STATE OF ALASKA
Department of Health and Social Services
Division of Public Assistance

Date: April 20, 2007

Subject: Aged, Disabled and Long Term Care Medicaid Manual Change #5

This manual change includes the 2007 Long Term Care community spouse resource and income allowance and household member standards that became effective January 1, 2007. These new standards were announced by broadcast on November 29, 2006. It also updates the resource limits for the low-income subsidy program, and co-payments for the 2007 Medicare Part D prescription drug coverage.

A description of these changes is included in the overview below.

OVERVIEW OF CHANGES

MS 506-E - Medicare Deductible/Coinsurance
Updates Medicare Part D 2007 coverage information with the new premiums, deductibles and copayment amounts.

MS 580-D(3) - Low Income Subsidy (LIS) Program
Updates the Medicare LIS Full and Reduced Subsidy levels for 2007. This includes changes in the resource limit, deductible, and co-insurance amounts for determining the amount of the subsidy.

Addendum 1 - Updates the 2007 Long Term Care community spouse resource and income allowance, and household member standards, updates the 2007 Pickle Amendment table, and the Federal Poverty Guidelines for Alaska effective April 1, 2007.

Addendum 5 - Adds the following Medicaid Notices:

- M060 - Child Support Cooperation Statement
- M061 - Child Support - Good Cause Allowed
- M062 - Child Support - Good Cause Not allowed
- M100 - Medicaid Approved - One Month Only
- M102 - Medicaid Application Approved
- M114 - Medicaid Approved 2nd Month
- M205 - Medicaid Denied - Citizenship/Identity

- M307 - Medicaid Pended - Citizen/ID Needed
- M308 - Medicaid - Citizenship/ID Proof Needed
- M601 - Medicaid Suspended
- M701 - Medicaid Benefits Change
- M710 - Medicare Drug Coverage Begins
- M801 - Medicaid Review Due

Addendum 6 - Updates the Low-Income Subsidy chart with the 2007 Medicare Part D information.

Addendum 7 - Updates the Medicare Part D 2007 Prescription Drug Plans that are available for dual eligibles in Alaska.

If you have any questions please contact any member of the Policy and Program Development Team at 465-3347 or email dpapolicy@health.state.ak.us.

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Note:

Send EIS notice "M710 – Medicare Drug Coverage Begins" when a Medicaid applicant has Medicare, and when a recipient becomes eligible for Medicare.

506 E. MEDICARE DEDUCTIBLE/COINSURANCE

A Medicare Part A beneficiary may be subject to deductible and coinsurance requirements. The beneficiary is responsible for a coinsurance amount when he or she receives services for more than 60 days during an illness period.

A Medicare Part B beneficiary may be subject to cost sharing (e.g., must pay the first $100 of a service in a given time period, or 20% of each service). These amounts can change each year.

Medicaid will pay the deductible and coinsurance expenses incurred by Medicaid recipients who are eligible for Part A and/or Part B Medicare.

A Medicare Part D beneficiary may be subject to premiums, deductibles, and coinsurance requirements. The basic coverage includes a monthly premium of approximately $35; an annual deductible of $265 and co-payment of 25% up to $2,400 in total drug costs. The beneficiary is then responsible for 100% of prescription drug costs until the total cost reaches $5,451.25. The gap in coverage where the beneficiary is responsible for 100% of drug costs is referred to as the "donut hole". After a beneficiary reaches the catastrophic limit of $5,451.25in total drug costs, the co-payment for prescriptions is $2.15 per generic or $5.35 per brand prescription drug.

Medicaid recipients who reside in nursing homes or medical institutions who are eligible for Part D Medicare will have no deductible, premiums, and co-payments. All other Medicaid recipients, and individuals in buy-in programs will have small co-payments.

If a dual eligible is not able to meet the co-payment requirement, he or she may be denied the prescription until payment is made. The Medicaid rule that prohibits pharmacists from denying prescriptions to those who cannot make the co-payment does not apply to dual eligibles enrolled in Medicare prescription drug plans.

506 F. HEALTH INSURANCE CLAIM NUMBER

The Medicare card shows the type of health insurance the person has, the effective date of the coverage, and the health insurance claim (*HIC*) number. This may be his/her own *SSN* , a spouse or parent SSN, and will have a suffix further clarifying eligibility type.

