Make Medicare Work Coalition (MMW)

Bulletin Newsletter

March 10, 2017

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Medicare Updates

Medicare Transition Supply Policy

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Part D, Medicare Advantage, and Medicaid-Medicaid Alignment Initiative (MMAI) plans to offer newly enrolled beneficiaries a one-time 30-day fill of a prescription that is not on the plan's formulary. This is called a transition supply and can be used anytime within the first 90 days of coverage with a plan. A transition supply is a temporary fill and intended to avoid interruptions in a beneficiary's medication usage so the individual has enough time to work with the plan to either request a formulary exception or find a drug that is on the plan's formulary and works as well. When an individual fills a transition supply of a current prescription with his or her new 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. The policy also applies to prescriptions with drug restrictions, such as prior authorization or step therapy.

The transition supply policy is intended to assist Medicare beneficiaries who are new to a plan or switched plans and discover that a drug they are taking is not on their new plan's formulary or has drug restrictions. In certain circumstances, plans may also be required to offer their current enrollees a transition fill within the first 90 days of coverage in the new calendar year if the prescription they are taking is impacted by formulary or drug restriction changes from one year to the next. For example, Susan takes Crestor but finds out when she goes to the pharmacy in early 2017 that her prescription is no longer covered by her plan. Susan's plan must offer her with a one-time 30-day fill to provide her with time to either request a formulary exception from her plan or find an alternative drug that is on the plan's formulary and works as well.

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. Beneficiaries who reside 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 plan. Note that plans must provide multiple 31 days transition as necessary during the 90 day transition period. Individuals in long-term care settings who use the transition supply policy should make sure the supply is from a participating pharmacy.

To view more information about Part D transition policy, please click here and see section 30.4.5.

Medicare General Enrollment Period

Individuals usually enroll in Medicare during their initial enrollment period (IEP) which is the time period that begins three months before their Medicare eligibility date and lasts for up to three months after their Medicare eligibility date. Other individuals may decide to delay enrolling in Medicare because they have other coverage that is primary to Medicare through their own, spouse's, or family member's current employment. These individuals receive a special enrollment period (SEP) to enroll in Part B without penalty when their primary coverage through an employer group plan ends or they stop working, whichever happens first. Individuals who did not enroll in Medicare using their IEP or a SEP, will have to use the Medicare general enrollment period (GEP) to enroll.

The Medicare GEP is an annual period of time (January 1 - March 31) that allows Medicare beneficiaries to enroll in Medicare Part A and/or Part B if they did not enroll when they were first eligible for Medicare. Individuals who use the GEP to enroll in Medicare will not have their coverage begin until July 1st of the same year. In addition, individuals who use this enrollment period usually have to pay a late enrollment penalty in addition to their Medicare premiums. Click here to read more about this general enrollment period and the late enrollment penalties for Medicare Part A and Part B.

Medicare Part A

Individuals who are eligible for premium free Medicare Part A can enroll in Part A at any time even if they missed their IEP or the opportunity to use a SEP once their employer health coverage came to an end. Individuals who are eligible for premium-free Part A include people who have enough Social Security covered work credits (also called quarters) through their own or spouse's work history. These individuals can enroll at any time, do not have to pay a late enrollment penalty for Part A and can even request their Part A coverage to be retroactive for six months from the date they sign up (if they were eligible for Part A during those 6 months but had not enrolled).

Individuals who are eligible to purchase Part A but do not have enough work credits must use the Medicare GEP to enroll by contacting the Social Security Administration. Enrollments can only be submitted January 1 through March 31 and coverage will not begin until July of that same year. Individuals who do not qualify for Medicare Part A premium free, must pay a monthly premium that is based on their number of Social Security covered work credits. In 2017, the monthly premiums for Part A are $227

each month for beneficiaries with 30-39 work credits and $413 each month for beneficiaries with less than 30 credits. Note, that individuals who enroll in Part A must also enroll in Part B or already be enrolled. In addition, Part A late enrollment penalties usually apply for this group of individuals and is 10% of the individual's Part A premium. The penalty is capped meaning they do not have to pay it for life, but must pay it for twice the number of years an individual was eligible for Part A but did not enroll. For example, if Mary was eligible for Part A for two years but did not enroll, she will have to pay the late enrollment penalty for four years (the penalty is in addition to the monthly Part A premium which varies depending on how many work credits a person has accrued).

