SENIOR HEALTH NEWS

Call The Pennsylvania Health Law Project
Help-Line to Sign Up – 1-800-274-3258 or 1-866-236-6310/TTY
Email staff@phlp.org

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Medicare Open Enrollment Period Starts November 15th!

It is that time of year again when all Medicare beneficiaries can make changes to their Medicare health plan and/or to their Part D plan. Every year, from November 15th through December 31st, anyone with Medicare can make changes to their plans. This six week period is known as the Open Enrollment Period. Any changes made during this period will take effect January 1, 2008.

Health Plans offering coverage in 2008 began marketing on October 1, 2007. As a result, consumers are receiving numerous mailings from the various plans available in 2008. In addition, plans will also be doing other marketing activities, like holding information sessions and appearing at health fairs. Here are some important things to remember about what Medicare plans can and cannot do when marketing their plans:

-Plan representatives cannot solicit door-to-door (unless they are invited);
-Plan representatives cannot enroll people over the phone (unless the person calls them);
-Plan representatives cannot misrepresent their plan's benefits or use high pressure sales tactics to enroll beneficiaries.

Any Medicare beneficiary currently enrolled in a Medicare health plan or a Medicare Part D plan should receive information from their current plan by October 31, 2007 that explains how the plan's costs, benefits, and drug coverage will be changing in the 2008 plan year. Usually, this information comes in a big packet and is difficult to read through and understand. However, it is very important that individuals review this information (or ask a friend, family member or trusted professional for help) so that they can decide whether they should remain in the same plan or change plans for next year. Individuals can also contact their plan directly to find out whether their drugs will be covered and how the costs are changing for 2008. Individuals enrolled in Medicare Advantage Plans should also make sure their doctors and other health care providers will continue to be in the plan's network and find out how the plan's benefits may be changing.

Medicare beneficiaries are generally locked-in to their plan choice for the entire year, unless they qualify for a Special Election Period to change plans. Dual eligibles (people with both Medicare and Medicaid) and individuals who qualify for a low-income subsidy can change their plan at any time during the year. See the article on page 8 for more information about Medicare plans available in PA for 2008.

Attention PACE and PACENET Members: Important Mailings Coming Soon!

PACE and PACENET are prescription programs for Pennsylvanians aged 65 and older with yearly incomes below $23,500 (single) and $31,500 (married couple). PACE and PACENET will be mailing letters to their members during the upcoming Part D Open Enrollment Period (November 15th through December 31st). In many cases, PACE/PACENET will be assigning members to new Part D plans for the upcoming year. This includes members who do not currently have any Part D coverage as well as members who have Part D, but whose plans will be changing in 2008. Members will have to contact PACE/PACENET by a date specified in the letter if they want to decline the enrollment or if they want to choose a different plan.

PACE/PACENET members should be on the lookout for these letters; they have to act fast if they do not want to be enrolled in Part D or enrolled into the plan the Program chooses for them. The law creating PACE Plus Medicare only requires that members be given 10 days to decline auto-enrollment into an assigned Part D Plan. Despite advocates' urging that seniors be given more time to understand the notice and decide whether they want to be auto-enrolled, PACE/PACENET has generally given members only the 10 days specified in the statute.

Given that short timeframe to make a major decision, it is important that PACE/PACENET members, their family, and their advocates understand how PACE Plus Medicare works so they can know their options and their rights. It's also important to know that PACE/PACENET members qualify for a Special Election Period to make **one** plan change during the year. Therefore, those who decline Part D enrollment, who enroll in a Part D Plan on their own, or who are auto-enrolled into a plan during the Open Enrollment Period do have one opportunity to change plans next year.

As a reminder, PACE and PACENET are considered "creditable coverage"-that is, these programs provide prescription coverage that is as good as, or better than, Medicare Part D. This means that persons on PACE or PACENET can decline enrollment into a Part D Plan when it is first offered to them. If these persons later lose PACE/PACENET coverage, they can then enroll into a Part D Plan without having to pay a penalty for delaying their enrollment.

