



August 2008

Low-Income Advocate Alert On Medicare Part D

Highlights of this Issue

- [Settlement Agreement Reached in Medicare Part D Dual Eligible Case.](#) Page 2
- [CMS Releases NEW BAE Policy.](#) Page 4
- [Congress Overrides Veto to Pass New Medicare Law with Improvements for Beneficiaries.](#) Page 5
- [CMS Responds to Language Access Advocates' Concerns.](#) Page 8
- [New Mailings and Updated Guidance from CMS.](#) Page 9
- [CMS Adds Compendia for Part B Cancer Drugs.](#) Page 11
- **California:** [Kaiser Special Needs Plan Disenrollments Update.](#) Page 12
- [Summary of new reports and studies re: Part D and Medicare Advantage.](#) Page 13
- And more...

This Alert contains both California-specific and national information for advocates.

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

IMPORTANT INFORMATION

SETTLEMENT AGREEMENT REACHED IN MEDICARE PART D CASE; JUDGE GRANTS PRELIMINARY APPROVAL

On July 9, 2008, District Court Judge Thelton Henderson preliminarily approved the settlement agreement that was filed on June 19, 2008 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 low-income beneficiaries. If approved by the judge, the agreement will make it easier for seniors and individuals with disabilities to access the full benefits of the Medicare Part D program and the Low Income Subsidy.

The case was filed against Michael Leavitt, Secretary of the Department of Health and Human Services, by the National Senior Citizens Law Center and the Center for Medicare Advocacy in April 2006 and was certified as a nationwide class action in January 2007. Pro bono counsel from the law firm of Wilson Sonsini Goodrich & Rosati later joined the plaintiff team.

The case was brought on behalf of 6.2 million low-income dual eligibles – individuals who receive both Medicare and Medicaid. The Medicare Modernization Act (the statute that created Part D) requires CMS to automatically enroll dual eligibles into Part D plans and to deem them eligible for the Low Income Subsidy, a program which subsidizes the premiums, deductibles and co-payments of dual eligibles and other low income beneficiaries. Unfortunately, the information management system that notifies plans and pharmacies of the enrollment and low-income status of dual eligibles has been dogged by extensive delays. As a result, many dual eligibles have struggled to obtain the medications they need at a price they can afford.

In exchange for the Plaintiffs' dismissal of their claims against the Secretary, CMS has agreed to make a number of changes that will streamline the Medicare Part D enrollment process. The agency will:

- Speed up the enrollment process for new dual eligibles. Instead of waiting several weeks to process files received from states identifying new dual eligibles, CMS will process these files within one business day of receipt. CMS will also allow states to submit these files more frequently than once per month;
- Require plans to update their systems to reflect subsidy eligibility when presented with evidence of subsidy eligibility by the beneficiary, even if CMS systems do not yet reflect subsidy eligibility;
- Require plans and CMS Regional Offices to provide additional assistance to beneficiaries who claim to have, but cannot provide evidence of, subsidy eligibility by contacting the state Medicaid agency to confirm eligibility. This

new protocol shifts the burden of proof away from beneficiaries and to plans and CMS when eligibility is in question.

- Educate pharmacy organizations about new policies intended to increase protections for dual eligibles who are not automatically enrolled in a plan and, therefore, are unable to obtain medications.
- For two years, hold quarterly monitoring meetings with Plaintiffs' counsel and provide documents and data in advance of those meetings.

These improvements will assist the hundreds of thousands of beneficiaries who become dually eligible and/or change plans each year. The court will retain jurisdiction over the agreement for a period of three years. The settlement agreement does not prevent individual class beneficiaries from filing separate claims for individual benefits.

The agreement must be approved by Judge Henderson in order to take effect. On July 9, 2008, Judge Henderson preliminarily approved the proposed settlement agreement, ordered that notice be distributed to the class by July 25, 2008 and set a hearing to determine the fairness of the agreement for October 6, 2008 at 10:00 a.m. Class members who object to the agreement must send objections in writing to NSCLC's Oakland office on or before September 8, 2008. The fairness hearing will be held in Courtroom No. 12 of the United States District Court for the Northern District of California, located at 450 Golden Gate Avenue, San Francisco, California. The settlement agreement and the formal class notice can be viewed at www.nsclc.org/areas/medicare-part-d.

