



# SENIOR HEALTH NEWS

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## Medicare 2011—It's That Time of Year to Review Your Coverage and Plan Choices

The Medicare Part D Open Enrollment Period (Nov 15<sup>th</sup>-Dec 31<sup>st</sup>) starts soon! Everyone on Medicare should take time to review their plan (whether it's a stand-alone Prescription Drug Plan or a Medicare Advantage Prescription Drug Plan) and decide whether to stay with their current plan or to change plans. Individuals should review their plan's coverage and costs for 2011 to decide whether their current plan will meet their needs in 2011 or whether they need to join a different plan. Individuals who wish to change their plan for 2011 will need to take action and enroll into a new plan by December 31, 2010. Remember, enrolling in a new plan will automatically disenroll someone from their current plan.

This year, it is especially important to review plan choices for the upcoming year because of the elimination of the Medicare Advantage Open Enrollment Period (that had been Jan 1<sup>st</sup>-Mar 31<sup>st</sup> of each year in the past). Please see page 5 for more details.

### Medicare Plan Options in 2011

There are 38 prescription drug plans available to consumers across Pennsylvania in 2011; 12 of these will be zero-premium for people with the full low-income subsidy. The list of 2011 zero-premium plans is now available on PHLP's website ([www.phlp.org](http://www.phlp.org)).

Every county has many Medicare Advantage Plan options in 2011; beneficiaries in Fulton County have the fewest Medicare Advantage plan choices (12 plans), while those living in Lancaster County have the most options (40 plans). Most counties have between 20-40 plans available to people on Medicare.

All but 9 counties (Bradford, Centre, Chester, Fulton, Franklin, Pike, Potter, Tioga, and Wayne) have at least one Special Needs Plan (SNP) available for people with both Medicare and Medicaid in 2011. It's important to note that some Special Needs Plans are terminating in certain counties. Most notably, UPMC for Life Specialty Plan will no longer operate in Armstrong and Indiana Counties after the end of the year. Other SNPs are changing their name. In counties where Unison had 2 SNPs for dual eligibles, it will only have one in 2011 and it will go by the name of UnitedHealthcare Dual Complete. In Bucks, Montgomery and Philadelphia counties, Senior Partners Silver will go by the name of Bravo Silver in 2011.

Information about all the 2011 Prescription Drug Plans (PDPs) and Medicare Advantage Plans is now available on [www.medicare.gov](http://www.medicare.gov) and in the *Medicare & You 2011 Handbook* that all Medicare beneficiaries should have received.

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### Medicare Part D Costs in 2011

Part D costs differ from Plan to Plan. The 2011 monthly premium for stand-alone Part D Plans in PA ranges from \$14.80 to \$120.30 per month. The “benchmark premium” for Part D plans in Pennsylvania next year is \$34.07. This is the maximum amount the Low-Income Subsidy (explained below) will pay toward a premium for someone awarded a full subsidy and in a standard Part D plan.

In addition to their Plan’s premium, consumers who do not qualify for a Subsidy will pay the following for a 2011 Standard Part D Plan:

- An annual deductible of **\$310**;
- During the initial coverage period, consumers pay a 25% co-pay for each medication until total drug costs reach **\$2840**;
- During the coverage gap (referred to as the “doughnut hole”) consumers pay 100% of their drug costs until their total out-of-pocket expenses reach **\$4550**; and
- During the catastrophic coverage period, consumers will pay either \$2.50/generics or \$6.30/brand names, or a 5% co-pay, *whichever is greater*.

These costs are very similar to the 2010 amounts except that now the initial coverage period ends when total drug costs reach \$2830.

**Please note:** Starting in 2011, individuals who enter the doughnut hole will get a 50% discount on their brand-name drugs and a 7% discount on their generic drugs while they are in the doughnut hole.

