

Medicare Costs Assistance Programs – Frequently Asked Questions

1. What programs are available to help reduce Medicare costs?

Four programs that can lower Medicare costs for people with limited incomes and assets are:

- Medicare Savings Programs (MSPs) (see question 2-6)
- Medicaid (see question 7-8)
- Extra Help, also called the Low-Income Subsidy (LIS) (see question 10-14)
- State Pharmaceutical Assistance Program (SPAP) (see question 15)

2. What are Medicare Savings Programs and what do they cover?

Medicare Savings Programs (MSPs), sometimes referred to as Medicare Buy-In Programs, are designed to help pay for Medicare costs if beneficiaries have limited income and savings. There are three programs for people who are over 65 or currently receiving Social Security Disability Insurance (SSDI), with different benefits and eligibility requirements:

- **Qualified Medicare Beneficiary (QMB):** Pays for Medicare Parts A and B premiums. If an individual has QMB, they typically should not be billed for Medicare-covered services when seeing Medicare providers or providers in their Medicare Advantage Plan's network.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Pays for the Medicare Part B premium.
- **Qualifying Individual (QI) Program:** Pays for the Medicare Part B premium.

Additionally, all three MSPs allow people to enroll in Part B outside of the usual enrollment periods, eliminate any Part B late enrollment penalty, and provide automatic enrollment in the Extra Help program.

3. What are the eligibility requirements for MSPs?

Each state can set different eligibility requirements for Medicare Savings Programs (MSPs), within limits established by federal law. This means that states may have higher income and asset limits and more generous rules for how certain types of income and assets are counted. It is important to know that many states require beneficiaries to access any income they may be entitled to, including Social Security retirement benefits or pensions, in order to apply for an MSP.

Income generally means any income – including some non-taxable income – but certain types of income, like income earned from a job, are only partially counted.

Assets are resources such as:

- Savings and checking accounts
- Stocks
- Bonds
- Mutual funds
- Retirement accounts
- Real estate

In any state with an asset limit, certain resources are never counted when determining eligibility for MSPs. These include:

- An individual’s primary residence
- One car
- Household goods and wedding/engagement rings
- Burial spaces
- Burial funds up to \$1,500 per person
- Life insurance with a cash value of less than \$1,500

Note: Some states may exclude other assets as well.

MSP Type	Income limit	Asset Limit *
Qualified Medicare Beneficiary (QMB) Program - 100% FPL	Individual: \$1,350 Couple: \$1,824	Individual: \$9,950 Couple: \$14,910
Specified Low-Income Medicare Beneficiary (SMLB) Program - 120% FPL	Individual: \$1,616 Couple: \$2,184	Individual: \$9,950 Couple: \$14,910
Qualifying Individual (QI) Program - 135% FPL	Individual: \$1,816 Couple: \$2,455	Individual: \$9,950 Couple: \$14,910

* Alabama, Arizona, Connecticut, Delaware, Louisiana, Massachusetts, Mississippi, New Mexico, New York, Oregon, Vermont, Washington, and the District of Columbia do not have asset limits for MSPs (as of January 2026).

4. What are the steps to apply for a Medicare Savings Program (MSP)?

Exact processes may vary between states to apply for an MSP. In general, even before applying, someone should:

- Call their local Medicaid office for detailed application information, submission options (online, by mail, in person, or through community health centers and other organizations), and any other state-specific guidelines.
- Contact their State Health Insurance Assistance Program (SHIP) to find out if they offer assistance with the MSP application.

Gather documents that may be required for the application, including:

- Social Security card
- Medicare card
- Birth certificate, passport, or green card
- Proof of address (e.g., electric or phone bill)
- Proof of income (e.g., Social Security Administration award letter, income tax return, pay stub)
- Information about assets (e.g., bank statements, stock certificates, life insurance policies)

Some states may use data from other government sources to confirm application information and may not require applicants to submit proof or documentation, while others may require the submission of a substantial amount of personal and financial documents. Some states may require original documents or official copies, while in others, copies are acceptable. Be sure not to send originals of any hard-to-replace documents, like passports or green cards, through the mail.

People should keep a copy of the full application as they submitted it, and, if possible, mail or submit materials in a way that provides proof of delivery.

