SENIOR HEALTH NEWS

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Preparing for January 2007!
Solutions to Potential Part D Problems for Dual Eligibles

Many dual eligible consumers (people with Medicare and Medical Assistance [MA]) experienced significant problems accessing medications and paying high costs at the pharmacy at the beginning of 2006 when Medicare Part D started. As we move into Year 2 of Part D, we prepare for new and similar problems. Here are some things to look out for and fixes to take:

I have Medicare and Medical Assistance and the plan I've been in has started charging me a premium in 2007 (is no longer a zero premium plan) or has dropped me.

Dual eligible individuals are able to enroll in one of 20 stand-alone Part D plans that will not charge them any monthly premium in 2007. These plans are called "zero premium" plans. But, some plans that were zero premium in 2006 are either 1) no longer offering coverage in 2007 or 2) no longer zero premium in 2007.

If you're a dual eligible who is currently enrolled in a plan that is increasing its premium or dropping out of the program, you should have received information from your plan telling you about the changes. You may have also received a notice from Medicare . If Medicare initially enrolled you into a plan that is increasing their premium or dropping out of the program, Medicare will auto-enroll you to a different zero-premium plan for coverage starting January 1, 2007 unless you make a different choice by the end of the year. This process is called reassignment and the notices Medicare sent out about this were on blue paper.

Consumers who are not sure if they were auto-enrolled into a new plan should call 1-800-MEDICARE [(1-877-486-2048)(TTY)] or check www.medicare.gov to find out 1) if they were autoenrolled into a new plan and 2) if so, which one. If a consumer was auto-enrolled into a new plan, the individual should contact their plan to get their membership information in order to access medications after January 1, 2007.

If someone remains enrolled in their current (2006) plan that will no longer be a zero-premium plan in 2007, they will have to start paying a premium in 2007. Remember that dual eligibles can change plans at any time, so you may want to consider switching to a different plan that will not charge a premium.

If the plan that you were enrolled in for 2006 is no longer participating in Part D in 2007, you should have been enrolled into a different plan offered by the same company or auto-enrolled into a new zero-premium plan by Medicare.

I went to the pharmacy and I was told that I do not have any Part D coverage.

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If you are dual eligible but your pharmacy's computer reports that you have no prescription drug coverage, ask the pharmacy to bill Wellpoint. This is a back-up plan for full dual eligibles who do not have coverage through a Part D plan. Your pharmacist can find out how to bill Wellpoint by contacting Medicare or looking on the Pennsylvania Health Law Project website , www.phlp.org. If you need assistance with this or if you are not able to get prescriptions, please call us at 1-800-274-3258 (phone)/ 1-866-236-6310 (TTY).

My new plan does not have me listed as enrolled with them.

Whether you chose a new plan or were auto-enrolled by Medicare into a new zero premium plan, you may experience problems with enrollment. If, for some reason, you do not show up as listed in the plan you joined, you should contact 1-800-MEDICARE [(1-877-486-2048) (TTY)] and file a complaint for follow-up by the Regional Office. If you need medications immediately, you can either buy the medications yourself and get reimbursed from the plan once the problem is resolved . If you have the ACCESS card, you can ask the pharmacy to bill Wellpoint (see above). If Wellpoint doesn't work, ask the pharmacist to ask MA Fee- for-Service to do a "super prior authorization" to cover your medications through MA until your plan can cover you. MA will approve this if the pharmacist can show MA that he or she has been unable to get your medications covered using your plan or Wellpoint. The MA phone number for pharmacists is 1-800-558-4477.

I had the low income subsidy (Extra Help) in 2006 and nothing has changed, yet Medicare tells me that I don't have it in 2007.

If you had the low income subsidy in 2006 because you had MA, as long as you had MA at some point between July 2006 and December 2006, you should have the subsidy for all of 2007. You should not be charged a deductible and your copayment should be between $1 and $5.15. You should show your ACCESS card to the pharmacy and have the pharmacy call your plan to verify that you are a dual eligible and should get the subsidy.

