

# SHIC

# talk

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

October 2009



Dear friends,

The Insurance Department is gearing up for the Medicare Part D annual enrollment period events that begin Nov. 16 in Bismarck. As you'll see on the schedule on page two, we will again be providing free help in 10 towns across the state. Last year was a great success and I look forward to the Department helping even more North Dakotans this year.

Additionally, Part D assistance through 2-1-1 begins Oct. 1. Please encourage beneficiaries to use this free service available statewide. Beneficiaries will need to have their list of medications with dosages and their current health insurance coverage available.

In August, the North Dakota Insurance Department held 10 CHAT sessions across North Dakota. CHAT (Choosing Healthplans All Together) is a computerized exercise that allows players to make choices concerning health care plans. However, there were more choices than resources. The goal of this project is to get input from North Dakota citizens on their health care priorities.

Although the formal results are not yet available, comments from participants were fascinating. Here are a few of the responses:

What surprised you about the CHAT session?

"How difficult the choices are when all aspects of health care are vital."

"It really made me evaluate what is most important to me and my family."

What, if anything, did you find most valuable about doing CHAT?

"Seeing the entire picture of how many elements make up a solid health care plan."

"Determining what I really need compared to what I want."

In October, the North Dakota Insurance Department will hold four additional CHAT sessions focusing on people with limited incomes. The collective results are forthcoming; please email the Department at [insurance@nd.gov](mailto:insurance@nd.gov) to request a copy of the final report.

Thank you for your work with the State Health Insurance Counseling Program (SHIC) and Prescription Connection programs. Your assistance is invaluable.

Sincerely,

  
Adam Hamm  
Insurance Commissioner



## 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 <sup>th</sup> 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 <sup>th</sup> Ave. S.
Valley City	9 a.m.–4 p.m.	Friday, Dec. 4	Senior Center 139 2 <sup>nd</sup> Ave. SE

### IVAN Part D training

1-3 p.m. CST Thursday, Nov. 12

Learn about 2010 changes to Part D, Low-Income Subsidy and  
Medicare Savings Program changes.

More information to follow in future issues of SHIC Talk.

## Important MIPPA changes effective January 2010

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The Medicare Improvement for Patients and Providers Act (MIPPA) encompasses significant changes and opportunities effective January 2010.

Low income subsidy and Medicare savings programs:

- All Medicare Savings Programs (QMB, SLMB and QI) have an asset limit concurrent with the full LIS subsidy (i.e. in 2009 this would be \$7,790 for a single person/\$12,440 for a couple).

- States are prohibited from recovering the value of Medicare cost sharing paid under Medicare Savings Programs.

- When an applicant applies for LIS, upon consent of the beneficiary, the application will then be forwarded to their state for consideration of Medicaid or MSP eligibility.

- SSA will not consider in-kind support and maintenance as income for LIS application. SSA will not consider the cash surrender of life insurance policies as a resource.

Psychiatric services:

Medicare coverage of psychiatric services increases from 50 to 55 percent.

Medigap:

Medicare supplement plans must meet certain changes recommended by the National Association of Insurance Commissioners (NAIC) by June 1, 2010. More information to follow in a later addition of SHIPTalk.

Prescription Drug Coverage and Part D:

Medicare PDP's are allowed to cover barbiturates and benzodiazepines.

Medicare Advantage Plans:

Plans must include the type of the plan (i.e. PFFS, HMO, etc.) in the plan name.

## New CMS rules cause changes in North Dakota for durable medical equipment providers

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Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by Oct. 1,

2009 and Oct. 2, 2009, respectively. If suppliers have made the decision not to obtain accreditation or a surety bond when required, they may want to voluntarily terminate their enrollment in the Medicare program before the implementation dates above.

In North Dakota, this may mean large gaps between durable medical equipment providers in the rural areas.

## Quality assurance: Does Medicare cover glucose monitors?

**Question:** I have diabetes and need to check my glucose levels with a glucose monitor regularly. Will Medicare pay for this?

**Answer:** Yes, Medicare pays for 80 percent of the cost of self-monitoring equipment and supplies, including glucose monitors, test strips and lancets. To get the supplies, go to a Medicare-certified supplier.

Medicare requires that you or your caregiver explicitly ask for a refill of your supplies before they are sent to you. Medicare will not pay for supplies that are sent to you automatically.