It is important to mention that because the Part A monthly premium is expensive, some individuals may want to explore alternative and perhaps less costly coverage options, such as Medicaid, Medicaid Spenddown or the Marketplace. **Individuals who are not eligible for premium-free Medicare Part A are eligible to purchase a Marketplace plan instead of Medicare if they choose.** For some people, coverage through the Marketplace may be option especially if they are eligible to receive premium tax subsidies and/or cost sharing assistance.

Medicare Part B

Enrollment in Medicare Part B for people who missed their initial eligibility date or SEP is the same for all eligible beneficiaries, regardless of whether they have accrued enough work credits or not. Individuals who did not sign up when they were eligible will only be able to do so during the Medicare GEP (January 1 - March 31) and coverage will not begin until July 1. In addition, a late enrollment penalty usually applies, which is 10% of the standard Medicare Part B premium for every full 12 months a beneficiary was eligible but did not enroll. The Part B penalty is not capped, which means the longer an individual goes without enrolling in Part B, the higher the penalty and the individual must pay it for as long as they are enrolled in Part B. (Note that Medicare beneficiaries with a disability under age 65 and a Part B penalty will have their penalty waived when they turn 65.) Click here to read more about this general enrollment period and the late enrollment penalties for Medicare Part A and Part B.

Medicare Saving Programs (MSPs) can assist beneficiaries pay for Medicare Part A and/or Part B premiums if they are found eligible. MSPs are administered through the state Medicaid program and assist beneficiaries pay for Medicare premiums, deductible and cost-sharing depending on which MSP a beneficiary qualifies for. The three MSPs include:

- Qualified Medicare Beneficiary (QMB) pays for the Medicare Part A and part B monthly premiums, deductible and co-insurance amounts (including Part A premiums for individuals who are not eligible for premium free Medicare)
- Specified Low-income Medicare Beneficiary (SLMB) pays the monthly Part B premium
- Qualified Individual (QI) pays the monthly Part B premium

Eligibility and the type of MSP a beneficiary qualifies for is determined by Medicaid

and based on a beneficiary's income and assets. In addition, MSPs also pay any late enrollment penalties if a beneficiary is found eligible. The current income and asset limits for all three MSPs can be found in the Chart of Benefits referenced in the "Resources" section below.

It is important to note that the QMB program pays the Part A and Part B premiums and penalties if the individual is eligible and meets the income and asset limits. However, individuals who do not qualify for premium free Part A will have to use the Medicare GEP to enroll in Part A first and pay at least one month's Part A premium before QMB will thereafter begin paying the premium and any enrollment penalties.This is because state of Illinois does not have a buy-in agreement with CMS to allow individuals who are not eligible for premium free Part A to be found eligible for QMB to enroll in Part A at any time during the year.

Extra Help Updates

New 2017 Extra Help Income and Asset Limits
Extra Help is a federal benefits program that provides Medicare beneficiaries with limited incomes assistance in paying for their monthly plan premiums, annual drug deductibles and drug co-payments. Beneficiaries must be enrolled in a Part D plan (including a Medicare Advantage plan that includes drug coverage) to receive assistance from Extra Help in paying for their prescription drug expenses. Individuals who qualify for Extra Help and are not enrolled in a Part D, will be assigned to one by CMS. The level of Extra Help beneficiaries qualify for depends on their income and assets.

Full Extra Help provides the following benefits to a beneficiary who is enrolled in a Part D or MA plan:
The entire monthly Part D plan premium is covered if the plan is at or below the Extra Help benchmark and a basic plan. The benchmark amount is calculated by CMS and changes every year. Beneficiaries with Extra Help that are in plans with premiums that are above the benchmark or in an enhanced plan will be responsible for the premium amount that is over the benchmark or the portion of the plan that makes it enhanced. The Extra Help benchmark for Illinois in 2017 is $28.68.

