AgeOptions Topical Brief: 
Medicare Part D and the Annual Enrollment Period – What You Need to Know

November 2018

The Medicare Open Enrollment Period (OEP) is here! The Medicare OEP began October 15th and ends December 7th. This is the time when people with Medicare can enroll, disenroll or switch Medicare Part D plans, including Medicare Advantage plans. Medicare beneficiaries should take action to make sure their current Part D plan will continue to work for them next year, or determine if they need to find another plan that will better suit their prescription drug and/or health needs. This is also the opportunity for people with Medicare who do not have a Part D plan to consider enrolling in a plan to obtain drug coverage and avoid paying a higher late enrollment penalty if they ever choose to enroll in a plan in the future.

This Brief will review how the Medicare Part D benefit works for stand-alone prescription drug plans and Medicare Advantage plan coverage in 2019 and what professionals need to know when assisting clients in making important decisions about enrolling in or changing plans for next year. Additionally, the Brief reviews the numerous Medicare policy changes that may affect a beneficiary’s Medicare coverage and cost of healthcare services in 2019. Please utilize the Table of Contents Section below to navigate through the Topical Brief.

Table of Contents

- 2019 Medicare Policy Updates...........................................................................................................2
- Medicare Part D Benefit Parameters in 2019.....................................................................................4
- What is TrOOP? .................................................................................................................................5
- Medicare Part D Late Enrollment Penalty in 2019..............................................................................6
- 2019 Medicare Part D Premium IRMAA.............................................................................................6
- Medicare Part D: Stand-Alone PDPs.................................................................................................7
- Part D and Medicare Advantage Plans.............................................................................................9
- Medicare Part D and Extra Help.......................................................................................................11
- Training Tutorials & Resources.......................................................................................................13
Medicare Updates for 2019

Part D Donut Hole Closing Sooner
The Bipartisan Budget Act of 2018 closes the Medicare Part D donut hole for *brand* name drugs one year sooner - in 2019 instead of 2020. This means that beginning in 2019, beneficiaries will receive a 75% discount on covered *brand* name drugs during the donut hole/coverage gap phase. This means that a beneficiary will pay no more than 25% in cost sharing for their brand name drugs. The new law requires drug manufacturers to provide increased discounts on brand name drugs during the donut hole (70% from the manufacturer and 5% from the plan). The Donut Hole for *generic* drugs does not close until 2020. In 2019, beneficiaries will pay 37% for generic drugs in the coverage gap.

Beginning in 2020, the donut hole will be completely closed, and beneficiaries will pay no more than 25% for both covered brand name and generic drugs throughout the entire plan year. Please refer to the Medicare Part D Benefit Parameters section below for more detailed information about cost-sharing during the coverage gap phase in 2019 and 2020.

Medicare Part D and Opioids
Beginning in 2019, CMS will allow Medicare Part D plans to voluntarily implement drug management programs for beneficiaries who are at high risk of abusing or misusing frequently abused drugs (opioids and benzodiazepines) required by the Comprehensive Addiction and Recovery Act (CARA) of 2016. Plans may limit at risk beneficiaries to selected prescribers and pharmacies to access frequently abused drugs through a new “Lock-in” provision. Plans can impose these limitations only if the plan engages in case management services with the prescribers and beneficiaries.

Written notice to beneficiaries is required before limiting access to frequently abused drugs with the opportunity for beneficiaries to select their prescriber and pharmacy preferences. The notice also explains appeal rights. Some beneficiaries are exempt, including beneficiaries with cancer-related pain, residents of LTC facilities, and beneficiaries receiving hospice care or palliative care.

Beneficiaries with the Extra Help/Low-Income Subsidy (LIS) who are identified as being at-risk for opioid abuse cannot use their LIS Special Enrollment Period (SEP) to change plans. They will receive written notice from their plan about the LIS SEP limitation. LIS SEP limitation lasts as long as the individual is enrolled in the plan, once an “at-risk” determination is successfully appealed, or “at-risk” status is expired or terminated by the plan (reassessed at the 12-month period). At-risk beneficiaries will still be able to use the Medicare Annual Enrollment Period or other SEPs to change plans. For more information, Click Here.