Note:

The HIC # may be changed by SSA with subsequent changes in eligibility. If this occurs, update the MERE screen accordingly and send an email to ***DMA_TPL@health.state.ak.us*** *so the Medicare Buy-In Administrator can make a manual override correction to the Medicare Buy-In file.*

Note:

Premium refunds are not counted as income when determining eligibility. They are counted in the post eligibility, or nursing home income credit determination only up to the amount that has been allowed as a medical expense deduction on previous income credits. If prior nursing home income credits contained an allowance for the individual to pay the Part B premium, the current income credit must be adjusted to remove that allowance when Buy-In begins.

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506 N. SDX, BENDEX, and SVES

The SSA produces the State Data Exchange (*SDX*), the Beneficiary Data Exchange (BENDEX), and the State Verification Exchange System (SVES) information systems. Information from these sources is useful in determining who is eligible for or receiving Part A or Part B.

SDX contains a record of all people who are eligible for SSI payments or federally administered state supplements.

BENDEX provides only the data exchange that the state has requested. The BENDEX file provides SSA payment status, SSI payment status and Medicare eligibility, Supplemental Medical Insurance premium (Part B) payer, changes to *HIC* #, and Medicare entitlement dates. SSA sends Bendex data to the state each time a change occurs to the beneficiary record or household.

SVES provides data when an inquiry is initiated on EIS. A response is returned to EIS within approximately three working days. The information from the SVES response from SSA verifies social security number, social security, Title II benefits, and supplemental security income.

506 O. SOCIAL SECURITY OFFICES

The following Social Security offices and telephone/fax numbers are available to the public:

SSA National Number: 1-800-325-1213
TTY Users: 1-800-325-0778

Anchorage
222 W. 8th Ave, RM A11
Anchorage, AK 99513
907-271-4455
1-866-772-3081
907-271-4878 (fax)

Juneau
709 W. 9th Street, RM 231
PO Box 21327
Juneau, AK 99802
907-586-7070
1-800-478-7124
907-576-7320 (fax)

Fairbanks
101 12th St., RM 138
Fairbanks, AK 99707
907-456-5390
1-800-478-0391
907-456-0333 (fax)

Ketchikan
628 Mill St., RM 503
Ketchikan, Ak 99901
907-225-5200
1-800-478-5199
907-225-8976 (fax)

SeniorCare Office at:

Alaska SeniorCare Program
855 W. Commercial Drive
Wasilla, Ak 99654

Refer to Chapter 126 of the Administrative Procedures Manual for more detailed instructions.

3. Subsidy Levels

The LIS has two basic levels of assistance.

- **Full Subsidy** - is for individuals with annual incomes below 135% of the Federal Poverty Guidelines (FPG) and countable assets below $6,120 for individuals and $9,190 for couples. These individuals pay no premium, no deductible, and small co-payments.

- **Reduced Subsidy** – is for individuals with annual incomes between 135% and 150% FPG and countable assets below $10,000 for individuals and $20,000 for couples. These individuals pay a sliding-scale premium, a $53 deductible, 15 percent co-insurance up to $5,451.25 in total drug spending, and small co-payments.

The level of annual income determines the amount of the subsidy.

- **Income at or below 135%FPG** qualifies for a 100% premium subsidy. The beneficiary pays $0 annual deductible, $2.15 or $5.35 co-payment per prescription drug, and $0 co-payment after $3,850 out-of-pocket expenses have been paid.

- **Income at 136%and up to 140%FPG** qualifies for a 75% premium subsidy. The beneficiary pays $53 annual deductible, 15% co-insurance, and a $2.15 or $5.35 co-payment per prescription drug after $3,850 out-of-pocket expenses have been paid.

- **Income at 141%and up to 145%FPG** qualifies for a 50% premium subsidy. The beneficiary pays $53 annual deductible, and a $2.15 or $5.35 co-payment per prescription drug after $3,850 out-of-pocket expenses have been paid.

Income at 146%and up to 149%FPG qualifies for a 25% premium subsidy. The beneficiary pays $50 annual deductible, and a $2.15 or $5.35 co-payment per prescription drug after $3,850 out-of-pocket expenses have been paid.

- **Income at 150%FPG** qualifies for a 0% premium subsidy. The beneficiary pays $50 annual deductible, and a $2.15 or $5.35 co-payment per prescription drug after $3,850 out-of-pocket expenses have been paid.

See Addendum 1 for the current annual federal poverty guidelines for Alaska.

