

SHIC

talk

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

December 2009



Dear friends,

Thank you to all of our volunteers who participated in the Insurance Department's Medicare Part D annual enrollment events this year, and thanks to those who helped beneficiaries compare plans from your own offices. As you will see in Cindy's column on page 11, attendance at the events was lower than last year, but phone intakes were up substantially. This shift in volume was a benefit to those who attended the events—wait times were much shorter than last year. You are a big part of why these events are a success; thank you for your support.

Last time you heard from me, the Insurance Department was preparing to conduct four more limited-income CHAT sessions. CHAT, or Choosing Healthplans All Together, is the name of the health insurance study we conducted around the state this summer and fall. CHAT gave us a unique opportunity to get direct input from North Dakotans of varying backgrounds as to what is important in a basic health insurance plan. We are currently evaluating the results of the study and look forward to sharing the final report with consumers, legislators and many other stakeholders.

As you know, the next open enrollment period is for Medicare Advantage plans, running Jan. 1 through March 31. It is always a good idea for beneficiaries to review the pros and cons between a Medicare Advantage Plan and Original Medicare to ensure they are choosing the appropriate plan for their needs. Beneficiaries should also check with their medical facilities to make sure the Medicare Advantage plan will be accepted.

Thank you for your dedication to the SHIC program and the Insurance Department in 2009.

Happy holidays!

Sincerely,


Adam Hamm
Insurance Commissioner



Advantra Freedom and Wellcare leaving North Dakota

Nearly 2,000 people will be losing their Medicare Advantage (MA) Plan in North Dakota Dec. 31, 2009 due to non-plan renewals. In most instances, these people may have guaranteed issue for a supplement. 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 for a Medigap Plan 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.

Additionally, if these individuals had drug coverage in their MA plan, they will need to select a new drug plan. There is a special open enrollment period (SEP) for their Part D plan:

Non-renewals—A SEP exists for members of MA plans that will be affected by plan or contract non-renewals and plan service area reductions that are effective January 1 of the contract year. In order to provide sufficient time for members to evaluate their options, the SEP begins Oct. 1 and ends on Jan. 31 of the following year. During this SEP, a beneficiary may choose an effective date of Nov. 1, Dec. 1, Jan. 1 or Feb. 1; however, the effective date may not be earlier than the date the new MA organization receives the enrollment request. Only enrollment requests received in January will have an effective date of Feb. 1.

Questions? Call SHIC at 1-888-575-6611.

Low-income subsidy information

The following are Full Low-Income Subsidy and Medicaid Plans for 2010:

- Aetna Medicare RX Essentials PDP
- BravoRx PDP
- First Health Part D Premier PDP
- HealthSpring Prescription Drug Plan-Reg 25 PDP
- SilverScript Value PDP
- AARP MedicareRx Saver PDP

- Community CCRx Basic PDP
- PrescribaRx Bronze PDP

The North Dakota benchmark for PDP plans is \$37.55 (this is for determining LIS eligible plans).

The national average premium is \$31.94 (this is the rate which used to figure the late enrollment penalty).

Does Medicare cover screenings for heart disease?

Yes. Medicare covers blood tests every five years to screen for cholesterol, for lipid and triglyceride levels, and for other signs of cardiovascular disease (or indications that you are at high risk for it).

Medicare will pay 100 percent of its approved amount for these tests, even before you have met the Part B deductible.

The American Heart Association estimates that over 80 million Americans have one or more forms of heart disease, including high blood pressure, coronary heart disease and stroke. Heart disease and stroke are the first and third leading causes of death in the US. Heart screening can save your life and improve your quality of life by treating the condition before it results in more severe health problems.

Medicare Parts B/D Coverage Issues

This table provides a quick and easy reference guide for the most frequent B/D coverage determination scenarios facing Part D plans and Part D pharmacy providers. It does not address all potential situations. For more extensive discussion, please refer to the Medicare Part B vs. Part D Coverage Issues document available at:

