CALIFORNIA HEALTH ADVOCATES

Medicare Parts C & D: Highlights of 2013 Changes

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Our Focus

California Health Advocates
provides quality Medicare and related healthcare coverage information, education and policy advocacy.

www.cahealthadvocates.org

- **Policy** – Conduct public policy research to support recommendations for improving rights and protections for Medicare beneficiaries and their families
- **Training** – Provide timely and high-quality information on Medicare through our website, fact sheets, policy briefs and educational workshops
- **Advocacy** – Bring the experiences of Medicare beneficiaries to the public, and especially legislators and their staff at federal and state levels, through media and educational campaigns

Our Projects

- **Senior Medicare Patrol 1-855-613-7080**
  - *Empowering Seniors to Prevent Fraud*
- **Counseling Tools**
  - *Fact Sheets and Comparison Charts* (updated with 2013 info coming soon)
- **California Medicare Coalition**
  - *Provides a forum for all who serve Medicare beneficiaries to get updates on Medicare and to improve education and outreach*

Overview

- Stand-alone Medicare Part D plans in 2013
- Medicare Advantage (Part C) plans in 2013
- Changes in Medicare Advantage and Medicare Part D
- What's new for people with Extra Help
- Miscellaneous

Objectives

At the end of today's webinar, participants will be able to:

- Look up info about 2013 Medicare Part D and Medicare Advantage plans
- List options a beneficiary may have whose plan is not renewing or is consolidating
- Look up info for LIS and benchmark plans

Thumbnail sketch of Medicare

Original Medicare

Part A
Hospital Insurance

Part B
Outpatient Medical Services
Coinsurance=20%

Part C
Medicare Advantage Plans
Must have Parts A+B

MA-PD
MA-only

HMO
PPO
PFFS
SNP

Part D
Rx drug Plans
Must have Part A or B

Premium
Deductible≤$325
Cost-sharing

Initial coverage
Coverage gap
Catastrophic coverage

Annual Election Period (AEP)

- Technical term "Annual Coordinated Election Period," commonly called "Open Enrollment"
- New dates: Oct 15 – Dec 7
- Medicare Advantage (MA or Part C) and Part D plans only
  - Parts A and B – General Enrollment Period (Jan-Mar)
  - People with retiree health benefits

STAND-ALONE MEDICARE PART D PLANS IN 2013

CA PDP Landscape

(Please refer to "Medicare Part D Plans – Changes in CA from 2012-2013")

No. of plans available	32
Lowest premium is AARP MedicareRx Saver Plus (S5921-376)	$15.00
Highest premium is Humana Complete (S5884-060)	$118.60
No. of plans renewing *(6 plans consolidated under 2 plans)*	26
No. of plans with higher premiums	18
No. of plans with decreased premiums	8
No. of new plans	6

CA PDP Landscape *(cont.)*

No. of plans with $325 deductible	14
No. of plans $0<deductible<$325	3
No. of plans with $0 deductible	15
No. of plans with no coverage in gap	21
No. of plans with many/some/few coverage in gap	11
No. of benchmark plans	6
2012 benchmark → 2013 benchmark	4
New benchmark	2

Consolidated Plans
(Effective 01/01/2013)

2012 Plan Name	Premium	Consolidated Plan Name 2013	Premium
Community CCRx Basic	$48.90	SilverScript Basic	$30.60
CVS Caremark Value	$28.20		
Health Net Orange Option 1	$31.90		
Community CCRx Choice	$91.50	SilverScript Plus	$113.10
CVS Caremark Plus	$81.90		
Health Net Orange Option 2	$87.60		

Consolidated plans

- When 2 or more plans become 1
- Plans being consolidated are NOT non-renewal
  - Members received notice about consolidation with ANoC, mailed by Sep 30
  - Members can change plans during AEP
  - If member does nothing, “crosswalked” into the consolidated plan
  - Members do not have SEP or guaranteed issue rights

2012 Plans not renewing

Plan name	Contract-Plan ID	Premium
1. Blue Shield Medicare Premium	S2468-002	$108.20
2. BravoRx	S5998-013	$37.10
3. WellCare Signature	S5967-066	$55.40

Non-renewing plans

- Notice to members about non-renewal – plan must send by Oct 2
- Beneficiaries can make change during AEP or SEP
  - AEP dates: Oct 15 – Dec 7
    - Change made during AEP effective Jan 1
  - SEP dates: Dec 8 – last day of Feb
    - Change made during SEP effective 1st day of following month

Medicare Part D Costs 2013

(standard plan)

Out-of-pocket threshold (before reaching catastrophic coverage)	**$4,750** = ($325 + $661.25 + $3,763.75)		
	Drug costs	**Beneficiary pays (TrOOP)**	**Plan pays**
Before meeting deductible	0-$325	100% = $325	0%
Initial coverage	>$325-$2,970	25% = $661.25	75%
Coverage gap (doughnut hole)	>$2,970-$6,733.75	100% = $3,763.75 minus discounts	0%
Catastrophic coverage	>$6,733.75	Greater of 5% or $2.65/$6.60	95%

