



**February 2009**

## **Low-Income Advocate Alert On Medicare Part D**

### *Highlights of this Issue*

- [Premium Increases and Reassignment Contribute in a Busy AEP.](#) Page 2
- [CMS Suspends Enrollment and Marketing Activities of WellPoint and WellCare.](#) Page 3
- [March 31 Deadline for QMB Eligibility In States Without Buy-In.](#) Page 5
- [Stimulus Bill Extends QI Program.](#) Page 6
- [CMS Bans Reference Based Pricing in 2010.](#) Page 6
- [Limited English Proficient Beneficiaries Still Waiting for Access.](#) Page 7
- [LIS 2009 Income and Asset Limits Released.](#) Page 10
- [California Report.](#) Page 12
- [Updated Tools for Advocates from NSCLC.](#) Page 13
- And more...

**To receive this Alert in alternative formatting,  
call (510) 663-1055 x. 301.**

## **IMPORTANT INFORMATION**

---

### **PREMIUM INCREASES AND REASSIGNMENT CONTRIBUTE TO A BUSY AEP**

The 2008 Annual Enrollment Period began on November 15<sup>th</sup>, 2008 and ended on December 31<sup>st</sup>, 2008. The new plan year began on January 1, 2009. Reports from State Health Insurance Assistance Programs (SHIPs), legal services organizations and other groups that advise Medicare beneficiaries indicate that this was perhaps the busiest AEP on record with significant increases in the numbers of beneficiaries seeking advice.

#### **Premium Increases**

Many of the beneficiaries who were contacting advocates this Fall were motivated to re-examine their options after discovering that the plan they were enrolled in for 2008 would be raising its premium significantly in 2009. A report from the Kaiser Family Foundation found that more than 90% of enrollees were facing an increase in premiums. According to the report, if current enrollees remained in their 2008 plan in 2009, the weighted average monthly premium for PDPs would increase by \$7.40 per month, from \$29.89 in 2008 to \$37.29 in 2009. (See p. 14 for more information about and a link to the KFF report.)

The Centers for Medicare and Medicaid Services (CMS) has not yet released information about the number or percent of beneficiaries who changed plans during the Annual Enrollment Period. In 2006, only 2.4 million changed (1.1 million of whom were LIS recipients who were automatically reassigned to a new plan by CMS). In 2007, 3.1 million made a switch (2.1 million LIS recipients re-assigned)

#### **Reassignment of LIS Recipients Continues; Fewer Benchmark Plans Available**

During the 2008 AEP, 2.2 million LIS recipients had to change to a new plan to retain a \$0 premium. Beneficiaries had to change plans because the plan they were enrolled in for 2008 was losing its “benchmark” status in 2009. Beneficiaries eligible for the full premium LIS can enroll in a benchmark plan and pay no premium. LIS beneficiaries enrolled in non-benchmark plans are liable for a premium equal to the difference between the plan’s premium and the “benchmark” amount. Plans lost their benchmark status in 2009 because they were either: 1) no longer offered in 2009; 2) charging a premium above the low income benchmark amount in 2009; or 3) switching from a standard plan to an enhanced plan.

The majority of beneficiaries affected (1.6 million) were automatically reassigned to a new plan by Medicare, but Medicare’s reassignment process does not consider the prescription drug needs of the beneficiary, which means the new plan may not cover their

drugs. The remaining 620,000 LIS recipients affected by changes in benchmark plans had to change plans on their own in order to avoid the new premium costs.

In every state, at least three of the plans that qualified as benchmark plans in 2008 will not maintain benchmark status in 2009. The total number of benchmark plans offered across all states decreased by nearly 40% between 2008 and 2009 and has decreased by over 50% since 2007. With fewer plans to choose from, it becomes less likely that LIS recipients will find plans they can afford that cover the medications they need. Many advocates have reported that they were forced to enroll LIS recipients (including dual eligibles) into plans with premiums in order to ensure that all of their drugs were covered.

In November, NSCLC released a report, “*Musical Chairs: An analysis of the Part D Annual Reassignment Process*,” discussing in detail the impact of the reassignment process on low income beneficiaries.<sup>1</sup> The report includes a state-by-state analysis of the changes to benchmark plans.

### **Medicare.gov Plagued by Accuracy, Transparency Problems; Limited SEP Available**

Advocates experienced an increase in problems with Medicare.gov during the enrollment season. The bulk of the problems related to accuracy – beneficiary specific information, such as LIS status, was wrong, formulary information on Medicare.gov did not match information on plan websites or information for particular plans was unavailable. In other cases, the problem was transparency – the information on Medicare.gov did not reflect the true price of drugs under a particular plan either because prices displayed were only available at certain pharmacies or because plan cost-sharing was not properly reflected in the information displayed (see discussion of Reference Based Pricing below).