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf

Part B Coverage Categories	Part B Coverage Description	Retail and Home Infusion Pharmacy Setting B/D Coverage	LTC Pharmacy Setting B/D Coverage	Comments
Durable Medical Equipment (DME) Supply Drugs NOTE: Only available for beneficiaries residing in their "home" ¹	Drugs that require administration via covered DME (e.g. inhalation drugs, IV drugs "requiring" ² a pump for infusion, insulin via infusion pump) ³	Part B	Part D Because most LTC facilities are not considered a beneficiary's "home" ⁴	Blood Glucose Testing Strips and Lancets covered under Part B DME benefit are never available under Part D because they are not Part D drugs.
Drugs furnished "incident to" a physician service	Injectable/ Intravenous drugs 1) administered "incident to" a physician service <u>and</u> 2) considered by Part B carrier as "not usually self-administered".	Part D Because by definition a pharmacy cannot provide a drug "incident to" a physician's service (Only a physician office would bill Part B for "incident to" drugs).	Part D Because by definition a pharmacy cannot provide a drug "incident to" a physician's service (Only a physician office would bill Part B for "incident to" drugs).	Part D plans should not implement pharmacy edits to determine B vs. D coverage for injectable/IV drugs only covered under Part B when furnished "incident to" a physician service.

¹ In addition to a hospital, a SNF or a distinct part SNF, the following LTC facilities cannot be considered a home for purposes of receiving the Medicare Part B DME benefit:

- A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF)
- A Medicaid-only NF that primarily furnishes skilled care;
- A non-participating nursing home (i.e. neither Medicare nor Medicaid) that provides primarily skilled care; and
- An institution which has a distinct part SNF and which also primarily furnishes skilled care.

² The DMERCs determines whether or not an IV drug requires a pump for infusion.

³ The DMERCs do a medically necessity determination with regard to whether a nebulizer or infusion pump is medically necessary for a specific drug/condition.

⁴ If a facility does not meet the criteria in footnote 1, it would be considered a home, and Part B could cover the drugs.

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Part B Coverage Categories	Part B Coverage Description	Retail and Home Infusion Pharmacy Setting B/D Coverage	LTC Pharmacy Setting B/D Coverage	Comments
Immunosuppressant Drugs	Drugs used in immunosuppressive therapy for beneficiaries that received transplant from Medicare approved facility and were entitled to Medicare Part A at time of transplant (i.e. "Medicare Covered Transplant").	<p><u>B or D:</u> Part B for Medicare Covered Transplant</p> <p>Part D for all other situations</p>	<p><u>B or D:</u> Part B for Medicare Covered Transplant</p> <p>Part D for all other situations</p>	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.
Oral Anti-Cancer Drugs	Oral drugs used for cancer treatment that contain same active ingredient (or pro-drug) as injectable dosage forms that would be covered as 1) not usually self administered and 2) provided incident to a physician's service	<p><u>B or D:</u> Part B for cancer treatment</p> <p>Part D for all other indications</p>	<p><u>B or D:</u> Part B for cancer treatment</p> <p>Part D for all other indications</p>	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.
Oral Anti-emetic Drugs	Oral anti-emetic drugs used as full therapeutic replacement for IV anti-emetic drugs within 48 hrs of chemo	<p><u>B or D:</u> Part B within 48 hrs of chemo</p> <p>Part D all other situations</p>	<p><u>B or D:</u> Part B within 48 hrs of chemo</p> <p>Part D all other situations</p>	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.

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Part B Coverage Categories	Part B Coverage Description	Retail and Home Infusion Pharmacy Setting B/D Coverage	LTC Pharmacy Setting B/D Coverage	Comments
Erythropoietin (EPO)	Treatment of anemia for person with chronic renal failure who are undergoing dialysis	<p><u>B or D:</u> Part B for treatment of anemia for beneficiaries undergoing dialysis</p> <p>Part D all other situations</p>	<p><u>B or D:</u> Part B for treatment of anemia for beneficiaries undergoing dialysis</p> <p>Part D all other situations</p>	EPO may be covered under Part B “incident to” physician’s service for other indications but a pharmacy would not be billing for “incident to” drugs
Prophylactic Vaccines	Influenza; Pneumococcal; and Hepatitis B (for intermediate to high risk beneficiaries).	<p><u>B or D:</u> Part B for Influenza, Pneumococcal, & Hepatitis B (for intermediate to high risk)</p> <p>Part D for all others</p>	<p><u>B or D:</u> Part B for influenza, pneumococcal, & Hepatitis B (for intermediate to high risk)</p> <p>Part D for all others</p>	Vaccines given directly related to the treatment of an injury or direct exposure to a disease or condition are always covered under Part B
Parenteral Nutrition	Prosthetic benefit for individuals with “permanent” dysfunction of the digestive tract. If medical record, including the judgment or the attending physician, indicates that the impairment will be long and indefinite duration, the test of permanence is met.	<p><u>B or D:</u> Part B if “permanent” dysfunction of digestive tract</p> <p>Part D for all other situations</p>	<p><u>B or D:</u> Part B if “permanent” dysfunction of digestive tract</p> <p>Part D for all other situations</p>	Part D does not pay for the equipment/supplies and professional services associated with the provision of parenteral nutrition or other Part D covered infusion therapy.