CGDP – 2013 coinsurance

	Brand name	Generic
Beneficiary coinsurance	47.5%	79%
Plan's liability (subsidy)	2.5%	21%
Plan's liability does not count toward TrOOP		
Discount from drug manufacturers who signed agreement	50%	n/a

Part D Coverage Gap – Shrinking
Brand name drug example (2013)

- Beneficiary in "donut hole"
- Price of brand name drug = $98
- Dispensing fee = $2
- 50% manufacture's discount applies to price of brand name drug, but not dispensing fee, thus $49
- Beneficiary's liability is 47.5% of price after manufacturer's discount + 47.5% of dispensing fee, thus $47.50

Part D Coverage Gap – Shrinking
Brand name drug example (2013) *cont.*

- Plan's liability = Price of drug + dispensing fee minus manufacturer's liability minus beneficiary liability
  - $100 - $49 - $47.50 = $3.50
- What counts toward TrOOP = manufacturer's liability + beneficiary's liability
  - $49 + $47.50 = $96.50
  - Plan's liability does not count toward TrOOP

Part D Coverage Gap – Shrinking
Generic drug example (2013)

- Beneficiary exceeds Initial Coverage Limit in her plan.
- Price of generic drug = $20
- Dispensing fee = $2
- 21% subsidy applies to price of generic drug AND dispensing fee.
- After subsidy, beneficiary pays $17.38.
- What beneficiary pays is counted toward TrOOP = $17.38.

MEDICARE ADVANTAGE (PART C) PLANS IN 2013

CA Landscape – MA plans

4 Types of MA plans	HMO, PPO, PFFS and SNP
HMO-PD (38 counties)	Premium range = $0-$182
	156 plans with $0 premium 6 plans with $182 premium
HMO-only (31 plans in 20 counties)	Premium range = $0 or $99
Health Net, Humana, UnitedHealthcare	17 plans with $0 premium 14 plans with $99 premium (all Health Net)

CA Landscape – MA plans

Local PPO-PD (13 plans in 11 counties: Fresno, LA, Orange, Riverside, Sacramento-2, San Diego-2, San Francisco, San Mateo, Sonoma, Tulare, Ventura)	Premium range = $0 to $203
Health Net, Anthem	1 plan at $0 2 plans at $203
PFFS-PD (70 plans in 25 counties)	Premium range = $0-$175
Universal American, UnitedHealthcare, Humana	5 plans at $0 6 plans at $175
PFFS-only (70 plans in 25 counties)	Premium range = $0-$125
Universal American, UnitedHealthcare, Humana	12 plans at $0 2 plans at $125

Special Needs Plans

	How many statewide?	In how many counties?	Which counties?
D-SNP	95	30	Alameda, Amador, CCC, El Dorado, Fresno, Kern, Kings, LA, Madera, Marin, Mariposa, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo, Yuba
C-SNP	53	9	**Alameda**, Kern, LA, Orange, Riverside, San Bernardino, **San Diego**, Santa Clara, Stanislaus
I-SNP	7	5	LA, Orange, Riverside, San Bernardino, Santa Clara

Beneficiaries affected by non-renewing plans in CA

	No. of beneficiaries
All plan types statewide	25,068
Local PPO (11 counties)	20,370
HMOs (11 counties)	4,698

Non-renewing plans

- Notice to members about non-renewal – plan must send by Oct 2
- Beneficiaries can make change during AEP or SEP
  - AEP dates: Oct 15 – Dec 7
    - Change made during AEP effective Jan 1
  - SEP dates: Dec 8 – last day of Feb
    - Change made during SEP effective 1st day of following month

What about Medigap?

- Does Melanie have guaranteed issue right to buy a Medigap?
- YES!
  - 2012 Choosing a Medigap Policy (CMS Product No. 02110)
  - CA law gives beneficiaries in a terminating MA plan a period of 123 days http://cahealthadvocates.org/medigap/other.html

Consolidated plans

- When 2 or more plans become 1
- Plans being consolidated are NOT non-renewal
  - Members received notice about consolidation with ANoC, mailed by Sep 30
  - Members can change plans during AEP
  - If member does nothing, “crosswalked” into the consolidated plan
  - Members do not have SEP or guaranteed issue rights

CHANGES IN MEDICARE ADVANTAGE AND MEDICARE PART D

Medicare Advantage – MOOP

- MOOP – Maximum out-of-pocket
- All local MA plans (HMO, local PPO and PFFS) must establish a MOOP liability amount inclusive of all Medicare Parts A and B services
  - Mandatory MOOP (see range next slide)
  - Voluntary MOOP – If plans choose to adopt lower MOOP, can have more flexibility in establishing cost-sharing amounts

MOOP Range Amounts

MA type	Voluntary	Mandatory
HMO	$0-$3,400	$3,401-$6,700
Local PPO	$0-$3,400 in-network	$3,401-$6,700 in-network
	$0-$5,100 in- and out-of-network	$3,401-$10,000 in- and out-of-network
PFFS	$0-$3,400	$3,401-$6,700

5-Star Overall Plan Rating

- Warning to plans that misuse rating in marketing
  - A plan rated 5-stars in a specific category cannot promote itself as a “5-star plan”
- 5-star SEP
  - Applies only when enrolling in a plan with 5-star overall rating

