SENIOR HEALTH NEWS

The Pennsylvania Health Law Project Help-Line
–800-274-3258 or 1-866-236-6310 (TTY)

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The NEW Medicare Prescription Drug Benefit Begins January 1, 2006

As the January 1, 2006 startup of the Medicare Prescription Drug Benefit approaches, consumers still have many questions and concerns. Here are some answers to the most commonly asked questions we are seeing right now:

1) Do I have to take Medicare Prescription Drug Coverage?

For people with Pennsylvania Medical Assistance (Medicaid) in addition to their Medicare, the answer is YES. This is because Medical Assistance prescription drug coverage is ending on December 31st for these individuals (called dual eligibles). If these dual eligible consumers do not join a Medicare Prescription Drug Plan on their own by December 31, 2005, they could find themselves in a plan that does not cover their prescriptions or they could find themselves without drug coverage on January 1, 2006.

For everyone else, the answer is NO. Technically, the benefit is voluntary. People now enrolled in Medicare have until May 15, 2006 to decide whether or not to sign up for the benefit. However, those who do not enroll by May 15, 2006 (the initial enrollment period) may face a penalty for delayed enrollment. Everyone who does not join a Medicare Prescription Drug Plan by May 15, 2006 will be penalized if they do not have other prescription drug coverage that is as good as, or better than the Medicare benefit. The penalty is a 1% increase in the premium for every

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Lawsuit Filed Against CMS Over Passive Enrollment

On November 30, 2005, PHLP and Community Legal Services filed a class action lawsuit against CMS (the Federal Agency that oversees the Medicare and Medicaid programs) on behalf of dual eligible consumers (those with Medicare and Medicaid) and consumer advocacy organizations over the "passive enrollment" of Pennsylvania's dual eligible consumers into Medicare HMOs.

The lawsuit challenges CMS' authority to enroll people into a Medicare HMO if they have previously chosen to get their Medicare coverage through the Original Medicare Program. The lawsuit also claims that consumers did not get proper notice about this change and were not given enough information to make an informed decision. Consumers who are passively enrolled into a Medicare HMO may lose access to providers and experience a disruption in their care. See the article on pages 6 and 7 for more information about passive en-

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month that the person delayed enrolling into a Medicare drug plan. This penalty will be applied to the monthly premium at the time the individual joins a plan.

2) How do I find a Medicare Prescription Drug Plan that will work for me?

There are well over 50 Medicare Prescription Drug Plans available in Pennsylvania. Each plan has different costs, covers different drugs, and works with different pharmacies. You need to be sure to join a plan that covers your drugs (including your dosage and quantity, too). You need to check to make sure that you can continue to go a pharmacy that is convenient. If you are considering a Medicare HMO, you need to make sure your hospital, doctors and other health providers participate in the plan.

The task of comparing plans is proving difficult for many consumers. The following resources are available for finding plans that cover the drugs you take and that allow you to go to the pharmacies you choose. These resources are for anyone on Medicare or anyone trying to help someone on Medicare:

- Medicare:
  - 1-800-MEDICARE (1-800-633-4227 or 1-866-486-2048 (TTY))
  - www.medicare.gov—Compare Prescription Drug Plan tool
- APPRISE: 1-800-783-7067

The Pennsylvania Health Law Project is NOT generally available to help consumers pick which plan works for their individual circumstances. However, please do call our toll-free helpline 1-800-274-3258 or 1-866-236-6310 (TTY) if you encounter any problems, to report concerns, or if you need assistance with enrollment into a plan or into the "extra-help"/subsidy program.

3) If I don't pick a plan, will I be assigned to one?

Only dual eligibles will be assigned to a plan, if they do not pick one on their own by December 31, 2005. See pages 6 and 7 for more information about this.

4) Can I change Medicare Prescription Drug Plans once I join a plan?

Generally, consumers will be locked-in to their Medicare Prescription Drug Plan after May 15, 2006. Consumers are allowed to change their plans every year during a six week period which starts November 15th and ends December 31st.

After May 15, 2006, consumers can only change their plans outside of this six week period if they qualify for a Special Election Period. One example of a Special Election Period is when a person goes into or comes out of a nursing home.

Dual eligibles (people with both Medicare and Medical Assistance) qualify for an ongoing Special Election Period, so these consumers will be able to change plans at any time during the year.

5) Can I still apply for extra help or the low-income subsidy?

