

SHIC

talk

A program of the N.D. Insurance Department • Adam W. Hamm, Insurance Commissioner

June 2008

Commissioner's comments



Dear friends:

The Insurance Department's mission—protecting the public good—has once again been put into action. I recently served a cease and desist order to a Fargo insurance agent after receiving information that the agent was borrowing money from previous or current insurance clients and failed to repay the money. State law prohibits a licensed insurance agent from soliciting or accepting a loan from anyone with whom the agent has had an insurance relationship within the last 10 years. A cease and desist order bars an agent from engaging in the business of insurance.

Several of the clients defrauded by this agent are senior citizens who lost their retirement savings. Here are some tips to ensure an insurance policy or investment is credible:

- Find out if the agent is licensed to do business in North Dakota and is in good standing by calling the North Dakota Insurance Department.
- Find out if the insurance policy or investment is registered through the North Dakota Insurance Department or the North Dakota Securities Department, respectively.

This is just another example of the ND Department of Insurance protecting the public's good.

Lastly, SHIC will be doing statewide commercials advertising low-income subsidy for Part D co-pay and premium assistance. The commercials will include Prescription Connection for North Dakota information for those that are having trouble in the coverage gap. They will be aired statewide this summer. By advertising these programs, we will give hope to people who are struggling due to rising medication costs.

Sincerely,

A handwritten signature in black ink, appearing to be 'A. Hamm', written in a cursive style.

Adam W. Hamm
Insurance Commissioner

NORTH
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a program of the
North Dakota
Insurance Department

SHIC
State Health
Insurance Counseling

What is a medical savings account?

A Medicare medical savings account (MSA) plan is a Medicare private health plan that differs from other private health plans in four main ways:

1. It has a very high-deductible.

In most cases the plan will only pay for covered services once you have spent a certain amount out-of-pocket (reached your deductible). MSA plan deductibles tend to be very high, as much as \$10,050 in 2008. Once you reach your deductible, the plan will generally cover all or most of the costs of Medicare-covered hospital and medical services (Part A and Part B services).

2. It cannot offer Medicare drug coverage (Part D).

If you are in an MSA plan and want Medicare drug coverage, you must join a stand-alone drug plan (PDP).

3. It has a medical savings account.

The MSA plan will open a bank account for you. The plan will deposit a certain amount of

money (that it gets from Medicare) into the account. You can use this money to pay for medical expenses during your deductible. **The amount that the plan deposits into your account will generally be much lower than your deductible, so you will have high out-of-pocket costs to pay until you meet your deductible.** The deposit will not be taxed as long as you use it to pay for qualified medical expenses.

4. When you can enroll.

You can only enroll in an MSA plan:

- When you are first eligible for Medicare
- From Nov. 15 to Dec. 31 of each year during the annual coordinated election period

You cannot join an MSA:

- During the open enrollment period
- If you have any other types of health insurance, including Medicaid, Veterans Benefits, Federal Employee Health Benefits or many kinds of employer or retiree insurance.

Source: Medicare

How much will I pay in a Medicare Medical Savings Account plan?

In a Medicare medical savings account (MSA) plan, you will continue to pay the Part B premium. You generally will not have a premium to pay for the plan. You will only have a separate premium to pay if your plan offers supplemental benefits (like vision or dental care) that you choose to buy. If your plan offers supplemental benefits, you always have a choice of whether or not to take them.

You can use the money in your savings account to pay for medical services. Your costs for services will be different depending on:

- Whether you are in your deductible period or coverage period.
- Before you have reached your deductible

(the amount you must pay out of pocket before your coverage begins) you will pay the full cost of Medicare-covered services. Your deductible can be as high as \$10,050 in 2008.

- Once you meet your deductible and have coverage, you will pay nothing for Medicare-covered hospital and medical services (Parts A and B) if you go to a doctor who accepts the Medicare amount as payment in full (takes assignment). If you go to a doctor who does not take assignment, you may be responsible for up to 15 percent of the cost of the service (less in some states). Your deductible can be as high as \$10,050 in 2008.

- Which doctors you use.

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If the plan has a network and you use in-network doctors:

• You will pay the plan’s rate. Even if this rate is higher than the Medicare-approved amount, you will have to pay the full plan rate during the deductible. However, only the Medicare-approved amount plus up to 15 percent (less in some states) must count toward your deductible. If the plan rate is higher, it is up to the plan whether that additional amount will count toward your deductible. If the plan rate is higher than the Medicare-approved rate it will not count toward your deductible, it is cheaper for you to go out-of-network (see below).

