

Session Objectives

- This session should help you to
 - Differentiate between Medicare Part A, Part B, and Part D drug coverage
 - Summarize Part D eligibility and enrollment requirements
 - Compare and choose drug plans
 - Describe Extra Help with drug plan costs
 - Explain Medicare Advantage plans
 - Understand Plan marketing rules

Medicare Prescription Drug Coverage



- Prescription drug coverage under Part A, Part B, or Part D depends on
 - Medical necessity
 - Health care setting
 - Medical indication (why you need it, like for cancer)
 - Any special drug coverage requirements
 - Such as immunosuppressive drugs following a transplant

Part A Prescription Drug Coverage

- Part A generally pays for all drugs during a covered inpatient stay
 - Received as part of treatment in a hospital or skilled nursing facility, (SNF)
- Drugs used in hospice care for symptom control and pain relief only

Part B Prescription Drug Coverage

- Part B covers limited outpatient drugs
 - Most injectable and infusible drugs given as part of a doctor's service
 - Drugs and biologicals
 - Used for the treatment of End-Stage Renal Disease (ESRD)
 - Drugs used at home with some types of Part B-covered durable medical equipment (DME)
 - Such as nebulizers and infusion pumps
 - Some oral drugs with special coverage requirements like
 - Certain oral anti-cancer and antiemetic drugs
 - Immunosuppressive drugs, under certain circumstances

Part B Immunization Coverage

- Part B covers certain immunizations as part of Medicare-covered preventive services
 - Flu shot (once per flu season)
 - Pneumococcal shot (to prevent pneumonia)
 - Covers a second pneumonia shot
 - Hepatitis B shot
- Part B may cover certain vaccines after exposure to a disease or after an injury
 - Tetanus shot

NOTE: the shingles vaccine must be covered by all Part D plans

Part D Medicare Prescription Drug Coverage

- Medicare prescription drug plans (PDP) in Illinois
 - There are 25 PDP plans total
 - There are 9 Basic Benchmark PDP plans
 - Benchmark plans have zero premium for people with full Extra Help for Part D
 - There are 57 Medicare Advantage plans with Prescription Drug coverage, (MA-PD) - available in certain zip codes in Illinois
 - There are 10 Special Needs Plans (SNP)

Pages 156 – 161 in the Medicare & You 2016 Handbook

Medicare Drug Plans



- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
 - Different tier and/or copayment levels
 - Deductible
 - Coverage for drugs not typically covered by Part D
- Benefits and costs may change each year

Medicare Drug Plan Costs

- In 2016, most people will pay
 - A monthly premium
 - National average premium = \$34.10
 - A yearly deductible (if applicable) \$360 or less
 - Copayments or coinsurance
 - 45% for covered brand-name drugs in the coverage gap
 - 58% for covered generic drugs in the coverage gap
 - Very little after spending \$4,850 out of pocket

Improved Coverage in the Coverage Gap

Gap will be closed in 4 years!

Year	What You Pay for Covered Brand-Name Drugs in the Coverage Gap	What You Pay for Covered Generic Drugs in the Coverage Gap
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Standard Structure in 2016

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1, 2016. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
<p>Ms. Smith pays the first \$360 of her drug costs before her plan starts to pay its share.</p>	<p>Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches \$3,310.</p>	<p>Once Ms. Smith and her plan have spent \$3,310 for covered drugs, she's in the coverage gap. In 2016, she pays 45% of the plan's cost for her covered <u>brand-name</u> prescription drugs and 58% of the plan's cost for covered <u>generic</u> drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.</p>	<p>Once Ms. Smith has spent \$4,850 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.</p>

True Out-of-Pocket (TrOOP) Costs

- TrOOP = Expenses that count toward your out-of-pocket threshold (**\$4,850** in **2016**)
- After threshold you get catastrophic coverage
 - You pay only small copayment or coinsurance for covered drugs
- Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if you switch plans mid-year

Part D Monthly Premium and Income-Related Monthly Adjustment Amounts (IRMAA)