Acknowledging that some information on Medicare.gov was inaccurate, CMS granted an extremely limited Special Enrollment Period to beneficiaries who had signed up for a plan believing they had chosen the lowest cost plan only to find out now that a less expensive plan was available. A beneficiary qualifies for this SEP if: 1) they are enrolled in a plan that is on a list created by CMS; 2) the beneficiary’s drug costs under the current plan will expose them to the donut hole and 3) a less expensive plan is now available. CMS has not provided information on how long this SEP will last. For more information about this SEP or to access the list of plans covered, contact Kevin Prindiville at NSCLC ([kprindiville@nsclc.org](mailto:kprindiville@nsclc.org)).

### **Problems in Transition to New Coverage Year; CMS Takes Action Against WellPoint and WellCare**

CMS has suspended the marketing and enrollment activities of two of the largest providers of Medicare private plans – WellPoint, Inc. and WellCare – due to enrollment and marketing problems that impeded access to care for enrollees.

---

<sup>1</sup> Available at: [www.nsclc.org/areas/medicare-part-d/musical-chairs-an-analysis-of-the-part-d-annual-reassignment-process](http://www.nsclc.org/areas/medicare-part-d/musical-chairs-an-analysis-of-the-part-d-annual-reassignment-process).

CMS took action against WellPoint on January 12, 2009 after receiving reports of enrollment problems. CMS suspended the marketing and enrollment activities of WellPoint, Inc. and granted a Special Enrollment Period to recipients who want to disenroll from a WellPoint plan. Until the suspension is lifted, WellPoint-sponsored Medicare Advantage and Part D plans will not be able to market to or enroll new members. During the suspension, Low Income Subsidy recipients will not be autoenrolled into WellPoint-sponsored plans even if the plans otherwise qualify for autoenrollment. Beneficiaries who want to disenroll from a WellPoint plan had until the end of January to request a Special Enrollment Period (SEP) to disenroll.

In February, CMS announced that the enrollment and marketing activities of another plan, WellCare, would be suspended effective March 7, 2009 due to complaints about enrollment and marketing. CMS took this action due to WellCare's failure to provide adequate service to its enrollees in enrollment and disenrollment operations, appeals and grievances, timely and proper responses to beneficiary complaints and requests for assistance, and marketing and agent/broker oversight activities. In January alone, CMS received over 2,500 complaints from Medicare beneficiaries enrolled in WellCare's plans. Past marketing audits revealed that WellCare engaged in illegal door-to-door solicitation as well as activities which misled and confused beneficiaries. Beneficiary complaint data shows that WellCare has the highest rate of marketing complaints among MA plans – three times the national average. The suspension will not be lifted until WellCare corrects these deficiencies and demonstrates to CMS that they are not likely to recur.

While advocates are pleased to see CMS taking aggressive action against plans that fail to comply with CMS rules and regulations, they are concerned that CMS waited until after the end of the Annual Enrollment Period to take action. They are also concerned about the impact the enrollment suspension has on the number of benchmark plans available to low income beneficiaries (Wellpoint offered at least 1 benchmark plan in all but 1 state; WellCare offers benchmark plans in 15 states) and the limited duration of the SEP that was established to allow beneficiaries to disenroll.

WellPoint and WellCare both offer MA-PDs and PDPs in every state. WellPoint Plans are offered under a variety of names - Unicare, Anthem and, in some states, Blue Shield or Blue Cross and Blue Shield. WellPoint also runs the Point of Service Facilitated Enrollment system. CMS has indicated that this contract remains in place. While Wellpoint is under suspension, beneficiaries who use the POS system will be enrolled into a non-WellPoint benchmark plan after their initial claims are paid by the POS system.

## **Open Enrollment Period Provides Continuing Opportunity to Make Changes to Coverage**

While the AEP ended on December 31, 2008, the Medicare Open Enrollment Period continues until March 31, 2009. During the Open Enrollment Period beneficiaries can make Medicare Advantage (MA) related changes. The following changes are allowed:

- Medicare Advantage Prescription Drug Plan (MA-PD) to a different MA-PD
- MA-PD to Original Medicare and a Prescription Drug Plan (PDP)
- Original Medicare and a PDP to an MA-PD
- MA-only plan to a different MA-only plan
- MA-only plan to original Medicare
- Original Medicare to an MA-only plan

For more information on Enrollment Periods and Special enrollment Periods, see NSCLC's "Prescription Drug Enrollment Periods."<sup>2</sup>

## **MARCH 31 DEADLINE FOR QMB ELIGIBILITY IN STATES WITHOUT BUY-IN**

A reminder: in 15 states, the first quarter of 2009 is the only time when certain low-income individuals, including some senior immigrants, may qualify for valuable benefits through a Medicare Savings Program (MSP). Therefore, advocates in those states should take advantage of Medicare's general enrollment period, which ends March 31, to evaluate clients' eligibility for MSP benefits, in particular the Qualified Medicare Beneficiary (QMB) program. The 15 states are: Alabama, Arizona, California, Colorado, Illinois, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, Oregon, South Carolina, Utah and Virginia.

