

SHIC Talk

A publication of the North Dakota Insurance Department's SHIC program



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Federal Employee Health Benefits

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July 2012

SHIC counselor pop quiz

True or false:

You can only disenroll from a Medicare Advantage plan during the fall open enrollment period if you qualify for a special enrollment period.

Go to page 4 to see the answer.





Adam Hamm
Insurance Commissioner

July 2012

A note from the Commissioner

Dear friends,

As I'm sure you've heard by now, the Supreme Court of the United States recently issued its ruling on the Patient Protection and Affordable Care Act. A five-to-four majority of the Supreme Court held that the provision requiring individual citizens to purchase health insurance coverage is permissible under the taxing authority of the U.S. Constitution. While I am disappointed with the ruling, I have a deep respect for the rule of the law.

While some of the bigger provisions like the individual mandate don't take effect until 2014, the Insurance Department has been busy handling an increased number of filings due to companies making changes to be compliant with the law.

We have also been reporting regularly to the interim Health Care Reform Review Committee of the legislature. And as we look ahead to the 2013 legislative session, we will undoubtedly be looking at some changes that will need to be made in order to comply with the health care reform law.

Now that the Supreme Court has ruled definitively, issues surrounding the law will move back to the political branches of the federal government. As that process unfolds, we will continue to do what we can to attempt to make this law work for North Dakotans.

Sincerely,

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

Adam Hamm

Questions from SHIP counselors to Medicare

My client recently received a letter from an organization called the Medicare Secondary Payer Recovery Contractor (MSPRC). The letter instructed my client to repay nearly \$3,000 to Medicare within 60 days. I called the number listed on the letter and waited on hold for nearly 30 minutes. When I finally reached a representative, I was told that my client had a car accident two years ago and that his injuries should have been covered by the automobile insurance company instead of by Medicare. What is MSPRC, and how can my client get Medicare to pay his claims?

As you already discovered, MSPRC stands for Medicare as Secondary Payer Recovery Contractor. MSPRC is a Medicare contractor hired by the Centers for Medicare and Medicaid Services (CMS) to make sure that Medicare does not pay for medical services when another insurer should be paying first before Medicare. Clients generally deal with MSPRC in two instances: they receive medical services for which Medicare pays but then receive notice from MSPRC that the payments are being recouped or they receive notice from Medicare that medical service payments are denied because they have an open case with MSPRC.

From your email, it sounds like client falls into the former category (i.e., he must repay medical payments made by Medicare). Unfortunately,



people with Medicare

who are involved in accidents often end up in very difficult situations.

Sometimes Medicare seeks to recover payments that it doesn't feel it should have paid, even when an accident occurred many years ago.

When a person with Medicare is in an accident, a case should be opened with MSPRC. In some instances Medicare will make a conditional, or temporary, payment after an accident. This means that while another insurance company is resolving the claim, Medicare will pay the cost of the medical care. However, Medicare expects these costs to be repaid once the settlement or payment from the

other insurer is finalized. If the settlement or payment has already been finalized, then Medicare will usually deny the medical claims until the other insurance payment has been used first. After the other insurance has paid primary, Medicare will pay second.

Before calling MSPRC, your client should carefully consider whether this is the correct way to resolve the situation. If Medicare is recouping payments it has made for claims it believes to be related to an accident, your client should call MSPRC. During this call, your client should provide evidence that these claims were unrelated to the accident or that no other payer was available.

If Medicare will not pay for claims that are unrelated to an accident because another insurance plan is primary, it may be that these claims were submitted or processed incorrectly. If claims are not being submitted correctly, this should be resolved by speaking to the claims department at 800-MEDICARE, or the Medicare Coordination of Benefits hotline at 800-999-1118.

(CMS)

Federal Employee Health Benefits—news you can use

Do Federal Employee Health Benefit (FEHB) Plans and Medicare cover the same types of expenses?

In general, yes. Some FEHB plans may provide coverage for certain items that Medicare doesn't cover, including but not limited to:

- Routine physicals and emergency care outside of the United States

- Some preventive services
- Dental and vision care

Medicare may cover some services and supplies that some FEHB plans may not cover, including but not limited to:

- Some orthopedic and prosthetic devices, and durable medical equipment
- Home health care
- Limited chiropractic supplies

Since I have FEHB coverage, do I need Medicare coverage?