Wilson Sonsini Goodrich & Rosati joined the plaintiff team in June 2007. Pro bono counsel from the firm played an integral role in developing the final settlement agreement.

Questions about the settlement should be directed to Kevin Prindiville (kprindiville@nsclc.org) or Anna Rich (arich@nsclc.org) in NSCLC's Oakland office or Gill Deford at the Center for Medicare Advocacy (gdeford@medicareadvocacy.org). Information about the pro bono activities of Wilson Sonsini Goodrich & Rosati can be found at www.wsg.com/probono.

ADVOCACY OPPORTUNITY: As mentioned above, under the settlement agreement, CMS has agreed to change the auto-enrollment/deeming process to allow states to submit files more frequently than once per month. We have heard that CMS has already begun talking to states about the new process. Now would be a good time to talk to your state about the benefits of submitting files more frequently. For beneficiaries, more frequent file submissions mean improved access to medically necessary drugs at subsidized prices.

CMS RELEASES NEW BEST AVAILABLE EVIDENCE MEMO

On August 4, 2008, CMS released to plans a new version of the Best Available Evidence policy.¹ As mentioned above, this new BAE policy was developed as part of the settlement of the *Situ* case. The new policy clarifies the existing requirement that plans accept BAE and informs plans of a new requirement that they assist beneficiaries who claim to be subsidy eligible, but do not have BAE. The new policy is effective immediately.

Plans regularly seem to be confused about their obligations under the BAE policy. The new memorandum states very clearly that a plan must accept BAE presented by a beneficiary or individual acting on behalf of the beneficiary and rely on BAE to provide the beneficiary with medications at a reduced cost-sharing level. The plan must make the medications available at the reduced cost-sharing level as soon as it has received the BAE. The plan then has 72 hours to update its systems to reflect the correct cost-sharing status for the beneficiary. Where CMS systems do not reflect the correct subsidy level for the beneficiary, plans must submit a request to CMS to have the status corrected in CMS systems.

The new policy also creates a new process for assisting beneficiaries who claim to be subsidy eligible, but are unable to provide BAE. Under this process, when a beneficiary claims to be subsidy eligible, but plan records do not reflect subsidy eligibility, the plan is required to collect information from the beneficiary, including the day the beneficiary will run out of medication, and submit that information to a contact in the CMS Regional Office. The plan must submit the information within one business day of being notified that the beneficiary claims to be LIS eligible, but does not have BAE.

Once the CMS RO receives the information from the plan, the case will be entered into the Complaint Tracking Module. The RO will then contact the State Medicaid office to attempt to confirm the Medicaid and/or institutional status of the beneficiary and will share the results of this inquiry with the plan. The RO will contact the state and report back to the plan before the day the beneficiary indicated she would run out of medications or within 10 days, whichever comes first. When the beneficiary has less than 3 days of medication remaining, the RO will contact the State within one day of receiving the information from the plan and will reply to the plan within one business day of receiving a response from the State.

As soon as the plan receives a response from the RO confirming the subsidy eligibility of the beneficiary, the plan must provide the beneficiary with medication at the reduced cost-sharing level. The plan must also attempt to notify the beneficiary of the results of the RO inquiry within one business day. If the plan is unable to reach the beneficiary on the initial attempt, it must continue its attempts until it has tried to reach the beneficiary four times. The fourth attempt must be in writing. Notice to the beneficiary must

¹www.nslc.org/areas/medicare-part-d/cms-releases-new-best-available-evidence-policy

indicate that if the beneficiary does not agree with the results of the RO inquiry, the plan will provide contact information for the appropriate RO.

