Make Medicare Work Coalition (MMW)

Bulletin Newsletter

December 28, 2016

The MMW Coalition wishes you a Healthy and Happy New Year!

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Medicare Updates

2017 Medicare Premiums, Deductibles and Costs

The Centers for Medicare and Medicaid Services (CMS) recently released the 2017 Medicare premiums, deductibles and cost-sharing amounts. These are the out-of-pocket amounts that Medicare does not cover and that a beneficiary is responsible for paying. The 2017 Medicare costs can be found here. Medicare costs include Part A premiums (for individuals who do not have enough work credits to qualify for premium-free Part A), Part A inpatient hospital deductibles and co-pay amounts, skilled nursing facility co-pays, and the annual Part B deductible and monthly Part B premium amounts.

An important note about Part B premiums in 2017

In 2017, not all Medicare beneficiaries will pay the same monthly Part B premium. In October 2016, the Social Security Administration (SSA) announced a 0.3% cost of living adjustment (COLA) for Social Security benefits in 2017. Because of the "hold harmless" provision, the majority of beneficiaries (about 70%) will pay a slight increase in their monthly Part B premium - from $104.90 per month in 2016 to an average of $109 per month in 2017. The hold harmless provision is part of the Social Security Act, a law that protects Social Security recipients from paying a higher Part B premium if they did not receive a Social Security cost of living increase high enough to cover the Part B premium increase. The premium is an "average" of $109 because the COLA increase is a percentage of a beneficiary's Social Security benefits. As a result, the increased Social Security benefit and premium amount will slightly vary for each beneficiary.

Medicare beneficiaries who are not subject to the hold harmless provision will have to pay higher Part B premiums in 2017. This includes beneficiaries who are new to

Medicare in 2017, do not have their Part B premium deducted from their Social Security benefits or do not receive Social Security benefits, have higher incomes, and people who have their premium paid for by a Medicare Savings Programs.

The different Part B premiums in 2017 will be:

- An average of $109 per month for most beneficiaries through the hold harmless provision
- $134 per month for beneficiaries who are new to Medicare in 2017, do not have their Part B premium deducted from their Social Security benefits or do not receive Social Security benefits, or have their Part B premium paid by a Medicare Savings Program such as QMB, SLMB or QI (these groups are NOT subject to the hold harmless provision)
- Beneficiaries with annual incomes of more than $85,000 (single) or $170,000 (married) are also NOT subject to the hold harmless provision. They will pay a Part B premium of $134.00 **plus** the income related premium amount each month (which is reviewed below).

Beneficiaries who are enrolled in one of the Medicare Savings Program (QMB, SLMB or QI) will have the higher Part B premium ($134) paid for them by their Medicare Savings Program (MSP). However, the beneficiary will be responsible for paying the higher Part B premium if at some point in the future they no longer qualify for MSP.

Higher Part B premiums for Beneficiaries with Higher Incomes
Beneficiaries with incomes of more than $85,000 (single) or $170,000 (married) pay an additional income related adjustment amount in addition to the standard Part B premium. Higher income beneficiaries are not subject to the hold harmless provision and will pay the standard Part B premium of $134 in 2017 **plus** an additional amount called the Income Related Monthly Adjustment Amount (IRMAA). The IRMAA amount a beneficiary pays varies and depends on their income and tax filing status. (Note: People with Medicare who have to a pay an IRMAA amount for Part B usually also have to pay an IRMAA amount for Medicare Part D.) To view the Medicare IRMAA amounts higher income beneficiaries pay in 2017, click here.

2016-2017 Medicare Premium Comparison Supplement Guide
The Illinois Senior Health Insurance Program (SHIP) has posted an updated Medicare Supplement Premium Comparison Guide on their website that lists premium estimates of Medicare Supplement polices (also referred to as Medigap plans) in Illinois. The guide is available online on the SHIP website at https://www.illinois.gov/aging/ship/Pages/default.aspx.

The guide includes estimated annual premiums for the Chicago area, Northern and Central Illinois, and Southern areas. The guide also lists premium estimates for Medicare Select plans (a variation of a standard Medigap plan that offers a lower premium but requires beneficiaries to use a network of hospitals and in some cases doctors for non-emergency services). The guide is a great resource to use when helping people with Medicare compare and shop for Medigap plans.