Low performing plans

- Rating of <3 stars for 3 consecutive years
- CMS may terminate contract
- Beneficiaries cannot enroll in a low performing plan online using Plan Finder
  - Must contact plan directly to enroll
- CMS notice to beneficiaries
  - Alert about plan's low rating
  - SEP to change to higher quality plan

Part D appeals process

- Prescribers allowed to request reconsideration on beneficiary's behalf
  - Independent Review Entity (IRE) review
  - No need to appoint prescriber as authorized representative
  - Prescriber to notify beneficiary about request for IRE review on his/her behalf
  - IRE to notify prescriber of its decision

Benzodiazepine and Barbiturates

- MIPPA expanded Part D coverage
  - Barbiturates -
    - Treatment of epilepsy, cancer or mental disorder
  - Benzodiazepines
- Conditions that apply to other Part D drug apply to benzodiazepines and barbiturates

Benzodiazepine and Barbiturates

- Dual eligible beneficiaries
  - May have copayments for these drugs in 2013
    - Currently, if drug covered by Medi-Cal, no copayments
  - May face prior authorization, step therapy and/or quantity limits in their Part D plan

Part D IRMAA for Higher Income Part D Enrollees – 2013

Income bracket (single)	Income bracket (file jointly)	IRMAA
≤$85,000	≤$170,000	n/a
>$85,000 but ≤ $107,000	>$170,000 but ≤ $214,000	$11.60
>$107,000 but ≤ $160,000	>$214,000 but ≤ $320,000	$29.90
>$160,000 but ≤ $214,000	>$320,000 but ≤ $428,000	$48.30
>$214,000	>$428,000	$66.60

WHAT'S NEW FOR PEOPLE WITH EXTRA HELP

Benchmark plans

CA benchmark amount $29.88 (2013)

2012	2013	
Aetna CVS/pharmacy Prescription Drug Plan	**Aetna CVS/pharmacy Prescription Drug Plan**	**$28.60**
EnvisionRxPlus Silver	**EnvisionRxPlus Silver**	**$29.10**
Humana Walmart-Preferred Rx	**Humana Walmart-Preferred Rx**	**$18.50**
CVS Caremark Value	**SilverScript Basic** *(de minimis waived)*	**$30.60**
Health Net Orange Option 1		
WellCare Classic	**SmartD Rx Saver** *(de minimis waived)*	**$31.40**
	AARP MedicareRx Saver Plus	**$15.00**

Low Income Subsidy

- Income limits for eligibility based on FPL not yet released for 2013 (numbers expected Jan 2013)
- Resource limits (numbers expected Jan 2013, CHA fact sheet E-003 will be updated)
- CA benchmark amount/LIS = $29.88
- National average premium = $31.17 (for LEP calculation)

Reassignment
(Reference CMS Prod. No. 11221-P)

Beneficiary's current plan (PDP or MA-PDP) is not renewing next year

- CMS reassigns all LIS beneficiaries into a different benchmark plan including
- Beneficiaries receiving partial LIS
- Beneficiaries who chose their plan ("choosers")

Reassignment (cont.)
(Reference CMS Prod. No. 11221-P)

Beneficiary's current plan will not be a benchmark plan next year	
CMS reassigns LIS beneficiary into a different benchmark plan if	CMS will not reassign if
Beneficiary was auto-enrolled or reassigned into current plan and	Beneficiary chose his/her plan ("chooser")
Beneficiary has full (100%) LIS	Beneficiary has partial LIS

MISCELLANEOUS

Mental health parity

	Beneficiary cost-sharing	Medicare pays
2010-2011	45%	55%
2012	40%	60%
2013	**35%**	**65%**
2014	20%	80%

Dates to remember

Sep 16-30	CMS mails *M&Y* 2013 handbook
Sep 30	Plans send ANOC/EoC
Oct 1	Marketing of MA and PD plans may begin
Oct 2	Beneficiaries of non-renewing plans must receive notice
Oct 11	plan ratings go ‘live’ on Medicare.gov
Oct 15	Plans must post PA and ST criteria on their websites
Oct 15-Dec 7	Annual Election Period (Open Enrollment)
Dec 8-Feb 28	SEP for beneficiaries in non-renewing plans
Dec 8-Nov 30	SEP for 5-star plans
Jan 1-Feb 14	MA Annual Disenrollment Period
Jan 1-Mar 31	General Enrollment Period (Medicare Parts A&B)

Resources

- Understanding Medicare Enrollment Periods (CMS Prod. No. 11219, revised Nov 2011)
- 2012 Choosing a Medigap Policy (CMS Product No. 02110)
- Guide to Consumer Mailings from CMS, Social Security, & Plans in 2012/2013
- Correcting LIS Status Based on BAE (CMS Prod. No. 11325-P, Jan 2012)
- Reassignment (CMS Prod. No. 11221-P, Aug 2012)
- Changes in qualifying for Extra Help (CMS Prod. No. 11232-P, Aug 2012)

Contact Information

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  Health Insurance Counseling & Advocacy Program

  Medicare benefits counseling program