PACE Plus Medicare

Even though PACE/PACENET members already have coverage as good as Medicare Part D, the state continues to encourage these consumers to enroll into a Part D Plan. This effort is called **PACE Plus Medicare**. If PACE/PACENET members join a Part D Plan, the state saves money because the Part D Plan becomes the primary prescription coverage and PACE/PACENET then becomes the secondary coverage. In exchange for the member joining a Part D Plan, PACE/PACENET will help pay most of the costs of the Part D Plan (described on the following pages in more detail).

Under PACE Plus Medicare, the state partners with certain Part D plans. The partner plans are stand-alone prescription drug plans (PDPs) who have special agreements with the state to accept auto-enrollments of PACE and PACENET members and to accept payments from PACE for member's Part D premiums. These plans have also agreed not to apply their prior authorization

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or step therapy requirements to PACE Plus Medicare enrollees. In addition to the partner plans, PACE also has agreements with certain other Part D plans (including many of the Medicare Advantage plans that include drug coverage, called MA-PDs) that allows them to pay some or all of the Part D plan premium on behalf of PACE members. Below is a review of the costs under PACE Plus Medicare for PACE and PACENET enrollees.

PACE Plus Medicare Costs for PACE members who enroll into a Part D Plan

If a PACE member is auto-enrolled into a Part D Plan or joins one on her own, this is how it works:

- PACE pays the Part D Plan premium (up to $26.59 in 2008) for those in a PDP or MA-PD that is a partner plan or that otherwise has an agreement with PACE.
- Member must use a pharmacy that is in their Plan's network and that participates with PACE.
- Member must show both Part D Plan ID card and PACE card at the pharmacy.
- PACE helps with the Plan's co-pays and covers medications during the Plan's deductible and "donut hole" so that the member never pays more than $6/$9 for medications covered by the PACE program.

PACE Plus Medicare Costs for PACENET members who enroll into a Part D Plan

If a PACENET member is auto-enrolled into a Part D Plan or joins one on their own, this is how it works:

- The member pays their Part D Plan's premium at the pharmacy in 2008 if they are in a partner Plan or a Plan that has an agreement with PACENET (***note***: this is different from 2007 where the member paid the premium directly to the Plan).
- The member's PACENET deductible is eliminated.
- Member must use a pharmacy that is in their Plan's network and that participates with PACENET.
- Member must how both Part D Plan ID card and PACENET card at the pharmacy.
- PACENET helps with the Plan's co-pays and covers medications during the Plan's deductible and "donut hole" so that members never pays more than $8/$15 for drugs covered by PACENET program.

Please note that PACE/PACENET automatically pays for drugs not covered by a Part D plan as long as the drug is covered by PACE/PACENET.

Part D Enrollments for 2008-2 Letters Will Come from the PACE Program

Currently, PACE/PACENET has 11 partner plans. However, in 2008, the number of partner plans is decreasing to 5. As a result, it is expected that thousands of PACE/PACENET members are going to be receiving notices from the Program reassigning them to different Part D plans. The 5 partner plans available next year are: AmeriHealth Advantage Rx Option 1; Community Care Rx Basic; Advantage Star Plan; Silver Script and AARP Medicare Rx Saver. PACE/PACENET reviews a member's medications, cost-sharing for those medications and pharmacy preference and chooses a partner plan that it believes will best meet the member's needs.

In October 2007, PACE/PACENET mailed letters to all members asking them not to make any Part D Plan changes or choices for 2008 until they receive further information and a recommendation from PACE/PACENET. In early November 2007, PACE/PACENET will send members an

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other letter notifying them whether the Program will be auto-enrolling them into a partner plan and, if so, gives the name of the plan. There are a number of different letters being sent to members, and the language of these notices will be different based on the member's circumstances:

- If a person is not already in a Part D Plan, he is told that PACE/PACENET will auto-enroll him into the recommended partner Plan for 2008 unless the person contacts PACE/PACENET by a date specified in the letter to decline the enrollment or to choose a different plan.