Medicare will also cover 80 percent of the cost of diabetes self-management training and education if your doctor says that you need these services. You

can get up to 10 hours of self-management training for your first year, and two hours every year thereafter.

Medical nutrition therapy services also are covered for people with diabetes (or kidney disease) when referred by a doctor and consists of an initial assessment, follow-up visit for interventions and reassessments as needed during a 12-month period beginning with the initial assessment to assure you are following the dietary plan. These services can be given by a registered dietician or Medicare-approved nutrition professional and include nutritional assessment and counseling.

Glaucoma screening for people with diabetes or a family history of glaucoma is also covered by Medicare.

This is adapted from [www.medicareinteractive.org](http://www.medicareinteractive.org)

## Check your skills: annual enrollment period quiz

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1. If an individual enrolls in a Part D plan on Nov. 20 and realizes that there is a better drug plan available for him, can he switch plans before Dec. 31?

**Answer:** Yes. Beneficiaries may switch their drug plans during the annual enrollment period (AEP) simply by enrolling in a new one. The last enrollment choice made during the AEP will be the choice that becomes effective.

2. Do Medicare beneficiaries who are automatically enrolled in a Part D plan have the opportunity to change plans after their enrollment takes effect?

**Answer:** Yes. All individuals whose enrollment is facilitated by CMS because they qualified for low income subsidy have a continuous special enrollment period (SEP) to switch to another plan.

3. During the AEP, can an individual enroll in a Part D drug plan in person at a Social Security office?

**Answer:** No. Enrollment can be done by:

- Calling the plan's toll free number
- Enrolling online at [www.medicare.gov](http://www.medicare.gov)
- Sending a paper enrollment form to the plan
- Calling 1-800-MEDICARE

4. If a beneficiary enrolls in a Part D plan during the AEP, will she begin receiving coverage from the plan immediately upon enrollment?

**Answer:** No. If a beneficiary enrolls in a Part D plan during the AEP, she will begin receiving coverage from the plan effective Jan. 1 of the following year.

5. If a beneficiary has VA coverage (or IHS or an employer group health plan), they will not be penalized for taking out a Part D plan.

**Answer:** Yes. If a beneficiary enrolls in a Part D plan and has the above coverage, they will have no late enrollment penalty.

## Observation status can cause financial problems for unpaid prescriptions of Medicare beneficiary

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Medicare beneficiaries may have found that they are responsible for some of their medication costs in a hospital facility after they have received care. After further review, and reports to the North Dakota Insurance Department, these individuals were in the hospital under the status of ‘observation.’

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged. Observation status is commonly assigned to patients who admit to the emergency room and then require a significant period of monitoring before a decision is made concerning their admission or discharge.

Coverage of outpatient observation services is considered that of an outpatient. Therefore, prescription drugs are usually denied Part A coverage, because the patient does not have the ‘inpatient’ status. Hospitals are not required to have the patient sign an Advanced Beneficiary Notice

(ABN) regarding these charges. Due to these guidelines from CMS, many Medicare beneficiaries are confused when these prescription charges are not paid by Medicare. The beneficiary first learns of their financial responsibility when they receive the bill from the hospital.

If this scenario happens, a Medicare beneficiary can submit the bill for prescriptions directly to their Part D plan for reimbursement. The beneficiary should ask the plan for a claim form and submit a copy of the bill, along with the form, directly to the plan. It is important to know that the reimbursement will almost always be less than what the facility charges for the medication. This is due to the hospital pharmacy being an out-of-network provider.

Some medical facilities will waive a portion of the remaining balance after the plan pays their share, so negotiate with the provider. Additionally, certain hospitals will let you bring your own prescriptions into the facility, so check with the health care provider to review their policies.

## Medicare Part B premiums may rise for some in 2010

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For the first time in many years, Americans may not receive cost-of-living increases (COLA) in their Social Security check in 2010. However, millions of Medicare beneficiaries will face much higher Medicare Part B premiums next year.

Medicare Part B premiums are used for Medicare-covered services such as physician services, durable medical equipment and outpatient therapy.

Under a hold-harmless provision of federal law, basic Medicare Part B premiums cannot rise higher than last year’s COLA. So, a zero COLA means that the basic premium (currently \$96.40 a month) must stay the same.

This hold-harmless policy gives this protection to the majority of people enrolled in Medicare Part B who also receive Social Security, Railroad Retirement or

Civil Service retiree benefits.