- Based on income above a certain limit
 - Fewer than 5% pay a higher premium
 - Uses same thresholds used to compute IRMAA for the Part B premium
 - Income as reported on your IRS tax return from 2 years ago
- Required to pay if you have Part D coverage
 - Failure to pay will result in disenrollment

Income-Related Monthly Adjustment Amount (IRMAA)

Your Yearly Income in 2014 Filing an Individual Tax Return	Your Yearly Income in 2014 Filing a Joint Tax Return	In 2016 You Pay Monthly
\$85,000 or less	\$170,000 or less	Your Plan Premium (YPP)
Above \$85,000 Up to \$107,000	Above \$170,000 Up to \$214,000	YPP + \$12.70*
Above \$107,000 Up to \$160,000	Above \$214,000 Up to \$320,000	YPP + \$32.80*
Above \$160,000 Up to \$214,000	Above \$320,000 Up to \$428,000	YPP + \$52.80*
Above \$214,000	Above \$428,000	YPP + \$72.90*

* *IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.*

Part D Covered Drugs



- Prescription brand-name and generic drugs
 - Approved by the U.S. Food and Drug Administration
 - Used and sold in United States
 - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
 - And supplies associated with injection of insulin
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan

Required Coverage



- All drugs in 6 protected categories
 1. Cancer medications
 2. HIV/AIDS treatments
 3. Antidepressants
 4. Antipsychotic medications
 5. Anticonvulsive treatments
 6. Immunosuppressants
- All commercially available vaccines
 - Except those covered under Part B (e.g., flu shot)

Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs

Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

Tier Structure Example

Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand name
3	High copayment	Non-preferred, brand name
4 or Specialty	Highest copayment or coinsurance	Unique, very high cost

Tiers are listed on the Medicare.gov plan finder

Formulary Changes

- Plans may only change categories and classes at the beginning of each plan year
 - May make maintenance changes during year (after March 1)
 - Such as replacing brand-name drug with new generic
- Plan usually must notify you 60 days before changes
 - You will be able to use drug until end of calendar year if taking the drug before the change occurs
- Plans may remove drugs withdrawn from the market by the FDA or the manufacturer without a 60-day notification
- The Medicare.gov plan finder notes if all listed drugs are on the formulary for each plan (must enter drugs first)

How Plans Manage Access to Drugs

Prior Authorization	<ul style="list-style-type: none">▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered
Step Therapy	<ul style="list-style-type: none">▪ Must first try similar, less expensive drug▪ Doctor may request an exception if<ul style="list-style-type: none">• Similar, less expensive drug didn't work, or• Step therapy drug is medically necessary
Quantity Limits	<ul style="list-style-type: none">▪ Plan may limit drug quantities over a period of time for safety and/or cost▪ Doctor may request an exception if additional amount is medically necessary

Watch for these provisions on the Medicare.gov plan finder

If Your Prescription Changes



- Get up-to-date formulary information from your plan's
 - Website
 - Customer service center
- Give your doctor a copy of plan's formulary
- If the new drug isn't on the plan's formulary
 - Can request an exemption from the plan
 - May have to pay full price if plan still won't cover

Medication Therapy Management



- A pharmacist or other health professional does a comprehensive review of all your medications and talks with you about
 - How to get the most benefits from the drugs you take
 - Any concerns you have, like medication costs and drug reactions
 - How best to take your medications
 - Any questions or problems you have about your prescription and over-the-counter medication
- Your drug plan may enroll you if you meet all of these conditions:
 1. You have more than one chronic health condition
 2. You take several different medications
 3. Your medications have a combined cost of more than **\$3,507** per year

Part D Eligibility Requirements



- You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan
- You must have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
- You must live in the plan's service area
 - You can't be incarcerated
 - You can't be unlawfully present in the U.S.
 - You can't live outside the United States
- You must join a plan to get drug coverage

Creditable Drug Coverage

- Current or past prescription drug coverage
 - For example, employer group health plans, retiree plans, Veterans Affairs, TRICARE, the Indian Health Service, and the Federal Employee Health Benefits Program (notice must be out by November 15)
- If it pays, on average, as much as Medicare's standard drug coverage, its creditable
- Plans inform yearly about whether creditable
- With creditable coverage you may not have to pay a late enrollment penalty