Enrollment in Medicare Part A (often referred to as "hospital" coverage) is a necessary prerequisite to receiving MSP benefits. The majority of states have "buy-in" agreements with the federal government that allow dual eligibles (i.e. those eligible for both Medicare and Medicaid) to enroll in Medicare Part A all year. In the remaining 15 states, however, the three general Medicare enrollment months are the only time when individuals who don't already have Medicare Part A can sign up.

MSPs provide beneficiaries with assistance in paying Medicare premiums, deductibles and co-insurance. The scope of the benefit varies depending on individuals' eligibility for particular programs. It is most meaningful for individuals, such as qualified senior immigrants, who do not have free Medicare Part A because they lack 40 quarters of work history, but whose income is low enough to receive a state subsidy for Part A through QMB. As dual eligibles, MSP beneficiaries also automatically qualify for the Low

---

<sup>2</sup> Available at: [www.nsclc.org/areas/medicare-part-d/advocate/Guides/Enrollment-Periods](http://www.nsclc.org/areas/medicare-part-d/advocate/Guides/Enrollment-Periods).

Income Subsidy (“extra help”) for Medicare Part D prescription drug coverage. For more detailed information, see NSCLC’s online article.<sup>3</sup>

## STIMULUS PACKAGE EXTENDS Q-I PROGRAM, PROVIDES ONE TIME INCREASE IN SOCIAL SECURITY AND SSI PAYMENTS AND INCREASES MEDICAID FMAP

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009. The legislation contains a number of important provisions for dual eligibles and other Medicare beneficiaries. First, the legislation provides a one time payment of \$250 to all Social Security and SSI recipients. This payment is expected to be made by the end of May 2009. It is important to note that these payments will not count as income for purpose of determining eligibility for or amount of benefits under any Federal or federally funded program, such as SSI, Medicaid, Food Stamps or Housing Assistance. Also, it does not count toward the resource limit for SSI or any other Federal or federally funded program for 9 months following the date of receipt. The legislation also extends the Qualified Individual (QI) program until December 31, 2010. Finally, the legislation includes an increase in the Federal Medical Assistance Percentages (FMAP), which are used to determine the amount of Federal matching funds for State Medicaid expenditures. The increase in the matching rates should prevent States from reducing Medicaid eligibility.<sup>4</sup>

### **POLICY NEWS**

---

## NEW PART D PRICING SCHEME CAUSES CONFUSION, INCREASED COSTS; CMS AGREES TO BAN SCHEME IN 2010

During the fall, advocates discovered that a number of national Part D plan sponsors, including HealthNet, SilverScript, and Sterling, are using what CMS calls “reference-based pricing” to tack on additional charges for certain brand name drugs. Under this pricing scheme, beneficiaries who do not receive the LIS must pay the tiered co-pay amount plus an additional penalty calculated as the difference between the full price of the drug and the full price of its generic equivalent. For example, under the SilverScript Value Plan, a beneficiary who needs the drug Cardizem will have to pay not only the \$98 co-pay, but also a “penalty” of \$103.27 (the full cost of the drug minus the cost of its generic equivalent), for a total cost of \$201.27.

The Medicare.gov Plan Finder does not include details of the actual cost of the drugs that are subject to the penalty. According to one of the plans that uses this pricing, the costs of these drugs can also vary by pharmacy due to varying contracting rates with each

---

<sup>3</sup> Available at: [www.nsclc.org/areas/medicare-part-d](http://www.nsclc.org/areas/medicare-part-d).

<sup>4</sup> For more information on the impact of the stimulus bill on seniors, visit: [www.nsclc.org](http://www.nsclc.org).

pharmacy. Moreover, advocates who have contacted 1-800-MEDICARE have found that many plan customer service representatives are unaware of the penalty and have been unable to provide actual beneficiary costs. The Plan Finder's initial screen showing the lowest price plans makes no reference to the penalty pricing, and a vaguely worded footnote (the now infamous "Footnote 8") appears only if the user continues to the Plan Compare screen. Consequently, it is nearly impossible to determine the true cost of a drug on a plan's formulary, and to compare drugs meaningfully.

As a result, beneficiaries who believe they signed up for the lowest cost prescription drug plan that includes their necessary medications may be instead charged much higher co-payments. (Most Low Income Subsidy recipients, who pay fixed, low co-payments, are not affected.)