Higher Part B & Part D Premiums for Higher Income Beneficiaries
Beginning in 2019, beneficiaries with modified adjusted gross incomes of $500,000 or more ($750,000 or more for a couple) will pay an increased Income Related Monthly Adjustment Amount (IRMAA) for their Medicare Part B and Part D premiums. Premium costs for this income bracket will increase from 80% to 85%. This is a provision of the Bipartisan Budget Act. To view full details of the Part D IRMAA level brackets, please refer to the 2019 Medicare Part D Premium IRMAA section below.

Medicare Advantage Open Enrollment Period
Beginning in 2019, a new Medicare Advantage (MA) Open Enrollment and Disenrollment Period will be available from January 1st – March 31st of every year as stated in the Section 17005 of the 21st Century Cures Act. A beneficiary enrolled in a MA plan will be able to make a one-time change to another MA plan or return to Original Medicare and enroll in a stand-alone prescription drug plan.
(PDP) during this time. Beneficiaries can also continue to use the Medicare Annual Enrollment Period (October 15 - December 7) to enroll in, switch or disenroll from MA plans for the following calendar year. The Medicare Advantage Disenrollment Period will no longer be offered (previously from January 1 – February 14 of each year).

**Medicare Advantage Plans to Expand Supplemental Benefits**
The 2019 CMS Call Letter announced that Medicare Advantage (MA) plans will be allowed to include additional supplemental benefits not covered under Original Medicare as long as the new benefits increase an individual’s health or quality of life. CMS has reinterpreted the definition of “primarily health related benefits” offered by MA plans to include items or services that are used to:

- diagnose, prevent, or treat an illness or injury
- compensate for physical impairments
- improve the functional/psychological impact of injuries or health conditions
- reduce avoidable emergency and healthcare utilization

For example, MA plans may begin to offer supplemental benefits that include transportation, assistive devices, home and bathroom safety modifications, over-the-counter drugs, adult day services, and/or in-home support services. The Medicare.gov Plan Finder Tool indicates whether a Medicare Advantage plan is offering these new expanded supplemental benefits, however, the plan needs to be contacted for details on the type of services being offered. For more information on the expanded supplemental benefits, [Click Here](#).

**Medicare Advantage & Step Therapy for Part B Drugs**
Beginning January 1, 2019, Medicare Advantage (MA) plans will have the option of applying step therapy to Medicare Part B medications. Plans will only be allowed to apply step therapy to new Part B prescriptions or physician administered Part B drugs. Step therapy cannot be applied to ongoing Part B drug treatment. If step therapy is applied to a drug, the plan must offer drug management care coordination services. Members can request an exception from the Part B drug step therapy and have the right to appeal.

Plans must disclose Part B step therapy requirements in their Annual Notice of Change and Explanation of Coverage materials. Additionally, a beneficiary can call the MA plan for more information regarding Part B medication coverage rules. MA plans will still be required to cover all medically necessary Part B drugs. For more information, [Click Here](#).

**Change in Extra Help Special Enrollment Period (SEP)**
Beginning January 1, 2019, beneficiaries with Extra Help/LIS will no longer have a continuous SEP to enroll, disenroll or change plans at any time during the year. LIS beneficiaries, including dual-eligibles, will be limited to using their LIS SEP to once per calendar quarter for the first nine months of the year (January to March, April to June, and July to September). An LIS SEP will not be available the last quarter of the year, as the Medicare Annual Enrollment Period (October 15 - December 7) can be used to make plan changes in the fourth quarter with a plan effective date of January 1.

Plan changes using the LIS SEP will still continue to take effect the first of the month following the month of the enrollment request. SEP is considered “used” in the month enrollment request is made and not the plan effective date. For more information, [Click Here](#).
**SEP for Gain, Loss, or Change in Dual-Eligible or LIS Status**

Effective January 1, 2019, Medicare beneficiaries who have a change in LIS or dual-eligible status are eligible to receive a one-time SEP. Beneficiaries who gain, lose or have a change in LIS or Medicaid status are eligible for a one-time opportunity to make a plan election within three months of the change or notification of the change – whichever is later. The plan change using this SEP is effective the first day of the month following the month of enrollment. For more information, [Click Here](#), and scroll down to Section 30.3.8.

### Medicare Part D Benefit Parameters in 2019

Earlier this year, the Centers for Medicare and Medicaid Services (CMS) announced the 2019 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 Part D prescriptions drugs that are covered by the plan and are based on a calendar year. 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 lists the 2019 Part D benefit parameters please click [here](#) see pages 48-49).