- The entire Part D plan drug deductible is covered (up to $400 in 2017).
- Help with drug co-pays. Beneficiaries pay $1.20/$3.70 (generic/brand name) or $3.30/$8.25 (generic/brand name) for each 30-day supply.
- Eliminates the donut hole - beneficiaries pay low co-pays throughout the year for formulary drugs
- Individuals with full Extra Help who reach their True Out-of-Pocket (TrOOP) limit ($4,950 in 2017), will not have any drug co-pays for the remainder of the calendar year.
- People with any level of Extra Help receive a continuous Special Enrollment Period (SEP) to change Part D or Medicare Advantage plans anytime during the year (up to once per month, although it is not recommended to switch that often).
- The Part D late enrollment penalty is waived

Partial Extra Help provides the following benefits:
CMS will pay either the entire amount or a portion of the Part D plan premium, depending on the beneficiary's Extra Help subsidy level. If the individual is at the higher end of the income limit for Extra Help, they will be responsible for part of their premium regardless of whether the premium is at or below the benchmark.

- A reduced annual drug deductible ($82 in 2017 and applies only if the plan has a deductible) that must be met before Extra Help assistance is provided.
- Helps pay for each 30-day supply prescription co-pays: $3.30/generics and $8.25/brand names or 15% coinsurance for covered drugs. Which amount beneficiaries pay will depend on their income and asset levels.
- Reduced cost in the donut hole. Once beneficiaries with partial Extra Help reach the TrOOP amount, they have a co-pay of $3.30 for generics/$8.25 for brand names for the remainder of the calendar year
- People on any level of Extra Help receive a continuous SEP to change Part D or MA plans anytime during the year.
- The Part D late enrollment penalty is waived for as long as they qualify for Extra Help

Individuals with Medicare and Medicaid who live in a long-term care facility or receive home and community based services through a Medicaid waiver program automatically qualify for full Extra Help and receive assistance paying for their entire monthly premium, annual drug deductible and do not have any drug co-pays. The National Council on Aging (NCOA) has created a useful chart that lists the different subsidy levels for Extra Help.

The Extra Help program (also referred to as the Low-Income Subsidy or LIS) income limits are updated annually once the U.S. Department of Health and Human Services (HHS) announces the current year's Federal Poverty Levels (FPLs). The new Extra Help program income and asset limits for 2017 are as follows:

	2017 Monthly Extra Help Income Limits*	**2017 Extra Help Resource Limits***
Full LIS	Household of 1 $1,377/month	Single $8,890
	Household of 2 $1,847/month	Married $14,090
Partial LIS	Household of 1 $1,528/month	Single $13,820
	Household of 2 $2,050/month	Married $27,600

*Income limits include a $20 income disregard. Resource limits include $1,500 per person for burial expenses. Please note that the 2017 income limits do not go into effect until April 1, 2017.

Medicare Special Enrollment Period for Loss of Extra Help in 2017 ends March 31 st
Medicare beneficiaries who lost their Extra Help and no longer eligible for the program effective January 1, 2017, qualify for a one-time SEP from January 1 through March 31 to

change to another Medicare Part D or Medicare Advantage (MA) plan. These beneficiaries should have received a letter from CMS in September 2016 that notified them that they no longer qualify for "deemed status" and as result will no longer automatically qualify for Extra Help in 2017. If a beneficiary is no longer "deemed" eligible for Extra Help, it is because they no longer qualify for Medicaid, a Medicare Savings Program (QMB, SLMB or QI), or Supplemental Security Income (SSI). Please note that some individuals may still qualify for Extra Help based on the program's income and asset limits (and not their deemed status) and should submit an application to the Social Security Admiration to determine eligibility.

Since Extra Help is no longer helping these beneficiaries pay for their monthly plan premiums, annual deductible and prescription drug co-pays, the plan they are enrolled in may no longer be the best or least expensive option. After March 31st, beneficiaries who did not take action to determine if they should change plans will be unable to make any changes until the next fall Medicare Open Enrollment Period. The SEP is valid for a one-time plan switch **through March 31, 2017** by calling 1-800-Medicare or through www.Medicare.gov**.** Any Part D plan changes a beneficiary makes will take effect the 1st of the following month.

Affordable Care Act Updates

Marketplace Special Enrollment Periods
The Marketplace open enrollment period (OEP) to obtain health coverage this year ended on January 31, 2017 which means that individuals who did not enroll in or change their health insurance plans will be unable to make any changes until the next Marketplace OEP for coverage in 2018. However, it is important to remember that individuals who experience a qualifying event or major life change may be eligible for a special enrollment period to enroll in health coverage through the Marketplace outside of the typical open enrollment period.

