



CMA Weekly Alert – September 27, 2007

A POTPOURRI OF PART D

On October 1, 2007 Medicare Part D plans are allowed to begin marketing efforts to entice beneficiaries prior to the 2007 Annual Coordinated Election Period (AEP) for Medicare Advantage (MA) and Prescription Drug Plans (PDPs). The AEP begins on November 15 and continues through December 31, 2007. During this time beneficiaries have the opportunity to change their existing plans if they wish. Enrollment changes made during the 2007 AEP will take effect on January 1, 2008.

As a prelude to the AEP, the Centers for Medicare & Medicaid Services (CMS) recently issued a "GUIDE TO CMS, SSA AND PLAN MAILINGS SUMMER AND FALL 2007." In forthcoming Alerts, we will discuss more about the factors beneficiaries need to consider before deciding to stay with, or change, their existing plans for the coming year. Here we discuss information beneficiaries should have received, or will be receiving shortly, and include a chart summarizing changes in standard Part D cost-sharing for 2008.

Late Enrollment Penalty (LEP) Letters

Some Part D beneficiaries have begun receiving letters from their plans telling them that they may owe a late enrollment penalty (LEP) for 2007. Given these letters, a LEP "refresher" is probably in order.

- People who don't enroll in Part D when they are first eligible to do so may be subject to a LEP if they decide to enroll later on. The LEP is a "lifetime" penalty. That is, the penalty amount will be added to their base monthly premium for as long as they remain enrolled in a Medicare prescription drug plan.
- The penalty is 1% of the average national monthly premium for each full month the person was eligible to enroll but did not do so. The penalty calculation start date is either May 16, 2006, or three months after the beneficiary first becomes eligible for Medicare.
- The national average monthly premium is \$27.32 in 2007. People who could have enrolled in Part D by May 15, 2006, but did not enroll until January 2007, will have \$1.91 (7%) added to their base monthly premium in 2007 ($\$27.32 \times .01 \times 7 \text{ months [June – December 2006]} = \1.91). The penalty calculation formula is adjusted each year based on the new national average monthly premium for the year the beneficiary actually enrolls in a plan.
- Some people are exempt from the LEP. People who had creditable prescription drug coverage instead of Part D are exempt from the penalty as long as they enrolled in a Part D plan within 63 days of losing their creditable coverage. People who qualified for the Extra Help Subsidy in 2006 or 2007 are exempt from the LEP. CMS recently announced that it is extending the late enrollment penalty exemption for people who qualify for extra help through 2008. Certain beneficiaries affected by Hurricane Katrina are also exempt from the penalty.

Based on information in Chapter 4 of the Medicare Prescription Drug Benefit Manual, the mechanics of determining, calculating and applying the penalty are summarized as follows:

- When a new member enrolls in a Part D plan, the plan is responsible for determining whether the person was previously enrolled in another Part D plan, or had other creditable coverage prior to enrolling in their plan, and whether there were any lapses in creditable coverage greater than 63 days. Depending on the date the person enrolled, the plan may use one of several methods to obtain this information. The

plan may be able to get this information from the member's enrollment form, or submit a query to CMS, or send the beneficiary an "attestation form." If the plan sends the member an attestation form, the member has 30 calendar days to respond, telling the plan whether he or she had creditable coverage and, if so, the source of that coverage.

- Once the plan has determined whether or not a beneficiary has a lapse in coverage, the plan informs CMS so that CMS can compute the LEP in those cases where a penalty is owed.
- CMS emphasizes that it is the only entity authorized to calculate and impose a LEP. The plan may not estimate or inform a beneficiary of the penalty amount until it receives formal notification of the penalty amount from CMS. Within 10 calendar days of receiving this formal notification from CMS, the plan must write to the member and advise him or her of the penalty amount.
- CMS specifies the information that must be included in this letter, including the monthly premium for the current year and the portion of that amount that is the LEP, the effective date of the penalty, the basis for the LEP (the number of uncovered months), the beneficiary's right to ask for reconsideration (review) of the penalty, and the reconsideration filing deadline. The plan continues to bill the member for the penalty even if the member has asked for reconsideration. If reconsideration is granted the beneficiary is to be reimbursed.
- Per CMS, plans must be flexible in collecting the penalty. They must offer beneficiaries a choice of payment cycles (annual, quarterly or monthly). The plan does not need to bill a beneficiary whose premium is being collected through Social Security deduction. SSA will collect the LEP amounts from people who chose this option.