If your plan will not update their system with your subsidy information, you should call 1-800-MEDICARE [(1-877-486-2048)(TTY)] to find out if it has a record of you having the subsidy. If Medicare shows you as having the subsidy, ask them to call the plan with you on the line and authorize you as a person with the subsidy. If Medicare does not have record of you having a subsidy, but you have Medical Assistance (MA), you can show your pharmacy your ACCESS card. Then ask the pharmacist to call your plan to see if they will update their system to show you have the subsidy. If the plan will not update their system, your pharmacist can call MA Pharmacy to have your medications covered until your plan gets information about your subsidy. If you have MA and are having problems getting your subsidy, please call us at 1-800-274-3258 (phone)/ 1-866-236-6310 (TTY).

If you got a notice that you no longer automatically qualify for the subsidy in 2007 because you lost MA, you can apply for the subsidy through the County Assistance office or through the Social Security Office. If you lost the subsidy, but you are still receiving MA, call us at 1-800-274-3258 (phone)/ 1-866-236-6310 (TTY).

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OMHSAS Older Adult Advisory Committee Sets Priorities for Coming Year

The Office of Mental Health and Substance Abuse Services (OMHSAS) Advisory Committee is comprised of three committees; the Adult Committee, the Older Adult Committee and the Children's Committee. These Committees are jointly responsible for advising the Deputy Secretary of OMHSAS, and fulfill the role of the state mental health planning council. The Committees advise OMHSAS on areas related to mental health, substance abuse, behavioral health disorders and cross-system disability. Stakeholders and OMHSAS agreed for the need for an Older Adult Committee distinct from the Adult Committee because of the unique needs of the older adult population.

Recently, each Committee completed an annual review of its goals and accomplishments and set priorities for the next year. All three Committees share the following three objectives:

- Ensuring the commitment to cultural competence is incorporated into all priorities
- Ensuring that special needs are accommodated for those who are deaf, hard of hearing or have physical disabilities
- Ensuring that quality management initiatives are embedded in all work; with data that is meaningful to consumers and families

The overarching goal for the Older Adult Committee continues to be to, "Assure that behavioral health services and supports recognize and accommodate the unique needs of older adults". To make progress toward that goal, the Older Adult Committee has outlined the following objectives for the upcoming year:

- Develop a collaboration with physical health partners (home health, VNA, etc) to promote behavioral health screenings for older adults
- Support efforts to promote a study of older adults thru the Legislative Budget & Finance Committee (as was done for the Children's Behavioral Health System)
- Ensure that peer services are available to older adults
- Adopt at least one recommendation of the Suicide Prevention Plan
- Coordinate an annual Suicide Awareness Day in Harrisburg
- Monitor Mobile Outpatient services to assess effectiveness in serving older adults
- Review the impact of dual eligibility on services provision
- Compile information from the Mental Health and Aging Case Review Model Pilot Program
- Establish an advisory role through the life of the Money Follows the Person project in transitioning geriatric state hospital consumers to a least restrictive community setting
- Establish a monitoring role in transitioning identified individuals from South Mountain Restoration Center.

The OMHSAS Advisory Committees meet every other month in the Harrisburg area, on the first Thursday of the month. The next meeting is scheduled for Thursday, January 4, 2007, 9:30am – 4:00pm at the Holiday Inn, 604 Station Road in Grantville. Voting members must be appointed to the Advisory Committees but any interested person is welcome to attend these meetings.

Can Family and Friends that provide care in the home ever be paid?

The ability to stay at home and obtain supportive services through the state and Medicaid funded home and community based services programs has made it possible for more and more consumers to stay out of institutions. In fact, there are nearly 11 different programs that help consumers over 60 or with permanent disabilities remain at home and avoid having to move to a nursing home. If you would like any information on these programs, please call us at 1-800-274-3258 (phone)/ 1-866-236-6310(TTY) or visit our website at www.phlp.org.

Right now, however, we want to report on relatively recent developments that permit some consumers who receive home and community based services to hire family members to provide some of their care. This is important! Whether because of choice of caregiver, difficulty in finding enough agency staff to cover the needed services, or the need to have back-up care-givers available if agency staff call out sick, these recent policy developments can help. Family members or friends of the consumers choosing can get paid to provide approved services.