### LIS Costs in 2011

The Low-Income Subsidy (LIS) program helps qualified consumers with the costs of Medicare Part D. In 2011, the co-pays for individuals who qualify for the low-income subsidy will stay the same as they are in 2010. So, individuals who qualify for the full subsidy will continue to pay \$1.10 or \$2.50 for generics and \$3.30 or \$6.30 for brand names depending on their income. Individuals who qualify for the partial subsidy continue to have their deductible reduced to \$63 and then pay 15% of their drug costs until they reach \$4550 in out of pocket expenses. At that point, they pay \$2.50 for generics and \$6.30 for brand name drugs for the rest of the year.

More information about the costs of Medicare coverage in 2011 can be found by contacting 1-800-MEDICARE (1-800-633-4227) or looking on [www.medicare.gov](http://www.medicare.gov).

## Medicare Coverage of Preventive Services Improves in 2011

Starting January 1<sup>st</sup>, Medicare beneficiaries will not have to pay for most preventive services they receive, and Medicare will start to cover some additional preventive services including an annual wellness visit. These improvements are the result of the federal health care reform bill (now known as the Affordable Care Act) that was signed into law in March 2010.

### Elimination of Cost-sharing For Most Preventive Services

Starting in January 2011, Medicare consumers will be able to get most preventive services at **no cost** to them (that is, they will not have to meet a deductible or pay co-pays) including:

- annual mammograms for those age 40 and older
- cervical cancer screening, including a Pap test and pelvic exam
- prostate cancer screening (for most codes)

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- colorectal cancer screenings
- diabetes screening
- cholesterol and other cardiovascular screenings
- medical nutrition therapy to help manage diabetes or kidney disease
- annual flu shots, the pneumonia vaccine, and the Hepatitis B vaccine
- bone mass measurement
- abdominal aortic aneurysm screening to check for bulging blood vessel
- HIV screening for those who request it or who are at increased risk

The Affordable Care Act changes how much someone has to pay for preventive services; it does not change the Medicare coverage policies or criteria for these services.

### **Coverage of Annual Wellness Visit and a Personalized Prevention Plan**

Also starting in January 2011, consumers who have been on Medicare for at least 1 year are eligible for an annual wellness visit at no cost. During the wellness, visit the medical provider:

- Will create or update a screening schedule for the next 5-10 years based on the individual's age and health status;
- May provide health education or preventive counseling services designed to reduce risk factors identified in the visit;
- Will include a health risk assessment to:
  - Establish or update the person's medical and family history
  - Create a list of current providers, suppliers and prescriptions
  - Take measurements of height, weight, blood pressure and other routine measurements
  - Detect cognitive impairments

As a reminder, Medicare already covers a "Welcome to Medicare Exam" for beneficiaries within their first year of Medicare Part B coverage.

### **Medicare Now Covers Smoking Cessation Counseling Services**

Medicare expanded their coverage of smoking cessation counseling services as of August 25, 2010 making the services available to any Medicare beneficiary who smokes. Prior to this, Medicare only covered these services if an individual had a smoking-related illness (such as heart disease, stroke, lung disease) or was taking a medication affected by tobacco use. Smoking cessation counseling services may be provided on an inpatient or an outpatient basis but are always covered by Medicare Part B. The consumer has the standard Medicare Part B costs (deductibles and coinsurance) for all counseling services received in 2010. Beginning on January 1, 2011, consumers will be able to receive these services at **no cost**.

The next edition of the Senior Health News in December 2010 will include more information about other 2011 changes to Medicare as a result of the Affordable Care Act.

## PACE and Medicare 2011

The Pharmaceutical Assistance Contract for the Elderly (or PACE/PACENET) recently announced its 2011 Partner Plans. There are four this year (up from two in 2010). Every year, the PACE/PACENET program partners with certain Part D plans; these are the plans that the Program works most closely with and enroll certain members into for Part D coverage.

The 2011 PACE/PACENET Partner Plans are:

- **AARP Medicare Rx Preferred**
- **CIGNA Medicare Rx Plan One**
- **Community CCRx Basic**
- **Wellcare Classic**

This list is also available on our website-  
[www.phlp.org](http://www.phlp.org).

