

SHIC

talk

A program of the North Dakota Insurance Department • Adam Hamm, Insurance Commissioner

April 2009



Dear friends,

The 61st Legislative Assembly is keeping us busy in the Insurance Department. Five hundred and seventy-six House bills and 440 Senate bills have been introduced during the session. The Insurance Department is sponsoring 15 bills and tracking more than 50. You can see all bills at the Legislative Council website, www.legis.nd.gov.

The North Dakota Insurance Department website, www.nd.gov/ndins, now has a volunteer page, filled with resources like the SHIC training manual and other important documents and links, for your reference. To see the new section, click on Consumers, then SHIC, then Volunteers.

www.nd.gov/ndins/consumer/shic/volunteers

SHIC is already working to recruit more volunteers for the 2009 Medicare Part D annual enrollment period. If you know anyone that may be interested in helping North Dakotans during this busy time of year, please share the ad on page 9 with them. Volunteer training for Part D only is less overwhelming for those who may not be able to commit to the full SHIC volunteer training.

Sincerely,

A handwritten signature in blue ink, appearing to read "Adam Hamm". The signature is fluid and cursive, written over a light blue background.

Adam Hamm
Insurance Commissioner

**NORTH
DAKOTA**

a program of the
North Dakota
Insurance Department

SHIC
State Health
Insurance Counseling

Updated income guidelines for Medicare programs included

Test your skills for Medicare's annual enrollment

1. Are beneficiaries who switched Medicare drug plans during the Annual Enrollment period allowed to fill a prescription that is not on the formulary of their new plan?
 - A) No, all enrollees in Medicare drug plans must follow the formulary restrictions of their plans.
 - B) No, only beneficiaries eligible for the low-income subsidy are entitled to a transition fill.
 - C) Yes, as long as the drug is not excluded from Medicare's drug coverage. This is called a transition fill.
 - D) Yes, all plans have to provide the enrollees with any drug you need for 30 days. This is called a transition fill
2. Which of the following is not an acceptable form of "Best Available Evidence" that a beneficiary can use to prove Low Income Subsidy status at the pharmacy counter:
 - A) Verbal reassurance
 - B) A copy of a recently submitted LIS application
 - C) A Medicaid card with a valid effective date
 - D) A Medicare card
3. A Medicare beneficiary is enrolled in a Medicare Advantage Plan with drug coverage (MA-PD) and wants to switch coverage during the Annual Enrollment Period (AEP). Which of the following changes can the beneficiary make during the Open Enrollment Period?
 - A) Enroll in Original Medicare and a stand alone PDP
 - B) Enroll as many times as he wants into different Medicare Advantage Plan with MA-PD with the last one being effective April 1
 - C) Enroll in Original Medicare and as many different stand alone PDP's with the last one being effective April 1

Answers:
1. C
2. D
3. A (only one switch can be made during annual enrollment)

MIPPA changes effective Jan. 1

Medicare Part B

Preventive benefits

- Beneficiaries new to Medicare now have 12 months after their initial Medicare Part B eligibility to receive their "Welcome to Medicare" physical exam (extended from the first six months of Medicare Part B eligibility).

NOTE: The annual Part B deductible does not apply to this initial physical exam, and MIPPA has added new services to the exam, including BMI assessment and end-of-life planning.

Outpatient therapy services

- The effective date of the exceptions process for outpatient therapy caps is extended through Dec. 31, 2009.

NOTE: This extension includes physical therapy, speech therapy and occupational therapy.

Medicare Part D

Low-income subsidy

- The late enrollment penalty is eliminated for all LIS eligible individuals.

Coverage for anti-cancer drugs

- The standards for determining whether Part D will cover specific anti-cancer drugs now include additional medical compendia.

Medicare Savings Programs

Qualified Individual (QI) Program

- The QI program, which assists Medicare beneficiaries with incomes between 120% and 135% of the federal poverty levels and limited assets, is extended through Dec. 31, 2009.