- If a person was previously auto-enrolled into a partner Plan by PACE/PACENET and the assigned plan is now changing, she is told that PACE/PACENET will auto-enroll her into the new plan for 2008 unless the person contacts PACE/PACENET by the date specified in the letter to decline the enrollment or to choose a different plan.

- If the person was previously auto-enrolled into a partner Plan by PACE/PACENET and the assigned plan is the same for 2008, he is told that he will be enrolled in the same plan for 2008 unless he contacts PACE/PACENET by the date specified in the letter to decline the enrollment or to choose a different plan.

- If the person is currently in a **non-partner** Part D Plan that she enrolled in on her own, she is told that if she wants to switch to the recommended partner plan she should notify PACE/PACENET by the date specified in the letter and PACE/PACENET will auto-enroll her into the partner plan.

Some members will be receiving letters to let them know that the Program will not be auto-enrolling them into Part D. This includes members that currently have coverage through a retiree plan or a Medicare Advantage Plan. These individuals will be told that PACE/PACENET cannot assign them to a Part D plan because it may disrupt their health benefits. These folks will be referred to their current plan to find out their options for getting Part D coverage. Also, members who have not used their PACE/PACENET benefits recently will not be enrolled into a Part D plan and will receive letters about this. Finally, certain members will receive letters in November telling them they are not eligible for Part D because they do not have Medicare.

What about PACE/PACENET members who do not join a Part D Plan?

Because PACE/PACENET is "creditable coverage", members can decline auto-enrollment and choose not to enroll into a Part D Plan. For members who do not have Part D, the PACE/PACENET programs will work the same in 2008 as they do now. PACE members must show their card at the pharmacy and they will pay $6/$9 co-pays for PACE-covered drugs. PACENET members must show their card at the pharmacy, pay a PACENET monthly deductible ($26.59 in 2008), and pay $8/$15 co-pays for PACENET-covered drugs.

For more information, see the PACE Plus Medicare Q & A on the Department of Aging's website at www.aging.state.pa.us or call the PACE/PACENET Program at 1-800-225-7223.

PACE Plus Medicare Piloting Auto-Enrollment into Medicare Advantage Plan With Drug Coverage

Up until now, PACE/PACENET has only auto-enrolled members with Original Medicare coverage into stand-alone Part D Plans (PDPs). PACE/PACENET has not previously auto-enrolled anyone known to be in a Medicare Advantage Plan (regardless of whether or not the plan included prescription drug coverage). Beginning in October 2007, PACE/PACENET is piloting an auto-enrollment process for members who are currently covered by Geisinger Health Plan Gold plans with no drug coverage. Geisinger Health Plan offers a number of Medicare Advantage plans in certain counties in central PA.

Approximately 6,000 PACE/PACENET members are currently enrolled in Medicare Advantage plans without drug coverage through Geisinger Health Plan Gold. Beginning in October 2007, PACE/PACENET is notifying these members that the Program is planning to auto-enroll them into a Geisinger Gold Medicare Advantage Plan with drug coverage (MA-PD). Letters sent to these members tell them they can decline the auto-enrollment by contacting the program by a certain date. If affected members do not contact the program by this date, they will be enrolled into the MA-PD plan effective either November 1st or December 1st. The effective date will depend on when the program sent the letter (in October or November).

For those members who are auto-enrolled into the MA-PD, PACE will pay the Part D portion of the MA-PD plan premium, cover the prescription deductible and donut hole, cover any medications the MA-PD does not cover, and cover any prescription co-pays in excess of the $6/$9 PACE co-pays. PACENET members will no longer pay the PACENET deductible at the pharmacy. Instead, they will pay the MA-PD plan premium directly to Geisinger Gold. PACENET will cover the prescription deductible and donut hole, cover any medications that Geisinger Gold does not cover, and cover any prescription co-pays in excess of the $8/$15 PACENET co-pays.