4. LIS Premium Payment Limits

In order to get Medicare Part D coverage, the individual must enroll in a prescription drug plan (*PDP*). The prescription drug benefit is provided through private stand-alone prescription drug plans (PDP's). Each plan will contract with certain pharmacies, and may have different costs. There are eleven organizations that have plans available in Alaska. See Addendum 7 for a list of drug plans and their costs.

The maximum amount of the Medicare Part D premium covered by the LIS is limited. For 2007 the standard premium rate that the LIS will cover in Alaska is $33.56 per month. If an individual chooses a plan that has a premium in excess of this amount, the individual must pay the difference.

5. *EIS* Information

The Low-Income Subsidy Assistance Application (LISA) screen is used when DPA make the LIS eligibility determination.

EIS INFORMATION	
Program Type on REAP Screen	
GA	LIS Application (Y)
Subsidy Level on LISA Screen	

ADDENDUM 1
PROGRAM STANDARDS

Refer to **APA Addendum 1** for APA Need Standards and Supplemental Security Income Eligibility/Payment Standards.

Year	1/1/2006	1/1/2007
Special Long Term Care Income Standard	1,656	1,656
Alaska *NH* Personal Needs Allowance	75	75
Alaska *HCB* Personal Needs Allowance	1,656	1,656
Alaska *ALH* Personal Needs Allowance	1,396	1,396
Maximum Community Spouse Resource Allowance	99,540	101,640
Community Spouse Monthly Maintenance Need Standard	2,488.50	2,541
Monthly Need Standard for Additional Household Members	829	847

Effective 4/1/2007										
	Monthly Federal Poverty Guidelines for Alaska					Annual Federal Poverty Guidelines for Alaska				
HH Size	*QMB*	*SLMB* Base	*SLMB* Plus	*QDWI*	Working Disabled	Low-Income Subsidy (LIS)				
	100%	120%	135%	200%	250%	135%	140%	145%	149%	150%
1	1,065	1,277	1,437	2,129	2,661	17,240	17,878	18,517	19,028	19,155
2	1,427	1,712	1,926	2,854	3,567	23,112	23,968	24,824	25,509	25,680
3	1,790				4,473	28,985	30,058	31,132	31,991	32,205
4	2,152				5,380	34,857	36,148	37,439	38,472	38,730
5	2,515				6,286	40,730	42,238	43,747	44,954	45,255
6	2,877				7,192	46,602	48,328	50,054	51,435	51,780
7	3,240				8,098	52,475	54,418	56,362	57,917	58,305
8	3,602				9,005	58,347	60,508	62,669	64,398	64,830
Addl.	363				907	5,873	6,090	6,308	6,482	6,525

Note:

The QMB , SLMB's, and QDWI eligibility categories follow APA/SSI policy, which recognizes only one and two-person households. The Working Disabled Medicaid Buy-In and the LIS categories use the entire household size to determine the 250% standard.

MEDICARE PART A MONTHLY PREMIUM			
Year	2005	2006	2007
<30 qrts.	$375.00	$393.00	$410.00
>30 - <39 qrts.	$209.00	$216.00	$226.00

MEDICARE PART - B MONTHLY PREMIUM			
Year	2005	2006	2007
	$78.20	$88.50	$93.50

PICKLE AMENDMENT TABLE					
Period	Reduction Factor		Period	Reduction Factor	
	2006	2007		2006	2007
May - June 1977	.298	.289	Jan. 1992 - Dec. 1992	.700	.678
July 1977 - June 1978	.316	.306	Jan. 1993 - Dec. 1993	.721	.698
July 1978 - June 1979	.336	.326	Jan. 1994 - Dec. 1994	.740	.716
July 1979 - June 1980	.370	.358	Jan. 1995 - Dec. 1995	.761	.736
July 1980 - June 1981	.423	.409	Jan. 1996 - Dec. 1996	.781	.756
July 1981 - June 1982	.470	.455	Jan. 1997 - Dec. 1997	.803	.778
July 1982 - Dec. 1983	.505	.489	Jan. 1998 - Dec. 1998	.820	.794
Jan. 1984 - Dec. 1984	.522	.506	Jan. 1999 - Dec. 1999	.831	.804
Jan. 1985 - Dec. 1985	.541	.523	Jan. 2000 - Dec. 2000	.851	.824
Jan. 1986 - Dec. 1986	.557	.540	Jan. 2001 - Dec. 2001	.881	.852
Jan. 1987 - Dec. 1987	.565	.547	Jan. 2002 - Dec. 2002	.903	.875
Jan. 1988 - Dec. 1988	.588	.570	Jan. 2003 - Dec. 2003	.916	.887
Jan. 1989 - Dec. 1989	.612	.592	Jan. 2004 - Dec. 2004	.935	.905
Jan. 1990 - Dec. 1990	.641	.620	Jan. 2005 - Dec. 2005	.961	.930
Jan. 1991 - Dec. 1991	.675	.654	Jan. 2006 - Dec. 2006		.968

