The Medicare Counselor

July/August/September 2015

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This issue of The Medicare Counselor features a frequently asked question from the Medicare Rights Center Consumer Helpline, information on the Medigaps, and a Dear Emily article on the Low Income Subsidy (LIS).

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Medicare Resources

- **Medicare Interactive:** http://www.medicareinteractive.org
- **Medicare Rights Center:** http://www.medicarerights.org
- **Medicare:** http://www.medicare.gov
- **Guide to Medigap Policies:** http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1255

Hot Topic from the Helpline

I have heard that I can make changes to my Medicare coverage during Fall Open Enrollment. What exactly is Fall Open Enrollment, and what do I have to do during this time?

- Helpline caller

Fall Open Enrollment occurs from October 15 to December 7. During this time, you can make changes to the way in which you receive your Medicare benefits for the upcoming plan year. With a few exceptions, this period is the only time during the year when beneficiaries can make changes to their Medicare coverage. For example, you can switch to a different Part D plan and/or Medicare Advantage Plan. Additionally, if you have a Medicare Advantage Plan, you can switch to Original Medicare with a separate Part D plan or vice versa.

Even if you are satisfied with your current Medicare coverage, it is important to check to see if there is another plan in your area that will offer you better health and/or drug coverage at a more affordable price. Research shows that people with Medicare prescription drug coverage (Part D) could lower their costs by comparing plans each year. It is important to know that plan benefits can and do change each year. For example, drug plans can change their formularies, or the list of covered drugs, each year. A drug you took last year that was listed on the formulary may not necessarily be on the formulary this year. It is important to be aware of these changes before committing to the same plan for the next calendar year.

The simplest way to find a drug plan that works best for you is to do what is called a “Plan Finder.” Plan Finder is a tool on www.Medicare.gov where you can input all the prescriptions you take, as well

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as the dosages, and the pharmacies where you prefer to go to. Once all of this information is in the system, you can see which plans offer the best coverage of your drugs. For instance, Plan Finder clearly identifies if any restrictions apply to your prescriptions, such as quantity limits (limit on the amount covered) prior authorization (doctor must get permission from plan to prescribe the medication), or step therapy (you must try a less expensive drug first).

Plan Finder allows you to find the Part D plan that is the most cost effective for you, with the best coverage and the least restrictions. You can access a Plan Finder by going on www.Medicare.gov or calling 800-Medicare and requesting one.

If you have a Medicare Advantage Plan, it is also important to confirm that it will still offer you the best coverage for the next calendar year. Review the Annual Notice of Change (ANOC) and/or Evidence of Coverage (EOC) for any changes in the plan's costs, benefits and rules for the upcoming year. Also, review the updated provider directory information sent by the plan to make sure that all of your doctors are still in-network Then call both the plan and the provider to confirm their network status. Plan networks typically shift from year to year, so don't assume your primary care provider or specialists will stay in the plan's network next year.

Again, even if you are happy with your current coverage, take advantage of Fall Open Enrollment to find the best plan for you. Once you have decided on a plan, call 800-Medicare and enroll directly with them. As always, keep records of every conversation you have with Medicare or plan representatives. You must make these changes between October 15 and December 7, and changes will be effective January1.

Guide to Medigaps

Medigap policies are supplemental health insurance policies sold by private insurance companies that work with Original Medicare. If a beneficiary has a Medigap policy, Original Medicare first pays its share of the cost for care and then the Medigap policy pays all or part of the remaining costs, including deductibles, coinsurances, and copayments. Beneficiaries should do their research prior to buying a Medigap policy. Some points to consider include:

A. Medigaps only work with Original Medicare. Beneficiaries must be enrolled in Medicare Part A and Part B in order to be eligible for Medigap coverage. Medigaps are guaranteed renewable, meaning that as long as the beneficiary pays the premium, he/she can keep the plan. If a beneficiary wants to enroll in a Medicare Advantage plan, then Medigaps do not apply to him/her.

B. Purchasing a Medigap policy at the best time. In New York State, insurance companies must sell Medicare beneficiaries a Medigap policy at any time, regardless of their age or health status. Medicare beneficiaries under the age of 65 have the same rights to buy a Medigap policy as beneficiaries 65 and older.

C. Comparing the ten different standardized policies. In New York State, Medigaps are community-rated, meaning that premiums are the same regardless of the beneficiary's age or health status. However, Medigaps premiums do vary by region in New York State. There are ten Standardized plans (A, B, C, D, F, G, K, L, M, N). Each lettered plan pays for a certain set of benefits; the benefits are the same no matter which insurance company sells the plan. Different insurance companies charge different premiums for the exact same plan, so it is important to shop around. The most popular policies are Medigaps Plans C and F because they cover key benefits but they cost more than other plans. Plans K and L may have lower monthly premiums, but only pay part of the cost of most Medicare coinsurances and deductibles.