The new policy requires plans to develop appropriate call center scripts to identify BAE cases and allow members to either submit BAE or request assistance verifying subsidy status. Plan sponsor websites must also contain a link to CMS' BAE policy website.²

CMS has set up a new category in its Complaint Tracking Module to identify problems with implementing the BAE policy. When filing a complaint against a plan for failing to follow the new policy, advocates should be sure to request that the complaint be filed in the "Best Available Evidence" category.

CONGRESSES PASSES NEW MEDICARE LAW; INCLUDES IMPORTANT PROVISIONS FOR LOW-INCOME BENEFICIARIES

On July 15, the House (383/41) and Senate (70/26) voted to override the President's veto of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The Act, introduced by Ways & Means Chair Charles Rangel (D-NY), was originally approved in the House on June 24 and in the Senate on July 9. While most of the publicity around the new law has focused on a retroactive rescission of a ten-percent reduction in Medicare payments to doctors, the Act also contains a number of important beneficiary-centered improvements to the Medicare program. Some of these improvements relate specifically to low-income beneficiaries, while others – including provisions addressing marketing activities, Private-Fee-for-Service Plans, Special Needs Plans, Part D, and language access – benefit both low-income and non-low-income beneficiaries.

- **Improvements for Low Income Beneficiaries**

QI Program Extension. The MIPPA extends and increases funding for the Qualifying Individual (QI) Program. The QI Program provides State payment of the Medicare Part B premiums for individuals with incomes below 135 percent of the federal poverty level. The Act extends the QI Program from June 2008 to December 31, 2009 and increases the total allocation for the January-September period from \$300,000,000 to \$350,000,000 and for the October-December period from \$100,000,000 to \$150,000,000.

Improved Access to Medicare Savings Programs and the Low Income Subsidy. The MIPPA contains important provisions designed to increase enrollment in Medicare Savings Programs (MSP) and the Low Income Subsidy (LIS). Medicare Savings Programs—including the QMB, SLMB and QI Programs—help low-income beneficiaries pay Medicare premiums and, in some cases, assist with deductibles, and co-insurance. MSP recipients are eligible for the Low-Income Subsidy (LIS) which allows low-income Medicare beneficiaries to eliminate most of their Part D out-of-pocket costs.

² www.cms.hhs.gov/PrescriptionDrugCovContra/17_Best_Available_Evidence_Policy.asp

The Act takes steps to coordinate these two programs while reducing barriers to enrollment in both programs.

Most significantly, the Act raises, effective January 1, 2010, the resource limit for the MSP to the LIS “standard” resource limit. The LIS actually has two resource limits. The “standard” limit is three times the SSI resource limit for 2006 plus an increase equal to the annual percentage increase in the consumer price index. For 2008, the standard limit is \$6,290 for an individual and \$9,440 for a couple. The other LIS resource limit started at \$10,000 for an individual or \$20,000 for a couple in 2006 and also increases annually based on the increase in the consumer price index. Raising the MSP resource limit to the “standard” limit represents a significant improvement over the current MSP resource limits of \$4,000 for an individual and \$6,000 for couple.

The Act also requires the Social Security Administration to transmit LIS application data to states for consideration of MSP eligibility (effective January 1, 2010), prohibits the value of any life insurance policy and in-kind support and maintenance from being taken into consideration when determining the resources of an individual for LIS eligibility (effective January 1, 2010), eliminates the Part D late enrollment penalty for LIS recipients (effective January 2009) and provides for judicial review of LIS eligibility determinations made by SSA (effective immediately).

- **Marketing Restrictions**

The MIPPA places prohibitions and limitations on certain sales and marketing activities, effective January 1, 2009. The Act prohibits Medicare Advantage and Prescription Drug Plans from conducting the following marketing activities: the direct contact of prospective enrollees by unsolicited means, including door-to-door sales and outbound telemarketing; the sale of non-health products during any activity or presentation conducted with respect to a MA plan; the provision of meals of any sort; and sale and marketing activities in health care settings and at educational events. The Act also requires CMS to establish standards on the scope of marketing appointments, the co-branding of products, and the use of gifts and agent compensation and training. The Act also enhances the ability of states to address fraudulent marketing practices.

