

CLOSING THE Prescription Drug Coverage Gap

Most Medicare prescription drug plans (Part D) have a temporary limit on their coverage of prescription drugs. This “coverage gap” or “doughnut hole” is reached after you and your drug plan have spent a certain amount of money for covered drugs. While in the gap you have to pay the full costs of your prescription drugs (up to a limit of \$4,550 in out-of-pocket costs in 2011). Every month that you fill a prescription, your drug plan mails you an Explanation of Benefits (EOB) notice, which tells you how much you have spent on covered drugs and if you’ve reached the gap.

The good news is that the Affordable Care Act, passed by Congress and signed by the President in 2010, includes benefits to help close that gap and make your Medicare prescriptions more affordable. Starting January 1, 2011, if you reach the coverage gap, you will get a 50% discount on covered brand-name drugs when you buy them at a pharmacy or order them through the mail and you will get some help for generic drugs. You can expect additional savings on your brand-name and generic drugs during the gap over the next few years until it’s closed in 2020.

How does the 50% coverage gap discount work for brand-name drugs?

Companies that make brand-name prescription drugs must sign agreements with Medicare to participate in the Medicare Coverage Gap Discount Program. This program requires the companies to offer discounts on brand-name drugs to people who have reached the coverage gap. Once you’ve reached the gap, you will automatically get a 50% discount on your brand-name prescription drugs at the time you buy them. With this discount, you will only pay 50% of the price for the brand-name drug, but, the entire price (including the 50% discount the drug company pays) will count toward the amount you need to get out of the gap and qualify for catastrophic coverage. Once you reach catastrophic coverage, you only pay a small coinsurance or copayment for the

rest of the year. You will still need to pay any dispensing fee (cost to fill a prescription) for your prescription. The dispensing fee isn’t discounted. It is added to the discounted amount of your prescription.

How is coverage for generic drugs changing in the coverage gap?

In 2011, Medicare will pay 7% of the price for generic drugs during the coverage gap. You will pay the remaining 93% of that price. What you pay for generic drugs during the gap will decrease each year until it reaches 25% in 2020. The coverage for generic drugs works differently than the 50% discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

What happens if I fill a prescription and only part of the amount is in the coverage gap?

The 50% discount will only apply to the portion of your claim that’s in the coverage gap. For example, if you fill a prescription that costs \$100, and only \$50 of that cost is in the coverage gap, the discount will only apply to that \$50. In this case, you would pay your normal copayment on the \$50 portion of the prescription that’s not in the coverage gap, plus \$25 (50% of the \$50 portion that’s in the coverage gap).

What if I don’t get a discount, and I think I should have?

If you think that you have reached the coverage gap and you don’t get a discount when you pay for your brand-name prescription, you should review your next Explanation of Benefits (EOB) notice. If the discount doesn’t appear on the EOB, you should work with your drug plan to make sure that your prescription records are correct and up-to-date. If your drug plan doesn’t agree that you are owed a discount, you can appeal by calling 1-800-MEDICARE (1-800-633-4227).

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Questions?

Call the Senior Health Insurance Counseling Program (SHIP) at LIFE Senior Services sponsored by the Oklahoma Insurance Department. The SHIP Program may be reached at (918) 664-9000 or toll-free at (866) 664-9009.



LIFE’s Vintage NEWSMAGAZINE Health Care REFORM



WHY IT’S Good News FOR YOU

If you’re like millions of Medicare beneficiaries, you’re not sure how health reform will affect you and your current coverage through Medicare. Although full implementation of the new law will continue for several years, more than a dozen key provisions have already taken effect, including some which will affect Medicare beneficiaries.

First and foremost, it’s important to know that the new legislation will not cut any benefits provided under traditional Medicare – and it will even improve some benefits. These benefit improvements include:

More Help with Prescription Drug Costs:

- If you are someone who falls into the Medicare prescription drug “doughnut hole” or coverage gap – provisions of the new health reform will help.
- The plan provided a one-time \$250 payment to individuals who reached the coverage gap.
- Drug company discounts on brand-name drugs and federal subsidies and discounts for all drugs will gradually reduce the gap, eliminating it by 2020. That means that individuals, who now pay 100 percent of their drug costs once they reach the doughnut hole, will ultimately pay 25 percent.
- And, as under current law, once your out-of-pocket drug costs reach the “catastrophic” level of coverage, you will pay only 5 percent of the cost of your medications for the rest of the year.

Better Preventive Care:

Many health analysts believe that regular check-ups and preventive care help improve the overall health of older people and provide for a better quality of life. Provisions of the new legislation will help in this area also.

- Currently, Medicare pays for a general check-up when someone first enters the program but starting in 2011, the legislation provides for a new, free annual wellness visit.
- You will no longer pay any out-of-pocket costs for most preventive benefits under Medicare such as screenings for cancer and diabetes.

Reduce Medicare spending growth:

- Over the years, Medicare spending will continue to grow, but at a slightly slower rate (6% per year, instead of 6.6%). The plan is expected to save Medicare about \$475 billion over 10 years and is expected to extend the solvency of the Medicare Trust Fund for an additional 11 years. Specifically, it will:
 - Slow the rate of payment increases to Medicare providers, including hospitals, nursing homes, and home health agencies. Doctors will not be affected. Many providers – whose profits will increase with newly insured patients – have agreed to these new payments.
 - Reduce payments to Medicare Advantage (MA) plans. About 75% of seniors are enrolled in traditional Medicare; the rest are enrolled in private MA insurance plans. Many of these MA providers offer extra benefits like eyeglasses or hearing aids ... extras which may be reduced as Medicare Advantage subsidies are brought more in line with the cost of traditional Medicare benefits. However, MA plans will not be allowed to eliminate any guaranteed benefits.
 - The legislation also provides more money to fight Medicare fraud via an independent payment advisory board. This board will make recommendations on how to save money in Medicare and extend the financial solvency of the program.