On November 26, a group of advocacy organizations filed a complaint with the Centers for Medicare and Medicaid Services (CMS) asking the agency to stop marketing of plans that include the new "penalty" pricing and to allow beneficiaries who enroll in plans without adequate information about penalty pricing a special enrollment period to change plans later.<sup>5</sup> In a letter dated January 15, CMS responded to the complaint and indicated that, because of transparency concerns, reference based pricing would not be allowed in 2010. Plans will be allowed to utilize the pricing scheme in 2009 and CMS has not indicated a willingness to grant a general Special Enrollment Period to beneficiaries subject to it. If you have a client who is unable to afford a drug they need because of reference based pricing, please contact Georgia Burke ([gburke@nsclc.org](mailto:gburke@nsclc.org)) at NSCLC.

## LIMITED ENGLISH PROFICIENT BENEFICIARIES STILL WAITING FOR ACCESS

In November, the California Medicare Part D Coalition released a report, "*Please Hold: Medicare Plans Leave Limited English Proficient Beneficiaries Waiting for Access*," that shows that limited English proficient (LEP) Medicare beneficiaries are often unable to get important information from Medicare prescription drug plans in their preferred language.

Key findings include:

- California's low-income Part D plans are only able to connect limited English proficient dual eligibles to someone speaking their language 69% of the time.
- Non-Spanish speaking LEP beneficiaries have an even harder time getting information from plans, connecting with someone who speaks their language only 57% of the time.
- Plan representatives repeatedly refused to provide services in languages other than English.
- Multiple callers were told that they had reached an English-only line and needed to call back with an English speaker.

---

<sup>5</sup> Available at: [www.nsclc.org/areas/medicare-part-d/reference-based-pricing-in-medicare-part-d](http://www.nsclc.org/areas/medicare-part-d/reference-based-pricing-in-medicare-part-d).

- Even those beneficiaries who were provided an interpreter were frequently unable to get the information they needed.
- Written materials were never available in any language other than English or Spanish, and Spanish written materials were not always available.

The report was released by the California Medicare Part D Language Access Coalition, an informal coalition of advocates in legal and community-based organizations serving limited English proficient and low-income communities in California. The effort was led by the National Senior Citizens Law Center, the National Health Law Program, the Greenlining Institute, Asian & Pacific Islander American Health Forum and the Health Consumer Center of Los Angeles.

## NEW BILL TO SHINE LIGHT ON PHARMACEUTICAL GIFTS AND PAYMENTS TO DOCTORS

One driver of skyrocketing drug costs is the \$25 billion spent by the pharmaceutical industry every year in gifts and payments to doctors. The evidence is clear: this spending means patients get higher cost, and sometimes unnecessary, drugs. One important step is transparency on physician-industry financial relationships.

The Physician Payments Sunshine Act (S.301), a bill introduced this year by Senators Kohl and Grassley, would require the pharmaceutical and medical device industry to publicly report the gifts and payments they make to doctors. Increased transparency of these financial relationships will allow the government and consumers to make informed decisions about prescription drug and medical device use.<sup>6</sup>

The National Senior Citizens Law Center is working with the Prescription Project to build broad support for the Sunshine Act in Congress. The Prescription Project leads the National Coalition for Appropriate Prescribing.

With your support, a strong version of the Sunshine Act can pass this year. Please contact Gabrielle Cosel at the Prescription Project to help make this happen: [gcasel@communitycatalyst.org](mailto:gcasel@communitycatalyst.org); 617-275-2856.

## AGENCY NEWS

---

### CMS RELEASES NEW MEDICARE REGULATIONS

On January 12, the Center for Medicare and Medicaid Services (CMS) issued final regulations affecting Medicare Part C (Medicare Advantage) and Medicare Part D

---

<sup>6</sup> See a fact sheet on the bill at: [www.prescriptionproject.org/tools/solutions\\_factsheets/files/0008.pdf](http://www.prescriptionproject.org/tools/solutions_factsheets/files/0008.pdf).

(prescription drug) plans.<sup>7</sup> The rules cover a range of topics and some are quite technical. Highlights of interest to advocates include:

