Make Medicare Work Coalition Topical Brief: Medicare Part D – What You Need to Know

November 11, 2015

To view other MMW materials and resources, including past MMW Bulletin newsletters, fact sheets, and recorded webinars, visit our MMW Coalition webpage at http://ageoptions.org/services-and-programs_makemedicarework.html

Medicare Open Enrollment Period

The annual Medicare Open Enrollment for Medicare Part D and Medicare Advantage Plans began October 15th and ends December 7th**.** During this time, people with Medicare can enroll, disenroll, or switch to any Medicare Part D, including Medicare Advantage, plan that they choose. Any changes made during the open enrollment period will take effect January 1, 2016.

Now is the time Medicare beneficiaries should check to determine if the Part D plan they currently are enrolled in will continue to meet their needs in 2016 or if they need to switch plans. Beneficiaries who are not enrolled in a Part D plan and are past their initial Medicare eligibly date should also consider reviewing their prescription drug and /or health needs and enrolling in a plan (although they may be faced with paying late enrollment penalties).

Some factors individuals should consider when reviewing how their Part D plan will work for them in 2016 include:

- The plan's monthly premium
- If the plan has an annual drug deductible
- Are their prescriptions on the Part D plan's formulary?
- Do their drugs have any restrictions such as prior authorization, quantity limits or step therapy?
- Will the beneficiary go into the Part D donut hole/coverage gap?
- Does the plan offer preferred pharmacy options that may lower their drug co-pays?

A Medicare beneficiary can receive Medicare Part D in one of two ways: a stand-alone prescription drug plan (also called a PDP) that covers only prescription drugs or a Medicare Advantage (MA) plan that provides coverage for health services and prescription drugs through one plan. This Brief will review how the Medicare Part D benefit works for both types of coverage in 2016 and what counselors and professionals need to know when assisting clients in making important decisions about enrolling in these types of plans and navigating their benefits next year.

2016 Medicare Part D Benefit Parameters

The Centers for Medicare and Medicaid Services (CMS) have announced the 2016 standard Medicare Part D benefit amounts. These limits are adjusted each year by CMS using methodology that is based on beneficiaries' drug expenditures and to ensure that the Part D benefit continues to provide coverage for a share of a beneficiary's drug expenses. Note that the limits listed below only apply to prescriptions drugs that are covered by the plan. Money spent on any prescriptions that are

not on the plan's formulary will not count toward reaching the deductible, donut hole, or catastrophic coverage phases. To view the CMS notice that shares the 2016 Part D benefit parameters please click here (see pages 41-42).

		2015	2016
Annual Deductible	Beneficiary pays this amount out-of-pocket in the beginning of the plan year, before the plan pays anything.	Up to $320	Up to $360
Initial Coverage Limit	You pay a co-pay or co-insurance amount for each formulary prescription and the plan pays the rest of the cost. Once the amount that both the beneficiary and the plan spend together reaches the Initial Coverage Limit amount, the beneficiary moves into the donut hole phase.	Up to $2,960	Up to $3,310
Donut Hole begins (also called the Coverage Gap)	During the "donut hole" phase, the Part D plan does not pay anything toward the costs of drugs, but beneficiaries will receive discounts. In 2016, you will receive a 55% discount on brand names and 42% discount on generics.	$2,960	$3,310
Catastrophic coverage begins once the True Out-of-pocket Threshold (TROOP) is met. (Donut hole ends.)	Once someone's True Out of Pocket Costs (TrOOP) are met, they reach the Catastrophic Coverage phase. During Catastrophic Coverage, the plan pays 95% of drug expenses and the beneficiary pays 5% **or** a co-pay of $2.95 (for generics or preferred multi-source drugs) or $7.40 (for all other drugs on the formulary) – whichever is higher. TrOOP costs are a beneficiary's out-of-pocket drug costs for a Part D plan (e.g., co-pays, deductible amounts) and determine when catastrophic coverage will begin. TrOOP is tracked by the Part D plan. Note: monthly Part D plan premiums do not count towards TrOOP. For more on TrOOP, click here.	$4,700 (TROOP amount)	$4,850 (TROOP amount)
Copayment amount for generic or preferred multi-source drugs after Catastrophic coverage begins		$2.65 or 5%*	$2.95 or 5%*
Copayment amount for all other drugs after Catastrophic coverage begins		$6.60 or 5%*	$7.40 or 5%*