The decision to enroll is yours.

Part A — if you are entitled to Part A without paying the premium, consider taking it even if you're still working. It may help cover some of the hospital related costs that your FEHB plan may not cover, such as deductibles, coinsurance and charges that exceed the plan's allowable charges.

Part B — if you are retired and enrolled in a fee-for-service

(FFS), Part B and your FFS plan may combine to provide almost complete coverage for all medical expenses.

If you are enrolled in an HMO, you may not need Part B. HMOs provide most medical services for small co-pays. However, you may want to consider Part B:

- It pays for costs involved with seeing doctors outside the Plan's network

- It pays for costs for non-emergency care in the U.S. if travel involved

- Required for Medicare Advantage & TRICARE

If you are working and have FEHB or you are covered under your spouse's group health insurance plan, you do not have to enroll in Part B when you turn 65. You'll have a special enrollment period when you retire or your spouse retires to enroll in Part B with no penalty.

Part C — Medicare Advantage is another way to get Medicare benefits. You may receive extra benefits such as vision or dental that Part A and Part B don't cover. If you wish to enroll in a Medicare Advantage plan, you must be enrolled in Part A and Part B. Contact your retirement office to discuss the option of suspending your FEHB enrollment.

continued on page 5

Pop quiz answer from page 1

False.

Medicare Managed Care Manual—Chapter 2

30.5—Medicare Advantage Disenrollment Period (MADP) Medicare Advantage (MA) plan enrollees have an annual opportunity to prospectively disenroll from any MA plan and return to Original Medicare between Jan. 1 and Feb. 14 of every year. The effective date of a disenrollment request made using the MADP will be the first of the month following receipt of the disenrollment request.

Regardless of whether the MA plan included Part D drug coverage, MA enrollees using the MADP to disenroll from MA from Jan. 1 through Feb. 14 are eligible for a coordinating Part D SEP to enroll in a PDP and may request enrollment in a PDP at any time during the MADP (see § 30.3.8 of Chapter 3 of the Medicare Prescription Drug Manual).

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“FEHB,” continued from page 4

Part D — Federal retirees and employees will likely not benefit from enrolling in Part D as comprehensive drug coverage is included in their FEHB plan. However, retirees with limited resources may want to consider enrolling in Part D if they qualify for Extra Help.

Is my FEHB plan or Medicare the primary payer?

Under most circumstances, your FEHB Plan must pay benefits first when you are an active Federal employee or reemployed annuitant and either you or your covered spouse has Medicare.

Medicare must pay benefits

first when you are an annuitant and either you or your covered spouse has Medicare

Can I change my FEHB enrollment when I become eligible for Medicare?

Yes, you may change your FEHB enrollment to any available plan or option at any time beginning 30 days before you become eligible for Medicare.

You may use this enrollment change opportunity only once. You may also change your enrollment during Medicare’s Annual Enrollment Period or because of another event that permits enrollment changes, such

as a change in family status.

Should I change plans?

Once Medicare becomes the primary payer, you may find that a lower cost FEHB plan is adequate for your needs, especially if you are currently enrolled in a plan’s high option. Also, some plans waive deductibles, coinsurance, and copayments when Medicare is primary.

Carefully review your plan’s benefits before you make any changes.

(CMS)



Understanding Medicare

Mental health coverage

Medicare covers mental health services differently depending on whether the beneficiary is receiving that service as an inpatient or an outpatient. Starting in 2012, some preventive

mental health services will be added to Medicare coverage. These services will be covered 100 percent by Medicare, with no patient cost sharing.

