



CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

Los Angeles Office
3435 Wilshire Blvd., Suite 2860
L.A., CA 90010
Ph: (213)381-3670
FAX: (213) 381-7154

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Department of Health and Human Services
Attention: CMS-4133-P
Electronic Submission

Comments on Proposed Rule to Create an Option for Prescription Drug Plans to Lower their Premiums for Low-Income Subsidy Beneficiaries

We appreciate that CMS in this proposal has acknowledged and attempted to address a serious, fundamental problem with the Medicare Part D program. We believe, however, that the proposed regulation falls short of its stated goals. The regulation aims to balance the twin goals of: 1) introducing beneficiary stability; while 2) maintaining the integrity of the competitive bidding process. In an attempt to meet these goals, the regulation would guarantee that beneficiaries in all regions have a choice of benchmark plans offered by at least 5 different organizations each year. The regulation, because it only ensures a minimum number of benchmark plans but does nothing to guarantee that those plans will be the same high quality plans from one year to the next, fails to introduce to the Part D program the stability and predictability that Low Income Subsidy (LIS) beneficiaries so desperately need. Different solutions are needed.

I. “Background” Section

The Problem

The Background section of the proposed regulation states the problem succinctly and, for the most part, accurately. Full premium subsidy LIS recipients can join a Part D plan and pay no monthly premium as long as the plan’s premium is below an amount known as the regional benchmark. Both plan premiums and the benchmark amount are determined by a formula which averages plan bid amounts. Since plan bids vary from one year to the next, plan premiums and regional benchmark premiums also vary annually. As a result, a plan’s premium may be below the benchmark one year, but not the next.

Beneficiaries enrolled in these plans are put in a difficult position. If they stay in these plans they must pay the difference between the plan's premium and the benchmark. Switching to a plan with a premium below the benchmark, on the other hand, "disrupts continuity and stability in coverage." Federal Register Vol. 73, No. 5 at 1303.

To date, CMS has addressed this problem by automatically reassigning some, but not all, LIS beneficiaries who are in plans with premiums that will rise above the benchmark amount. The proposal implies that all full premium subsidy recipients in these plans are reassigned. Federal Register Vol. 73, No. 5 at 1302. In fact, only those full subsidy recipients who were auto-enrolled into the plan are reassigned. Full subsidy recipients who self enrolled into a plan whose premium will no longer be below the benchmark are not reassigned and, if they do not switch plans themselves, are charged a premium. CMS refers to these beneficiaries as "choosers." In addition, as the proposal mentions, no partial subsidy recipients are reassigned.

Impact on Beneficiaries

The Background section's focus on beneficiaries who were reassigned to a different organization minimizes the extent of the problem since these are not the only beneficiaries affected by changes to benchmark plans. These changes also impact the benefits of beneficiaries reassigned to a plan within the same organization, choosers (who were not reassigned) and partial subsidy recipients (who were not reassigned). In 2007, 2.5 million full subsidy recipients were enrolled in plans whose premiums rose above the benchmark in 2008. Of those, nearly 1 million were reassigned to a plan offered by the same organization, 1.15 million were reassigned to a plan offered by a different organization, and approximately 440,000 were "choosers." CMS has not provided information about how many partial subsidy recipients were in these plans.

Beneficiaries in every region were affected. The number of beneficiaries reassigned to a new organization ranged from 43 in Region 34 (Alaska) to 401,334 in Region 32 (California).¹ The number of beneficiaries reassigned within the same organization ranged from 382 in Region 18 (Missouri) to 109,325 in Region 11 (Florida). The number of "choosers" ranged from 500 in Region 34 (Alaska) to 97,262 in Region 32 (California). The total number of beneficiaries affected by changes to benchmark plans ranged from 4,444 in Region 34 (Alaska) to 600,941 in Region 32 (California). The average number of beneficiaries affected by the changes was 75,480 per region.

But looking at reassignment totals in isolation does not tell the whole story. The number of LIS recipients in each region or state varies widely. For example, the 4,444 beneficiaries affected in Alaska represent 32% of all LIS recipients in the state. In 48 states and the District of Columbia at least 1 in 10 LIS recipients were affected by changes

¹ Centers for Medicare and Medicaid Services, "Year 2007 Re-Assignment Data – Premium Increases," November 2007 and "Year 2007 Chooser Data," November 2007. Available at: www.cms.hhs.gov/limitedincomeandresources/

in benchmark plans; in 19 of these states at least 1 in 4 LIS recipients were affected; and in California and Florida more than half of the LIS recipients in the state were in plans whose premiums rose above the benchmark in 2008.² Nationally, 28% of LIS recipients were forced to change plans to avoid paying premiums in 2008.

