

Elder Law Newsletter

▲ A Publication of the Minnesota State Bar Association Elder Law Section ▲

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Winter 2005/2006

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A Word from the Chair . . .

Time just seems to fly by! In my short time as Chair of the Governing Council for the Elder Law section I've already seen some great accomplishments.

We had 256 attendees at the 2005 Elder Law Institute and many more will watch the video re-plays. The Institute touched on a wide variety of topics in the elder law field and it was very well received by the participants. We were very fortunate to have so many talented trainers. I personally learned that I am much better at speaking extemporaneously than I am at reading biographical material off cue cards as I fumbled through a myriad of introductions. And to think it was all caught on tape, I'm so proud!

We presented a number of awards at the Institute to recognize outstanding contributions to the field of elder law. Catherine Reher was the very deserving recipient of the 2005 Mary Alice Gooderl award. We even managed to take her by surprise. Special awards were presented to Randall Brown and Marcus Stubbles for their extraordinary pro-bono work in the Marten case. We also presented an award to Erin Furlong, the section's first Student Law Clerk. She will be a hard act to follow. Congratulations to all of our award winners!

This year the section is working very hard to serve our members. Our mission is to enhance the skills and knowledge of the Minnesota lawyers practicing in the area of elder law and to serve as a liaison with the Bar Association and the general public on issues related to the field of elder law. We are committed to turning out high quality newsletters and creating a website that contains valuable information and resources for elder law practitioners. Let me know if you have any ideas on how we can better serve you.

Best wishes in the new year,
Kathleen M. Eveslage, Esq.

Elder Law Newsletter Editorial Committee

Chair: Jonathan Dyrud, Esq.

Editor In Chief: David A. Rephan, Esq.

Co-Editor: Joel Mullen

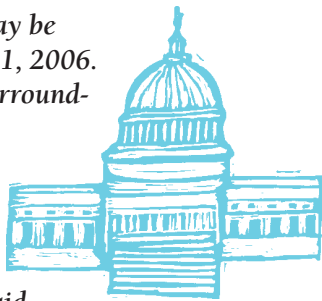
Committee Members: Julian Zweber, Esq.,
Kim Dayton, Esq., Vicki Ahl, Esq., Sharon K. Kirts, Esq.,
Lynn Lindsey, Esq.

Featured Contributors: Kim Dayton, Esq.



LEGISLATIVE REPORT

The federal Medicaid laws may be changed as soon as February 1, 2006. Because of the uncertainty surrounding these potential changes, there will be no legislative report this issue. The next issue will contain a legislative report, including any changes to the federal Medicaid laws. The Editor. ▲



UPCOMING EVENTS

Gardianships and Conservatorships Minnesota CLE

- Minneapolis: 1/27/06 Live
- Brainard: 3/03/06 Video
- St. Cloud: 3/09/06 Video
- Crookston: 3/10/06 Video
- Moorhead: 3/10/06 Video
- Minneapolis: 3/14/06 Video
- Park Rapids: 3/17/06 Video
- Mankato: 3/23/06 Video
- Duluth: 4/13/06 Video ▲

COMMITTEE UPDATES

The Elder Law Council ByLaws Committee

We are working on updating the Section Bylaws to add language on the appointment of the Section's representative and alternate representative to the MSBA Assembly, to allow for non-voting student members, and to properly refer to the new structure of the MSBA. Stuart Bear, Richard Hawke, Suzanne Sandahl and Tom O'Connell are the present members of the Bylaws Committee.

CHAIR: Thomas R. O'Connell
toconnell@cbsb.net

The Strategic Planning Committee

We consist of a chair and several members. The treasurer of the Elder Law Section is an automatic member of the Committee. The main job of the Committee is to analyze the budget and make recommendations for the following year. We also make recommendations to the Governing Council regarding policy and specific requests for budget expenditures. At our next meeting we will consider making budget plans that extend beyond the immediate year.

