is found eligible. In addition, while taking a low-income subsidy application, SSA must screen for Medicare Savings Plan (MSP) eligibility. If it appears that the individual is eligible for MSP, SSA must facilitate, through local Medicaid agencies (the Departments of Social Services or Human Resources Agency in New York City), applica-

tions for the MSP. State Medicaid rules must be used for calculating countable income in the MSP determination.

Applicants found eligible for the MSP must be offered enrollment into the MSP. If the applicant accepts MSP enrollment, the individual becomes deemed eligible for the low-income subsidy.

Benefits specialists need to be proactive to ensure that eligible individuals apply for the low-income

subsidy, that individuals who might be eligible for the Medicare Savings Plan do indeed apply for it, and that individuals who should be dual eligibles have received the letter informing them that they will not need to apply for the low-income subsidy as they are being auto enrolled in it.

Benefits specialists should also remember that making decisions about whether to apply for the low-income subsidy may be especially tough if individuals are paying a significant spend down or buy-in premium. Readers should carefully look at this issue's Technical Assistance Corner that deals with this dilemma.

Picking a Prescription Drug Plan

As stated earlier, CMS will auto-enroll dually eligible recipients into the lowest premium Prescription Drug Plan (PDP) offered. These individuals will have the option to

switch from their assigned plan into another plan if they choose but should be advised to do so before December 31, 2005 to avoid lapses in drug coverage. Additionally, Medicare only recipients will need to actively enroll in a Medicare PDP if they wish to have prescription drug coverage through Part D.

Individuals may choose an initial PDP or change their plan by filing a paper application with the plan directly or by applying online using the Medicare Part D Drug Plan Finder Tool. An individual may have an appointed representative who acts on their behalf when dealing with Medicare on Part D enrollment and other related issues. A signed agreement should be submitted to the PDP annually, legally appointing the individual who is acting on behalf of the beneficiary.

There are many resources that a beneficiary could use to advise them on how to compare and choose a plan in their area:

- a provider, counselor or benefits specialist
- 1-800-Medicare (manning phones 24 hours a day); TTY users dial 1-877-486-2048
- the Medicare website, www.medicare.gov, and its Medicare Part D Drug Plan Finder Tool
- local health care organizations
- local pharmacies
- the Health Insurance Information Counseling Assistance Program (HIICAP), 1-800-333-4114

The Medicare Part D Drug Plan Finder Tool provides general information about various drug plans. This online tool will help beneficiaries view case-specific information regarding their level of benefits including costs, levels of coverage, and names and addresses of preferred and non-preferred pharmacies in their area. It will also allow individuals to enroll in a plan or switch their plan.

Additionally, the Drug Plan Finder Tool will provide beneficiaries with: 1) side-by-side comparisons of up to three different drug plans offered by companies in their region, 2) specific cost information for each plan, 3) a search tool that allows an individual to input their medications in order to find a PDP that provides their medications, and 4) identification of the best plan for the individual based on their specific medications and benefit level.

Benefits specialists should alert beneficiaries and individuals assisting beneficiaries that the Drug Plan Finder Tool is not perfect and that any

PDP it selects as the best plan for the beneficiary should be confirmed by going to their pharmacy of choice and confirming that all their prescription drugs are indeed covered at their benefit level. Beneficiaries can change PDPs if they are not happy with them. Medicare only individuals may enroll in a new plan during the annual coordinated election period from November 15th through December 31st of each year. Dual eligible beneficiaries may switch plans once a month, anytime during the year.

What if Drug Plan Does Not Cover a Needed Drug?

Drug plans do not have to cover all Part D drugs. Medicare will provide plans with a list of drugs that the PDP must cover, allowing the plan to decide which additional drugs it will cover. But what if a beneficiary's new Medicare drug plan does not cover the medications that he or she currently takes? The PDP must have a transition process for cases like this. The processes, however, may differ.

The PDP may offer a one-time refill or the plan may explore substitutions with the beneficiary's physicians before the new coverage takes effect. Keep in mind that plans must explain the transition process to a beneficiary upon request and must include their transition process on their website.