Changes to benchmark plans are accompanied by significant challenges for beneficiaries. We have heard reports from across the country that data transfer delays that have left reassigned beneficiaries without a plan or in a plan but without the proper subsidy for weeks. Other beneficiaries have been reassigned to plans that do not cover all of their medications or plans with less comprehensive formularies and higher rates of utilization management. Beneficiaries who had endured long, difficult exceptions process with their 2007 plan were reassigned to new plans where they would have to restart the cumbersome process all over again. Furthermore, data necessary for a plan to provide effective Medication Therapy Management to the beneficiary are lost when the beneficiary is reassigned to a new plan.

“Choosers” and partial subsidy beneficiaries who are not reassigned also reported problems. It is our impression that very few “choosers” switched to a new plan to avoid paying premiums. Beneficiary advocates and counselors have told us that the “choosers” and partial subsidy recipients they met were not switching plans either because they did not understand that their premiums would be increasing or because they understandably fear the disruption, uncertainty and transaction costs associated with switching plans. Other “choosers” stayed in their plan and will pay premiums because, after evaluating other options, they found that there was no other plan that covered all of their medications. As these LIS recipients begin receiving premium bills from their plans, a new hurdle has arisen. Since beneficiaries are justifiably leery of the automatic withholding process, many low income seniors have no mechanism – checking accounts, credit cards, etc. – for paying the premiums they owe. Although CMS guidance allows plan-wide policies against disenrolling LIS recipients who do not pay monthly premiums, beneficiaries and advocates have been unable to obtain confirmation that any plan has such a policy.

A decline in the quality of benchmark plans is another serious concern. In many regions, the benchmark plans that offered the most comprehensive formularies in 2007 are no longer benchmark plans in 2008. These plans have been replaced by newer plans offering slimmer formularies with more utilization management, forcing many beneficiaries to remain in or join a non-benchmark plan in order to ensure that all of their medications would be covered.

We are concerned that the changes to benchmark plans mark the beginning of a trend toward a two tiered Part D system. One tier of limited formulary, high utilization management benchmark plans whose membership is comprised overwhelmingly of LIS

² “Low Income Medicare Beneficiaries Who Will Have to Change Plans to Avoid Paying Premiums in 2008,” the National Senior Citizens Law Center. Available at: www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-18.4955802464/article.2007-11-20.8864273801/at_download/attachment

beneficiaries and a second tier of comprehensive formulary, low utilization management plans which cater to non-LIS beneficiaries.

The Proposed Rule

We are pleased to see that CMS recognizes the problems posed by the instability inherent in the Part D program and is undertaking efforts to address the problem. We agree that the statute permits PDP sponsors to establish a separate premium for LIS eligible individuals. We do not believe, however, that the proposed rule is adequate to ensure the “continuity of care and stability,” that it is meant to provide and that low income beneficiaries need.

II. “Provisions of the Proposed Regulations” Section

The essential failure of the proposed regulation is its focus on the quantity, not consistency of benchmark plans offered in a region. The regulation ensures that LIS recipients in each region would have a choice of at least 5 organizations offering \$0 premium plans.

The proposed regulation’s focus on the number of plans alone does nothing to ensure stability for beneficiaries. The proposed regulation would allow a scenario where the five plans offered in a region are all plans that were not below the benchmark the year before. In such an instance, every LIS recipient in the region would need to be reassigned or switch plans to avoid a premium.

The Numbers. Since the beginning of Part D in 2006, few states have seen significant changes in the total number of organizations offering benchmark plans from one year to the next. There has been, however, wide variation in which plans are offered from one year to the next. It is because of these changes in benchmark plans offered – not a decrease in the total number of plans offered – that so many beneficiaries were affected in 2008. If the goal is to increase beneficiary stability, the focus must be on which plans are offered, not how many are offered.