PACE/PACENET is considering expanding auto-enrollment of members in Medicare Advanatage plans without drug coverage into Medicare Advantage plans with drug coverage. Stay tuned to future editions of the Senior Health News for updates about this development. Individuals who have questions or concerns about this auto-enrollment can contact the PACE/PACENET program for additional information at 1-800-225-7223.

Are you an advocate or provider working with dual eligible clients over 60 years old in Southeastern PA who wants to stay up to date on Part D developments? Join the PHLP e-mail list serve! To join, e-mail staff@phlp.org with subject “join Part D list serve”.

PHLP staff are also available in Southeastern PA to conduct trainings on Part D related issues to help social service agencies and their dual eligible clients navigate their healthcare coverage. Trainings focus on eligibility for Medicare Savings Programs and the Low-Income Subsidy, healthcare access for dual eligibles, the rights that dual eligibles have under Part D and the appeals and grievance processes that are available to all Part D enrollees. Contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310 TTY).

Please feel free to copy and post or distribute this announcement.

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Medicare Part D: 2008

Update on Recent Changes and Enrollment Information

These trainings will discuss: 2008 Plan Choices, Enrollment Information and Updates, Subsidy Redetermination Processes, and State Programs (ie., PACE, CRDP, and SPBP) Plus Medicare Developments

Call The Pennsylvania Health Law Project
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Dates and Locations

November 7, 2007-1:00-3:00 pm
Westmoreland County Area Agency on Aging
Troutman's Building, Conference Room
200 S. Main St
Greensburg, PA 15601

November 9, 2007-1:30-3:30 pm
Carnegie Library of Pittsburgh
Downtown & Business, Meeting Room
612 Smithfield St
Pittsburgh, PA 15222

November 13, 2007-1:30-3:30 pm
Southwestern PA Area Agency on Aging
Conference Room A
305 Chamber Plaza
Charleroi, PA 15022

November 14, 2007-9:30-11:30 am
Butler Area Public Library, Meeting Room 1
218 N. McKean St
Butler, PA 16001

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www.phlp.org !!

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Understanding Medicare Advantage Plans (or Medicare Part C)

Learn about the kinds of Medicare Advantage plans available to consumers, how they work for low-income consumers and others, and what issues advocates are seeing with access to services and marketing concerns.

Monday November 19, 2007
9:00 -11:30 AM
Philadelphia

Call The Pennsylvania Health Law Project
Help-Line to Sign Up —1-800-274-3258 or 1-866-236-6310/TTY

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Email staff@phlp.org

Visit us online at www.phlp.org !!

Location
Philadelphia Bar Association
1101 Market Street—11th Floor
Philadelphia, PA

Note: Arrive early and Bring Photo ID to get through Building Security

Information About 2008 Medicare Plans Now Available!

Earlier this month, Medicare announced the Medicare health plans and Part D plans that will be available in 2008. This information can be found at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048/TTY). Also, 2008 Medicare plans are listed in the Medicare & You 2008 Handbook that is currently being mailed to Medicare beneficiaries.

In 2008, there will be 63 stand-alone Prescription Drug Plans (compared to 66 available in 2007). Of these 63 plans, 18 will be zero-premium plans for dual eligibles and others approved for the full low-income subsidy. In 2007, there are 26 zero-premium plans available to people with the full subsidy. Remember, prescription drugs plans are available statewide. There are 255 Medicare health plans available in 2008, compared to 224 available in 2007. Medicare health plan options differ depending on the county in which a Medicare beneficiary lives. Finally, there are 27 Medicare Special Needs Plans available in 2008, compared to 14 available in 2007. Medicare Special Needs Plans can limit their enrollment to certain Medicare beneficiaries including persons who: have both Medicare and Medicaid, live in a nursing home, or have certain chronic conditions (such as diabetes).

Although individuals have until December 31, 2007 to enroll in or change plans for 2008, Medicare is encouraging individuals to enroll in the new plan by the first week in December to ensure that the enrollment is processed and coverage is in place for January 1, 2008. Individuals can enroll in plans by contacting the plan they want to join directly, enrolling online at www.medicare.gov, or calling 1-800-MEDICARE (1-800-633-4887 or 1-877-486-2048/TTY).