If a beneficiary wants to get long-term coverage for a non-covered medication, he or she will most likely need to file an exception request. This is because Medicare will only pay for drugs that a plan has on its formulary or a drug that a plan approves through its appeals and exceptions process. An exception is a beneficiary's request for his or her plan to cover a medically necessary drug that is not on the drug plan's formulary.

A beneficiary should contact the PDP to request an exception as soon as the individual is told that a certain drug will not be covered. The beneficiary will need to submit oral or written support from the doctor that substantiates the need for the drug. The plan must grant an exception when the drug is medically necessary.

Two types of exceptions can be requested. A beneficiary may submit a standard request in which the plan must respond within 72 hours. Alternatively, a beneficiary may submit an expedited request in which the plan must respond within 24 hours. An expedited request may be granted when a beneficiary's life, health or ability to regain maximum function is threatened.

Websites to Support Your Medicare Part D Work

- ❖ Medicare's Website, www.medicare.gov
- ❖ New York Medicaid Agency, the Department of Health, www.health.state.ny.us/health_care/medicaid/index.htm
- ❖ the Kaiser Family Foundation, www.kff.org
- ❖ the Medicare Rights Center (NYC), www.medicarerights.com
- ❖ the Center for Medicare Advocacy, www.medicareadv.com

If a plan grants the request for exception, it will cover the refills for the remainder of the calendar year as long as the drug is safe and the doctor continues to prescribe the drug. If a plan denies the request for exception, the PDP must issue a "Notice of Denial of Medicare Prescription Drug Coverage." The beneficiary may appeal the plan's decision. Preferably, a prescribing doctor or representative should act on the beneficiary's behalf. If on appeal, the drug is not approved, the Medicare only individual will need to pay for it out-of-pocket or the doctor will need to prescribe another covered drug by the plan unless the individual is a dual eligible.

New York's Medicaid Wrap-Around Program

In limited circumstances, New York's Medicaid program will provide an additional wrap-around benefit for drugs not covered by the prescription drug plan in addition to the federally excluded drug categories (benzodiazepines, barbiturates and certain over-the-counter drugs). This will occur only after the prescribing doctor has requested an exception request with the prescription drug plan and has received a denial. The Medicaid program will only pay for the drug if the prescribing doctor has verified through the Medicare Verification System (MVS), at 1-800-292-7004, that a coverage request was made and denied. The prescribing doctor will then receive an MVS number which must be included on the prescription. Thereafter, the pharmacy filling the prescription must call 1-800-292-7004 and respond to a short series of questions and use the MVS number on the claim at the time of claim submission.

Medicare, Medicaid, and the Younger Individual with a Disability: Key Issues for Benefits Planning

Although plenty of good resources have emerged that explain the Medicare Part D program (see box, p. 158), only a small number of those resources focus on younger individuals with disabilities. Still fewer of those resources even acknowledge the special issues faced by potential Part D recipients who are working or plan to go to work.

This part of the article addresses the special issues faced by younger individuals. In particular, we focus on the interaction between Part D and some of the key work incentives, including extended Medicare, 1619(b) Medicaid, and the Medicaid buy-in.

What Happens to Medicare When an SSDI Recipient Works?

An SSDI recipient who works can receive an SSDI check throughout a nine-month trial work period and, in some cases, throughout a subsequent 36-month extended period of eligibility (EPE). If he or she performs substantial gainful activity (SGA) by earning more than \$860 monthly in 2006 (or \$1,450 monthly if legally blind) after the EPE, the right to a benefit check will end. Medicare eligibility continues throughout the trial work period and EPE. Thereafter, if the person earns less than the SGA amount (\$860 in 2006) and SSDI benefits continue, Medicare benefits will likewise continue under normal rules.

Extended Medicare Provisions. Individuals who lose SSDI by earning above the SGA level can have extended Medicare coverage if their disability continues. Medicare coverage continues under normal rules (Part A, cost free; Part B optional and subject to premium payment; Part D optional, but subject to auto-enrollment for those dually eligible for Medicaid and Medicare) for at least 93 months following the SSDI trial work period, even if SSDI benefits have been terminated because of earnings.