CHAIR: Monica Lewis, Esq., Volunteers of America
mlewis@voamn.org

The Newsletter Committee

We have a new editor in David A. Rephan and co-editor Joel Mullen. The committee plans to build on the great work of the previous committee and plans on little functional change to the look or content to the newsletter. We have received great feedback from section members in the past and encourage any member to submit ideas for improvement. As always, we are on the lookout for article submissions, so if you have an idea for an article you would like to submit or see in the newsletter, please send us your ideas.

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MEDICARE PART D: WHAT LAWYERS NEED TO KNOW

by Kim Dayton, William Mitchell College of Law/
Of Counsel, Long & Reher

Under the Medicare Prescription Drug and Modernization Act of 2003 (MMA) as implemented by the Centers for Medicare and Medicaid Services (CMS), a new Medicare prescription drug benefit (Medicare Part D) will begin on January 1, 2006. The Medicare Part D enrollment process began on November 15 and will continue through May 15, 2006 for all persons who are or will become eligible for Medicare between now and July 2006. Many advocates for the elderly and disabled have been critical of the MMA's prescription drug benefit provisions from the outset, but the full details of its problems are just now starting to become apparent, as seniors and disabled Medicare beneficiaries struggle to decide whether they should enroll in Part D and if so, which of the myriad of prescription drug plans (PDPs) offers the best match for their own prescription drug needs. Lawyers who work with Medicare-eligible clients—including those who do not hold themselves out as experts in Medicare—can expect to receive questions about Part D from confused seniors who need assistance with the complexities of the Part D program. Only licensed insurance agents can actually give advice about which plan to purchase, as Part D plans are considered insurance products under state law and regulations. Still, it is important to be conversant as to some of the key components of Part D. What follows is a short overview of the Part D program and some of the issues and problems that have developed in just the few weeks since the enrollment process began.

Under Medicare Part D, all persons eligible for Medicare Parts A and B, including those 65 and older and disabled persons who otherwise meet the criteria for Medicare eligibility, will have the option to enroll in the prescription drug program. But not all persons eligible for Part D will actually benefit from the program—early estimates are that one-quarter to one-third of those who can enroll for Part D don't need the program and will end up spending more out-of-pocket for premiums and medications if they enroll than if they don't. Many seniors already have drug coverage that is equal to or better than Part D's minimum requirement—so called "creditable coverage." Generally, such persons should stick with their current insurance plan until the precise workings of Part D become clear. In some instances, those who decide to enroll in Part D may inadvertently jeopardize other health coverage they have through an employer or union insurance program—some such health plans for retirees and spouses will automatically terminate if the participant elects Part D coverage. Persons who are dually eligible for Medicare and Medicaid, however, *must* enroll in Part D—if they failed to do so by October 1, they have

presumably been enrolled automatically in a randomly chosen prescription drug plan being offered in their region, whether or not the plan even offers the drugs they need. Adding to the confusion, dual-eligibles will need to remain enrolled in the prescription drug component of state MA programs if their prescription drug needs include drugs in categories that are statutorily excluded from Part D, such as benzodiazepine and certain other classes of prescription and over the counter medications. In short, the Medicare Part D enrollment process is a minefield; stepping in the wrong direction can cost seniors money and prevent easy access to the prescription drugs that they need to stay healthy and active.

How does Part D work?

The MMA delegates responsibility for providing prescription drug benefits under Part D to the private sector. CMS has entered into contracts with dozens of providers around the country who are offering a wide variety of "Part D" insurance packages, either as free standing plans or as part of a Medicare Advantage (managed care) health insurance plan. Each state is assigned to one of 34 regions for which a set of approved Part D packages is available. In Region 25, encompassing Minnesota, Iowa, Montana, Nebraska, North Dakota, South Dakota, and Wyoming, seventeen companies are offering a total of 41 free standing PDPs, each with a different formulary, different monthly premiums, and different non-standard benefit options. For example, the range for monthly premiums in Region 25 for the 41 available plan is \$1.89/month to \$99.90/month. In addition, some Medicare Advantage plans will offer drug coverage as part of the larger package of hospital and medical insurance provided by the plan.