Yes, you can apply for the extra help at any time.* The extra help greatly lowers the costs you have to pay for the Medicare Prescription Drug Benefit. In order to qualify, you must meet the following income and asset guidelines:

- Single person: Yearly income below $14, 355 and resources below $10,000
- Married couple: Yearly income below $19,245 and resources below $20,000

Not all income and resources are counted. If you want more information about this extra help, call the Social Security Admini-

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stration at 1-800-772-1213 or call the PHLP helpline.

***Remember, dual eligibles automatically qualify for this help and do not need to apply for this.**

6. What if I need a prescription filled in the beginning of January and I do not know which Plan I have?

There is concern that individuals will fall through the cracks and not get the drug coverage they need when the new benefit begins in January. **Medicare is taking steps to make sure all full benefit dual eligibles get Medicare Drug Coverage on January 1, 2006. These steps include:**

- Having a system in place for the pharmacy to find out plan and co-payment information for dual eligibles who do not know their Medicare Prescription Drug Plan information. You will need to present your Medicare and Medical Assistance cards at the pharmacy so the pharmacist can get this information.
- CMS is also setting up a point-of-sale mechanism for dual eligible consumers who are not in a Medicare Prescription Drug Plan on January 1, 2006 and who go to a pharmacy to get a prescription filled. This point-of-sale mechanism would allow consumers who show proof that they have Medicare and Medical Assistance to get their prescription filled and for Medicare to facilitate enrollment into a Medicare Prescription Drug Plan.

7. What if I cannot get a drug I need through my Medicare Prescription Drug Plan?

You should ask the plan about their transition policy and whether that policy covers a one-time fill of a prescription for a medication that is not on the plan's formulary. You or your doctor can also request an exception from the Plan. Each plan will have a different process, so you should ask your plan about this. If you request an exception, your doctor will need to send the plan information about why you need a drug that is not on the plan's formulary. The plan then decides whether or not to cover the drug. There are further appeal options if the plan does not cover it for you. You can contact our helpline if you need assistance with this.

If you are a dual eligible, you can also think about changing prescription drug plans. You are able to change plans at any time. If you do change plans, you will be in the new plan on the first of the following month.

8. What if I cannot afford the co-pays for my medications?

Unfortunately, there is no requirement that the pharmacy must give you your prescriptions if you cannot pay the co-pay. Pharmacies have the option of waiving co-pays on a case by case basis. However, they are not required to do so. If you are denied medications because you cannot pay the Medicare Prescription Drug Plan co-pays, please contact the helpline.

For up-to-date information or individual assistance, please see the PHLP website at www.phlp.org or call our toll-free helpline at 800-274-3258 or 1-866-236-6310 (TTY).

Access Cards and Fee for Service: 101

Consumers who have Medicare and who are also enrolled in a Medical Assistance HMO will be taken out of their physical health Medical Assistance HMO and will be moved into Medical Assistance Fee for Service starting January 1, 2006. This means that dual eligibles who have been in a Medicaid HMO will have a different process for accessing some physical health services and will be using the Access card in place of their Medical Assistance HMO card. Below are some answers to some frequently asked questions:

What is an Access Card?
The Access Card is a yellow or green Medical Assistance card. After January 1, 2006, you will present this card to your health care providers when you get medical services.

How do I get an Access Card?
You should have received an Access card when you first became eligible for Medical Assistance. If you cannot find your card, you should contact your local County Assistance Office to ask for a new card.

When do I have to show my Access Card?
You should show your Access card every time you receive medical services, even if you also have other kinds of insurance, such as Medicare or private insurance. If you have Medicare or other kinds of health insurance, you should show all of your cards. Your provider should bill your other insurance, including Medicare, first.

What is Fee for Service?
Fee-for-Service means that the Department of Public Welfare pays medical providers directly for services received by Medical Assistance recipients. In HealthChoices, the Department of Public Welfare paid managed care organizations to provide medical services to Medical Assistance consumers and the managed care organizations paid medical providers.

What will be different for dual eligibles in accessing medical services in Fee-for-Service?
Some things will not change at all. For example, dual eligibles will still be able to see any Medicare provider for Medicare covered services and should not be billed by the Medicare provider. For services not covered by Medicare, you will have to see a provider who takes Medical Assistance. If you are trying to get a service that is not covered by Medicare, you may have to have the service prior authorized by Medical Assistance. If the service is denied, you can appeal by asking for a fair hearing.