Medicare Part D planning tips. Depending on whether the SSDI recipient completed their trial work period and when, the individual may have just a few months of eligibility left under the Extended Medicare provisions, or up to 8 and 1/2 years of eligibility remaining under those provisions. Even after the Extended Medicare eligibility period ends, there is an option for continued Medicare eligibility by paying a premium (known as "Premium HI"). Looking at the long-range picture, the individual may need to think about Medicaid once again becoming their primary source of prescription drug coverage when Extended Medicare ends.

Medicaid Work Incentives: Section 1619(b) and the Medicaid Buy-In

Medicaid is historically thought of as a program for individuals with limited income and resources. However, two special work incentives – the 1619(b) program and the Medicaid buy-in – allow for Medicaid eligibility for individuals who are working and earning substantial wages. Obtaining or retaining Medicaid, through any of the methods discussed below, can be an important part of reducing costs associated with the Medi-

care Part D program, as individuals who are eligible for both Medicare and Medicaid are eligible for the full low-income subsidy program.

Medicaid will also be important to dually eligible recipients (i.e., those using Part D for prescription drugs) because it will continue to pay for many services that Medicare will not cover. When Medicare does cover a service that Medicaid also covers, Medicare will pay first and then Medicaid will typically pay any copayments (i.e., 20 percent of the charge for the item or service that Medicare will not cover).

Section 1619(b) - Continued Medicaid for Wage Earners

SSI is a cash benefit program for individuals with disabilities or blindness who have limited income and resources. In New York, SSI recipients qualify for Medicaid automatically. Even \$1 in SSI benefits guarantees automatic Medicaid eligibility.

If an SSI beneficiary works, the first \$65 of wages each month is not counted (or \$85 if there is no unearned income). The SSI check is then reduced by \$1 for every additional \$2 of gross monthly wages. For a person who lives alone, SSI eligibility will cease if they earn \$1,465 or more per month in 2006. This is because countable income, at this rate of pay, would be equal to the SSI living alone rate of \$690 per month. For a person getting the 2006 SSI living with others rate of \$626 per month, SSI eligibility will cease if they earn \$1,337 or more per month.

If the individual receives a combination of SSDI and SSI, the SSI payment will be lost at a much lower level of earned income. For example, an individual who gets \$520 per month in SSDI and \$190 per month in SSI will lose SSI if monthly gross wages are \$445 or higher.

Section 1619(b) allows automatic Medicaid to continue if a person loses SSI due to wages. If the person is still disabled and would be eligible for SSI if the wages were not counted, Medicaid should continue if they meet other 1619(b) criteria (a given in most cases). In New York, the 2006 income limit is \$40,462. The income limit can be higher if medical expenses are high enough.

Medicare Part D planning tips. Individuals with continuing disabilities who receive both SSI and SSDI and work for significant wages will almost certainly retain Medicare for at least 93 months after their SSDI trial work period. If the

individual works for significant wages and keeps Medicare, but does not retain Medicaid through 1619(b), the individual may not qualify for the low-income subsidy program. This means they could face monthly premiums, deductibles, cost-sharing, and higher prescription co-payments. Obtaining or retaining 1619(b) guarantees eligibility for Part D as dually eligible and guarantees the full low-income subsidy.

Key 2006 Social Security and Medicare Changes

SSI Monthly Payment Rates for New York

Living Alone - \$690

Living with Others - \$626

Living in the Household of another - \$425

Couple - \$973

Social Security Disability Insurance Thresholds

Substantial gainful activity - \$860 per month (\$1,450 for legally blind)

Trial work month - \$620

SSI Student Earned Income Exclusion Amounts

Up to \$1,460 per month excluded

Up to \$5,910 per year excluded

Section 1619(b) Eligibility Thresholds

Base amount - \$17,580

Title 19 or Medicaid amount - \$22,882

Total threshold - \$40,462

Medicare Part B Premium

\$88.50 per month

Medicaid Eligibility - the Medically Needy or Spend Down Program

An individual with a disability who is not eligible for SSI benefits (or eligible for continued Medicaid as a former SSI recipient under the 1619(b) rules discussed above) must apply separately for Medicaid. A single individual with a disability will be eligible, under 2006 rules, if countable income is no more than \$692 per month and resources no more than \$4,150. If countable income is more than \$692 the individual will qualify only with a spend down.