Initial Enrollment Period (IEP)

- When you first become eligible to get Medicare
 - 7-month IEP for Part D

If You Join	Coverage Begins
During the 3 months <u>before</u> you turn 65	Date eligible for Medicare
During the month you turn 65	First day of the following month
During the 3 months <u>after</u> you turn 65	First day of the month after month you apply

When You Can Join or Switch Plans



- Medicare's Open Enrollment Period is **October 15–December 7 each year**, coverage starts **January 1**
 - Compare your current drug plan with all 2016 plans
 - May switch to different drug plan, or switch to MA-PD plan or vice versa
- MA Disenrollment period January 1–February 14 each year is available if you need to leave a MA-PA plan and switch to Original Medicare and join a Part D plan

Special Enrollment Period (SEP)



- Life events that allow an SEP include
 - You permanently move out of your plan's service area
 - You lose other creditable prescription coverage
 - You weren't properly told that your other coverage wasn't creditable, or your other coverage was reduced and is no longer creditable
 - You enter, live in, or leave a long-term care facility
 - You have a continuous SEP if you qualify for Extra Help
 - You join or switch to a plan that has a 5-star rating
 - Other exceptional circumstances



5-Star Special Enrollment Period (SEP)

- Use Medicare Plan Finder tool at Medicare.gov to see quality and performance ratings
- Star ratings are given once a year, assigned in October of the past year
- Use 5-star SEP to switch to any 5-star plan one time
 - December 8–November 30 of following year
 - Coverage starts first day of month after enrolled
 - Be careful not to switch from a Medicare Advantage (MA) Plan with drug coverage to an MA Plan with **no** Part D coverage

<input type="checkbox"/> MedicareBlue Rx Value Plus (PDP) (S5743-007-0) ☆ ←					
Organization: MedicareBlue Rx					
Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles:[?] and Drug Copay[?] / Coinsurance:[?]	Drug Coverage [?], Drug Restrictions[?] and Other Programs:	Overall Star Rating:[?]	
Retail Annual: \$1,546 Mail Order Annual: N/A	\$31.80	Annual Drug Deductible: \$160 Drug Copay/ Coinsurance: \$0 - \$35, 29% - 50%	All Your Drugs on Formulary: No Drug Restrictions: No Lower Your Drug Costs MTM Program[?]: Yes	☆ ← This plan got Medicare's highest rating (5 stars)	<input type="button" value="Enroll"/>

Low Performing Plan

- Low performing star rating status
 - You may have a one-time option to switch to another Medicare drug plan with a rating of 3, 4, or 5 stars if your plan's summary rating was less than 3 stars for the last 3 years
 - Low Performance Icon (LPI) appears on Plan Finder 
 - Plans may not attempt to discredit their LPI status by showcasing a separate higher rating
- CMS sends out LPI notices to plan members in October and February

Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
 - Exceptions if you have
 - Creditable coverage
 - Extra Help or Low Income Subsidy (LIS)
- Pay penalty for as long as you have coverage
 - 1% of base beneficiary premium (**\$34.10** in **2016**)
 - For each full month eligible and not enrolled
 - Amount is recalculated every year from the new base premium amount

Part D Penalty Example

Ann didn't join when she was first eligible—by June 2013, and she had no drug coverage from any other source. She joined a Medicare drug plan during the 2015 Open Enrollment Period. Her coverage began on January 1, 2016. She was without creditable prescription drug coverage from July 2013–December 2015 which is 30 months; meaning a 30% penalty.

Here's the math:

.30 (30% penalty) × \$34.10 (2016 base beneficiary premium) = \$10.23

\$10.23 (rounded to the nearest \$0.10) = \$10.20

\$10.20 = Ann's monthly late enrollment penalty for 2016

NOTE: Penalty lasts for as long as she takes Medicare Part D

What Is Extra Help?