*During the catastrophic coverage phase in 2016, the beneficiary will pay a co-pay of $2.95/$7.40 or 5% of the drug costs, whichever is greater. (In 2015, the beneficiary pays the greater of $2.65/$6.60 or 5% of the drug cost.)

Part D and the Donut Hole in 2016 – How it Will Work

In 2016, the Medicare Part D coverage gap (also referred to as the donut hole) will begin when the beneficiary has filled $3,310 worth of formulary drugs with their Part D plan This is the full cost of the drugs, not just the co-pay amounts the beneficiary is charged at the pharmacy. This amount includes what the beneficiary and the plan pay. The donut hole continues until the beneficiary has reached the TROOP amount ($4,850 in 2016).

Due to the Affordable Care Act, beneficiaries will continue to receive discounts once they enter the donut hole. In 2016, beneficiaries will receive a 55% discount on brand name drugs and a 42% discount on generic drugs. The discounts are off the full cost of the drugs and will be applied immediately at the pharmacy counter once a person enters the donut hole.

The donut hole discounts are provided in part by drug manufacturers and in part by federal government subsidies. In 2016, 50% of the brand name drug discount will be covered by the drug manufacturer, and the other 5% will be provided by a government subsidy. For generic drugs, the full 42% discount is provided a government subsidy given to the plan.

It is important to note that only the portion of the discount provided by the drug manufactures will apply toward the amount a beneficiary need to get out of the donut hole (the TROOP amount). The discounts provided by government subsidies do not count toward TROOP. All discounts provided in the donut hole are reflected in the www.Medicare.gov online prescription drug Plan Finder when searching and comparing plans. The discounts for brand name and generic drugs will increase each year until 2020 when the donut hole is eliminated. Beginning in 2020, beneficiaries will pay the standard Medicare Part D cost-sharing amount (25%) for covered drugs throughout the calendar year.

Part D Late Enrollment Penalty

The open enrollment period is a good time for Medicare beneficiaries to enroll in a Medicare Part D plan if they did not do so when they were first eligible. This includes individuals who missed signing up for a Part D plan during their Medicare initial enrollment period or who failed to enroll in a plan within 63 days of when other creditable drug coverage ended (such as an employer group health plan or retiree plan). Note that individuals who enroll in a Part D plan may have to pay a Part D late enrollment penalty that is based on the number of months they were without credible Part D coverage and were eligible to enroll in Part D but did not.

The Part D penalty is 1% extra premium (based off the national base premium) for each month you were eligible to enroll in a Part D plan but did not. The national base premium is adjusted every year and in 2016 will be $34.10. For example, if John was eligible for Part D but did not enroll until 12 months after his initial enrollment period ended, he will have to pay an extra 12% penalty on his Part D premium. John's late enrollment penalty for 2016 will be $4.10 (.12% x $34.10 = $4.09). The penalty is usually rounded to the nearest ten cents and is paid in addition to the monthly Part D plan premium. Note that the Part D penalty is calculated using then national base premium and the base premium changes every year, so John's Part D penalty amount will also change every year. The Part D penalty is not capped, meaning the penalty will be costlier the longer a beneficiary goes without Part D plan.