In addition to annual premium estimates, the guide also defines Medigap terminology, explains how Medigap plans work and which benefits are included, includes information about the different guaranteed issue rights beneficiaries have to purchase a policy outside of their Medigap open enrollment period, and information about buying Medigap policies for Medicare beneficiaries with disabilities under the age of

65. Please note that a beneficiary will need to contact the company directly to obtain an actual premium quote for a specific Medigap plan. To learn more about Medigap plans and how they work, visit the Illinois SHIP website and the MMW Coalition website.

Medicare Advantage Disenrollment Period

The Medicare Advantage Disenrollment period is a period of time during the first six weeks of the year when Medicare beneficiaries can disenroll from a Medicare Advantage (MA) plan and return to original Medicare. This disenrollment period begins January 1st and ends February 14th of every year. During this time, Medicare beneficiaries can only disenroll from a Medicare Advantage plan with or without prescription drug coverage (MA or MA-PD) and return to original Medicare Part A and Part B. This disenrollment period cannot be used to switch to another Medicare Advantage plan. Beneficiaries who use this disenrollment period will receive a special enrollment period (SEP) to enroll in a stand-alone Part D plan that covers only drugs but will not receive any special guaranteed issue rights to purchase a Medicare Supplement (Medigap) policy to help pay for the deductibles and cost sharing amounts not covered by Medicare (for example, the 20% Medicare Part B coinsurance for doctors visits). It is important that beneficiaries who use this disenrollment period are aware that they will be responsible for Medicare deductibles and cost sharing once they return to original Medicare.

Individuals may apply to any Medigap company in Illinois for a policy to help pay for these out-of-pocket costs, but could be denied coverage if they are past their Medigap Open Enrollment Period. Since the Medicare Advantage Disenrollment Period does not provide beneficiaries with guaranteed issue rights to purchase any Medigap policy, companies are allowed to deny individuals a policy because of their health history or a pre-existing condition. In Illinois, however, there are currently two companies that offer guaranteed issue Medigap policies to individuals age 65 and older throughout the year. BlueCross BlueShield of Illinois and Health Alliance will sell a Medigap policy to beneficiaries enrolled in Medicare Part A and Part B regardless of their health history. Individuals may be charged the highest premium rate on file with the Illinois Department of Insurance but will not be denied coverage. People with disabilities and on Medicare under the age of 65 who miss their Medigap Open Enrollment Period can only enroll in select Medigap policies that include BCBS of Illinois or Health Alliance from October 15 through December 7. For more information, please view a useful chart created by the Medicare Rights Center that details a beneficiary's options during the Medicare Advantage Disenrollment Period.

Arriva No Longer a Medicare National Mail Order Diabetic Supplier

The Medicare National Mail Order Program for diabetic testing supplies is a program for Medicare beneficiaries who choose to have their diabetic supplies mailed to their home. In order for Medicare to cover the supplies, beneficiaries must use certain suppliers that contract with Medicare. In October 2016, CMS mailed a letter to beneficiaries who had received diabetic testing supplies from Arriva, a medical equipment and diabetic supplies provider, to notify them that beginning November 4, 2016, Arriva is no longer a Medicare national mail order supplier. This means that beneficiaries who had used Arriva for their diabetic testing supplies in the past will need to find a new mail order supplier that contracts with Medicare in order for their supplies to be covered. Medicare will no longer pay for supplies delivered by Arriva to beneficiaries' homes.

Beneficiaries can visit www.Medicare.gov/supplier, enter their zip code, and choose "Mail Order Diabetic Supplies" under the Competitive Bid Categories section to search for a new supplier that contracts with Medicare. Beneficiaries may also buy their diabetic testing supplies by visiting any pharmacy that participates in Medicare. It is important to note that beneficiaries who switch mail order suppliers or decide to obtain their supplies from a pharmacy, may need to transfer their prescription or obtain a new one from their physician. Beneficiaries can also call 1-800-MEDICARE if they need help locating a Medicare national mail order supplier. Click here to view a copy of the letter CMS mailed to beneficiaries.