The changes noted above take effect Jan. 1, 2009. There are additional changes from MIPPA that take effect at later dates. For a complete list of other MIPPA changes, visit HAP's September Conference Call page at www.hapnetwork.org/conference-calls/.

Upcoming events

Turning 65 seminars

Bismarck

6:30–9 p.m. Tuesday, June 2

Doublewood Inn, 1400 E. Interchange Ave.

Fargo

6:30–9 p.m. Tuesday, June 9

Country Inn and Suites, 3316 13th Avenue South

Registration is required by May 22. To register or for more information, call Jan Frank at 1.888.575.6611 or email her at janfrank@nd.gov.

SHIC new counselor training

May 5, 6 and 7

Comfort Suites, 929 Gateway Ave., Bismarck

Register by calling Jan Frank at 1-888-575-6611 or emailing her at janfrank@nd.gov.

SHIC recertification/update training via IVN

9 a.m.–3 p.m. May 15th

Agenda will be forthcoming

See location chart below

SHIC recertification/update training via IVN locations

Group	Site	Room Type	Contact Name	Contact Phone	Contact Email
NDUS	Bismarck-BSC NECE 345	Host	Pat Gross	701-224-5484	james.gross@bsc.nodak.edu
NDUS - Public	Bottineau-MiSU-B Arntzen 1	Receive	Nancy Underwood	701-228-5421	nancy.underwood@msub.nodak.edu
NDUS - Public	Devils Lake-LRSC Admin 172	Receive	Lois Bachmeier	662-1639	lois.bachmeier@lrsc.nodak.edu
NDUS - Public	Dickinson-DSU Klinefelter 220	Receive	Kathleen Obritsch	483-2541	Kathleen.Obritsch@dsu.nodak.edu
NDUS - Public	Fargo-NDSU EML 170	Receive	Stephen Beckermann	231-8486	stephen.beckermann@ndsu.edu
NDUS - Public	Grand Forks-UND Gamble 120	Receive	Heidi Flaten	701-777-3308	heidiflaten@mail.und.edu
NDUS - Public	Mayville-MaSU Library 114	Receive	Marjorie Fugleberg	701-788-4817	Marjorie.Fugleberg@mayvillestate.edu
NDUS - Public	Minot-MiSU Admin 152-HD	Receive	Carla Davis	858-3239	carla.davis@minotstateu.edu
NDUS - Public	Valley City-VCSU Rhoades 107	Receive	Connie Stavens	701-845-7256	connie.stavens@vcsu.edu
NDUS - Public	Wahpeton-NDSCS Library 117	Receive	Wanda Worrel	701-671-2566	Wanda.Worrel@ndscs.nodak.edu
NDUS - Public	Williston-WSC Main 107	Receive	Wanda Meyer	701-774-4231	wanda.meyer@wsc.nodak.edu

Quality assurance

Q: How can I make the hospital and Medicare understand that my mother and doctor do not feel she should be discharged from her facility? The doctor asked for a review of the decision to discharge, but she was still told she had to leave. What can she do?

A: You can still take steps to appeal this decision. The steps you need to take depend on how much time has passed since she lost the review, and whether or not your mother is still in the hospital. If your mother is still in the hospital, she can ask the Qualified Independent Contractor (QIC) for an immediate (expedited) reconsideration. To get one, she can call the QIC by noon

the day after she received the decision. The hospital cannot charge her for care until the QIC reached its decision.

If your mother missed the deadline for an expedited reconsideration or has already left the hospital, she can request a standard reconsideration by the QIC within 180 days. The hospital can bill her before the QIC makes its decision, but MUST reimburse her for any amounts she paid out-of-pocket if the QIC rules in her favor.

North Dakota's QIC can be reached at 1-800-472-2902.

