

October 2007

Low-Income Advocate Alert On Medicare Part D

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- A new report by the Medicare Rights Center and California Health Advocates on the need for **standardization** of private Medicare plans. Page 8.
- A new, comprehensive chart of Medicare Part D **enrollment periods**. Page 8.

This new Alert combines both California-specific and national information; future NSCLC Part D Alerts for advocates will also provide both a state and a nation-wide focus.

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call (510) 663-1055 x. 301.**

IMPORTANT INFORMATION

NEW 2008 PLANS ANNOUNCED- 1.6 MILLION WILL BE REASSIGNED

- **Benchmarks, New Part D and Medicare Advantage Plans Announced**

On September 27, 2007, the Centers for Medicare and Medicaid Services (CMS) released lists of the Part D and Medicare Advantage plans that will be offered in 2008. Excel files showing the Part D and Medicare Advantage plans that will be available in each state are available on CMS' website.¹

CMS has also identified the 2008 “benchmark” amounts for each region. A prescription drug plan qualifies as a “benchmark plan” if it offers basic coverage with premiums equal to or lower than the regional benchmark amount. The benchmark amounts are set annually by a complicated formula, based on weighted averages of plan premiums. Low-income beneficiaries who are eligible for a full subsidy may enroll in a benchmark plan without paying any premium. These 2008 regional benchmark amounts are available online.² CMS also permits premium-free enrollment in basic plans with a premium within a “de minimis” amount—for 2008, \$1 over the benchmark (in 2007, the de minimis amount was \$2). Plans that qualify as “de minimis,” however, are not eligible to receive automatic enrollment of Low Income Subsidy recipients by CMS.

The plans' 2008 formularies will not be available for comparison at the Medicare.gov Plan Finder until October 11. Once this information becomes available, beneficiaries should begin to compare costs (including co-payments, deductibles and premiums), availability of medication, and any limitations on use of medication (e.g., dosage limits or step therapy requirements) before deciding whether to remain in their current plan next year. Part D plans' costs and benefit structures can change every calendar year.

- **1.6 Million Beneficiaries Face Reassignment in 2008**

According to CMS, nearly 1.6 million Low Income Subsidy (LIS) recipients will automatically be reassigned to a new plan, effective January 1, 2008, because the plan to which CMS originally assigned them will not continue as a benchmark or de minimis plan in 2008. For low-income beneficiaries this is a drastic increase in volatility—last year, only 250,000 low-income beneficiaries were assigned to a plan with a new corporate sponsor, and 920,000 were reassigned to a plan offered by the same plan sponsor.

Automatic reassignment will be done only for beneficiaries who are eligible for a full premium subsidy and who have remained in the plan into which they were automatically enrolled. Other Part D beneficiaries—specifically, those not eligible for the full LIS, or those who have chosen their own plan (a.k.a. “choosers”)—will be responsible for

¹ Go to <http://www.cms.hhs.gov/PrescriptionDrugCovGenIn>.

² Go to www.cms.hhs.gov/apps/files/FactSheetPartDBenchmark.pdf.

switching plans themselves if they wish to avoid paying premiums that exceed the benchmark.

The recently released plan data shows why so many beneficiaries are affected. Many benchmark plans from 2007 failed to qualify for benchmark or de minimis status in 2008. For example, in Florida, only two of last year's benchmark plans will continue as benchmark or de minimis plans in 2008. In many states, LIS recipients subject to reassignment will include those enrolled in UnitedHealthCare's AARP-branded plans. UnitedHealthCare was the largest single sponsor of Part D enrollment this year, but in 2008 its plans will no longer be available at the benchmark or de minimis level in many states, including in California, Florida, New York, and Ohio. Humana, with the second largest enrollment in 2007, also will not have benchmark plans in a number of large states including California, New York, New Jersey and Ohio.

California beneficiaries can access a chart showing what is happening to the 2007 benchmark and de minimis plans on NSCLC's site for California advocates.³

LIS ELIGIBILITY FOR 2008: REDETERMINATION AND REDEEMING

The Social Security Administration (SSA) and the Centers for Medicare and Medicaid Services (CMS) both have annual processes for re-evaluating the LIS eligibility of current LIS recipients. As a reminder, there are two routes for receiving the LIS: (1) being automatically "deemed" eligible for the LIS by virtue of eligibility for full Medicaid benefits, a Medicare Savings Program (MSP, e.g., Qualified Medicare Beneficiaries), or SSI; and (2) being "determined" eligible for the LIS by SSA after submitting an application. CMS' review process is called "redeeming," while SSA's process is called "redetermination."

- **Redetermination**

SSA's redetermination process in 2007 will differ somewhat from the process last year. This year, most LIS beneficiaries who had been found eligible for the LIS by SSA will simply be passively redetermined as eligible for 2008 without receiving any notice by SSA.