How will I get behavioral health services?
You will remain in your Medical Assistance Behavioral Health HMO and continue to get your mental health and drug and alcohol services in the same way.

How do I find providers who take Medical Assistance Fee For Service (the ACCESS card?
To find providers who take Medical Assistance, you can ask the County Assistance office for a list of providers.

If I do not have my Access card, can I still receive Medical Services?
Yes, you can still receive medical services even if you do not have your Access card. Your provider can look up your Medical Assistance number using your Social Security number and birth date.

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No-Premium Prescription Drug Plans for Dual Eligibles and Others Approved for the Full Low-Income Subsidy

Medicare has approved 15 stand-alone Prescription Drug Plans that people who qualify for the full subsidy can join without having to pay a monthly premium. A stand-alone plan is one that is not part of an HMO. These 15 plans are considered basic plans and have premiums less than the subsidy amount of $32.59.

Unfortunately, it has been challenging for consumers, and those assisting them, to determine which plans are the no-premium plans. The Medicare & You 2006 Handbooks that were sent to all Pennsylvanians who have Medicare in October contains wrong information. Pages 97A-97F list the available stand-alone prescription drug plans in Pennsylvania. Every plan listed indicates that the full premium amount will be covered for people who qualify for the full subsidy (the most extra help). This is incorrect.

Here is a list of the no-premium plans available in Pennsylvania for those who qualify for the full subsidy:

1. Aetna Medicare Rx Essentials (800-213-4599**)**
2. First Health Premier (800-588-3322)
3. Blue Rx Basic (888-697-8714)
4. Humana PDP Standard (800-281-6918)
5. Community Care Rx BASIC (866-684-5353)
6. PacifiCare Saver Plan (800-943-0399)
7. Prescription Pathway Bronze Plan (800-825-8200)
8. Amerihealth Advantage Rx Option 1 (866-456-1695)
9. Advantage Star Plan (877-279-0370)
10. Silver Script (866-552-6106)
11. Medicare Rx Rewards (866-892-5335)
12. AARP Medicare Rx Plan (888-867-5564)
13. United Medicare MedAdvance (888-556-7047)
14. Wellcare Signature (888-423-5252)
15. YOURx Plan by Medco (800-758-3605)

Dual eligibles and individuals who qualify for the full subsidy are not limited to joining one of these 15 plans. However, if individuals join a plan that is not on this list, they will have to pay part of the premium.

NOTE: Medicare has issued a corrected version of the Medicare & You Handbook but only on the Centers for Medicare & Medicaid Services website (www.cms.hhs.gov). Nothing has been sent to consumers correcting for this error. In the corrected version that is on the CMS website, only these 15 plans are listed as having the full premium covered for people that are dual eligible or that are approved for the full low-income subsidy.

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What should I do if I lose my Access Card?
You should report any lost or stolen Access Cards as soon as possible to the local County Assistance Office. You should be sent a new card.

If you have any other questions about accessing Medical Assistance with an Access card or have trouble accessing services, please call the Pennsylvania Health Law Project helpline at 1-800-274-3258, or 1-866-236-6310 TTY.

Enrollment of Dual Eligibles into Medicare Prescription Drug Benefit—Automatic Enrollment and Passive Enrollment Explained

Dual eligible consumers (those who have **both** Medicare **and** Medical Assistance) need to join a Medicare Prescription Drug Plan by December 31, 2005 because Medical Assistance drug coverage ends on this date. To make sure dual eligibles do not have a gap in prescription drug coverage, Medicare has two processes to enroll these individuals into a Medicare Prescription Drug Plan who do not join a Plan on their own by the end of the year:

1) Auto-enrollment into a stand-alone Prescription Drug Plan (PDP)
2) Passive Enrollment into a Medicare HMO that includes drug coverage.

AUTO-ENROLLMENT OF DUALS:
Medicare is auto-enrolling the following groups of dual eligibles into stand-alone prescription plans:

- Dual eligibles with Original Medicare (red, white, and blue card) and who get their Medical Assistance coverage through an Access card
- Dual eligibles with Original Medicare in a Medical Assistance HMO who opted-out of the *Medicare* HMO by October 31, 2005
- Dual eligibles with Original Medicare who joined a Medical Assistance HMO after August 15, 2005

At the beginning of November, Medicare started auto-enrolling these dual eligibles into one of the 15 no-premium stand-alone PDPs listed on page 5. This auto-enrollment into a PDP is random. This means you may be enrolled into a plan that does not cover your prescription drugs.

