



**CALIFORNIA HEALTH ADVOCATES**  
Medicare: Policy, Advocacy and Education



# 2011 Part D and MA Updates

**CDA HICAP Webinar**

**October 14, 2010**

*Presented by*

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# Our Focus

***California Health Advocates***  
***provides quality Medicare and related healthcare coverage***  
***information, education and policy advocacy.***

**[www.cahealthadvocates.org](http://www.cahealthadvocates.org)**

- **Policy** – Conduct public policy research to support recommendations for improving rights and protections for Medicare beneficiaries and their families
- **Training** – Provide timely and high-quality information on Medicare through our website, fact sheets, policy briefs and educational workshops
- **Advocacy** – Bring the experiences of Medicare beneficiaries to the public, and especially legislators and their staff at federal and state levels, through media and educational campaigns



# Outline

- I. Changes that affect Medicare Advantage (Part C)
- II. Changes that affect Medicare Part D
- III. Changes that affect both Medicare Advantage (Part C) and Part D
- IV. Marketing
- V. LIS Update



# MA (Part C) Changes

- Preventive Services
- Maximum Out-of-Pocket
- PFFS plans must contract
- MA Disenrollment Period and coordinating Part D SEP



# Expanded Preventive Services

- No out-of-pocket cost sharing for most Medicare-covered preventive and screening services
- Cost-sharing continues for
  - Digital rectal exam (part of prostate cancer screening)
  - Glaucoma screening
  - Diabetes self-management training services
  - Barium enema (part of colorectal cancer screening)



# Annual Wellness Visit

- Every 12 months, starting 12 months after the “Welcome to Medicare” Exam
- No cost-sharing for this visit or “Welcome to Medicare” Exam in Original Medicare
- Measure height, weight, BMI, blood pressure and other routine measurements
- Establish or update
  - Individual’s medical and family history
  - List of beneficiary’s providers
  - List of medications
- Detect cognitive impairment



## Medicare Advantage – MOOP

- MOOP – Maximum out-of-pocket
- All local MA plans must establish a mandatory MOOP liability amount inclusive of all Medicare Parts A and B services
  - MOOP = \$6,700 in 2011
  - Voluntary MOOP = \$3,400 if plans choose to adopt, can have more flexibility in establishing cost-sharing amounts



## MA plan cost-sharing

- Cannot be more than that in Original Medicare for
  - Chemotherapy
  - Renal dialysis
  - Skilled nursing care
- Charge allowed for services that have no cost-sharing in Original Medicare if non-discriminatory



# Miscellaneous

- Some PFFS must contract with providers if in area that has at least 2 coordinated care plans.
- Payments to MAOs
  - Freeze in 2011, same rate as 2011
  - Payments will be reduced starting 2012



## Medicare Advantage Disenrollment Period

- **MADP “replaces” the MA OEP**
  - January 1 – February 14 (45 days)
  - Only allows beneficiary to disenroll from a MA plan, **CANNOT** enroll in a MA plan
  - Can join stand-alone Part D plan whether disenrolled from MA-PD or MA-only



# Coordinating Part D SEP

- Two ways to disenroll from MA-PD:
  - Enroll in stand-alone Part D plan will automatically disenroll beneficiary from MA-PD
  - Disenroll from MA-PD first then enroll in stand-alone Part D plan separately
- One way to disenroll from MA-only:
  - Request disenrollment from MA-only, then enroll in a stand-alone Part D plan



# Coordinating Part D SEP

- Changes made during MADP are effective the first of the following month
- One chance only to enroll in a stand-alone Part D plan
- SEP ends when beneficiary enrolls in stand-alone Part D plan or Feb 14, whichever is earlier



# Medicare Part D Changes

- Shrinking Coverage Gap
- Part D IRMAA



# Medicare Part D Costs 2011

(standard plan)

Total out-of-pocket (TrOOP) = **\$4,550** (\$310 + \$632.50 + \$3,607.50)  
before reaching catastrophic coverage

	Drug costs	Beneficiary pays (TrOOP)	Plan pays
Before meeting deductible	0-\$310	100% = \$310	0%
Initial coverage	>\$310-\$2,840	25% = \$632.50	75%
Coverage gap (doughnut hole)	>\$2,840-\$6,447.50	100% = \$3,607.50 minus discounts	0%
Catastrophic coverage	>\$6,447.50	Greater of 5% or \$2.50/\$6.30	95%



## Part D Coverage Gap – Shrinking 2011 Discounts

- Starting 2011, coverage gap decreases each year until 2020 when enrollee pays 25% coinsurance
- When: Effective Jan 1, 2011
- Who: Beneficiaries who fall into coverage gap in a Medicare prescription drug plan BUT NOT
  - LIS-eligible beneficiaries
  - Those in a retiree drug subsidy program