Beneficiaries should receive a Notice of Action within 45 days of filing an application. This notice will inform them of their application status. If they receive a denial and are told they do not qualify for an MSP, beneficiaries have the right to request a fair hearing to challenge that decision.

If beneficiaries receive an approval:

- If they are found eligible for SLMB or QI, the state will pay for the Part B premium starting the month indicated on the beneficiary's Notice of Action. However, it may take several months for the Part B premium (e.g., \$202.90 in 2026) to stop being taken out of their monthly Social Security check. Do not be concerned—beneficiaries should be reimbursed with a lump-sum check for each month the premium should have been paid.
- If they are found eligible for QMB, their benefits begin the month after the application is approved.

If beneficiaries do not receive a Notice of Action within 45 days, they should contact the Medicaid office.

People enrolled in the MSP need to renew (recertify) every year. If they do not receive a notice in the mail with information about how to recertify, they should contact their local Medicaid office.

5. Is it still possible to apply for a Medicare Savings Program (MSP) if an individual's income appears to be above the stated guidelines?

If an individual's income is above the Medicare Savings Program (MSP) income and asset guidelines in their state, it may still make sense to apply. They may qualify for an MSP because some income and assets may not be counted when determining eligibility.

In all states, the following income is not counted:

- The first \$20 of all income
- The first \$65 of the beneficiary's income from work
- Half of the beneficiary's income from work (after the \$65 is deducted)
- Food stamps (Supplemental Nutrition Assistance Program, or SNAP, support)

In addition to the above, some states may disregard or exclude other income, such as the cost of certain health insurance premiums (like Part D premiums). Also, in some states, the eligibility limits may be higher if there are more than two people in the household.

In all states, the following assets are not counted:

- The beneficiary's primary residence
- One car
- Household goods and wedding/engagement rings
- Burial spaces
- Burial funds up to \$1,500 per person
- Life insurance with a cash value of less than \$1,500

Many states do not count other types of assets as well. Beneficiaries should call their SHIP to learn more about income and asset limits in their states.

6. What is QMB improper billing and how can beneficiaries protect themselves?

In Medicare, the term improper billing refers to a provider inappropriately billing a beneficiary who is enrolled in the QMB program for Medicare cost-sharing. Cost-sharing can include deductibles, coinsurance, and copayments. Federal law prohibits Medicare providers from billing individuals enrolled in QMB for any Medicare cost-sharing.

If beneficiaries have QMB and are enrolled in Original Medicare, they should not be billed when receiving a Medicare-covered service from:

- A participating provider (one who accepts assignment) or
- A non-participating provider

If beneficiaries have QMB and are enrolled in a Medicare Advantage Plan, they should not be billed when receiving a Medicare-covered service from:

- In-network providers, as long as they follow the plan's coverage rules, such as obtaining prior authorization to see certain specialists.

To protect themselves from improper billing, beneficiaries should be aware that:

- Original Medicare and Medicare Advantage providers who do not accept Medicaid must still comply with improper billing protections and cannot bill them.
- They retain their improper billing protections even when receiving care from Medicare providers in other states.

- They can be billed if they are enrolled in a Medicare Advantage Plan and see an out-of-network provider, or if they have Original Medicare and see an opt-out provider after signing a private contract.
- They cannot choose to waive these protections and pay Medicare cost-sharing, and a provider cannot ask them to do so.

If beneficiaries have QMB, the Medicare providers they see must accept Medicare payment and any QMB/Medicaid payment as full payment for any Medicare-covered services. Providers who violate improper billing protections may be subject to penalties. If beneficiaries are having issues with a provider who continues to bill them, or if they have unpaid cost-sharing bills that have been sent to collection agencies, they should call 1-800-MEDICARE or contact their Medicare Advantage Plan.

7. How does Medicaid work with Medicare?

If an individual is eligible for both Medicare and Medicaid (dually eligible), they can enroll in both. Medicaid can cover services that Medicare does not and help pay Medicare's out-of-pocket costs. Below are a few examples of how Medicaid can work with Medicare.

