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2013 Medicare Costs

Medicare recently updated its premiums, deductibles, and co-pay amounts for 2013. The following costs are effective January 1st.

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 2013, the Part A hospital deductible will be $1,184 (up from $1,156 in 2012). If someone is in the hospital longer than 60 days, their cost-sharing in 2013 will be:

- $296/day for days 61-90 (up from $289 in 2012)
- $592/day for days 91-150 (up from $578 in 2012)

Medicare beneficiaries in a skilled nursing facility that accepts Medicare will pay $148/day for days 21-100 (compared to $144.50 in 2012). There is no cost for Medicare-covered 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 2013 will be $104.90/month (up from $99.90 in 2012). 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.

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(Continued from Page 1) The Part B annual deductible will be $147 in 2013 (up from $140 in 2012). Individuals have to meet this deductible before Medicare starts covering most Part B services. Once the deductible is met, Medicare covers physical health services at 80%. In 2013, Medicare will cover outpatient mental health treatment at 65% (up from 60% in 2012). Starting in 2014, Medicare will cover both physical health services and outpatient mental health treatment at 80%.

Medicare Part D

Beneficiaries who do **not** qualify for any level of subsidy will pay the following for a 2013 standard Part D Plan in addition to the plan's premium:

- An annual deductible of **$325** (up from $320 in 2012);
- During the initial coverage period, a 25% co-pay for each prescription until the consumer's total drug costs reach **$2,970** (up from $2,930 in 2012);
- During the coverage gap (also referred to as the "doughnut hole"), a percentage of the costs of drugs (in 2013, 47.5% of the cost of brand name drugs and 79% for generic drugs plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$4,750*** (this figure was $4,700 for 2012); and
- During the catastrophic coverage period, a co-pay of **$2.65** for generics and **$6.60** for name brand drugs, or a 5% co-pay, **whichever is greater** (the current co-pays are $2.60 and $6.50).

**Not all of the costs consumers pay during the doughnut hole count toward total out-of-pocket expenses.*

Part D Costs for Individuals who Receive the Low-Income Subsidy

Individuals who qualify for the **full** low-income subsidy (LIS)--this includes **all** dual eligibles who have Medicare and also receive some level of benefit through Medical Assistance--will have the following costs in 2013:

- $0 premium (as long as they're enrolled in a Part D plan that provides standard benefits and charges a premium less than $36.57-see www.phlp.org for a list of these prescription drug plans);
- Small co-pays for their medication as follows:
  - $1.15 generics/$3.50 brand name (if income less than 100% FPL); or
  - $2.65 generics/$6.60 brand name; or
  - $0 if someone is a **full** dual eligible (has Medicare and full Medicaid coverage) **and** is receiving long term care services in a nursing home **or** through a Home and Community-Based Services Waiver program.

Individuals who qualify for a **partial subsidy** in 2013 will pay the following:

- Some portion of their monthly Part D plan premium depending on their level of subsidy;
- A deductible no higher than $66 (if the plan charges a deductible higher than this amount);
- A 15% co-pay for their drugs once the deductible is met until they spend $4,750 out-of-pocket;
- Co-pays of $2.65/generics and $6.60/brand name drugs for the rest of the year.

Please note: there is **no** coverage gap or "doughnut hole" for people who receive **any** level of subsidy.

Reminder: In 2013, Medicare Part D Plans Cover Benzodiazepines and Certain Barbiturates

Effective January 1, 2013, medications classified as benzodiazepines and barbiturates (used for treatment of certain conditions) can be covered under Medicare Part D. Up until now, Medicare law excluded these types of medications from Medicare Part D coverage. The Affordable Care Act changed the law and expanded Part D coverage to include benzodiazepines and certain barbiturates at the beginning of the 2013 plan year.

Benzodiazepines are anti-anxiety medications such as Ativan, Diazepam and Klonopin. Beginning on January 1st, benzodiazepines are included as a covered drug class in Part D plan drug formularies. Like with other Part D covered drugs, plans can limit access to these medications by only covering certain benzodiazepines on their formularies, requiring prior authorizations, or imposing quantity limits or step therapy requirements (where the plan requires its members to have tried other medications first before it will approve coverage of a certain medication).

Barbiturates are a class of drugs that act as depressants to the central nervous system and they include medications such as Phenobarbital and Amytal Sodium. Under the Affordable Care Act, barbiturates must be covered by Part D plans if they are used in the treatment of cancer, epilepsy and chronic mental health disorders. Again, Part D plans can have special rules for their coverage of these medications. If barbiturates are being prescribed for any other purpose than those conditions noted, they continue to be excluded from Part D coverage.