In 2008, most states have either the same number of (15) or more (21, including DC) benchmark plans than they did in 2007. Only 15 states (representing 10 out of 34 PDP regions) had fewer benchmark plan sponsors in 2008 than 2007. Moreover, the correlation between number of benchmark plans and beneficiary stability has been weak. Of the 12 states in which at least 30% of LIS recipients were affected by changes to benchmark plans, only six had fewer benchmark plan sponsors in 2008 than 2007; 3 experienced no change in the total number of benchmark plan sponsors (including California where over 50% of LIS recipients were affected); and 3 actually experienced an increase in the total number of benchmark plan sponsors (including Florida where over 50% of LIS recipients were affected).

MA Penetration. Access to benchmark plans is shrinking in some regions (e.g. Nevada and Arizona) with high Medicare Advantage enrollment, a fact that the proposal acknowledges by focusing its solution on “key regions with significant MA enrollment.” Federal Register Vol. 73, No. 5 at 1304. Since the Part D premiums of Medicare Advantage plans offering prescription drug coverage are included in the benchmark calculation and since Medicare Advantage plans can use the subsidies they receive to reduce their Part D premiums (often reducing them to \$0), as more beneficiaries join these plans, the benchmark amount will drop. CMS appears to be concerned that MA plans with subsidized premiums in certain regions could eventually drive the benchmark so low that there will be no PDPs with premiums below it. This is an important problem but should be addressed by a more direct solution (see alternatives section below). Trying to solve this problem by establishing a minimum number of plans without taking any action to ensure that the same plans are below the benchmark from one year to the next does nothing to provide beneficiary stability.

The regulation also does nothing to address the potential decrease, in regions with high rates of MA penetration, in the number of plans eligible to receive auto-assignments. Plans that benefit from the new rule would retain their current LIS enrollees, but would not be eligible for new auto-assignments. Auto-enrollees would be concentrated in a very few plans. Within the current Pat D regulatory framework, such a concentration would decrease incentives for plans to compete to offer high quality, comprehensive benefits.

Our concerns about the impact of the proposal on the quality of coverage and service provided by the benchmark plans extend beyond those areas where MA penetration is high. The proposed rule does nothing to ensure that the benchmark plans offered in each region are high quality plans. We are concerned that the proposal will only further encourage plans to compete to become the least expensive plan instead of trying to offer high quality, comprehensive benefits. As CMS looks to address the problem of benchmark plan changes, it should take steps that will guarantee that benchmark plans are high quality plans.

Plan Participation. We are also skeptical as to whether plans would exercise the option provided by the proposed change. Under current CMS guidance, PDPs are permitted the option of not disenrolling LIS recipients who do not pay premiums owed. This guidance allows plans effectively to offer LIS recipients a \$0 premium even if they are not a benchmark or de minimis plan. We are not aware of any plans that have exercised this option. The proposal would, of course, go further in encouraging plans to participate by allowing them to retain their current LIS enrollees. However, since the proposal requires plans to commit to participate before they know what their premium or the benchmark amount will be, those plans that do choose to participate are exposing themselves to some level of risk. This risk may be too great for many plans.

For the reasons discussed above, we do not endorse CMS’s proposal. Our recommendations of alternatives are set out in Section III. If, however, CMS adopts the rule, we urge the following modifications:

- Raise the minimum number of organizations from 5 to 10. Increasing the minimum number of plans will not cure the problems with the regulation, but it would likely increase the number of plans that would remain benchmark plans year after year.
- Extend the benefit of the rule to partial subsidy recipients. Like full subsidy recipients, partial subsidy recipients are automatically enrolled into benchmark plans by CMS. CMS should use its authority to ensure that partial subsidy recipients remain in plans which do not require them to pay more than they would in a benchmark plan.
- Clarify how beneficiaries in plans that fall under the new rule would be treated if they enroll in the plan or qualify for the LIS during the contract year.

Comments on Anticipated Effects and other Alternatives will be provided in the section below.

III. “Regulatory Impact Statement” Section

Overall Impact

The proposal projects that the “proposed rule would lead to Federal savings of approximately \$20 million per year.” Federal Register Vol. 73, No. 5 at 1304. It does not explain, however, the source of these savings. More information should be provided about how the rule would lead to Federal savings.