Medicare Part D planning tips for individuals who would only be eligible for Medicaid with a spend down. If the individual is already eligible for Medicare and would be required to get prescription drugs through Part D, deciding

whether to pay the spend down to keep Medicaid involves a balancing of several factors:

- Determining the out-of-pocket costs for Part D coverage with dual eligibility (for Medicaid and Medicare) and comparing that with the out-of-pocket costs for Part D coverage with Medicare eligibility only.
- With dual eligibility, there is automatic eligibility for the full low-income subsidy.
- With Medicare only eligibility, eligibility for the subsidy is based upon a needs test.
- Determining what Medicaid is currently paying for (or would be paying for) to see how giving up Medicaid would affect the individual's bottom line.

If, given the high cost of the spend down, it appears to be more beneficial to give up Medicaid, some other factors should be considered:

- Whether all allowable expenses are being used to reduce the spend down;
- Whether the individual is now eligible or could be eligible for the Medicaid buy-in.

The Medicaid Buy-In

New York is one of about 30 states to implement this optional program. New York's Medicaid Buy-In has two eligibility groups: the "Basic Coverage Group" and the "Medical Improvement Group."

The Basic Coverage Group. To be eligible, an individual must have a disability that meets the medical criteria established for the SSI program, but have too much income to qualify for SSI. In addition to following the usual Medicaid rules, the specific requirements are:

- Disability - Certified disabled under SSI criteria
- No SGA test - In determining disability, there is no "substantial gainful activity" (SGA) test (i.e., earnings over \$860 per month in 2006 are irrelevant)
- Age - Be at least 16 but not yet 65 years old
- Work - Be engaged in paid work (includes part-time and full-time work)
- Income - Have a gross income that may be as high as \$48,876 for an individual and \$65,172 for a couple (as of January 1, 2005; 2006 figures unavailable)
- Resources - Have non-exempt resources that do not exceed \$10,000

The Medical Improvement Group. To be

eligible, an individual must meet all the criteria met by individuals in the Basic Coverage Group (other than the requirement of meeting the SSI test for disability). Additionally, the individual must be no longer disabled under the SSI criteria but continue to have a severe medically determined impairment. Keep in mind that loss of eligibility under the Basic Coverage Group must be the direct and specific result of loss of disability status because of medical improvement. Finally, an individual in the Medical Improvement Group must be employed at least 40 hours per month and earn at least the federally required minimum wage.

How the premium works. For both groups, individuals with net monthly income below 150 percent of the federal poverty level (FPL) will not need to pay a premium. Individuals with a net income above 150 percent of the FPL but below 250 percent of the FPL will have a premium calculated as follows: 3 percent of net earned income plus 7.5 percent of net unearned income. As this is written there continues to be a moratorium on premium payments until systems support for automated premium collection and tracking is available.

Example: How the Medicaid Buy-In Works.

John is 33, has a mental illness, and attends college. He is single, receives \$912 in SSDI benefits, and must pay a \$200 spend down to qualify for Medicaid. Currently, John is not eligible for the buy-in because he is not working. Medicaid has, historically, paid for his weekly mental health counseling sessions, his psychiatrist every three months, and his prescription drugs. John accepts a job and will earn \$265 gross for working about 30 hours per month. Through payroll deductions, he is paying "applicable taxes."

Under the spend down program, John will see his spend down increase by \$100 to \$300 per month. However, if John applies for the buy-in, now that he meets the work requirement, he should be eligible with no premium payment due. Here is how John's countable income is determined:

Step 1: Unearned income	\$912.00
General income exclusion	- 20.00
Counted unearned income	\$892.00
Step 2: Earned Income	\$265.00
Earned income exclusion	- 65.00
Additional 50% exclusion	-100.00
Counted earned income	\$100.00

Step 3: Counted unearned income	\$892.00
Counted earned income	+100.00
Total counted income	\$992.00

Since \$992 is below the 2005 monthly figure for 250 percent of FPL, i.e., \$1994, he will be eligible for the buy-in if he meets all other criteria. Since countable income is also below 150 percent of FPL, i.e., \$1197 per month in 2005, he will not face a monthly premium even when premiums become a part of the program. John will save \$300 per month that he would have owed under the spend down program.

