



**June 2008**

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

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- Senate considers legislation to restore Medicare doctor payments and improve beneficiary protections. Page 3.
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This Alert contains both California-specific and national information for advocates.

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

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## **IMPORTANT INFORMATION**

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### **PART D PLAN BEGINS DISENROLLING LIS RECIPIENTS FOR NON-PAYMENT OF PREMIUMS**

Low income Medicare Part D enrollees are beginning to suffer the consequences of market volatility and increased monthly premiums in 2008. California advocates recently learned that Humana, one of the largest private sponsors of Part D coverage, has begun to send disenrollment notices to recipients of the Low Income Subsidy (LIS) who have failed to pay new monthly premiums in 2008. Advocates have grave concerns, as the form disenrollment letters, approved by the Centers for Medicare and Medicaid Services (CMS), fail to alert recipients of important continuing rights.

- **Low Income “Choosers” Pay More in 2008**

LIS recipients who receive the full subsidy level are entitled to Part D drug coverage with no monthly premium as long as they are enrolled in a prescription drug plan with a premium below a regional benchmark amount set by CMS. Since both regional benchmark amounts and individual plans' monthly premiums change annually, the choice of drug plans that full LIS recipients can enroll in with no monthly premium also changes from year to year.

In 2008, many drug plans' premiums, including Humana's, rose about the benchmark level. Although LIS recipients who were enrolled in a plan assigned to them by CMS were automatically transferred to a different plan, those low-income beneficiaries who affirmatively chose their own plan (dubbed “choosers”) were not automatically reassigned. Instead, choosers who did not change plans themselves and stayed put became responsible for new monthly payments for the difference between the regional benchmark and their plan's 2008 premium. It is believed that a large number of choosers who stayed put may not have realized that they might be responsible for payments starting in 2008, either because notices were insufficient or too confusing, or because they simply assumed that they would continue to pay no premiums as in 2007.

CMS guidance gives Part D plans the option to disenroll LIS beneficiaries for failure to pay monthly premiums, but does not require plans to do so. The only requirement is that any policy on involuntary disenrollments must be applied consistently to all LIS recipients in that particular plan. If a plan decides to terminate beneficiaries' enrollment for failure to pay premiums, it is required to provide enrollees with notice and a grace period. (For more details about disenrollment for failure to pay premiums, see CMS' PDP Guidance on Eligibility, Enrollment and Disenrollment § 40.3.1.)

Because Part D plans are not required to make their disenrollment policy public, choosers had to decide whether or not to stay in a plan that became more expensive in 2008 without knowing if they would be kicked out if they were unable to make monthly premium payments.

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- **Humana Begins Disenrollments with Inadequate Notices**

California advocates recently learned that Humana has already begun sending disenrollment notices to LIS recipients who have failed to pay premiums in 2008 (Humana's lowest cost plan is no longer below the benchmark in California).

Humana based its notices on CMS' "model" notices for disenrollment due to non-payment of premiums. Unfortunately, the notices were not written with low-income beneficiaries in mind—resulting in a woefully inadequate message that fails to communicate important rights that all LIS recipients enjoy. Specifically, the notices fail to inform LIS beneficiaries:

- that they have a continuing Special Enrollment Period (SEP) that allows them to switch to a new plan each month;
- that they are exempt from the late enrollment penalty;
- that \$0 premium plans are available;
- and that, if they are a full benefit dual eligible, they will be randomly auto-enrolled into a new plan if they get disenrolled from Humana, with no gap in coverage.

Instead, the LIS beneficiaries who receive these notices are misleadingly told that if they fail to pay premiums they will **lose** prescription drug coverage, that they will not have an opportunity to enroll in another plan and that they may face a late enrollment penalty when they try to re-enroll later.

California Health Advocates and NSCLC filed a complaint with CMS about the form of the notices and CMS indicated a willingness to revise the notices as part of its revisions to the MA/PDP Enrollment and Disenrollment Guidance (see below). If your clients have received similar notices from Humana or other plans, or if you would like a copy of NSCLC's complaint, please contact Kevin Prindiville, [kprindiville@nsclc.org](mailto:kprindiville@nsclc.org).