- **Medicaid can provide secondary insurance:** For services covered by both Medicare and Medicaid (such as doctor visits, hospital care, home care, and skilled nursing facility care), Medicare is the primary payer. Medicaid is the payer of last resort, meaning it always pays last. When beneficiaries visit a provider or facility that accepts both forms of insurance, Medicare will pay first, and Medicaid may cover the individual's Medicare cost-sharing, including coinsurance and copays.
- **Medicaid can provide premium assistance:** In many cases, if an individual has both Medicare and Medicaid, they will also be enrolled in a Medicare Savings Program (MSP).
- **Medicaid can provide cost-sharing assistance:** In addition to covering cost-sharing for Medicaid services, people with Medicaid and QMB are protected from all Medicare cost sharing.
- **Medicaid can provide prescription drug assistance:** Dually eligible individuals are automatically enrolled in the Extra Help program to assist with their prescription drug costs.
- **Medicaid can offer care coordination:** Some states require certain Medicaid enrollees to access their coverage through Medicaid private health plans, also known as Medicaid Managed Care (MMC) plans. Being enrolled in one of these plans may offer optional enrollment into a Medicare Advantage Plan operated by the same company as their MMC

plan that is designed to better coordinate Medicare and Medicaid benefits. (Note: Beneficiaries cannot be required to enroll in a Medicare Advantage Plan.)

Note: If an individual has Medicaid, they have an additional SEP once per month to enroll in an integrated Dual-Eligible Special Needs Plan (D-SNP). An integrated D-SNP is a type of Medicare Advantage Plan that meets certain requirements to provide Medicare and Medicaid benefits together.

Beneficiaries should call 1-800-MEDICARE or contact their local Medicaid office to learn more about Medicare and Medicaid costs and coverage.

9. What are other strategies to save on health care costs?

In addition to programs and additional insurance that can lower health care costs, some facilities provide care at reduced rates, including: Government-funded health centers across the country that provide medical care regardless of an individual's ability to pay. These clinics are generally run, authorized, or funded by the Health Resources and Services Administration (HRSA). They may also be called:

- Federally Qualified Health Centers (FQHCs)
- FQHC Look-Alikes
- Migrant Health Centers
- Health Care for the Homeless Program Centers
- Public Housing Primary Care Centers
- Tribal Organization-run Outpatient Health Programs

People with Medicare can get care from these publicly-funded health centers. The centers provide Medicare-covered medical services and may offer some services that Medicare does not cover, like dental services.

A unique advantage of government-funded health centers is that they may waive the Part B deductible and coinsurance, if an individual's annual income is at or below the federal poverty level. While private providers may waive cost sharing based on need, they may not do so widely or consistently. The Hill-Burton program offers free or reduced-cost care at Hill-Burton facilities. Most states have at least one facility that participates in this program. Each facility chooses which services it will provide and at what (if any) cost. Services that are fully covered by other types of insurance (like Medicare or Medicaid) are not eligible for Hill-Burton coverage. The Hill-Burton

Program does not cover Medicare cost-sharing. However, it does cover Medicaid copayments—except for long-term care facility services—as well as Medicaid spend-down amounts.

Eligibility for the Hill-Burton Program is based on a beneficiary's income and family size. Beneficiaries may apply for Hill-Burton assistance before or after they receive care, or even after a bill has been sent to collections. To apply, beneficiaries should contact the Admissions, Business, or Patient Accounts Office at a Hill-Burton facility.

10. What is Extra help and what are the benefits of enrolling in Extra help?

Extra Help is a federal program that helps pay for some to most of the out-of-pocket costs of Medicare prescription drug coverage. It is also known as the Part D Low-Income Subsidy (LIS).

- Lowers the Part D premium by up to state-specific benchmark amount
- Lowers the copay or coinsurance for prescription drugs
- Gives eligible individuals a Special Enrollment Period (SEP) once per month to enroll in a stand-alone Part D plan
 - Beneficiaries with Original Medicare can use this SEP to change their stand-alone Part D plan.
 - Beneficiaries in a Medicare Advantage Plan can use this SEP to switch to Original Medicare with a stand-alone Part D plan.
 - Beneficiaries cannot use this SEP to enroll in a Medicare Advantage Plan with or without drug coverage.
- Eliminates any Part D late enrollment penalty that beneficiaries may have incurred if they delayed Part D enrollment.

