November 11, 2016

Medicare Open Enrollment Period

The Medicare open enrollment period began October 15 and ends December 7th. During this time people with Medicare can enroll, disenroll or switch Medicare Part D plans, including Medicare Advantage plans. Any plan changes made during the open enrollment period will take effect January 1, 2017. Now is the time Medicare beneficiaries should do their homework and make sure their current Part D plan will continue to work for them, or determine if they need to find another plan that will better suit their prescription drug and/or health needs. This is also an 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 late enrollment penalty.

Medicare Part D: A Quick Refresher

A Medicare beneficiary can receive Medicare Part D in one of two ways: a stand-alone prescription drug plan (also called a PDP) that covers only prescription drugs or a Medicare Advantage (MA) plan that provides coverage for health services and prescription drugs through one plan. This Brief will review how the Medicare Part D benefit works for both types of coverage in 2017 and what counselors and professionals need to know when assisting clients in making important decisions about enrolling in these types of plans and navigating their benefits next year.

Beneficiaries who are enrolled in Part D plans should have received an Annual Notice of Change (ANOC) from their plans notifying them on how their Part D plans are changing in 2017. Plans are required to mail ANOCs out annually by October 1st to their members and include information about coverage, costs and the areas the plan serves. Beneficiaries should carefully review this notice to determine if their current plan will continue to meet their needs by considering the following:

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

Once the Medicare Open Enrollment Period (OEP) ends, beneficiaries will be "locked" into their plans for all of 2017 unless they qualify for a special enrollment period (SEP) to switch or disenroll from their plan. The next time beneficiaries will have the opportunity to change plans will be during the next Medicare OEP in the fall of 2017 for coverage in 2018.

**Medicare Part D Benefit Parameters in 2017**

The Centers for Medicare and Medicaid Services (CMS) have announced the 2017 standard Medicare Part D benefit amounts. These limits are adjusted each year by CMS using methodology that is based on beneficiaries' drug expenditures and to ensure that the Part D benefit continues to provide coverage for a share of a beneficiary's drug expenses. Note that the limits listed below only apply to prescriptions drugs that are covered by the plan. Money spent on any prescriptions that are not on the plan's formulary will not count toward reaching the deductible, donut hole, or catastrophic coverage phases. To view the CMS notice that lists the 2017 Part D benefit parameters please click [here](#) (see pages 68-69).

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Beneficiary pays 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 $360</td>
</tr>
<tr>
<td><strong>Initial Coverage Limit</strong></td>
<td>You pay a co-pay or co-insurance amount for each formulary prescription and the plan pays the rest of the cost. Once the amount that both the beneficiary and the plan spend together reaches the Initial Coverage Limit amount, the beneficiary moves into the donut hole phase.</td>
<td>Up to $3,310</td>
</tr>
<tr>
<td><strong>Donut Hole begins (also called the Coverage Gap)</strong></td>
<td>During the &quot;donut hole&quot; phase, the Part D plan does not pay anything toward the costs of drugs, but beneficiaries receive discounts. In 2017, beneficiaries will receive a 60% discount on brand names and 49% discount on generics.</td>
<td>$3,310</td>
</tr>
<tr>
<td><strong>Catastrophic coverage begins once the True Out-of-pocket Threshold (TROOP) is met. (Donut hole</strong></td>
<td>Once someone's True Out of Pocket Costs (TrOOP) are met, they reach the Catastrophic Coverage phase. During Catastrophic Coverage in 2017, the plan will pay 95% of drug expenses and the beneficiary will</td>
<td>$4,850 (TROOP amount)</td>
</tr>
</tbody>
</table>
ends.) pay 5% or a co-pay of $3.30 (for generics or preferred multi-source drugs) or $8.25 (for all other drugs on the formulary) - whichever is higher.

TrOOP costs are a beneficiary's out-of-pocket drug costs for a Part D plan (e.g., co-pays, deductible amounts) and determine when catastrophic coverage will begin. TrOOP is tracked by the Part D plan. Note: monthly Part D plan premiums do not count towards TrOOP.

| Copayment amount for generic or preferred multi-source drugs after Catastrophic coverage begins | $2.95 or 5%* | $3.30 or 5%* |
| Copayment amount for all other drugs after Catastrophic coverage begins | $7.40 or 5%* | $8.25 or 5%* |

*During the catastrophic coverage phase in 2017, the beneficiary will pay a co-pay of $3.30/$8.25 or 5% of the drug costs, whichever is greater. (In 2016, the beneficiary pays the greater of $2.95/7.40 or 5% of the drug cost.)

