Make Medicare Work Coalition Bulletin
December 12, 2014

Medicare Updates

2015 Medicare Premiums, Deductibles and Co-insurance Amounts
The Centers for Medicare and Medicaid Services (CMS) recently released the 2015 Medicare premiums, deductibles and cost-sharing amounts. These are the out-of-pocket amounts a beneficiary is responsible for paying and that Medicare does not cover.

In 2015, the monthly Part B premium will remain at $104.90 for most beneficiaries. Beneficiaries with annual incomes greater than $85,000 ($170,000 if filing a joint tax return) will pay a higher Part B premium. CMS has created a handout that lists the 2015 amounts. Click here to view the handout (available in multiple languages, including English, Spanish, Armenian, Bengali, Chinese, Farsi, French, German, Hmong, Italian, Korean, Polish, Russian, Tagalog, Tongan, and Vietnamese).

2015 Medicare Part B and Part D Premium Amounts for Beneficiaries with Higher Incomes
Earlier this year, CMS released the 2015 Medicare Part D Income-Related Monthly Adjustment (IRMA) amounts for individuals with incomes higher than $85,000 if filing an individual tax return or $170,000 if filing a joint tax return. According to Social Security, this affects less than 5% of Medicare beneficiaries.

The Part D IRMA amount depends on the beneficiary’s income that is reported on his/her tax return and is in addition to any monthly Part D plan premium. The IRMA amount is paid separately from the Part D plan premium and directly to Social Security. Individuals who pay Part D IRMA amounts usually also pay higher Part B premiums that are based on income. Individuals with IRMA-related questions or who have had a change in income since filing their last tax return should contact Social Security at (800) 772-1213 to report the decrease in income. To view the Part D IRMA amounts click here (see page 4).

Medicare General Enrollment Period
Individuals who did not enroll in Medicare Part A and/or Part B when they were first eligible can enroll during the Medicare General Enrollment period, which begins January 1 and ends March 31 of every year. Coverage will subsequently begin July 1 of the same year. Individuals who use this enrollment period to enroll in Medicare usually have to pay a late enrollment penalty in addition to any Medicare premium(s).
(Note that individuals who delayed enrolling in Medicare because they were covered by a group health plan that is primary to Medicare (such as a current employer plan) receive a special enrollment period to enroll in Medicare at any time during the year, depending on when coverage their group health plan coverage ends. For more information about transitioning from employer-based coverage to Medicare, see our MMW resources on that topic here.

The Part B late enrollment penalty is 10% of the Part B premium for every 12 months the individual could have, but did not enroll in Part B. The Part B penalty is not capped and is paid in addition to the monthly Part B premium.

The Part A late enrollment penalty applies to people who do not receive Part A premium-free and did not enroll when they were first eligible. The Part A late enrollment penalty is 10% of the current Part A premium and the individual pays it for twice the number of years s/he was eligible but did not enroll. (For example, if Susan enrolls into Medicare Part A one year late, she will pay the Part A premium penalty for two years.) Most people with Medicare receive Part A premium-free and therefore will not have to pay this penalty, but some individuals age 65 and older must pay a premium for Part A if they meet other qualifying criteria but do not meet Medicare’s work history requirement (40 credits of work with contributions to Social Security or Railroad Retirement).

Note: Individuals who do not receive Part A premium-free and would like to purchase it (and are not eligible for a Medicare Savings Program) may wish to review their coverage options through the Affordable Care Act (ACA) Marketplace. Purchasing a Marketplace plan may be less expensive than paying monthly premiums for Medicare Parts A, B, and D. It is important to note that individuals who are eligible for premium free Part A are NOT allowed to purchase a plan from the Marketplace.

To view more information about Medicare enrollment periods and late enrollment penalties, visit Medicare’s website at: http://www.medicare.gov/Pubs/pdf/11219.pdf.

**Medicare Part D Transition Supply**

This is a reminder that individuals who are new to a Part D plan or Medicare-Medicaid Alignment Initiative (MMAI) plan are eligible to receive a one-time transition fill of prescription drugs if they discover that their drugs are not on their new plan’s formulary in early 2015. Part D and MMAI plans are required by CMS to provide new enrollees a one-time 30 day fill of a prescription (called a transition supply) that is not on a Part D or MMAI plan’s formulary at any time within the first 90 days of coverage. This policy also applies to prescriptions with drug restrictions, such as prior authorization or step therapy. The transition supply policy is helpful for Medicare beneficiaries who are new to Part D or who switched plans and discover that a drug they are taking is not on their new plan’s formulary or has restrictions.