As of January 1st, the ACCESS card will no longer cover benzodiazepines or barbiturates used for treatment of cancer, epilepsy chronic mental health disorders because Part D plans can now cover these medications. This is true even if someone's Part D plan does not cover her particular benzodiazepine or barbiturate on their formulary. Up until the end of 2012, full dual eligibles (those with Medicare and full coverage through Medicaid) were able to use their Medicaid ACCESS card at the pharmacy to cover prescriptions for benzodiazepines and barbiturates because these medications were not Part D covered drugs.

All Medicare beneficiaries taking these types of medications should check with their Part D plan to see if their medications are on the plan's formulary and check to see if there are any special rules for coverage of those medications. If the medications are not covered by the plan, the beneficiary will have to find out how their doctor can request a formulary exception or consider changing Part D plans if they qualify for a Special Enrollment Period (all dual eligibles have an ongoing Special Enrollment Period (SEP) and can change plans at any time during the year). See the next page for more information about plan's requirements in terms of transition refills for these types of medications.

Those who have questions about this change or who need help accessing their prescription medications through their Part D plan can call PHLP's Helpline or APPRISE at 1-800-783-7067.

Medicare Part D Transition Requirements

Within the first 90 days of coverage in a new plan year (starting January 1st), Part D plans must offer a temporary supply of medications for new enrollees in need of a drug that is either not included in the Plan's formulary or that requires authorization from the plan before it can be covered. This transition requirement also extends to current enrollees who are affected by changes to a plan's formulary from one year to the next. The one-time temporary supply (a 30 day refill) is to be provided to allow time for the prescriber to either switch the person to another appropriate medication covered by the plan or to seek authorization or a formulary exception from the plan. These transition rules also apply to the first 90 days of coverage when someone switches plans during the year.

The Centers for Medicare & Medicaid Services (CMS) issued a memorandum to Part D plans in October 2012 instructing them to treat all prescriptions for benzodiazepines and barbiturates used in the treatment of cancer, epilepsy, and chronic mental health disorders as transition refills since Part D plans did not previously cover these types of medications and the plan would not have the member's treatment history for these medications. Therefore, individuals taking these types of medications should have their benzodiazepine and certain barbiturate medications covered by their Part D plan the first time they get the prescription filled within the first three months of 2013; then, if the plan requires prior authorization or a formulary exception in order to continue to cover the medication, the individual will need to talk to their doctor and have the doctor submit information to the plan to get it approved for continued coverage this year.

Happy New Year!

In 2012, PHLP's Helpline answered more than a thousand calls from older Pennsylvanians and their families, friends, and advocates. Please **support PHLP** by making a donation through the United Way.

For Southeast PA, go to www.uwsepa.org and select donor choice number 10277.

For the Capital Region, go to www.uwcr.org and pledge a donation to PHLP.

For the Pittsburgh Region, go to www.unitedwaypittsburgh.org and select agency code number 11089521.

Final Phase of Medicaid Managed Care Expansion Begins

From January 10th through January 17th, DPW will mail out managed care plan enrollment information to over 205,000 Medicaid consumers living in Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming counties.

This marks the beginning of the final phase of statewide expansion of HealthChoices (what DPW calls mandatory managed care for most Medicaid consumers). HealthChoices now exists in 45 counties and 4 zones: Southeast, Southwest, Lehigh/Capital and New West. The remaining 22 counties listed above will make up the **HealthChoices New East Zone** that DPW is planning to have go live on March 1, 2013.

Consumers will have until **February 7th** to enroll into one of the three available plans. Those who do not enroll in a plan by February 7th will be randomly auto-assigned to a plan effective March 1st. The three plans available to consumers in the New East Zone are:

- **Amerihealth Northeast**,
- **CoventryCares**, and
- **Geisinger Health Plan (GHP Family).**

Those currently enrolled in a Voluntary Plan with Amerihealth Mercy can either stay in the plan they are in (in which case they will move into HealthChoices with Amerihealth Northeast effective March 1st) or they can switch to a new plan by February 7th that will go into effect March 1st.

Those currently enrolled in a Voluntary Plan with United Healthcare Community Plan will not be able to stay in this plan since it is no longer doing business as a Medicaid plan in the Zone as of the end of February. As a result, all those in United Healthcare will need to enroll in one of the three available plans by February 7th or else they will be auto-assigned to a plan.

As a reminder, certain Medicaid consumers in the New East Zone will **not** be affected by the expansion of HealthChoices because they are exempt from Medicaid managed care. The following groups of Medicaid consumers remain in the fee-for-service system and continue to have coverage through their ACCESS card:

- **Full Dual Eligibles**: those on Medicare who also have full Medicaid through their ACCESS card
- **Aging (PDA) Waiver participants**
- **LIFE Program participants**
- **HIPP participants:** consumers who are also enrolled in employer-sponsored health insurance for which Medicaid is paying the premium

Please Note: Beginning March 1st, women eligible for Medicaid under the Breast & Cervical Cancer Prevention and Treatment Program (BCCPT) will no longer be exempt from Medicaid managed care and will be required to join a HealthChoices plan.