Special Enrollment Period for Beneficiaries in Poor Performing Part D Plans

CMS has established a special enrollment period (SEP) for beneficiaries in low performing Part D plans. The new SEP will allow individuals in Part D plans that received an overall star rating of less than three stars for three or more years to switch to another higher-rated Part D plan. These low rated plans are highlighted on the Medicare.gov online Plan Finder with the following special symbol: 

In late October, CMS mailed notices to beneficiaries in low performing plans. The letter informs them that their plan received a low rating, and if they do not make a switch during the OEP (October 15 – December 7), they will receive a one-time SEP in 2016 to change plans (if they choose do so). Individuals will only be able to use this SEP to switch to a higher-rated plan with three or more stars. In addition, an individual who decides to use this SEP will need to call 1-800-Medicare directly and **cannot** make the switch by calling the plan. Click here to view CMS guidance to Part D plans that contains information about this SEP (see page 87).

Medicare Part D: Stand-Alone PDPs

Medicare PDPs are insurance plans offered by private companies that contract with Medicare and offer only Medicare prescription drug coverage for prescriptions. Each plan has a formulary (a list of covered drugs) as well as premium, deductible and co-pay amounts that vary from plan to plan. A beneficiary must be enrolled in Medicare Part A and/or Part B to enroll in a Part D plan. Below is a quick snapshot look at how many Part D plans are offered in Illinois and how associated costs are changing in 2016.

Stand-Alone PDPs in Illinois		
	2015	**2016**
Number of PDPs in IL	32	25
Annual Deductible	$0 - $320	$0 - $360
Monthly Premium	$15.70 - $131.90	$18.40 - $157.40
Number of plans that offer a $0 premium with full LIS	9	9
Number of plans that offer some coverage in the gap	8	5
Benefit type	14 Basic 18 Enhanced	13 Basic 12 Enhanced

** Please note the chart above does not include sanctioned Part D plans.

Click here to view a landscape (spreadsheet) of all stand-alone PDPs offered in Illinois in 2016. The chart also lists which plans will offer a $0 premium with full Extra Help (also referred to as the Low-Income Subsidy or LIS).

Aetna 2016 Part D Drug Pricing - Clarification

Many beneficiaries and counselors have reported significant changes in drug pricing from 2015 to 2016 listed on the Medicare Plan Finder for Aetna and Coventry First Health Part D plans. The changes include drugs that have a substantial increase in 2016 but also drugs that are significantly lower than competitor prices. As a result, many counselors thought it to be an error but Aetna has released a Q&A document stating the pricing is accurate. Click here to for the Aetna's Q&A. Thank you to the Illinois Senior Health Insurance Program (SHIP) for sharing this information.

Sanctions on United American Company part D Plans
The Centers for Medicare and Medicaid Services (CMS) have placed sanctions on United American Insurance Company Part D plans for failure to properly administer the Part D prescription drug benefit. This means that CMS has suspended United American from marketing and enrolling new members into their Part D plans.

The three United American PDP plans currently sanctioned in Illinois include:

- United American – Enhanced (S5755-020)
- United American - Select (S5755-088)
- United American – Essential (S5755-122)

The sanction will not affect current members - they may continue using their United American plan. However, it is important for United American members to contact the plan to find out if their current plan will continue to work for them next year because 2016 plan and pricing information for United American plans is blocked on the Medicare.gov Plan Finder. United American members were mailed a notice notifying them of the sanctions earlier this fall. The letter detailed their options, including changing plans during the open enrollment period (October 15 - December 7). Current members who experience issues obtaining their prescriptions should contact 1-800-Medicare if they are unable to resolve the issue with the plan and to determine if they are eligible for a special enrollment period to switch to another Part D plan after the OEP ends.

Part D and Medicare Advantage Plans

Medicare Advantage and the Open Enrollment Period
The Medicare Open Enrollment Period is also the time beneficiaries can switch, enroll in, or disenroll from Medicare Advantage (MA) plans (also referred to as Medicare health plans or Medicare Part C). Individuals interested in or already enrolled in MA plans should review the plan to determine how it will work in 2016. In addition to making certain their MA plan will continue to cover their prescription drugs, MA plan enrollees should also evaluate the health services that are covered through their plan. This includes understanding how an MA plan works, how much each health service costs with a specific plan, and if their preferred doctors and providers are part of the MA plan's network.