Consumers who have been auto-enrolled into a PDP should receive a notice from the U.S. Department of Health and Human Services. These notices are printed on yellow paper. The notices tell individuals which stand-alone prescription drug plan Medicare will enroll them in on January 1, 2006 if they do not join a plan on their own by December 31, 2005.

If you fit into one of the groups listed above and you have not received this notice, you should call 1-800-MEDICARE (1-800-633-4227 or 1-866-486-2048 TTY) to find out which Plan you will be auto-enrolled into on January 1, 2006.

Medicare will continue to auto-enroll individuals who become dual eligibles on a monthly basis and will continue to notify individuals about this auto-enrollment.

IMPORTANT: If you have not yet joined a Plan, you should contact the plan that Medicare will auto-enroll you into to make sure that Plan covers your drugs and meets your needs. If that plan does not meet your needs, you need to join a different Plan by the end of the year.

PASSIVE ENROLLMENT OF DUALS

Instead of randomly assigning all dual eligibles to a PDP, CMS has decided to passively enroll over 110,000 of Pennsylvania's dual eligibles into Medicare HMOs without their requesting such a change. This plan is now the subject of a class action lawsuit filed in federal court on behalf of Pennsylvania's dual eligibles.

Passive enrollment is a process that moves over 110,000 of Pennsylvania's dual

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eligibles out of Original Medicare (red, white, and blue card) and puts them into the **Medicare** HMO connected to their Medical Assistance HMO, effective January 1, 2006.

Although the Medicare HMOs sent consumers letters, many consumers were confused and none received any information from CMS on passive enrollment. The letters told dual eligibles they had to opt-out of the HMO by October 31, 2005, even though enrollment into Medicare Prescription Drug Plans was not to begin until November 15. Consumers were confused by the letters and did not understand what this change could mean to them.

For many, enrollment into a Medicare HMO will greatly affect their access to health care. In Pennsylvania, dual eligibles can see any Medicare provider and are not limited to providers who accept their Medical Assistance. However, enrollment into a Medicare HMO may limit the providers that a dual eligible can access. The Medicare HMOs engaging in passive enrollment have all agreed to a 90 day transition policy during which time their members can continue to see their current providers who are not in the HMO's network. After the first 90 days, however, consumers in these Medicare HMOs (with few exceptions) can only see providers who are in the Medicare HMO network This includes physicians, psychiatrists, durable medical equipment providers, pharmacies and specialists. In addition, a dual eligible in a Medicare HMO can't enroll in a different Medicare Prescription Drug Plan, even if the managed care plan doesn't cover most of their prescription drugs.

IMPORTANT: If you have not opted out of the Medicare HMO, you should do the following:

1) **Check to see if all of the medical providers you use are in the Medicare HMO's network.**

2) **Check to see if the Medicare HMO will continue to cover all the prescription medications you are taking now.**

3) **Be sure you understand how your ability to access providers, suppliers, etc. will change.**
4) **If you want to remain in the plan, do nothing. If you do not want to remain in the plan, choose a stand-alone drug plan or another HMO that will meet your needs. See page 5 on picking a plan that has no premium for dual eligibles and that might meet your needs.**

If the Medicare HMO will not meet your needs, you should choose another Prescription Drug Plan and enroll by December 31, 2005. Your enrollment into a different Plan will automatically take you out of the Medicare HMO.

If you opted-out of the Medicare HMO after October 31, 2005, you need to join a Medicare Prescription Plan before the end of the year to make sure you have drug coverage after 1/1/06.

If you have any problems enrolling in a new plan or securing information, please contact the Pennsylvania Health Law Project at 800-274-3258. Also call us with questions about passive enrollment or the lawsuit against CMS for doing this to dual eligibles.

Enrollment of Dual Eligibles
- For those Currently in a Medicare HMO

If you are already a member of a Medicare HMO, you should not have received an auto-enrollment notice or a passive enrollment notice. If you did, call your Medicare HMO and confirm whether you are scheduled to be passively enrolled or to remain in the plan you chose.

If you decide to stay in your Medicare HMO, you will get your prescription drugs through your current Medicare HMO or a different HMO within the same company. You can join a different Medicare HMO or join a stand-alone prescription drug plan. Please note that if you join a stand-alone drug plan, you will be taken out of your Medicare HMO and placed back into original Medicare.

For any questions about or problems with enrollment of dual eligibles, please call the Pennsylvania Health Law Project at 800-274-3258.

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