Under both the Aging waiver (or PDA Waiver) and the Options program, covered "personal assistance services" needed by a consumer may be provided by family members (**other than a spouse or minor child**) or friends. Personal assistance service is in-home personal care and other approved support activities for consumers with functional disabilities who need assistance to accomplish daily living tasks. The services are generally services that the person would perform for herself were she functionally able to do so. They include primarily "hands-on" personal care assistance with such things as:

- Getting in and out of bed, wheelchair, or motor vehicle;
- Ambulating, with or without mechanical aids, inside the home;
- Routine bodily functions, including eating or feeding (including meal preparation and clean-up) and toileting;
- Bathing, dressing, personal hygiene and grooming; and
- Health maintenance activities (i.e. insulin injections, medication administration and skin care).

Personal Assistance Services may also include supplemental services such as home support services (shopping, doing laundry, cleaning, seasonal chores, etc.), companion-type services (assistance with transportation, reading, letter writing, etc.), or other household management tasks.

In order for a family member or friend to be able to be hired and paid to meet the consumer's personal assistance needs, s/he must be 18 years of age or older, have the required skills to perform personal assistance services as specified in the consumer's service plan, possess basic math, reading, and writing skills, possess a valid Social Security number; and be willing to submit to and pass a criminal record check.

The policies for permitting family members or friends to be paid to provide services under other home and community based waiver programs differ. Please contact the Pennsylvania Health Law Project at 1-800-274-3258 (phone)/ 1-866-236-6310 (TTY) for more information.

Medicare Cost Changes Announced!

Medicare costs are going up in 2007, as follows:

Medicare Part A Premiums (Hospital Insurance)

Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare covered employment.

Those not eligible for premium-free hospital insurance with less than 30 quarters of Medicare covered employment, pay $410.00 per month.

Those not eligible for premium-free hospital insurance with 30-39 quarters of Medicare covered employment, pay $226 per month.

Medicare Part B Premiums (Medical Insurance)

Medicare Part B standard premiums are going up to$93.50/ month. Beginning in 2007, individuals with incomes over $80,000 and married couples with incomes over $160,000 will pay higher monthly premium amounts for Part B. The amounts are based on income, with the highest possible monthly premium (for individuals with income above $200,000 and married couples with income over $400,000) costing $161.40/month.

Deductibles and Coinsurances

Part A Deductible (Hospital Insurance)
The deductible is going up to $992.00 per Benefit Period.

Coinsurance
The coinsurance for hospitalization will $248.00 a day for the 61st - 90th day each benefit period in 2007.

It will go up to $496.00 a day for the 91st - 150th day for each lifetime reserve day (total of 60 lifetime reserve days - non-renewable).

Skilled Nursing Facility Coinsurance
This coinsurance will be $124 a day for the 21st - 100th day of each benefit period.

Part B Deductible (Medical Insurance)
The Part B Deductible is $131.00 per year.

Don't forget that there is help for you. The programs described on page 6 might be able to help you with some of these costs!

Programs Available to Help with Medicare Costs

Consumers on Medicare have a significant amount of cost sharing for their coverage as well as for any health care or services they receive under the program. The good news is that there are programs available to help beneficiaries with limited income and assets with at least some of those Medicare costs.

Medicare Savings Program

The Medicare Savings Program (MSP) is a program offered through Pennsylvania's Department of Public Welfare. It helps Medicare beneficiaries pay their Medicare Part B premium ($93.50/month for 2007), that typically is deducted from a person's Social Security check. Medicare beneficiaries are eligible for MSP if they meet these income and asset guidelines:

- **Income** less than 135% of the federal poverty level for the household size (currently $1103/mo. for a single person, $1485/mo. for a married couple)
- **Assets** no more than $4,000 for a single person, $6,000 for a married couple

Consumers can apply for this benefit through their County Assistance Office or online at www.compass.state.pa.us. If the application is approved, Medical Assistance will begin to pay the consumer's Part B premium directly to Medicare and the consumer should see a corresponding $93.50 increase in their Social Security benefits. A second advantage to the MSP is that consumers who are found eligible for this program are considered "dual eligibles". As such, they automatically qualify for a full Low-Income Subsidy (see below) that will pay most of the costs of prescription coverage under **Medicare Part D**!