Note: Extra Help is not a replacement for Part D or a plan on its own. Beneficiaries must still have a Part D plan to receive Medicare prescription drug coverage and Extra Help assistance. If beneficiaries do not choose a plan, they will, in most cases, be automatically enrolled in one.

11. What are the eligibility criteria and what are the steps to apply for Extra Help?

Extra Help eligibility

1. If an individual's monthly income is up to \$2,015 in 2026 (\$2,725 for couples) and their assets are below specified limits, they may be eligible for Extra Help (see the Extra Help income and asset limit chart for details). These limits include a \$20 income disregard that

the Social Security Administration (SSA) automatically subtracts from beneficiaries' monthly unearned income (e.g., retirement income). Even if an individual's income or assets are above the eligibility limits, they may still qualify for Extra Help because certain types of income and assets are not counted, in addition to the \$20 mentioned above.

2. If an individual is enrolled in Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (MSP), they automatically qualify for Extra Help regardless of whether they separately meet Extra Help's eligibility requirements. Beneficiaries should receive a purple-colored notice from the Centers for Medicare & Medicaid Services (CMS) informing them that they do not need to apply for Extra Help.

Medicare prescription drug assistance	Income limit	Asset Limit
Extra Help/Low-Income Subsidy (LIS) Program - 150% FPL	Individual: \$2,015 Couple: \$2,725	Individual: \$18,090 Couple: \$36,100

Extra Help application process

If beneficiaries do not have Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (MSP), they can apply for the Extra Help program through the Social Security Administration (SSA) using either the agency's print or online application. (If they have Medicaid, SSI, or an MSP, they should be automatically enrolled in Extra Help.)

To apply online, beneficiaries visit www.ssa.gov. Depending on processes in different states, this application can also serve to screen beneficiaries for an MSP or function as a partial application for the MSP. Beneficiaries should complete the entire application and provide accurate information so they can get all the benefits for which they qualify.

12. What can beneficiaries do if their Extra Help application is denied?

If the Social Security Administration (SSA) denies an Extra Help application and the beneficiary disagrees, they have two opportunities to request that their case be reexamined.

1. Before the final decision

If an individual's application is going to be denied, they will receive a Pre-Decisional Notice before the formal denial. This notice explains that the beneficiary may not be eligible for Extra Help and why. If beneficiaries believe SSA's decision is based on incorrect information, they can correct their application.

Beneficiaries have 10 days from the date on the notice to make corrections. It may be fastest to call or visit their local SSA field office using the contact information provided in the notice. They can also call SSA's national hotline at 800-772-1213.

2. After the final decision

Once SSA makes a final decision, beneficiaries will receive either a Notice of Award or a Notice of Denial. If beneficiaries disagree with SSA's decision, they can appeal. It is better to appeal than to reapply, because if the appeal is successful, Extra Help will be effective from the first day of the month the original application was submitted.

Appeal process

1. Request a hearing within 60 days of receiving SSA's decision.
Note: If beneficiaries have a good reason for missing the appeal deadline, they may qualify for a good cause extension.
2. If beneficiaries do not want a hearing, they can request a case review, where an SSA agent will review their application and any additional information submitted.
3. Set a hearing date by calling their local SSA office or the national hotline at 800-772-1213. Beneficiaries can also download a form online and mail it to request a hearing. SSA will generally suggest a date at least 20 days after receiving the request, giving beneficiaries time to prepare. However, they can waive the 20-day preparation period if they want the hearing to be held sooner.
4. Participate in the hearing. Hearings are held by phone. Beneficiaries will receive a notice in the mail confirming the hearing date and providing a toll-free number to call. The notice will also explain how to submit supporting evidence (e.g., bank statements showing assets). If beneficiaries have a scheduling conflict, they can reschedule the hearing for good cause.
5. After the hearing or case review, SSA will send a notice with the final decision. If beneficiaries still disagree with the outcome, they can file an appeal in Federal District Court.

14. How can beneficiaries keep Extra Help from year to year?

To keep Extra Help benefits from year to year, beneficiaries must continue to meet the eligibility requirements. Depending on an individual's state and how they initially qualified for Extra Help, this process may be automatic or may require beneficiaries to submit information to confirm their continued eligibility.