## SENATORS PROPOSE DUELING MEDICARE BILLS

The Senate is poised to debate competing bills that would each restore 10% cuts in Medicare payments to doctors. Without legislation, the cuts will automatically take effect July 1. Although there is broad consensus that the cuts must be restored, Democrats and Republicans agree on little else about what should be in the "doctor fix."

Senator Max Baucus (D-MT), Chairman of the Senate Finance Committee, has offered a Democratic bill that includes many beneficiary-friendly provisions, including an increase in asset test thresholds for Medicare Savings Programs, streamlining of applications for the low income subsidy (LIS), tightened controls on marketing of Medicare Advantage plans, and phased-in parity for mental health coverage in Medicare. Costs of improvements would be met primarily by modest reductions in the current overpayments to Medicare Advantage plans. The Baucus bill is supported by many low income advocacy groups, including NSCLC, as a first step in a path toward more comprehensive improvements in the Medicare benefit. The White House has threatened presidential veto of the Baucus bill.

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Senator Charles Grassley (R-IA) offered a competing Republican version that also restores doctor payments but includes very few additional beneficiary protections and does not touch overpayments to Medicare Advantage plans.

Both bills are to be considered directly on the Senate floor without committee review. House action also will be required.

## SENATE COMMITTEE LOOKS AT IMPROVEMENTS TO THE MEDICARE LOW INCOME SUBSIDY

In a May 22 hearing, the Senate Special Committee on Aging listened to proposals to improve the Low Income Subsidy (LIS) program for Medicare Part D beneficiaries, focusing on expansion of beneficiary participation.

Laura Summers, of Georgetown University's Health Policy Institute, testified that, according to the Centers for Medicare and Medicaid Services (CMS), almost two-thirds (63 percent) of persons eligible for the LIS on the basis of income were not receiving the subsidy as of January 2008. Citing recently published Commonwealth Fund-financed studies conducted by Georgetown, NSCLC and the Center for Medicare Advocacy, she argued that the program could be strengthened by simplifying the enrollment process, eliminating the current asset test and aligning rules and procedures for the LIS and the Medicare Savings Programs. She further proposed a legislative change to ensure that low income subsidy assistance is not counted as income for purposes of eligibility for other federal needs-based programs. She also urged a more pro-active and targeted program to enroll eligible individuals, with targeted outreach to ethnic and linguistic minority groups.

Joyce Payne, a Board member of AARP, joined in recommending the elimination of the asset test, reduction in red tape, and coordination of MSP and LIS eligibility.

Lisa Emerson, Program Manager for Oregon's Senior Health Insurance Benefits Assistance Program (SHIBA), testified that the current income and asset limits do not make the program available to enough people who need it, noting that the criteria for patient assistance programs operated by drug companies are more generous. She reported a recurrent problem when individuals qualifying for the LIS change plans. Their LIS eligibility information sometimes does not get transferred in a timely manner and they overpay for their drugs. She urged simplification and elimination of the asset test. She also noted that, because of the complexity of the Part D benefit and because of the significant changes in Part D insurance plan designs that occur each year, the need for one-on-one counseling provided by State Health Insurance Programs (SHIPs) has far outstripped resources.

GAO testimony reported that the Social Security Administration is in discussions with the Internal Revenue Service about ways to identify beneficiaries who may qualify for the LIS.

An Oregon beneficiary reported that her mother's modest savings prevented her from qualifying for the low income subsidy and also told the Committee about frustrating and ultimately futile

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experiences trying to get information and assistance from the 1-800-MEDICARE phone line and from her mother's Medicare Advantage plan. Hearing testimony is available at [http://aging.senate.gov/hearing\\_detail.cfm?id=298208&](http://aging.senate.gov/hearing_detail.cfm?id=298208&).

A number of reports detailing the need for LIS improvements were released in conjunction with the hearing. See below for more information about these reports.

## SSA & CMS CONDUCT SPRING LOW INCOME SUBSIDY OUTREACH

In an effort to encourage more beneficiaries to apply and become eligible for the Low Income Subsidy, CMS and SSA began extensive outreach activities this Spring. The 2008 Spring LIS Campaign was launched on May 16th with a LIS Partner Summit in Washington, DC.<sup>1</sup> The campaign will last until July and will target areas where available data suggests large groups of potentially eligible beneficiaries reside. CMS is working with local community based organizations and media to spread the word about the benefits of the LIS and has updated its LIS Outreach Toolkit.<sup>2</sup>

The CMS campaign will complement the outreach efforts of SSA. SSA has created new posters and flyers describing the savings provided to LIS recipients.<sup>3</sup> The SSA outreach included events around Mother's Day and Father's Day.