In this example, John will be required to use the Medicare Part D program, effective January 1, 2006, to pay for his prescription drugs. However, it will still make sense to retain Medicaid through the buy-in after January 1, 2006. This is because Medicaid will continue to pay for mental health counseling sessions and his psychiatrist (subject to partial payment through Medicare Part B). Retaining Medicaid will also ensure that John continues to be “dual eligible” for Medicare Part D purposes, making him eligible for the full low-income subsidy program.

Medicare Part D Planning Tips: For those who would be eligible for Medicare Part D, based on current or past SSDI eligibility, continued eligibility for Medicare and the requirement to use Medicare Part D for prescription drugs will be a given. Deciding whether to seek and then retain Medicaid buy-in coverage involves a similar cost/benefit analysis as suggested in the Medicaid spend down section, above.

Keep in mind some special savings that go with Medicaid buy-in eligibility:

- It eliminates any spend down being paid; as this is written, since the Medicaid buy-in program still does not require premiums, we can factor in a \$0 per month premium payment.
- It ensures dual eligibility status for Part D purposes, again guaranteeing eligibility for the full low-income subsidy program.

Conclusion

The Medicare Prescription Drug Plan will have a significant impact on New York’s Medicare only and dual eligible population. Benefits specialists will be expected to know the basics about the program so they may provide benefits counseling to individuals

working or considering working who are eligible for this benefit. As always, readers are encouraged to call our Statewide Work Incentives Hotline at 1-888-224-3272 (toll free) if you have questions about the issues discussed in this newsletter.

The Technical Assistance Corner

Question: I am writing this in mid-December 2005. I receive Social Security Disability Insurance (SSDI) of \$762 per month. I also receive Medicaid with a spend down of \$50 per month. Sometimes I meet the spend down by incurring at least \$50 in monthly medical expenses, sometimes I do not. I did meet the spend down back in August of 2005. I am covered by Medicare and wonder if I should be applying for the Medicare Part D prescription drug program. Currently, I do not take a regular prescription but my doctor is talking about having me start on a mild anti-depressant.

I have been offered a job earning \$900 per month starting in March 2006. I have not used any trial work period months as this will be the first work I have done since I started getting SSDI. How will this job affect my eligibility for Medicare Part D benefits and how much will I need to pay in out-of-pocket expenses to have Part D coverage?

I am very concerned about my long-term eligibility for SSDI, Medicare, Medicaid, and the new Part D benefit if I choose to apply for it. Can I expect things to change if I stay at this job throughout 2006 and into 2007? Will I lose SSDI after my nine-month trial work period? If so, will this also mean that I lose Medicare and this new Part D coverage? I have a lot of decisions to make and could use your help.

Answer. It sounds like you do not have regular prescription drug costs now, but may in the future. The first thing we can tell you is that starting in January 2006 you will no longer be able to get any prescription drugs covered by Medicaid because you will be eligible for Medicare Part D if you choose to take it. Based on our analysis that follows, it sounds like Part D may be a good choice for you if you can get Medicaid for little or no cost. If you have to pay out-of-pocket to get Medicaid, the analysis could be different.

Under the new Part D program, you will limit your out-of-pocket costs associated with the program if you qualify for the low-income subsidy program (referred to as “extra help”). You can qualify for “extra help” in three different ways.

First, if you meet the spend down requirement, you will be considered “dually eligible” (eligible for Medicaid and Medicare) for Part D purposes. This will make you eligible for the full low-income subsidy, meaning your monthly out-of-pocket expenses for Part D coverage will probably be limited to small copayments for any drugs you need. Second, you will also establish dual eligible status if you qualify for the Medicaid buy-in program. Since you will be working in March 2006, if you accept the job, this would qualify you for the buy-in program and eliminate your Medicaid spend down. By doing this, you will be deemed eligible for the full low-income subsidy as well. (It is not clear whether any premium you might eventually owe under the buy-in program will offset any savings through the low-income subsidy.) Finally, if you cannot or will not do either of the first two, you can always apply for the low-income subsidy through the Social Security Administration application process. Based on a quick review of your current income, it seems clear that you would qualify for the low-income subsidy program. If you go to work in March, your income will go up which may affect your eligibility for the subsidy or extra help benefit.