Therefore, women living in the New East zone who receive their Medicaid coverage under the BCCPT program will also receive the mailing in January from DPW instructing them to pick a managed care plan by February 7th.

Medicaid Payment For Primary Care Services Increasing in 2013

As of January 1, 2013, federal law requires that state Medicaid payment rates to certain physicians for certain primary care services cannot be less than Medicare rates. This change should hopefully improve access to care for recipients whose only coverage is Medicaid as well as for dual eligible individuals (those that have both Medicare and Medicaid coverage).

As in many states, Pennsylvania's Medicaid reimbursement rates have often been lower than Medicare's rates for the same service. As a result, Pennsylvania Medicaid typically did not pay Medicare providers any additional amount beyond what Medicare had already paid for services rendered to dual eligibles. That is because the state's payment has not been based on the Medicare rate but rather on the state's Medicaid rate for the service. So, for example, if an office visit to a primary care physician has a Medicare rate of $100, Medicare pays the provider $80 (Medicare Part B covers 80% of the Medicare approved rate for outpatient services). If the state's Medicaid payment rate for that service was $80 or less, however, then the state paid nothing else to the provider saying the provider had already received full payment from Medicare. Now, under the new rule, the state cannot have a payment rate less than Medicare's rate and thus will be required to pay the provider the 20% (in this case, $20) not covered by Medicare.

This payment change is part of the Affordable Care Act and is to be in effect until the end of 2014. It will extend beyond 2014 only if additional legislation is passed to continue the increased Medicaid payments. Currently, the increased payments are entirely funded by federal dollars. The change impacts Medicaid payments to **certain providers** including those who practice family medicine, general internal medicine, and pediatrics and certain associated subspecialties of these groups (such as Endocrinology, Geriatric Medicine, Hematology, Medical Oncology, Nephrology and Rheumatology) **for certain primary care services** including all evaluation and management services and vaccine administration. Practitioners working under a doctor's supervision such as Nurse Practitioners and Physician Assistants and providing the eligible primary care services would also be entitled to the higher payments.

Physicians can contact the Department of Public Welfare Provider Services Line at 1-800-537-8862 to find out how to become a Medicaid-enrolled provider or for questions about the increased Medicaid payments. Generally, Pennsylvania Medicaid requires that a provider be enrolled with the program in order to receive Medicaid payment. The balance billing protections that currently exist for dual eligible beneficiaries remain in place - a dual eligible consumer must tell the provider about all coverage before they receive a service and the provider can refuse to treat the consumer if he doesn't accept all of her insurances; however, if the provider treats the dual eligible consumer, then he cannot bill her for any more than the small Medicaid co-pay that may be required for the service even if the provider does not participate with the Medicaid program. With this increase in Medicaid payments to providers, advocates are hopeful that balance billing problems will be significantly reduced.

New FMS Vendor for OLTL Waivers Started January 1st

Individuals who receive waiver services through one of the programs administered by the Office of Long-Term Living (Aging, Attendant Care, CommCare, Independence, and OBRA) **and** who use the consumer directed model have a new provider of Financial Management Services (FMS). As of January 1st. Public Partnerships, LLC (PPL) is the new provider of FMS services for the entire state. PPL is responsible for the administrative tasks associated with consumers hiring their own workers to provide Personal Assistance Services including writing paychecks, paying required taxes, and handling paperwork related to workers compensation and other employment-related issues.

PPL sent large packets to all waiver recipients using the consumer-directed model in recent weeks to be completed and returned. Advocates are concerned that there was confusion on the part of consumers and family members about the transition to the new provider as well as the rushed process and size of the packets that needed to be completed. Problems with caregivers being paid by the previous FMS providers heightened concerns about the transition to PPL and caregivers being paid accurately and timely. Waiver consumers who experience problems with their caregivers being paid by PPL can contact PHLP's Helpline at 1-800-274-3258.

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COLAs Disregarded until March 2013 for Certain Categories of Medical Assistance

Under Medical Assistance (MA) eligibility rules, County Assistance Offices (CAO) are not to count the Social Security Cost of Living Adjustment for individuals receiving benefits under the Healthy Horizons categories (including QMB, QMB Plus, SLMB and QI-1) until the second month after the Federal Poverty Levels are updated (which usually happens late January or early February). This means that individuals receiving benefits under the above mentioned categories should not have their 2013 incomes counted for eligibility until March or April depending on when the poverty limits are updated this year.

Individuals receiving termination notices from the CAO in January or February telling them that they no longer qualify for benefits due to their adjusted Social Security income are encouraged to contact our Helpline (1-800-274-3258) so that we can check your category of eligibility and help resolve the eligibility problem if the CAO is prematurely counting someone's 2013 income.

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