- **Private-Fee-for-Service Plans**

The MIPPA revises the requirements for Private-Fee-for-Service (PFFS) Plans. The Act requires plans in counties where there are two or more Medicare Advantage Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs) to form networks of providers, beginning plan year 2011. The Act also requires PFFS plans to have the same quality improvement programs as local Medicare Advantage PPOs, effective plan year 2010.

- **Special Needs Plans**

The MIPPA extends both the authority for Special Needs Plans (SNPs) and the moratorium on new SNPs through December 31, 2010. Beginning January 2010, the Act also increases care management requirements for SNPs and requires SNPs for dual eligibles to have contracts with State Medicaid agencies related to the provision of Medicaid benefits. The Act notes that this new provision does not require States to enter into contracts with SNPs. Also effective January 1, 2010, the Act limits out-of-pocket costs for dual eligibles and Qualified Medicare Beneficiaries (QMBs) to the amount of cost-sharing that would be permitted if the dual or QMB were in original Medicare.

- **Part D Drugs**

The new law includes some expansion of the drugs that can be covered under Part D. The Act:

- permits coverage under Part D of barbiturates for certain conditions and of benzodiazepines, effective January 1, 2012;
- codifies current guidance concerning coverage of “protected classes” of drugs under Part D and authorizes modification of the protected classes through rulemaking;
- authorizes Medicare to revise the compendia used for identifying medically accepted indications for Part D drugs and provides that certain criteria for anti-cancer drugs covered under Part D should be the same as the criteria for anti-cancers drugs covered under Part B.

- **Language Access**

The MIPPA requires the Inspector General of HHS to prepare and publish a report evaluating Medicare plan and provider compliance with Title VI guidance and CLAS standards as well as the costs of compliance/non-compliance, within the next two years. After publication of the report, HHS is then required to implement, within one year, changes responsive to the recommendations in the report. The Act also gives HHS eighteen months to submit a report evaluating approaches and recommendations for identifying and collecting data on health care disparities on the basis of race, ethnicity, and gender. HHS has two years (from the time of enactment) to implement the approaches and recommendations identified in its report. Finally, beginning in 2010, the new law requires SSA to translate application forms for the MSP and the LIS into at least the ten languages (other than English) that are most often used by individuals applying for hospital insurance benefits.

CMS RESPONDS TO LANGUAGE ACCESS ADVOCATES

In early July, the California Medicare Part D Language Access Coalition finally received a response from CMS³ to a letter that the Coalition sent in March outlining priorities for improving services to limited English proficient Medicare beneficiaries.⁴ The letter addressed three distinct areas in need of improvement: plan call centers, 1-800-MEDICARE and written materials.

Plan Call Centers: CMS stated that the agency has taken steps towards monitoring plan compliance with the requirement that plan call centers provide services to non-English speaking beneficiaries. The agency reports that it is currently working on a project to measure plan compliance. The results of this effort will then be used to take corrective action against plans that do not meet the requirements and to develop a “star rating” reflecting each plan’s ability to accommodate LEP beneficiaries. The rating will be part of the performance metrics posted at Medicare.gov.

1-800-Medicare: CMS indicated a willingness to respond to allegations of problems for LEP beneficiaries. If advocates have non-English speaking clients who are having problems using 1-800-MEDICARE, please contact Kevin Prindiville (kprindiville@nslc.org) or Katharine Hsiao (khsiao@nslc.org).

Translations of Written Materials: The response did little to address Coalition concerns about the dearth of translated materials. With regard to CMS materials, the agency noted that, while CMS does translate its notices into Spanish, it only distributes the translated notices to beneficiaries who call to request the Spanish version of the notice. Between September 2007 and June 2008, CMS mailed 10 notices to beneficiaries with information about LIS eligibility, reassignment, changes to plan premiums and Social Security withholding but received only 1,300 requests for Spanish versions of these documents.

The response about written materials originating from plans indicated that CMS has no plans to change current requirements and guidance but did not discuss plans for ensuring that plans are meeting the current requirements.