This is the first year that late enrollment penalties will actually be collected. While there has been time to establish the process, concerns still exist. If this follows the pattern of the 2006/2007 Social Security Part D premium deduction process, advocates should be ready for a whole new set of problems in 2008. The first LEP call received at the Center was from a beneficiary who received a letter from his *very own plan* - the one that has covered him from March 1, 2006 to the present day - telling him that information they received from CMS indicates he has had a lapse in coverage greater than 63 days and, therefore, will be subject to a penalty. As of this printing he has completed and returned his attestation form, and waits to see what will happen next.

Reminder: Low Income Subsidy ("Extra help") Letters Sent in September

Beneficiaries who rely on "Extra Help" (Social Security's Low Income Subsidy) to pay for Part D premiums and co-pays need to pay attention to the mailings they may receive this month. These mailings are color coded, which will make it easier for advocates and other helpers to decipher some of the letters their clients have received. The following mailings are being sent in September:

Loss of Deemed Status Letter (Pub. 11198). This is a **GRAY letter** that was mailed in mid-September 2007. It is going to people who will not be deemed eligible for Extra Help in 2008. This includes people who lost eligibility for Medicaid, the Medicare Savings Program, or SSI during 2007. People who receive this mailing, but think they may still qualify for Extra Help based on their income and assets, should apply for Extra Help through the Social Security Administration or their State Medicaid office. (An Extra Help application and postage paid envelope are enclosed with this mailing.)

Change in Extra Help Co-Payment Letter (Pub. 11199). This is an **ORANGE letter** being mailed in late September 2007. It is going to people who will still automatically qualify for Extra Help in 2008, but may have a change in their co-pay amounts. If they have had an increase in their income or assets, their co-pays may go up slightly; if their income or assets have decreased, their co-pays should fall accordingly. Read more about the 2008 co-pay levels in the next section of this Alert.

NOTE: In August 2007 Social Security mailed a **Letter to Review Eligibility for Extra Help** (Form 1026) to a sample of people who were chosen for re-determination of their eligibility for Extra Help. (These are people who applied for Extra Help as opposed to being deemed eligible for the program.) People who received this letter had 30 days in which to reply by completing the Income and Resources Summary enclosed with the letter. Any change to eligibility (increase, decrease or termination) will be effective January 1, 2008. People who received but did not respond to this letter will lose their Extra Help benefits in 2008.

Advocates should be aware that beneficiaries may have received these letters which they may not recognize or understand, and be prepared to help them navigate the processes signaled by the mailings.

Medicare Part D Cost Sharing for 2008

2007 amounts are also shown for comparison purposes.

Standard Benefit	2007	2008
Annual Deductible	\$265	\$275
Initial Coverage Limit (beneficiary pays 25% of this amount)	\$2400 (($\$2400 - \265) x 25% = \$533.75 out-of-pocket)	\$2510 (($\$2510 - \275) x 25% = \$558.75 out-of-pocket)
Once in the donut hole, beneficiary pays the next...	\$3051.25	\$3216.25
Out-of-Pocket Threshold	\$3850 (\$265 + \$533.75 + \$3051.25)	\$4050 (\$275 + \$558.75 + \$3216.25)
Minimum cost sharing during Catastrophic Coverage	\$2.15 (generic) \$5.35 (brand name)	\$2.25 (generic) \$5.60 (brand name)
Full Benefit Dual co-pays		
if institutionalized	\$0	\$0
in community, income up to 100% FPL	\$1/\$3.10 up to out-of-pocket threshold (\$0 after out-of pocket threshold)	\$1.05/\$3.10 up to out-of-pocket threshold (\$0 after out-of pocket threshold)
in community, income > 100% FPL	\$2.15/\$5.35 (\$0 after out-of- pocket threshold)	\$2.25/\$5.60 (\$0 after out-of-pocket threshold)
Non-full benefit dual FULL SUBSIDY		
resources < \$6,120 (single) or < \$9,190 (couple)	\$2.15/\$5.35 (\$0 after out-of-pocket threshold)	\$2.25/\$5.60 (\$0 after out-of-pocket threshold)
resources < \$10,210 (single) or < \$20,410 (couple)	Deductible \$53 15% co-insurance (\$2.15/\$5.35 after out-of-pocket threshold)	Deductible \$56 15% co-insurance (\$2.25/\$5.60 after out-of-pocket threshold)
Non-full benefit dual PARTIAL SUBSIDY		
	Deductible \$53 15% co-insurance (\$2.15/\$5.35 after out-of-pocket threshold)	Deductible \$56 15% co-insurance (\$2.25/\$5.60 after out-of-pocket threshold)
	Premium amount based on sliding scale	Premium amount based on sliding scale

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