In 2016, some Medicare Advantage plans offered in Illinois have an annual health deductible (this is separate than any drug deductible the plan may have in place). It is important to call the plan to find out which health services apply towards the deductible. For example, some plans have health deductibles in which only services received out-of-network apply and services received in-network do not.

Medicare Advantage Out of Pocket Maximum Limit
CMS requires all MA plans, including Special Needs Plans, to set an annual maximum out-of-pocket (MOOP) limit of no more than $6,700 in 2016 for Part A and Part B services received at in-network providers. This means that once a beneficiary reaches the MOOP amount, s/he no longer has to pay any co-pays or co-insurance for in-network Part A and B services for the remainder of the calendar year. MOOP limits vary by plan – many have limits lower than $6,700. Please note: prescription drugs are **not** included in the MOOP amount. You may find the MOOP amount for a specific MA plan by contacting the plan or doing a health plan search (using the prescription drug Plan Finder) on www.Medicare.gov.

Medicare Advantage Plans in Illinois and Cook County

State of Illinois: MA-PDs (MA plans that include drug coverage)		
Illinois	**2015**	**2016**
Number of MA-PD plans	878	833
Annual drug deductible	$0 - $320	$0 - $360
Monthly premium range in IL	$0 - $157	$0 - $188
Number of plans that offer some coverage in the gap	259	214
Types of MA-PD plans offered	Local HMO – 276 Local PPO – 429 Regional PPO – 102 PFFS - 71	Local HMO – 286 Local PPO – 391 Regional PPO – 54 PFFS - 102

Cook County: MA-PDs		
Cook County	**2015**	**2016**
Number of MA-PD plans offered in Cook County	20	23
Annual deductible	$0 - $320	$0 - $360
Premium range in Cook County	$0 - $157	$0 - $188
Number of plans that offer some coverage in the gap	11	11
Types of MA-PD plans offered	Local HMO – 12 Local PPO – 6 Regional PPO – 1 PFFS – 1	Local HMO – 15 Local PPO – 6 Regional PPO – 1 PFFS – 1

Click here to view a landscape of all 2016 Medicare Advantage plans offered in Illinois by county.

Special Needs Plans in Illinois and Cook County

Medicare Special Needs Plans (SNPs) are Medicare Advantage plans for people with Medicare Parts A and B and who:

- are dual eligibles (have both Medicare and Medicaid)
  or
- are institutionalized
  or
- have a specific chronic or disabling condition.

The three types of SNPs listed above are different than regular MA plans in that they are designed to tailor benefits, provider choices and formularies to the needs of the specific group of people the SNP serves. All SNPs must include prescription drug coverage, and an individual must be a beneficiary who meets the requirements of one of the categories listed above to be eligible to enroll. Please note that the SNPs offered for dual eligibles are different than the Medicare-Medicaid Alignment Initiative (MMAI) plans for people with Medicare and Medicaid in select areas of Illinois.

Special Needs Plans in Illinois		
Illinois	**2015**	**2016**
Number of SNPs	111	64
Monthly premium range	$0 - $28.20	$0 - $29.60
Annual drug Deductible	$0 - $320	$0 - $360
Coverage in the gap	1	2
Type of SNP	Chronic or disabling condition: 52 Dual-eligible: 55 Institutional: 4	Chronic or disabling condition: 6 Dual-eligible: 52 Institutional: 6

Special Needs Plans in Cook County		
Cook County	**2015**	**2016**
Number of SNPs	5	6
Monthly premium range	$17.90 - $28.20	$0 - $29.60
Annual drug Deductible	All plans have a $320 drug deductible	$0 - $360
Coverage in the gap	None of the plans offer coverage in the gap	1
Type of SNP	Dual-eligible: 4 Institutional: 1 Chronic or disabling condition: 0	Dual-eligible: 4 Institutional: 1 Chronic or disabling condition: 1

Click here to view a landscape of Special Needs Plans offered in Illinois by county.