In some cases, Part D plans may also offer current enrollees a transition supply within the first 90 days of coverage in the new contract year if their drug(s) is impacted by a formulary or drug restriction change from this year to the next. (For example, if Joe takes Lipitor, and Joe’s Part D plan covers Lipitor in 2014, but decides to require step therapy for Lipitor in 2015, Joe’s plan may have to offer him a 30 day transition supply of Lipitor in the first 90 days of 2015.) The transition supply rule only applies to current plan enrollees if the plan did not work with the beneficiary prior to the new contract year to find another equivalent drug on the formulary or complete a formulary exception request before the new coverage year began. Click here and see section 30.4.5 for more information.
Individuals in long-term care facilities will be provided up to a 31 day transition supply during the first 90 days they are in a new Part D plan. (Note that in this case, Part D plans must provide multiple 31 day transition fills as necessary during the 90 day period.) Individuals in long-term care settings who use the transition supply policy should make sure the supply is from a participating pharmacy in order for the drug to be covered by the plan.

If an individual fills a transition supply of a current prescription with his/her Part D plan, the plan is required to notify the member in writing within three business days, explaining that the one-time supply was a temporary fill. This is intended to allow the member enough time to work with his/her doctor to find another drug on the formulary that would work as well or to request a formulary exception from the plan for the remainder of the year. To view more information about Part D transition policy, please click here and see section 30.4.

**Medicare Beneficiaries Losing Extra Help in 2015 – What They Need to Know**

People with Medicare who will no longer automatically receive Extra Help (called “deemed eligible”) beginning January 1, 2015 will be eligible for a special enrollment period (SEP) to change Part D plans if they did not make a change during the October 15 - December 7 Medicare Annual Enrollment Period. The SEP is valid for a one-time Part D plan switch that may be made from January 1st through March 31st. Any plan change will take effect the 1st of the following month. See [this Medicare fact sheet](#) for more information (page 8).

These individuals should have received a letter from CMS in September on grey colored paper notifying them that they since they are no longer deemed eligible, they will no longer receive assistance through the Extra Help program in 2015. Click here to view the letter. Individuals should review their current plan to determine if it will continue to be the most affordable and best suited plan for them, since Extra Help will no longer help them pay for their Part D costs, including premiums, deductible and co-pays.

A person is deemed eligible and automatically qualifies for Extra Help without having to apply if s/he meets one of the following criteria listed below:

- Has Medicare and Medicaid (meeting a Medicaid spenddown, even for just one month during the year, will also “deem” an individual eligible for Extra Help)
- Enrolled in one of the Medicare Savings Programs (QMB, SLMB or QI)
- Receives Medicare and Supplemental Security Income (SSI)

If a person is no longer “deemed” eligible for Extra Help, it is because they no longer qualify for one of the programs listed above. **Some of these individuals may still qualify for Extra Help and should submit an Extra Help application to SSA to determine eligibility.**

**Upcoming CMS Webinar on Medicare Rights and Protections**

CMS will be hosting a training webinar on December 16th from 12:00 – 1:30 pm. CT on the rights and protections a beneficiary has under the Medicare program. On the day of the webinar, you can join the audio portion by calling 1- 800-603-1774 and entering the conference ID: 66788144. Webinar details will be posted online at [http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Monthly-Stakeholder-and-Partner-Update-Webinar.html](http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Monthly-Stakeholder-and-Partner-Update-Webinar.html).
Medicaid Updates

Auto-Assignment Suspension in Harmony and Family Health Network Plans
The Illinois Department of Healthcare and Family Services (HFS) recently announced that as of November 13, 2014 the state has suspended auto-assignments into Harmony Health Plan and Family Health Network due to low quality scores. Both these plans are mandatory managed care plans for families (Medicaid Family Health Plans) and ACA Adults on Medicaid. In addition, the state has also suspended auto-assignment into Illinois Partnership for Health, an Accountable Care Entity (ACE). Please note this does not affect individuals in managed care plans through the Medicare-Medicaid Alignment Initiative (MMAI) or the Integrated care Program (ICP). For more information please see the Health Management Associate’s newsletter: http://www.healthmanagement.com/assets/Weekly-Roundup/111914-HMA-Roundup.pdf#nameddest=infocus.