If beneficiaries qualified for Extra Help automatically because they had Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (MSP):

- If they still have Medicaid, SSI, or an MSP, they do not need to take any action. Their state should inform Medicare that they are still enrolled in one of these programs, and they will continue receiving Extra Help. They should not receive any notice unless their copayments are changing for the next year. If their income has changed enough to affect their copayments, they should receive a notice in early October.
- If they no longer have Medicaid, SSI, or an MSP, they should apply for Extra Help. If they do not apply, their Extra Help will end on December 31 of the year they last were enrolled in one of these programs or of the next year, depending on the month in which they last had Medicaid, SSI or and MSP. Beneficiaries should receive a letter in the fall explaining that they will lose Extra Help, along with an application and a postage-paid envelope. They can also choose to apply online. If beneficiaries applied for Extra Help directly with SSA:

SSA may send a letter in August or September titled "Social Security Administration Review of Your Eligibility for Extra Help." This letter outlines the financial and personal information beneficiaries provided when they applied and asks if any of it has changed.

Note: If a beneficiary and their spouse applied for Extra Help together, they will receive only one letter.

If beneficiaries receive this letter, they must complete the enclosed Review of Your Eligibility form and return it to SSA within 30 days. SSA will use their responses to determine whether they still qualify for Extra Help, based on any changes in income or assets.

If beneficiaries do not return the form, their Extra Help will end on December 31. If they need more time, they should call their local Social Security office to request a 30-day extension. Any changes to their Extra Help benefits will take effect on January 1.

Once SSA has reviewed any submitted forms, beneficiaries will receive a notice explaining whether their Extra Help benefit has stayed the same, increased, decreased, or ended. If they lose Extra Help, they can appeal or reapply.

15. What is a State Pharmaceutical Assistance Program?

Many states offer State Pharmaceutical Assistance Programs (SPAPs) to help residents pay for prescription drugs. Each program works differently.

States may coordinate their drug assistance programs with Medicare's prescription drug benefit (Part D). Some SPAPs require beneficiaries to sign up for Part D in order to qualify for assistance. In these cases, if a drug is covered by both the SPAP and an individual's Part D plan, both the amount the individual pays for their prescriptions and the amount the SPAP pays will count toward the out-of-pocket maximum beneficiaries must reach before entering catastrophic coverage.

SPAPs may also help pay for a Part D plan's:

- Premium
- Deductible
- Copayments.

Certain states have qualified SPAPs. People enrolled in those programs also have a Special Enrollment Period (SEP) that allows them to enroll in or change their Part D or Medicare Advantage Plan.

Beneficiaries can visit www.medicare.gov to find out if their state has an SPAP, whether they are eligible, how the SPAP works, and how to enroll.

16. What are other strategies to save on Medicare prescription drug costs?

- **Charity Programs:** There may be charities that can help reduce prescription costs. The amount the charity pays may be included in the person's TrOOP.
- **Patient Assistance Programs (PAPs):** Beneficiaries may be eligible to receive free or low-cost drugs directly from the company that manufactures them, through a PAP. In most cases, an individual's doctor must apply on their behalf. Not all PAPs allow people to apply if they are eligible for or have Part D. If a beneficiary is enrolled in a PAP, they may be required to pay a copay. PAP copays may count toward their Part D plan's out-of-pocket limit (\$2,100 in 2026), but beneficiaries must submit receipts and any other required documentation to their

plan. However, the amount the PAP pays for prescription drugs will usually not count toward the out-of-pocket limit.

- **Prescription Drug Discount Programs:** Beneficiaries may be able to get medications at a reduced price through national or local discount programs or cards.
- **Note:** Beneficiaries cannot use a prescription drug discount program and Part D coverage at the same time—they must choose between them at the pharmacy.
- **Safety Net Providers:** Pharmacies in certain government-funded hospitals and community health centers may provide medications at lower costs or charge beneficiaries based on their income. These centers and clinics include Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Some centers may waive copays for drugs covered by an individual's Part D plan if requested. Be sure to contact the facility directly to learn which benefits it offers and whether costs paid there will count toward TrOOP.