Every approved PDP must offer at least two specific drug choices in each of six "classes" of prescription medications, but this doesn't mean that the particular drug that a senior takes for, say, high blood pressure will be included in a contracting provider's formulary. Moreover, it's likely that for some drugs at least, no PDP in a region will include the drug in its formulary. If a drug isn't in the PDP that the senior chooses, she'll have to pay for that drug herself, and her out-of-pocket costs for the drug won't count towards the annual out-of-pocket expense that the legislation mandates a senior spend (currently \$3600/year, not including Part D premiums). Thus, persons who decide to enroll in Part D will have to decide which of these programs is their best option, given their historical and anticipated future prescription drug needs, whether they have access to com-

Medicare Part D. continued on page 4

parable coverage through an employer- or union-sponsored health plan, and their ability or willingness to assume the risk that their drug needs will change significantly during the calendar year. In making their decision, potential Part D beneficiaries must be mindful that if they do not enroll in Part D when they first become eligible to do so, they'll pay a penalty of 1% per month, compounded, for every month of delay. Although that doesn't seem significant at the moment—when the average Part D premium is \$32/month—most experts assume that the Part D premium will rise significantly after 2006 due to Part D enrollment rates lower than Congress anticipated when it enacted the MMA in 2003.

Avoiding the “doughnut hole”?

One of the features of Part D is that it contains a significant gap in coverage once a beneficiary's drug costs total \$2250. This gap, called the donut hole, effectively means that every beneficiary whose total *drug costs* exceed \$5100/year will be *required* to spend a total of \$3600 out-of-pocket on drugs (in addition to the monthly premium).

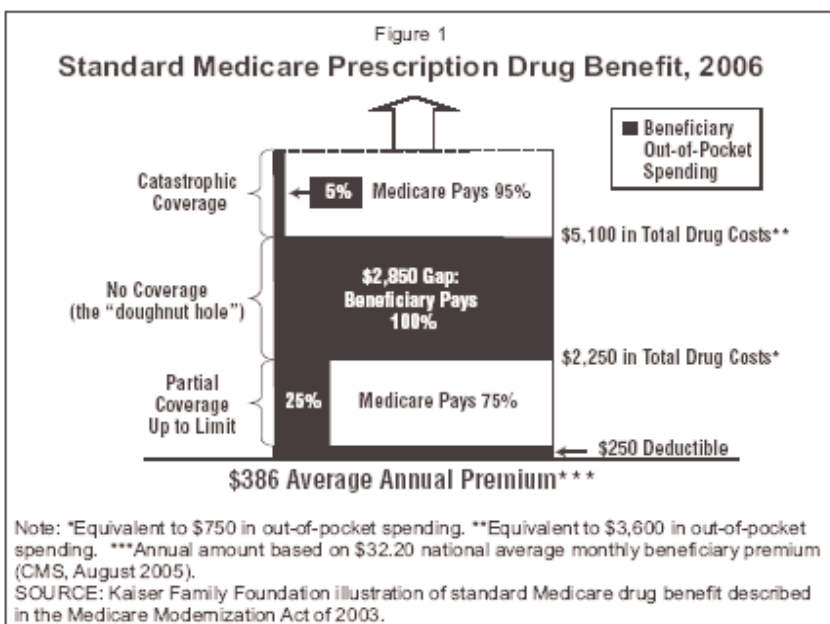
Despite what some advertising of Part D plans seems to suggest, there is no way that a senior who has high drug costs can avoid the donut hole. The plans' variations in premiums and co-pays that are being offered merely alter the allocation of a person's total outlays for prescription drugs. The law does not permit Part D providers to offer coverage once the total cost of a person's drugs amounts to \$2250, until those costs hit \$5100. The best a person can do is choose the plan with the lowest costs for drugs, in the hope that total outlays (by the beneficiary and the insurer) costs will not hit the \$2250 benchmark. It is illegal for Medigap policies or other insurance policies to cover the donut hole.