Note:

If the last month in which an applicant received SSI while, or immediately before, receiving Social Security was in any of the periods above, multiply the present year amount of the Social Security by the corresponding years reduction factor.

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ADDENDUM 5
MEDICAID *EIS* NOTICES

Notice Number	Notice Title	Use
M001	Rights and Choices for Waiver Recipients	When authorizing Medicaid with waiver services or converting an individual from regular Medicaid coverage to waiver services. This notice tells the recipient that he or she should contact the care coordinator or waiver managing agency if there are problems or concerns with service providers, etc.
M002	*MQT* Trust Referral	When denying a Medicaid application due to excess income. It informs the applicant that Medicaid coverage may be available through use of a Qualifying Income Trust. It refers the denied applicant to contact Alaska Legal Services or the Alaska Bar Association if he or she wishes to investigate use of a trust.
M003	No Cost of Care Due	It is important to send this notice on *LTC* HCB Waiver and all Nursing Home cases that currently do not have a *COC* liability. This notices informs the recipient about *COC* , that the current obligation is zero, but in the future there may be an obligation. This way if there is ever a spike in monthly income, the agency can assess a *COC* liability for that month the income was received.
M005	Notice to Transfer Resources to Spouse	To inform a new Medicaid recipient that he or she has one year to transfer any resources above $2000 to his or her community spouse before the next renewal date. Failure to send this notice may result in the new recipient not completing the transfer(s) and becoming resource ineligible at the annual review.
M006	Application for Other Benefits	When an individual appears to be eligible for a benefit from another program.
M007	Request for Social Security Number	When Social Security enumeration is required by the Medicaid program.
M012	Long Term Care Caseworker Introduction	When a case is transferred from a regular Medicaid caseworker to a new caseworker due to application for the HCB Waiver program or admission to an LTC facility.

M060	Child Support Cooperation Statement	When requesting cooperation with *CSSD* activities.
M061	Child Support - Good Cause Allowed	When a good cause determination IS allowed from cooperating with CSSD.
M062	Child Support - Good Cause Not Allowed	When a good cause determination is NOT allowed from cooperating with CSSD.
M100	Medicaid Approved - One Month Only	When an individual is only eligible for Medicaid during the application month.
M102	Medicaid Application Approved	When approving a Medicaid-only case.
M103	Retroactive Medicaid Approved	When applicant is Medicaid eligible in one of three months preceding month of application.
M106	Emergency Medical Treatment Approved	For approving emergency coverage for aliens.
M110	Medicaid Approved *QMB* coverage	For approving *QMB* coverage to pay for Medicare Part A and Part B premiums, deductibles, and coinsurance.
M111	Special Medicaid Coupon	When a disability exam or a waiver determination is needed.
M112	Medicaid Approval Waiver Services	For approving *LTC* Medicaid. Explains that eligibility has been met due to being found eligible for HCB Waiver services.
M113	Specified Low Income Medicare Benefit	For approving *SLMB* coverage to pay for Medicare Part B premiums.
M114	Medicaid Approved 2nd Month	When Medicaid eligibility begins in the 2nd month of application.