<table>
<thead>
<tr>
<th>Medicare Part D Benefit Limits</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Beneficiary pays <em>up to</em> this amount out-of-pocket in the beginning of the plan year, before the plan pays anything for prescriptions on the formulary.</td>
<td>Up to $405</td>
</tr>
<tr>
<td><strong>Initial Coverage Limit</strong></td>
<td>After the deductible is met, the plan and the beneficiary begin paying their share of the drug costs. <strong>Beneficiaries will pay no more than 25% of the cost sharing.</strong> (Many plans offer cost sharing lower than 25% in Initial Coverage.) Once the amount that both the beneficiary and the plan spend together reaches the $3,820 Initial Coverage Limit amount, the beneficiary moves into the “Donut Hole” phase.</td>
<td>Up to $3,750</td>
</tr>
<tr>
<td><strong>Donut Hole begins (also called the Coverage Gap)</strong></td>
<td>During the “Donut Hole” phase, drug costs <em>usually</em> increase. <strong>The donut hole closes for brand name drugs in 2019, so beneficiaries will pay 25% cost sharing.</strong> Beneficiaries will pay 37% cost sharing for generic drugs. Donut hole for generics closes in 2020.</td>
<td>$3,750</td>
</tr>
<tr>
<td><strong>Catastrophic coverage begins once the True Out-of-pocket Threshold (TrOOP) is met.</strong> (Donut hole ends.)</td>
<td>Once someone’s True Out of Pocket Costs (TrOOP) are met, they reach the Catastrophic Coverage phase. During Catastrophic Coverage in 2019, the plan will pay 95% of drug expenses and the beneficiary will pay 5% or a co-pay of $3.40 (for generics or preferred multi-source drugs) or $8.50 (for all other drugs on the formulary) – whichever is higher.</td>
<td>$5,000 (TrOOP amount)</td>
</tr>
<tr>
<td><strong>Copayment amount for generic or preferred multi-source drugs after</strong></td>
<td>$3.35 or 5%*</td>
<td>$3.40 or 5%*</td>
</tr>
<tr>
<td>Catastrophic coverage begins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment amount for all other drugs after Catastrophic coverage begins</td>
<td>$8.35 or 5%*</td>
<td>$8.50 or 5%*</td>
</tr>
</tbody>
</table>

*During the catastrophic coverage phase in 2019, the beneficiary will pay a co-pay of $3.40/$8.50 or 5% of the drug costs, whichever is greater. (In 2018, the beneficiary pays the greater of $3.35/$8.35 or 5% of the drug cost.)

**Part D and the Donut Hole in 2019 – How it Will Work**

In 2019, the Medicare Part D coverage gap (also referred to as the Donut Hole) will begin when the beneficiary has filled $3,820 worth of formulary drugs with their Part D plan. This amount includes the full cost of the drugs (what the beneficiary and the plan pays), and not just the co-pay amounts the beneficiary is charged. The Donut Hole continues until the beneficiary has reached the TrOOP amount ($5,100 in 2019).

Once in the Donut Hole, beneficiaries receive discounts on formulary drugs under a provision of the Affordable Care Act. The discounts are off the full cost of the drugs and applied immediately at the pharmacy counter or through mail order once a person enters the donut hole. However, in 2019, the Donut Hole “closes” for brand name drugs. **This means that when beneficiaries leave the Initial Coverage Limit phase and enter the Donut Hole, they will receive a 75% discount on brand name drugs, as outlined in the Standard Medicare Part D Defined Benefit.** Of the 75% discount, 70% is covered by the drug manufacturers and the other 5% is provided by the plan. Many plans choose to offer a larger discount than the 75% discount outlined by the Medicare Part D Defined Benefit during the Initial Coverage Limit. As a result, beneficiaries may see a slight increase in their cost of brand name drugs when they enter the “Donut Hole” phase and have to pay the 25%.

The Donut Hole for generic drugs does not close until 2020. **In 2019, beneficiaries will receive a 63% discount on generic drugs,** which is provided entirely by a government subsidy. It is important to note that only the portion of the discount provided by the drug manufacturers will apply toward the amount a beneficiary needs to get out of the Donut Hole (the TrOOP amount). The discounts provided by government subsidies do not count toward TrOOP. Beginning in 2020, beneficiaries will pay no more than 25% co-insurance for covered brand name and generic drugs throughout the entire plan year.