Anticipated Effects

The benchmark plan landscape in 2008 suggests that the proposed regulation would have little impact on the problem facing low income beneficiaries. In 2008, under the de minimis demonstration project, only 2 of the 34 PDP regions had fewer than 5 organizations offering plans with premiums below the benchmark (Nevada (2) and Arizona (4)). Other than these two, only 5 regions had fewer than 10 organizations offering benchmark plans (Florida (5), Louisiana (7), California (8), New Mexico (8), Hawaii (9)). In 24 of the regions there were 12 or more organizations offering plans with premiums below the benchmark.

According to the proposed regulation, had the demonstration project not been in place, and assuming that plans would not have adjusted their bids accordingly, 5 regions would have had fewer than 3 benchmark plan sponsors, 7 regions would have had fewer than 5 benchmark plan sponsors, and 10 regions would have had fewer than 7 benchmark plan sponsors. All 34 PDP regions experienced some level of reassignment in 2008. Even

assuming the regulation, despite the shortcomings detailed above, was effective, it would only impact 7 out of 34 regions.

The proposal itself admits that the regulation would result in 500,000 more beneficiary reassignments than would occur under the de minimis policy used in 2008. The regulation does not mention how many new “choosers” would be affected. The proposal should provide more information about which states/regions and how many beneficiaries (reassignees and choosers) would be affected by the 5 organization minimum.

Alternatives Considered

The proposed regulation invited comments on two alternative proposals as well as additional ideas for addressing the challenges posed by changes to benchmark plans.

The proposal notes that CMS considered 2 alternatives. We support the first alternative: allowing all non-enhanced PDPs the option of offering their plan to LIS beneficiaries for no premium. This proposal is both consistent with and an improvement over current CMS guidance which provides plans the option of developing policies against disenrolling LIS recipients for non-payment of premiums, but, we have heard from CMS staff, prohibits plans from informing beneficiaries of their policies. As a result, we do not know whether any plans are exercising this option.

Plans may be more likely to exercise an option that treats LIS recipients differently from other enrollees if doing so allows them to retain their auto-assignees. It is also more likely that plans would participate in this alternative, as opposed to the regulation proposed, because they would be able to decide whether or not to participate after knowing the difference between their premium and the benchmark amount. We believe that CMS exaggerates the negative impact of such a proposal on the bidding process. Plans would still be motivated to keep their bids low in order actually to fall below the benchmark and, therefore, qualify for auto-assignments. Plans would also be motivated to offer robust formularies in an effort to attract LIS recipients shopping for a new plan.

We do not support the second alternative: changing the current reassignment process so that beneficiaries would be informed of \$0 premium plans but would have to take action to change to such a plan. Based on our experience with “choosers” and others who are not reassigned, we believe that placing the burden on beneficiaries to make the change would result in beneficiaries remaining in plans they cannot afford and would increase the premium collection problems described above. This approach would only delay the disruptions caused by having to enroll in a new plan, and it would add to the disruption the uncertainties of figuring out how to pay the new premium amount.

We urge CMS to adopt other approaches that address more effectively the problem of instability caused by reassignment. We believe that several changes, in combination, will be necessary to achieve the goal of beneficiary stability:

1. Develop beneficiary-centered solutions.

Due to the market-based nature of Part D there will always be changes to benchmark plans. A solution that focuses on plan stability will, therefore, never fully address the problem. A better approach may be to focus on providing beneficiaries access to the same coverage each year.

For example, CMS could use data that it and plans have to “intelligently” reassign affected beneficiaries to plans that cover their current medications without the limitation of utilization management. If more than one plan covers the beneficiary’s medications, the Secretary would enroll the beneficiary into one of these plans on a random basis. Such intelligent reassignment would not be prohibited by the statute since Section 1860D–1(b)(1)(C) only applies to a beneficiary “who has failed to enroll in a prescription drug plan of MA-PD plan.” In the case of reassignment, the beneficiaries are already enrolled in plans. The Secretary is using his authority to ensure that the beneficiaries remain in plans with premiums below the benchmark. Intelligent reassignment would also ensure that beneficiaries remain in plans that cover their drugs. Plans that offer comprehensive benefits at low prices should be rewarded with enrollees. Those plans that offer limited benefits should not be rewarded with automatic enrollments.

Another beneficiary-centered approach would be to “grandfather” the coverage of reassigned beneficiaries. Plans would be required to provide reassigned beneficiaries with the drugs they were receiving in their old plan.