PACE/PACENET is currently sending out notices to let individual members know whether the Program: (1) recommends that they keep their current part D coverage; (2) recommends they change their Part D coverage, or (3) will take action to enroll them into a partner plan for 2011. Consumers should read the notice carefully, or show it to a family member or professional for assistance, so that they know whether they need to take any action by **November 24, 2010**.

Individuals who receive a letter indicating that the Program is going to take some action on their behalf and who don't respond by November 24<sup>th</sup> will be enrolled in the Part D plan that PACE chose for them starting January 1, 2011.

**Note: It is especially important for people who are currently enrolled in a Medicare Advantage plan to read their notices carefully and make sure PACE/PACENET knows about their Medicare Advantage coverage. If PACE/PACENET does not know that some-**

**one is in a Medicare Advantage plan, the Program may take action to auto-enroll him in a partner plan. This will result in the individual losing their Medicare Advantage coverage. If a PACE/PACENET member has a Medicare Advantage plan that she wants to keep, she needs to notify PACE about this!**

When PACE/PACENET auto-enrolls a member into a Partner plan, it uses an "intelligent assignment" process which means it reviews the medications a consumer takes, and the pharmacy (ies) he prefers and auto-enrolls the member into the partner plan that will best meet his needs. Also keep in mind that PACE and PACENET are "creditable" coverage (prescription coverage as good as or better than Part D) which means that members do not need to be enrolled in a Part D plan at all.

### **PACE Plus Medicare**

PACE will pay the Part D plan premium (up to \$34.07 in 2011) for PACE members enrolled into a PACE Partner Plan or any other Part D plan that has a signed agreement with PACE. PACE will pay the Part D costs (above the \$6/\$9 PACE co-pays) for all PACE Members regardless of which Part D plan they are enrolled in. PACE also acts as the secondary coverage to the individual's Medicare Part D plan, so individuals with both Medicare Part D and PACE should never pay more than \$6 for generic drugs and \$9 for brand name drugs as long as the medication is covered by the PACE program and they are going to a pharmacy that works with both their Part D plan and with PACE.

PACENET members will be responsible for paying their Part D plan premium (even if they are enrolled in a Partner plan). However, PACENET acts as secondary insurance to Part D, so

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PACENET members should never pay more than \$8 for generic drugs and \$15 for brand-name drugs at the pharmacy as long as that medication is covered by the PACE program and they are going to a pharmacy that works with both their Part D plan and with PACE. PACENET members who choose not to join Part D will generally have to pay a \$34.07 premium at the pharmacy each month before they can get their drugs at the \$8/\$15 co-pay amount.

For more information on PACE/PACENET auto-enrollment into Medicare part D and how PACE/PACENET coverage work together with Medicare Part D, go to the PACE/PACENET website at <https://pacecares.fhsc.com>.

## **Annual Disenrollment Period Replaces Medicare Advantage Open Enrollment Period Starting January 1st**

Starting January 1, 2011, the separate Medicare Advantage Open Enrollment Period (that had run from January 1 through March 31<sup>st</sup> in past years) will be eliminated and replaced by the Medicare Advantage Annual Disenrollment Period (ADP). The ADP will run from January 1<sup>st</sup> through February 14<sup>th</sup>. During that period, anyone in a Medicare Advantage plan can disenroll from that Plan and go back to Original Medicare. Individuals who take advantage of the ADP to disenroll from a Medicare Advantage plan that includes Part D prescription drug coverage will get a Special Enrollment Period allowing them to enroll in a stand-alone Prescription Drug Plan. Individuals cannot change Medicare Advantage Plans or enroll in a Medicare Advantage Plan during this ADP; they can only use the ADP to disenroll from a Medicare Advantage Plan and go to Original Medicare.

Because of the limitations on what plan changes can be made after January 1<sup>st</sup>, it is critical that Medicare beneficiaries spend time during the upcoming Medicare Annual Open Enrollment Period (which runs from November 15<sup>th</sup> through December 31<sup>st</sup>) evaluating their plan options and choosing a plan that will be affordable and that will cover their drugs (and other providers if in a Medicare Advantage plan) in 2011. Individuals can only change plans after January 1<sup>st</sup> if they are able to use the ADP described above, or if they qualify for a Special Enrollment Period. Individuals can contact APPRISE (1-800-783-7067) and/or Medicare (1-800-633-4227) for assistance with their 2011 Plan options. Low-income individuals can contact PHLP's HELPLINE for assistance at 1-800-274-3258.