M115	Working Disabled Medicaid Approved	For approving Working Disabled Medicaid Buy-In. Informs the individual that they may have to pay a monthly premium.
M118	Back-Dated Medicaid Approved	When an individual receives a finding of disability and Medicaid is approved for prior months.
M120	Cost of Care / *LTC* Facility	Cost of Care (*COC*) requires adverse action. Send to Medicaid recipients residing in a *LTC* facility who are assessed a *COC* . Send a copy of the notice to the facility attention: Patient Billing.
M121	Medicaid Approved *LTC* Facility	When approving Medicaid for a resident of a *LTC* facility.
M122	*CCMC* Waiver Svcs Approved Child on *DKC*	When approving *CCMC* Waiver Medicaid for a child who is receiving *DKC* and does not have a disability determination from *DDS* . The notice informs the parent (s) that the waiver can be approved due to *DKC* eligibility, and encourages the parents to complete all paperwork so a *DDS* determination can be made.
M123	*CCMC* Waiver Services Approved	When approving Medicaid with *CCMC* Waiver services for a child who already has an approved State-only Disability Determination or is receiving SSI .
M124	*MRDD* Waiver Svcs Approved Child on *DKC*	When approving Medicaid with *MRDD* Waiver services for a child who is receiving *DKC* and does not have a disability determination from *DDS* . The notice informs the parent(s) that the waiver can be approved due to *DKC* eligibility, and encourages the parents to complete all paperwork so a *DDS* determination can be made.
M130	Cost of Care / Waiver	When an HCB Waiver recipient has a *COC* liability assessed. It instructs the recipient to work with his or her care coordinator in determining which service providers to pay directly. A copy of the notice should be sent to the Trustee and the care coordinator.
M131	*APD* Waiver Services Approved	When approving Medicaid with *APD* Waiver services. This includes new applications and case conversions from regular APA Medicaid.

M132	*MRDD* Waiver Services Approved	When approving Medicaid with *MRDD* Waiver services. This includes new applications, conversions from regular APA Medicaid, and SSI children approved for Waiver Services.
M133	Older Alaskan Waiver Services Approved	When approving Medicaid with *OA* Waiver services. This includes new applications and case conversions from regular APA Medicaid.
M136	Breast/Cervical Cancer Medicaid Approved	For approving Breast/Cervical Cancer Medicaid. Informs client that coverage will continue until treatment for cancer is completed.
M140	APA Medicaid Qualified Income Trust	When approving APA Related Medicaid due to the establishment of a Qualifying Income Trust.
M141	Medicaid Special Needs or Pooled Trust	When any category of Medicaid is approved due to the establishment of a Special Needs or Pooled Asset Trust that has been approved by the Medicaid Policy officer.
M142	Medicaid Trust Information *LTC*	For all *LTC* Medicaid recipients who have an established Qualifying Income Trust. Send a copy of the notice to the trustee(s). A copy of this notice should be sent with every renewal and whenever there is a change in trustee.
M143	Special Needs or Pooled Trust Info	For all Medicaid recipients who have an established Special Needs or Pooled Trust. Send a copy of the notice to the trustee and/or guardian. A copy of this notice should be sent with every renewal and whenever there is a change in trustee.
M144	Miller Trust Information	For all Medicaid recipients who have established a *QIT* in order to qualify for regular APA Medicaid. Send a copy of the notice to the trustee. A copy of this notice should be sent with every renewal and whenever there is a change in trustee.
M200	Medicaid Denied Application Process	When applicant does not show up for appointment, or reschedule an appointment.
M201	Medicaid Denied Failure To Provide	When applicant does not provide requested information needed to determine eligibility.

M205	Medicaid Denied - Citizenship/Identity	When an applicant does not respond to the request for, or provide proof of citizenship or identity.
M207	Medicaid Denied Over Income	When applicant is not Medicaid eligible due to having too much income.
M208	Medicaid Denied Over Resource	When applicant is not Medicaid eligible due to being over the resource level.
M213	Medicaid Denied Other Reasons	When application is denied for other reasons (e.g., nonresident, request to withdraw application, receipt of benefits from another state, loss of contact).
M216	Medicaid Denied - No Eligible Category	When applicant does not fit into any Medicaid eligibility category.
M221	Retroactive Medicaid Denied	When applicant is not eligible in any of the three months preceding the month of application.
M301	Medicaid Pended Information Needed.	When information is needed from a new application to determine eligibility.
M302	Medicaid Held for a Disability Decision	When a *DDS* decision is needed in order to establish eligibility. It informs the applicant that their Medicaid application being held until the decision is received.
M303	Incomplete Medicaid Review Info Needed	To request information needed from a review.
M304	Retro-Med Pended Information Needed	To request information needed to determine Medicaid eligible for any of the three months prior to month of application.
M305	Pend New Waiver Application	When a new waiver application is received. It provides *DSDS* contact information and provides a free form area to request other information.
M306	Medicaid Residency Information Needed	When Alaska residency is questionable.
M307	Medicaid Pended - Citizen/ID Needed	When an application is received and proof of citizenship/ identity is needed.