- Program to help people pay for Medicare prescription drug costs
 - Also called the Low-income Subsidy (LIS)
- For people with limited income and resources
 - Lowest income and resources
 - Pay no premiums or deductible and small or no copayments
 - Slightly higher income and resources
 - Pay a reduced deductible and a little more out of pocket
- No coverage gap if you qualify
- No late enrollment penalty if you qualify
- Continuous Special Enrollment Period

2015 Extra Help

Income and Resource Limits

- Income limits
 - Below 150% of the federal poverty level
 - \$1,471.25 per month for an individual or \$1,991.25 per month for a family size of 2
 - Based on family size
- Resources limits
 - Up to \$13,640 for an individual, or \$27,250 for a married couple
 - Includes \$1,500/person for funeral or burial expenses
 - Counts savings and investments
 - Real estate (except your home)

Qualifying for Extra Help

- You automatically qualify for Extra Help if you get
 - Full Medicaid coverage
 - Supplemental Security Income
 - Help from Medicaid paying your Part B premium (Medicare Savings Program such as QMB, SLIB, and QI1)
 - If you meet Medicaid 'spend down' one time during the year
- All others must apply
 - Online at socialsecurity.gov/medicare/prescriptionhelp/
 - SHIP counselors can do Extra Help application
 - Call Social Security (SSA) at 1-800-772-1213 (TTY 1-800-325-0778)
 - Ask for "Application for Help With Medicare Prescription Drug Plan Costs" (SSA-1020)

Automatic and Facilitated Enrollment

People With Medicare and...	Basis for Qualifying	Data Source	Enrollment
Full Medicaid benefits	Automatically qualify	State Medicaid agency	<p>Automatic enrollment in Part D drug plan (unless already in a drug plan)</p> <ul style="list-style-type: none"> ▪ Letter on YELLOW paper ▪ Coverage starts first month eligible for Medicare and Medicaid ▪ Continuous Special Enrollment Period (SEP)
Medicare Savings Program	Automatically qualify	State Medicaid agency	<p>Facilitated enrollment in Part D drug plan</p> <ul style="list-style-type: none"> ▪ Letter on GREEN paper ▪ Coverage starts 2 months after CMS receives notice of your eligibility ▪ Continuous SEP
Supplemental Security Income benefits	Automatically qualify	Social Security (SSA)	
Limited income and resources	Must apply and qualify	SSA (most) or state Medicaid agency	

2016 Extra Help Copayments

Institutionalized	\$0
Receiving Home and Community-Based Services – such as community care services	\$0
Up to or at 100% Federal Poverty Level (FPL)	\$1.20/\$3.60
Full Extra Help – up to 135% FPL	\$2.95/\$7.40
Partial Extra Help (Deductible/Cost-Sharing)	\$74 Deductible & 15% coinsurance

(Generic/Brand Name)

Extra Help Benchmark Plans

Benchmark = zero premium with full Extra Help

- There are 9 benchmark plans in Illinois
- These plan premium are in **blue ink** in the Medicare & You handbook
- The Plan finder will calculate the plan premiums and copays at the Extra Help rate for you when you use a personal search.
- If a beneficiary enrolls in a plan that has an above benchmark premium, they will have to pay the difference.
- The copays for drugs are the same regardless of the plan chosen.

Changes in Qualifying for Extra Help



- Medicare reestablishes eligibility each fall for next year
 - If you no longer automatically qualify
 - Medicare sends “Loss-of-Deemed-Status” notice in September (GRAY paper)
 - Includes Social Security application to reapply
 - If your status changes and you again automatically qualify
 - Medicare sends “Deemed Status” notice (PURPLE paper)
 - If you automatically qualify, but your copayment changed
 - Medicare sends “Change in Extra Help Co-payment” notice in early October (ORANGE paper)

Redetermination Process

- People who applied and qualified for Extra Help
 - Four types of redetermination processes
 1. Initial
 2. Cyclical or recurring
 3. Subsidy-changing event (SCE)
 4. Other event (change other than SCE)

Reassignment Notices



- People reassigned notified by CMS early November (BLUE paper)
 - Three versions of notice
 - People whose plans are leaving Medicare program
 - CMS product No. 11208 (MA-PD)
 - CMS product No. 11443 (MA)
 - People whose premiums are increasing
 - CMS product No. 11209

Types of Medicare Advantage Plans



- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan
- Private Fee-for-Service
- Medicare Medical Savings Account

Medicare Health Maintenance Organization (HMO) Plan

Can you get your health care from any doctor or hospital?	No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out of network for certain services, usually for a higher cost. This is called an HMO with a point-of-service option.
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO Plan that offers prescription drug coverage.
Do you need to choose a primary care doctor?	In most cases, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
What else do you need to know about this type of plan?	<ul style="list-style-type: none">▪ If your doctor or other health care provider leaves the plan, your plan will notify you and you can choose another plan doctor.▪ If you get health care outside the plan's network, you may have to pay the full cost.▪ It's important that you follow the plan rules. For example, the plan may require prior approval for certain services.