2010 deductibles and premiums

Hospital deductible

\$1,100 per benefit period

Hospital coinsurance

- Days 61-90 \$275 per day
- Days 91-150 \$550 per day

Skilled nursing facility coinsurance

- Days 21-100 \$137.50 per day

Premium for voluntary enrollees

- 30-39 quarters of coverage \$254 per month
- Less than 30 quarters of coverage \$461 per month

Medicare Part B

Deductible \$155 per year
Premium \$96.40 for most beneficiaries.
Please see note and chart below.

Beneficiaries who file an individual tax return

Annual income	Monthly premium
< \$85,000	\$110.50
> \$85,000, but < \$107,000	\$154.70
> \$107,000, but < \$160,000	\$221.00
> \$160,000, but < \$214,000	\$287.30
> \$214,000	\$353.60

Beneficiaries who file a joint tax return

Annual income	Monthly premium
< \$170,000	\$110.50
> \$170,000, but < \$214,000	\$154.70
> \$214,000, but < \$320,000	\$221.00
> \$320,000, but < \$428,000	\$287.30
> \$428,000	\$353.60

Married beneficiaries who file separate tax returns

Annual income	Monthly premium
< \$85,000	\$110.50
> \$85,000, but < \$129,000	\$287.30
> \$129,000	\$353.60

Part B Premium in 2010:

The Social Security Administration (SSA) announced that there will be no cost of living adjustment (COLA) increase in 2010. This means beneficiaries will see no increase in their Social Security benefits in 2010. Current law, known as the hold harmless provision, protects most beneficiaries from a negative net income. In short, the provision states that a beneficiary is protected from seeing a decrease in their Social Security benefits due to an increase in their Part B premium.

About 73 percent of current Medicare beneficiaries will continue to have the same Part B monthly premium of \$96.40 in 2010. However, the remaining 27 percent are not protected by the hold harmless provision because they are either higher income or do not have their Part B premium taken from their Social Security benefits. These beneficiaries will pay a higher Part B premium in 2010, beginning at \$110.50. The remaining 27 percent includes beneficiaries new to Medicare in 2010 (3 percent), those who already pay an adjusted Part B premium because of a higher income (5 percent), and those whose Part B premium is paid by Medicaid through one of the Medicare Savings Programs (17 percent).
Source: CMS

SHIC planning new long-term care seminars

The State Health Insurance Counseling (SHIC) Program is planning a new series of seminars for consumers focused on long-term care insurance.

“Our goal is to hold a few seminars in the spring of 2010,” Cindy Sheldon, program director, said. The seminars will resemble the Department’s successful “Turning 65” seminars, aimed at providing consumers with basic information.

Topics in the new long-term care sessions may include: what is long-term care, what is long-term care insurance, other options for long term care, information on the North Dakota tax credit and the Long-Term Care Partnership Program.

Will Medicare cover the 2009 H1N1 flu vaccine?

Yes. Medicare will cover administration of the 2009 H1N1 flu. Your doctor or health care provider can't charge you for the 2009 H1N1 vaccine because they received the vaccine for free. You pay nothing for the 2009 H1N1 vaccine's administration if your doctor or health care provider accepts assignment.

Assignment means that your doctor, provider or supplier has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. The Part B deductible and coinsurance don't apply to the 2009 H1N1 vaccine or its administration.

Do I also need to get the seasonal flu vaccine?

Yes, you should still get the seasonal flu vaccine. Medicare will pay for the seasonal flu vaccine once per flu season. You pay nothing if your doctor or health care provider accepts assignment. The seasonal flu vaccine is different from the 2009 H1N1 flu vaccine. The CDC is encouraging people to get both

vaccines.

Are there medicines to treat the 2009 H1N1 flu?