Please note- All discounts provided in the Donut Hole are reflected in the www.Medicare.gov online Plan Finder Tool when searching and comparing plans.

**What is TrOOP?**

True Out-of-Pocket or “TrOOP” costs are Part D expenses that count towards a beneficiary’s out-of-pocket limit and used to determine when Catastrophic Coverage begins. In order for beneficiaries to get out of the donut hole, their true out-of-pocket expense must reach $5,100 in 2019.

The following expenses can be applied towards a beneficiary’s TrOOP amount:

- The deductible and co-payment or coinsurance amounts paid by a beneficiary for Part D drugs that are on the plan’s formulary (include amounts paid by a family member or other person on behalf of the beneficiary)
- 70% manufacturers’ discounts on brand name drugs
• Amounts paid by Medicare’s Extra Help program
• A charity program

The following expenses do not count towards TrOOP:
• Monthly premiums
• Any payment for a drug that is not on the plan’s formulary
• Amounts paid by an employer or retiree plan
• Government subsidies provided to the plans during the donut hole
• Drug purchases outside of the U.S

Once TrOOP is met, beneficiaries enter the catastrophic phase of Part D and begin to pay lower cost sharing amounts as described in the benefits parameter chart above.

**Medicare Part D Late Enrollment Penalty in 2019**

People with Medicare who do not enroll in a Part D plan when they are first eligible during their Initial Enrollment Period and decide to enroll at a later date, are subject to paying a Part D late enrollment penalty (LEP). Individuals who become eligible for Medicare, but have other prescription drug coverage that Medicare considers creditable, can delay enrolling in a Part D plan and keep their other coverage. Creditable drug coverage is drug coverage that is considered as good as or better than Medicare Part D. This can include beneficiaries who have other creditable drug coverage offered through an employer, retiree, or union group health plan. If a beneficiary has other coverage, their plan should notify them in writing every year of whether their drug coverage is creditable. If beneficiaries do not receive a notice, they should contact their plan to request a notice and file it away. Beneficiaries who have other creditable drug coverage do not have to pay a LEP if they decide to enroll in a Part D plan at a later time. Once beneficiaries no longer qualify for other creditable drug coverage, they receive a special enrollment period that lasts 63 days to enroll in a Medicare Part D plan without paying a penalty.

Medicare beneficiaries who missed their IEP, did not have creditable coverage or went longer than 63 days without it, will most likely have to pay a late enrollment penalty if they decide to enroll in a plan during the Medicare open enrollment period. The penalty 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. Individuals who are charged a LEP must pay this penalty in addition to their monthly Part D premium and as long as they are enrolled in a Part D plan.

The Part D penalty is 1% extra premium (based off the national base premium) for each month an individual was eligible to enroll in a Part D plan, but did not. The national base premium is adjusted every year and in 2019 will be $33.19. For example, if Amy did not enroll in Part D until 12 months after her initial enrollment period ended, she will have to pay a 12% penalty. Amy’s late enrollment penalty for 2019 will be $4.00 (.12 x $33.19 = $4.00). 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 the national base premium and the base premium changes every year, so Amy’s Part D penalty amount will change every year. The Part D penalty is not capped, meaning the longer a beneficiary goes without creditable drug coverage, the more expensive their penalty will be when they finally enroll in a Part D plan.

**2019 Medicare Part D Premium IRMAA**

Medicare beneficiaries with annual incomes greater than $85,000 ($170,000 if married and filing a joint tax return) must pay an extra amount each month in addition to their monthly Part D plan premium.
premium. This is called an Income Related Monthly Adjustment Amount (IRMAA). Part D IRMAA is based on an individual’s modified adjusted gross income (MAGI). IRMAA amounts are based on a sliding scale, using income reported to Social Security Administration (SSA) from the IRS and from a beneficiary’s most recent tax return. For many beneficiaries, their IRMAA amount for 2019 will be based on income reported on their 2017 federal tax returns.