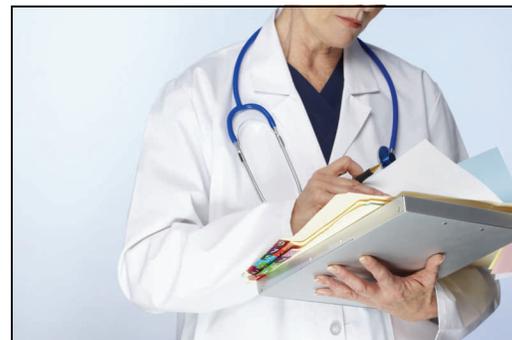
Whether the plan has a network or not, if you use doctors who do not participate in the plan:

• You will pay the least to see doctors who take assignment. Doctors who take assignment have agreed to take Medicare’s approved amount as payment in full. You will only be responsible for the 20 percent coinsurance. Everything you pay to see doctors who take assignment will count toward meeting your

deductible. To find which doctors take assignment, you can call your plan, 1-800-Medicare or go to Medicare.gov.

You will pay up to 15 percent more than the Medicare-approved amount to see “non-participating” doctors who accept Medicare but do not take assignment. That means you

have to pay the 20 percent coinsurance plus any amount, up to 15 percent more, than the Medicare-



approved amount. Everything you pay will count toward meeting your deductible. (Under federal law, non-participating providers can charge you no more than 15 percent above the Medicare-approved amount. Some states have lower limits).

Source: Medicare

What you should know: Medicare’s Competitive Bidding Program

You may have heard that Congress changed the way that Medicare determines how much it pays for certain durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) and who can furnish these items. Starting July 2008, you’ll begin to see the effect of a new Competitive Bidding Program in certain areas of the country. Here’s what you need to know about this new program:

Who will be affected by the new Competitive Bidding Program?

The new Competitive Bidding Program applies to you if your permanent residence is in a ZIP code that is part of a Competitive Bidding Area (CBA) or if you get certain

items while visiting a CBA. Your permanent residence is the address where Social Security mails your benefits check. The following areas will be affected initially:

- Charlotte-Gastonia-Concord, NC-SC
- Cincinnati-Middletown, OH-KY-IN
- Cleveland-Elyria-Mentor, OH
- Dallas-Fort Worth-Arlington, TX
- Kansas City, MO-KS
- Miami-Fort Lauderdale-Miami Beach, FL
- Orlando-Kissimmee, FL
- Pittsburgh, PA
- Riverside-San Bernadino-Ontario, CA
- San Juan-Caguas-Guaynabo, PR

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To find out if your ZIP code is included in a CBA, call 1-800-MEDICARE or search for CBA ZIP codes at www.medicare.gov. The program is scheduled to expand to 70 additional areas in 2009.

How does this new program work?

Under the new Competitive Bidding Program, supplies who do business in a Competitive Bidding Area (CBA) must submit a bid in order to be awarded a contract to sell to people with Medicare. Contracts will only be awarded to those supplies who offer the best price; who meet Medicare's eligibility, quality and financial standards; and who are accredited by an independent accrediting organization. These supplies are called contract suppliers.

In most cases, only contract suppliers will be



able to provide people with Medicare with certain items and file claims with Medicare

for payments. Contract suppliers can't charge more than the single payment amount set by Medicare based on the bids received for an item, and this price can't be higher than the current Medicare (fee schedule) allowed amount.

How do I know if my equipment or supplies are included in the program?

Ten product categories are included in the Competitive Bidding Program:

- Oxygen supplies and equipment
- Standard power wheelchairs, scooters and related accessories (includes wheelchair cushions)
- Complex rehabilitative power wheelchairs and related accessories (includes wheelchair cushions)
- Mail-order diabetic supplies
- Enteral nutrients, equipment and supplies
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Negative pressure wound therapy devices and related supplies and accessories
- Walkers and related accessories
- Group 2 support surfaces, including mattresses and overlays (in Miami-Ford Lauderdale-Miami Beach and San Juan-Caguas-Guaynabo only)

To check if an item you use is included in the program, call 1-800-MEDICARE or visit www.medicare.gov.

How will I know if my supplier is a contract supplier?

To see a list of the contract suppliers in your area or to check if a supplier you use is included in the program, call 1-800-MEDICARE or visit www.medicare.gov.

Source: Medicare

CMS seeks to minimize instability in drug benefit

The Centers for Medicare and Medicaid Services (CMS) announced recently that it will change how it calculates the premium subsidy for low-income people with Medicare under the Part D drug benefit in an effort to reduce the number of people who have to change plans to avoid paying premiums.

Under the new regulation, the benchmark that determines the maximum Part D premium subsidy for low-income people with extra help will be determined by the average Part D premium in the region, with the average now weighted by enrollment of individuals receiving extra help. That means the premium of Part D plans with many low-income enrollees will count for more in the calculation and may therefore be less likely to have a premium that is above the benchmark. It also means that Medicare private health plans that use overpayments for medical services to eliminate their drug premium will count for less in the calculation.

