CMA Weekly Alert – August 16, 2007

WHY THE *CHAMP ACT* IS GOOD MEDICINE FOR MEDICARE BENEFICIARIES – PART 2

This is the second in a series of *Weekly Alerts* that describe relevant provisions of the comprehensive CHAMP legislation. CHAMP, more formally known as the *Children's Health and Medicare Protection Act of 2007*, H.R. 3162, was passed by the House of Representatives on August 1, 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.

This week's *Alert* describes provisions that make substantial improvements to Medicare Part D, the prescription drug program, and to Medicare Part C, the Medicare Advantage program. Prior to passing CHAMP, the House Ways & Means Committee, which has jurisdiction over the Medicare program, held numerous hearings addressing the myriad problems beneficiaries experience with their prescription drug plans and Medicare Advantage plans. Many of the provisions in CHAMP address and correct the problems identified at these hearings by beneficiaries, state regulators, and policy analysts. For example, CHAMP provisions codify and strengthen protections found in "guidance" bulletins issued by the Centers for Medicare & Medicaid Services (CMS) that lack the legal authority of the Medicare statute and regulations. They also add new protections, including protections in plan enrollment and beneficiary cost-sharing responsibilities.

Improvements to Medicare Part D, the Prescription Drug Program

Section 221. Improving calculation of TrOOP: This provision allows drug costs paid by the Indian Health Service, an Indian tribe or trial organization, or an urban Indian organization, and by AIDS Drugs Assistance Programs (ADAPs) to count toward Part D "true out-of-pocket expenses" (TrOOP) when calculating payments made by beneficiaries to their out-of-pocket limit. This would enable more individuals to get out of the coverage gap ("Donut Hole") and to become eligible for catastrophic coverage under Part D.

Section 222. Protecting beneficiaries from formulary changes: This section allows an individual who has been prescribed a drug to change drug plans if his or her drug plan eliminates the drug from the formulary or increases cost sharing mid-year. A beneficiary would still be unable to change plans if the drug is removed from the formulary because of action by the FDA.

Section 223. Adding benzodiazepines as a covered drug: This provision removes benzodiazepines from the list of drugs excluded from Part D coverage so that plans must include some of these drugs, used by many older people and people with disabilities, on their formularies.

Section 224. Updating drug compendia: This section provides for updating of drug compendia, used to support a request for coverage of an off-label drug use, using the same process as is used for drugs covered under Part B. The section does not address other issues beneficiaries have encountered involving reliance on the three statutorily-specified drug compendia, such as the definition of medical necessity for drug coverage and access to the compendia.

Section 225. Codifying the "six protected classes" of drugs: This provision codifies CMS guidance that requires plan formularies to include all or substantially all drugs in six therapeutic classes: anticonvulsants, antineoplastics, antiretrovirals, antidepressants, antipsychotics, and immunosupressants. The provision only allows the use of prior authorization and step therapy for initiations of medications within the six classes if CMS has approved such use. Plans

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cannot use prior authorization or step therapy for antiretrovirals or for enrollees who are already stabilized on a drug treatment regimen.

Section 226. Eliminating the late enrollment penalty for subsidy-eligible individuals: This section eliminates the Part D late enrollment penalty for all individuals eligible for the full or partial low-income subsidy (LIS), known as "extra help".

Section 227. Protecting enrollment of LIS-eligible individuals: This provision codifies a special enrollment period (SEP) for LIS-eligible individuals and provides for facilitated enrollment of those LIS-eligible individuals who do not choose their own Part D plan into a prescription drug plan that is most appropriate for such individuals. Individuals may still decline enrollment into the plan chosen by CMS or may change their enrollment.

Improvements to Medicare Part C, the Medicare Advantage Program

Section 401. Protecting the integrity of the Medicare Program: This provision protects the integrity of the Medicare program by providing for a phased-in equalization of payments between Medicare Advantage plans and traditional Medicare, as recommended by the Congressional Budget Office and the Medicare Payment Advisory Committee (MedPAC). The section also repeals the PPO stabilization fund.