**Please support PHLP by making a donation through the United Way of Southeastern PA. Go to [www.uwsepa.org](http://www.uwsepa.org) and select Donor Choice number 10277.**

## Low-Income Beneficiaries to Receive Important Notices from Medicare in Upcoming Weeks

Medicare beneficiaries receiving the full low-income subsidy (LIS) who are currently in a zero-premium Part D plan that will no longer be a zero-premium plan in 2011 will soon get a notice from Medicare explaining whether they need to take action or not before the end of the year to avoid paying a premium starting in January. There are two notices being sent: one to “choosers” (individuals who enrolled in a plan of their choice rather than the plan that Medicare picked for them) and one for those who will be reassigned to a different plan by Medicare (these individuals remained in the plan that Medicare picked for them).

Remember—anyone who gets **any** help from Medical Assistance (whether it’s full medical coverage or just payment of the Part B premium) automatically gets the full LIS.

### Choosers Notice

This notice will be sent out the week of November 15<sup>th</sup> on **tan** colored paper. The notice will tell people that their current plan will not be zero-premium in 2011 and that individuals will have to make a different plan choice and enroll into the new plan by December 31, 2010 to avoid paying some amount of premium starting in January. If they don’t make any change before the end of the year, they’ll remain in their current plan and start to pay a premium in 2011.

### Reassignment Notice

This notice will be sent out the week of November 8<sup>th</sup> on **blue** colored paper. The notice will tell people that their current plan will no longer be zero-premium in 2011 and that Medicare will enroll them into a different plan that will be zero-premium in 2011. Individuals who do nothing before the end of the year will be enrolled in the new plan that Medicare picked for them starting January 1, 2011. Individuals who wish to remain enrolled in their current plan in 2011 must call 1-800-MEDICARE (1-800-633-4227) or their plan to let them know that. Those who choose this option will start paying some amount of premium as of January 1<sup>st</sup>. Finally, individuals can join a different plan on their own by December 31, 2010 and will be enrolled in the plan of their choice starting January 1, 2011.

Reassignment notices will also be sent to low-income subsidy recipients whose Part D plan or Medicare Ad-

vantage plan is terminating at the end of the year. Medicare will enroll these individuals into a stand-alone prescription drug plan to start January 1, 2011. Individuals who choose a different plan and enroll by the end of the year will be covered by the plan they choose as of January 1<sup>st</sup>. Individuals who do nothing will have Original Medicare and a stand-alone drug plan starting in January. **If these individuals do not have Medical Assistance or any other secondary coverage, they will only have Medicare in 2011 and could face significant cost-sharing.**

### 2<sup>nd</sup> Reassignment Notice

In mid-December, Medicare will send **ALL** beneficiaries impacted by reassignments another notice on **blue** paper. This notice reminds people that they will be enrolled into the plan that Medicare picked for them as of January 1st unless they make a different choice by December 31, 2010. In addition, the notice will, for the first time, provide detailed information about the new plan’s costs and drug coverage to help affected individuals with their decision making. The notice will tell individuals whether their current drugs are or are NOT covered by the plan and whether there are any limitations on coverage of their drugs under the new plan.

### Some important information to keep in mind:

- In most cases, Medicare randomly enrolls people into plans.
- All notices will be sent on Medicare letterhead.
- Individuals have until December 31, 2010 to make a new Medicare plan choice for 2011; however, enrolling by early December will help ensure that all the systems are updated and that the person receives all the information (including their ID card) from their new plan by January 1st.

Consumers who receive any of these notices should read them carefully. Individuals with questions or needing assistance with 2011 plan options can call the PHLP HELPLINE at 1-800-274-3258, APPRISE at 1-800-783-7067 or Medicare at 1-800-MEDICARE (1-800-633-4227).