**Part D and the Donut Hole in 2017 - How it Will Work**

In 2017, the Medicare Part D coverage gap (also referred to as the donut hole) will begin when the beneficiary has filled $3,700 worth of formulary drugs with their Part D plan. This amount includes the full cost of the drugs (what the beneficiary and the plan pay), and not just the co-pay amounts the beneficiary is charged at the pharmacy. The donut hole continues until the beneficiary has reached the TROOP amount ($4,950 in 2017).

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 will be applied immediately at the pharmacy counter once a person enters the donut hole. In 2017, beneficiaries will receive a 60% discount on brand name drugs (50% in part by drug manufacturers and the other 10% is provided by a government subsidy). For generic drugs, beneficiaries receive a 49% discount, which is provided entirely by a government subsidy. It is important to note that only the portion of the discount provided by the drug manufactures 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.

All discounts provided in the donut hole are reflected in the www.Medicare.gov online prescription drug Plan Finder when searching and comparing plans. The discounts for brand name and generic drugs will increase each year until 2020 when the donut hole is expected to be closed.
is eliminated. Beginning in 2020, beneficiaries will pay the standard Medicare Part D cost-sharing amount (25%) for covered drugs throughout the calendar year. Below is a snapshot of the discount provided in the donut hole through 2020.

| Discounts a Medicare Beneficiary Receives in the Donut Hole for Formulary Drugs |
|--------------------------|----------------|----------------|----------------|----------------|----------------|
|                         | 2016 | 2017 | 2018 | 2019 | 2020 |
| Brand Name Drugs       | 55%  | 60%  | 65%  | 70%  | 75%  |
| Generic Drugs           | 42%  | 49%  | 56%  | 63%  | 75%  |

In order for beneficiaries to get out of the donut hole, their true out-of-pocket expenses (also referred to as TrOOP amount) must reach $4,950 in 2017. Once TrOOP is met, beneficiaries enter the Catastrophic Phase and begin to pay lower cost sharing amount as described in the benefits parameter chart above. 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 drugs that are on the plan's formulary (include amounts paid by a family member or other person on behalf of the beneficiary)
- 50% 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.

**Medicare Part D Late Enrollment Penalty**

Medicare does impose a Medicare Part D late enrollment penalty (LEP) if beneficiaries do not enroll in a Part D plan when they are first eligible during their Initial Enrollment Period. 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. This can include beneficiaries who have other creditable drug coverage offered through an employer, retiree, or union group health plan. In addition, 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.

The Medicare open enrollment period is a good time for beneficiaries to enroll in a Medicare Part D plan if they did not do so when they were first eligible during their IEP or if they did not enroll once their other creditable group health coverage ended. Individuals who missed their IEP or went longer than 63 days without creditable drug coverage and use the Medicare OEP to enroll in a Part D plan, usually have to pay a late enrollment penalty. 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 2017 will be $35.63. For example, if Michael was eligible for Part D but did not enroll until 12 months after his initial enrollment period ended, he will have to pay an extra 12% penalty. Michael's late enrollment penalty for 2017 will be $4.10 (.12% x $35.63 = $4.28). The penalty is usually rounded to the nearest ten cents and is paid in addition to the monthly Part D plan premium. Note that the Part D penalty is calculated using then national base premium and the base premium changes every year, so Michael's Part D penalty amount will also change every year. The Part D penalty is not capped, meaning the penalty will be costlier the longer a beneficiary goes without Part D plan.

2017 Medicare Part D Premium Income Amounts
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. This is called an Income Related Monthly Adjustment Amount (IRMAA). Part D IRMAAs, a provision of the Affordable Care Act that began in January 2011, are based on an individual's modified adjusted gross income (MAGI). IRMAA amounts are based on a sliding scale, using income reported to SSA from the IRS and from a beneficiary's most recent tax return. For many beneficiaries, their IRMAA amount for 2017 will be based on income reported on their 2015 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. The Social Security Administration (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 2017. Click here for more information on Part D IRMAA. Refer to the chart below for 2017 IRMAA amounts.