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<sup>1</sup> CMS indicated that the Summit would be recorded and that the recording would be made available at [www.cms.hhs.gov](http://www.cms.hhs.gov) in the "near future."

<sup>2</sup> Available at [www.cms.hhs.gov/Partnerships/Toolkits/itemdetail.asp?itemID=CMS1188820](http://www.cms.hhs.gov/Partnerships/Toolkits/itemdetail.asp?itemID=CMS1188820)

<sup>3</sup> Available at [www.ssa.gov/prescriptionhelp/10692A.pdf](http://www.ssa.gov/prescriptionhelp/10692A.pdf)

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## **PART D NEWS & VIEWS**

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### **SHIP FUNDING INCREASES IN 2008**

In early June, CMS announced that it will distribute \$15 million to State Health Insurance Programs (SHIPs).<sup>4</sup> SHIPs provide invaluable counseling and advocacy to Medicare beneficiaries making decisions about their Medicare coverage and/or having problems accessing Medicare benefits. Each state has its own SHIP program, often with its own name. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). Most SHIPs rely heavily on volunteers – who are often Medicare beneficiaries themselves – to serve the needs of Medicare beneficiaries in their states. Always an important resource, the role of SHIPs has increased since the implementation of Part D. Now more than ever, Medicare beneficiaries turn to SHIPs for counseling as they make important decisions about their health care coverage.

In 2007, SHIPs received \$30 million from CMS. In 2008, CMS will provide SHIPs with more than \$50 million in funding. The \$15 million distributed in June is in addition to \$36 million that was distributed in April. An additional \$1.5 million will be distributed in September.

While the increase in funding is certainly welcome, given the important role SHIPs play in helping beneficiaries navigate the complexities of Part D and Medicare Advantage plans, more needs to be done to support these programs.

### **AGENCY ACTION**

In the final year of the current administration, CMS has been busy issuing proposed and final regulations and updating guidance.

- **CMS Issues Final Rule on Medicare Part D Low Income Benchmark Plans**

In early April, the Centers for Medicare and Medicaid Services (CMS) issued a final rule which changes the way that it will determine which Medicare Part D prescription drug plans will be available to full Low Income Subsidy (LIS) recipients for a \$0 premium.<sup>5</sup> According to CMS, the final rule is designed to increase stability for LIS beneficiaries, many of whom have had to switch plans in order to remain in plans with no monthly premium. Whether or not the new rule will actually increase stability is still up for debate.

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<sup>5</sup> The final rule is available at: [www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CMS4133F.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CMS4133F.pdf). CMS also issued the following correction to the final rule: [www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CMS4133C.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CMS4133C.pdf). NSCLC comments to the proposed rule can be viewed at: [www.nsclc.org/areas/medicare-part-d/area\\_folder.2006-09-28.5758698482/area\\_folder.2006-10-12.202247391](http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.202247391)

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As discussed in previous Alerts, dual eligibles and other full LIS recipients can join a Part D plan and pay no monthly premium as long as the plan's premium is below an amount known as the "regional benchmark." CMS calculates the regional benchmarks based on plan premiums. Since plan premiums change every year, so do the benchmarks. As a result, a beneficiary may be enrolled in a plan with a premium that is below the benchmark one year, but not the next. These beneficiaries need to change plans in order to avoid paying premiums.

In the Fall of 2007, CMS reassigned 2.1 million LIS recipients to new plans in order to ensure that they would not pay premiums in 2008. An additional 400,000 LIS recipients received notices indicating that they would be charged premiums in 2008 if they did not switch plans themselves. The number of beneficiaries affected would have been even larger but for the fact that CMS used its "demonstration authority" to create a "de minimis" policy that allowed more plans to qualify as benchmark plans.

CMS issued a proposed rule in January of this year to address this problem. That rule would have ensured that every region had at least 5 benchmark plans. According to CMS, those who submitted comments on the proposed rule – including NSCLC and other advocates – agreed that the proposed rule would not accomplish the goal of increasing beneficiary stability. CMS abandoned the proposal and adopted, instead, a proposal suggested in some of the comments.