Extra Help Updates

Loss of Extra Help Special Enrollment Period

Individuals who automatically qualify for and receive Extra Help without having to complete an Extra Help application are often referred to as "deemed eligible". Beneficiaries who are deemed eligible include the following group of beneficiaries listed below:

- Beneficiaries who have Medicare and Medicaid (Medicaid spenddown, even for just one month during the year, will also "deem" an individual eligible for Extra Help)
- Beneficiaries enrolled in one of the Medicare Savings Programs (QMB, SLMB or QI)
- Beneficiaries who receive 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. These individuals should have received a letter from CMS in September on grey colored paper notifying them that since they are no longer deemed eligible, they will no longer receive assistance through the Extra Help program in 2017. Click here to view a sample letter. Some of these individuals may still qualify for Extra Help because even though they no longer qualify for one of the programs listed above, they may still meet the income and asset limits for the Extra Help program. Individuals who may qualify based on income and asset limits should submit an application to SSA to determine eligibility.

Medicare beneficiaries who received a grey letter and will no longer automatically qualify for Extra Help beginning January 1, 2017 will be eligible for a special enrollment period (SEP) to change Part D plans. The SEP is valid for a one-time Part D plan switch anytime from **January 1 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. Since Extra Help will no longer help these beneficiaries pay for their Part D costs in 2017 (premiums, deductible and co-pays), they should review their current plan to determine if it will continue to be the most affordable plan that meets their prescription drug needs.

Medicaid Managed Care Updates

MMAI and MLTSS Updates

The Illinois Senior Health Insurance Program (SHIP) recently shared information that HFS has begun passive enrollment again into Medicare-Medicaid Alignment Initiative (MMAI) program in affected areas that include the Chicagoland area and Central Illinois. To find out which specific counties MMAI currently operates in, click here.

In the Chicagoland area, dual eligibles (beneficiaries with Medicare and Medicaid) will continue to be passively enrolled into MMAI, meaning they will receive a letter from Illinois Client Enrollment Services explaining the MMAI program and their plan options. The letter will also include the name of the plan the beneficiary will be passively enrolled in (automatically enrolled) if they do not take action within 60 days of receiving the letter. Beneficiaries have the following options:

- Compare their MMAI plan options and choose a plan that best meets their needs
- Opt out of the MMAI program by contacting Client Enrollment Services and return to fee service Medicare and Medicaid OR
- Do nothing and allow passive enrollment into the MMAI plan listed in the letter to take place.

In Central Illinois, about 5,000 dual eligibles will receive MMAI letters and be passively enrolled into the Molina Healthcare MMAI plan which is the only MMAI plan available in the area. CMS has granted HFS a special exception to enroll dual eligibles into Molina even though it is the only plan currently available in the area. Individuals who are enrolled the Molina MMAI plan have the option remaining in the plan or opting out and returning to fee-for-service Medicare and Medicaid at any time of the year. Passive enrollments will be conducted in two phases with 2,500 of the enrollments going into effect February 1, 2017 and the remainder 2,500 going into effect March 1, 2017. Please note that dual eligibles in Central Illinois that already opted out of MMAI and dual eligibles that were enrolled in the Health Alliance MMAI plan that left the MMAI program at the end of 2015 will not be passively enrolled into MMAI. ***A special thank you to the Illinois SHIP for sharing this important information!***

Beneficiaries who decide to remain in MMAI should make certain that the plan they choose or will be passively enrolled into includes their providers as part of the plan's network. It is important to remember that dual eligible beneficiaries have the option of opting out of MMAI or changing MMAI plans at any time of the year. If a beneficiary opts out, he or she will return to fee-for-service Medicare and Medicaid for their medical services. Dual eligibles who opt out of a MMAI plan and return to fee-for-service Medicare and Medicaid should make sure to enroll in a Part D plan that covers their prescription drugs.

Dual eligibles who receive long term services and supports (LTSS)

In the greater Chicago area only, (includes Cook, DuPage, Kankakee, Kane, Lake and Will counties) dual eligible individuals who receive MMAI notices AND currently receive long term care services and supports will be required to receive their LTSS through a managed care organization through either a MMAI plan or a MLTSS (Medicaid Managed Long Term Services and Supports) plan.