The IRMAA amount is paid to the federal government, not to the Part D plan. It is usually deducted from a beneficiary's Social Security check if the individual receives Social Security benefits, or billed by Medicare if they are not yet receiving benefits. SSA will notify beneficiaries if they are required to pay an IRMAA amount. Beneficiaries must pay the IRMAA amount to maintain their Part D coverage. If they do not, they may be disenrolled from their Part D plan. Beneficiaries who pay Part D IRMAA amounts are usually also required to pay Part B IRMAA amounts, which have yet to be announced for 2019. Beneficiaries who experience a major life changing event that results in a change of income, may complete and submit a form to SSA to appeal the IRMAA. Some examples of life changing events include marriage, divorce, death of a spouse, stopped working or work reduction, loss of pension, or loss on income producing property. Please click here for more information on Part D IRMAA. Refer to the chart below to determine how much of an IRMAA amount a beneficiary will pay.

<table>
<thead>
<tr>
<th>2019 Part D IRMAA Amounts (Based on 2017 tax returns)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiaries who file an individual tax return</strong></td>
<td><strong>Beneficiaries who are married and filing a joint tax return</strong></td>
</tr>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
</tr>
<tr>
<td>$85,001 - $107,000</td>
<td>$170,001 - $214,000</td>
</tr>
<tr>
<td>$107,001 - $133,500</td>
<td>$214,001 - $267,000</td>
</tr>
<tr>
<td>$133,501 - $160,000</td>
<td>$267,001 - $320,000</td>
</tr>
<tr>
<td>$160,001 - $500,000</td>
<td>$320,001 - $750,000</td>
</tr>
<tr>
<td>Greater than $500,001</td>
<td>Greater than $750,001</td>
</tr>
</tbody>
</table>

Note: IRMAA amounts for beneficiaries who are married but file separate tax returns can be found in the CMS announcement mentioned above.

Medicare Part D: Stand-Alone PDPs

Medicare PDPs are insurance plans offered by private companies that contract with Medicare and offer only coverage for prescriptions drugs. Each plan has a formulary (a list of covered drugs) which varies by plan. Stand-alone PDPs charge a monthly premium for coverage, which also varies depending on the plan a beneficiary chooses. Some plans may also have an annual deductible which must be paid by the beneficiary before the plan begins to provide coverage for drugs. A beneficiary must be enrolled in Medicare Part A and/or Part B to enroll in a Part D plan.

Comparing Part D Plans – Why It’s Important to Shop Around

The Medicare Open Enrollment Period is the time of year all beneficiaries with Part D plans should make sure their plans will not only continue to cover their prescription drugs, but they should also take the time to compare their options to make sure they are enrolled in the least expensive plan that meets their healthcare needs. The easiest 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 offered in their geographic area. Medicare’s online Plan Finder tool can help you compare annual estimated costs that include the premium, deductible, and cost sharing amounts. When comparing Part D plans, beneficiaries should review the following elements:

- **Coverage**
  - Are all of the individual’s prescriptions on the Part D plan’s formulary?
  - If prescriptions are on the formulary, do they have any drug restrictions, such as quantity limits, step-therapy, or prior authorization? If so, the beneficiary may need to work with the prescribing physician to submit additional forms to the Part D plan documenting why the beneficiary needs to take that specific drug.

- **Costs**
  - What is the plan’s monthly premium, does the plan have an annual deductible, and what are the cost sharing amounts for prescriptions they fill?
  - If the plan has an annual deductible, beneficiaries should carefully review how much their prescriptions will cost during the deductible phase. Each Part D plan prices their drugs differently, so the full price beneficiaries pay for drugs during the deductible phase may vary from plan to plan. In addition, some plans may choose not to charge their members for lower cost generics that are commonly prescribed during the deductible phase (usually Tier 1 drugs) and provide coverage for these types of medications before the deductible amount is met.
  - Cost sharing amounts (co-insurance and co-pays) should also be carefully reviewed especially if an individual will enter the donut hole. Part D plans place formulary drugs on “tiers” and each tier has a different cost sharing amount. Prescription drugs on lower tiers usually cost less. The higher the tier level, the more expensive the cost sharing amount will be for drugs on that tier. It is important that individuals pay close attention to whether a plan’s tier uses a co-payment amount, which is a set dollar amount, or a co-insurance amount, which is a percentage of the retail cost of the drug amount. In addition, how much a plan will charge for each tier will also vary from plan to plan.