The final rule adopted by CMS will change the way that the regional benchmarks are calculated. Under the old regulatory framework, benchmarks were established by averaging plan premiums after weighting for total Part D enrollment. Under the new rule, premiums will be weighted by LIS enrollment. The premiums of plans with a high number of LIS enrollees will be given greater weight while premiums of plans with no LIS enrollees will not be factored in at all. CMS did not adopt alternative suggestions by beneficiary advocates for increasing stability, such as excluding heavily subsidized Medicare Advantage plans from the benchmark calculation or increasing beneficiary protections.

According to CMS, the new rule will result in fewer reassignments than if the old regulatory structure were followed without a de minimis policy. But the new rule may result in a higher number of reassignments than the de minimis policy that CMS has been using under CMS' demonstration authority.

It is still too early to tell what effect the final rule will have on LIS recipients in 2009 and beyond. Advocates remain concerned about a "race to the bottom" in which prescription drug plans available to low-income Medicare beneficiaries provide increasingly inadequate coverage. It is clear, however, that even with this change, benchmark plans will continue to change from year to year and LIS recipients will continue to be exposed to annual disruptions in coverage.

- **CMS Issues Final Rule Making Technical Changes to Part D Rules**

On April 15, 2008 CMS published in the Federal Register a final regulation to make policy and technical changes to its Part D rules.<sup>6</sup> The regulation became effective on June 9, 2008. Some

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<sup>6</sup> Available at 73 Fed. Reg. 20486 (April 15, 2008).

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of the policy changes CMS are discussed only in the preamble. Others are included as changes to the text of the regulations themselves. Among the provisions addressed in the final rule:

- **Eligibility and Enrollment:** Under the new final regulations, Part D plans may use individual providers, provider groups, and pharmacies to distribute printed comparative plan information, as long as these entities display printed comparative information about all of the different Part D plans with which they contract. They are not obligated to display comparative information about plans with which they do not contract.
- **Definition of Covered Drugs:** The final regulation discusses and modifies the definition of a Part D covered drug.
  1. Erectile dysfunction drugs: CMS confirms that no regulatory change is required to implement the statutory change that excludes erectile dysfunction drugs from coverage under Part D. These drugs may be covered if they are used to treat a condition other than sexual or erectile dysfunction for which the drug has received FDA approval.
  2. Weight loss or weight gain agents: CMS clarifies that agents when used for anorexia, weight loss, or weight gain are specifically excluded from coverage, even when not used for cosmetic purposes. CMS describes as "an error" its statement in the preamble of the January 2005 final regulation that weight loss drugs could potentially be covered. Plans may cover weight loss agents used to treat morbid obesity under enhanced alternative coverage but not under their standard coverage. However, CMS reasserts its previous statement that prescriptions used to treat AIDS wasting and cachexia are not considered agents used for weight gain or for cosmetic purposes.
  3. Insulin inhalation drugs and supplies: CMS has broadened its definition of a covered drug in the regulation to include all products directly associated with delivery of insulin, including the insulin inhalation chamber and future potential delivery mechanisms.
  4. Vaccine administration fee: The definition of a Part D drug is also amended to include reference to vaccine administration on or after January 1, 2008, to be consistent with statutory changes.
- **Long-Term Care Facilities:** CMS makes a number of clarifications:
  1. The definition of long-term care facility includes an institution for mental disease (IMD) to the extent that it is a nursing facility and serves full benefit dual eligible individuals for whom Medicaid payment is made.
  2. Part D covers drug costs for inpatients in hospitals that meet the definition of a medical institution if they have exhausted their Part A inpatient days and for whom payment for drug costs is no longer available under Part A or Part B.
  3. Part D plans are not compliant with CMS long-term care pharmacy access standards if they do not provide access to Part D covered drugs via a network pharmacy for enrollees who reside in long-term care facilities. CMS states in the preamble that drug plans should contract with the pharmacies serving the facilities in which enrollees reside, and plans may need to enter into a retroactive contract. CMS also

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"encourages" plans to coordinate with in-house and state-run pharmacies used by many ICF/MRs, IMDs, and long-term care hospitals. Further, CMS expects that situations in which a beneficiary is hospitalized and exhausts Part A coverage will rarely occur, so that the plans would only have to contract with hospital pharmacies to provide coverage to these individuals on an as-needed basis.