Medicare beneficiaries who need additional help in finding out about 2008 plan options or picking a plan can contact the APPRISE Program at 1-800-783-7067. Dual eligible individuals can contact PHLP's HELPLINE for assistance at 1-800-274-3258 or 1-866-236-6310/TTY.

PHLP Launches New Screening For Medicare Part D Low-Income Subsidy

Good news! PHLP's "Quickscreen" has been expanded to include eligibility for the Medicare Part D Low-Income Subsidy. The Quickscreen tool has been praised as an easy and efficient tool for consumers and advocates alike in screening for eligibility of publicly funded health insurance programs in Pennsylvania. This electronic screening has traditionally included all categories of Medical Assistance, CHIP, AdultBasic and PACE/PACENet.

To use this screening tool, go to our website at www.phlp.org and find the Quickscreen link in the box on the right side of the Home page. Answer the questions as instructed and the Quickscreen will find categories of eligibility for you. If you indicate that you also have Medicare, you will also be screened for the Low-Income Subsidy of Medicare Part D. In addition to screening for programs, the Quickscreen will direct you to online applications and links to other helpful information.

Please email us at staff@phlp.org or call the HELPLINE at 1-800-274-3258/1-866-236-6310 (TTY) if you have questions or run into technical difficulty regarding the Quickscreen.

Medicare Waiving Part D Late Enrollment Penalty for LIS Recipients in 2008

Medicare beneficiaries generally have to enroll in Part D when it is first offered to them or they will be subject to a late enrollment penalty if they decide to join later. The late enrollment penalty is 1% for every month that someone delays enrollment into Part D. This penalty lasts for the entire time someone has Part D coverage. Individuals who have "creditable coverage" (prescription coverage that is as good or better than Part D) are not subject to the late enrollment penalty when they join Part D, as long as there has not been a break in coverage longer than 63 days.

Medicare recently announced that they would waive the late enrollment penalty for any Medicare beneficiary who qualifies for the low-income subsidy (LIS) and who enrolls in a Part D plan through December 31, 2008. Medicare also waived the penalty in 2006 and 2007 for LIS recipients.

The waiver of the late enrollment penalty for LIS recipients who enroll in Part D by December 31, 2008 lasts for the remainder of the time the person has Part D (even if they lose the LIS in later years). If an LIS recipient joins Part D and has the late enrollment penalty waived but then is without Part D coverage (or other creditable coverage) for a period of 63 days or longer, he will be penalized should he decide to re-enroll in a Part D plan at a later time. However, uncovered months in 2006, 2007, and 2008 will not be factored in when determining the amount of his late enrollment penalty.

Anyone who delayed enrollment in Part D who does not have creditable coverage is encouraged to apply for the subsidy! Individuals can get LIS applications at the local Social Security or County Assistance Offices. People can also apply online at www.ssa.gov/prescriptionhelp.

Bravo Health Takes Over Senior Partners Medicare Advantage Plan

On August 1, 2007, Bravo Health (formerly known as Elderhealth) took over the Senior Partners Silver Medicare Advantage Plan. Senior Partners is a Special Needs Plan for individuals with both Medicare and Medicaid who live in Philadelphia, Bucks, and Montgomery counties. Although the name of the plan has not changed, it is now administered by Bravo Health.

All members of Senior Partners should have have received notification about this change prior to August 1, 2007. In addition, members should have received new identification cards. Members should be showing their new ID cards to all of their health care providers such as their doctors as well as their pharmacies. The benefits should stay the same until December 31, 2007.

Members should currently be receiving information from Senior Partners about any plan changes that will take effect in 2008. Members should pay close attention to this information so they can decide whether they want to remain enrolled in that plan during 2008 or whether they want to change plans. Individuals who want to change plans for 2008 should enroll in a new plan by December 31, 2007 so that the new plan starts on January 1, 2008. Since all members of Senior Partners should be dual eligibles, they can change their plan at any time (even after December 31, 2007).