<table>
<thead>
<tr>
<th>Beneficiaries who file an individual tax return</th>
<th>Beneficiaries who are married and filing a joint tax return</th>
<th>2017 Part D IRMAA Amounts (in addition to the Part D plan monthly premium)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>$0</td>
</tr>
<tr>
<td>$85,001 - $107,000</td>
<td>$170,001 - $214,000</td>
<td>$13.30</td>
</tr>
<tr>
<td>$107,001 - $160,000</td>
<td>$214,001 - $320,000</td>
<td>$34.20</td>
</tr>
<tr>
<td>$160,001 - $214,000</td>
<td>$320,001 - $428,000</td>
<td>$55.20</td>
</tr>
<tr>
<td>Greater than $214,000</td>
<td>Greater than $428,000</td>
<td>$76.20</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
A beneficiary must be enrolled in Medicare Part A and/or Part B to enroll in a Part D plan. Below is a quick snapshot look at how many Part D plans are offered in Illinois and how associated costs are changing in 2016.

<table>
<thead>
<tr>
<th>Stand-Alone PDPs in Illinois</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PDPs offered in IL</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$0 - $360</td>
<td>$0 - $400</td>
</tr>
<tr>
<td>Monthly Premium</td>
<td>$18.40 - $157.40</td>
<td>$17.00 - $163.70</td>
</tr>
<tr>
<td>Number of plans that offer a $0 premium with full LIS</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Number of plans that offer some coverage in the gap</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Benefit type</td>
<td>13 Basic</td>
<td>10 Basic</td>
</tr>
<tr>
<td></td>
<td>12 Enhanced</td>
<td>11 Enhanced</td>
</tr>
</tbody>
</table>

** Please note the chart above includes sanctioned Part D plans. Sanctioned plans are not allowed to accept new enrollees, but current enrollees can remain in the plan.

Click here to view a landscape created by CMS of all stand-alone PDPs offered in Illinois in 2017. 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).

**Medicare Part D Sanctions**

The Centers for Medicare and Medicaid Services (CMS) have the authority to place sanctions on Medicare Part D plans (stand-alone PDPs and Medicare Advantage plans) when a plan fails to properly administer the benefit. Depending on the situation, CMS may decide to take one of several actions that include imposing fines, suspending marketing and enrollment into the plan, or terminating the plan's contract.

Currently in Illinois, CMS has placed sanctions on the Cigna-HealthSpring Rx Company effective January 21, 2016. As a result, Cigna-HealthSpring is not allowed to market plans to potential new enrollees, new enrollments into their plans are suspended, and plan information is suppressed on the www.Medicare.gov Plan Finder. The sanctions effect the following plans in Illinois:

- Cigna-HealthSpring Rx Secure (PDP) S5617-224 - offered statewide
- Cigna-HealthSpring Rx Extra (PDP) S5617-262 - offered statewide
- Cigna-HealthSpring Advantage (HMO) H1415-013 - offered in Cook, DuPage, Kane and Will counties
- Cigna-HealthSpring Premier (HMO-POS) H1415-021 - offered in Cook, DuPage, Kane and Will counties
- Cigna-HealthSpring Primary (HMO) H1415-024 - offered in Cook, DuPage, Kane and Will counties

The sanction will not affect current members and they may continue using their Cigna-HealthSpring plan. However, it is important for Cigna-HealthSpring members to contact their current plan to find out if it will continue to work for them next year since 2017 plan and pricing information for Cigna-HealthSpring plans are blocked on the Medicare.gov Plan Finder. Current members have the option of remaining in their plan or switching plans during the Medicare OEP (October 15 - December 7). Cigna members who
experience issues obtaining their prescriptions after the OEP ends, should contact 1-800-Medicare if they are unable to resolve the issue with the plan and to determine if they are eligible for a special enrollment period to switch to another Part D plan.

**Part D and Medicare Advantage Plans**
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). Medicare Advantage plans are managed care plans that are owned and operated by private companies that are contracted with Medicare to provide enrollees with 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 opt to receive their Medicare benefits through the MA plan and not through ordinal Medicare. 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. The following types of MA plans are currently offered in Illinois.

**Health Maintenance Organizations (HMOs)**
Beneficiaries enrolled in Medicare HMOs must utilize providers or 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 care is received out-of-network. Individuals in HMOs are usually required to choose a primary care physician 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 certain specified services 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. 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 the plan has contracted with to balance bill beneficiaries, which means PFFS providers can charge beneficiaries up to 15% more than the payment made by the 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 have both Medicare and Medicaid, are institutionalized, or have certain chronic health conditions. To join a SNP, an individual must meet the criteria of one of the groups. 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 learn more about SNPs, click here.

