



CMA Weekly Alert – August 9, 2007

WHY THE CHAMP ACT IS GOOD MEDICINE FOR MEDICARE BENEFICIARIES

On Thursday, August 1, 2007, the House of Representatives passed H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007. Contrary to statements by health insurance plans and other providers, CHAMP protects Medicare by reducing costly overpayments that threaten the integrity of the entire Medicare program. Also contrary to statements by providers, CHAMP expands, not reduces, Medicare benefits and coverage, particularly for individuals with low incomes. Indeed, CHAMP includes the most comprehensive and extensive improvement in protections for individuals with low-incomes in almost twenty years.

The Center for Medicare Advocacy is publishing a series of *Weekly Alerts* that describe relevant provisions of the comprehensive CHAMP legislation. This week's *Alert* describes provisions that make substantial improvements in programs that help low-income Medicare beneficiaries with Medicare's cost-sharing, provide assistance to beneficiaries with limited English proficiency, and provide assistance to rural beneficiaries. As we have reported in the past, the majority of these individuals are **not** in private health insurance plans. They would receive more assistance from the provisions in CHAMP directed towards them than they would receive through the continued overpayment of private insurance companies that offer Medicare Advantage plans. For more information on Medicare Advantage plans, see the *CMA Weekly Alert* of July 12, 2007 at http://www.medicareadvocacy.org/MA_07_07.12.MAHype.htm.

Protections for Low-Income Beneficiaries

Many provisions of CHAMP expand eligibility to include those with modest savings, stabilize the Qualified Individual (QI) program, and ease access to enrollment in both Medicare Savings Programs and the Part D Low-Income Subsidy. These enhancements for Medicare beneficiaries include:

§211. Improving assets tests for Medicare Savings Program and Low-Income Subsidy Program. This provision increases the amount of resources allowed when qualifying for assistance with Medicare cost-sharing (premiums and co-payments) to \$17,000 for an individual and \$34,000 for a couple. Starting in 2010, the limit is increased annually by the Consumer Price Index.

§212. Making QI program permanent and expanding eligibility. This provision makes permanent the Qualified Individual program that provides assistance with premiums for certain low-income beneficiaries, and raises the QI income level to 150% of the federal poverty level. QI, first authorized in 1997, is set to expire on September 30, 2007.

§213. Eliminating barriers to enrollment. This provision ensures that administrative barriers do not prevent low-income Medicare beneficiaries from receiving assistance under the Part D low-income subsidy (LIS), which reduces Part D premiums and co-payments and covers the coverage gap, or "donut hole," for individuals below 150% of the poverty line.

§214. Eliminating application of Medicaid estate recovery to Medicare Savings Programs benefits. This provision eliminates states' option to recover benefits paid to assist with Medicare cost-sharing from estates of deceased beneficiaries. Estate recovery has been found to be a barrier to application for Medicare Savings Programs.

§215. Eliminating Part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals. This provision ensures that dual eligible beneficiaries receiving care through a home and community-based care waiver are treated the same, with respect to cost-sharing under Part D, as beneficiaries who are in nursing homes. This ensures the lowest income Medicare beneficiaries can choose to receive care in the least restrictive community setting without penalty.

§216. Exempting certain income and resources from determination of eligibility for Part D Low-income Subsidy. This provision exempts in-kind support and maintenance, life insurance, and balances on retirement accounts from being counted in determining eligibility for the subsidy.

§217. Capping out-of-pocket spending under Part D to 5 percent of income annually for the lowest income Medicare beneficiaries. This provision ensures that the poorest Medicare beneficiaries are not rendered financially devastated by cost-sharing for their Part D drugs.

§218. Assigning low-income beneficiaries to Part D plans that best meet their needs. This provision promotes the well-being of poor Medicare beneficiaries by having them assigned to plans most likely to cover their drugs and to have pharmacies that are accessible to them.

§226. Eliminating the late enrollment penalty for Part D for recipients of the low-income subsidy. This provision makes permanent the administrative action by CMS that waived the late penalty for LIS recipients for 2006 and 2007.

§227. Making permanent a special enrollment period for beneficiaries receiving the low-income subsidy. This provision allows Medicare beneficiaries who qualify for the low income subsidy to enroll in a Part D plan or Medicare Advantage plan with drug coverage any time during the year, without waiting for the annual election period (November 15 through December 31).

Assistance for Minority Beneficiaries and Non-English Speaking Beneficiaries

These provisions move in the direction of eliminating disparities in health care by collecting data and by providing additional access for non-English speaking beneficiaries.

§231. Medicare data on race, ethnicity, and primary language. This provision directs the Secretary of Health and Human Services to collect data on race, ethnicity, and primary language of Medicare beneficiaries, including - where practicable - populations not normally counted in other federal data. The Secretary will protect the data, raise awareness to the public about reporting, and analyze the data using new measures to better capture racial and other disparities.

§232. Ensuring effective communication in Medicare. This provision directs the Secretary to consider and issue a report as to how Medicare could implement a language interpretation service and corresponding payment system, using the results of the demonstration project outlined in §233.

§233. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services. This provision outlines a three-year demonstration project for providers of Medicare Parts A, B, C, & D to engage in providing translation services to beneficiaries with Limited English Proficiency (LEP). The 24 grantees should be from a variety of providers, including those from rural and urban areas and those from areas with beneficiaries who speak different languages.

§234. Demonstration to improve care to previously uninsured. This provision directs the Secretary to conduct a two-year demonstration project aimed at Medicare beneficiaries who were previously uninsured. The project will be conducted in at least 10 sites to evaluate potential improvements to beneficiary access to care, utilization of services, and cost-effectiveness.

§235. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare. This provision directs the Office of the Inspector General in the Department of Health and Human Services to conduct and issue a report on provider and plan compliance with national standards on culturally and linguistically appropriate services. It also directs the Secretary to implement changes to address any deficiencies cited in the report.

§236. IOM report on impact of language access services. This provision directs the Secretary to commission an Institute of Medicine (IOM) study on the impact of language access services on the health care of beneficiaries with LEP.

Protecting Beneficiaries in Rural Communities

In Title VI, Subtitle B the CHAMP Act extends various provisions enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which relate to rural access for Medicare beneficiaries. These provisions include a two-year extension of a provision which established a minimum payment for all physicians in rural counties and a two-year extension for incentive payments to physicians operating in physician scarcity areas. There are also provisions for a two-year extension of reasonable costs payments for certain laboratory tests furnished to hospital patients in rural areas, a two-year extension for increased payments for ground ambulance services in rural areas, and a one-year extension for a hold harmless provision for rural hospitals providing outpatient services under the prospective payment system.

The Center will provide additional information in the future about improvements the CHAMP Act makes for Medicare beneficiaries regarding preventive coverage, Part C protections, and Part D.

[Click here to read a Judith Stein editorial on the CHAMP Act.](#)

For further information on the provisions discussed above, please contact attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028.