## New Medicare Durable Medical Equipment and Supplies Program To Begin in SW Pennsylvania

Medicare will start a new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program **on January 1, 2011** in certain regions of the country. One of those regions is the Pittsburgh Competitive Bidding Area which consists of Allegheny, Armstrong, Beaver, Butler, Fayette, Washington and Westmoreland counties along with small sections of Clarion, Greene, Indiana, Lawrence, and Venango counties. Whether a consumer lives in the Pittsburgh Competitive Bidding Area depends on their zip code and can be determined by calling 1-800- MEDICARE or by going to [www.dmecompetitivebid.com/palmetto/CBIC.nsf/DocsCat/Home](http://www.dmecompetitivebid.com/palmetto/CBIC.nsf/DocsCat/Home).

The DMEPOS Program will change how beneficiaries in **Original Medicare** obtain their durable medical equipment and supplies; beneficiaries enrolled in Medicare Advantage Plans are not affected by DMEPOS and can continue to use any suppliers authorized by their Plan.

Consumers in Original Medicare are those that use their red, white and blue Medicare card to receive health care and treatment. Currently, if those consumers need any durable medical equipment or supplies they can go to any provider or supplier who accepts Medicare. Under DMEPOS, affected consumers must use a contract supplier that has been chosen by Medicare through a competitive bidding process. Medicare announced the DMEPOS contract suppliers in early November. Contracts were awarded to providers offering a low price and meeting certain other criteria. The list of contract suppliers by region can be found at [www.cms.hhs.gov/DMEPOSCompetitiveBid/01A2\\_Contract\\_Supplier\\_Lists.asp](http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp)

DMEPOS will affect Medicare beneficiaries who have Original Medicare and who permanently reside in a

zip code included in the Pittsburgh Metropolitan Area, or who are visiting in the Pittsburgh Metropolitan Area and who need an item covered by DMEPOS. In most cases, beginning January 1<sup>st</sup>, these Medicare beneficiaries will only be able to use contract suppliers to obtain the following items covered by DMEPOS:

- Oxygen, oxygen equipment & supplies
- Standard power wheelchairs and scooters
- Complex rehabilitative power chairs and accessories (group 2)
- Mail-order diabetic supplies
- Enteral nutrients, equipment & supplies
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs)
- Hospital beds and related accessories
- Walkers and related accessories

Note that there is a process in place to allow consumers to continue to use current non-contract suppliers. However, this exceptions process is only available to consumers who are renting durable medical equipment before January 1, 2011 and whose non-contract supplier elects to be "grandfathered" by Medicare.

Medicare will be mailing out a letter and a brochure to all Medicare beneficiaries in the Competitive Bidding Areas that explains the DMEPOS program. Suppliers that are currently serving Original Medicare beneficiaries are responsible for notifying their customers whether they will be a contract supplier under DMEPOS and, if not, whether or not they will elect to be "grandfathered".

Anyone having questions or concerns about the DMEPOS program can contact PHLP's Helpline at 1-800-274-3258.

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## Upcoming PHLP Trainings on Programs for Low-Income Medicare Beneficiaries

PHLP and North Penn Legal Services are jointly sponsoring a training-***Working with Low-Income Medicare Beneficiaries: What You Need to Know***. The trainings will cover various topics related to helping low-income Medicare beneficiaries with their health care costs and accessing care including:

- How Medical Assistance Programs Can Help
- Qualifying for Medical Assistance
- How Dual Eligibles Access Care
- Getting Extra Help with Medicare Part D costs

### **November 17, 2010 @ 1pm -3pm**

Center for Independent Living  
24 E. 3rd St.  
Williamsport, PA 17701

### **December 1, 2010 @ 1pm-3pm**

Lehigh County Government Center  
Public Hearing Room  
17 South Seventh St.  
Allentown, PA 18101

***An RSVP is required to estimate attendance. Please contact [staff@phlp.org](mailto:staff@phlp.org) or leave a message on our Helpline at (800) 274-3258 to RSVP.***



Pennsylvania Health Law Project

The Corn Exchange

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