Individuals interested in switching or enrolling in MA plans should review the plan to determine how it will work in 2017. In addition to making certain their MA plan will continue to cover their prescription drugs, MA plan enrollees should also evaluate the health services that are covered through their plan. This includes understanding how an MA plan works, how much each health service costs with a specific plan, and if their preferred doctors and providers are part of the MA plan's network. 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 2017, some MA plans offered in Illinois may 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.

**Medicare Advantage Out of Pocket Maximum Limit**
One way beneficiaries can estimate the most a Medicare Advantage plan will cost them for health care annually 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 2017 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 have to pay any co-pays or co-insurance 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 prescription drug Plan Finder) at www.Medicare.gov.

**Medicare Advantage Plans in Illinois and Cook County**

<table>
<thead>
<tr>
<th>State of Illinois: MA-PDs (MA plans that include drug coverage)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>2016</td>
<td>2017</td>
</tr>
<tr>
<td>Number of MA-PD plans</td>
<td>833</td>
<td>885</td>
</tr>
<tr>
<td>Annual drug deductible</td>
<td>$0 - $360</td>
<td>$0 - $400</td>
</tr>
<tr>
<td>Monthly premium range in IL</td>
<td>$0 - $188</td>
<td>$0 - $179</td>
</tr>
</tbody>
</table>
Number of plans that offer some coverage in the gap: 214

Types of MA-PD plans offered:
- Local HMO: 286
- Local PPO: 391
- Regional PPO: 54
- PFFS: 102

Local HMO: 550
- Local PPO: 183
- Regional PPO: 102
- PFFS: 54

### Cook County: MA-PDs

<table>
<thead>
<tr>
<th>Cook County</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MA-PD plans offered in Cook County</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Annual deductible</td>
<td>$0 - $360</td>
<td>$0 - $400</td>
</tr>
<tr>
<td>Premium range in Cook County</td>
<td>$0 - $188</td>
<td>$0 - $179</td>
</tr>
<tr>
<td>Number of plans that offer some coverage in the gap</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Types of MA-PD plans offered</td>
<td>Local HMO - 15&lt;br&gt;Local PPO - 6&lt;br&gt;Regional PPO - 1&lt;br&gt;PFFS - 1</td>
<td>Local HMO - 18&lt;br&gt;Local PPO - 5&lt;br&gt;Regional PPO - 1&lt;br&gt;PFFS - 1</td>
</tr>
</tbody>
</table>

**Please note the chart above includes sanctioned Part D plans. Sanctioned plans are not allowed to accept new enrollees, but current enrollees can remain in the plan. Click [here](#) to view a landscape spreadsheet of all 2017 Medicare Advantage plans offered in Illinois (you can sort by state and county).**

### Special Needs Plans in Illinois and Cook County

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

- are dual eligibles (have both Medicare and Medicaid) or
- are institutionalized (may include beneficiaries living in the community who have been determined as needing institutional level care, but receive home and community based services through one of the Medicaid waiver programs) or
- have a specific chronic or disabling condition.

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

### Special Needs Plans in Illinois

<table>
<thead>
<tr>
<th>Illinois</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of SNPs</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Monthly premium range</td>
<td>$0 - $29.60</td>
<td>$0 - $30.10</td>
</tr>
<tr>
<td>Annual drug Deductible</td>
<td>$0 - $360</td>
<td>$0 - $400</td>
</tr>
<tr>
<td>Coverage in the gap</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
### Special Needs Plans in Cook County

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of SNPs</strong></td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Monthly premium</strong></td>
<td>$0 - $29.60</td>
<td>$0 - $28.70</td>
</tr>
<tr>
<td><strong>Annual drug</strong></td>
<td>$0 - $360</td>
<td>$0 - $400</td>
</tr>
<tr>
<td><strong>Coverage in the</strong></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Type of SNP</strong></td>
<td>Dual-eligible: 4</td>
<td>Dual-eligible: 3</td>
</tr>
<tr>
<td></td>
<td>Institutional: 1</td>
<td>Institutional: 1</td>
</tr>
<tr>
<td></td>
<td>Chronic or disabling condition: 1</td>
<td>Chronic or disabling condition: 2</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- Chronic or disabling condition: 6
- Dual-eligible: 52
- Institutional: 6

- Chronic or disabling condition: 3
- Dual-eligible: 25
- Institutional: 8

- 1 plan for individuals with End-Stage Renal Disease that requires dialysis (in Cook County)
- 2 plans for people with cardiovascular diseases, chronic heart failure and diabetes (1 in Cook County and 1 in DuPage County)

Click [here](#) to view a landscape of Special Needs Plans offered in Illinois by county.