## Part D Coverage Gap – Shrinking 2011 Discounts

- What: Discount and subsidy apply to Part D-covered drugs in plan's formulary or granted an exception by the plan
  - Brand name drugs – 50% discount
    - Drug manufacturers who signed agreement
  - Generic drugs – 7% discount
    - Subsidy from government
- Where: Point-of-Sale (e.g. at the pharmacy)



## Brand name vs. “generic”

- Not all Part D covered drugs are “applicable drugs” for the coverage gap discount program – only brand name drugs whose manufacturer has signed an agreement.
- If not an “applicable drug,” the “generic” coverage gap cost-sharing applies
  - E.g. Medical supplies for delivery of insulin



## Part D Coverage Gap – Shrinking 2011 Discounts

- How: Brand name drug example
- Beneficiary exceeds Initial Coverage Limit in her plan.
- Price of brand name drug = \$60
- Dispensing fee = \$2
- Discount applies to price of brand name drug, but not dispensing fee.
- After discount, beneficiary pays \$32.
- Price of drug is counted toward TrOOP, \$60 or \$62.



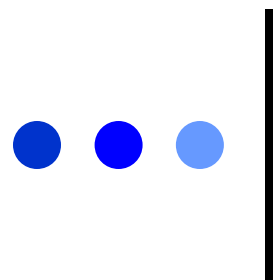
## Part D Coverage Gap – Shrinking 2011 Discounts

- How: Generic drug example
- Beneficiary exceeds Initial Coverage Limit in her plan.
- Price of generic drug = \$20
- Dispensing fee = \$2
- 7% subsidy applies to price of generic drug AND dispensing fee.
- After subsidy, beneficiary pays \$20.46.
- What beneficiary pays is counted toward TrOOP, \$20.46.



## Part D Coverage Gap – Shrinking 2011 Discounts

- How: Straddling example
- A portion of the price of the drug is in the gap.
- Price of drug = \$100, \$50 is in the gap
- Discount applies to amount in the gap.
- After discount, beneficiary pays \$25 in the gap.
- Price of drug is counted toward TrOOP.



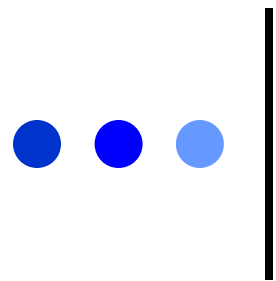
## Higher Part D Premiums for Higher Income Individuals - 2011

- Reduction in Part D premium subsidies – those with higher income pay higher Part D premiums, effective January 1, 2011
- Based on income reported to the IRS
- IRMAA-related premium deducted from SS check or billed separately from premium paid to plan



# Higher Part D Premiums for Higher Income Individuals - 2011

Individual income bracket	Percentage	Of national base premium \$32.34
≤\$85,000	No increase	n/a
>\$85,000 but ≤\$107,000	35%	\$11.32
>\$107,000 but ≤\$160,000	50%	\$16.17
>\$160,000 but ≤\$214,000	65%	\$21.02
>\$214,000	80%	\$25.87



## Part D – Other Changes

- Starting in 2011, payments made by AIDS Drug Assistance Program (ADAP) and Indian Health Services (IHS) will count toward TrOOP



# Parts C and D Changes

- Non-renewing plans
  - Notice – plan must send 90 days before date of non-renewal; inform members of all other options
  - Calls to members – e.g. SHIP info
  - SEP = Oct 1 to Jan 31
    - Change made during SEP before Dec 31 effective Jan 1
    - Change made during SEP before Jan 31 effective Feb 1



# Parts C and D Changes

- Annual Coordinated Election Period
  - New dates starting 2011 for 2012 plan year: **October 15 – December 7**



# Marketing - Enrollment kit

- Cover letter with plan's customer service info and Medicare's number
- Any network requirements
- Summary of Benefits – specifics on plan's coverage and cost
- Eligibility requirements
- Appeal rights and instructions
- Costs can change in subsequent years
- Info about LIS and how to apply
- Plan ratings info



## Marketing no-no's

- Cold calls – agent CANNOT ask beneficiary to introduce neighbor
- Beneficiary's signature – CANNOT obtain under pretext
- Mailings must NOT look like they are from a government source; must include plan name and logo.



## Marketing – some requirements

- Alternate formats – all explanatory marketing materials must include statement that materials are available in alternate formats and how to get them
- Sales/marketing events – invitation to events must include 2 statements:
  - A sales person or licensed authorized representative will be present with information and applications.
  - “For accommodation of persons with special needs at sales meetings call <insert phone and TTY number>.”