Problems with formularies

One important issue that is not explained clearly in the literature that has been sent out to seniors is that a PDP can change the drugs in its formulary at *any time*—so that someone who selects a plan based on the plan's coverage of a particular set of medications isn't guaranteed that those drugs will be covered even a month or two into the benefit year. But seniors can't change their plan until the next enrollment period (Nov. 15 to Dec. 31, 2006). Providers must give notice to beneficiaries that they plan to drop a particular drug, and the beneficiary can ask for a waiver, but if the waiver is denied, the enrollee will have to pay for full cost of the now-not-covered drug until she is able to enroll—during an open enrollment period—in a different plan that covers the drug. The new benefit period begins on January 1 of the following year. Obviously, this system leads to the potential for a “bait and switch” of specific drugs by providers after the close of the enrollment period. Because there isn't a mandate to maintain the formulary that was in place when the beneficiary enrolled, the provider can substitute medications that are cheaper for it to purchase, but which might not serve the especial needs of an enrollee who chose the plan because it offered a specific drug as part of its formulary.

Another problem with the MMA is that it precludes Medicare coverage of some important classes of drugs used widely by seniors and those with disabilities. Medications excluded encompass drugs for anorexia, weight loss or weight gain; symptomatic relief of coughs and colds; non-prescription (OTC) drugs; barbiturates; benzodiazepines; and prescription vitamins and minerals. Many PDPs purport to cover these drugs (usually for a higher premium) as part of an extended package of benefits, but seniors should be mindful that what they spend on Part D-excluded medications does

not count towards the \$3600 out-of-pocket that they'll have to spend because of Part D's donut hole provision. Most states will continue to cover some of these drugs as part of their medical assistance or pharmaceutical assistance program, but low income individuals must separately apply for coverage of Part D-excluded drugs through the relevant state health assistance program. A list of Part D-excluded drugs for that Minnesota will continue to cover for state Medicaid beneficiaries is available at <http://www.cms.hhs.gov/medicarerereform/states/mnexdrugcov0106.pdf>.



Formulary and plan finding tools

In mid-November, CMS launched a formulary finder and a plan finding tool on its website that were intended to help seniors determine which PDP offered the best match for them. Theoretically, a senior can use a form to enter their drugs and dosages. Unfortunately, seniors and their advocates are reporting that the tool doesn't work as it is supposed to. The Center for Medicare Advocacy has identified numerous problems with both the plan finding tool and the formulary finder, see <http://www.medicareadvocacy.org/AlertPDFs/11.23.05.InfoProblems.pdf>. These include:

- At times, entering multiple drugs at once produces a result that says no plan covering all of the drugs is available in the area, even when this is not the case. Entering each drug separately may, in fact, produce results showing that all of the drugs are covered, even though entering them simultaneously does not. Information has also been generated by the Plan Finder showing that a drug is not covered, though the hard copy of the plan's formulary shows that the drug is covered.
- The tool indicates that some plans are not covering all of the drugs in the classes of drugs that should have all, or substantially all, drugs in six categories: anticancer, anticonvulsant, antidepressant, antipsychotic, immunosuppressant, and HIV/AIDS. Drugs that are not supposed to be covered—barbiturates, benzodiazepines, weight loss/gain—are covered in some plans that have supplemental benefits for higher premiums.
- Plans' utilization management tools are not explained in the Plan Finder. While it may say that prior authorization and step therapy are required, there is no explanation as to what these terms mean. There is also no reference to the Transition Process—the ability to obtain medications during the time a drug is taken off the formulary.
- The "Important Notes" section for particular plans is not consistent from plan to plan. One national plan may state it is national and another national plan may not indicate it is a national plan. Also, some plans indicate that a beneficiary will pay more for an out-of-network pharmacy while other plans do not mention this at all.
- Co-payment amounts are inconsistently reported. Some plans use confusing descriptions by listing, for instance, that there are injectable and non-injectable versions of the drug, but without indicat-

ing the tiers on which they appear.

- The tool does not warn you if one of the pharmacies you entered is not in the network or has higher costs.
- In some instances, the Formulary Finder states that no plans in the entire state cover a particular drug when we know that this is not the case.
- When using the Formulary Finder, one receives results for both PDPs and MA-PDs. Many people will not know the difference, and could find themselves looking at the wrong type of plan and selecting a plan that will require them to get all of their health coverage from a Medicare Advantage plan when they never meant to select that type of plan.
- When a drug is found, the Formulary Finder indicates which tier the drug is on, but it does not give the cost-sharing amounts for that tier. It also does not indicate whether the cost sharing exceeds the cost of the drug."