Section 411. Regulating marketing and other abuses: This provsion requests the National Association of Insurance Commissioners (NAIC) to develop, and submit to CMS, model regulations regarding marketing, enrollment, broker and agent training and certification, agent and broker commissions, and market conduct. NAIC is to consult with a working group composed of representatives of Medicare private plans, consumer groups, Medicare beneficiaries, and State Health Insurance Assistance Programs (SHIP) and report back within 12 months of enactment. The model regulations will be reviewed by CMS and published in the Federal Register. They will apply to Medicare Advantage and prescription drug plans.

Importantly, this provision also:

- Gives states additional authority to oversee and regulate marketing abuses
- Increases civil money sanctions
- Requires disclosure of market and advertising contract violations and sanctions
- Requires a standard definition of benefits and formats for marketing materials
- Provides additional funding for SHIPs

Section 412. Limiting out of pocket costs: This section prohibits Medicare Advantage plans from imposing cost-sharing that is greater than the cost-sharing imposed under traditional Medicare. It also limits cost sharing for dual eligibles and those eligible for QMB to the cost sharing imposed under their state Medicaid program.

Section 413. Improving enrollment periods: This section provides for a continuous open enrollment period for full-benefit dual eligibles and QMBs and prohibits their auto-enrollment into a Medicare Advantage plan. It also extends access to a Medigap policy for individuals who leave a Medicare Advantage plan after 24 months if they had dropped the policy to enroll in a Medicare Advantage plan.

Section 414. Improving information to beneficiaries: This section requires CMS to publish information about certain plan administrative costs and enrollment data.

Section 412. Requiring all Medicare Advantage plans to meet the same quality standards. This section requires private fee-for-service (PFFS) plans and Medicare Savings Account (MSA) plans to report the same performance information as other Medicare Advantage plans.

Section 422. Improving quality reporting measures concerning racial disparities. This provision requires CMS to develop quality measures for Part C plans to measure disparities in the amount and quality of services provided to racial and ethnic minorities and sets timeframe for reporting findings to Congress.

Section 423. Strengthening audit authority: This provision requires plans to submit data with respect to risk adjustment and adds enforcement authority in connection with audits.

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Section 424. Improving risk adjustment: This provision requires CMS to evaluate and report to Congress concerning the adequacy of its risk adjustment system, which helps connect payment amounts to the healthcare needs of individual beneficiaries.

Section 425. Eliminating special treatment for private fee-for-service plans: This provision protects beneficiaries by reducing the amount they can be billed by providers (balance billing).

Section 425. Renaming of Medicare Advantage Program: This provision reduces beneficiary confusion generated by the name "Medicare Advantage" by renaming the program simply the Medicare Part C program.

Section 431. Extending and revision of authority for special needs plans (SNPS): This provision extends the authorization of SNPs for 3 years, and requires that 90% of enrollees in a plan for duals be full-benefit duals or QMBS, and that 90% of enrollees in a plan for people with chronic conditions have the condition that the plan is to serve. The provision also:

- Requires institutional SNPs to coordinate with the state Medicaid program and to contract with a sufficient number of long-term care and other providers
- Requires dual SNPS to coordinate with the state Medicaid program, including a description of how Medicaid will pay cost-sharing and provide supplemental services
- Limits out of pocket costs for Part A and B services to the Medicaid cost sharing for those services
- Identifies the chronic conditions that SNPs for chronic conditions may serve; requires management of a chronic care improvement program for each condition that exceeds similar programs under other Part C plans; requires plans to have a sufficient network of providers to meet the needs of the population
- Establishes additional quality standards and reporting for SNPs
- Provides for transition of non-qualified SNPs, including the transition of enrollees

Section 432. Extending and revising authority for Medicare reasonable cost contracts: This provision extends for 3 years the authorization of managed care entities that are cost contract plans and not Part C plans, and applies Part C marketing, quality improvement, and other protections to cost plans.

Correction

In last week's Alert discussing provisions of the CHAMP Act that help low income Medicare beneficiaries, we incorrectly described two provisions, which had been changed between introduction of the bill and final passage by the House.

Below is a correct restatement of the relevant provisions.

§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.

§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.

The Center will provide additional information in the future about improvements the CHAMP Act makes to preventive coverage and other items and services covered under Medicare Part A and Part B.

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.

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