Recent projections by AARP estimate the increase will affect about one in four Medicare beneficiaries.

The increase will affect beneficiaries who:

1. Do not have their Part B premiums withheld from Social Security checks
2. Pay a Part B premium based on higher income
3. Are newly enrolled in Part B
4. Have their Part B premiums paid by Medicaid (low-income people will not be affected, but the state will pay the higher premium)

## The Senate's turn: help for donut hole issues

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The health care plan outlined by President Obama would close the Part D coverage gap, providing people with Medicare coverage for all of their medicines throughout the year. Even as the gap narrows in the years before it is fully closed in 2019, people with Medicare would receive 50 percent discounts on brand name drugs.

The health reform bill pending in the House of Representatives, America's Affordable Health Choices Act (HR 3200), would phase out the coverage gap, also known as the doughnut hole, over 12 years and provide similar discounts in the interim. HR 3200 helps pay for the improved coverage by securing price concessions from drug manufacturers.

We don't know yet what the Senate will do, but an unofficial summary of the health care bill drafted by Senate Finance Committee Chairman Max Baucus, Democrat of Montana, does not include a plan to close the doughnut hole but does mandate 50 percent discounts on brand name drugs in the coverage gap for middle-income consumers.

While the discount program may help people with Medicare better afford some prescription drugs in the short term, it is not sufficient. Closing the doughnut hole will provide people with Medicare coverage for

all their drugs, both brand name and generic, at lower copayments that remain consistent throughout the year.

When the Senate Finance Committee marks up its health care bill later this month, it should include a full phase-out of the doughnut hole.

People who fall in the coverage gap spend, on average, \$4,080 out-of-pocket for the prescription drugs. The high cost of drugs in the doughnut hole force people to skip doses or split pills, putting their health at risk. Please write your senators and representative and tell them that health care reform legislation must close the doughnut hole.

*Source: [Medicarerights.org](http://Medicarerights.org)*



## Medicare Advantage and Medicare Advantage/PDP plan nonrenewal in North Dakota

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Approximately 1,000 people will not have plan renewals in North Dakota from their Medicare Advantage (or MA/PDP) plans in 2010. In most instances, these people MAY have guaranteed issue for a supplement. Guaranteed issue means that a company cannot turn the beneficiary down for coverage.

Guaranteed issue #1 per the 2009 CMS choosing a Medigap policy:

- You are in a MA plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.

- You may have a right to buy Medigap Plan A, B, C, F, K or L that is sold in your state by any insurance company.

- You can apply up to 60 calendar days before the date your health care coverage will end. You must apply no later than 63 calendar days after your health care coverage ends.

Please encourage beneficiaries to call a SHIC counselor if they find themselves without a plan. An instruction sheet will be provided to help with the transition.

## Medicare Drug Coverage: Standard Beneficiary Cost Sharing (2010)

	Beneficiary Spending (TrOOP)	Plan Spending	TOTAL
Annual Deductible	\$310	\$0	\$310
Initial Coverage Period*	25% of drug costs up to \$630	75% of drug costs up to \$1,890	\$2,520**
Coverage Gap (Doughnut Hole)*	100% of drug costs up to \$3,610	\$0	\$3,610
<b>TOTAL</b>	\$4,550	\$1,890	<b>Beneficiary + Plan: \$6,440</b>
<b>Catastrophic Benefit (After \$4,550 in TrOOP)</b>	Greater of 5% of drug price or \$2.50/\$6.30 co-pay	Balance of drug cost	

\*After meeting the Annual Deductible in a standard plan, a beneficiary enters the Initial Coverage Period. During the Initial Coverage Period, the beneficiary pays 25 percent of prescription drug costs, up to \$630 out-of-pocket; the plan pays 75 percent of these drug costs, up to \$1,890. Only “true” out-of-pocket (TrOOP) expenditures – contributions from friends, relatives, and certain charitable foundations and state pharmacy assistance program payments – count towards a beneficiary’s TrOOP. Any amount paid by other insurance may not count towards TrOOP. Likewise, any payments for prescription drugs not on the plan’s formulary will not count.

\*\*Beneficiaries enter the coverage gap when total drug costs reach \$2,830 (Annual Deductible + Initial Coverage Period).

