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Low-Income Advocate Alert On Medicare Part D

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Annual Enrollment Period Update

The Medicare Part D Annual Enrollment Period is upon us once again. The enrollment period begins November 15, 2009 and lasts until December 31, 2009. New plan benefit packages take effect January 1, 2010. Plan marketing of 2010 plans began on October 1, 2009. It is important that all beneficiaries take the time this Fall to review changes to their plan for 2010. The plan that worked best in 2009, may not work the best in 2010.

Plan Offerings in 2010

On October 1, 2009 the Centers for Medicare and Medicaid Services released information about the plans that will be offered in 2010.[1] The information reveals that while there has been some winnowing of plan options, beneficiaries still have a dizzying array of plans from which to choose. According to the Kaiser Family Foundation, 1,510 Prescription Drug Plans (PDPs) will be offered nationally in 2010, down from a high of over 1,800 in 2007.[2] The number of PDPs available per region ranges from 39 in Alaska and Hawaii to 53 in Pennsylvania and West Virginia.[3] In addition, beneficiaries will have numerous Medicare Advantage Prescription Drug Plans to choose from depending on the county.

Plan premiums continue to rise, though at a slightly lower rate than in years past. The Kaiser Family Foundation reports that the average monthly PDP premium (weighted by 2009 enrollment) will rise by 11% from $35.09 2009 to $38.85 in 2010.[4] Average weighted premiums have risen by 50% since the program began in 2006.[5] While the rate of increase has slowed, the higher premiums will likely result in overall reductions of Social Security checks since the Social Security Administration has projected that there will be no cost-of-living increase for Social Security recipients next year. (See story below.)

"Benchmark" Plans, Low Income Subsidy Recipients and Reassignment

According to data provided by CMS, over **3.5 million** LIS recipients are enrolled in plans that will not be "benchmark" plans in 2010. Beneficiaries eligible for the full premium LIS can enroll in a benchmark plan and pay no premium. LIS beneficiaries enrolled in non-benchmark plans are liable for a premium equal to the difference between the plan's premium and the "benchmark" amount.

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[1] See PDP, MA and SNP Landscape Source Files, at www.cms.hhs.gov/PrescriptionDrugCovGenin/.
[2] See "Medicare Part D Spotlight: Part D Plan Availability in 2010 and Key Changes Since 2006," at www.kff.org/medicare/upload/7986.pdf.
[3] Id.
[4] Id.
[5] Id.

Of this 3.5 million, about 1.55 million are enrolled in plans that are benchmark plans in 2009, but will not be in 2010. Individuals who were automatically enrolled into one of these plans will be automatically reassigned by CMS to a new, benchmark plan effective January 1, 2010. Medicare's reassignment process does not consider the prescription drug needs of the beneficiary, which means the new plan may not cover their drugs. Reassigned beneficiaries will receive a notice informing them of the reassignment and are welcome to choose their own plan at anytime. Any affirmative decision made by the beneficiary will trump the planned reassignment. Approximately 1.1 million LIS recipients will be reassigned.[6]

The remaining 450,000 LIS recipients who are currently enrolled in plans that are benchmark plans in 2009, but will not be in 2010, will not be reassigned. CMS refers to these beneficiaries as "choosers" since they self-enrolled into plans. Choosers will receive a tan notice informing them that they face a premium liability in 2010 and providing information about benchmark plans available in their region. Choosers must change plans on their own to avoid paying premiums in 2010.

In addition to the 1.5 million beneficiaries at risk of facing a premium liability in 2010 described above, an additional 2 million LIS recipients are enrolled in PDPs that are not benchmark plans in 2009 and will not become benchmark plans in 2010. These individuals have owed premiums for all of 2009 and will face premiums again in 2010 if they do not switch plans on their own. CMS will, for the first time this year, provide the tan chooser notice described above to these individuals.

Analysis conducted by the Kaiser Family Foundation reveals that the number of benchmark plans available in each region continues to very widely; Maine and New Hampshire will have 3 plans, Arkansas will have 14.[7] The number of plans available between 2009 and 2010 will decrease in 19 of 34 regions and increase in just 10.[8] Plans lose benchmark status because they either: 1) are no longer offered; 2) are charging a premium above the low income benchmark amount; or 3) are switching from a standard plan to an enhanced plan. With fewer plans to choose from, it becomes less likely that LIS recipients will find plans they can afford that cover the medications they need. Advocates in states with a small number of benchmark plans report that they often have to enroll LIS recipients (including dual eligibles) into plans with premiums in order to ensure that all of their drugs were covered.