2009 Medicare Part D annual enrollment events

City	Time	Date	Location and address
Bismarck	9 a.m.–4 p.m.	Monday, Nov. 16	Doublewood Inn Heritage Ballroom 1400 E. Interchange Ave.
Devils Lake	9 a.m.–4 p.m.	Wednesday, Nov. 18	Lake Region State College Chautauqua Gallery 1801 College Dr. N.
Grand Forks	9 a.m.–4 p.m.	Thursday, Nov. 19	Guest House (formerly the Townhouse) Parlors B and C 710 1st Ave. N.
Jamestown	9 a.m.–4 p.m.	Friday, Nov. 20	Jamestown College Reiland Auditorium 610 7 th Ave. NE
Williston	9 a.m.–4 p.m.	Monday, Nov. 23	Williston Armory 10 Main St.
Minot	9 a.m.–4 p.m.	Tuesday, Nov. 24	Sleep Inn Celebrations Center 2400 10th St. SW
Dickinson	9 a.m.–4 p.m.	Monday, Nov. 30	Dickinson State University Student Center ballrooms 291 Campus Drive
Wahpeton	9 a.m.–4 p.m.	Wednesday, Dec. 2	Eagles Club 114 Dakota Ave.
Fargo	9 a.m.–4 p.m.	Thursday, Dec. 3	Doublewood Inn Birch and Walnut rooms 3333 13 th Ave. S.
Valley City	9 a.m.–4 p.m.	Friday, Dec. 4	Senior Center 139 2 nd Ave. SE

The following information is in response to feedback from the recent SHIC counselor evaluations. Many of you expressed a desire for more information regarding Medicare Savings Programs, low-income subsidy and Medicaid. We hope this section is helpful. Please call the SHIC office at 1-888-575-6611 with any questions.

Medicare Savings Programs

What are Medicare Savings Programs?

Medicare Savings Programs are a group of Medicaid programs that help Medicare beneficiaries pay some of their out-of-pocket Medicare costs, such as premiums and co-insurance amounts.

There are three Medicare Savings Programs (MSPs) that a Medicare-eligible person may qualify for depending on their financial resources:

- Qualified Medicare Beneficiary (QMB);
- Specified Low-Income Medicare Beneficiary (SLMB); and
- Qualified Individual (QI).

What are the benefits of enrolling in a Medicare Savings Program?

- **Enrollees do not have to pay their monthly Medicare Part B premium.**

Usually, Medicare beneficiaries have to pay a monthly premium for their Medicare Part B health insurance, which is deducted automatically from their monthly Social Security check. Beneficiaries who qualify for any of the three Medicare Savings Programs, however, no longer have to pay their monthly Medicare Part B premium. The state Medicaid program will pay it for them. As a result, MSP enrollees will have more money in their pocket every month.

- **Enrollees automatically qualify to get extra help paying their Medicare prescription drug plan costs.**

All Medicare beneficiaries who qualify for any of the Medicare Savings Programs will also automatically qualify for extra help paying for their Medicare prescription drug plan costs. This extra help, which is also known as the Low-Income Subsidy, will pay the plan's monthly premium and other out-of-pocket costs, such as the annual deductible.

- **QMB enrollees have even lower out-of-pocket costs.**

Medicare beneficiaries who qualify for the QMB program will see added savings, since the state Medicaid program will pay any Medicare co-insurance amounts and deductibles for the beneficiary. Additionally, if a beneficiary did not qualify for premium-free Medicare Part A coverage prior to qualifying for the QMB program, Medicaid will also pay that premium. This means there is no charge to the QMB beneficiary for any part of their Medicare insurance coverage such as stays in the hospital and visits to the doctor.

Who qualifies for Medicare Savings Programs?

- **Medicare-eligible individuals who meet the income and asset requirements.**

Individuals with incomes and assets below the level set by federal law are eligible for Medicare Savings Programs. States have the option of expanding the federal eligibility criteria to allow more beneficiaries to qualify for and enroll in a MSP.

The table below sets forth the **maximum amount** of income and assets an individual or couple can have and still be found eligible under the federal eligibility requirements.

NOTE: It is very important to check with the State Medicaid Agency because states may adopt less restrictive eligibility requirements, including higher thresholds and additional income or asset disregards.