What are long term services and supports (LTSS)?

Long term services and supports (LTSS) are services that are covered by Medicaid and include care people receive when they reside in a long-term care facility or services through a Home and Community Based Services (HCBS) Medicaid Waiver

Program. HCBS waiver programs require individuals to receive coverage for their LTSS services either through a MMAI or MLTSS plan and includes dual eligibles on one of the following five Medicaid HCBS waivers:

- Persons with Disabilities Waiver (often referred to as the Home Services program),
- Persons with Brain Injuries Waiver
- Persons who are Elderly/Aging Waiver (also known as the Community Care Program)
- Persons with HIV/AIDS Waiver, and
- the Supportive Living Facility Waiver

Dual eligibles who decide to remain in MMAI and not opt-out, will receive their LTSS through a MMAI plan along with all of their medical and prescription drug services. If a dual eligible who is receiving LTSS opts out of MMAI, they will be required to enroll in a MLTSS plan. They can return to fee-for-service Medicare and Medicaid for their medical and prescription care, but dual eligibles cannot opt out of MLTSS. If an individual contacts Client Enrollment Services (CES) to opt out of MMAI, CES will educate them about the MLTSS program and prompt them to choose a MLTSS plan to enroll in. Before choosing a MLTSS plan, the individual should make certain their LTSS providers are in network with the plan. CES can assist individuals compare MLTSS plans and provider networks. A dual eligible cannot be enrolled in both MMAI and MLTSS.

Once the individual is enrolled in a MLTSS plan, they have the option of switching MTLSS plans once in the first 90 days of coverage. This is helpful in the instance an individual's specific LTSS provider is not part of a plan's network but does work with another plan. After the initial 90 days of MLTSS enrollment, the individual is then locked into their MTLSS plan for 12 months. The only option available during the 12 month lock in period if a person is unhappy with their MTLSS plan is to enroll in (opt back into) an MMAI plan of their choice which can be done at any time of the year by calling CES. To compare MMAI or MLTSS options, an individual can visit the Client Enrollment Services website at http://enrollhfs.illinois.gov/ or call 1-877-912-8880. For more information about MMAI and MTLSS, visit the MMW website here.

Temporary Suspension of Enrollment into Mandatory Medicaid Managed Care in Central Illinois

The Illinois Department of Healthcare and Family Services (HFS) has temporarily suspended mandatory enrollment into Medicaid managed care plans in Central Illinois for people who are part of Medicaid's Family Health Program (FHP). Affected counties include Champaign, Christian, DeWitt, Ford, Logan, Macon, Menard, Piatt, Sangamon and Vermilion. The Medicaid Family Health Program provides Medicaid only coverage in Illinois for children, parents and people who receive Affordable Care Act Medicaid.

In October, HFS announced that one of two available managed care plan choices in Central Illinois, Health Alliance Connect, will be ending its participation in mandatory Medicaid managed care areas. Effective December 31st, individuals in Central Illinois will be disenrolled from Health Alliance and be returned to fee-for-service Medicaid. For the time being and until further notice, only individuals who are disenrolled from Health Alliance and newly eligible FHP individuals will be placed into fee-for-service

Medicaid.

Individuals who are enrolled in the other managed care organization, Molina Health Plan, will remain in Molina. Individuals enrolled in Molina who are in their Medicaid managed care open enrollment date have the option of choosing to remain in Molina or returning to fee-for-service Medicaid. Each member's open enrollment date is different and based on the anniversary date of when they were initially enrolled in managed care. Individuals in fee-for-service Medicaid should use their HFS medical card to receive coverage for services. It is important to remind providers to also check the MEDI system to determine what type of coverage individuals are enrolled IN so they can bill accordingly. For more information, click here to view the HFS provider notice.

Affordable Care Act Updates

Marketplace Open Enrollment Period - There is Still Time to Enroll in or Change Plans!