- **Waiver or Reduction of Cost-Sharing by Pharmacies:** CMS clarifies that waivers or reductions of cost-sharing by pharmacies only count as incurred costs towards the out-of-pocket limit (TrOOP) that gets beneficiaries out of the coverage gap if the pharmacy is not providing other wrap-around coverage. In other words, pharmacies operated by group health plans or under government-funded programs may waive or reduce cost sharing, but the waived or reduced cost-sharing amount will not count towards TrOOP. Most importantly, cost-sharing waivers or reductions applied by safety-net provider pharmacies, including federally-qualified health centers, will not count because these entities use government funding to help pay for the cost of the drugs.
- **Access to Home Infusion Pharmacies:** The Part D plan pharmacy network must provide adequate access to home infusion pharmacies that (1) are capable of delivering home infused drugs that can be administered appropriately; (2) while not required to directly arrange for supplies, can ensure that the services and supplies necessary for home infusion therapy are in place before the drugs are delivered; and (3) can deliver the drugs within 24 hours of discharge from an acute care setting, or later if so prescribed. CMS reminds plans that they are ultimately responsible for compliance with these obligations, and that the agency will investigate complaints about access problems.
- **Coordination of Benefits with Other Providers of Prescription Drug Coverage:** Part D plans should use the CMS reconciliation process to coordinate benefits where payment was made to a plan on behalf of a beneficiary who transferred enrollment to another plan. CMS declined to extend the reconciliation process to address inaccurate cost-sharing amounts withheld from pharmacies, but reiterated that plan sponsors are required to pay for covered Part D drugs provided during the retroactive enrollment periods, even if the pharmacy is not a network pharmacy.
- **Grievance and Appeals Issues:** The regulations make technical corrections to the definition of "appointed representative" to allow the representative to file a grievance on the enrollee's behalf, and to the definition of "projected value," limiting the projected value of a drug for purposes of meeting the jurisdiction amount for a hearing to benefits incurred within a plan year. Additionally, plans must deliver written notice to an enrollee within 3 calendar days of denying a request to expedite a coverage determination, but providing the notice to both the appointed representative and the enrollee "could be confusing for an enrollee..."
- **Premium Subsidy for Late Enrollment Penalty:** The initial Part D regulations failed to include the calculation of the subsidy of the late enrollment penalty (LEP) for individuals who are not eligible for the full subsidy. This final regulation provides for a sliding scale subsidy, with higher subsidization available for individuals with incomes below 135% of the federal poverty level. CMS notes that its demonstration to waive the

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LEP applies only to low-income subsidy eligible individuals who enroll in a Part D plan in 2006, 2007, and 2008. CMS indicates that it "may consider" suggesting to Congress that the LEP be waived for low-income subsidy recipients.

Thanks to Vicki Gottlich and the Center for Medicare Advocacy for allowing us to reprint the above summary of the technical changes final rule.

- **CMS Issues Final Rule on Part D E-Prescribing**

A final rule on Medicare E-Prescribing standards was published in the Federal Register on April 7, 2008.<sup>7</sup> While E-Prescribing is optional for pharmacists and physicians, CMS requires Part D plans to develop systems to support E-Prescribing. The new regulation sets standards for plans to follow as they develop systems for the electronic transmission of prescription information for drugs covered by Part D. The new regulation sets standards for sharing 4 types of information: formulary and benefits, medication history, fill status notification, and identification of individual health care providers. To view the final rule and learn more about E-Prescribing in the Medicare program visit [www.cms.hhs.gov/EPrescribing](http://www.cms.hhs.gov/EPrescribing).

- **CMS Issues New Batch of Proposed Regulations**

On Friday May 9, CMS issued a new set of Medicare Part D proposed regulations. The 50 pages of regulations cover plan marketing, Special Needs Plans, the Best Available Evidence policy and more. Advocates are currently busy reviewing the regulations and preparing comments. Comments on the proposed regulations are due by 5:00PM on July 15, 2008. NSCLC hope to have a final version of its comments available on its website by early July. To view the proposed regulations and get more information about filing comments, visit <http://www.cms.hhs.gov/HealthPlansGenInfo/>.