Some examples of SEPs include loss of qualifying health coverage, a permanent move, a marriage, a birth of a baby, a divorce, or gaining citizenship or lawful presence in the U.S. In addition, individuals who have experience a change in their eligibility for financial assistance may also qualify for a SEP, including individuals who no longer qualify for Medicaid and individuals who are enrolled in a qualified health plan through the Marketplace and experience a change in income or household size that impacts their eligibility for premium tax credits or cost sharing assistance.

The www.healthcare.gov website has created a screening tool individuals can complete to determine if they are eligible for a SEP. To apply for a SEP, individuals must call the Marketplace call center at 1-800-318-2596. If they qualify, most SEPs provide 60 days to select and enroll in a Marketplace plan. In addition, the Center of Budget and Policy Priorities has also created useful chart of Marketplace SEPs that lists each available SEP, what triggers it, who can use it and the timing of when the

SEP goes into effect. Click here to view the chart.

Useful Tips for Tax Filers and Reporting Health Coverage
Tax filing season is here and with it may come questions about the tax forms individuals are receiving in the mail about their health care coverage. Most individuals will only need to check a box indicating they had minimum essential health coverage in 2016. Others may have to fill out additional forms if they had a Marketplace plan and received advanced premium tax credits, did not have health coverage last year and need to pay a fine, or did not have coverage but qualify for a hardship exemption from paying the fine. Some individuals may not a have tax filing requirement can just keep the forms for their records. The IRS has created a useful Q&A document that explains what tax filers need to know about reporting their health coverage on their tax forms and what individuals can do with specific forms they receive.

All individuals who have a Marketplace plan and received advanced premium tax credits, which were paid directly to the health plan, are required to file a tax return. When they file their returns, the IRS will compare the premium tax credits they received in 2016 (based off their self-reported income) to their final 2016 income and determine if these individuals are owed a refund for not receiving enough premium tax credits to put towards their Marketplace plan or received too much and now have to pay some of it back.

Families USA has also created a useful infographic that explains which forms are needed for Marketplace consumers when filing taxes. Individuals who have a Marketplace plan and confused about whether they need to complete additional forms regarding their health coverage, can also contact the Marketplace Call Center at 1-800-318-2596.

Other Resources

2017 Federal Poverty Guidelines Released
The U.S. Department of Health and Human Services (HHS) recently announced the 2017 Federal Poverty Levels (FPLs). These levels are updated every year and used to determine the income limits for many federal benefit programs such as Medicaid, Medicare Savings Program and Extra Help. In 2017, the FPLs will slightly raise the income limits for a number of federal programs. Click here to view the 2017 FPLs by household size.

Updated AgeOptions Chart of Benefits
AgeOptions has released an updated Chart of Benefits to reflect the recently announced FPLs. This chart is meant as a resource tool for professionals to use when screening clients for benefit programs. The chart lists income, asset and eligibility requirements for various public programs in Illinois including Medicaid, Medicare Savings Program, Extra Help, the Benefits Access Program, Supplemental Security Income (SSI), LIHEAP, SNAP (Food Stamps), Access to Care, Community Spousal

Impoverishment and other programs.

Please note that this chart is designed for professionals and should not be altered or distributed to consumers. The chart is meant as a quick reference tool (a "cheat sheet") for counselors and does not provide detailed explanations for consumers about how each program works. The chart is updated whenever income, asset or eligibility requirements for programs change. Please note that the new Medicaid, Medicare Savings Programs, and Extra Help income limits listed in the chart do not go into effect until April 1, 2017. Click here to view the chart.

New Benefits Check Up Website
The National Council on Aging (NCOA) has announced a new redesigned Benefits Check Up website that is now easier to use. Benefits Check Up is a web-based tool that assists people age 55 and older find and enroll in public and private benefits such as Medicaid, Medicare Savings Programs, Extra Help, SNAP benefits, and more. Individuals (or someone on their behalf) can complete a questionnaire and the tool will screen individuals and provide them with a report of programs they may qualify for.

The tool is helpful for counselors and professionals who are new to benefits counseling since it "shadow screens" for multiple programs at once and can also be used by consumers or their family members. Once the questionnaire is completed, Benefits Check Up provides the user with a printable report of programs they may qualify for and information on how to apply.

To access the Make Medicare Work Coalition's materials on Medicare, Medicaid, and the Affordable Care Act, view a calendar of MMW events or **sign up for our MMW email list,** please visit our website using the button below. If you would like to stop receiving MMW emails, please reply to this email with the word "Unsubscribe."

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