For about 500,000 beneficiaries selected for active redetermination, SSA in late August sent redetermination forms, called the SSA Form 1026-OCP-SM-REDE. (This form is nearly identical to the 1026-B.) Beneficiaries who receive the form **must** complete and return it to SSA within 30 days. The recipient may contact the field office within the 30 day period to request a one-time extension of up to 30 days. If the form is not returned within 30 days, SSA has stated that it will place follow-up phone calls to confirm that these recipients do not intend to apply for the LIS for 2008. If no form is returned, SSA will notify current LIS recipients that their subsidy will be terminated effective January 2007. (If the subsidy is terminated, the individual can reapply.) Once SSA has received the completed form, it will reevaluate the beneficiary's eligibility for the subsidy based on the

³ Go to http://www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.6262442724.
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information provided and a data match with other federal agencies. Beneficiaries will be notified in writing of the result of the redetermination.

Beneficiaries who were selected for active redetermination by SSA include:

- Beneficiaries for whom SSA data indicate a potential change in subsidy eligibility;
- Beneficiaries who report receiving in-kind support and maintenance;
- Beneficiaries who are members of a couple with different filing dates or different subsidy amounts;
- Beneficiaries who reported an event that could impact LIS eligibility or amount (such as a change in income or assets);
- Beneficiaries who did not respond to a request by SSA's Office of Quality Performance for review of eligibility; and
- Beneficiaries for whom the Office of Quality Performance found errors in their record.

SSA's LIS redetermination process is described in Section HI 03050.011 of SSA's Program Operations Manual System (POMS) (see <https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0603050011!opendocument>). The POMS includes a sample copy of the 1026-OCP-SM-REDE.

• Redeeming

Beneficiaries who were deemed eligible for the LIS for 2007 based on Medicaid/Medi-Cal, Medicare Savings Program, or SSI eligibility and who appear on a State file (sent monthly to CMS) between July and December, 2007 will be "re-deemed" for all of 2008.

Conversely, deemed-eligible individuals who do not appear on a State file during that time period will lose the LIS on December 31, 2007.

In September, CMS mailed notices to 447,000 beneficiaries who may not be redeemed in 2008 based on their absence from the State's July or August monthly file. The mailing included an SSA application for the LIS.

Redeeming is a particularly critical issue for "medically needy" individuals who need to meet a Share of Cost (SOC) or "spend-down" to qualify for Medicaid. These individuals must meet their Share of Cost/spend-down in any one month between July and December, 2007, in order to be deemed automatically eligible for the LIS in 2008.

For more detailed information about the redeeming and redetermination process, see NSCLC's tool, "The Low Income Subsidy: Redetermination and Redeeming," (Fall 2007).⁴

WAIVER OF 2008 LATE ENROLLMENT PENALTY FOR LIS RECIPIENTS

⁴ Go to www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630.
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The 2008 late enrollment penalty will be waived for any beneficiary who qualifies for the LIS and who enrolls in a drug plan through December 31, 2008. This means that Medicare beneficiaries who are eligible for LIS but have waited to enroll in a Medicare prescription drug plan may enroll at any time in 2008 without having to pay an added percentage of their premium as a penalty. The late enrollment penalty was also waived for LIS recipients in 2006 and 2007.

The waiver protects these individuals as long as they remain enrolled in a Part D plan. If they disenroll after 2008 and then have a continuous period of 63 days or more without creditable prescription drug coverage, they will incur a late enrollment penalty upon re-enrollment into a Medicare drug plan. Their uncovered months in 2006, 2007, and 2008, however, will not be a factor in determining their late enrollment penalty.

PART D NEWS & VIEWS

LEGISLATION

- **Part D-Related Legislation**

Despite strong support by advocates for low-income Medicare beneficiaries, the Senate and US House of Representatives decided not to address Medicare in reauthorizing the State Children's Health Insurance Program (SCHIP) (the SCHIP bill was then vetoed by President Bush).

The Senate has announced, however, that it intends to deal with Medicare in separate legislation later this fall. The proposed improvements to Medicare Part D that have already been passed by the House include loosening the asset limit and simplifying application procedures for the Low Income Subsidy (LIS); providing an "intelligent" auto-assignment procedure for dual eligibles; setting an annual cap on out-of-pocket expenditures by LIS recipients; eliminating cost sharing for dual eligibles receiving services through a home and community based care waiver; and making a variety of other beneficiary-friendly changes to Part D. Advocates are encouraged to contact their Senators to support improvements to Medicare Part D; contact NSCLC's Oakland office for more details.