Beginning in 2019, the Illinois Department of Healthcare and Family Services (HFS) will no longer contract with dual-eligible SNPs in Illinois and beginning in 2017, HFS also will no longer accept new enrollments into dual SNPs. As a result, two companies in 2017, Health Alliance Medicare and Meridian Health Plans, will discontinue offering offer dual-eligible SNPs in Illinois after December 31, 2016. Individuals affected by this change will be notified by their plan of their options. Beneficiaries in a dual SNP offered by Health Alliance or Meridian will have the option of enrolling in a Medicare Advantage plan, including another dual SNP if one is offered in their area, or a MMAI.
Finding and Enrolling in the Right Part D Plan - Why It's Important to Shop Around

It is important that Medicare beneficiaries utilize the Medicare Open Enrollment Period each year to compare Medicare Part D plans to determine if their current plan will continue to work for them next year or if there is better plan that is more affordable and better suits their needs. The easiest way to "shop around" and compare plans is to use the [www.Medicare.gov](http://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. In addition, the Plan Finder has now made it easier to search for the best pharmacy selection by plan in order to maximize a beneficiary's savings. There are a number of variables to consider when choosing a Part D plan. Below is a summary of the main factors that should be reviewed prior to enrolling in a plan.

- **Estimated annual drug costs**, including the monthly premium, annual deductible (if the plan has one), and cost sharing amounts.
  - Review how the plan structures its cost sharing. 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 percentage of the retail cost of the drug amount.

- **Drug coverage**. This includes making certain drugs are on the plan's formulary, what the beneficiary's co-pay or co-insurance will be, if the beneficiary will enter the donut hole and if any of the prescriptions have drug restrictions such as quantity limits, prior authorization or step therapy.
  - It is important to note that some Part D plans that have annual deductibles, do not apply tier 1 drugs towards the deductible (usually inexpensive preferred generics). This means that even though the plan has a deductible, certain drugs may be covered before the deductible has been met. Although, a plan may not apply tier 1 drugs towards a deductible, a beneficiary should be made aware that any higher tiered prescription that is prescribed in the future may apply towards any unmet deductible amount.

- **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](http://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 - the pharmacy is in the plan's network and
the member pays a co-pay or co-insurance amount that is set by the plan. All Part D plans 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 Part D plans offer a preferred pharmacy network.
- Mail order pharmacy - some plans, not all, offer a mail order service. Plans that offer mail order mail prescriptions using their own contracted mail order pharmacy directly to the beneficiary's home (up to a 90-day supply). Depending on the plan, mail order drug costs may be less expensive that using a retail pharmacy (although not always).
- 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.

- Plan star ratings. CMS reviews Part D plans on quality and performance to help individuals compare and make informed plan choices. Plans are evaluated on certain measures and CMS provides each plan with an overall star rating from 1 to 5, with 5 being "excellent" and 1 being "poor". The overall ratings, as well as how each plan did on specific measures are available on the Plan Finder.
- CMS has established a SEP that can be used throughout the year for beneficiaries in low performing Part D plans. This SEP allows beneficiaries in Part D plans that received an overall star rating of less than three stars for three or more years to switch to another higher-rated Part D plan with three or more stars. CMS mails individuals in consistently low performing plans a letter in late October encouraging them to compare their plans to higher rated plans in their area. Beneficiaries must contact 1-800-Medicare directly to use this SEP. These low rated plans are identified on the Medicare.gov online Plan Finder with a low performing icon. To learn more about the SEP for beneficiaries in low performing plans, click here (see page 87).
- Medicare offers a special enrollment period to switch to a 5-star Part D plan if one is available in the beneficiary’s area, however, Illinois does not have any 5-star plans currently offered this year or in 2017.

Beneficiaries can enroll in or switch Part D plans by calling 1-800-Medicare, submitting an online enrollment via www.Medicare.gov, or contacting the plan directly. Individuals who are switching Part D plans for 2017 do not need to disenroll from their current plan as they will be automatically disenrolled on December 31, 2016 by Medicare and have their new plan begin on January 1, 2017.

