DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR BENEFICIARY CHOICES

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To: All Part D Plan Sponsors and MA Organizations

From: Abby L. Block, Director
Center for Beneficiary Choices

Subject: Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries

Due to high participation in the Medicare Prescription Drug Program and beneficiaries' choice of low-cost plans, CMS projects larger than expected savings in Part D expenditures in 2007 and thereafter. Steady growth and a surge in enrollment at the end of the open enrollment period led to high participation in the Part D program. In the last month of program enrollment, over 2 million people joined a Medicare Prescription Drug Plan. As a result, over 38 million Medicare beneficiaries have good drug coverage – that's over 90 percent of all beneficiaries. The broad participation of low-cost beneficiaries is helping to keep overall costs down. In addition, beneficiaries have overwhelmingly chosen plans with low premiums which is driving down costs as well. Last July, experts estimated that the average premium would be $37. Based on the actual choices that seniors have made, the average premium that beneficiaries will pay in 2006 is now less than $24, down from the most recent estimate of $25.

In order to ensure that Medicare beneficiaries continue to have strong incentives to enroll in low-cost plans, as they did in 2006, today Secretary Leavitt has announced a new transitional approach that will help ensure that low-income beneficiaries have access to a variety of affordable plans.

An important factor in the choices for low-income beneficiaries is the computation of the regional low-income benchmark premium amounts. Beginning in 2007, the statute requires that CMS compute these amounts, in part, by weighting the standardized Part D bids for Prescription Drug Plans (PDPs) and MA-PD plans based on plan enrollment. For 2006, MA-PD plans were assigned a weight based upon prior enrollment. Because actual enrollment was not yet available for PDPs, all PDP organizations were assigned equal weight.

In the absence of the transitional approach, starting in 2007, the bid amounts for PDPs would not be weighted equally, but rather would be weighted by actual enrollment in each PDP. Given that many beneficiaries have chosen low-cost plans, this change in the weighting methodology would reduce the regional low-income benchmark premium amounts.

Medicare contributions depend on the low-income benchmark premium and the national average monthly bid amount -- the lower these amounts, the lower Medicare spending. So, beneficiary choice of low-cost plans means savings for Medicare.

The availability of low-income premium subsidies, however, is also tied to the level of the low-income benchmark premiums. Reductions in these amounts would limit the amount of extra help that is available to low-income Medicare beneficiaries.

Transitional Approach.

Low Income Benchmark Premium Amounts. Under the transitional approach, CMS will implement a strategy to transition to weighting using actual PDP enrollment for the low-income benchmark premium amounts. In 2007, CMS will calculate the low-income benchmark premium amounts using the same weighting methodology applied in 2006, i.e., all PDP bids will be weighted equally. Subsequently, the low-income benchmark premium amounts will move to actual enrollment weighting.

De Minimis Premium Policy for Low-Income Subsidy Eligibles. To provide additional protection for low-income beneficiaries, Part D plans will be required to charge full-premium subsidy eligible beneficiaries a monthly beneficiary premium equal to the applicable low-income premium subsidy amount, if the plan's base beneficiary premium adjusted to reflect any difference between the plan's bid and that national average bid exceeds the low-income premium subsidy amount by $1 or less. This approach will eliminate the need to move low-income subsidy beneficiaries to new plans simply because their existing plan's premium exceeded the low-income premium subsidy by a de minimis amount.

Additional Time for Bid Modification. This guidance provides notice of an alternative policy for determining the Part D low-income subsidy amount benchmarks. Any organization that believes that the policy announced here is inconsistent with the basis of their bid development may request to resubmit their bid. If the organization can demonstrate that the policy conflicts with their expectations they will be given permission to resubmit.

To support this process, plans may e-mail actuarial-bids@cms.hhs.gov with their request to resubmit. This request must be received within 72 hours of this notice and must include the basis of the original bid submission and how this policy will affect the bid development. This request must identify all of the plans that the organization would like to resubmit. To the extent that sufficient documentation is provided, organizations will be notified that they have an opportunity to resubmit their bids. Only changes to the bid development related to an alternative expectation of low-income subsidy enrollment will be permitted as part of this resubmission. Other bid factors may not be changed after the June 5th bid submission deadline.

Further Information
If you have questions, please contact Meghan Elrington at (410) 786-8675.