CMS has released detailed information about the impact changes to "benchmark" plans will have on beneficiaries in each region. Advocates can use the data provided to determine which plans will lose benchmark status in 2010, learn what will happen to LIS recipients in those plans and find out how many LIS recipients are in each plan.[9] An explanation of changes to benchmark plans in **California** is available at www.nsclc.org/areas/medicare-part-d/California-Benchmark-Changes-2010/at_download/attachment.

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[6] According to CMS, an additional 1 million LIS recipients would have needed to be reassigned had the agency not decided in August to adjust the formula for determining LIS benchmark amounts.
[7] See note 2.
[8] Id.
[9] Information about plans losing benchmark status and total numbers of reassignments is available at www.cms.hhs.gov/PrescriptionDrugCovGenin/. Data on LIS enrollment by plan is available at www.cms.hhs.gov/MCRAdvPartDEnrolData/. Scroll down to the "Downloads" under the chart.

Medicare Advantage Plan Terminations

A number of Medicare Advantage plans have made a business decision to not continue in 2010. Private Fee For Service (PFFS) plans and small plans with limited enrollment are among the most likely to be terminating their participation in the program. Non-LIS individuals enrolled in MA-PDs that are terminating will need to enroll in a PDP or new MA-PD by the end of December to ensure that they have drug coverage on January 1, 2010. LIS individuals who are disenrolled from terminating MA-PDs will be automatically enrolled by CMS into "benchmark" PDPs if they do not choose a new MA-PD or PDP for themselves. The reassignment numbers discussed above do not include these individuals.

Humana changes lowest cost plan

Humana's lowest cost plan this year is Humana Value, which is an enhanced plan. It replaces Humana Standard, which was a basic plan. Although the Humana Value premium in many regions is below the regional benchmark, LIS beneficiaries who want to join Humana Value will have to pay small premiums to cover the "enhanced" portion of the plan benefit. Current enrollees in Humana Standard are being "mapped" into Humana Value.

WellPoint suspension lifted

CMS has lifted WellPoint's marketing/enrollment suspension, which had been in effect since January of 2009. The plan was allowed to begin marketing again on October 1 and can accept enrollments with a January 1, 2010 effective date. In regions where WellPoint plans are below the LIS benchmark, WellPoint will not receive any reassignments, auto-assignments or facilitated assignments. CMS will be keeping a close eye on them and wants to hear about any problems that arise. As noted below, WellPoint also is no longer the Point-of-Sale contractor for Part D.

WellCare suspension continues

WellCare, which was suspended in March 2009, remains under suspension at this time. WellCare may keep its current enrollees but may not market its plans to new enrollees or accept any new enrollments. WellCare plans do not appear on the plan landscapes released by CMS. However, they will appear on the Medicare.gov plan finder with the notation that they are not available for new enrollments.

LI NET: New CMS System Will Handle Auto-Enrollments and Point of Sale Facilitated Enrollments

Expect to hear more from CMS in the coming months about the Limited Income Newly Eligible Transition (LI NET) program. This new system combines the Auto-Enrollment and the Point of Service (POS) Facilitated Enrollment processes. Below is a summary of what we know about LI NET so far.

Auto-Enrollment and Retroactive Coverage (Full Benefit Dual Eligibles and SSI-only Recipients)

Under the current system, when CMS learns about a full benefit dual eligible (FBDE) or Supplemental Security Income (SSI) recipient who is not enrolled in a Part D plan, CMS automatically enrolls the individual into a plan. The enrollment is random among the "benchmark" plans offered in the region. The effective date of the enrollment is the first day that the individual was a full dual or the first day of the last uncovered month, whichever is later. The effective date is frequently retroactive. The "benchmark" plan is responsible for Part D covered costs incurred during the retroactive period and going forward.

> Ms. Garcia is eligible for Medicare, but not enrolled in a Part D plan. In June 2009, her state notifies CMS that they have found her eligible for Medicaid retroactive to March 2009. CMS enrolls her into Benchmark Plan X (one of five benchmark plans offered in her state) effective March 1, 2009 and going forward. Ms. Garcia can seek retroactive reimbursement from Plan X for Part D covered costs incurred since March 1, 2009.

When the LI NET program begins on January 1, 2010, this process will change. Instead of enrolling the individual into a "benchmark" plan to cover current and retroactive periods, CMS will automatically enroll the individual into the LI NET plan. The effective date of the enrollment will, as before, be the first day the individual was eligible for both Medicare and Medicaid or the first day of the last uncovered month, whichever is later. The LI NET plan is responsible for Part D covered costs incurred during any retroactive period and the current period. CMS will then prospectively enroll the individual into one of the "benchmark" plans offered in the region. The prospective enrollment will take place on the first day of the month after the month that follows the LI NET enrollment. Until the prospective enrollment takes effect, the individual will remain enrolled in the LI NET plan (unless they affirmatively choose another plan).