In addition, there have been reports that some plans have raised their prices in the three weeks since the tool was launched. I ran a hypothetical search for a plan that included three specific medications and was directed to plans that did not cover two of the three drugs I inputted—but nothing in the cost information told me that I'd be fully responsible for the costs of those drugs, nor that my out-of-pocket costs for those medications wouldn't count towards the Part D annual maximum.

Problems for low income beneficiaries and dual eligibles

Part D's implementation and substance presents a number of additional problems for low-income individuals, including but not limited to so called "dual eligibles"—persons who are entitled to participate in both Medicare and state medical assistance programs. The Kaiser Family Foundation has published an extensive discussion of issues facing low income seniors as Part D is implemented and takes effect, see generally <http://www.kff.org/medicare/upload/Medicare-Part-D-Issues-for-Dual-Eligibles-on-the-Eve-of-Implementation-Issue-Brief.pdf>. Only a few of these problems are discussed in this article.

First, it appears that most low-income seniors don't know that they can apply for assistance to pay part D premiums and co-pays. Unmarried seniors whose individual monthly incomes are \$1,197 or less and have assets below \$11,500 are eligible for assistance, as are couples whose monthly

Medicare Part D, continued on page 6

Medicare Part D, continued from page 5

income is \$1,604 or less and whose assets are valued at less than \$23,000. Last spring, the Social Security Administration mailed applications to more than 19 million persons who are potentially eligible for the Part D low-income premiums and co-pay subsidy. SSA estimates that some 14 million Medicare beneficiaries are legally entitled to some assistance in connection with their prescription drug costs under Part D. But only 3.8 million applications for assistance have been returned, and only 28% of the 2.4 million applications processed so far have been approved for assistance. This suggests both that large numbers of seniors eligible for low-income subsidies are not aware of the need to apply for assistance, and that SSA may be denying assistance to persons who should be found eligible. Moreover, there is some anecdotal evidence that many seniors who applied for low income assistance in the spring or summer *think* that they have enrolled in Part D. But the low income subsidy application process is entirely separate from Part D enrollment, and there is no mechanism in place for identifying seniors who have confused these distinct components of Part D and therefore mistakenly fail to enroll in Part D during the initial enrollment period.

Current Medicaid beneficiaries—those already classified as dually eligible—should by now have been automatically enrolled in either a free standing or a Medicare Advantage plan, depending on whether they currently receive other health care through traditional Medicare (Parts A and B) or Medicare Advantage. The auto-enrollment process made no effort to match auto-enrollees with plans whose formularies fit their drug needs. Although dual-eligibles can change plans before the end of December, few are likely to understand that they need to do so if the drugs they need aren't covered by the plan in which they have been enrolled. After January 1, dual-eligibles can switch plans at any time, but must wait until the beginning of the month following the change to receive the benefits of the new plan—resulting in a gap in their coverage that could compromise their ability to obtain the drugs they need.

Some advocates have been concerned that the auto-enrollment process missed thousands of dual-eligibles. CMS recently announced that it has contracted with two private companies which jointly will be responsible for determining the entitlement of a possible dual eligible to the subsidies available to dual-eligibles, and for enrolling in dual-eligibles who were “missed” during the auto-enrollment process in a plan if they are determined to be eligible for Medicaid. This announcement should at least partially alleviate concerns that impoverished seniors won't be able to get their medications if they were somehow missed during the auto-enrollment process—provided that the contractors are able to get the correct

procedures in place by the beginning of January. CMS's announcement regarding its plan to account for “missed” dual eligibles is available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1736>.