2. Make the de minimis demonstration permanent.

CMS says in the Background Statement to the proposed rules that its “de minimis policy has demonstrated the advantages of continuity of care and stability that result from permitting LIS-eligible individuals effectively to be charged a lower total premium.” Federal Register Vol. 73, No. 5 at 1303. Yet CMS admits that fewer beneficiaries would have to be moved to a new plan under the de minimis policy than under its proposed 5-plan sponsor policy. CMS’ goal is to protect beneficiaries by increasing the stability of their drug coverage. The easiest way to achieve that goal in a manner that benefits the largest number of LIS-eligible people is to adopt the de minimis demonstration and make it permanent.

We believe that CMS’ goal of beneficiary stability outweighs any concerns about the integrity of the bidding process. The de minimis policy does a better job of protecting that stability. It also provides a good middle ground in that it allows plans to submit their bids according to their best estimates of costs and profits, but it also gives CMS the flexibility to promote quality health care by ensuring stability for beneficiaries. Plans would still be motivated to keep their bids low in order to actually fall below the benchmark and, therefore, qualify for auto-assignments.

As an alternative to establishing a de minimis policy based on a fixed dollar amount, CMS could instead use a fixed percentage. For example, the de minimis amount would always be 10% of the regional benchmark amount.

3. Calculate the LIS benchmark without including the rebates applied by MA-PDs to reduce their Part D premiums.

The Social Security Act authorizes CMS to create regulations that require the benchmark amount to be determined without taking into consideration the rebates applied by MA-PDs to reduce the premiums they charge for prescription drug coverage.

Section 1860D-14(b)(2) of the Social Security Act provides, in general, that the low-income benchmark premium amount for a PDP region is the weighted average of certain amounts set forth under Section 1860D-14(b)(2)(B) of the Social Security Act. In the case of an MA-PD plan, the amount prescribed by this latter section is “*the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits.*” Social Security Act, § 1860D-14(b)(2)(B)(iii) (emphasis added). The term “MA monthly prescription drug beneficiary premium” is defined by Section 1854(b)(2)(B) of the Social Security Act as consisting of two parts, 1) “the base beneficiary premium (as determined under section [1860D-13\(a\)\(2\)](#) and as adjusted under section [1860D-13\(a\)\(1\)\(B\)](#))” and 2) “the amount of rebate credited toward such amount under section [1854\(b\)\(1\)\(C\)\(ii\)\(II\)](#).”

Current CMS regulations, specifically 42 C.F.R. § 423.780(b)(2)(ii)(C), prescribe the use of the entire MA monthly prescription drug beneficiary premium to calculate the low-income benchmark premium amount. This is in direct conflict with Section 1860D-14(b)(2)(B)(iii), which clearly calls for the application of only “a portion” of the MA monthly prescription drug beneficiary premium in making that calculation.

In order to comply with Section 1860D-14(b)(2)(B), CMS must decide which element of Section 1854(b)(2)(B)’s formula should be considered for purposes of determining the benchmark amount. The adjusted base beneficiary premium is a more accurate reflection of the actual costs the MA-PD plan expects to incur in providing prescription drug coverage to a beneficiary. As such, this is the portion that should be used for purposes of determining the benchmark amount.

CMS’ policy of using the entire amount in the calculation results in a lower benchmark amount that does not reflect the true cost of providing prescription drug coverage. As a result, in states with high rates of MA-PD penetration, the benchmark amount has decreased significantly. In fact, in those regions CMS defines as “key regions,” the benchmark has dropped so low that only a handful of stand-alone Prescription Drug Plans are able to offer plans with premiums below the benchmark. As we noted above, Nevada and Arizona, two states with high MA-PD concentration, have seen a reduction in the number of benchmark plans. In other states with high MA-PD concentration, such as California and Florida, substantial proportions of their LIS-eligible populations had to be

reassigned to other plans. Indeed, reassignment rates correlate more closely with MA penetration rates than with the number of available benchmark plans.

We share CMS' concern that as MA enrollment grows, the number of benchmark plans available declines. The most direct way to confront this particular problem is to fulfill the statutory requirement that only a portion of the MA monthly prescription drug beneficiary premium be included in the benchmark calculation.

We thank CMS for the opportunity to submit comments on the proposed rules. We look forward to working together to ensure that LIS-eligible Medicare beneficiaries have access to the prescription drug coverage to which they are entitled.

David Lipschutz
Interim President/CEO and Staff Attorney
California Health Advocates