Non Renewing Medicare Advantage Plans

In 2016, there are only two types of plans no longer being offered in Illinois. Both plans are United Healthcare Medicare Advantage plans that are terminating effective December 31, 2015. The plans are:

- Care Improvement Plus Medicare Advantage PPO (H0084-001)
- Care Improvement Plus Gold Rx PPO-SNP (H0084-004)

This change affects 2,839 beneficiaries throughout multiple counties in Illinois, but do not include Cook or the Collar Counties. These plans are currently offered in the following counties:

> Adams, Bond, Bureau, Carroll, Christian, De Witt, Ford, Fulton, Greene, Hancock, Henderson, Henry, Jersey, Jo Daviess, Knox, Livingston, Logan, Macoupin, Madison, Marshall, McDonough, McLean, Menard, Mercer, Montgomery, Morgan, Peoria, Pike, Rock Island, Sangamon, Schuyler, St. Clair, Stephenson, Tazewell, Warren, Washington, Woodford

Members in the two plans received letters in early October notifying them that their plan will no longer be offered in 2016. The letter included a list of available MA and PDP plans in their area and listed the following options:

- Enroll in another MA plan offered in their county during the open enrollment period (October 15 – December 7) or utilize an additional special enrollment period (SEP) from January 1 to February 29, 2016 to enroll in a plan
- Return to Original Medicare and receive a SEP through February 29 to enroll in a stand-alone PDP. Beneficiaries who return to Original Medicare also receive guaranteed issue rights to buy a Medigap policy up to 63 days after their MA coverage ends and can choose from one of the following plans offered by any insurance company (Plan A, B, C, F, K, or L).

Members who do not take action by December 31, 2015 will return to Original Medicare effective January 1, 2016.

Finding and Enrolling in the Right Part D Plan

It is especially important for Medicare beneficiaries with Part D to compare Part D plans annually to make certain that their plan will cover their prescription drug needs and determine if there is a less expensive plan available in 2016. The most efficient way to shop around and compare plans is to use the www.Medicare.gov Plan Finder tool, which allows individuals to compare stand-alone PDPs and MA plans. Medicare's online Plan Finder tool can help you compare annual estimated costs that include the premium, deductible, and cost sharing amounts. In addition, the Plan Finder has now made it easier to search for the best pharmacy selection by plan in order to maximize a beneficiary's savings.

Beneficiaries can enroll in or switch Part D plans by calling 1-800-Medicare, submitting an online enrollment via www.Medicare.gov, or contacting the plan directly. Individuals who are switching Part D plans for 2016 do not need to disenroll from their current plan as they will be automatically disenrolled on December 31, 2015 by Medicare and have their new plan begin on January 1, 2016.

There a number of components to consider when choosing a Part D plan. Below is a summary of the main factors that should be reviewed prior to enrolling in a plan.

- Estimated annual drug costs, including the monthly premium, annual deductible (if the plan has one), and cost sharing amounts.
- Drug coverage. This includes making certain drugs are on the plan's formulary, what the beneficiary's co-pay or co-insurance will be, if the beneficiary will enter the donut hole and if any of the prescriptions have drug restrictions such as quantity limits, prior authorization or step therapy.

  It is important to note that in 2016 there are some plans with annual deductibles that do not have tier 1 drugs apply towards the deductible. This may result in significant cost savings for beneficiaries who take tier 1 drugs that fall into this category and result in these plans being the least expensive option despite having a deductible. Although a beneficiary cannot anticipate their future drug needs, it is important they recognize that any unmet deductible amount may apply if they are prescribed any higher tiered drugs during the rest of the year.
- Pharmacy selection (standard, preferred and mail order). See below for a more detailed explanation.
- Plan star ratings. CMS reviews Part D plans on quality and performance to help individuals compare and make informed plan choices. Plans are evaluated on certain measures and CMS provides each plan with an overall star rating from 1 to 5, with 5 being "excellent" and 1 being

"poor". The overall ratings, as well as how each plan did on specific measures are available on the Plan Finder. This year, CMS has added a new rating measure under each plan that includes reasons why members left that plan.