Members can call Bravo at 1-866-467-3133 or 1-800-964-2561/TTY if they have any questions about the take over. Please call PHLP's HELPLINE at 1-800-274-3258 or 1-866-236-6310/TTY if members have been having problems using their plan.

Assisted Living Update

The Secretary of the Department of Public Welfare has assembled a workgroup to meet with her and other state officials to help draft the Assisted Living Regulations. The Assisted Living Workgroup first met on October 17th. The next meeting is on November 6th, from 12:30-3:00 at the PHFA building in Harrisburg. The Assisted Living Workgroup meetings are "sunshine" meetings, and thus members of the public are welcome to attend and observe.

At the October 17th meeting, Secretary Richman announced a very aggressive schedule of bi-weekly working meetings leading up to the anticipated issuance of the proposed regulations in the Pennsylvania Bulletin around the middle of March. Once the proposed regulations are published in the Pennsylvania Bulletin, there will be a public comment process that will run at least 30 days. Then, the Department will review all public comments and work to respond to them in the final regulations that are expected to be issued by the end of 2008.

The new regulations will build off the personal care home regulations, as the state is charged with crafting assisted living regulations that meet or exceed what is contained in the personal care home regulations. The workgroup will only address the content of the new regulations and will not directly address the issue of the home and community based services waiver that the Department will be preparing to submit to the Centers for Medicare and Medicaid Services to help fund Assisted Living through Medicaid dollars.

Stay tuned to our website www.phlp.org for updates between now and the next SHN edition in December!

Letter from Beneficiary Regarding Medicare Part D's Coverage of Shingles Vaccine

PHLP received the following letter from a Medicare consumer in response to an article that appeared in a previous version of the Senior Health News:

"The article about Zostavax in your February 2007 *Senior Health News* ("Shingle Vaccine for People over 60 -- but how to get it?," pages 7-8), states the following: "That means the doctor may charge a consumer for the vaccine (about $150) and require the consumer to file paperwork with his Medicare Part D plan to be reimbursed. At the present time, PHLP is not aware of whether consumers have tried this, or what has been the outcome." I have, in fact, "tried this" and will share my reimbursement ordeal with you.

The Zostavax vaccine was administered in my doctor's office in April. Unfortunately, his insurance department submitted the claim for three charges under Medicare Part B: the office visit, administration of the vaccine and the vaccine itself. All three charges were rejected, the first two because they were coded incorrectly and the third because Zostavax falls under Part D, of course, not Part B.

Neither my doctor nor his insurance personnel were aware of this. Moreover, my Medicare Rx Plan (AARP) had no written procedures available to subscribers about how to recover the cost of the vaccine. And what's even more astounding, there was absolutely no information on the Medicare Web site. That's when I did a Google search and found your newsletter, which was literally the only online source that explained all the ramifications. The person who handles claims in my doctor's insurance department even asked me to fax it to her.

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I paid my doctor for the vaccine and then submitted a "Direct Member Reimbursement" claim to Prescription Solutions (AARP Medicare Rx plan's mail order pharmacy) and have indeed received payment, less a $28 co-pay. My doctor has yet to re-file the claim for administration of the vaccine because the required code was not in their computer system, but in the interim they have voided the charge for the office visit, citing information they recently received from Medicare.

Hopefully, others may find this information useful."

PHLP thanks this consumer for writing the letter and sharing this information. The February 2007 SHN can be found on our website at www.phlp.org.

Update on the LIS Redetermination Processes

In the August 2007 Senor Health News, we reported on the redeeming and redetermination processes for the low-income subsidy (LIS) in 2008. In that newsletter, we incorrectly stated that individuals selected for redetermination by the Social Security Administration (SSA) would only have to return the redetermination paperwork if the income and asset information listed was incorrect or had changed. However, after the publication of that newsletter, we learned that the process used this year differs from last year. Therefore, **anyone who receives the Redetermination form from SSA must complete the form and return it to Social Security within 30 days, even if nothing has changed**. SSA sent out the redetermination forms to individuals selected for redetermination at the end of August. Information from national advocates indicates that Social Security intends to place follow-up phone calls to individuals who have not returned the redetermination form within 30 days to confirm that the individual does not intend to apply for the LIS for 2008. Individuals who do not complete the redetermination form and return it to SSA will be notified that their subsidy will end as of December 31, 2007; these individuals can reapply for the LIS at any time.