CMS also graciously agreed to meet with Coalition members to further discuss the issues raised in the original letter and CMS response. The response and offer of a meeting are positive signs that the agency is interested in improving services for LEP beneficiaries.

If you are interested in working on language access issues in Medicare Part D and Medicare Advantage or are already working on these issues in your state, please let Kevin (kprindiville@nslc.org) and/or Katharine (khsiao@nslc.org) know.

³ www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391/cms-responds-to-california-language-access-coalition/at_download/attachment

⁴ www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391/california-part-d-language-access-working-group-letter-to-cms/at_download/attachment

AGENCY NEWS

CMS PUBLISHES 2008 GUIDE TO MAILINGS

CMS has released an updated version of its annual Guide to CMS & SSA Mailings. The helpful chart lists the various notices and other materials that both SSA and CMS will be sending out during the Fall.

One notice that was missing from this year's Guide is the tan-colored "Chooser" notice, which had been mailed to beneficiaries who had self enrolled in a plan that was a benchmark plan in 2007 but not in 2008. The notice informed them that if they stayed in the plan they would be liable for a premium, explained that they had the right to switch to a different plan and listed zero premium plans that were available in the region.

Advocates contacted CMS to share concerns about the omission of these notices and to request that they be sent again this year. CMS has since reported that the agency has decided that it will send chooser notices this fall, despite the fact that the notice was originally omitted from the list. This is a welcome development since the chooser notice sent by CMS was much more effective at relaying information about changes in premiums and included information about beneficiary rights and options (such as the explanation of the right to change plans and the list of available zero premium plans) that were not included in plan materials. Thanks to Elaine Wong Eakin of California Health Advocates for flagging the issue.

CMS RELEASES UPDATED GUIDANCE

CMS recently released updated versions of its guidance on Part D Eligibility, Enrollment and Disenrollment (PDP Manual, Chapter 3; Managed Care Manual, Chapter 2)⁵ and its guidance on Formulary Requirements (Prescription Drug Benefit Manual, Chapter 6)⁶. The updates include a number of clarifications and relatively small incremental improvements in procedures and notices, some of which had been previously announced by CMS.

For the Eligibility and Enrollment Guidance, highlights include:

Part B SEP: A Special Enrollment Period is established for individuals involuntarily disenrolled from an MA-PD plan due to loss of Part B.

⁵ www.cms.hhs.gov/MedicarePresDrugEligEnrol (PDP Guidance);
www.cms.hhs.gov/MedicareMangCareEligEnrol (MA Guidance)

⁶ www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage

Involuntary Disenrollment: Grace periods for non-payment of premiums cannot start to run until after the beneficiary has been notified of non-payment.

Chronic Condition SNPs: Plans must verify eligibility either through contact with the treating physician or through use of CMS approved prequalification assessment tool. Individuals who were enrolled pending verification and were found not eligible have a Special Enrollment Period in which to change plans.

Notices: Model enrollment/disenrollment notices now include a new paragraph stating that individuals receiving extra help can change plans at any time. Enrollment notices also contain new disclosures, including a disclosure that agents and brokers are paid for enrollments. Model letters responding to disenrollment requests contain clearer instructions for enrollees.

Private-Fee-For-Service Plans (PFFS): Forms acknowledging enrollment in PFFS plans include improved descriptions of how PFFS plans operate.

Language Access: Model enrollment forms include a section for beneficiaries to indicate their preference for information to be sent in another language or format (limited to the languages that the plan offers). In addition, the model forms provide beneficiaries with a plan phone number to call if they need information in another language or form (unfortunately these notices are only required to appear in English).

The Formulary Guidance primarily incorporates piecemeal changes that have been issued in the last year, including:

Retrospective Determination of a Medically Accepted Indication: If a plan determines that a previously approved use of a drug is not for a medically accepted indication, the plan may not retrospectively charge the enrollee. In addition, a plan is expected to continue coverage of the drug “to the extent it determines that doing so is necessary to avoid risk to the enrollee’s health while providing for a transition to another form of treatment.”