Medicare Preferred Provider Organization (PPO) Plan

Can you get your health care from any doctor or hospital?	In most cases, yes. PPOs have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
Are prescription drugs covered?	In most cases, yes. If you want Medicare drug coverage, you must join a PPO Plan that offers prescription drug coverage. You may contact individual plans to find out if they offer prescription drug coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	In most cases, no.
What else do you need to know about this type of plan?	<ul style="list-style-type: none">▪ PPO Plans aren't the same as Original Medicare or Medigap.▪ Medicare PPO Plans usually offer extra benefits than Original Medicare, but you may have to pay extra for these benefits.

Medicare Private Fee-for-Service (PFFS) Plan

Can you get your health care from any doctor or hospital?	In some cases, yes. You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more.
Are prescription drugs covered?	If PFFS plan offers drug coverage you must take it through the plan. In Illinois only one PFFS Plan doesn't offer drug coverage; you can join a stand alone Medicare Prescription Drug Plan (Part D) to add to this plan only .
Do you need to choose a primary care doctor or specialist?	No.

Medicare Private Fee-for-Service (PFFS) Plan (Continued)

What else do you need to know about this type of plan?

- PFFS Plans aren't the same as Original Medicare or Medigap
- The plan decides how much you must pay for services
- Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before
- Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before
- For each service you get, make sure that your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms
- In an emergency, doctors, hospitals, and other providers must treat you

Medicare Special Needs Plans (SNPs)

Can you get your health care from any doctor or hospital?	You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage (Part D).
Do you need to choose a primary care doctor?	Generally, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

SNPs are listed on Medicare.gov plan finder under 'refine your search' option

Medicare Special Needs Plans (SNPs) Continued

What else do you need to know about this type of plan?

- A plan must limit plan membership to people in one of the following groups:
 1. Those living in certain institutions (like a nursing home), or who require nursing care at home
 2. Those eligible for both Medicare and Medicaid
 3. Those with specific chronic or disabling conditions
- Plan may further limit membership
- Plan should coordinate your needed services and providers
- Plan should make sure providers that you use accept Medicaid if you have Medicare and Medicaid
- Plan should make sure that plan's providers serve people where you live, if you live in an institution

Marketing Reminders

- Marketing for 2016
 - May not occur before October 1
- Marketing star ratings in materials
 - Individual measures may be marketed
 - Communicated in conjunction with overall performance rating
 - Low-performing star rating status
 - Low Performance Icon (LPI) 
 - Plans may not attempt to discredit their LPI status by showcasing a separate higher rating

Nominal Gift Reminders

- Nominal gifts
 - Organizations can offer gifts to potential enrollees
 - Must be of nominal value
 - Defined in Medicare Marketing Guidelines
 - Currently \$15 or less based on retail value
 - Given regardless of beneficiary enrollment
 - May not be in the form of cash or other monetary rebates

Unsolicited Beneficiary Contact

- Prohibited Unsolicited Marketing Activities for Part D and MA Plans
 - Electronic communications
 - Unless express permission is given
 - Door-to-door solicitation
 - Calls/visits after attending sales event
 - Unless express permission given
 - Common areas

NOTE: This does not apply to Medicare supplement policies

Cross-Selling Prohibition

- Cross-selling
 - Prohibited during any Medicare Advantage or Part D sales activity or presentation
 - Can't market non-health related products
 - Annuities
 - Life insurance
 - Other products
 - Allowed on inbound calls per beneficiaries' request