- **Pharmacy Selection** (standard, preferred and mail order)
  - Each Part D plan works with a network of contracted pharmacies that beneficiaries may use to fill their prescription drugs and be covered. Part D plans will not make a payment on a drug if the pharmacy used is not in-network. Each pharmacy network varies from plan to plan. The www.Medicare.gov Plan Finder is the best way to determine what pharmacy options a plan offers. The three types of pharmacy options a plan may offer include:
    - Standard network pharmacy – A standard network 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 are required to 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 plans offer a preferred pharmacy.
    - Mail order pharmacy – Some plans, not all, offer a mail order service. Plans that offer mail order, mail prescriptions directly to the beneficiary’s home (up to a 90-day supply) using their own contracted mail order pharmacy. Depending on the plan, mail order drug costs may be less expensive that using a retail pharmacy (although not always).

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.
• Star Ratings
  o CMS reviews Part D plans every year 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. Low rated plans are identified on the Medicare.gov online Plan Finder with the following icon:

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. Note that beneficiaries who decide to switch Part D plans for 2019 do not need to disenroll from their current plan. They will be automatically disenrolled from their old plan by CMS on December 31, 2018 and have their new plan begin on January 1, 2019. Click here to view a landscape created by CMS of all stand-alone PDPs offered in Illinois in 2019. The landscape also lists which plans will offer a $0 premium with full Extra Help (also referred to as the Low-Income Subsidy or LIS).

### Part D and Medicare Advantage Plans

**Medicare Advantage plans** are managed care plans that are owned and operated by private companies that are contracted with Medicare to provide enrollees their Medicare benefits. Medicare pays the plan a fixed amount each month to provide a beneficiary Part A, Part B, and Part D benefits (if drug coverage is included) all through one plan. (Note, that some MA plans do not include drug coverage. These types of plans are called MA-only.) Beneficiaries who enroll in MA plans choose to receive their Medicare benefits through the MA plan and not through original Medicare, and should use the insurance card provided to them by their MA plan when they receive care. Beneficiaries enrolled in MA plans usually have to use doctors, hospitals and other medical providers that work with the plan (called a network) in order for a service to be covered or to pay less.

**Comparing Medicare Advantage Plans- Why it’s important to Shop Around**
The Medicare OEP 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 switching or enrolling in MA plans should review the plan to determine how it will work in 2019. Medicare Advantage enrollees need to make certain their MA plan will continue to cover their prescription drugs. (Please note- the tips describing how to compare prescription drug benefits in the Medicare Part D section above, also apply to prescription drug coverage embedded in MA plans.) Additionally, 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. It is important for beneficiaries enrolling MA plans to understand that they usually have to continue paying their monthly Part B premium in addition to any premium the MA plan may charge (some MA plans offer a $0 monthly premium).

In 2019, some MA plans offered in Illinois have an annual health deductible in addition to a drug deductible that must be met before the plan will begin to pay the cost of their share of services. The best way to determine if a plan has a health and/or drug deductible is to visit the www.Medicare.gov Plan Finder and contact the plan to for more information, such as if the deductible applies to in-network or out-of-network healthcare services. The following types of MA plans are currently offered in Illinois:
Health Maintenance Organizations (HMOs)- Beneficiaries enrolled in Medicare HMOs must utilize providers and hospitals in the plan’s network for a service to be covered, except in an emergency. Services are not typically covered by a HMO if a beneficiary receives care out-of-network. Individuals in HMOs are usually required to choose a primary care physician (PCP) that helps coordinate their care. In addition, individuals usually need a referral from their PCP to visit a specialist or receive specialty care. To learn more about Medicare HMOs, click here.

HMO Point-of-Service (POS)- HMO (POS) plans are HMO plans that allow beneficiaries the flexibility of receiving specified services or certain treatment out of network or without a referral from a PCP for a higher co-payment or co-insurance. Beneficiaries must contact the plan directly to learn which out-of-network services a HMO-POS plan covers.

Preferred Provider Organizations (PPOs)- PPOs are managed care plans that allow beneficiaries the flexibility to receive medical care out-of-network at a higher cost sharing amount. Beneficiaries in PPOs usually pay less if they use doctors and medical providers that belong to the plan’s network. In addition, beneficiaries in PPOs do not need to choose a PCP and a referral is not required to visit a specialist. Beneficiaries enrolled in PPOs should not only ask a new provider if the provider "accepts the plan", but should also ask if they are in-network in order to maximize their savings. To learn more about Medicare PPOs, click here.