Yes. There are drugs your doctor may prescribe for treating both seasonal and H1N1 flu called "antiviral drugs." These drugs can make you better faster and may also prevent serious complications.

This flu season, antiviral drugs are being used mainly to treat people who are very sick, such as people who need to be hospitalized, and to treat sick people who are more likely to get serious flu complications.

Contact your doctor for advice on how to treat the H1N1 flu. Remember, most people with 2009 H1N1 flu have had mild illness and haven't needed medical care or antiviral drugs, and the same is true of seasonal flu. If you have Medicare prescription drug coverage, antiviral drugs may be covered. Check with your plan.

Source: CMS

Help stop medical discount card fraud

The U.S. Federal Trade Commission (FTC) needs your help in halting a surge in the fraudulent marketing of medical discount cards. In these schemes, marketers typically represent that consumers will receive low-cost health insurance or medical benefits. In reality, consumers do not receive health insurance or any meaningful medical benefits. Instead, they receive a card that purports to provide discounted rates with medical providers. Consumers find that the promised discounted rates are illusory.

These bogus medical discount programs are marketed to consumers in a variety of ways, including illegal

recorded telephone calls (robocalls), unsolicited faxes, radio and television ads and web sites. Regardless of the medium, the ads often target seniors, claiming that the discount cards will supplement Medicare.

The FTC, which is the federal government's consumer protection agency, brings federal court law enforcement actions to stop fraud and obtain refunds for consumers. If you have information about a medical discount card scheme, or learn of a victim of such a scheme, please contact the FTC by calling Artie DeCastro at 202-326-2747.

**Do you need 2010 Medicare & You
manuals or other CMS products?
Call 1-888-575-6611.**

MA and PDP Plan Marketing Fact Sheet

What marketing activities are MA and PDP plans permitted to do?

- **Provide beverages and light snacks to potential enrollees**
 - Including fruit, raw vegetables, pastries, cookies, crackers, muffins, yogurt, nuts
 - Cannot be bundled as a meal
- **Send direct mail to potential enrollees**
- **Call current enrollees to conduct business specifically related to current plan**
- **Call former enrollees for disenrollment survey**
 - Must call after effective date of disenrollment
- **Enrolling agents and brokers may call the beneficiaries they enrolled**
- **Market plans in healthcare common areas**
 - Including hospital or nursing home cafeterias, community or rec rooms, conference rooms
- **Participate in educational events**
 - May distribute Medicare information, health educational materials, and business cards (only upon beneficiary request) when invited to participate in the event
 - Must provide disclaimer that “event only for educational purposes and no plan specific benefits or details will be shared” when organizing, sponsoring, or promoting as an educational event
- **Visit potential enrollees at their homes**
 - Only upon beneficiary request
- **Identify specific type of plan to be discussed**
 - Prior to marketing event or in-home appointments
 - Additional types of plans may be discussed at separate appointment (only upon beneficiary request) at least 48 hours later

What marketing activities are plans NOT permitted to do?

- **Provide potential enrollees meals or subsidize the cost of meals**
- **Contact potential enrollees unsolicited**
 - Including door-to-door marketing, outbound marketing calls, marketing calls to former enrollees, calls to confirm receipt of mailed information, calls to confirm appointments, approaching potential enrollees in common areas, follow-up calls or visits after sales events, email
- **Market plans or collect enrollment forms at educational events**
 - Including health fairs, conference expositions, state or community-sponsored events
- **Market non-health care related products**
 - Including annuities and life insurance
- **Market plans or collect enrollment forms in healthcare settings**
 - Including waiting or exam rooms, hospital rooms, dialysis clinics, pharmacy counters
- **Cannot use name or logo of a co-branded network partner on membership materials**
 - Including ID or membership cards

MA and PDP Plan Marketing Fact Sheet

What marketing activities are providers permitted to do?

- **Distribute and/or make available plan marketing materials**
 - Must include materials from all plans with which they participate
 - Make available PDP enrollment applications
 - Cannot make available MA (including MA-PD) enrollment applications
- **Provide patients with benefits information about different plans**
- **Educate patients on the type of plans that might best suit them**
 - Providers cannot steer patients to any one plan or group of plans

What marketing activities are providers NOT permitted to do?