Some 20% of all dual eligibles reside in nursing homes; this group is likely to have additional problems with Part D. The auto-enrollment process will assuredly result in these beneficiaries' enrollment in plans that don't include their drugs or the pharmacy that their facility uses. A large percentage of nursing home residents for whom this occurs won't have the ability to understand that they need to switch to a more suitable plan, nor do they have family members who can assist them. But the MMA doesn't mandate that care facilities provide their residents with assistance in determining whether they need to make a change. Although the law does provide some protections to nursing home residents against loss of access to necessary medications, see generally <http://www.kff.org/medicare/upload/Medicare-Part-D-Issues-for-Dual-Eligibles-on-the-Eve-of-Implementation-Issue-Brief.pdf>. Many of these protections are not available to residents of assisted living and personal care homes.

Elsewhere in this newsletter, you'll find a list of websites that can help you help clients who are befuddled by the complexities and uncertainties inherent in the Part D program. Your best advice may be that seniors avoid ineffective and sometimes inaccurate “tools” and “finders” and instead simply compile a complete list of their past drug needs, expenditures, and payment sources, and make an appointment with a SHIP counselor by contacting their local Area Agency on Aging. Contact information for Minnesota's AAAs is available at <http://www.tcaging.org/findinghelp/hicsites.html>. ▲

WEB-BASED RESOURCES

WEB SITES TO VISIT (OR TO AVOID) FOR MEDICARE PART D INFORMATION AND ENROLLMENT ASSISTANCE

Prepared by Kim Dayton, William Mitchell College of Law

As most elder law practitioners are aware by now, the Medicare Part D program is in its enrollment phase, which runs from November 15, 2005 through May 15, 2006. The enrollment materials that seniors have received from CMS and insurance companies are confusing, and many potential enrollees and their advocates are likely to turn to the Web for assistance in sorting out the mess. A Google search for “Medicare Part D” will yield thousands of websites that provide information—some of it useful, some of it misleading—about the enrollment process, what plans are available, and how to decide whether enrollment makes sense give a particular person’s historical or projected prescription drug needs. Sadly, the sites one would expect to offer the best information don’t necessarily do so. Below is listing of the websites most likely to turn up in a search for Part D information, and my opinion (as of the end of November) about the relative value and reliability of each site as a general or state-specific resource for practitioners and clients.

General Information

Kaiser Family Foundation/Medicare Part D Information
<http://kff.org/medicare/rxdrugbenefit.cfm>

- KFF, always a leader in providing comprehensive health care information, offers general information about Part D, a calculator for estimating annual drug expenditures for Part D enrollees based on past drug usage, and a chart showing the plans that are available in each state.
- KFF’s Part D Fact Sheet is the Web’s best concise summary of how Part D operates

Centers for Medicare and Medicaid Services (CMS)
<http://www.medicare.gov/pdphome.asp>

- The federal government’s official website for Part D
- Site offers general information, state specific information, and a “finding tool” that is intended to help seniors identify the plan that is right for them
- Minnesota information is available at <http://www.medicare.gov/medicarereform/mapdpdocs/PDPLandscapemn.pdf>
- Warning: The CMS website contains many “file not found” bad internal links, and some incorrect information. Moreover, the plan finding tool may not be reliable.

For a listing of just some of the problems that have been identified with the tool, see http://lawprofessors.typepad.com/elder_law/2005/11/cma_medicare_pa.html

Families USA Prescription Drug Coverage Area
<http://www.familiesusa.org/issues/medicare/rx-drug-center/>

- This site, developed by a major advocacy organization, contains general information organized for three specific audiences—advocates, legislators, and consumers.
- Unfortunately, the site’s “Choosing a Plan” area currently links to CMS and the above described, defective finding tool.

Medicare Rights Center/Part D Information
<http://medicarerights.org/drughelp.html>

- This site offers a number of PDF documents explaining the drug benefit in general terms, and giving advice about how to choose a plan.
- The site is one of the best for information about low-income beneficiaries and how such persons can apply for financial assistance.
- Also offers information for nursing home residents (and their advocates)—a group that will face special problems as the Part D benefit takes effect on January 1, 2006.
http://medicarerights.org/nursing_home_partd_flier.pdf
- Many of the site’s documents are available in Spanish.