> Ms. Garcia is eligible for Medicare, but not enrolled in a Part D plan. In June 2010, her state notifies CMS that they have found her eligible for Medicaid retroactive to March 2010. CMS immediately enrolls her into LI NET effective March 1, 2009. Ms. Garcia can seek retroactive reimbursement from LI NET for

> Part D covered costs incurred since March 1, 2010. Ms. Garcia remains enrolled in LI NET in June and July 2010. CMS prospectively enrolls Ms. Garcia into Benchmark Plan Y (one of five benchmark plans offered in her state) effective August 1, 2009.

Reimbursements will be based on claims information in CMS systems or submitted by the beneficiary (or the beneficiary's advocate), a pharmacist or an entity that paid for Mr. Smith's drugs. CMS hopes that having one plan – LI NET – to handle all retroactive claims will make the system more efficient and easier for beneficiaries to use.

The LI NET auto-enrollment process described above will only be used for full benefit dual eligibles and SSI-only beneficiaries. The facilitated enrollment process used for all other LIS recipients will remain unchanged.

Point of Sale (POS) Facilitated Enrollments

The POS system has been in place since the beginning of Part D. The POS is meant to function as a safety net for Low Income Subsidy recipients who present at the pharmacy without a Part D plan. The POS is often referred to as WellPoint, because that company has had the contract for the system since Part D began.

Under the current system, when a claim is successfully submitted using the POS, the POS contractor pays the claim. The individual for whom the claim is paid is then automatically enrolled into one of the "benchmark" plans offered in the region.

Effective January 1, 2010, the POS system will be integrated into the LI NET program. When a claim is successfully submitted at the point of sale, the individual will be automatically and immediately enrolled in the LI NET plan. The LI NET plan will provide retroactive coverage of varying length depending on whether the individual is a full dual eligible (up to 36 months retroactive coverage), a partial dual eligible (up to 30 days) or an LIS recipient only (up to 30 days). If the LIS status of the individual has not yet been confirmed, the LI NET plan will provide up to seven days of retroactive coverage.

In addition to paying immediate and retroactive claims, the LI NET plan will provide ongoing coverage for a temporary period of time. As with the auto-enrollment process described above, CMS will prospectively enroll individuals into one of the "benchmark" plans offered in the region as of the first day of the month after the month that follows the POS-triggered LI NET enrollment.

CMS has assured advocates that the process for filing a point of service claim under LI NET will be substantially similar to the four step process currently used by pharmacists. All LIS recipients, not just full-benefit dual eligibles, are eligible for the POS Facilitated Enrollment function of the LI NET program.

Reimbursement Requests

In addition to the functions described above, LI NET will be required to process reimbursement requests from LIS recipients who paid out-of-pocket for Part D covered drugs while LIS eligible and not enrolled in a Part D plan. LI NET will have no timely filing deadlines.

The LI NET Plan Benefit Package

The same LI NET plan is used for auto-enrollments, POS Facilitated Enrollments and reimbursement requests. The LINET plan will have an open formulary with no prior authorization restrictions and no network restrictions and will charge no premium or deductible. Individuals enrolled in LI NET will be responsible for the relevant LIS co-pay amounts.

Contractor

The LI NET program will be administered by Humana. Since the LI NET program encompasses the POS system, as of January 1, 2010, WellPoint will no longer be the contractor for the Point of Sale (POS) system.

More Information

So far, CMS has released only limited information about the LI NET program. The information is currently available at www.shiptalk.org.[10]

MIPPA Changes Kick In

Several changes in Medicare take place as of January 1, 2010 as a result of MIPPA, the Medicare Improvement for Patients and Providers Act of 2008. They include:

- Asset limits for MSP (QMB, SLMB and QI) will be the same as those for the Low Income Subsidy, $6,000 for individuals and $9,000 for couples, indexed for inflation. The indexed amount for 2010 has not yet been announced.

- Data Exchange: Starting January 1, SSA is required to pass information from LIS applicants to states so the states can screen LIS applicants for MSP. The date of the LIS application is the protected date for the MSP application. States are required to process applications within 45 days of receipt of the information from SSA. There has been testing of data transfer systems from federal to state programs but many details of the requirements for the states have not been

[10] See the LI NET Program Announcement at www.shiptalk.org/shiptalk/shiptalkinfolib/MiscDocs/LINET%20Announcement.pdf and “The LI NET Program” PowerPoint at www.shiptalk.org/shiptalk/shiptalkinfolib/MiscDocs/LINET%20PPT%20for%20SHIPs.ppt.

finalized and many states have not fully established their own protocols. Advocates need to be aware of the process and issues that are arising in your state.