- **Accept any enrollment applications**
- **Rank, order, or highlight any of the plans they discuss**
- **Advocate for any particular plan or group of plans**
 - Cannot use phrases such as, "You should enroll in this plan" or "I use this plan and I think it would be good for you too"
 - Cannot favor or appear to favor one plan or a group of plans over others

How to report potentially improper conduct

If you think, or have reason to believe, that a plan, agent or broker, or a provider is acting improperly, you may want to report their activities. Below are some key contact information for persons and organizations that deal with Medicare fraud, waste, and abuse.

CMS

Call 1-800-MEDICARE (or the SHIP Medicare hotline at 1-888-647-6701).

Senior Medicare Patrol

SMPs are organizations in every state whose purpose is to locate and report potential fraud and abuse. Find your local SMP at:

http://www.aoa.gov/smp/grantee/grantee_state.asp.

CMS redesigns Point-of-Sale process (formerly WellPoint)

The Centers for Medicare & Medicaid Services (CMS) has redesigned the Point-of-Sale Facilitated Enrollment (POS FE) process administered by WellPoint. Starting Jan., 2010, the new program will be known as the Limited Income Newly Eligible Transition (NET) Program, and it will be administered by Humana.

Limited Income NET provides coverage immediately

Limited Income NET will provide immediate prescription drug coverage for people with Medicare who are at the pharmacy counter and qualify for Extra Help, but aren't enrolled in a Medicare drug plan.

Limited Income NET covers all Part D covered drugs, and there are no prior authorization or network pharmacy restrictions during the time period covered by this program. The person will be charged the reduced copayment based on the level of Extra Help they get.

Limited Income NET will also cover prescriptions that eligible people filled within the last 30 days. See "The Limited Income NET Program for People With Retroactive Medicaid & SSI Eligibility" tip sheet for more details about how Limited Income NET works.

How does the pharmacist know a person is eligible?

If a pharmacy has reasonable assurance that a person is eligible for Medicaid or Extra Help (and they have no other Part D drug coverage), the pharmacy can submit the claim to Limited Income NET.

A pharmacy can confirm a person qualifies for Extra

Help either through an E1 query to Medicare's online eligibility/enrollment system (TrOOP Facilitator), or with one of the following:

- A copy of the person's Medicaid card that includes his/her name and effective eligibility date
- Documentation that shows Medicaid status, such as a copy of a state document, a printout from the state electronic enrollment file, or a screen print from the state's Medicaid system
- A copy of one of the following Extra Help letters from Social Security:
 - "Notice of Award"
 - "Notice of Change" indicating an award increase
 - "Notice of Planned Action" indicating an award reduction
 - "Notice of Important Information" indicating no change to the person's award

What if a person's eligibility can't be confirmed?

If Limited Income NET can't confirm a person is eligible for Medicaid or Extra Help through a CMS system, they will send a notice to the person asking for proof of eligibility. Proof of Medicaid or Extra Help eligibility can be faxed to Limited Income NET at 1-877-210-5592. A state or county Medicaid staff person can also call Limited Income NET on behalf of a person with Medicare at 1-800-783-1307 to verify the person qualifies for Medicaid or Extra Help.

If the person fails to provide proof, then the person (not the pharmacy) will be liable for the cost of the prescription.



Director's corner

Greetings!

Well, another busy annual enrollment period it was! I want to personally thank all the volunteers across the state that have helped us with the 10 statewide events. They were all successful, albeit not near as busy as last year. We had about half of the attendance compared to last year. Why do we think this was? We believe it is twofold; number one, First Health Part D Secure continues to be the cheapest PDP plan in 2010 as it was last year. Additionally, the 211 phone system was used more heavily this year. As of Dec. 7, 211 had received almost 800 calls.

Please remember, Jan. 1 through March 31 is the open enrollment period for Medicare Type C. This is the period of time where individuals can make changes to their Medicare Type C plans. Please see page 8 for Medicare Advantage marketing guidelines. If you are aware of agent or plan misrepresentation, please call the Insurance Department to report it.

Additionally, it is important for beneficiaries to weigh the pros and cons of enrolling in a Medicare Advantage Plan. It can be a great cost saving tool, but it is not for everyone.

As a reminder, Part B premiums may be going up for many in 2010. See page 6 for more details. You may be receiving calls after Jan. 1 concerning this issue; please be prepared.

Again, thank you for your assistance in making it another great year for SHIC and Prescription Connection.

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.