Just a reminder that the Health Insurance Marketplace open enrollment period is still under way through January 31, 2017. The deadline for coverage to begin on January 1st was Monday, December 19th but there is still time for people to enroll in or switch Marketplace plans for the 2017 coverage year. Qualifying individuals who do not have health insurance (people who are uninsured and do not have coverage through an employer, Medicare, or Medicaid) can shop for insurance through the Illinois Marketplace. Individuals who enroll or change plans by January 15, 2017 will have their new coverage begin on February 1, 2017. Individuals who enroll or change plans by January 31, 2017 will have their new coverage begin on March 1, 2017. Once the Marketplace OEP ends, individuals will only be able to enroll into a plan if they qualify for a special enrollment period.

Individuals who did not have minimum essential coverage in 2016 will be have to pay a penalty for the months they did not have coverage when they file their federal tax returns in 2017. Some examples of minimum essential coverage includes coverage with a Marketplace plan, Medicare Part A, Medicare Advantage, Medicaid, employer and retiree plans, COBRA and additional types of coverage. For a complete list of what is considered minimum essential coverage visit https://www.healthcare.gov/fees/plans-that-count-as-coverage. In addition, individuals who qualify for a hardship exemption will not have to pay a penalty. A hardship exemption is an exception that allows individuals to avoid paying the penalty for not having coverage. A list of qualifying exemptions can be found on the Healthcare.gov website here.

The penalty for not having coverage in 2016 is $695 for each person listed on an individual's tax return who did not have health coverage ($347.50 per child under 18) or 2.5% of the individual's household income, whichever is higher. The penalty amounts for not having coverage in 2017 (assessed when a person files federal taxes in 2018) will remain the same. To learn more about the penalty, click here.

If individuals are applying for Marketplace coverage for the first time

Individuals who are new to the Marketplace and applying for coverage for the first time, will need to create an account and fill out an application. This can be done online, over the phone by calling the Marketplace call center at (800) 318-2596, by mail, or by making an appointment for free in-person assistance from specially trained counselors called Navigators.

Once an account is created, individuals will be asked to estimate their expected income for 2017. This will determine if they qualify for premium and/or cost sharing assistance. Premium assistance is provided in the form of premium tax credits which can be applied to the plan an individual chooses to help lower the monthly premium they will owe. The amount of premium tax credits an individual receives will depend on a person's expected income for 2017. The Marketplace has created a helpful checklist applicants can use to gather the information and documents they will need prior to applying for coverage.

Once a person applies for coverage and determines if they qualify for premium tax credits, they can compare their plan options and choose a plan that best suits their health coverage needs. Individuals should consider how often they plan to use services, if their medical providers are in the plan's network, review the plan's cost sharing amounts such as deductibles and co-pays, and the plan's maximum out-of-pocket limit. The Center for Budget and Policy Priorities has created a useful worksheet individuals can use to help them compare Marketplace plans. Once a plan enrollment is complete, individuals should make sure to contact their plan to arrange payment of the monthly premium.

Individuals who already have Marketplace plans and why it is important they renew their coverage

During the Marketplace OEP, it is especially important for people who already have health insurance plans to log into their www.healthcare.gov account and renew their application. If individuals received premium tax subsidies and/or cost sharing assistance, they should make certain to update their estimated income for 2017 in order to receive the appropriate amount of assistance. Under-reporting income could result in individuals having to pay back premium tax credits they receive when they file federal income taxes. Individuals who over-report income and actually make less during the year may miss out on receiving premium tax credits to help offset their monthly plan premiums.

It is also very important for individuals who already have a health insurance plan through the Marketplace to find out if their current plan will continue to meet their health care needs in 2017 or determine if they need to switch plans. People with Marketplace coverage should research how their plan's monthly premium and cost sharing amounts are changing for next year (deductible and co-payment amounts), if there is a less expensive plan available, and whether their doctors and other medical providers will continue to be part of the plan's network. Individuals who do not do their "homework" now and find out after the Marketplace open enrollment period ends that their plan will not work for them, will not be able to enroll in or change plans until 2018 unless they qualify for a special enrollment period. Consumers can use the www.healthcare.gov website, call the Marketplace call center at **1-800-318-2596,** or make an appointment with a Navigator who can help them with comparing plans and

the application process.

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