Scope of Appointment Reminders



- Scope of Appointment
 - Must specify product type
 - Medicare Advantage, Medicare Prescription Drug Plans, Medigap, or other
 - 48 hours prior to marketing and/or in-home appointment
 - Additional products can only be discussed
 - Upon beneficiary request
 - At separate appointment

Marketing in Health Care Settings



- Marketing allowed in health care common areas
 - Hospital or nursing home cafeterias
 - Community or recreational rooms
 - Conference rooms
- No marketing in health care settings where patients intend to receive care
 - Waiting rooms
 - Exam rooms and hospital patient rooms
 - Dialysis centers and pharmacy counter areas

Educational Event Reminders



- Educational events for prospective members
 - No marketing activities at educational events
 - Plans may distribute
 - Medicare and/or health educational materials
 - Agent/broker business cards
 - Distributed material must not contain marketing information

Rewards and Incentives

NEW!

- Regulation 4159-F expands rewards and incentive programs
- Applies to Medicare Advantage Organizations
- Focus on encouraging participation in activities that promote
 - Improved health
 - Prevention of injuries and illness
 - Efficient use of health care resources

Licensure and Appointment of Agents

- Medicare Advantage and Prescription Drug Plan organization agents/brokers or other marketing representatives
 - Must comply with state-licensure laws
 - Applies to contracted and employed agents/brokers
 - Organizations must comply with state appointment laws
 - Plans must give information about agents
 - To check a producer license go to:
Insurance2.illinois.gov, producer tab, license lookup

Things to Consider Before Joining a Plan



- Important questions to ask
 - Do you have other current health insurance coverage?
 - Is any prescription drug coverage you might have as good as (creditable) Medicare drug coverage?
 - How does your current coverage work with Medicare?
 - Could joining a plan affect your current coverage or family member's coverage?

Steps to Choosing a Medicare Drug Plan



1. Prepare
2. Compare Plans on the Medicare Plan Finder
 - 2016 Plans go live on Medicare.gov Oct. 1st
3. Decide and Join
4. Print out and keep the enrollment confirmation

Step 1: Prepare



- Prepare by getting your information together
 - Current prescription drug coverage
 - Prescription drugs, dosages, and quantities
 - Preferred pharmacies
 - Medicare card
 - ZIP code

Step 2: Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more
- Star ratings will be on plan finder October 8

The screenshot shows the Medicare.gov website's Medicare Plan Finder interface. At the top, there are navigation links for 'Español', 'Email', 'Print', 'About Us', 'FAQ', 'Glossary', 'CMS.gov', and 'MyMedicare.gov Login'. The main header features the 'Medicare.gov' logo and a search bar. Below the header is a navigation menu with tabs for 'Sign Up / Change Plans', 'Your Medicare Costs', 'What Medicare Covers', 'Drug Coverage (Part D)', 'Supplements & Other Insurance', 'Claims & Appeals', 'Manage Your Health', and 'Forms, Help, & Resources'. The main content area is titled 'Medicare Plan Finder' and includes a brief introduction about general vs. personalized searches. Two search options are presented: 'General Search' with a 'ZIP Code' input field and a 'Find Plans' button, and 'Personalized Search' with fields for 'ZIP Code', 'Medicare Number' (with an example '123456789A'), 'Last Name', and 'Effective Date for Part A' (with 'Month' and 'Year' dropdowns). A woman on a bicycle is featured in the personalized search section. On the right side, there are sections for 'Plan Finder Multimedia' (with a video player), 'Additional Tools' (listing 'Find and Compare Medigap Policies', 'Search by Plan Name or ID', 'Enroll Now', 'Check Your Enrollment', and 'Medicare Complaint Form'), and 'Resources'.