Under the facts you present, you met the spend down in August 2005, meaning that you would be deemed eligible for the low-income subsidy as dually eligible for Medicaid and Medicare. According to the Centers for Medicare and Medicaid Services (CMS), those deemed to be dual eligibles will maintain that status for a year (this could change in the future if periodic redetermination of subsidy eligibility is required). Therefore, you should maintain your dual eligible status throughout 2006 even after you take the job and even if you do not pay the spend down in the future and do not apply for the Medicaid buy-in.

It is not exactly clear what will happen to your low-income subsidy status in 2007. Let's assume that you do not meet Medicaid eligibility criteria during the remainder of 2006 after you start working. For “extra help” purposes, your countable income is \$742 unearned ($\$762 - \20 exclusion = \$742) and \$417.50 of earned income ($\$900 - 65 = 835/2 = \417.50), for a total of \$1159.50 ($\$742 + 417.50 = \1159.50). Without considering an impairment related work expense

(we would have to ask some follow-up questions to establish an IRWE), you will qualify for a partial subsidy (i.e., your countable income is between 135 and 150 percent of the federal poverty level). However, if you do happen to meet the spend down when CMS is determining dual eligible status, you may be a dual eligible again. It may all depend on timing. (Note: Since the projected countable income of \$1159.50 is less than 150 percent of the federal poverty level for 2005, your best bet may be to apply for the Medicaid buy-in when you start working.

Your case gets even more complicated when we look at what may happen in 2007 after your trial work period ends. Of course, the substantial gainful activity figure for 2007 is not yet known, but there is a very good chance that you will face a loss of SSDI benefits if you continue earning at the \$900 rate. This, in turn, would make your total income go down which, ironically, would lower your income for low-income subsidy purposes.

At best, this response only points out some of the answers to your questions. What really needs to happen is that you should contact a benefits specialist at one of the regional Benefits Planning, Assistance and Outreach (BPAO) projects. A BPAO benefits specialist should be able to fully discuss your situation and help you to look at the various options available, enabling you to make educated decisions on how best to proceed. We can give you contact information for the BPAO in your area if you call us at 1-888-224-3272.

WHEN TO CALL OUR TOLL-FREE LINE FOR TECHNICAL ASSISTANCE

Our State Work Incentives Support Center offers a statewide, toll-free number to call for information and technical assistance on a wide range of issues involving benefits and work. The staff of Neighborhood Legal Services is available to take calls concerning any of the topics you see discussed in these newsletters. For example, if a caller seeks information about any of the information discussed in this article, you can call us at 1-888-224-3272 for more information on these issues.

The NY State Work Incentives Support Center will provide statewide services, including: training through traditional means and through use of the latest technology for distance learning; a toll-free technical assistance line, **1-888-224-3272** (English and Spanish); and a quarterly newsletter, *The Benefits Planner*. To subscribe to the Center's listserv, send your name and email address to tpg3@cornell.edu. To request a print copy of this newsletter, contact the toll-free number above.



Welcome to *The Benefits Planner*, a Quarterly Newsletter of the NY State Work Incentives Support Center

This newsletter will provide valuable information on how work for persons with disabilities affects government benefits, with an emphasis on the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) work incentives. Each newsletter will contribute to an ongoing dialogue on topics related to benefits and work. Back issues will appear on the Cornell University website, www.ilr.cornell.edu/edi/m-pubs.cfm and on the Social Security section of the Neighborhood Legal Services website, www.nls.org.

If you have special needs and would like *The Benefits Planner* sent in a special format, would like our Spanish version or would like the newsletter delivered by email, please call our toll-free technical assistance line, 1-888-224-3272.

NEIGHBORHOOD LEGAL SERVICES, INC.

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