- LIS Resources: In-kind support and the cash surrender value of a life insurance policy will no longer be counted as assets for LIS applicants.

- SNPs: Special Needs Plans may no longer enroll anyone who does not meet the statutory definition of the special needs individual for its SNP category. SNPs for dual eligibles (D-SNPs) that do not have agreements with their states to provide or arrange for Medicaid benefits for dual eligible members may operate but may not expand their service area.

CBO Projects No Cost-of-Living Increase in 2010 and Beyond

The Congressional Budget Office projects that there will be no COLAs in 2010, 2011 or 2012. However, Part B and Part D premiums are projected to increase in those years.

To prevent beneficiaries from seeing an absolute drop in their monthly Social Security check when Part B premium increases exceed COLAs, the Social Security Act includes a hold harmless clause. The clause reduces Part B premiums for individuals to a level that will ensure that their monthly social security checks do not dip below prior year levels. Excluded from the hold harmless provisions are high income individuals, persons whose Part B premiums are paid by Medicaid, and individuals who are receiving Social Security benefits for the first time.

For 2010, this means that virtually all middle class Part B enrollees will be exempt from Part B premium increases. However, because Medicaid programs are excluded from the hold harmless provisions, they will be required to pay the entire Part B premium increase for covered beneficiaries. Moreover, because middle income beneficiaries will not be paying the Part B increase, CMS will need to increase premiums even further for those groups excluded from the hold harmless provisions so that the agency can make up the gap in Part B funding. Some of that increase would fall on high income individuals, who make up only two percent of Part B enrollees, but most would fall on Medicaid programs, which cover 17-18 percent of Part B enrollees. New enrollees would also feel the impact.

This dynamic puts increased stress on state Medicaid budgets, which already face significant budget pressure. Advocates are concerned that, unless Congress addresses the problem, it will be another incentive for states to trim Medicaid services.

Monitoring of Situ Class Action Settlement Continues

Last October a federal judge approved a settlement agreement in the Medicare Part D class action lawsuit *Situ v. Leavitt*. Under the agreement, the Centers for Medicare and Medicaid Services (CMS) agreed to make significant changes to its administration of the prescription drug benefit for dual eligibles – including allowing states to submit files identifying dual eligibles more frequently, processing information from states upon receipt and strengthening the Best Available Evidence (BAE) policy.

Since the settlement was approved, lawyers from the National Senior Citizens Law Center and the Center for Medicare Advocacy have been meeting quarterly with CMS to monitor the implementation. According to information provided by CMS, implementation is well under way with nearly half of all states submitting files more than once a month. CMS is processing all files received within a day of receipt and actively investigating complaints of plans that fail to comply with BAE requirements.

These meetings provide a venue to share ongoing enrollment (including POS problems) and subsidy deeming (including BAE problems) issues with CMS. Please contact Kevin Prindiville kprindiville@nsclc.org or Anna Rich arich@nsclc.org to share stories of the problems dual eligibles continue to experience.

Ninth Circuit to Review Issue of Medicare Preemption

In *Uhm v. Humana*, the Ninth Circuit Court of Appeals is considering whether enrollees in Medicare plans can sue their plans for violation of state law. NSCLC, the Center for Medicare Advocacy, California Health Advocates and the Medicare Rights Center filed an amicus brief in the case, arguing that the Medicare statute does not preempt either common law claims or generally applicable state statutes.[11] The issue of Medicare preemption has implications for cases in which private Medicare plans violate state consumer protection (e.g. with regard to marketing) or personal injury laws. The case arose from claims by Medicare beneficiaries against their Part D insurer based on state law claims under consumer protection statutes and state common law. The District Court and the Ninth Circuit had dismissed the claims based on Federal preemption but the Ninth Circuit then agreed to a rehearing.

At NSCLC, the bulk of the work on the brief was done by our **Federal Rights Project** team. If you are interested in court access issues please consider joining our **Federal Rights Listserv**. The listserv provides recent case developments, strategy articles, and a

[11] The amicus brief is available at www.nsclc.org/areas/federal-rights/uhm-et-al-v-humana-inc-amicus-brief/at_download/attachment.

forum for discussion of issues affecting access to federal court to enforce rights under federal law, including rights under civil rights and public benefits statutes. We particularly emphasize federalism and access to justice developments. We also provide updates on political developments involving the courts, especially judicial nominations. To join, send an email to rbobroff@nsclc.org.