State Health Insurance Assistance Programs
<http://www.medicare.gov/contacts/static/allStateContacts.asp>

- CMS’s State Health Insurance Assistance Program (SHIP) has counselors in every state and several territories; these counselors are available to provide free one-on-one help to those having Medicare questions or problems. SHIP counselors have been trained to offer state-specific advice about Part D
- The Minnesota SHIP is the Senior LinkAge Line/Rx Connect, 800-333-2433.

Web-Based Resources, continued on page 8

Access to Benefits Coalition

<http://accesstobenefits.org/default.aspx>

- This national organization focuses its Part D information on low income individuals who may qualify for premium and co-pay assistance.
- Especially helpful is the site's "Tool Kit for Advocates", <http://accesstobenefits.org/Helpful%20Resources/Tools%20You%20Can%20Use/documents/AdvocatesToolKit.htm>

Social Security Administration

Part D POMS from the Program Operations Manual
<http://policy.ssa.gov/poms.nsf/subchapterlist!openview&restricttcategory=06030>

Minnesota Specific Information

Minnesota Senior Federation/Part D

<http://mnseniors.org/content/view/230/64/>

- As always, the Minnesota Senior Federation is the best all-around source for Minnesota-specific information pertaining to health care issues for seniors. The new Part D area of the site offers general information about Part D as well as pamphlets and chart comparing both stand-alone PDP plans and Medicare Advantage plans that offer prescription drug coverage
- The site also has a handy chart that allows a rough estimate of out-of-pocket costs for Part D enrollees based on past drug expenditures, <http://mnseniors.org/content/view/164/64/>, and explains in clear terms the Part D "donut hole".

Minnesota Board on Aging/Rx Connect

<http://www.mnaging.org/Medicare/PartD.html>

- Rx Connect is Minnesota's SHIP provider; unfortunately, its website is updated infrequently and doesn't offer much in the way of on-line information. The Rx Connect toll-free number is 800-333-2433
- This site offers a link to the Lewin Group's on-line calculator for determining prescription drug expense, but the calculator isn't based on current information about plans that have been approved by CMS, nor does it pertain specifically to Minnesota

Metropolitan Area Agency on Aging

<http://www.tcaging.org/calendar/presentations.html>

- The most useful feature here is a listing of community forums to be held in December and January on the Part D benefit.

Minnesota Department of Commerce/Insurance/Part D

<http://www.state.mn.us/portal/mn/jsp/content.do?id=-536881350&subchannel=-536881550&sc2=null&sc3=null&contentid=536908315&contenttype=EDITORIAL&programid=536886472&agency=Commerce>

- This site offers general information about purchasing a Part D plan, and cautionary advice about possible Part D frauds and scams. ▲

January 2006 MINNESOTA HEALTH CARE PROGRAMS FOR SENIORS

INCOME AND ASSET ELIGIBILITY FIGURES

by Long, Reher & Hanson, P.A.

Program	Income		Assets	
	SINGLE	COUPLE	SINGLE	COUPLE
Medical Assistance (MA) 100% FPG** 75% FPG (Method B spenddown standard) Full MA benefits, pays Medicare Part A and Part B premiums, deductibles, co-insurance and co-pays.	\$798 \$599	\$1,070 \$803	\$3,000	\$6,000
Qualified Medicare Beneficiary (QMB) (100% FPG) Pays Medicare Part A and Part B premiums, co-pays, and deductibles.	\$818*	\$1,090*	\$10,000	\$18,000
Service Limited Medicare Beneficiary SLMB (120% FPG) Pays Medicare Part B premiums	\$977*	\$1,303*	\$10,000	\$18,000
QI - 1 (135% FPG) Pays Medicare Part B premiums. Limited funding.	\$1,097*	\$1,464*	\$10,000	\$18,000
Medicare Prescription Drug Subsidy for Part D Participants with income at 150% FPG or below, on a sliding basis, are eligible for reduced or no monthly premiums, deductibles and co-payments depending upon income and resources. See POMS Section HI 03001.010, HI 03001.010 and HI 03020.055, www.ssa.gov .	Full subsidy: ≤ 135%		\$6,000	\$9,000
	\$1,077	\$1,444	\$10,000	\$20,000
	75% subsidy: ≤ 140%		\$10,000	\$20,000
	\$1,117	\$1,497	\$10,000	\$20,000
50% subsidy: ≤ 145%		\$10,000	\$20,000	
\$1,156	\$1,550	\$10,000	\$20,000	
20% subsidy: ≤ 150%		\$10,000	\$20,000	
\$1,196	\$1,603	\$10,000	\$20,000	

ELDERLY WAIVER (EW)

Pays full MA benefits plus home and community based services for people who are 65 years of age or older who require the level of care provided in a nursing facility.