CMS said that this new method of calculating the premium subsidy will result in less reassignments—CMS moves most people

with extra help to a below-benchmark plan when their current plan no longer qualifies for a full subsidy—than under its earlier proposal, which was strongly criticized by advocates and other stakeholders. Still, CMS estimates that if the rule had been in effect in 2007, 1.33 million low-income Part D enrollees would have been randomly assigned to new plans. That is slightly more than the number who were reassigned to new plans at the end of 2007 under a temporary policy that CMS is now scrapping.

CMS rejected advocates' recommendation that it use the real cost of drug coverage under Medicare private health plans in calculating the premium subsidy level. Advocates said that the zero-premium plans depressed the average by using excess payments for medical coverage to eliminate the premium. The agency argued it did not have the legal authority to take this approach. CMS also rejected advocates' calls to match individuals' drug coverage with the drugs covered by the plan in making reassignments.

Source: Medicare Watch

Medicare trustees warn of funding shortfall

The Hospital Insurance (HI) Trust Fund will exhaust its savings by 2019 and not draw enough money from payroll taxes to pay for hospital and other inpatient care under Medicare Part A, according to the most recent report by Medicare's trustees.

The HI Trust Fund will start eating into its

reserves in 2010, according to the trustees' report. When those savings are exhausted in 2019, payroll taxes will only be able to pay for 78 percent of the projected cost of hospital and other Part A care.

Medicare's financial problems stem from the overall rise in the cost and use of health care in

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the country, according to the Center on Budget and Policy Priorities (CBPP). From 1970 to 2006, Medicare's costs per person grew on average 8.7 percent each year, slower than the 9.7 percent average annual growth in private health insurance.

CBPP says the trustees' warning on Medicare's finances provides an opportunity to Congress to restrain the growth in Medicare spending. In

particular, the Medicare Payment Advisory Commission points out that Medicare private health plans are paid on average 13 percent more per enrollee than it would cost to care for the same person under Original Medicare. These overpayments will total \$150 billion over the next 10 years, according to the Congressional Budget Office.

Source: Medicare Watch

Case scenarios for quality assurance

Recently, CMS asked each SHIP to determine how they are going to provide quality assurance to their beneficiaries in their state. CMS's goal is to ensure that beneficiaries receive accurate, reliable and unbiased information. Due to this CMS request, we will provide a case scenario in every newsletter that we will share as a learning tool for ongoing education and consistency in problem-solving. To share a personal example, email csheldon@nd.gov.

Scenario #1

June, an 80-year-old beneficiary, came into the office and asked to speak with a SHIC counselor. The SHIC counselor applied for Extra Help (Low Income Subsidy-LIS) for June. Since June is not living with a spouse, she is maritally separated. People who are single, widowed, divorced or are not living with a spouse do not complete question two on the LIS application (LIS). June should not complete any boxes on the form that asks for information about the spouse.

Result: Based on June's information, she was awarded full subsidy. The LIS was used to defray premiums for the prescription drug plan as well as reduce co-pays for the medications.

Scenario #2

Carol, a 66-year-old woman, came to the office and stated that she was having trouble paying for her medications. The beneficiary had assistance with a Part D plan, but had already hit the coverage gap in April. Upon looking at her medication list, the SHIC counselor

determined that two of her medications (Aggrenox and Spiriva) were available through Boehringer Ingelheim Pharmaceuticals, Inc.



Solution: The SHIC counselor assisted the beneficiary in applying for the Patient Assistance Program. However, the beneficiary had to spend three percent of her annual household income on prescriptions before she would receive assistance. The SHIC counselor assisted the beneficiary with gathering receipts and with sending the proof of these expenditures to the company. The beneficiary did receive assistance through Boehringer Ingelheim Pharmaceuticals, Inc. while she was in the coverage gap.

Reminder: If a beneficiary is having trouble affording medications in the coverage gap, please have them contact Prescription Connection for North Dakota at 1.888.575.6611.



Director's corner

Greetings!

We recently held our New Counselor Training for SHIC in Bismarck. Fifteen new aspiring volunteers attended. We jazzed up the training by adding an interactive Jeopardy game to the agenda. We had a great time!

I attended the annual SHIP directors training in Maryland in May. It is always exciting to hear what other states are doing and to get new ideas about what is working. It also reminds me how fortunate we are in North Dakota. Other states struggle with volunteer retention daily ... we have volunteer turnover, but the majority of our volunteers have been active for years. What a difference our attitudes make. We take care of our people!

We have scheduled our Turning 65 events for this summer in Bismarck on Aug. 5 at Days Inn and in Fargo at Country Inn and Suites on Aug. 12. We hope to promote these events so they are heavily attended. Please let us know if you would like any flyers or other promotional materials to distribute.

Again, thank you for all you do. We greatly appreciate your hard work and dedication to the program.

Sincerely,

Cindy Sheldon

SHIC *talk*

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