AGENCY NEWS

CMS Issues Proposed Regulations to Improve the Part D and Medicare Advantage Programs

On October 9, 2009, CMS issued proposed regulations relating to Medicare Parts C and D. The proposed regulations are voluminous and cover a wide range of topics including increasing CMS ability to identify strong and weak plans during the plan application process, strengthening beneficiary protections, ensuring plan offerings with meaningful differences, improving plan payment rules and processes, improving data collection for oversight and quality assessment of plans and more.

The proposed regulations will be published in the Federal Register on October 22, 2009. Until then, the regulations can be viewed at www.federalregister.gov/inspection.aspx. Comments on the proposal must be submitted by December 8, 2009.

ANNOUNCEMENTS

Important Information for Advocates Working with Social Security and Supplemental Security Income Recipients

In September a federal judge granted **final approval** of a settlement agreement which will end the Social Security Administration's policy of concluding that someone is "fleeing to avoid prosecution" and then denying or suspending benefits based on the mere existence of an outstanding arrest warrant.

Your clients stand to benefit immensely from this settlement. **Approximately 80,000 beneficiaries are eligible for over $500 million in withheld benefits.**

ACTION: Help us spread the word and be sure to maintain contact information of any potential class members. If you are interested in receiving more information and regular updates about the settlement's implementation, join the National Senior Citizens Law Center's "**Martinez Settlement Listserv**" by emailing Oakland@nsclc.org.

Settlement Details and Background

Under the agreement, SSA has stopped, as of April 1, 2009, suspending or denying benefits due to the mere existence of a warrant – unless the warrant is issued in a criminal proceeding on a charge such as flight or escape. In addition, retroactive benefits will be paid to individuals who had benefits suspended or denied on or after January 1, 2007, or an administrative appeal decision after January 1, 2007 as well as those who had a live administrative claim on August 11, 2008, and who continue to be otherwise eligible. This group includes those who requested reconsideration of a suspension prior to 2007 and never received a response. All told, approximately 80,000 people in this group stand to receive over $500 million. People in this group will not be required to file a new application or to have a continuing disability review prior to reinstatement.

The settlement also ensures that people whose benefits were suspended or denied between 2000 and 2006 will be notified and given a chance to re-establish eligibility with a protective filing date of April 1, 2009 if they contact SSA within 6 months of receiving the notice. Any overpayments currently being collected from this group will be forgiven. **All told more than 200,000 people stand to benefit from the settlement agreement.**

The settlement resolves a lawsuit, *Martinez v. Astrue,* challenging the enforcement of a narrowly drawn provision of the Social Security Act, which seeks to prevent people from using government benefits to flee from arrest. Rather than trying to figure out who was actually fleeing prosecution, SSA implemented a computer dragnet that matched names in a warrant database to those at SSA. Many of the matches and automatic benefit suspensions involved false or unproven allegations, minor infractions or long-dormant arrest warrants. Individuals losing benefits were routinely, inaccurately informed by SSA staff that they could not appeal decisions.

Many elderly and disabled Americans rely on their retirement or disability benefits as their sole source of income. Individuals who lost benefits under this policy were left without this crucial support resulting in massive debt, homelessness, illness or worse.

The case and subsequent settlement do not pertain to individuals whose benefits were denied or suspended because of an alleged parole or probation violation.

The plaintiffs in the case are represented by the National Senior Citizens Law Center, pro bono counsel from the law firm of Munger, Tolles & Olson, the Mental Health Project of the Urban Justice Center, Disability Rights California, and the Legal Aid Society of San Mateo County.

The agreement will not take full effect until the appeal time has run –November 30, 2009. Class members should make sure that SSA has their current address to ensure that they receive SSA notices. Delivery of relief to class members will occur in phases throughout 2010 and beyond. Join the “Martinez Settlement Listserv” for more details about the

implementation. For more information about the policy, the case and the settlement agreement, visit: www.nsclc.org/areas/social-security-ssi/Martinez-Settlement.

Your Stories Are Needed

In order to help to get changes at the state and federal levels, we need to hear about the problems your low income clients are facing. We know that your time as advocates is already stretched thin, but any time you can take to report client stories would be extremely helpful. Do you have questions about Medicare Part D? Topics you'd like to see covered in future National Alerts? Tips or experiences with Medicare Part D that you'd like to share with advocates in other states? Please send all questions, comments and feedback to the National Senior Citizens Law Center attorneys, listed below.

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