SSA will notify individuals who return the redetermination form if they will no longer qualify for the LIS in 2008 or if the amount of their LIS will change in 2008. Individuals who are determined by SSA to continue to qualify for the same amount of LIS in 2008 will not receive any notification from SSA.

LIS Redeeming Process for Dual Eligibles

The August 2007 SHN also explained the redeeming process used to determine whether a dual eligible individual (someone who has both Medicare and Medicaid) who automatically qualified for the LIS in 2007 will continue to automatically qualify for the full LIS in 2008. This process started in July. Individuals who were deemed eligible for the LIS in 2007 but who did not appear on the state data file in either July or August were sent a notice (on grey paper) from Medicare in September telling them that they will no longer automatically qualify for the LIS as of December 31, 2007. An LIS application was mailed with these notices.

Individuals who received these grey notices but who go back on Medicaid at any point before the end of the year should appear on a data file from the State between now and the end of the year and automatically qualify for the LIS for all of 2008. Individuals who received that grey notice and who do not go back on Medical Assistance before the end of the year will lose their LIS effective December 31, 2007 unless they apply and are approved for an LIS.

Please call our HELPLINE (1-800-274-3258 or 1-866-236-6310/TTY) for more info!

Medicare Part D Reassignment Process Will Soon Be Underway

The Medicare Part D 2008 reassignment process will soon be underway and will affect some 17,000 low-income Medicare recipients across Pennsylvania. As a reminder, any consumer who has been approved for a full low-income subsidy (LIS) either because they are a dual eligible (on Medicare and getting any help from Medicaid), or because they applied and were approved for an LIS, can join any Part D Plan. If they enroll in one of the basic Part D Plans with a premium below the regional benchmark (a/k/a "zero premium plans") they will pay no premium because their LIS will cover the entire premium cost. Medicare assigns full LIS recipients to a zero-premium Part D plan if they do not enroll in a plan on their own. These individuals have the opportunity to decline the enrollment or choose a different plan.

Medicare has now announced all of the Part D plans for 2008. Some Plans currently participating in Part D will no longer be available in 2008, while many others will continue to participate but will change their premium and other cost-sharing for 2008. If Medicare previously assigned a LIS consumer to a Part D Plan that will no longer be participating in Part D in 2008, or to a Plan whose premium will exceed the 2008 regional benchmark ($26.59) by more than $1, that person will be reassigned by Medicare to another zero premium plan for 2008*.

This is how it works. In early November, Medicare will send out re-assignment notices on blue paper to consumers who have been approved for a full LIS for 2008, who did not choose their own plan and were assigned to a Plan by Medicare, and whose plan assignment must change for 2008. The notice will tell the consumer that they will be assigned to a different plan for 2008 either because their current plan will no longer participate in Part D (to view a copy of this notice go to http://www.cms.hhs.gov/partnerships/downloads/11208.pdf) or because their current plan's premium will increase and it will therefore no longer be a "zero premium plan" in 2008 (to view a copy of this notice go to http://www.cms.hhs.gov/partnerships/downloads/11209.pdf) .

The new plan assignment will be identified in the notice. The consumer then has two choices: 1) she can choose a different Part D Plan and enroll before the end of 2007 in which case she will be in her plan of choice beginning in 2008; or 2) she can do nothing in which case she will be enrolled into the plan Medicare assigned her to beginning in 2008. Consumers who get these notices are encouraged to review their Part D options and choose a "zero premium plan" that will cover their medications, let them use their current pharmacy, and not require prior authorizations for medications they had previously been able to access without a problem. Medicare's reassignment process picks zero-premium plans at random for affected consumers, so the plan Medicare picks may not be the best plan choice for someone. Please note: as of October 11, 2007 plan data for all the 2008 Part D plans is available on the Medicare website at www.medicare.gov.