- Definition of “negotiated price”: “Negotiated prices” are used to calculate true out of pocket expenses (TrOOP), which determine when a Medicare Part D enrollee enters the “donut hole” where non-LIS recipients must pay full drug costs. For the 2010 plan year and beyond, the regulation defines “negotiated price” as the price the drug plan pays the pharmacy for a prescription drug. Currently plans have the option of also using the price charged by a pharmacy benefits manager that acts as an intermediary with pharmacies, which often is higher. The change is expected to be advantageous for beneficiaries by slowing their entry into the donut hole.
- Special Needs Plans: Special Needs Plans (SNPs) may only enroll individuals who are in the category covered by the plan. In the past, CMS had allowed “disproportionate SNPs” to also enroll some members who were not within the SNP category. The regulations also require SNPs to have models of care and to use CMS approved methods for determining eligibility for chronic care SNPs.
- Cost sharing for dual eligibles: All MA plans must have contracts with their providers requiring that the provider not charge a dual eligible (someone entitled to both Medicare and Medicaid benefits) cost sharing beyond their liability to the plan. The provider must agree either to accept the amount paid to the provider of the plan or to bill the appropriate state agency, e.g., Medicaid.
- Best Available Evidence: CMS incorporated into its regulations the Best Available Evidence policy, which addresses plan obligations when an individual’s eligibility for the Low Income Subsidy does not appear on plan records. The policy had previously only been administrative guidance.<sup>8</sup>
- Appeals: A beneficiary’s physician may pursue a standard Part D appeal through reconsideration by the plan without written authorization by the beneficiary. Previously, this was only permitted for emergencies when expedited appeals were authorized.
- Late enrollment penalties: The regulations also provide for an abbreviated appeals process for decisions concerning imposition of a Late Enrollment Penalty on Part D enrollees.

The rules are final and effective March 13, 2008. However, CMS is accepting comments on portions of the regulations with a deadline of March 13.

---

<sup>7</sup> 74 Fed. Reg. 1494 (Jan. 12, 2009)

<sup>8</sup> Information about the BAE policy is available at:

[www.cms.hhs.gov/PrescriptionDrugCovContra/17\\_Best\\_Available\\_Evidence\\_Policy.asp](http://www.cms.hhs.gov/PrescriptionDrugCovContra/17_Best_Available_Evidence_Policy.asp)

On November 14<sup>th</sup>, CMS issued interim final rules that changed compensation structures for agents and brokers selling MA and PDP plans.<sup>9</sup> The rules use a six year formula for payment for initial enrollments and renewals. The purpose of the change is to eliminate financial incentives for brokers and agents to “churn” beneficiaries by moving them from one plan to another, even if the new plan does not offer advantages to the beneficiaries. The rules were effective November 10, 2008. These regulations were in addition to regulations CMS published on September 18, 2008 implementing key provisions from the Medicare Improvements for Patients and Providers Act.<sup>10</sup>

## CMS RELEASES, RESCINDS, THEN RE-RELEASES 2010 CALL LETTER

On January 8, 2009, the Centers for Medicare and Medicaid Services released for comment the draft 2010 Call Letter for Medicare Advantage organizations and Prescription Drug Plans. The Call Letter summarizes the requirements for companies that want to submit bids to offer MA plans or PDPs in 2010. Days after the change in Administration, the Call Letter was rescinded for further agency review. A new draft of the Call Letter, with significant revisions, was released on February 23.<sup>11</sup> Comments on the draft are due by March 6. If you are interested in filing comments, please contact Vicki Gottlich at the Center for Medicare Advocacy, [vgottlich@medicareadvocacy.org](mailto:vgottlich@medicareadvocacy.org).

## 2009 LIS RESOURCE AND ASSET LIMITS ANNOUNCED

On February 9, 2009, CMS announced the 2009 Low Income Subsidy Income and Resource Standards.<sup>12</sup> Beneficiaries who do not qualify for Medicaid, SSI or a Medicare Savings Plan must have incomes below 150% of the Federal Poverty Level in order to qualify for the LIS. In 2009, 150% of the FPL is \$1,353.75 (\$1,821.25 if married).

In 2009 the resource limit for the full premium subsidy is \$6,600 (\$9,910 if married). The resource limit for of the partial subsidy is \$11,010 (\$22,010 if married). Beneficiaries are allowed to exempt resources equal to \$1,500 for burial expenses. The limits stated here do not include this exclusion.

---

<sup>9</sup> 73 Fed. Reg. 67406 (Nov. 14, 2008)

<sup>10</sup> The Center for Medicare Advocacy prepared excellent summaries of these regulations at: [www.medicareadvocacy.org/Print/2008/MA\\_08\\_10.30.Marketting.htm](http://www.medicareadvocacy.org/Print/2008/MA_08_10.30.Marketting.htm) and [www.medicareadvocacy.org/MA\\_08\\_10.09.SNPInterimFinalRegs.htm](http://www.medicareadvocacy.org/MA_08_10.09.SNPInterimFinalRegs.htm).

<sup>11</sup> Available at: [www.cms.hhs.gov/PrescriptionDrugCovContra/01\\_Overview.asp](http://www.cms.hhs.gov/PrescriptionDrugCovContra/01_Overview.asp).