ACA Adult Medicaid Enrollment Statistics for Illinois
HFS has posted demographic data on Medicaid enrollment for ACA Adults (including CountyCare) in Illinois for ages 19-64. The data includes breakdowns by county, gender, race/ethnicity and age. Click here to view the data.

ACA Marketplace Updates

Marketplace Open Enrollment Period
The open enrollment period for the ACA Marketplace began on November 15, 2014 and ends on February 15, 2015. Enrollments and changes can only be made during this time unless an individual qualifies for a special enrollment period. Eligible individuals can use the www.healthcare.gov website to enroll or compare plans and determine if there is lower cost plan or one that better suits their health needs in 2015. Individuals who currently have a Marketplace plan can also renew their coverage through Healthcare.gov if they choose to stay with the same plan in 2015.

Below are important Marketplace dates to keep in mind when choosing and comparing coverage.
- November 15, 2014: Marketplace open enrollment period (OEP) begins. You can apply for, keep/renew or change plans.
- December 15, 2014: Enroll by December 15th if you want your new plan to begin on 1/1/15.
- February 15, 2015: Last day you can apply for 2015 coverage through the Marketplace.

Below is a list of helpful tips.
- Compare plans using Healthcare.gov. Review any premium, deductible, cost sharing and benefit (including prescription drug) changes to determine if the plan will continue to provide appropriate coverage in 2015 or if there is a lower cost plan available that better suits the individual’s health needs. The Center on Budget and Policy Priorities has created a useful Marketplace comparison worksheet that helps consumers look at what they should take into consideration when comparing plans. Click here to access the worksheet.

- Even if individuals are not changing plans for 2015, it is important that they visit Healthcare.gov to evaluate their eligibility for tax credits/cost-sharing assistance and renew their coverage with their current Marketplace plan. Individuals should log in to their Marketplace account to review
or update their personal and income information by visiting www.healthcare.gov or by calling the Marketplace. It is especially important to update an individual's income on his/her Marketplace application. An individual's income will determine whether s/he receives a premium tax credit and how much. Failure to report an increase in income may result in having to pay back tax credits received inappropriately. Not reporting a decrease in income may prevent an individual from receiving a higher premium tax credit to put toward paying his/her plan premium.

- The Marketplace will try to automatically enroll individuals who do nothing into their current plan (or a similar one if their current plan will not be available in 2015) along with the same premium tax credit they received in 2014. However, individuals who did not authorize the Marketplace to check their income with the IRS or who had 2013 tax returns that exceeded the allowable limit for premium tax credits will be automatically enrolled in 2015 without the tax credit.

- **Be aware of the penalty.** Individuals without minimum essential coverage in 2014 will be assessed a penalty during 2015 tax season on their federal tax return. [Click here](#) to learn more about the individual mandate penalty. In addition, individuals who do not use this open enrollment period to enroll in a plan for coverage in 2015, will have to wait until the next open enrollment period in the fall of 2015 to enroll in a plan for 2016.

Help is available. Individuals can call the Marketplace Call Center at 1-800-318-2596 or visit a local agency for assistance. Certified counselors called “Navigators” and “In-Person Counselors” at local organizations can assist individuals to apply, enroll in and compare Marketplace plans. To find help near you, visit [https://getcoveredillinois.gov/get-help](https://getcoveredillinois.gov/get-help).

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**Other Resources**

**Illinois Association Free and Charitable Clinics Updated Directory**

The Illinois Association of Free and Charitable Clinics has updated their directory of clinics for individuals who are uninsured or underinsured and do not qualify for Medicare or Medicaid. You can search for clinics by geographic area by visiting [http://www.illinoisfreeclinics.org/clinic-search/clinic-directory](http://www.illinoisfreeclinics.org/clinic-search/clinic-directory). Thanks you to the Illinois Senior Health Insurance Program (SHIP) for sharing this information.

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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.