Federal Eligibility Requirements

	QMB	SLMB	QI
Income Limits	At or below 100% of the Federal Poverty Level*	Between 100% and 120% of the Federal Poverty Level*	Between 120% and 135% of the Federal Poverty Level*
Asset Limits	\$4,000/individual \$6,000/married	\$4,000/individual \$6,000/married	\$4,000/individual \$6,000/married
Unearned Income Disregard	\$20 of unearned income (Social Security, pension, etc.) is not counted	\$20 of unearned income (Social Security, pension, etc.) is not counted	\$20 of unearned income (Social Security, pension, etc.) is not counted

* Federal Poverty Level figures change each year and are generally published in the *Federal Register* in late January or early February. They may be used as soon as they are published. The 2008 FPL figures are available at: <http://aspe.hhs.gov/poverty/08fedreg.htm>.

See: [42 U.S.C. § 1396a](#); [42 C.F.R. § 430](#) et. seq.

How can a person enroll in a Medicare Savings Program?

Medicare-eligible beneficiaries must apply for a Medicare Savings Program. There are several ways to apply.

- **Local Medicaid Offices:** Medicare Savings Program applications are available by phone or in person from local Medicaid offices. Medicaid offices can be located in the CMS contact directory: <http://www.cms.hhs.gov/apps/contacts/>.
- **BenefitsCheckUp:** Beneficiaries can download an application from the forms center at the Benefits Check Up website: <http://ssl1.benefitscheckup.org/ec/dspForms.cfm?cat=MSP>. After completing the form, the beneficiary should mail it to the designated address.

Medicare and Medicaid: Dual Eligible Beneficiaries

Medicare is a federally funded health insurance program for people aged 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). However, Medicare does not cover all health care costs. Individuals must make up any difference between what Medicare pays and what the health care provider charges. Some individuals may be able to pay these out-of-pocket costs with their own incomes, or through secondary or supplemental insurers. In some cases, Medicaid may pay some of these costs. Individuals who receive Medicare and Medicaid are called dual eligible beneficiaries or “dual eligibles.”

Medicaid is jointly funded by federal and state governments. There are federal minimum standards for eligibility and some federally required benefits. As a partially state-funded program, some of the eligibility requirements and the benefits offered under Medicaid may vary greatly from state to state. Medicaid programs are available to individuals with limited incomes and resources/assets. In some states, Medicaid is also available to individuals who have incomes and/or resources that are above the thresholds, but who have high medical expenses.

Which Medicare Beneficiaries Are Eligible to Enroll in Medicaid?

In order to qualify for Medicaid coverage, a Medicare beneficiary must meet the following three criteria:

- **Be a United States citizen or legal permanent resident.**
- **Be a member of a qualifying category.**

The beneficiary must possess characteristics that allow him/her to fit into a qualifying Medicaid category, such as blind, disabled, or over the age of 65.

- **Meet the income and resource limits set by the state.**

Medicaid coverage is limited to individuals whose incomes and assets are below dollar amounts established by the state in which they are applying. In some states, Medicaid may be available to individuals who do not meet the dollar limits imposed by the state, but whose incomes less medical expenses are below state-established dollar limits. Individuals who qualify for Medicaid in this manner are said to have “spent-down.” Generally, when they apply for Medicaid benefits, the state will notify them (based on their income and/or resources) of how much money they must spend on medical care before they will qualify for Medicaid to pay their remaining costs. The state will also let individuals know how much time

they have to accumulate these medical expenses. (This time period is called a “budget period” and is generally one month to six months, depending on the state.) The following kinds of medical expenses count toward the spend-down:

- Medical bills that an individual pays during the budget period, including Medicare premiums, copayments, and receipts for medical care that is not covered by Medicare. (Only the share that the individual pays counts—not the share that Medicare pays.)
- Unpaid medical expenses for which the individual is still responsible, regardless of the date that they were incurred, as long as they have not been counted in a previous spend-down period.

Medicaid will not pay the amount of the bills that are used to meet the spend-down, but it will pay for any excess or remaining medical expenses during the budget period. Not all states allow individuals to spend-down to Medicaid. Please check with your state Medicaid agency to find out if your state allows individuals to qualify for Medicaid by spending-down their income and/or resources.