<sup>12</sup> You can view CMS’ announcement of the new levels at: [www.nslc.org/areas/medicare-part-d](http://www.nslc.org/areas/medicare-part-d). Also see the Health Assistance Partnership’s helpful chart which displays 2009 LIS eligibility and cost-sharing levels side-by-side, available at: [www.hapnetwork.org/assets/pdfs/low-income-cost-sharing-chart-2009.pdf](http://www.hapnetwork.org/assets/pdfs/low-income-cost-sharing-chart-2009.pdf).

### A MEDICARE AGENDA FOR THE NEW ADMINISTRATION AND CONGRESS

NSCLC has developed for the new Administration and Congress a number of recommendations for improving Medicare Part D for low income beneficiaries.<sup>13</sup> Recommendations include: stabilizing the benefit by adjusting the benchmark formula or creating a Part D administered plan which LIS recipients and others could join, expanding availability of the Low Income Subsidy and Medicare Savings Programs by removing asset limits and improving access for Limited English Proficient beneficiaries by enforcing Title VI and contractual requirements for translation and interpretation services.

Many of our partners, including the Center for Medicare Advocacy and the Medicare Rights Center, have also developed proposals for the new Administration.<sup>14</sup>

### PART D CLASS ACTION LAWSUIT SETTLEMENT APPROVED

In October, District Court Judge Thelton Henderson approved the settlement agreement that was filed in June in the Medicare Part D class action lawsuit *Situ v. Leavitt*. Under the agreement, the Centers for Medicare and Medicaid Services (CMS) has agreed to make significant changes to its administration of the prescription drug benefit for dual eligibles.<sup>15</sup> A hearing to determine the fairness of the agreement was held on October 6, 2008. Judge Henderson approved the agreement and dismissed the case on October 21, 2008. Quarterly monitoring meetings between CMS and class counsel (NSCLC and CMA) began this month. These meetings provide a venue to share ongoing enrollment (including POS problems) and subsidy deeming (including BAE problems) issues with CMS. Please contact Kevin Prindiville ([kprindiville@nsclc.org](mailto:kprindiville@nsclc.org)) or Anna Rich ([arich@nsclc.org](mailto:arich@nsclc.org)) to share stories of the problems dual eligibles continue to experience.

---

<sup>13</sup> Available at: [www.nsclc.org/about-us/2008legadmin\\_Agenda.pdf](http://www.nsclc.org/about-us/2008legadmin_Agenda.pdf).

<sup>14</sup> Available at: [www.medicareadvocacy.org/Reform\\_08\\_12.23.RecommendationsforRealReform.htm](http://www.medicareadvocacy.org/Reform_08_12.23.RecommendationsforRealReform.htm) and [www.medicarerights.org/issues-actions/Obama\\_Administration\\_Transition\\_Memo.pdf](http://www.medicarerights.org/issues-actions/Obama_Administration_Transition_Memo.pdf) respectively.

<sup>15</sup> More information about these changes and a copy of the settlement agreement are available at: [www.nsclc.org/areas/medicare-part-d/part-d-library/Litigation/Settlement-Approved](http://www.nsclc.org/areas/medicare-part-d/part-d-library/Litigation/Settlement-Approved).

### NEW CALIFORNIA LAW REQUIRES PRIVATE HEALTH PLANS TO PROVIDE INTERPRETERS TO LIMITED ENGLISH PROFICIENT ENROLLEES

On January 1, 2009, SB 853, a California law requiring health and dental plans to provide interpreters and translated documents to enrollees, took effect. The new law creates a number of specific requirements that private health plans must follow to ensure that limited English proficient (LEP) enrollees can access the care they need. The law serves as a model for other states looking to improve the provision of medical services to LEP individuals.

For more information about SB 853 and its importance, please see the California Pan-Ethnic Health Network's new report, "A Blueprint for Success: Bringing Language Access to Millions of Californians," at [www.cpehn.org/pdfs/Sb853briefScreen.pdf](http://www.cpehn.org/pdfs/Sb853briefScreen.pdf)

### TENS OF THOUSANDS OF MEDI-CAL BENEFICIARIES LOSE PART B PREMIUM PAYMENT BENEFIT

California's final 2008-2009 budget contained a significant cut in benefits for Medicare eligible Medi-Cal beneficiaries who have an unmet share of cost (SOC). In the past, Medi-Cal has paid Medicare Part B premiums for all Medi-Cal beneficiaries, regardless of how much of a SOC the beneficiary has. The new budget terminates this assistance for those with a SOC of more than \$500, leaving 57,000 Medi-Cal beneficiaries to choose between paying the \$96.40 monthly Part B premiums on their own or going without necessary health coverage. NSCLC has created a fact sheet answering common questions about this cut.<sup>16</sup>

Unfortunately, this will likely not be the last cut impacting seniors in California. As of this writing, the budget stalemate continues with cuts proposed to many senior programs and benefits.