Medicare Low Income Subsidy

Because there is significant cost-sharing involved in obtaining prescription coverage under Medicare Part D (monthly premiums, annual deductible, co-pays for each prescription), two Low-Income Subsidy (LIS) programs were created to help low-income Medicare beneficiaries meet their Part D costs.

- **Consumers who qualify for a full LIS:** will not have to pay a monthly premium (as long as they enroll in a "zero premium plan"); will not have a deductible; will not have a "donut hole" gap in their coverage; and will only have to pay small co-pays (no greater than $5.35) for their prescriptions.

- **Consumers who qualify for a partial LIS:** will have their monthly premium reduced (based on a sliding scale); will have their annual deductible for a standard plan reduced from $250 to $53; will have no "donut hole" gap in coverage; and will have a 15% co-pay on their medications until their out-of-pocket costs reach $3600, after which their co-pays will be no greater than $5.35 per prescription for the rest of the year.

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Any Medicare beneficiary is eligible for a LIS if they meet the income and asset guidelines. This includes:

Single persons

- Whose income is no greater than $14, 700/year, *and*
- Who have no more than $10,000 in assets

Married couples

- Whose income is no greater than $19, 800/year, *and*
- Who have no more than $20,000 in assets

Medicare beneficiaries can apply for a LIS at any time throughout the year. Applications can be obtained directly from any Social Security Office or County Assistance Office. Consumers can also apply online for an LIS at www.ssa.gov.

Medical Assistance (the ACCESS card)

Low-income Medicare beneficiaries may also qualify for secondary medical coverage through Medical Assistance. There are many different ways to qualify for Medical Assistance and each has its own income and asset guidelines. If a person qualifies for an ACCESS card, that will be their secondary medical insurance and it will cover the person's Medicare cost-sharing (deductibles, co-pays, etc) for services covered under Medicare Part A or Part B. In addition, if a Medicare consumer qualifies for Medical Assistance coverage they are considered a "dual eligible" and automatically get a full LIS that will cover most of the costs of Medicare Part D!

Consumers who want to see if they are eligible for a Medical Assistance ACCESS card can contact their County Assistance for an application. In addition, persons can enroll online at www.compass.state.pa.us.

If you or any of your clients are struggling with Medicare costs and you want to know if you qualify for any of the programs described above, you can contact the PHLP Helpline at 1-800-274-3258 (phone) or 1-866-236-6310 (TTY).

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I'm in a new plan but it doesn't cover all of my medication.

If you go to the pharmacy and are told that your medication is not covered by your Part D plan, ask the pharmacy about a one-time fill (30 day supply). Part D plans are required to cover a one-time fill of medications during the first 90 days of coverage in a plan. This will give you time to get a prior authorization if necessary or seek an exception to the plan's formulary.

If you need a medication that is not covered under Part D (for example, benzodiazepines, barbiturates, or some over-the-counter medications) and you have the ACCESS card, you should have your pharmacy try to bill the non Part D covered medication through the ACCESS card.

If your plan refuses to cover your medication in this transition period, please call the Pennsylvania Health Law Project at 1-800-274-3258 (phone)/ 1-866-236-9310 (TTY).

January Begins Medicare Part B Open Enrollment Period

The open enrollment period for Medicare Part B is from January 1 until March 31. If you did not enroll during your 7-month initial enrollment period (the 3 months before you turn 65 and the 4 months after you turn 65), you can still enroll in Part B. If you enroll during the open enrollment between January 1, 2007 and March 31, 2007, your Part B benefits will begin on July 1, 2007.

Remember! Those who have delayed enrollment will have to pay the regular monthly premium (currently $93.50 [*unless adjusted by income—see p.5]*) plus an additional 10% of the premium ($9.35) for each full year that they delayed enrollment. The programs described on page 6. that help with your Medicare costs can also cover premiums that are higher because of delayed enrollment.

As the year ends, we take a moment to wish all our readers 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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