Part D and Pharmacy Selections
Each Part D plan works with a network of contracted pharmacies that beneficiaries may use to fill their prescription drugs and be covered. Each pharmacy network varies from plan to plan. There a three types of pharmacy options a plan may offer:

- Standard network pharmacy – the pharmacy is in the plan's network and the member pays a co-pay or co-insurance amount that is set by the plan. All Part D plans have standard network pharmacies.
- Preferred network pharmacy – some Part D plans also have special agreements with select "preferred" pharmacies that usually provide lower drug cost sharing if the preferred pharmacy is used. Not all Part D plans offer a preferred pharmacy network.
- Mail order pharmacy – some plans, not all, offer a mail order service. Plans that offer mail order mail prescriptions using their own contracted mail order pharmacy directly to the beneficiary's home (up to a 90-day supply). Depending on the plan, mail order drug costs may be less expensive that using a retail pharmacy (although not always).

A Part D plan will not make payment on a drug if the pharmacy is not part of their network. You can view costs for each type of pharmacy by using the Plan Finder. Depending on the plan, not all three options may be offered, but all plans are required to have a standard pharmacy network. Beneficiaries always have the choice of which type of pharmacy they would like to use each time a prescription is filled. Click here to view a step-by-step guide created by the MMW Coalition on how to locate a plan's pharmacy list on the Plan Finder.

Medicare.gov Plan Finder Training Tutorials and Resources
CMS has created a number of resources to help individuals navigate the Plan Finder:

- Medicare Training Program Plan Finder Toolkit – includes a PowerPoint presentation and worksheet, as well as five YouTube video tutorials on how to use the Plan Finder and an online demonstration
  - Navigating the Plan Finder PowerPoint – a step-by-step presentation on how to use the Plan Finder
  - Medicare Plan Finder worksheet – an intake sheet where you can gather all the information you need from a beneficiary to use the Plan Finder to search a Part D plan that best suits your needs
- Medicare Plan Finder FAQ

Medicare Part D and Extra Help

2016 Extra Help Co-Pays
Note: Extra Help is also referred to as the "Low Income Subsidy" or LIS.

In 2016, depending on the level of Extra Help a beneficiary receives (full or partial), he or she will pay the following co-pays for each 30-day supply filled:

Full Extra Help - between $1.20/$3.60 (generic/brand name) or $2.95/$7.40 (generic/brand name)*

Partial Extra Help – $2.95 (generic) and $7.40*(brand name) or 15% co-insurance for each 30-day supply*

*Which co-payment the beneficiary pays depends on his or her income. In addition, beneficiaries with partial Extra Help that are on the higher end of the income and/or asset limits will also be responsible for paying an annual $74 drug plan deductible in 2016 for covered drugs (up from $66 in 2015). The Extra Help deductible applies to beneficiaries with incomes between 135% and 150% of the Federal Poverty Level. The LIS income limits for 2016 will be announced in early 2016 once the federal poverty levels are released.

Stand-Alone PDPs

In 2016, nine stand-alone PDP plans will offer a $0 monthly premium to people who have full Extra Help. CMS will pay the entire monthly Part D plan premium for beneficiaries with full LIS if the plan is a basic plan and the monthly premium is at or below a certain premium amount, called the **LIS benchmark**. In Illinois, the LIS benchmark premium amount for 2016 is $28.23. This amount is calculated by CMS for each geographic region and changes every year. Please note some Part D plans may decide to waive the premium for people with full LIS if the plan's premium is less than $2 over the benchmark amount (called the "de minimis amount").