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EXPANDED Preventive Benefits

Key provisions from the Affordable Care Act expand preventive benefits for Medicare beneficiaries by ensuring that most preventive services will be free effective in 2011. These provisions include:

Elimination of Deductible and Coinsurance for Most Preventive Services:

As of January 1, 2011, the Affordable Care Act waives the Part B deductible and the coinsurance that would otherwise apply to most preventive services. This means that Medicare will pay 100 percent for most Medicare-covered preventive benefits; you won't pay anything.

Following are the preventive services for which you will still have to pay a coinsurance. (The coinsurance is usually 20 percent of the Medicare-approved amount.) You will also have to pay any remaining portion of your Part B deductible for these services.

- Glaucoma screening,
- Prostate cancer screening,
- Diabetes self-management training services,
- EKG screening, and
- Certain alternative tests under the colorectal screening. (NOTE: The Affordable Care Act waives the Part B deductible for tests that begin as colorectal cancer screening tests but, based on findings during the test, become diagnostic or therapeutic services.)

Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan:

The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time only initial preventive physical examination (IPPE or the "Welcome to Medicare" Examination), to provide coverage for annual wellness visits. As of January 1, 2011, Medicare will cover this Annual Wellness visit, every 12 months, starting a year (12 months) after you get your initial "Welcome to Medicare" physical exam. Even if you never had a Welcome to Medicare exam, you can now get your free Annual Wellness visit, each year. This is the first time Medicare will cover an annual exam, and there is no cost-sharing (coinsurance or deductible) for this service.

During the visit, you and your health care provider will develop a personalized prevention plan, building off of the initial exam. You should note that there are slight distinctions between the first wellness visit and subsequent such visits.

The initial Annual Wellness visit includes:

- routine measurements such as height, weight, blood pressure, body-mass index (or waist circumference, if appropriate);
- review of medical and family history;
- establishing a list of current providers, suppliers, and medications (including supplements);
- a personal risk assessment (including any mental health conditions);
- a review of functional ability and level of safety;
- detection of any cognitive impairment;
- screening for depression;
- establishing a schedule for Medicare's screening and preventive services you qualify for over the next 5 to 10 years; and,
- any other advice or referral services that may help intervene and treat potential health risks.

The subsequent wellness visits include:

- measurement of weight, blood pressure, and other measurements deemed appropriate (note: height and body-mass index not necessary, unless you have had significant weight change);
- an update to medical and family history;
- an update to the list of providers, suppliers, and medications (including supplements);
- a review of the initial personal risk assessment;
- detection of any cognitive impairment;
- an updated screening schedule; and,
- a review and update to list of referral services to help intervene and treat potential health risks.

HOW IT WILL CHANGE THE Medicare Advantage PROGRAM

The 2010 health reform law is designed to strengthen Medicare for its beneficiaries, extend the solvency of the Medicare program, and begin to change the health care system to one that delivers better access to care, improved quality, and greater efficiency. However, many Medicare beneficiaries in Medicare Advantage plans worry that these changes will result in a decline in their benefits and a harmful reduction in provider payments. Some even worry that Medicare Advantage health plans are being eliminated from the Medicare program. Instead, the new law will change the way the government reimburses insurance companies that offer Medicare Advantage health plans to beneficiaries. What will be gradually reduced are excess payments to Medicare Advantage plans. What won't change is that everyone will continue to be guaranteed that "Medicare's basic benefits cannot and will not be cut," says Secretary of Health and Human Services, Kathleen Sebelius.

Why changes are being made to the Medicare Advantage program:

Historically, Congress has enacted a number of changes that affect the role of private plans under Medicare, including adding new types of plans to the program, both increasing and decreasing Medicare payments to plans and tightening the rules governing the marketing of plans. The health reform law changes to the Medicare Advantage program are driven largely by concerns about the current payment system and its effect on Medicare spending which has paid insurers who offer these plans, on average, 13% more to provide care than it costs for people in traditional Medicare.

What the changes mean:

Health care reform will pay the private insurers less, meaning that companies offering Medicare Advantage plans may respond to payment changes in different ways, depending on the circumstances of the company, the location of their plans,

their historical commitment to the Medicare market, and their ability to leverage efficiencies in the delivery of care to members. For example, some may curtail extra benefits they offer such as routine vision care and health club memberships. Analysts believe plans will try to minimize the impact on members by adding or subtracting benefits slowly as payments are gradually reduced over several years, with the largest not beginning until 2015.

What else can we expect to see:

- The law offers bonuses to efficiently run Medicare Advantage plans. Beginning in 2012 high-quality plans with excellent track records that earn four or five stars from Medicare's rating system will receive bonus payments for their performance.
- The law will prohibit Medicare Advantage plans from imposing higher cost-sharing (copayment) requirements for some Medicare covered benefits (including chemotherapy, dialysis services, and skilled nursing care) than those charged under Original Medicare.
- The law will ensure that Medicare Advantage plans spend at least 85% of revenue on medical costs or activities that improve quality of care, rather than profit and overhead. This means making sure that the right patient gets the right treatment at the right time in the most efficient way possible.
- People enrolled in a Medicare Advantage plan as of January 1 will be allowed 45 days after the beginning of the calendar year to disenroll from the plan and return to traditional Medicare; they will not be allowed to switch from one Medicare Advantage plan to another during this time period.

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Questions?

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