What Benefits Do Dual Eligible Beneficiaries Receive?

Depending on the Medicaid program, a dual eligible may receive Medicaid health coverage and/or assistance in paying Medicare premiums and cost-sharing.

- **Medicaid health coverage:** The health care benefits offered by state Medicaid programs vary from state to state, but dual eligibles generally receive “wrap-around” coverage. Wrap-around coverage describes health insurance that pays for medically necessary items and services that a primary insurer (in this case, Medicare) will not cover. In many states, this coverage includes nursing home care, vision care, dental coverage, home and community-based care, hearing benefits, and non-emergency transportation to and from medical appointments.
- **Medicare premium and cost-sharing assistance:** All Medicaid programs offer assistance in paying some or all of an individual’s out-of-pocket Medicare costs. Out-of-pocket costs that may be covered include premiums, deductibles, and co-payments under Medicare Part A and Part B. In some states, Medicaid may assist in paying Medicare Advantage premiums under Part C. Check with your state Medicaid agency or local medical assistance office to learn what assistance is available.
- **Assistance with Medicare prescription drug plan costs and copayments:** All individuals who qualify for Medicaid are automatically entitled to reduced copayments on their Medicare prescription drugs, and no, or low, drug plan premiums and deductibles. Additionally, the so-called ‘doughnut hole’ is eliminated for all dual eligibles. See HAP’s [chart](#) on cost-sharing for low- income beneficiaries under Part D.

What Is Meant by “Full Dual Eligible” and “Partial Dual Eligible”?

Dual eligibles are either “full” or “partial” depending on the level of Medicaid benefits that they qualify for.

- **Full dual eligibles:** Medicare beneficiaries who are enrolled in a Medicaid program that provides Medicaid health coverage, as well as assistance in paying the beneficiaries’ Medicare premiums and cost-sharing. Medicaid programs that offer “full” Medicaid benefits include the SSI eligibility category and the low-income or medically-needy elderly or disabled.
- **Partial dual eligibles:** Medicare beneficiaries who are enrolled in a Medicaid program that does not offer Medicaid health coverage, but does provide assistance in paying Medicare premiums and other out-of-pocket costs. Medicaid programs that provide “partial” Medicaid benefits include Medicare Savings Programs (QMB, SLMB, QI, and QDWI). HAP has more [resources](#) on Medicare Savings Programs available online.



Medicare Part D volunteers

The North Dakota Insurance Department is looking for volunteers to do Medicare Part D work October to December 2009. Compare Part D plans online and help beneficiaries enroll in plans for 2010. Training is provided, computer knowledge is preferred and the hours are flexible to fit your schedule.

For more information,
call 1-888-575-6611.