ADDITIONAL RESOURCES FOR ADVOCATES

CMS MATERIALS

In addition to the materials described in the Section above, CMS has released other recent materials that may be of interest to advocates:

1. Guide to New Color-Coded Mailings

CMS has produced a useful chart detailing the mailings, many color-coded, that beneficiaries have received or will receive this summer and fall from CMS, SSA and P D plans. The chart was released in August 2007 and is available online.⁵ The Health Assistance Partnership has also produced a handy companion version with links to the actual CMS documents.⁶

2. New Tip Sheet Addresses Premium Withholding Problems

In August, CMS released a Tip Sheet to assist advocates and others who are working with beneficiaries who experienced premium withhold problems in 2006. As reported in previous Alerts, premium withholding errors continue to plague Medicare Part D beneficiaries. The tip sheet from CMS identifies three pools of beneficiaries (those who paid too much; those who paid too little; and those who had premiums automatically deducted but whose plans were not paid) and explains the expected timing for additional refunds or bills.⁷

3. Medicaid Tamper-Proof Pads Requirement Postponed

On September 29, 2007, President Bush signed a law delaying the implementation date for the new requirement that all paper Medicaid/Medi-Cal prescriptions be written on special tamper-resistant paper. The postponement came in response to the concerns of states and advocates that a rush to implement the new rule could result in denying access to medication for low-income Medicaid-only recipients. According to the new timetable, prescription papers must contain at least one of three tamper-resistant characteristics by April 1, 2008, and all three characteristics will be required on October 1, 2008. CMS' original guidance on the new rule is available on NSCLC's website.⁸ Note that this new requirement only applies to prescriptions paid for by Medicaid; it does not apply to prescriptions covered by a Part D plan.

4. New Medicare Numbers for 2008

CMS has announced the new dollar amounts relevant to the standard Medicare Part D benefit for 2008:

Part D Standard Benefit

Benefit Parameters	2007	2008
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⁵ Go to www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420

⁶ At <http://www.hapnetwork.org/assets/pdfs/links-to-cms-mailings.pdf>

⁷ Go to http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420

⁸ Go to www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420

Deductible	\$265	\$275
Initial Coverage Limit	\$2400	\$2510
Out-of-Pocket Threshold	\$3850	\$4050
Minimum Cost-Sharing in Catastrophic Coverage	\$2.15/\$5.35	\$2.25/\$5.60
LIS Copayments	2006	2007
Institutionalized	\$0	\$0
Up to or at 100% FPL	\$1/\$3.10	\$1.05/\$3.10
Other LIS	\$2.15/\$5.35	\$2.25/\$5.60
Partial LIS Deductible/Cost-Sharing	\$53/15%	\$56/15%

5. Suspension of PFFS Plans

CMS has announced that all seven of the major health insurance companies who voluntarily agreed to temporarily suspend all marketing of their Medicare Advantage Private-Fee-for-Service (PFFS) plans have since been found compliant with Medicare marketing requirements and may resume promotional activities. The decision to suspend marketing came in the wake of widespread reports of misleading and abusive marketing practices across the country. Conditions that the PFFS plans must follow, such as increasing training of agents and added disclaimers on all written materials, are described on CMS' website.⁹ Advocates who encounter violations of the conditions or any ongoing marketing abuses involving PFFS plans are encouraged to file complaints with CMS.

NATIONAL ADVOCACY MATERIALS

1. National Part D Conference Calls

The National Senior Citizens Law Center and the Center for Medicare Advocacy sponsor monthly conference calls for legal services attorneys or other low income advocates nationwide to discuss Medicare Part D. If you are an advocate and would like to participate, contact Kevin Prindiville or Anna Rich of the National Senior Citizens Law Center at (510) 663-1055, ext. 305 or arich@nsclc.org or Vicki Gottlich or Patricia Nemore of the Center for Medicare Advocacy at (202) 216-0028.

2. Part D Advocates' Alert

To receive this Alert, or to obtain alternative formatting, please contact Nancy Arevalo, oakland@nsclc.org or (510) 663-1055, ext. 301, and ask to be put on the Alert email list.

⁹ at www.cms.hhs.gov/PrivateFeeforServicePlans/.
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Alternatively, look for this and future Alerts by checking our website at www.nsclc.org/areas/medicare-part-d.

3. Other Reports and Information for Advocates

- NSCLC has recently updated its tool for advocates, “Exceptions and Appeals: A Practical Guide,” a resource for any advocate seeking to pursue an exception or appeal on behalf of Part D beneficiaries.¹⁰
- The Medicare Rights Center and California Health Advocates recently released a report about the need to standardize Medicare Part D benefit packages in order to help beneficiaries make informed choices, “Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans.”¹¹
- NSCLC has prepared a detailed chart for advocates covering all Medicare Part D Prescription Drug Program enrollment periods. The chart reflects the revised enrollment guidance released in June 2007.¹² Periods are grouped based on beneficiary circumstances.

Reporting Problems to CMS

Reporting problems with Medicare Part D provides CMS with important feedback about how this new program is affecting beneficiaries on the ground. Many issues involving access to medication may be resolved by contacting the plan or calling the 1-800-MEDICARE number. Individuals and advocates should also contact the CMS regional office to report problems; we recommend an email or a letter to establish a written record of the complaint. For CMS regional contact information, go to “Medicare Part D for Low Income Advocates: The Basics” at www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630.

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.

¹⁰ Go to http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630/area_folder.2006-10-31.2079546039.

¹¹ Go to <http://www.cahealthadvocates.org/advocacy/2007/09.html>.

¹² Go to http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630.

NSCLC has a “**Client Story Form**” to report problems your clients have faced. You can access the form at www.nsclc.org/areas/medicare-part-d. Thank you for sharing your stories and information.

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@nsclc.org

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