Note: Individuals with full LIS may enroll in any plan they choose (they are not limited to plans on the list below) but they will be responsible for any amount of the monthly premium that is over the benchmark. However, LIS will still pay the entire annual deductible and provide them with low prescription drug co-pays for drugs on the plan's formulary regardless of the Medicare Part D plan they are enrolled in, even if the plan's premium is over the benchmark.

If an individual with full LIS enrolls in an enhanced plan instead of a basic plan, the individual will also be responsible for the portion of the plan's premium that accounts for the "enhanced" benefit. For example, in 2016 in Illinois, the Humana Walmart Rx plan has a monthly premium of $18.40, which is below the LIS benchmark amount. However, a beneficiary with full LIS who enrolls in this plan would be responsible for a $14.10 monthly premium because LIS will not pay the portion of the premium that makes the plan "enhanced."

Below is a list of PDPs in 2016 that will offer a $0 premium with full LIS. Note that all the same plans that offer a $0 premium with full LIS this year will continue to do so in 2016.

Company Name	**Plan Name**	**Monthly Drug Premium** (Medicare will pay this premium for individuals with full LIS)	**Annual Drug Deductible** (Medicare will pay the deductible for individuals with full LIS)
Aetna Medicare	Aetna Medicare Rx Saver (S5810-051)	$25.70	$360
Cigna-HealthSpring Rx	Cigna-HealthSpring Rx Secure (S5617-224)	$30.70	$360
EnvisionRx Plus	EnvisionRxPlus Silver (S7694-017)	$30.00	$360
HISC – Blue Cross Blue Shield of Illinois	Blue Cross MedicareRx Basic (S5715-012)	$30.00	$360
Humana Insurance	Humana Preferred Rx	$26.70	$360

Company	Plan (S5884-107)		
SilverScript	SilverScript Choice (S5601-034)	$20.50	$0
Symphonix Health	Symphonix Value Rx (S0522-001)	$26.50	$360
UnitedHealthcare	AARP MedicareRx Saver Plus (S5921-362)	$31.30	$360
WellCare	WellCare Classic (S5967-154)	$30.20	$360

Click here for a printable version of this chart.

Medicare Advantage Plans for Individuals with Extra Help
Medicare Advantage plans that include prescription drug coverage (MA-PD plans) also work with Extra Help. MA-PD plans vary in premium. Some plans offer $0 monthly premium and others have a premium for health **and** prescription coverage. Beneficiaries in Medicare Advantage plans continue to pay their monthly Part B premium in addition to any extra premium amount the plan charges. (Some plans that offer a $0 premium do so because Medicare pays the private Medicare Advantage plan a fixed rate per member to provide beneficiaries with their Part A and B benefits.)

If an individual qualifies for Extra Help and is also enrolled in a MA-PD plan, Extra Help will help him or her pay for the prescription drug coverage portion of the plan premium, but not the health portion. The beneficiary is also still responsible for the plan's set co-pay or co-insurance amounts for health services, such as the doctor's co-pay amount, specialist co-pay, etc. Extra Help will not help to pay for the health co-pays set by the plan – just the prescription drug co-pays.

The same Extra Help guidance for people in stand-alone PDPs applies to people in MA-PD plans. This means they will receive help with their drug co-pays, annual drug deductible, and if the MA-PD plan has a premium, any portion of the premium that is specified for drug coverage and below the Extra Help benchmark as discussed earlier in this Brief.

Click here for a tip sheet created by MMW that lists the MA-PD plans in Cook and the Collar counties that offer $0 drug premium for beneficiaries with full Extra Help.

Click here to view a useful CMS spreadsheet that lists the amount of the premium Extra Help will pay for all Part D plans in Illinois (MA-PD and PDP plans), including partial Extra Help coverage.