**Please note:**

- HAP’s Web site has information about Part D cost sharing for beneficiaries receiving the low-income subsidy (LIS).
- Beneficiaries also may pay a monthly premium, which is approximately \$32, but varies by region and by plan.
- Beneficiaries reach the catastrophic benefit once they have spent \$4,550 out-of-pocket (in 2010) with approximate total drug spending at \$6,440 in prescription drug costs.
- Total out-of-pocket spending does not include the monthly premium.
- Because most plans do not follow the standard cost-sharing structure, calculating TrOOP may vary by plan.

Source: Table IV-7 of <http://www.cms.hhs.gov/MedicareAdvgtgSpecRateStats/Downloads/Announcement2010.pdf>

## Check your skills: shingles vaccine

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As of Jan. 1, 2008, Medicare pays for the vaccine and the administration of the vaccine for shingles under Part D. Beneficiaries can receive the vaccination in one of two ways:

1. At a network pharmacy (except for the state of Maine), which would bill the beneficiary's Part D plan directly; or
2. At the beneficiary's doctor's office.

If the beneficiary opts to receive the vaccination at a doctor's office (outside of the Part D plan's network), the physician would administer the vaccine and then bill the beneficiary for the entire charge, including both components (vaccine and administration). The beneficiary should submit a paper claim to the Part D sponsor for reimbursement of plan-allowable costs for both the vaccine cost and the administration fee.

## Rules for the H1N1 vaccine and seasonal flu coverage and reimbursement

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A new Special Edition MLN Matters article regarding Billing for the Administration of the Influenza A (H1N1) Vaccine is now available. This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine and also addresses seasonal flu coverage and reimbursement.



Note that Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. Such preparations are critical for the upcoming flu season, especially in planning for the influenza A (H1N1) vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e., the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A (H1N1) vaccination, then Medicare will pay for both.

Please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

All providers administering flu vaccine should review this article and be sure that their billing staffs are aware of this information. For more information, please read the article located at: [www.cms.hhs.gov/MLNMattersArticles/downloads/SE0920.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0920.pdf)

*Source: CMS*

# Traveling and Medicare coverage

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You should know how your Medicare coverage will work if you travel. The way you get your Medicare benefits—whether you have Original Medicare and supplemental insurance (Medigaps, retiree plan, etc.) or a Medicare private health plan (like an HMO or PPO)—and where you are traveling affects the health coverage you may be able to receive when you are away from home.

## Travel within the U.S.

If you have Original Medicare, the traditional fee-for-service program offered directly through the federal government, no matter where you travel in the 50 states, the District of Columbia and United States territories (such as Puerto Rico, Guam, American Samoa, the Northern Mariana Islands or the Virgin Islands), Original Medicare will cover your health care costs. With Original Medicare, you can see any doctor or go to any hospital in the country that takes Medicare (and most do).

If you are in a Medicare private health plan, a private insurance company that is paid by the federal government to supply your Medicare coverage to you, it is important to know your plan's rules for covering you if you go into another state.

Outside of your plan's service area (the geographical area within which a Medicare private health or drug plan provides coverage for its members) and network (a group of doctors, hospitals and pharmacies that contract with a private plan and to whom plan members must go to receive coverage for medical services), many plans only cover emergency and urgent care.

Some, often more expensive, plans cover you for non-emergency services if you go out of your service area. You should check with your plan to find out the specifics of its network, costs and restrictions.

## Travel outside the U.S.

Generally, Original Medicare does not provide any coverage when you are traveling outside of the US. It does not cover emergency services in foreign countries except in Canada and Mexico, and then only under very specific circumstances. Medicare will pay for

emergency care in Canada and Mexico if:

- 1) You are in the US when an emergency occurs and a Canadian or Mexican hospital is closer to you than the nearest US hospital that can treat the emergency;
- 2) You live in the US and a Canadian or Mexican hospital is closer to your home than the nearest US hospital that can treat your medical condition, regardless of whether an emergency exists; or
- 3) You are traveling between Alaska and the continental US and you experience a medical emergency in Canada. If a Canadian hospital is closer than the nearest US hospital, Medicare will pay for your emergency care in Canada. The requirement of this coverage is that you must be traveling "without unreasonable delay," the definition of which is determined by Medicare on a case-by-case basis.