---

<sup>16</sup> Available at: [www.nsclc.org/areas/medicare-part-d/california/fact-sheet-for-advocates/at\\_download/attachment](http://www.nsclc.org/areas/medicare-part-d/california/fact-sheet-for-advocates/at_download/attachment).

## TOOLS, REPORTS, STUDIES

---

### *Tools*

NSCLC has updated two useful tools for advocates assisting clients with Part D issues:

- [Enrollment Period Chart](#):<sup>17</sup> This chart lists all Part D enrollment periods available to Medicare beneficiaries and provides information on when enrollment and disenrollment rights start, on how long they last, and on special or unique elements of the enrollment right. It should be particularly useful when you have clients who need to change plans but who do not qualify for the continuous Special Enrollment Period (SEP) for Low Income Beneficiaries. The chart incorporates changes from CMS's most recent guidance.
- [Transition Rights Under Part D](#):<sup>18</sup> This tool summarizes CMS's requirements for plans to supply transition drug supplies to their enrollees. Note that transition supply rights apply not just at the beginning of the plan year but also when a beneficiary changes plans mid year, when a beneficiary experiences a change in level of care, and when a beneficiary resides in a nursing home or similar institution.

Other Tools:

- The Health Assistance Partnership has updated its very useful Low Income Subsidy eligibility and cost-sharing chart to reflect 2009 eligibility and cost-sharing levels.<sup>19</sup>

### *Reports*

California Health Advocates released two new reports on Medicare Advantage.

- [The Price is Right: the Selling of Medicare – New Marketing Rules Fail to Cure Problems in the Medicare Marketplace](#),<sup>20</sup> 1) reviews the past 2 years of changes in Medicare marketplace regulations; 2) explores unresolved systemic issues that prevent adequate marketing oversight; 3) analyzes selected new marketing rules, including their shortcomings; and 4) provides recommendations to better protect beneficiaries from ongoing marketing abuses.

---

<sup>17</sup> Available at: [www.nsclc.org/areas/medicare-part-d/advocate/Guides/transition-rights-under-part-d/at\\_download/attachment](http://www.nsclc.org/areas/medicare-part-d/advocate/Guides/transition-rights-under-part-d/at_download/attachment).

<sup>18</sup> Available at: [www.nsclc.org/areas/medicare-part-d/advocate/Guides/transition-rights-under-part-d/at\\_download/attachment](http://www.nsclc.org/areas/medicare-part-d/advocate/Guides/transition-rights-under-part-d/at_download/attachment).

<sup>19</sup> Available at: [www.hapnetwork.org/assets/pdfs/low-income-cost-sharing-chart-2009.pdf](http://www.hapnetwork.org/assets/pdfs/low-income-cost-sharing-chart-2009.pdf).

<sup>20</sup> Available at: [www.cahealthadvocates.org/pdf/advocacy/2008/CHA-PriceIsRight-Brief-2008-12.pdf](http://www.cahealthadvocates.org/pdf/advocacy/2008/CHA-PriceIsRight-Brief-2008-12.pdf).

- [Dual Eligibles & Medicare Advantage Plans: Do New Rules Make Them a Better Fit?](#),<sup>21</sup> explores the topic of dual eligibles in MA plans in general and whether recent legislative and regulatory changes make MA plans, as a whole, and Special Needs Plans, in particular, a more viable option for dual eligibles.

The Kaiser Family Foundation released a number of fact sheets and reports on the Part D program.

- [Medicare Prescription Drug Plan \(PDP\) Availability in 2009 \(November 2008\)](#),<sup>22</sup> contains 2009 state-specific summary data about available Medicare drug benefit options, including premium ranges, the number of stand-alone plans with gap coverage in the "doughnut hole," and the number of plans available at no cost to qualifying beneficiaries. The data reveals that the availability of plans for low-income subsidy (LIS) beneficiaries has substantially decreased. Monthly 2009 PDP premiums range from \$10.30 to \$136.80 with an average cost of \$45.45, and 75% of all plans will offer no gap coverage.
- [Medicare Part D 2009 Data Spotlight: Low-Income Subsidy Plan Availability, \(November 2008\)](#),<sup>23</sup> examines the availability of drug plans for beneficiaries receiving the LIS in 2009 and changes in availability since the program began in 2006. The report finds that while the number of plans available varies greatly by region, in general, options are dwindling for LIS recipients.
- [Medicare Part D 2009 Data Spotlight: Premiums \(November 2008\)](#),<sup>24</sup> analyzes the premiums charged by the 1,689 stand-alone Medicare Part D plans that are offered in markets across the country in 2009. The analysis finds premiums charged for Part D plans range widely, from \$10.30 per month to \$136.80 per month. If current enrollees remain in their current plan for 2009, the weighted average monthly premium for PDPs would increase by \$7.40 per month, from \$29.89 in 2008 to \$37.29 in 2009. The data spotlight also looks at premium changes in the stand-alone plans with the highest enrollment this year and shifts in the overall marketplace.
- [Medicare Part D 2009 Data Spotlight: The Coverage Gap, November 2008](#),<sup>25</sup> examines the coverage gap, or "donut hole," in Medicare drug plans available in 2009. While in the gap in coverage, Part D enrollees (other than those receiving low-income subsidies) are required to pay 100% of total drug costs until they reach the catastrophic coverage level. In 2009, nearly all Part D plans have a coverage gap, though one in four plans offer limited coverage in the gap -- generally coverage for all or some generic drugs, and some plans also cover some