D. Medigap coverage of prior medical conditions. Insurance policies may impose up to a six month waiting period before pre-existing conditions are covered. A pre-existing condition is considered a condition for which medical advice was given or treatment was recommended or received from a physician within six months before the effective date of Medigap coverage.

Under New York State regulation, the waiting period may either be reduced or waived entirely depending on the beneficiary's circumstances. Medigap insurers are required to reduce the waiting period by the number of days that the beneficiary was covered under "creditable" coverage so long as there were no breaks in coverage of more than 63 days. The following page lists examples of "creditable" types of coverage.

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Creditable types of coverage can include:

- Group health plan
- Health insurance coverage
- Medicare Advantage Plans
- Medicaid
- CHAMPUS and TRICARE
- A medical care program of the Indian Health Service or of a tribal organization
- A State health benefits risk pool
- Federal Employee Health Benefits Program
- A public health plan
- A health benefit plan issued under the Peace Corps Act
- Medigap, Medicare select coverage or Medicare Advantage plan

The New York Department of Financial Services maintains a list of Medigap policies. The Medicare Rights Center's information on Medigaps can be found here: http://medicarerights.org/fliers/Medigaps/Whole-Medigap-Packet-(NY).pdf

Dear Emily

Dear Emily,

Last year I helped my client apply for the Medicare Savings Program (MSP), which provided her with Full Extra Help. Previously she had applied directly for Extra Help and was receiving partial Extra Help. Since getting the MSP, she has had Full Extra Help. Is she going to have Extra Help next year? Her medications are very expensive, and she cannot afford her prescriptions without Extra Help.

Thanks,
Peg

Hi Peg,

As you know, the Low Income Subsidy (LIS), also known as Extra Help, provides assistance to Medicare beneficiaries with lower incomes. Extra Help assists with the payment of Medicare prescription drug plan premiums, copayments, and the annual deductible. People can qualify for Extra help in two ways. Individuals can apply directly for Extra Help. Individuals who apply directly for Extra Help will not need to reapply or recertify, unless the beneficiary gets a notice from Social Security Administration (SSA) saying that the person's income has changed. Other Medicare beneficiaries get their Extra Help by being automatically deemed eligible.

Dual eligible individuals, beneficiaries with the MSP, and those who receive Supplemental Security Income (SSI) are automatically approved for Full Extra Help benefits. The initial length of approval depends upon when the beneficiary is deemed eligible. For example, if a person is first deemed eligible before July 1, the Extra Help is initially granted through the end of the calendar year. On the other hand, if a person is deemed eligible for Full Extra Help from July through December, they will get approved for the rest of the entire calendar year, plus the entire next calendar year.

The Centers for Medicare and Medicaid Services (CMS) reviews deemed Extra Help recipients to decide if their benefit should be renewed. This process is known as re-deeming. If individuals still have the underlying benefit at any time after July 1, CMS will re-deem them eligible for the entire next calendar year. Therefore, as long as your client still has the Medicare Savings Program at some point during July through December 2015, then she should continue to have Extra Help for all of 2016 and will not receive a notice. Note that if she no longer qualifies for the MSP, but is enrolled in Medicaid or SSI, her deemed status will also continue. If her copay amount changes as a result, Medicare will send her an orange notice explaining this in early October.

If a beneficiary does not have the MSP (or Medicaid or SSI) in July or August 2015 he or she will lose deemed status for 2016 and receive a gray notice from CMS in September that includes an Extra Help application and encourages them to apply for Extra Help through SSA. Your client may receive this notice if her income has changed since applying for the MSP. Remember, individuals who receive gray notices are not necessarily ineligible for Extra Help. It is important to be mindful that beneficiaries with deemed Extra Help status through a Medicaid Spend Down, may receive conflicting information from CMS about their deemed status. If they failed to meet their spend down for July/August, CMS will automatically mail them the gray notice in September. However, as long as these beneficiaries meet their spend down at any time during the rest of the calendar year, they will retain deemed status for 2016. They should get a follow-up purple notice from CMS alerting them that they will keep deemed Extra Help for the upcoming year. Please feel free to contact the HIICAP helpline with any questions you may have at 800-480-2060 or hiicap@medicarerights.org.