- **Advocates Submit Comments on Part D Appeals Regulations and Updates to the Enrollment Guidance**

In May advocates submitted comments on proposed Part D appeals regulations and a draft update to the Part D and Medicare Advantage Enrollment Guidance. The proposed Part D appeals regulations included simple changes in language as well as substantive changes to the appeals process. Advocate comments focused on the lack of a defined process for enrollment appeals, improving timeframes for deciding appeals, the participation of CMS, the Independent Review Entity (IRE) and/or the plan sponsor in an ALJ hearing, submitting evidence for an ALJ hearing and more. Of particular concern to advocates was a proposal affecting beneficiaries who want changes in their medical condition that occurred after an initial Part D exception request to be considered on appeal. Under the proposal, they could only have that new evidence considered if they agreed to a remand back to the plan first, an approach that could significantly delay access to independent decisionmakers. The comments were submitted on May 16, 2008.<sup>8</sup>

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<sup>8</sup> NSCLC's comments are available at: [www.nsclc.org/areas/medicare-part-d/area\\_folder.2006-09-28.5758698482/area\\_folder.2006-10-12.2022247391](http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391)

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CMS' draft updated Enrollment Guidance seeks to further clarify enrollment rules and procedures for both Part D and Medicare Advantage plans. Advocates provided a litany of recommendations for improving enrollment policies as well as notices provided to beneficiaries. Comments to the draft enrollment guidance were submitted on May 12, 2008.<sup>9</sup>

- **CMS Releases Updated Guidance, 2009 Call Letter**

In April, CMS released an updated Creditable Coverage and Late Enrollment Penalty Guidance.<sup>10</sup> This guidance updates the section of Chapters 4 and 18 of the Medicare Prescription Drug Program Manual that discuss policies and procedures related to creditable coverage and the LEP. The update guidance details plan requirements for confirming and reporting creditable coverage information and outlines appeal rights beneficiaries may exercise in order to challenge the imposition of a Late Enrollment Penalty.

On March 19<sup>th</sup>, CMS released the 2009 Call Letter. The Call Letter outlines requirements for plans interested in submitting bids to provide benefits in 2009. The 2009 Call Letter also contains, as an attachment, the standardized model combined Annual Notice of Change/Evidence of Coverage to be sent by plans to their members this Fall. For the first time, plans will be required to use the exact language in the model ANOC/EOC. The Call Letter can be viewed at [www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf).

## PART D RARELY COVERS COMPOUND DRUGS

In the last several months, Medicare beneficiaries have encountered payment denials for “extemporaneous” compounds, which are compound drugs specially mixed and prepared by pharmacists from bulk ingredients. These drugs are particularly important for individuals with extreme allergies who may be allergic to binders in commercially available prescription drugs.

CMS and plans are taking the position that such drugs do not meet the statutory definition of a “covered Part D drug,” which requires that a drug be approved for safety and effectiveness by the Food and Drug Administration (FDA). The problem is that FDA approves particular formulations of drugs, e.g., a 5 mg pill or a 10 mg capsule, and treats pharmacist-prepared compounds as unapproved “new drugs.” However, recognizing the value of such compounds for patients, FDA historically has not taken enforcement actions against pharmacies engaged in traditional pharmacy compounding.

Part D plans originally had not denied coverage for such drugs but in late 2007 and early 2008 began to do so with CMS concurrence. At least one advocate appeal at the ALJ level has been denied.

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<sup>9</sup> NSCLC's comments are available at: [www.nsclc.org/areas/medicare-part-d/area\\_folder.2006-09-28.5758698482/area\\_folder.2006-10-12.2022247391](http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391)

<sup>10</sup> Available at [www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/CreditableCoverageLEPGuidanceUpdate041108.pdf](http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/CreditableCoverageLEPGuidanceUpdate041108.pdf)

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It is possible for a component of a compounded drug to be covered under Part D if it is not a so-called “bulk powder” or “bulk chemical.” Practically though, this means that very few are covered. The kind of situation where a component might still be covered is if it involves an FDA-approved drug that is crushed into a suspension/solution because a beneficiary needs to take something as a liquid instead of a solid.