**Medicare.gov Plan Finder Training Tutorials and Resources**

CMS has created a number of resources to help individuals navigate the Plan Finder:

- [Medicare Training Program Plan Finder Toolkit](#) - includes a PowerPoint presentations on how to use the Plan Finder and on 2017 Plan Finder updates, a worksheet to use with beneficiaries, five YouTube video tutorials on how to use the Plan Finder and an online demonstration
  - [Navigating the Plan Finder PowerPoint](#) - a step-by-step presentation on how to use the Plan Finder
  - [Medicare Plan Finder worksheet](#) - an intake sheet where you can gather all the information you need from a beneficiary to use the Plan Finder to search for a Part D plan that best suits the beneficiary’s needs
- [Medicare Plan Finder FAQ](#)
Medicare Part D and Extra Help
The Medicare Extra Help Program is a federal program that assists Medicare beneficiaries to pay for their Medicare Part D 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) accepts applications for the program and determines eligibility. A beneficiary must meet set income and asset limits to qualify for LIS. There are differently levels of Extra Help assistance available to people who qualify (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 received Medicare and Medicaid (dual-eligibles), 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, other benefits of Extra Help include waiving the Part D late enrollment penalty if beneficiary is paying one, no Medicare Part D donut hole, and a continuous SEP that can be used at any time throughout the year. Individuals who qualify for Extra help may choose a Part D plan that best suits their needs or will 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.

2017 Extra Help Co-Pays
In 2017, 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 $1.20/$3.70 (generic/brand name) or $3.30/$8.25 (generic/brand name)*
- **Partial Extra Help** - $3.30 (generic) and $8.25*(brand name) or 15% co-insurance for each 30-day supply*

*Which co-payment the beneficiary pays depends on his or her income. In addition, beneficiaries with partial Extra Help that are on the higher end of the income and/or asset limits will also be responsible for paying an annual $82 drug plan deductible in 2017 for covered drugs (up from $74 in 2016). The Extra Help deductible applies to beneficiaries with incomes between 135% and 150% of the Federal Poverty Level. The LIS income limits for 2017 will be announced in early 2017 once the federal poverty levels are released.

**Full Extra Help**
Beneficiaries who qualify for full Extra Help will also receive assistance paying for a Part D plan's monthly premium. In 2017, nine stand-alone PDP plans (including one sanctioned plan) will offer a $0 monthly premium to people with full Extra Help. CMS will pay the entire monthly Part D plan premium for beneficiaries with full Extra Help if the plan is a basic plan and the monthly premium is at or below a certain premium amount, called the Extra Help or LIS benchmark. In Illinois, the LIS benchmark premium amount for 2017 is $28.68. 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 the drugs are covered by a plan that is above the benchmark. Note that LIS will still pay the entire annual deductible and provide them with low prescription drug co-pays for drugs on the plan's formulary regardless of the Medicare Part D plan they are enrolled in, even if the plan's premium is over the benchmark.

If an individual with full LIS enrolls in an enhanced plan instead of a basic plan, the individual will be responsible for the portion of the plan's premium that accounts for the "enhanced" benefit. For example, in 2017 in Illinois, the Humana Walmart Rx plan (an enhanced plan) has a monthly premium of $17.00, which is below the LIS benchmark amount. However, a beneficiary with full LIS who enrolls in this plan would be responsible for a $9.30 monthly premium because LIS will not pay the portion of the premium that makes the plan "enhanced."

Below is a list of PDPs that will offer a $0 premium with full LIS in 2017.

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Plan Name</th>
<th>Monthly Drug Premium</th>
<th>Annual Drug Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Medicare</td>
<td>Aetna Medicare Rx Saver</td>
<td>$29.80</td>
<td>$400</td>
</tr>
<tr>
<td>Cigna-HealthSpring Rx</td>
<td>Cigna-HealthSpring Rx Secure</td>
<td>$20.60</td>
<td>$400</td>
</tr>
<tr>
<td>EnvisionRx Plus</td>
<td>EnvisionRxPlus</td>
<td>$29.00</td>
<td>$400</td>
</tr>
<tr>
<td>HISC - Blue Cross Blue Shield of Illinois</td>
<td>Blue Cross MedicareRx Basic</td>
<td>$26.10</td>
<td>$400</td>
</tr>
<tr>
<td>Humana Insurance Company</td>
<td>Humana Preferred Rx Plan</td>
<td>$25.90</td>
<td>$400</td>
</tr>
<tr>
<td>SilverScript</td>
<td>SilverScript Choice</td>
<td>$28.40</td>
<td>$0</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>Symphonix Value Rx</td>
<td>$27.40</td>
<td>$400</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>AARP MedicareRx Saver Plus</td>
<td>$29.80</td>
<td>$400</td>
</tr>
<tr>
<td>WellCare</td>
<td>WellCare Classic</td>
<td>$26.50</td>
<td>$400</td>
</tr>
</tbody>
</table>

***Note: Plans under sanction allows for current members to remain in this plan but
prohibits new members from enrolling in the plan.

