

## § 423.780

*subsidy eligibility determinations—eligibility determinations made by States. Redeterminations and appeals of low-income subsidy eligibility determinations by States must be made in the same manner and frequency as the redeterminations and appeals are made under the State's plan.*

(2) *Redeterminations and appeals of low-income subsidy eligibility—eligibility determinations made by Commissioner of Social Security.* Redeterminations and appeals of eligibility determinations made by the Commissioner will be made in the manner specified by the Commissioner of Social Security.

(d) *Application requirements.* (1) In order for applications for the subsidies under this subpart to be considered complete, applicants or personal representatives applying on the individual's behalf, must—

(i) Complete all required elements of the application; (ii) Provide any statements from financial institutions, as requested, to support information in the application; and

(iii) Certify, under penalty of perjury or similar sanction for false statements, as to the accuracy of the information provided on the application form.

(2) *Multiple applications.* If the individual or his or her personal representative has previously filed an application with the State or SSA which seeks subsidy eligibility for any portion of the eligibility period covered by a subsequent application, the later application is void if the individual has received a positive subsidy determination on that earlier application from the State or SSA.

### § 423.780 Premium subsidy.

(a) *Full subsidy eligible individuals.* Full subsidy eligible individuals are entitled to a premium subsidy equal to 100 percent of the premium subsidy amount.

(b) *Premium subsidy amount.* (1) The premium subsidy amount is equal to the lesser of—

(i) Under the Part D plan selected by the beneficiary, the portion of the monthly beneficiary premium attributable to basic coverage (for enrollees in PDPs) or the portion of the MA monthly prescription drug beneficiary

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premium attributable to basic prescription drug coverage (for enrollees in MA-PD plans); or

(ii) The greater of the low-income benchmark premium amount (determined under paragraph (b)(2) of this section) for the PDP region in which the subsidy eligible individual resides or the lowest monthly beneficiary premium for a PDP that offers basic prescription drug coverage in the PDP region.

(2) *Calculation of the low-income benchmark premium amount.* (i) The low-income benchmark premium amount for a PDP region is a weighted average of the premium amounts described in paragraph (b)(2)(ii) of this section, with the weight for each PDP and MA-PD plan equal to a percentage, the numerator being equal to the number of Part D low-income subsidy eligible individuals enrolled in the plan in the reference month (as defined in § 422.258(c)(1) of this chapter) and the denominator equal to the total number of Part D low-income subsidy eligible individuals enrolled in all PDP and MA-PD plans (but not including PACE, private fee-for-service plans or 1876 cost plans) in a PDP region in the reference month.

(ii) *Premium amounts.* The premium amounts used to calculate the low-income benchmark premium amount are as follows:

(A) The monthly beneficiary premium for a PDP that is basic prescription drug coverage;

(B) The portion of the monthly beneficiary premium attributable to basic prescription drug coverage for a PDP that is enhanced alternative coverage; or,

(C) The MA monthly prescription drug beneficiary premium (as defined under section 1854(b)(2)(B) of the Act) for a MA-PD plan and determined before the application of the monthly rebate computed under section 1854(b)(1)(C)(i) of the Act for that plan and year involved.

(c) *Special rule for 2006 to weight the low-income benchmark premium.* For purposes of calculating the low-income benchmark premium amount for 2006, CMS assigns equal weighting to PDP sponsors (including fallback entities) and assigns MA-PD plans a weight

based on prior enrollment. New MA-PD plans are assigned a zero weight. PACE, private fee-for-service plans and 1876 cost plans are not included.

(d) *Other low-income subsidy eligible individuals—sliding scale premium.* Other low-income subsidy eligible individuals are entitled to a premium subsidy based on a linear sliding scale ranging from 100 percent of the premium subsidy amount described in paragraph (b) of this section as follows:

(1) For individuals with income at or below 135 percent of the FPL applicable to their family size, the full premium subsidy amount.

(2) For individuals with income greater than 135 percent but at or below 140 percent of the FPL applicable to the family size, a premium subsidy equal to 75 percent of the premium subsidy amount.

(3) For individual with income greater than 140 percent but at or below 145 percent of the FPL applicable to the family size a premium subsidy equal to 50 percent of the premium subsidy amount.

(4) For individuals with income greater than 145 percent but below 150 percent of FPL applicable to the family size a premium subsidy equal to 25 percent of the premium subsidy amount.

(e) *Waiver of late enrollment penalty for subsidy-eligible individuals.* Subsidy eligible individuals, as defined in § 423.773, are not subject to a late enrollment penalty, as defined in § 423.46.

(f) *Waiver of de minimis premium amounts.* CMS will permit a Part D plan to waive a de minimis amount that is above the monthly beneficiary premium defined in § 423.780(b)(2)(ii)(A) or (B) for full subsidy individuals as defined in § 423.780(a) or § 423.780(d)(1), provided waiving the de minimis amount results in a monthly beneficiary premium that is equal to the established low income benchmark as defined in § 423.780(b)(2).

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**§ 423.782 Cost-sharing subsidy.**

(a) *Full subsidy eligible individuals.* Full subsidy eligible individuals are entitled to the following:

(1) Elimination of the annual deductible under § 423.104(d)(1).

(2) Reduction in cost-sharing for all covered Part D drugs covered under the PDP or MA-PD plan below the out-of-pocket limit (under § 423.104), including Part D drugs covered under the PDP or MA-PD plan obtained after the initial coverage limit (under § 423.104(d)(4)), as follows:

(i) Except as provided under paragraphs (a)(2)(ii) and (a)(2)(iii) of this section, copayment amounts not to exceed the copayment amounts specified in § 423.104(d)(5)(A). This applies to both:

(A) those full-benefit dual eligible individuals who are not institutionalized and who have income above 100 percent of the Federal poverty line applicable to the individual's family size and

(B) those individuals who have income under 135 percent of the Federal poverty line applicable to the individual's family size who meet the resources test described at § 423.773(b)(2).

(ii) Full-benefit dual-eligible individuals who are institutionalized or who are receiving home and community-based services have no cost-sharing for Part D drugs covered under their PDP or MA-PD plans.

(iii) Full-benefit dual eligible individuals with incomes that do not exceed 100 percent of the Federal poverty line applicable to the individual's family size are subject to cost-sharing for covered Part D drugs equal to the lesser of:

(A) A copayment amount of not more than \$1 for a generic drug or preferred drugs that are multiple source (as defined under section 1927(k)(7)(A)(i) of the Act) or \$3 for any other drug in 2006, or for years after 2006 the amounts specified in this paragraph (a)(2)(iii)(A) for the percentage increase in the Consumer Price Index, rounded to the nearest multiple of 5 cents or 10 cents, respectively; or

(B) The copayment amount charged to other individuals under this paragraph (a)(2)(i) of this section.

(3) Elimination of all cost-sharing for covered Part D drugs covered under the