If a beneficiary is a dual eligible and cannot get a compound drug through Part D, advocates should also try to get coverage through Medicaid. (Thanks to Jackie Cheney at the Medicare Rights Center who researched the issue.)

## **ADDITIONAL RESOURCES FOR ADVOCATES**

### **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 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@nslc.org](mailto:kprindiville@nslc.org).

#### **2. Part D Advocates' Alert**

To receive this Alert, or to obtain alternative formatting, please contact Nancy Arevalo, [oakland@nslc.org](mailto:oakland@nslc.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.nslc.org/areas/medicare-part-d](http://www.nslc.org/areas/medicare-part-d).

#### **3. Other Reports and Information for Advocates**

- The Center on Budget and Policy Priorities released a report detailing the benefits achieved by adopting important changes to Medicare Savings Programs. The report, entitled “Improving Medicare Savings Programs Would Help Low Income Seniors Cope With Higher Medical Expenses,”<sup>11</sup> makes the case for including several improvements to the MSPs in the Medicare legislation currently being crafted in the Senate. The report finds that after subtracting medical expense from income, an additional 2.4 million seniors live below poverty (as measured by Federal Poverty Level). Relief could be provided to these and other seniors by making simple changes to the MSPs. Recommended changes include aligning the MSP income and asset eligibility limits with the Part D Low Income Subsidy limits, requiring the Social Security Administration to screen LIS enrollees for MSP eligibility and increasing federal outreach funding to State

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<sup>11</sup> Available at [www.cbpp.org/5-20-08health.htm](http://www.cbpp.org/5-20-08health.htm)

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Health Insurance Programs. These improvements could be paid for, the study finds, by decreasing overpayments to Medicare Advantage plans.

- The Elder Economic Security Standard Index for California has been released. The Elder Index is a new tool that quantifies – for the first time in California – how much it actually costs seniors in each county to make ends meet.<sup>12</sup> Released at a hearing of the California Senate Aging & Long Term Care Subcommittee on February 26, 2008, this is part of a national effort to ensure that all older adults have the opportunity to age with dignity and economic well-being. The Elder Index provides a new framework to discuss income adequacy for elders and to develop policies related to: Social Security, Medicare, Medicaid, and food, housing, and transportation programs for older adults. The California Elder Economic Security Initiative is a statewide coalition being led by the Insight Center for Community Economic Development.<sup>13</sup> A national Elder Index Security Initiative is being led by Wider Opportunities for Women (WOW).<sup>14</sup>
- A new report from the California HealthCare Foundation, “The Medicare Drug Benefit: Options for Low-Income Californians in 2008,”<sup>15</sup> finds that benchmark plans in California cover fewer drugs, on average, than non-benchmark plans. The variation in drug coverage is the result of significant differences in brand name drug coverage. In California, benchmark plans cover 29% fewer brand name drugs, on average, than non-benchmark plans. The study also found that there is significant variation in the coverage provided by benchmark plans. The number of drugs covered by benchmark plans in California ranges from 1,121 to 2,153.
- The Commonwealth Fund has released three new issue briefs on Medicare Part D.
  - “Medicare Part D: How Do Vulnerable Beneficiaries Fare?” reports the results of a Fall 2006 survey of attorneys, counselors, health care professionals and others who directly assist low income Part D beneficiaries.<sup>16</sup> The survey results revealed that, even 6 months after the Part D program was implemented, serious problems remained for vulnerable beneficiaries. Survey respondents identified problems with auto-enrollment, formularies and utilization management tools, exceptions and appeals, the Low Income Subsidy, switching plans and more. The report makes several recommendations including, reconsidering the random auto-assignment process, simplifying the LIS, improving communication with beneficiaries and more. The report was authored by Laura Summers, Patricia Nemore (of CMA) and Jeanne Finberg (formerly of NSCLC).