---

<sup>21</sup> Available at: [www.cahealthadvocates.org/pdf/advocacy/2008/CHA-Dual-Eligibles.pdf](http://www.cahealthadvocates.org/pdf/advocacy/2008/CHA-Dual-Eligibles.pdf).

<sup>22</sup> Available at: [www.kff.org/medicare/upload/7426\\_05.pdf](http://www.kff.org/medicare/upload/7426_05.pdf).

<sup>23</sup> Available at: [www.kff.org/medicare/upload/7836.pdf](http://www.kff.org/medicare/upload/7836.pdf).

<sup>24</sup> Available at: [www.kff.org/medicare/upload/7835.pdf](http://www.kff.org/medicare/upload/7835.pdf).

<sup>25</sup> Available at: [www.kff.org/medicare/upload/7834.pdf](http://www.kff.org/medicare/upload/7834.pdf).

or a few brand-name drugs. Monthly premiums for PDPs that provide gap coverage are about double that of PDPs with no gap coverage.

The Government Accountability Office also released a number of reports that may be of interest to advocates.

- [Medicare Part D: Opportunities Exist for Improving Information Sent to Enrollees and Scheduling the Annual Election Period](#),<sup>26</sup> examines the stakeholders' views of the model ANOC and CMS's efforts to assure its effectiveness, and how the scheduling of the annual enrollment period (AEP) affects the enrollment process for beneficiaries switching PDPs.
- [Medicare: Callers Can Access 1-800-MEDICARE Services, but Responsibility within CMS for Limited English Proficiency Plan Unclear](#),<sup>27</sup> describes the extent to which access performance standards and targets have been met by the current contractor; the efforts by CMS to provide limited English proficient (LEP) callers with access to help line services and wait times experienced by these callers; CMS's oversight of callers' access to 1-800-MEDICARE; and the information's accuracy. The report notes that CMS has not identified an office responsible for acting as a point of contact for management of the LEP issues.
- [Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006](#),<sup>28</sup> indicates that MA self-reported actual medical expenditures as a percentage of revenue were lower than they had projected for both 2005 and 2006. In 2006, MA plans reported spending 83.3% of total revenue on medical expenses but had projected medical expenditures of 86.9% of total revenue. The actual profit was 6.6 percent of total revenue which is about \$1.3 billion more than MA organizations had projected.

## Your Stories Are Needed

In order to help to get changes at the state and federal levels, we need to hear about the problems your low income clients are facing. We know that your time as advocates is already stretched thin, but any time you can take to report client stories would be extremely helpful.

Do you have questions about Medicare Part D? Topics you'd like to see covered in future National Alerts? Tips or experiences with Medicare Part D that you'd like to share with advocates in other states? Please send all questions, comments and feedback to the National Senior Citizens Law Center attorneys, listed below.

Katharine Hsiao, Co-Directing Attorney, (510) 663-1055 ext. 306 or [khsiao@nslc.org](mailto:khsiao@nslc.org)

---

<sup>26</sup> Available at: [www.gao.gov/new.items/d094.pdf](http://www.gao.gov/new.items/d094.pdf).

<sup>27</sup> Available at: [www.gao.gov/new.items/d09104.pdf](http://www.gao.gov/new.items/d09104.pdf).

<sup>28</sup> Available at: [www.gao.gov/new.items/d09132r.pdf](http://www.gao.gov/new.items/d09132r.pdf).

Georgia Burke, Co-Directing Attorney, (510) 663-1055 ext. 303 or [gburke@nslc.org](mailto:gburke@nslc.org)  
Kevin Prindiville, Staff Attorney, (510) 663-1055 ext. 307 or [kprindiville@nslc.org](mailto:kprindiville@nslc.org)  
Anna Rich, Staff Attorney, (510) 663-1055 ext. 305 or [arich@nslc.org](mailto:arich@nslc.org)

NSCLC Legal Assistant Nancy Arévalo contributed to this Alert.