Diabetic supplies: The guidance clarifies that medical supplies directly associated with delivering insulin including syringes, needles, alcohol swabs, gauze and insulin delivery devices not covered under Part B satisfy the definition of a Part D drug. Test strips, lancets and needle disposal systems do not.

OTC Conversion: When a drug converts to OTC status, existing supplies of legend drugs can be covered by Part D, but the OTC version cannot. Plans may offer the OTC drug without charge as part of their administrative structure but, even if they do so, they must add another legend drug if the change to OTC status results in fewer than two Part D drugs in each therapeutic category. Plans also must notify enrollees that the OTC version will be dropped from Part D coverage.

Home Infusion Drugs: MA plans may bundle home infusion drugs as part of a bundled service as a mandatory supplemental benefit.

Inhaler Supplies: Accessories for meter dose inhalers, dry powder inhalers or nasal spray inhalers specifically packaged with the drug itself can be Part D drugs. Accessories, if sold separately (actuator, chamber) or not included on the drug product's NDA or ANDA, cannot be treated as Part D drugs.

Vaccine Administration: Vaccine and vaccine administration are bundled and treated as a single claim. Formularies must include all commercially available vaccines but utilization management tools may be used in limited circumstances. Additional details on fee-setting are included in the guidance.

Specialty Tier Placement: Plans may only put on the specialty tier those strengths, package sizes and formulations of a drug that would reasonably exceed the dollar per month threshold for specialty tiers, currently \$500 per month. Smaller packages, for example, may not be subject to specialty tier pricing. Also, for long-acting formulas (e.g., one dose effective for three months), plans must spread out the costs over the duration of effectiveness to determine if the drug meets the specialty tier dollar threshold.

ADVOCATES SUBMIT COMMENTS TO PROPOSED PART C AND D REGULATIONS

On July 15, numerous advocacy organizations submitted comments on proposed Medicare Part C and Part D regulations. The proposed regulations covered a wide variety of issues including Special Needs Plans, passive enrollment, exceptions and appeals, the Best Available Evidence policy, definitions of important terms like “incurred costs” and “negotiated price,” the Part D late enrollment penalty, plan marketing and more. Several advocacy groups (including NSCLC, the Center for Medicare Advocacy, the Medicare Rights Center, California Health Advocates, Health Assistance Partnership, National Council on Aging Organizations, Greater Boston Legal Services, Legal Services for the Elderly and others) worked together to develop detailed comments. NSCLC's version of these comments can be viewed at www.nsclc.org/areas/medicare-part-d.

CMS EXPANDS COMPENDIA FOR PART B CANCER DRUGS

CMS has added Elsevier Gold Standard's Clinical Pharmacology Compendium to the list of compendia that can support approval of coverage for an anti-cancer drug under Medicare Part B. The compendium list for Part B also includes the NCCN Drugs & Biologics Compendium and Thomson Micromedex DrugDex.

Under Part B, a drug may be covered if used for a “medically accepted indication.” For off-label uses, coverage must be supported by a showing that the use is listed in one of the compendia approved by CMS. CMS has the authority to revise its list of authoritative

compendia. Because the off-label use of drugs is particularly prevalent in the treatment of patients with cancer, the issue of whether a use is for a medically accepted indication is an important one for this population.

In contrast to Part B, the statutory section governing Part D, which lists three compendia, includes no provision authorizing CMS to add new compendia. The Part D compendia are: American Hospital Formulary Service Drug Information; United States Pharmacopeia-Drug Information (or its successor publications), and the DRUGDEX Information System.

For Medicaid, the statute identifies the same compendia as used for Part D. Medicaid is different, however, in that the statute allows, but does not require, states to exclude from coverage those uses of drugs that do not appear in those compendia.

In announcing the addition of the Elsevier compendium, CMS noted that it is exploring options to update compendium lists used for Medicare Part D and Medicaid to include “current well-respected compendia.” It is likely that legislative authority would be required for such updates. Advocates have argued, however, that exclusive reliance on compendia, even if lists are updated, is overly restrictive and that peer-reviewed studies and other evidence should be considered to demonstrate use for a medically accepted indication.