Step 3: Decide and Join

- Decide which plan is best for you and enroll
 - Online enrollment
 - Medicare.gov/find-a-plan/questions/home.aspx
 - Plan's website
 - Enroll with a SHIP counselor
 - Enroll by phone
 - 1-800-MEDICARE (1-800-633-4227)
 - TTY users should call 1-877-486-2048
 - Call plan
 - Mail or fax paper application to plan

1-800 Medicare



- This center is:
- Closed on Thanksgiving Day and Christmas Day, but is
- Open on New Years Day!
- Call volume is highest during Mondays and Tuesdays from 10 am to 4 pm
- The center takes over 4 million calls during the open enrollment season

Medicare's Limited Income Newly Eligible Transition (NET) Program

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare's Limited Income NET Program
 - Has an open formulary
 - Doesn't require prior authorization
 - Includes standard safety and abuse edits
 - To protect you from refilling too soon or therapy duplication
 - Has no network pharmacy restrictions
- Continuing Education credit webinars available
- Run by Humana at 1-800-783-1307

How Do You Access Medicare's Limited Income NET Program?

Auto-enrollment by CMS

- CMS auto-enrolls you if you have Medicare and get either full Medicaid coverage or SSI benefits.

Point-of-Sale (POS) Use

- You may use Medicare's Limited Income NET Program at the pharmacy counter (point-of-sale).

Submit a Receipt

- You may submit pharmacy receipts (not just a cashier's receipt) for prescriptions already paid for out of pocket during eligible periods.

Medicare Prescription Drug Coverage Resource Guide

Resources		Medicare Products
<p>Websites: Centers for Medicare & Medicaid Services (CMS) CMS.gov</p> <p>RxAssist - A directory of Patient Assistance Programs rxassist.org</p> <p>Medicare Part D Appeals MedicarePartDAppeals.com</p> <p>Contacts: Medicare.gov 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 (TTY)</p> <p>Social Security 1-800-772-1213 socialsecurity.gov</p> <p>Local State Health Insurance Programs Medicare.gov/contacts</p> <p>Limited Income NET Program (HUMANA) 1-800-783-1307 or 711 (TRS) Email: linetoutreach@humana.com</p> <p>Manuals/Guidance "Prescription Drug Benefit Manual" CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html</p> <p>"PDP Enrollment and Disenrollment Guidance" CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html</p>	<p>Manuals/Guidance (continued) "Medicare Premiums: Rules For Higher-Income Beneficiaries" SSA.gov/pubs/EN-05-10536.pdf</p> <p>"2014/2015 Guide to Mailings from CMS, Social Security, and Plans" CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/2014Mailings.pdf</p> <p>National Training Program – Partner Job Aids Visit the Training Library at CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram</p> <p>CMS Publications "Your Guide to Medicare Prescription Drug Coverage" (CMS Product No. 11109)</p> <p>"Things to Think About When You Compare Medicare Drug Coverage" (CMS Product No. 11163)</p> <p>"4 Ways to Help Lower Your Medicare Prescription Drug Costs" (CMS Product No. 11417)</p> <p>"How Medicare Drug Plans Use Pharmacies, Formularies, and Common Coverage Rules" (CMS Product No. 11136) To view or order these products: Single copies- Medicare.gov/Publications; Multiple copies (partners only) productordering.cms.hhs.gov</p> <p>CMS Partner Tip Sheets — CMS.gov/publications-for-partners.html</p>	<p>Partner Tip Sheets (continued) "Medicare Drug Coverage Under Medicare Part A, B, & D" (CMS Product No. 11315-P)</p> <p>"Handling Medicare Part D Complaints" (CMS Product No. 11259-P)</p> <p>"How Retiree Coverage Works With Medicare Prescription Drug Coverage" (CMS Product No. 11403-P)</p> <p>"Correcting Subsidy Status or Level Based on Best Evidence" (CMS Product No. 11325-P)</p> <p>"Information Partners Can Use On: Closing the Coverage Gap" (CMS Product No. 11495-P)</p> <p>"Information Pharmacists Can Use On: Closing the Coverage Gap" (CMS Product No. 11522-P)</p> <p>"LI NET for People at Pharmacy Counter" (CMS Product No. 11328-P)</p> <p>"LI NET for People With Retroactive Medicaid & SSI Eligibility" (CMS Product No. 11401-P)</p> <p>"How Medicare Plans Drug Coverage Work With a Medicare Advantage Plan or Medicare Cost Plan" (CMS Product No. 11135)</p>

CMS National Training Program (NTP)

To view all available NTP materials,
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[CMS.gov/outreach-and-
education/training/cmsnationaltrainingprogram/](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/)

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