Click [here](#) for a printable version of this chart.

**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:

- A monthly premium based on a sliding scale
- A reduced annual deductible (up to $82 in 2017) and
- A set co-payment amount of $3.30 for generics and $8.25 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](#).

**Medicare Advantage Plans for Individuals with 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.)

If an individual qualifies for Extra Help and is also enrolled in a MA-PD plan, Extra Help will help them pay for the prescription drug coverage portion of the plan premium, but not the health portion. The beneficiary is also still responsible for the plan's set co-pay or co-insurance amounts for health services, such as the doctor's co-pay amount, specialist co-pay, etc. Extra Help will not help to pay for the health co-pays or 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. This means they will receive help with their drug co-pays, annual drug deductible, and if the MA-PD plan has a premium, any portion of the premium that is specified for drug coverage and below the Extra Help benchmark as discussed earlier in this Brief.

Click [here](#) for a chart created by MMW that lists the MA-PD plans in Cook and the Collar counties that offer $0 drug premium for beneficiaries with full Extra Help.

Click [here](#) for a chart created by MMW that lists the Special Needs Plans (SNPs) in Cook and the Collar counties that offer a $0 drug premium with full Extra Help.

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 Medicare Part D 2017 Plan Report).
Guide to Consumer Mailings

Earlier this fall, CMS released their Guide to Consumer Mailings from CMS, SSA, and Medicare Plans in 2016/2017. Throughout the year, CMS, SSA, and Medicare plans send important notices to beneficiaries regarding their benefits, including information about their Extra Help and Medicare Savings Program eligibility, Medicare plan benefit changes, plan marketing materials, prescription co-payment changes, etc. The guide includes the mailing date, the sender of the letter, the letter color, a description of the action the beneficiary needs to take, and a link to a copy of the letter. This guide is helpful for counselors who assist Medicare beneficiaries in navigating their healthcare benefits throughout the year. Below is a quick summary of the letters being mailed to people with Extra Help/LIS during the fall.

"Loss of Deemed Status" (grey letter) was mailed to beneficiaries by CMS in September. It notifies beneficiaries that they will no longer automatically receive LIS effective January 1, 2017 because they no longer qualify for Medicaid, a Medicare Savings Program or SSI. The letter includes an application for Extra Help because some of these beneficiaries may still qualify for LIS based on their income and or assets but would need to apply through Social Security. Beneficiaries who lose their Extra Help are eligible for a SEP through March 31, 2017 to change plans.

"Change in Extra Help Co-payment" (orange letter) was mailed to individuals in early October and notifies them that will continue to automatically receive Extra Help in 2017 but that their Extra Help co-pay level will change. The letter lists what their co-pays will be as of January 1, 2017. An individual's Extra Help co-pay may change if s/he moves from one of the following categories to another:

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

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

LIS Blue Reassignment Letters. There are two different blue letters. CMS will mail out two different blue letters to people who receive full LIS and will be reassigned to a new plan in 2017. People who receive LIS and whose plans are leaving Medicare Part D will receive Blue Letter 1. People who receive full LIS and whose premium in 2017 will be above the LIS premium amount will receive Blue Letter 2 in late October/early November. Please note that people with LIS will be reassigned to a different plan only if Medicare had originally auto-assigned them to a plan and they haven't chosen a different plan.

Blue Reassignment Letter 1 informs people who receive LIS and whose plans are
leaving the Medicare Part D program which plan they will be reassigned to if they do not join a new plan on their own by December 31, 2016. Blue Reassignment letter 2 informs people who receive full LIS and whose plan premiums are increasing which plan they will be reassigned to if they do take action. Beneficiaries who wish to stay in their plan can do so by calling 1-800-Medicare and request to remain in that plan. If they do nothing, they will be re-assigned by CMS to a different plan. They also have the option of choosing and enrolling in a plan of their choice.

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