## Marketing – some requirements

- Mailings must include plan name and logo.
- Nominal gifts – if offered, must include statement that there is no obligation
- LIS info – any materials that mention Part D benefit must include LIS info
- PPO – non-network versus full/partial network plans
- Social networking websites – marketing allowed but subject to CMS monitoring



# LIS Changes

- Deductible and Cost-sharing
- Reassignment
- *De minimis* Policy
- Extension of Eligibility
- Redeeming
- Redetermination



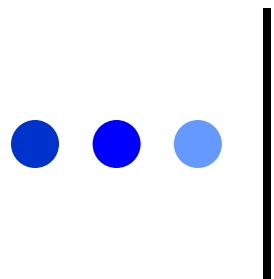
# Low Income Subsidy

- Income limits for eligibility based on FPL not yet released for 2011; expected Jan 2011
- Resource limits may be the same as for 2010
- CA benchmark amount/LIS = \$32.35
- National average premium = \$32.34 (for LEP calculation)



# Full Limited Income Subsidy (2011)

		<b>Income &lt;100% FPL Assets meet state requirements</b>	<b>Income &lt;135% FPL Assets ≤ \$6,600 (individual)</b>
<b>Premium</b>		\$0 in benchmark plan	\$0 in benchmark plan
<b>Deductible</b>		\$0	\$0
<b>Cost-sharing</b>	TrOOP ≤ \$4,550	≤\$1.10 generic ≤\$3.30 brand name	≤\$2.50 generic ≤\$6.30 brand name
	TrOOP > \$4,550	\$0	\$0



# Partial Limited Income Subsidy (2011)

		<b>Income &lt;135% FPL Assets &lt; \$11,010 (individual)</b>	<b>Income &lt;150% FPL Assets &lt; \$11,010 (individual)</b>
<b>Premium</b>		\$0 in benchmark plan	Discounted
<b>Deductible</b>		≤\$63	≤\$63
<b>Cost-sharing</b>	TrOOP ≤ \$4,550	15% or lower copayment	15% or lower copayment
	TrOOP > \$4,550	\$2.50 generic \$6.30 brand name	\$2.50 generic \$6.30 brand name



# Reassignment

- Fewer LIS beneficiaries are reassigned for 2011 plan year
  - Methodology to calculate Part D benchmark changed (don't include MA-PD rebates)
  - Part D sponsors may adopt a voluntary *de minimis* policy
    - *De minimis* amount in 2011 is \$2



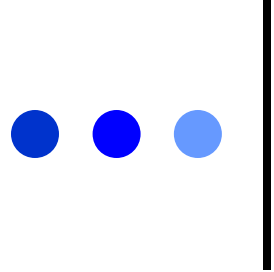
# Who is Reassigned?

- Full LIS beneficiaries
  - In a PDP that is terminating
  - Auto-enrolled in a PDP that is no longer a benchmark plan and sponsor does NOT choose to waive *de minimis* amount
  - In a MA plan that is terminating
- Reassigned to a different PDP



# Notices to reassigned beneficiaries

- Blue letter from CMS (2 versions)
  - Reason for reassignment
  - Formulary differences btw. old and new plans with respect to beneficiary's medication needs
  - Beneficiary's right to request an exception, to request a coverage determination and appeals rights
  - Beneficiary's options
  - List of benchmark plans
  - Sent within 30 days of reassignment



# Notices to reassigned beneficiaries

- From “losing” plan
  - If terminating, terminating notice must be send 90 days before the effective date of non-renewal or
  - ANOC if no longer benchmark plan



## “Choosers”

- Full LIS beneficiary not reassigned if
  - Beneficiary chose PDP whose premium will increase above benchmark
  - Tan notice
    - Fall – notice informs them of premium obligation if they don’t join a benchmark plan
    - Spring (started 2010) – notice reminds them that benchmark plans with \$0 premium are available



## Eligibility period

- For LIS-eligible widows and widowers
  - If spouse dies during the year, LIS eligibility would extend for one year beyond the date when eligibility would otherwise end



# Redeeming

- If not on state Medicaid files in Jul and Aug, beneficiary currently eligible for LIS may receive grey letter + LIS application.
  - Grey letter informs beneficiary no longer eligible for LIS after Dec 31, 2010.
- If on state Medicaid files btw. Sep and Dec, beneficiary may receive purple letter that LIS will continue in 2011.



# Redetermination

- Initial – those found eligible between May 2009 and April 2010
- Cyclical – those found eligible before April 2009
- Everyone is screened but a select group gets redetermination packet



# Optional grace period

- Part D sponsor may extend 3-month grace period.
- Beneficiary will lose LIS and has submitted LIS application to re-qualify.
- Sponsor must ask beneficiary if he/she wants grace period.
- Sponsor must alert beneficiary that if beneficiary does not re-qualify, beneficiary will be liable for premiums retroactively.



# California Health Advocates

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