M308	Medicaid - Citizenship/ID Proof Needed	For renewals or reminders when citizenship/identity is needed.
M320	Information Needed *TEFRA*	When pending a new *TEFRA* application. It requests information that is specific to the *TEFRA* Medicaid category.
M321	Pend Waiver Start Child on *DKC*	To request information when a *DKC* child has been selected from the *DSDS* waitlist for either the *CCMC* or *MRDD* Waiver. It requests the income and resource information of the child and completion of the MED 1 and MED 2 forms for a *DDS* decision.
M322	Pend *TEFRA* Disabled Child Denied *DKC*	For a *TEFRA* referral when a *DKC* case has been denied.
M350	Request Medical Insurance Information	When additional medical insurance exists and information is needed.
M351	Waiver and/or *DDS* Approval Needed	For Special *LTC* Category applicants who require *DSDS* waiver approval and *DDS* approval. It informs the applicant that their application is being processed and some of the eligibility factors are dependent on decisions from other agencies.
M401	Medicaid Closed Failure to Provide	When client has not provided requested information needed to determine eligibility.
M402	Failure to Complete Medicaid Review	Notifying recipient that case is closed due to no review received.
M407	Medicaid Closed Over Income	When countable income causes ineligibility - for timely notice of case closure.
M408	Medicaid Closed Over Resource	When countable resources causes ineligibility - for timely notice of case closure.
M410	Medicaid Review Received Case Closed	When closing Medicaid from a review for reasons that result in ineligibility.

M413	Medicaid Closes Other Reasons	When closing Medicaid for other reasons that result in ineligibility.
M419	Medicaid Stops Client Deceased	When recipient dies. State and Federal regulations require that we notify the family or estate of a deceased client whenever benefits stop.
M420	Breast/Cervical Cancer Medicaid Closure	For timely notice of case closure. Gives reason case is closing.
M463	Refused Other Possible Benefits	When individual does not comply with Development of Income requirements.
M501	Erroneous Discontinuance	When benefits are resumed after closing in error.
M502	Fair Hearing Request Benefits Continue	When a recipient requests continued benefits while awaiting a fair hearing decision. This notice informs the recipient that he or she will be responsible to repay the cost of benefits paid by Medicaid if the decision is not in their favor.
M601	Medicaid Suspended	To suspend Medicaid for one-month only if the client appears to be prospectively eligible after that month.
M701	Medicaid Benefits Change	When there is a change in the Medicaid category or waiver services.
M704	Change to Working Disabled Medicaid	When Working Disabled Buy-In eligibility is found upon ineligibility from another Medicaid category
M710	Medicare Drug Coverage Begins	When a Medicaid applicant has Medicare, and when a recipient becomes eligible for Medicare.
M715	Cost of Care Change	Whenever there is a change in the *COC* obligation.
M716	Long Term Care Ends Medicaid Continues	When Level-of-Care has been denied and ends HCB Waiver services but the recipient continues to be eligible for another Medicaid category. It informs the recipient that regular Medicaid coverage will continue and that he or she will have a new caseworker.
M720	Waiver Closed Living in *LTC* Facility	When a waiver services end because a recipient enters a *LTC* facility.

M721	Pend Waiver Application AP Med to Waiver	When a regular APA Medicaid recipient is pursuing HCB waiver services. It requests the additional items needed for waiver services.
M723	Medicaid Transfer of Asset Declaration	For APA Medicaid recipients who are pursuing HCB Waiver services. This is a notice version of the MED 3.
M801	Medicaid Review Due	When a system generated review is not automatically sent.
M802	Medicaid Review Approved	For approving continued Medicaid benefits.
M805	*SLMB* Medicare Review Approved	For approving *SLMB* review. Informs recipient that Medicaid will continue to pay for their Medicare Part B premiums.

