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Important Medicare Changes Start January 1

Starting January 1st, people on Medicare will get some important help through provisions of the Affordable Care Act. Here's a brief summary of some changes that will be in place for 2011:

-***Discounts on Medications while in the Part D Doughnut Hole***: Individuals enrolled in Medicare Part D will have a discount on their medications when they are in the doughnut hole (the gap in coverage in which Part D enrollees are required to pay the full cost of their drugs until they qualify for catastrophic coverage). In 2011, Part D enrollees who do not qualify for a Low-Income Subsidy will reach the doughnut hole when their total drug costs reach $2,840. They will remain in the doughnut hole until their ***out of pocket costs*** reach $4,550.

Beginning in 2011, however, individuals in the doughnut hole will get a 50% discount on brand name drugs and a 7% discount on generic drugs. This means that if someone takes a brand name medication that costs $100 while in the doughnut hole, they'll pay $50 (plus any small dispensing fee charged by the pharmacy). These discounts will increase each year until 2020 when the doughnut hole will be eliminated.

-***Annual Disenrollment Period Runs from January 1 through February 14th:*** Individuals enrolled in a Medicare Advantage plan for 2011 will have 45 days at the beginning of the year to disenroll from their plan and return to Original Medicare. This enrollment period, known as the Annual Disenrollment Period (ADP), will occur ever year starting in 2011. Individuals who take advantage of ADP will also get a Special Enrollment Period to join a Part D plan.

Please note that the only action someone can take during the ADP is to disenroll from their Medicare Advantage Plan and return to Original Medicare. Individuals cannot change Medicare Advantage Plans and individuals in Original Medicare cannot join a Medicare Advantage plan during this enrollment period. Individuals who take advantage of the ADP and who do not have any other insurance will have to pay Part A and B deductibles and coinsurance. Individuals can contact APPRISE (1-800-783-7067) to learn about whether they have a right to buy a Medigap policy to help with the cost-sharing under Original Medicare. The ADP replaces the now eliminated Medicare Advantage Open Enrollment Period that had been in effect from January 1st - March 31st in previous years.

-***Preventive Care Services Available at No Cost:*** Medicare beneficiaries will be able to get most preventive services at no cost--meaning they won't be subject to the Part B deductible or Part B coinsurance for these services after January 1st. Preventive services include mammograms, prostate cancer screenings, diabetes screenings, annual flu shots, and more. Medicare's coverage criteria for preventive services haven't changed; the difference

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is that people no longer have any Medicare cost-sharing for these services. In addition to getting preventive services at no cost, Medicare beneficiaries will no longer have to pay for smoking cessation services after January 1st. For additional information, see our October Senior Health News or a detailed fact sheet on our website (www.phlp.org).

-***Coverage of an Annual Wellness Visit:*** Individuals who have been on Medicare for more than one year will begin to have coverage for an annual wellness visit starting in 2011. Medicare currently covers a "Welcome to Medicare" exam only available to new Medicare beneficiaries (within their first 12 months of coverage). The new Annual Wellness visit will include the development of a personalized prevention plan and a health risk assessment to establish the person's medical history, create a screening schedule for the next 5-10 years based on the individual's age and health status, and detect cognitive impairments. The Annual Wellness Visit will be covered at no cost to the individual.

-**Medicare Advantage Plan enrollees will be better protected from high costs:** Medicare Advantage Plans will be prohibited from charging enrollees more than Original Medicare charges for certain services. Individuals with Original Medicare have certain costs for covered services as described earlier in this newsletter. Medicare Advantage plans have had discretion to decide what deductibles or cost-sharing to charge their members. As a result, some Medicare Advantage plans had been charging their members' higher costs for services than the individual would have paid if they were covered under Original Medicare. As of January 1st, however, Medicare Advantage plans will not be allowed to charge more than Original Medicare for certain expensive services like chemotherapy, dialysis, and skilled nursing facility stays. For example, a Medicare Advantage plan wouldn't be allowed to charge more than 20% coinsurance for chemotherapy or dialysis services.

Also, starting in 2011, Medicare Advantage plans must limit members' out-of-pocket costs for certain services (those that would normally be covered under Part A and B like hospital stays, skilled nursing facility stays, doctor visits, etc.). Plans will be required to set a maximum out-of-pocket limit of $6,700; however, plans can choose to impose a lower maximum out-of-pocket cost limitation of $3,400. This means that once an individual reaches that maximum out-of- pocket spending limit, they will have no further cost-sharing required of them for the remainder of the year even if they need additional services to which the out-of-pocket maximum applies.

Individuals with questions or who experience any problems related to these changes after January 1st should call PHLP's Helpline at 1-800-274-3258.

Happy Holidays from PHLP!