Private Fee-For-Service (PFFS)- Beneficiaries in PFFS plans can generally visit any doctor or provider that agrees to treat them and accepts the plans’ payment and terms. The PFFS plan determines how much it will pay providers and how much a beneficiary pays when they receive care. In addition, some PFFS plans have a network of providers that agree to always treat their members. Other doctors and providers that are out of network may decide to not treat beneficiaries even if the provider has seen them before. Beneficiaries in PFFS plans should always make sure the provider accepts the plan’s terms and payment prior to receiving a service. They should also be aware that some PFFS plans allow providers that the plan has contracted with to balance bill beneficiaries, which means providers can charge beneficiaries up to 15% more than the payment made by the PFFS plan. Contact a PFFS plan directly to find out if they allow their providers to balance bill. Individuals in PFFS plans do not need to choose a PCP or obtain a referral to visit a specialist. If the PFFS plan does not include drug coverage, a beneficiary may enroll in a stand-alone PDP. To learn more about PFFS plans, click here.

Special Needs Plans (SNPs) - SNPs are managed care plans that provide focused and specialized healthcare for specific groups of beneficiaries including individuals who are institutionalized and individuals who have certain chronic health conditions. All SNPs must include prescription drug coverage. Each type of SNP tailors its benefits to the population it serves by offering provider networks and prescription formularies for the group it serves. To join a SNP, an individual must meet the criteria of one of the groups. To learn more about SNPs, click here. Click here to view a landscape of Special Needs Plans in Illinois by county.

Medicare Advantage Out of Pocket Maximum Limit
One way beneficiaries can estimate the most a Medicare Advantage plan will cost them annually for health care is to find out a plan’s Maximum Out-of-Pocket 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 2019 for Part A and Part B services received at in-network providers. MOOP limits vary by plan – many have limits lower than $6,700. This means that once a beneficiary reaches the MOOP amount, they no longer pay cost sharing amounts for in-network Part A and B services for the remainder of the
calendar year. MA plans, like PPOs, that provide some coverage for out-of-network care may have a separate MOOP amount for services that are received out-of-network. 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 Plan Finder) at www.Medicare.gov.

**Medicare Part D & Extra Help**

The Medicare Extra Help Program is a federal program that assists Medicare beneficiaries to pay for their Medicare Part D plan premiums, deductibles, and cost sharing amounts. Extra Help is also commonly referred to as the **Low-Income Subsidy or LIS**. The Social Security Administration (SSA) processes applications for the program and determines eligibility. A beneficiary must meet set income and asset limits to qualify for LIS. There are different levels of Extra Help assistance available to people who qualify (called full or partial) which depends on their income and assets. Some groups of beneficiaries may automatically qualify for Extra Help without having to submit an application to SSA. These groups of beneficiaries are referred to as “deemed eligible” and include people who receive Medicare and Medicaid (dual-eligibles), are enrolled in a Medicare Savings Program (QMB, SLMB or QI), or receive Supplemental Security Income (SSI).

In addition to qualifying for premium and cost sharing assistance, additional benefits of Extra Help include waiving the Part D late enrollment penalty if the beneficiary is paying one, no Medicare Part D donut hole, and a **quarterly Special Enrollment Period**. Individuals who qualify for Extra Help may choose a Part D plan that best suits their needs or they will be randomly assigned to a plan by CMS if one is not chosen. It is also important to note that Extra Help will only help pay for prescription drugs that are on a Part D plan’s formulary, which means that is still important for people with Extra Help to check their Part D plan’s formulary.

**2019 Extra Help Co-Pays**

In 2019, depending on the level of Extra Help a beneficiary receives (full or partial), they will pay the following co-pays for each 30-day supply filled:

- **Full Extra Help** - between $1.25/$3.80 (generic/brand name) or $3.40/$8.50 (generic/brand name)*
- **Partial Extra Help** – $3.40 (generic) and $8.50*(brand name) or 15% co-insurance for each 30-day supply*

*Which co-payment the beneficiary pays depends on their 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 drug plan deductible (up to $85 in 2019). The Extra Help deductible applies to beneficiaries with incomes between 135% and 150% of the Federal Poverty Level. The LIS income limits for next year will be announced in early 2019 once the federal poverty levels are released and the assets limits will be released in late 2018 once the consumer price index is announced.