Income Eligibility

There are two income limits for EW. People with incomes equal to or less than the Special Income Standard (SIS) (currently \$1,809) are eligible for EW without an MA spenddown. They must contribute any income over the maintenance needs allowance (\$789) and other applicable deductions to the cost of services received under EW. This is known as the waiver obligation. All other MA services are provided without a spenddown. A recipient whose income is equal to or less than \$789 is eligible for EW and MA without a spenddown. A recipient who has income greater

than \$1,809 must spend down his or her income in excess of the current MA medically needy income standard of \$599. Excess income must be applied towards the cost of EW services and other medical services needed by the applicant. The applicant is responsible for paying bills used to meet the spenddown. A community spouse is entitled to a spousal income allowance as explained above.

Asset Eligibility

The rules are the same as those for MA for Nursing Home Residents (see page 10).

* \$20 disregard included
** FPG is Federal Poverty Guidelines

ALTERNATIVE CARE (AC)

Minnesota funded program pays home care and community services. Recipient may have to pay a fee depending upon recipient's assets and income. A recipient is eligible if income and assets would be inadequate to fund a nursing facility stay for more than 135 days subject to a limit of \$21,586. Spousal impoverishment rules apply.

MEDICAL ASSISTANCE FOR NURSING HOME RESIDENTS

In addition to full MA benefits, pays for home health care and for skilled and custodial care in a nursing home.

Income Eligibility

A nursing home resident must pay all of his/her income to the nursing home less allowable deductions including a \$79 personal needs allowance (\$90 for certain veterans and spouses of veterans) and an allowance for payment of medical insurance premiums. Further, a community spouse is entitled to a spousal allocation to bring his or her income to \$1,604/month (or up to \$2,489 if shelter costs are greater than \$482 per month). MA pays the rest of the nursing home cost. Community spouse keeps all his/her income.

Asset Eligibility

In addition to exempt and unavailable assets, a nursing home resident may have only \$3,000. If married, the community spouse keeps \$28,001 or 1/2 (one-half) of all available assets owned by either spouse up to \$99,540. Assets must be reduced properly. Current penalty for uncompensated transfers is \$4,198 per month.

2005 SOCIAL SECURITY ADMINISTRATION BENEFITS

Retirement Survivors Disability Insurance (RSDI)

Maximum Benefit: \$2,053/month (Age 65 and 6 months)

Retirement Earnings Limit for the Year Turning Age 65: \$33,240/year‡

Retirement Earnings Limit for Years Before Age 65: \$12,480/year‡‡

‡ Applies only to months prior to attaining full retirement age. \$1 in benefits will be withheld for every \$3 in earnings above the limit.

‡‡ \$1 in benefits withheld for every \$2 in earnings above the limit.

Medicare

Part A Premium:

- \$393 for less than 30 quarters of Medicare-covered employment;
- \$216 for 30-39 quarters of Medicare-covered employment;
- \$0 for 40 quarters or more of Medicare-covered employment

Part A Skilled Nursing Facility Co-Payment:

- Up to \$119 per day for days 21-100

Part A In patient Hospital Deductible:

- A total of \$952 per spell of illness for hospital stay of 1-60 days;
- \$238 per day for days 61-90;
- \$476 per day for days 91-150;
- All costs for each day beyond 150 days.

Part B Premium:

- \$88.50/month

Part B Deductible:

- \$124 per year (Plus 20% of the Medicare-approved amount for services after the deductible has been met.)

Supplemental Security Income (SSI)

Individual:

- \$603/month (Asset Limit: \$2,000)

Couple:

- \$904/month (Asset Limit: \$3,000) ▲