As the year ends, we take a moment to wish all our readers happy and safe holidays and a healthy new year! PHLP is a small non-profit 501(c)(3) law firm. We encourage you to consider us when you are making any year-end contributions to charitable organizations.

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Changes to Medicare Costs in 2011

In November, the Center for Medicare & Medicaid Services (CMS) announced changes to Medicare premiums, deductibles and co-pays that will take effect January 1, 2011.

Medicare Part A

Part A is the hospital benefit of Medicare that covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice (care for the terminally ill) services. In 2011, the Part A hospital deductible will be $1,132 (up from $1,100 in 2010). If someone is in the hospital longer than 60 days, their cost-sharing in 2011 will be:

- $283/day for days 61-90 (up from $275 in 2010)
- $566/day for days 91-150 (up from $550 in 2010)

Medicare beneficiaries in a skilled nursing facility that accepts Medicare will pay $141.50/day for days 21-100 (compared to $137.50 in 2010). There is no cost for skilled nursing facility care for the first 20 days.

Medicare Part B

Part B is the medical benefit of Medicare that covers physician services, outpatient hospital services, tests, ambulance services, durable medical equipment and some home health services. The Part B premium in 2011 will be $115.40/month.* As in previous years, beneficiaries with higher income (i.e., a modified adjusted gross annual income greater than $85,000 for a single person/$170,000 for a married couple) will pay a higher Part B monthly premium on a sliding scale, depending on their income.

The Part B deductible will be $162 in 2011 (up from $155 in 2010). Individuals have to meet this deductible before Medicare starts covering most Part B covered services.

Medicare Part D

The costs of a Medicare Part D standard plan for 2011 were already detailed in our October Newsletter, available at www.phlp.org.

Beginning in 2011, Medicare beneficiaries with high incomes (who will be paying a higher Part B premium as noted above) will now also pay an additional income-related Part D premium. This additional Part D premium will be paid directly to Medicare through a withholding from their Social Security checks.

**Note: Under Medicare's "hold harmless" clause, those who paid a Part B premium of $96.40 or $110.50 in 2010, and who have their premium automatically withheld from their Social Security check, will not have their premium increase but will continue to pay their current premium in 2011.*

Slight Increase to Asset Limits for LIS and MSP in 2011

Effective January 1, 2011, the asset limits to qualify for the Part D Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSP) are increasing. The Part D LIS helps with Medicare Part D costs by eliminating the donut hole, reducing co-pays, and helping with the annual deductible and monthly premium costs. MSP provides coverage of the Medicare Part B premium and may help with Medicare Parts A and B cost-sharing for qualified individuals. Individuals apply for LIS through the Social Security Administration and apply for MSP through the PA Department of Public Welfare.

Part D Low-Income Subsidy (LIS)

LIS asset limits in 2011 will be:

- **Full Subsidy-$6,680 for a single person and $10,020 for a married couple** (these limits are currently $6,600/single person and $9,910/married couple)
- **Partial Subsidy-$11,140 for a single person and $22,260 for a married couple**

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(these limits are currently 11,010/single person and $22,010/ married couple).

In addition to the asset limits, there are income limits as well. Individuals must have income below 135% FPL (currently $1,218/mo for a single person and $1,640/mo for a married couple) to qualify for a ***full*** subsidy and below 150% FPL (currently $1,354/mo for a single person and $1,821/mo for a married couple) to qualify for a ***partial*** subsidy.

Please note that the asset limits shown above are *after* all deductions and disregards are taken (including the $1,500 per person disregard the Social Security Administration gives if someone plans to use their assets for funeral or burial expenses)

Medicare Savings Programs (MSP)

As of January 1, 2010, federal law requires MSP asset limits to match the asset limits for the full Low-Income Subsidy. Therefore, **in 2011, the MSP asset limits will be $6,680 for a single person and $10,020 for a married couple**. Again, these amounts are after all deductions and disregards are taken. The current MSP asset limits are $6,600 (single) and $9,910 (married couple). In addition to the asset limit, income must be below 135% FPL to qualify for MSP (see the note above regarding FPLs).

Please contact PHLP's Helpline at 1-800-274-3258 with questions about qualifying for either LIS or MSP.

Will Doctors Stop Taking Medicare?

Every year, organized physician groups sound an alarm, "If Congress doesn't act, Medicare payments to physicians will decrease, and physicians will stop taking Medicare." This year is no exception. The American Medical Association prepared a statement noting that access to care for Pennsylvania seniors and people with disabilities "will get much worse unless Congress acts very soon to prevent steep cuts in Medicare rates."

Fortunately, Congress did act to prevent the 20% pay cut, an action they have taken every year since the threat of these "automatic" pay cuts began. But because Congressional action is in the form of a temporary stopgap, rather than a permanent fix to the problem, the "scare tactic" of pay cuts and physicians leaving Medicare will continue to be raised.