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ADDENDUM 6
MEDICARE PART D LOW INCOME SUBSIDY GUIDE
Effective January 1, 2007

CATEGORY	Full Subsidy Eligible	Reduced Subsidy Eligible	Full Benefit Dual Eligible				Standard Medicare Beneficiaries (Not LIS Eligible)	SeniorCare Prescription Drug Coverage (*Must be age 65 or older*)
DESCRIPTION	**Premium, deductible and cost sharing subsidy for low-income Medicare Part D recipients.**							
APPLICATION FORM	SSA 1020 – Application	SSA 1020 – Application	None – State transmits eligibility file to SSA				N/A	SeniorCare Application
INCOME	<135% PFL	<150% FPL	Dual Eligible (100% FPL)	Dual Eligible (>100% FPL)	Dual Eligible (Institutionalized)	Deemed Eligible Medicare Premium *SLMB* = <120% FPL>	>150% FPL	<$20,913 Single < $28,053 Couple
RESOURCE LIMIT	$6,120 Single $9,190 Couple	$10,210 Single $20,410 Couple				*SLMB* PLUS = <135% FPL>	None	$50,000 Single $100,000 Couple
PRESCRIPTION DRUG PLAN	Facilitated Auto-Enroll	Recipient Enrolls	Auto-Enrolled	Auto-Enrolled	Auto-Enrolled	Auto-Enrolled	Voluntary Enrolls	Recipient Enrolls

RECIPIENT PREMIUMS DEDUCTIBLES And CO-PAYS	$0 premium No Deductible $2.15 or $5.35 co-pay $0 co-pay after $3,850 out-of-pocket expenses	Sliding scale premium $50 Deductible *May be covered by SeniorCare 15% co-insurance $2.15 - $5.35 co-pay after $3,850 out-of-pocket expenses	$0 premium No Deductible $1 or $3.10 co-pay $0 co-pay after $3,850 out-of-pocket expenses	$0 premium No Deductible $2.15 or $5.35 co-pay; $0 co-pay after $3,850 out-of-pocket expenses	$0 premium No Deductible $0 co-pay	$0 premium No Deductible $2.15 or $5.35 co-pay $0 co-pay after $3,850 out-of-pocket expenses	100% premium $265 Deductible 25% coinsurance up to $2,400 100% co-pay between $2,400 and $5,451.25 $2.15 or $5.25 co-pay after $5,451.25	SeniorCare pays premium not to exceed $33.56/ month and deductible not to exceed $265/ annually Income level determines co-payments or co-insurance client pays
COVERAGE GAP	None	None	None	None	None	None	Recipient pays 100% after $2,400 in total drug costs and up to $4,451.25 in total drug costs	Income level determines whether recipient is subject to coverage gap.

CORRESPONDING *EIS* MEDICAID SUBTYPE			SI = SSI ST = APA eligible QM = *QMB* NS = Ineligible for SSI /APA due to requirements that do not apply to Medicaid	AS = Waiver in Asst. Living BB = Lost SSI / APA due to1977 SSA *Cola* BC = Breast & Cervical Cancer DW = Working Disabled Buy-In GF = Eligible for MED in 1973 IN = *HCB* Waiver PM = 1619b, Disabled Adult Children, Disabled Widowers	*NH* = Nursing Home	SL = SLMB		AS BB GF NS RC SL SS ST PM

				QD = Qualified Disabled & Working Individuals RC = Refuse Cash SS = Eligible for AF/SSI / APA in 1972 ST = APA Eligible				

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ADDENDUM 7

PRESCRIPTION DRUG PLANS AVAILABLE IN ALASKA
as of January 1, 2007

Company Name	Plan Name	Telephone
Aetna Life Insurance Co.	Aetna Medicare Rx Essentials	1-800-445-1796
CIGNA HealthCare	CIGNATURE Rx Value Plan	1-800-735-1459
Health Net	Health Net Orange Option 1	1-800-606-3604
	Health Net Orange option 2	
HealthSpring Prescription Drug Plan	HealthSpring Prescription Drug Plan - Reg 34	1-888-802-2415
Humana Insurance Company	Humana *PDP* Standard S5884-094	1-800-706-0872
NMHC Group Solutions	NMHC Medicare PDP Gold	1-866-443-1095
RxAmerica	Advantage Star Plan by RxAmerica	1-877-279-0370
SilverScript	SilverScript	1-866-552-6106
Sterling Life Insurance Company	Sterling Rx	1-888-909-1713
Unicare	Medicare Rx Rewards Value	1-888-949-5384
United HealthCare	AARP Medicare Rx Plan	1-888-867-5564
	AARP Medicare Rx Plan - Saver	
WellCare	WellCare Classic	1-888-423-5252

There may be other medicare drug plans available in addition to those listed above. However, a dual eligible Medicaid/Medicare recipient who joins a plan that is not listed above may have to pay a monthly premium.

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