**Full Extra Help**

Full Extra Help provides beneficiaries the following benefits:

- Helps pay the Part D annual drug deductible (if the plan has one)
- Low co-pays for prescription drugs that are on the plan’s formulary
- Helps to pay the full monthly Part D plan premium for a basic plan that is at or below the Extra Help benchmark amount (in 2019, seven stand-alone Part D plans will offer a $0 monthly premium to beneficiaries with full Extra Help).

In Illinois, the LIS benchmark premium amount for 2019 is $27.37. 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”).

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. In some instances, this may be a good option if none of the $0 premium plans cover a beneficiary’s drugs but those drugs are covered by a plan that is above the benchmark. Note that Extra Help 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 be responsible for the portion of the plan’s premium that accounts for the “enhanced” benefit. Extra Help will not pay the portion of the premium that makes the plan “enhanced.”

**Partial Extra Help**
Beneficiaries who qualify for partial Extra Help also receive assistance paying for their Medicare Part D plan costs, but the amount of assistance they receive is less than full Extra Help. Depending on their income and assets, beneficiaries with partial Extra Help receive the following benefits:
- Assistance paying for the plan’s monthly premium that is based on a sliding scale
- A reduced annual deductible (up to $85 in 2019) and
- A set co-payment amount of $3.40 for generics and $8.50 for brand-names or 15% co-insurance that is based on the full cost of the drug.

To view a chart created by the National Council on Aging (NCOA) that lists the different levels of Extra Help by income and asset amounts, click [here](Note: This chart currently shows 2018 amounts, 2019 will be released January/February).

**Medicare Advantage Plans and Extra Help**
Medicare Advantage plans that include prescription drug coverage (commonly referred to as 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.)

Extra Help will help beneficiaries enrolled in MA-PD plans pay for the prescription drug coverage portion of the plan, but not for health related costs. Extra Help will help pay for the annual drug deductible, drug co-pays or co-insurance amounts, and any portion of the premium that is for drug coverage and up to the LIS benchmark amount. The beneficiary is 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 or any health deductible 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.

**Click here** for 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 (click on 2019 Plan and Premium Information for Medicare Plans Offering Part D Coverage).

**Guide to Consumer Mailings**
Earlier this year, CMS released a Guide to Consumer Mailings from CMS, SSA and Medicare plans for 2018-2019. 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 changes, plan marketing materials, etc. The guide includes the month the letter is mailed, 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 a helpful tool for counselors who assist Medicare beneficiaries in navigating their healthcare benefits throughout the year.

**Training Tutorials and Resources**
AgeOptions and CMS have created a number of resources to help beneficiaries and professionals navigate the Plan Finder:

- **MMW Medicare Plan Finder Webinar** – The Medicare Plan Finder Demo Webinar will review how to use the Medicare Plan Finder tool to compare standalone Medicare Part D prescription drug plans and Medicare Advantage plans. We will also review the Extra Help program and how it works with an individual's Part D plan.
- **MMW Annual Open Enrollment Period Webinar** - This webinar provided an overview of what professionals need to know when helping Medicare beneficiaries enroll in and compare Medicare Part D plans, including Medicare Advantage health plans, for coverage in 2019. The webinar reviewed 2019 Medicare Part D and health plan options in Illinois, Part D benefit parameters, and factors beneficiaries should take into consideration when making decisions about their coverage.
- **“Navigating the Medicare Plan Finder” presentation** – a step-by-step slide presentation on how to use the Medicare Plan Finder from beginning to end.
- **Medicare Plan Finder Worksheet** – an intake sheet where you can gather all the information you need from a beneficiary and use the Plan Finder to search for a Part D plan that best suits the beneficiary's needs
- **Medicare Plan Finder FAQ** – a list of Frequently Asked Questions about Plan Finder
- **Senior Health Insurance Program (SHIP)** - Beneficiaries who would like assistance or have questions about comparing their Medicare plan options can contact SHIP at (800) 252-8966 for free and unbiased Medicare counseling.
- **CMS 1-800-Medicare** – Medicare representatives can assist individuals compare Part D plans and find the most affordable plan that works for them.

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](http://ageoptions.org/services-and-programs_makemedicarework.html)