To understand the situation, it is worth asking three questions:

- *Should seniors be worried?*
- *Why does this happen?*
- *What does Congress really need to do?*

Should seniors be worried? The answer is probably not.

A government report in 2009 found that less than 3% of Medicare beneficiaries nationwide reported trouble accessing care because physicians would not accept Medicare. A 2009 report on Medicare Physician Services by the U.S. Government Accountability Office noted that between calendar years 2000 and 2008 the number of physicians willing to serve Medicare beneficiaries and accept Medicare fees went up, not down.

Medicare beneficiaries make up a large percentage of most physician practices that serve adults for the simple reason that older people and people with disabilities require more physician visits than younger, healthier people. That means most doctors are dependent on Medicare for a

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significant portion of their income. Doctors who can afford to stop accepting Medicare, or who can limit the number of Medicare patients in their practice, are those who have enough young, healthy patients in their practice or who serve higher income patients able to pay higher rates.

Because most doctors accept Medicare, a physician decision to stop accepting it is a rare event. Overall, Medicare is a program popular with physicians and patients and as a result most seniors and people with disabilities do not need to worry.

What causes this recurrent crisis, and the threat of a drastic pay cut?

In 1997, as part of the Balanced Budget Act, Congress created a formula called the Sustainable Growth Rate (SGR). Under SGR, the total amount of money that Medicare spends on physician services is supposed to depend on the growth in physician costs, Medicare enrollment, and the gross domestic product per person in the country. Under that formula, if the money spent on doctor services is too much in one year, then the amounts paid to physicians for the services they provide are supposed to be reduced in the following year to move total spending back.

When Congress created the SGR formula, they did not think about the difference between limiting the total amount of money spent and limiting the number of services provided. Since 1997, many services became more complex. SGR ended up giving an incentive to doctors to schedule more office visits for their patients and do more procedures, but penalizing doctors who chose to spend more time with their patients during office visits, or who did not "speed up."

In the meantime, the SGR formula stated that if payments to physicians were rising too fast, the cuts would be more severe with each passing year. So far, Congress has acted each year to prevent the cuts, but the threatened amount to be cut has increased until it reached 21.2% in 2010.

What does this have to do with health reform, and what does Congress need to do?

The SGR formula and the threats to decrease physician payments have nothing to do with the Affordable Care Act (the health reform law). None of the proposed savings in health reform come from the 1997 SGR formula. In the course of the Congressional debate around health reform some members of Congress sought to include a change in the SGR formula (the "doc fix"). However, the "doc fix" did not make it into the Affordable Care Act. The SGR formula is a factor in calculating the federal budget, and the deficit; this makes it difficult for Congress to create a permanent fix for the problem.

Most national health policy experts agree that the amount the United States now spends on physician services is about right. The problem is that too much of the spending goes to specialists and not enough to primary care providers. Although many physicians and policy experts agree that Congress needs to get rid of the SGR formula, it may not be on the agenda anytime soon. Until then, physicians will continue to sound the alarm and threaten to stop taking Medicare if Congress doesn't stop the cuts and Congress will respond by preventing the cuts for another six months to one year.

So – should seniors be worried?

Traditional Medicare is a popular program, and it is likely that the majority of doctors will continue to take it. They will use their own professional organizations to pressure Congress to protect their financial interests; so large cuts, such as required by the SGR, are unlikely. Disagreements among high paid specialists, and lower paid specialists and primary care doctors, are likely but should not directly involve patients.

Doctor participation in Medicare managed care (Medicare Advantage Plans) is much harder to predict. In that case, the managed care organization determines payment. Doctors agree to participate in a managed care plan's network if they agree to the provider reimbursement and the other requirements imposed by that plan. Since not all doctors participate with Medicare Advantage Plans, it's important that people check with a plan about whether their doctor is in the network before joining.

Integrated Care Alert!

PHLP just learned that the PA Departments of Aging and Public Welfare plan to apply for federal funds to be made available from the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation, with the aim of improving care to dual eligibles (people who have both Medicare and Medicaid).

CMS is seeking proposals to fund up to 15 states interested in short term strategic planning around integrating care for dual eligibles. Readers may remember that Pennsylvania considered a controversial Integrated Care Initiative (ICI) in 2008 but eventually decided to postpone its efforts after criticism from dual eligible consumers and their advocates. The Commonwealth's Integrated Care Initiative efforts were detailed in past editions of the Senior Health News.

Proposals for this strategic planning funding are due February 1, 2011. Pennsylvania has expressed interest in this funding and seeks stakeholder input on the development of the its proposal to CMS. Please contact PHLP's Helpline at 1-800-274-3258 for additional information. We will report on the state's application for funds in upcoming newsletters.

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