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<sup>12</sup> The county-by-county index is available at [www.healthpolicy.ucla.edu/elder\\_index08feb.html](http://www.healthpolicy.ucla.edu/elder_index08feb.html)

<sup>13</sup> For more information about the coalition and the EESI visit <http://www.insightcced.org/index.php/insight-communities/cfess/california-elder-economic-security-initiative>

<sup>14</sup> For more information visit [www.wowonline.org/ourprograms/eesi](http://www.wowonline.org/ourprograms/eesi)

<sup>15</sup> Available at [www.chcf.org/topics/view.cfm?itemID=133594](http://www.chcf.org/topics/view.cfm?itemID=133594)

<sup>16</sup> Available at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=683551](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=683551)

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- “Medicare Part D: State and Local Efforts to Assist Beneficiaries” explores the various efforts that states and local communities undertook to assist beneficiaries during and since the implementation of Medicare Part D.<sup>17</sup> The report examines the impact of local collaborations, efforts to reach out to culturally and linguistically diverse populations, steps taken by states to fill the gaps of Part D coverage and more. The report was co-authored by Laura Summers, Ellen O’Brien, Patricia Nemore (of CMA) and Katharine Hsiao (of NSCLC).
  - “Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries” describes the continued confusion faced by Part D beneficiaries choosing plans and makes a series of recommendations for standardizing plan offerings to decrease beneficiary confusion.<sup>18</sup>
  - A MedPAC report, “Experiences Obtaining Drugs Under Part D: Focus Groups with Beneficiaries, Physicians and Pharmacists,”<sup>19</sup> reveals that while beneficiaries, pharmacists and providers are generally satisfied with the drug coverage provided by Medicare Part D, concerns about the program (the coverage gap, access to accurate information from 1-800-MEDICARE, drug denials, confusing formularies, etc.) remain. Low income beneficiaries surveyed demonstrated a lack of awareness of the Low Income Subsidy and confusion with regard to auto-enrollment and reassignment. Many of the LIS recipients that participated in the survey were not aware that they could switch plans at any time.
  - A new Government Accountability Office report finds that there are likely millions of Medicare beneficiaries who are eligible for the Low Income Subsidy but have not applied.<sup>20</sup> In 2007, the Social Security Administration approved approximately 570,000 applications for the LIS, denied 403,000 applications and determined that an additional 281,000 applications did not need a determination. The report examines and provides data regarding the most common reasons for denials, namely, excess income and excess assets. The report also explores the challenges of identifying potentially eligible beneficiaries who have not yet applied and recommends that SSA continue to work with the Internal Revenue Service to identify these beneficiaries.
  - Two new reports from the Office of the Inspector General explore the Medicare Part D experience of nursing home residents. The first report, “Availability of Medicare Part D Drugs to Dual-Eligible Nursing Home Residents,”<sup>21</sup> finds that many long term care facilities are paying for Part D covered drugs for their residents. Facilities often pay for drugs when a beneficiary needs a drug that is not on the beneficiary’s Part D plan’s formulary or when the drug requires prior authorization. The second report, “Role of

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<sup>17</sup> Available at

[www.commonwealthfund.org/usr\\_doc/Summer\\_McarePartDstatelocalefforts\\_1126\\_ib.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Summer_McarePartDstatelocalefforts_1126_ib.pdf?section=4039)

<sup>18</sup> Available at [www.commonwealthfund.org/usr\\_doc/Hoadley\\_MedicarePartD\\_1118\\_ib.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Hoadley_MedicarePartD_1118_ib.pdf?section=4039)

<sup>19</sup> Available at [www.medpac.gov/documents/May08\\_PartDFocusGroup\\_CONTRACTOR\\_JS.pdf](http://www.medpac.gov/documents/May08_PartDFocusGroup_CONTRACTOR_JS.pdf)

<sup>20</sup> Available at [www.gao.gov/new.items/d08812t.pdf](http://www.gao.gov/new.items/d08812t.pdf)

<sup>21</sup> Available at [www.oig.hhs.gov/oei/reports/oei-02-06-00190.pdf](http://www.oig.hhs.gov/oei/reports/oei-02-06-00190.pdf)

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Nursing Homes and Long Term Care Pharmacies in Assisting Dual-Eligible Residents With Selecting Part D Plans,”<sup>22</sup> finds that the practices of some long term care providers “may not be in accordance with CMS guidance that does not allow nursing homes to request, require, coach, or steer residents to select plans.”

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

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<sup>22</sup> Available at [www.oig.hhs.gov/oei/reports/oei-02-06-00191.pdf](http://www.oig.hhs.gov/oei/reports/oei-02-06-00191.pdf)