The other exception to Medicare's moratorium on coverage of care that you receive outside of the United States is related to travel on a cruise ship. Medicare will pay for medical care you get on a cruise ship if:

- 1) The ship is registered to the U.S.;
- 2) The doctor is registered with the Coast Guard; and
- 3) You get the care while the ship is in U.S. territorial waters. This means the ship is within six hours of arrival at or departure from a US port.

If you have a Medicare private plan you must be able to receive emergency coverage outside of the U.S. under the same circumstances as people with Original Medicare. However, your plan may not cover as much of the cost of these services as they normally would if you went to a doctor or hospital in the plan's network, and other rules may apply. Before traveling outside of the U.S., you should check with your private plan to see under what circumstances they will cover your medical care abroad.

continued ...

If you have Original Medicare you may have the option to purchase a supplemental plan known as a Medigap. These plans may provide emergency care outside of the U.S. For example, in most states (including New York), Medigap plans C through J cover 80 percent of the cost of emergency care abroad during the first two months of a trip.

If you have other supplemental coverage, such as retiree insurance, you should check to see if they cover medical care outside of the US. Again, some Medicare private health plans such as HMOs cover the costs of emergency care abroad, but most do not (except for the specific circumstances listed above). You should check your plan's coverage rules for more information.

You also have the option to buy separate travel insurance from a private company, whether you have Original Medicare (with or without supplemental coverage) or a Medicare private health plan.

An insurance agent or travel agent could also provide more information about purchasing travel insurance. Travel insurance does not necessarily have to include health coverage, so find out exact benefits before you purchase a plan if you enroll in a Part D plan.

Source: The Medicare Counselor

## Generic drug roundup

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Each year, the Food and Drug Administration (FDA) approves many generic drugs that treat a wide variety of conditions and help consumers save money.

Significant approvals for prescription products granted by FDA's Office of Generic Drugs since January 2009 include:

Brand name	Generic
Ambien	Zolpidem
Coreg	Carvedilol
Casodex	Bicalutamide
CoSopt Ophthalmic Solution	Dorzolamide and Timolol Maleate
Depakote	Divalproex
Fosamax	Alendronate Sodium
Imitrex	Sumatriptan
Keppra	Levetiracetam Oral
Kytril	Granisetron
Pravachol	Pravastatin
Plan B	Levonorgestrel Tablets
Razadyne	Galantamine
Requip	Ropinirole
Risperdal	Risperidone
Trileptal	Oxcarbazepine
Topamax	Topiramate
Zyrtec	Cetirizine

## Director's corner

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Greetings!

We just finished our Fall SHIC Update training and boy was it a success! We had 64 of the 92 counselors there. We had fun learning about 'Making Sense of Sensory Losses as we Age,' presented by Dena Kemmet from NDSU Extension Services. We also enjoyed 'Who Gets Grandma's Yellow Pie Plate' by Merry Green from the Minot Commission on Aging. Merry's presentation was about the distribution of personal effects.

We also learned more details about Medicaid in North Dakota, the changes surrounding MIPPA implementation and the 2010 Part D cost sharing. As always, we laughed with Sharon St. Aubin as she presented real case management issues with the 'CSI-Medicare problem solving' session. What REALLY topped off the day was when we had to eat our lunch in the dark!

Thank you to all the presenters and participants. It was an educational yet fun day.

We are busy gearing up for this year's Part D annual enrollment period. As you know, we are now training SHIC counselors to be trained only in Part D, which makes it a lot less intense. If you know anyone that would like to become trained, it is not too late. Please let me know and we can get them trained before Nov. 15.

As always, we appreciate all you do.

Sincerely,



Cindy Sheldon

### 2-1-1 to start Oct. 1

The North Dakota Insurance Department encourages you to review your Medicare Part D plan every year. Call 2-1-1 for a plan comparison beginning Oct. 1. Have a list of your medications ready, along with your health insurance information. After answering a few questions, you'll get a customized comparison list of Part D plans mailed to you.



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600 East Boulevard Avenue  
Bismarck, ND 58505  
Phone: 701.328.2440  
Toll-free: 888.575.6611  
Fax: 701.328.4880  
TTY: 800.366.6888  
Web: [www.nd.gov/ndins](http://www.nd.gov/ndins)  
Email: [ndshic@nd.gov](mailto:ndshic@nd.gov)

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For Medicare-related resources, please visit  
[www.medicarerights.org](http://www.medicarerights.org).