CALIFORNIA NEWS

KAISER SPECIAL NEEDS PLAN DISENROLLMENTS - UPDATE

As mentioned in the March 2008 Alert,⁷ earlier this year Kaiser Permanents announced that it would be involuntarily disenrolling from its Special Needs Plan (SNP) for dual eligible members whose Medi-Cal eligibility has not been verified by California’s Department of Health Care Services (DHCS). Beginning the first week of March, a series of four letters were sent to approximately 6,000 members whose Medi-Cal eligibility could not be confirmed. Follow-up letters were mailed in April, May and July. According to Kaiser, most of the members they contacted responding by either reestablishing their Medi-Cal eligibility or enrolling in Kaiser’s Senior Advantage Plan.

The remaining 1,800 members who have neither reestablished Medi-Cal eligibility nor enrolled in another plan will be involuntarily disenrolled effective August 1, 2008. Members who are involuntarily disenrolled are entitled to a Special Enrollment Period extending three months following the effective date of involuntary disenrollment in which to either choose to join Kaiser Senior Advantage, another Medicare Advantage plan, or stay in original Medicare and enroll in a Part D plan. *See* PDP Enrollment Guidance § 20.3.8(8)(F); MA Guidance § 30.4.4(10).

⁷ www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630/area_folder.2007-03-30.5858093107/low-income-advocate-alert-on-medicare-part-d-march-2008/at_download/attachment

This round of disenrollments will only affect individuals who, according to DHCS, are not eligible for any Medi-Cal benefits. Individuals who have Medi-Cal with a share of cost (SOC) are not included in this current round of disenrollments. Those affected will include a small number of partial duals (e.g. QMB-only, SLMB-only, QI-only).

For more information, including copies of the notices that were sent, contact Kevin Prindiville (kprindiville@nslc.org).

REPORTS & STUDIES

- A new report from the U. S. House of Representatives Committee on Oversight and Government Reform found that Medicare Part D plans are spending substantially more money paying for drugs for dual eligibles than the Medicaid program would have paid for the same drugs for the same beneficiaries. The report, “**Medicare Part D: Drug Pricing and Manufacturer Windfalls**,”⁸ (July 2008) compared the costs of drugs purchased under the Medicare Part D program with the costs of drugs purchased under Medicaid. The results indicated that drugs purchased under Medicare Part D cost, on average, 30% more than what they would cost under Medicaid. Drug prices are higher under Part D because Part D insurers have not negotiated the same discounts as Medicaid, and the administrative expenses and profits of the private insurers are high. Part D plan administrative expenses and profits account for 10% (\$4.6 billion) of the costs of Medicare Part D and are almost six times greater than administrative costs under traditional Medicare. After rebates and discounts from drug manufacturers, in 2006 and 2007 Medicare Part D insurers paid \$16.2 billion for the top 100 drugs used by dual eligibles. If they would have been able to obtain the same discounts as Medicaid, the costs would have been cut to \$12.4 billion. The fact that almost every drug is more expensive under Medicare Part D than under Medicaid, the report finds, has resulted in a windfall of \$3.7 billion for drug manufacturers. Thirteen manufacturers received windfall revenues exceeding \$100 million in 2006 and 2007. The report concludes that if Medicare Part D insurers paid Medicaid prices for drugs used by dual eligibles, federal taxpayers would save \$86 billion over the next ten years.
- In the issue brief “**Medicare Advantage in 2008**”⁹ (June 2008), the Kaiser Family Foundation reports a rapid increase in Medicare Advantage (MA) enrollment in recent years. The number of Medicare beneficiaries in MA plans at the end of 2007 was 8.2 million, up from 5.1 million (or 34 percent) in 2004. Preliminary data indicate continued growth in 2008. Nineteen percent of all Medicare beneficiaries were enrolled in MA plans in 2007, up from 12 percent in 2004. In 2007, 33 percent of Medicare beneficiaries enrolled in a Part D plan were in an MA plan.