*** Please note**: If a person with the full LIS enrolled in a Part D plan on his own that will no longer be a zero-premium plan in 2008, he will get a tan notice from Medicare telling him the plan will no longer be zero-premium and that he will have to pay a premium if he stays in that plan. If he does not want to pay the premium, he will need to change plans and join a plan that will be zero-premium in 2008.

2008 Medicare Premium, Deductibles, and Other Costs Announced

Earlier this month, Medicare announced the 2008 costs for Medicare Parts A, B and D. More information about 2008 costs can be found in the Medicare & You 2008 handbook.

Part A Costs

Part A covers inpatient hospital, skilled nursing facility, some home health care, and hospice services. Most people on Medicare get their Part A benefits for free and do not have to pay a monthly premium. This is because they (or their spouse) has worked at least 40 quarters in Medicare covered employment. Individuals who have not earned at least 40 quarters of work have to pay the following costs for their Part A coverage in 2008: $233 per month (for individuals with 30-39 work quarters) or $423 per month (for individuals with less than 30 work quarters). In 2008, the Part A hospital deductible is $1,024 (up from $952 in 2007). If someone is in the hospital for longer than 60 days, their costs next year will be $256 per day for days 61 through 90 and $512 per day for hospital stays beyond the 90th day (compared to $248 and $496 in 2007). Finally, consumers who are in a Medicare-covered skilled nursing facility stay for longer than 20 days will pay $128 per day for days 21 through 100 in 2008; this is compared to $124 per day in 2007.

Part B Costs

Part B covers physician's services, outpatient hospital services, certain home health services, durable medical equipment, and other services. All Medicare beneficiaries pay a monthly premium for Part B coverage (some individuals with limited income and assets qualify for the state to pay the Part B premium for them). The 2008 Part B premium is $96.40 (increased from $93.50 in 2007). Individuals with incomes over $82,000 (single) and $164,000 (married couple) pay higher premiums according to their income. The Medicare Part B deductible will be $135 in 2008 (compared to $131 in 2007).

Part D Costs

Part D costs differ from plan to plan. The national average monthly Part D premium in 2008 is $27.32. In PA, the stand-alone Prescription Drug Plan monthly premiums range from $15.40 to $99. In addition to the premium, consumers who do not qualify for a subsidy pay the following for a standard Part D plan* in 2008:

- An annual deductible that is fixed at **$275** for 2008 ($265 in 2007).
- A 25% co-pay for each of her drugs until her total drug costs reach **$2510** in 2008 ($2400 in 2007) during the initial coverage period.
- 100% of her drug costs during the coverage gap (also referred to as the "donut hole") until her total out of pocket expenses amount to **$4050** in 2008 ($3850 in 2007).
- Either small co-pays of **$2.25** for generic drugs and **$5.60** for brand name drugs ($2.15 and $5.35 in 2007), or **5%** of the drug cost, *whichever is greater,* during the catastrophic coverage phase that starts when she has spent $4050 out of pocket and lasts for the rest of the year.

** Plans can charge different amounts as long as their charges are "actuarially equivalent" to the standard costs.*

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Part D Costs for Low-Income Subsidy (LIS) Recipients

In 2008, co-pays are increasing slightly for individuals with the full LIS. Individuals that currently pay $1 for generics and $3.10 for brand name medications will pay $1.05 for generics and $3.10 for brand names. Those that currently pay $2.15 for generics and $5.35 for brand name drugs will pay $2.25 for generics and $5.60 for brand name drugs next year. Individuals who qualify for a partial subsidy will have a deductible limited to $56 in 2008 (up from $53 in 2007). They will continue to pay 15% of their drug costs until their total out-of-pocket expenses reach $4050 ($3850 in 2007). They will then pay $2.25 for generic medications and $5.60 for brand name drugs. As a reminder, no one with either a full or partial subsidy is subject to the donut hole.

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