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Insurance
Department

S H I C

State Health Insurance
Counseling Program

Adam W. Hamm, Commissioner

Quick Guide to SEPs Enrollment in Medicare Drug Coverage

Continuous (May switch plans at any time)	<ul style="list-style-type: none"> • Full dual-eligibles, Medicare Savings Program enrollees, and all other beneficiaries receiving LIS • Beneficiaries residing in long-term care facilities
Two Months	<ul style="list-style-type: none"> • Moving out of a long-term care facility • An involuntary loss of creditable coverage
Three Months	<ul style="list-style-type: none"> • Loss of dual-eligible status • Loss of LIS eligibility at the end of the plan year [January 1 to March 31] • Loss of LIS eligibility during the plan year [From the month of notification to two months afterwards] • Loss of SPAP eligibility • Inadequate notification of creditable coverage status • A permanent move from a plan's service area with notification to the plan after the move [Within 6 months of the move, SEP begins month of notification and ends 2 months later] • A permanent move from a plan's service area with NO notification to the plan [If plan is unable to contact the beneficiary, the SEP lasts from the 6th month to the 8th month after the move] • Upon enrollment in Part B during the General Enrollment Period (GEP) [April 1 to June 30 with coverage effective July 1] • Beneficiaries involuntarily disenrolled from an MA-PD due to loss of Part B but still entitled to Part A • Those with enrollment or non-enrollment due to an error by a federal employee • Beneficiaries enrolling in an EGHP plan or disenrolling from an EGHP to enroll in a drug plan • Beneficiaries found either ineligible for a SNP after enrollment or need to join a new chronic care SNP
Four Months	<ul style="list-style-type: none"> • Those who permanently move from a plan's service area and notify the plan in advance of the move [SEP begins the month prior to the move and ends 2 months after the move]
Twelve Months	<ul style="list-style-type: none"> • Those enrolling in Medicare for the first time who join a Medicare Advantage plan (MA-only and MA-PD) during their IEP for Part B • Beneficiaries who drop a Medigap policy to join an MA plan for the first time
Remainder of Calendar Year	<ul style="list-style-type: none"> • Individuals belonging to a qualified SPAP are eligible to make one enrollment choice at any time • Individual eligible for Medicare due to disability have a SEP along with the additional Part D IEP upon turning 65 [SEP begins and ends concurrently with the additional Part D IEP – 3 months before to 3 months after 65th birthday]
Discretionary	<ul style="list-style-type: none"> • Upon disenrollment from a PDP at any time in order to enroll in an MA SNP • Individuals may disenroll from a plan to enroll in or maintain other creditable drug coverage • Other situations give CMS discretion to create a SEP [SEP length is dependent upon CMS's decision]

Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2009)

ELIGIBILITY GROUP		COST-SHARING			
Monthly Income Limit	Resource Limit	Annual Deductible	Monthly Premium	Costs Until TrOOP Totals \$4,350 ²	Catastrophic Benefit After TrOOP Totals \$4,350 ²
Deemed Eligible for Extra Help: Medicare and Medicaid*, Medicare Savings Programs**, and SSI-only					
Full dual-eligible beneficiaries with income less than 100% FPL: <ul style="list-style-type: none"> • Single: ≤ \$902.50 • Married: ≤ \$1,214.17 	Resource limits differ by state. Check with your state Medicaid agency.	\$0	\$0 ¹	\$1.10 for generic and preferred brand drugs or \$3.20 for all other drugs	\$0
All deemed beneficiaries with income between 100% and 135% FPL: <ul style="list-style-type: none"> • Single: \$902.50 to \$1,218.38 • Married: \$1,214.17 to \$1,639.13 	Resource limits differ by state. Check with your state Medicaid agency.	\$0	\$0 ¹	\$2.40 for generic and preferred brand drugs or \$6.00 for all other drugs	\$0
Must Apply for Extra Help: Other Low-Income Beneficiaries					
Below 135% FPL: <ul style="list-style-type: none"> • Single: ≤ \$1,218.38 • Married: ≤ \$1,639.13 	<ul style="list-style-type: none"> • Single: < \$8,100³ • Married: < \$12,910³ 	\$0	\$0 ¹	\$2.40 for generic and preferred brand drugs or \$6.00 for all other drugs	\$0
Below 135% FPL: <ul style="list-style-type: none"> • Single: ≤ \$1,218.38 • Married: ≤ \$1,639.13 	<ul style="list-style-type: none"> • Single: \$8,100 - \$12,510³ • Married: \$12,910 - \$25,010³ 	\$60	\$0 ¹	15% co-insurance	Greater of 5% of drug price OR \$2.40/generic and preferred brand or \$6.00/all other drugs
Between 135% and 150% FPL: <ul style="list-style-type: none"> • Single: 1,218.38 to \$1,353.75 • Married: \$1,639.13 to \$1,821.25 	<ul style="list-style-type: none"> • Single: \$8,100 - \$12,510³ • Married: \$12,910 - \$25,010³ 	\$60	Premium based on income: <ul style="list-style-type: none"> • 135% to 140% FPL - 25% of the monthly premium • 140% to 145% FPL - 50% of the monthly premium • 145% to 150% FPL - 75% of the monthly premium 	15% co-insurance	Greater of 5% of drug price OR \$2.40/generic and preferred brand or \$6.00/all other drugs