Letters! Letters! Letters! The Extra Help Edition

Guide to Consumer Mailings
The Centers for Medicare & Medicaid Services recently released their Guide to Consumer Mailings from CMS, the Social Security Administration (SSA) and Medicare Plans in 2015/2016. Throughout the year, CMS, SSA, and Medicare plans send important notices to beneficiaries regarding their benefits, including information about their Extra Help and Medicare Savings Program eligibility, Medicare plan benefit changes, plan marketing materials, prescription co-payment changes, etc. The guide includes the mailing date, the sender of the letter, the letter color, a description of the action the beneficiary needs to take, and a link to a copy of the letter. This guide is helpful for counselors who assist Medicare beneficiaries in navigating their healthcare benefits throughout the year. Below is a quick summary of the letters being mailed to people with Extra Help/LIS during the fall.

"Loss of Deemed Status" (grey letter) was mailed to beneficiaries by CMS in September. It notifies beneficiaries that they will no longer automatically receive LIS effective January 1, 2016 because they no longer qualify for Medicaid, a Medicare Savings Program or Supplemental Security Income (SSI). The letter includes an application for Extra Help because some of these beneficiaries may still qualify for LIS based on their income and or assets but would need to apply through Social Security. Beneficiaries who lose their Extra Help are eligible for a SEP through March 31, 2016 to change plans.

"Change in Extra Help Co-payment" (orange letter) was mailed to individuals in early October and notifies them that will continue to automatically receive Extra Help in 2016 but that their Extra Help co-pay level will change. The letter lists what their co-pays will be as of January 1, 2016. An individual's Extra Help co-pay may change if s/he move from one of the following categories to another:

- Institutionalized with Medicare and Medicaid
- Have Medicare and Medicaid
- Have Medicare and Medicaid with a change in income level
- Belong to a Medicare Savings Program
- Begin receiving SSI

Low-Income Subsidy (LIS) Choosers (tan letter) is mailed in early November. It notifies people with LIS who chose and enrolled in a plan on their own (instead of being automatically enrolled by CMS) that their Part D plan premium is changing and they are responsible for paying a portion of the premium because it is over the benchmark. Individuals who receive a tan letter should look at the list of Part D plans that offer a $0 premium with full LIS, comparing the drug lists and possible restrictions. If they choose to stay in their current plan, they will be responsible for a portion of the premium. Someone might choose to do this (and may still save money) if the current plan offers better coverage of the drugs they take than any of the $0 premium plans.

LIS Blue Reassignment Letters. There are two different blue letters. People who receive LIS and whose plans are leaving Medicare Part D will receive Blue Letter 1. People who receive full LIS and whose premium in 2016 will be above the LIS premium amount will receive Blue Letter 2 in late October/early November. CMS will mail out two different blue letters to people who receive full LIS and will be reassigned to a new plan in 2016. Please note that people with LIS will be reassigned to a different plan only if Medicare had originally auto-assigned them to a plan and they haven't chosen a different plan.

Blue Reassignment Letter 1 informs people who receive LIS and whose plans are leaving the Medicare Part D program which plan they will be reassigned to if they do not join a new plan on their own by December 31, 2015.

Blue Reassignment letter 2 informs people who receive full LIS and whose plan premiums are increasing which plan they will be reassigned to if they do take action. Beneficiaries who wish to stay in their plan can do so plan calling 1-800-Medicare and request to remain in that plan. If they do nothing, they will be re-assigned by CMS to a different plan. They also have the option of choosing and enrolling in a plan of their choice.

As a general reminder, beneficiaries with Extra Help are also eligible for a continuous SEP, which means they can switch their Medicare Part D plans (PDPs and MA plans) at any time during they year.

As always, feel free to contact us with any comments or questions. If you would like to unsubscribe and not receive updates and information from the Make Medicare Work Coalition, please contact us by calling (708)383-0258 or emailing Georgia.Gerdes@ageoptions.org Alicia.Donegan@ageoptions.org or Erin.Weir@ageoptions.org.

November 11, 2015