MA enrollment remains more common in urban than rural areas. At the end of 2007, 22 percent of all Medicare beneficiaries in urban areas were enrolled in an MA plan,

⁸ www.oversight.house.gov/documents/20080724101850.pdf

⁹ www.kff.org/medicare/upload/7775.pdf

as opposed to only 10 percent of beneficiaries in rural areas. Data from the CMS Annual Plan Report from July 2007 show that of the 8.55 million total MA enrollees nationwide, 1.33 million are in employer group plans. Over half (53%) of all MA enrollment is concentrated in three companies – UnitedHealthcare, Humana and Kaiser – and various Blue Cross Blue Shield affiliates. While Prescription Drug Plan enrollment still dominates most companies’ total Medicare enrollment, the fact that the companies that sponsor the most popular PDP plans also offer MA plans presents an opportunity for a shift in enrollment between the two sectors. The report points out that companies have a financial incentive to move beneficiaries from PDP to MA plans because more revenue is available in the MA program. The report concludes that growth in MA plan offerings reflects the industry’s response to higher payments, the ease of setting up Private Fee For Service plans that have no networks, and the availability of existing administrative structures used to market Medigap and other insurance products. The report encourages policymakers to consider the long-term impacts of MA expansion on Medicare’s financing and stability and warns that changing direction will only become more difficult as MA enrollment grows.

- The GAO report, “**Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005**”¹⁰ (June 2008) measured the accuracy of MA organization’s revenue and expenditure projections with their actual expenses. The results indicate that MA self-reported actual medical expenditures as a percentage of revenue were lower than plans had projected for 2005. They reported spending 85.7 percent of total revenue on medical expenses but had projected medical expenditures of 90.2 percent of total revenue. The actual profit was 5.1 percent of total revenue which is about \$1.14 billion more than MA organizations had projected. CMS commented on the report stating that, even if factually accurate, the results for 2005 are of historical significance only, and that the difference between projected and actual expenses and profits did not affect Medicare payments to MA organizations or the benefits they would have provided. Although the GAO agrees that these results may not be representative of subsequent years, it asserts that it is incorrect to suggest that there is no relationship between the Adjusted Community Rate Proposal (ACRP) process used in 2005 and the bidding process that began in 2006. Under both systems, plans offered enhanced benefit packages to attract higher enrollment. The inaccuracy of projections could have impacted the types and costs of services that MA beneficiaries received. If projections for medical expenses had been more accurately reflected, MA organizations would have been able to provide additional benefits or cost-sharing reductions to beneficiaries and would have still maintained their projected profit margin of 1.8 percent of total revenue.
- MedPac has released “A Data Book: Healthcare Spending and the Medicare Program.” The data book contains interesting chapters on the demographics of the Medicare population¹¹ and dual eligible beneficiaries in particular.¹² Not surprisingly, the data reveal that dual eligibles are more likely to report poorer health status, are

¹⁰ www.gao.gov/new.items/d08827r.pdf

¹¹ www.medpac.gov/chapters/Jun08DataBookSec2.pdf

¹² www.medpac.gov/chapters/Jun08DataBookSec3.pdf

more likely to be disabled, and account for a disproportionate share of Medicare spending. The data also reveal that 45% of Medicare beneficiaries have income below 200% of the Federal Poverty Level. “Medicare Beneficiary Demographics” and “Dual eligible Beneficiaries”

ADDITIONAL RESOURCES FOR ADVOCATES

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 and certain other low income advocates nationwide to discuss Medicare Part D. If you are an advocate and would like to participate, contact Kevin Prindiville of the National Senior Citizens Law Center, kprindiville@nsclc.org.

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

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.

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. If you would rather not use the form, a plain email is fine too. 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
Georgia Burke, Co-Directing Attorney, (510) 663-1055 ext. 303 or gburke@nsclc.org
Kevin Prindiville, Staff Attorney, (510) 663-1055 ext. 307 or kprindiville@nsclc.org
Anna Rich, Staff Attorney, (510) 663-1055 ext. 305 or arich@nsclc.org

NSCLC law clerk Erica Stuckey and intern Nancy Arevalo contributed to this Alert.