Notes

FPL = Federal Poverty Level. The FPL for 2009 is effective through March 31, 2010. In 2009, 100% of the FPL is \$10,830 for an individual (or \$903 per month) and \$14,570 for a married couple (or \$1,214 per month) in the 48 contiguous states and the District of Columbia. Income limits are higher in Alaska and Hawaii and for beneficiaries living with dependents. Federal Poverty Guidelines for 2009 were release in the Federal Register on January 23, 2009 and are located at: <http://edocket.access.gpo.gov/2009/pdf/E9-1510.pdf>. Annual and monthly income charts as well as information about income levels for Alaska and Hawaii are located at: <http://www.hapnetwork.org/medicaid/fpl-2009.html>.

Deemed eligible beneficiaries do not need to apply for Extra Help. State Medicaid offices send a monthly file to CMS containing information about beneficiaries in all of the deemed eligible groups—including dual eligible beneficiaries, Medicare beneficiaries with a Medicare Savings Program, and SSI-only beneficiaries.

Footnotes

* This group is also called full dual eligible beneficiaries.

** This group includes Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB), and Qualifying Individuals (QI-1).

¹ Beneficiaries in this group receive the maximum premium subsidy amount. Beneficiaries enrolled in a plan that charges a higher monthly premium than the maximum subsidy amount (or in an enhanced Medicare drug plan) must pay the difference in cost with no help from the low-income subsidy.

² Total out-of-pocket drug costs include amounts paid by the extra help (or low-income subsidy) and true out-of-pocket (TrOOP) costs paid by the beneficiary. TrOOP costs include amounts paid by the beneficiary, friends, relatives, certain charities, qualified State Pharmacy Assistance Programs (SPAPs), and the low-income subsidy toward the annual plan deductible, co-payments or co-insurance amounts. Catastrophic coverage begins once the beneficiary's TrOOP reaches \$4,350 on drugs covered by the Medicare drug plan.

³ These resource limits include \$1,500 per person for burial expenses.

Director's corner

Happy spring!

As you just discovered, most of this newsletter was devoted to providing basic information on the Medicare Savings Program, low-income subsidy and Medicaid. This was requested from quite a few counselors through the SHIC evaluation form you recently completed. We hope this information will help you in your volunteer position. If you would like to read additional information that is very valuable to SHIC, visit www.healthassistancepartnership.org. We use this website daily and hope you will find it useful, too.

Additionally, there are updated income guidelines for some programs. As you see, the Low-Income Subsidy income and asset guidelines have increased for a single person. Income can be \$16,245 with an asset level of \$12,510. As a couple, the income guidelines have increased to \$21,855 with \$25,010 in assets.

Thank you to those who participated in the counselor evaluation. We appreciate your honesty about the current status of the program and areas of need. We will be discussing the counselor evaluation forms in more detail at the SHIC Update/Recertification Training on May 15. Please come with feedback from the 2008 annual enrollment period (AEP) on how to make it more efficient in 2009 and what we can do as a state office to make your volunteer experience more enjoyable and fulfilling.

I sure hope you have had a chance to refresh yourselves after the AEP. I am sure you will be excited to hear that we have made some revisions to next year's agenda. We will be starting 2-1-1 earlier and using a drug retrieval code card (yellow cards featured in the last issue) for Medicare.gov to help with easier drug list retrieval. We will be discussing this in more detail at the Update/Recertification Training.

Please remember to register for the Update/Recertification Training by emailing Jan at janfrank@nd.gov or calling her at 1.888.575.6611. Also, if you know retirees in the area that would like an introduction to Medicare, please let them know about our Turning 65 seminars in Fargo and Bismarck. Our goal for the fall is to reach the northern and western area of the state.

Take care and thanks for all you do!

Sincerely,



Cindy Sheldon



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If you have questions about any content or have suggestions for content for our next publication, please contact Cindy Sheldon, director, at 701.328.9604 or csheldon@nd.gov.

For Medicare-related resources, please visit www.medicarerights.org.