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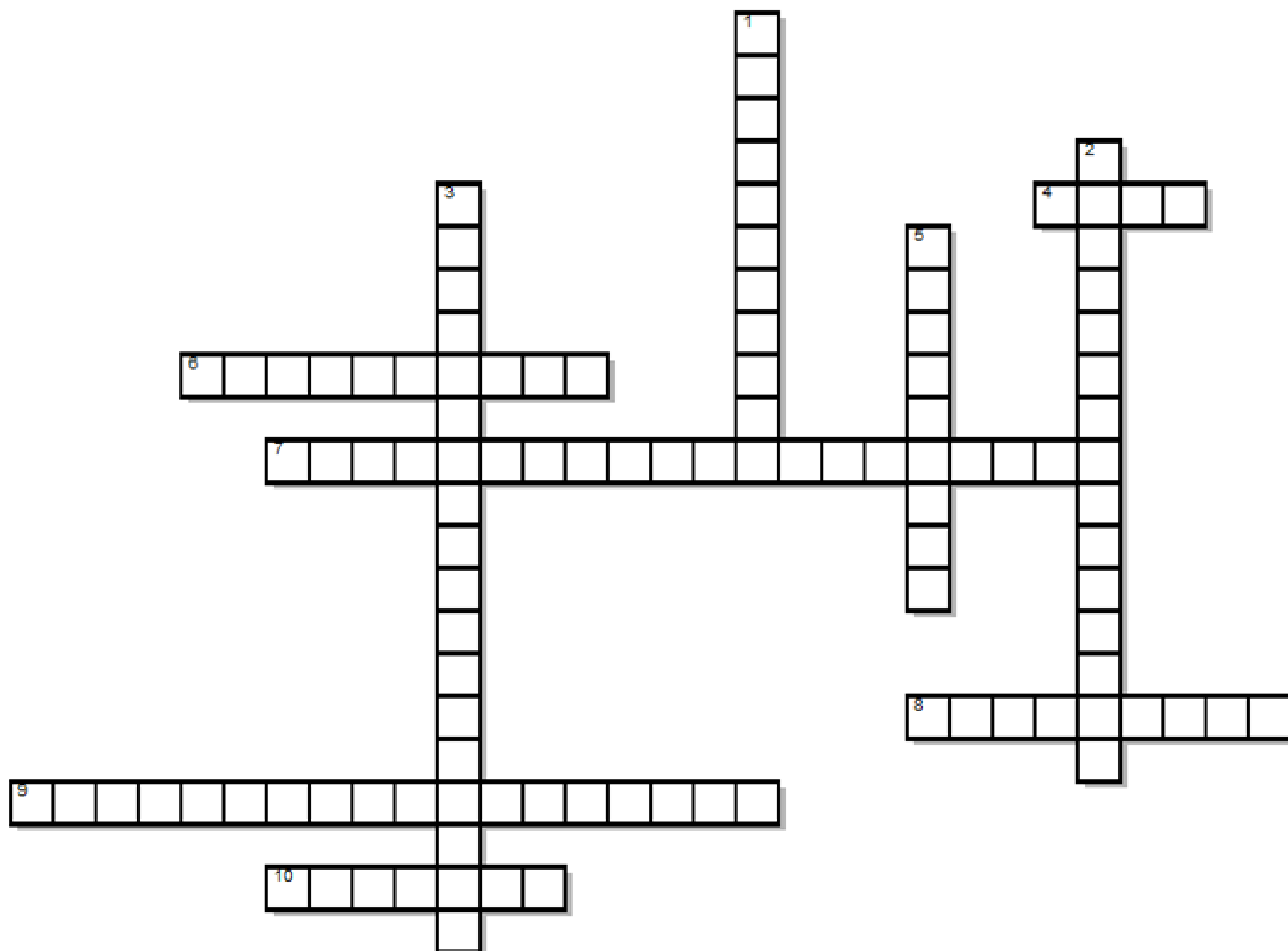
Medicare Crossword Puzzle



ACROSS

4 The month your Part B coverage would become effective if you enroll in Part B during the General Enrollment Period.

6 The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay

7 The notice you receive from your Medicare Advantage or Part D plan by September 30 that gives a summary of any changes in the plan's cost and coverage that will take effect January 1 of the next year.

8 The list of prescription drugs for which a Medicare prescription drug plan will help pay.

9 The annual period you can change your Medicare coverage for the upcoming plan year.

10 A supplemental insurance policy that is sold by private insurance companies to fill gaps in Medicare.

DOWN

1 The portion of the cost of care you are required to pay after your health insurance pays.

2 Rights that require insurance companies to sell or offer you a Medigap policy without health underwriting or pre-existing condition exclusions after you lose certain kinds of health insurance.

3 Health insurance coverage you had within 63 days of securing a new insurance policy that can be used to shorten the waiting period for pre-existing conditions.

5 A federal program administered by Social Security that helps people with Medicare who have low incomes and assets pay for their Medicare prescription drug coverage.

Answers

1. Coinsurance
2. Guaranteed Issue
3. Creditable Coverage
4. July
5. Extra Help
6. Deductible
7. Annual Notice of Change
8. Formulary
9. Fall Open Enrollment
10. Medigap

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