Outpatient coverage

Medicare Part B will pay 80 percent of its approved amount for an initial visit to a licensed psychiatrist to determine a diagnosis, and for brief appointments to manage medications. These brief supervision meetings between doctor and patient are designed to evaluate a prescribed method of treatment and determine whether the beneficiary is meeting treatment goals. For other appointments after that initial visit, Medicare will pay 60 percent of the approved amount in 2012. The beneficiary or their supplemental insurer is responsible for the remaining 40 percent of the cost. The amount of cost sharing a person with Medicare must pay for mental health services will decrease in the coming years. This is because Congress passed legislation

continued on page 6

“Mental health coverage,” continued from page 5

that reduces how much people with Medicare pay for outpatient mental health treatment to be in line with coinsurance amounts for other medical services. Medicare cost sharing for outpatient mental health services over time will be:

Year	Cost sharing
2010–2011	45 percent
2012	40 percent
2013	35 percent
2014	20 percent

The services, which Part B covers at 60 percent in 2012, are:

- Individual and group therapy;
- Family counseling to help with treatment; tests to make sure the proper care is being administered;
- Activity therapies, such as art, dance or music therapy;
- Occupational therapy.

Outpatient mental health services can take place in an outpatient hospital program, a doctor or therapist’s office or a clinic. Medicare will help pay for outpatient mental health services received from general practitioners, nurse practitioners, physicians’ assistants, psychiatrists, clinical psychologists, clinical social workers and/or clinical nurse specialists.

Medicare will only pay for the services of non-medical doctors (such as psychologists and clinical social workers) if the providers are Medicare-certified and take assignment, meaning that they accept Medicare’s approved amount as payment in full. Medicare will pay for the services of medical doctors (such as psychiatrists) who do

not take Medicare assignment (non-participating providers), but these doctors can charge up to 15 percent above Medicare’s approved amount in addition to the Medicare coinsurance.

Inpatient coverage

Medicare Part A pays for inpatient mental health services in either psychiatric hospitals (hospitals that only treat mental health patients) or in general hospitals. If a beneficiary receives care in a psychiatric hospital, Medicare helps pay for up to 190 days of inpatient care in a lifetime. After someone has reached that limit, Medicare may help pay for mental health care at a general hospital. Out-of-pocket costs are the same in a psychiatric hospital as they are in any hospital. If a patient enters a psychiatric hospital within 60 days of being an inpatient at a different hospital, they are in the same benefit period and do not have to pay the deductible again. A benefit period begins the day someone starts getting inpatient care and ends when they’ve been out of the hospital or skilled nursing facility for 60 days in a row.

New mental health preventive care screenings

Medicare now covers yearly screenings for depression. This screening is part of a new series of Medicare preventive care benefits. Most preventive care services are covered 100 percent by Medicare, meaning no cost sharing to beneficiaries. These screenings are designed to be completed by a doctor or other

primary care provider to ensure correct diagnosis, treatment and follow-up. For Medicare to cover the annual depression screening, the screening must take place in a primary care setting. This means it will not be covered if the screening takes place in an emergency room, skilled nursing facility or as a hospital inpatient.

The annual depression screening includes a questionnaire that the beneficiary completes themselves or with the help of a doctor. This questionnaire is designed to indicate if someone is at risk for or has symptoms of depression.

If the results of the questionnaire indicate that a person may be at risk for or have symptoms of depression, their doctor will do a more thorough evaluation. If a beneficiary’s doctor believes they do suffer from depression, the physician will provide treatment and follow-up or a referral to a mental health professional for further care. If someone is determined to suffer from depression and is treated for that depression by the screening doctor or referred to another physician, then that treatment is not considered part of the preventive screening and will not be covered by Medicare at 100 percent.

It is important to remind clients that all preventive care that results in a diagnosis or requires a referral is no longer considered preventive care and Medicare cost sharing will apply to those cases.

(CMS)

Dear Marci,



I heard one of the benefits of the Affordable Care Act is that it will close the doughnut hole. What's the doughnut hole and how is it closing?

The coverage gap or as it's more commonly known, the doughnut hole, is one of the four coverage periods people with Medicare Part D can be in during the year. Many people find out they've reached the doughnut hole when they unexpectedly get a big bill at the pharmacy.

You reach the doughnut hole after you have gone through the deductible and initial coverage periods. This year, you enter the doughnut hole when your total drug costs reach \$2,930. Your total drug costs are what you and

your plan have spent on covered prescriptions since the start of the year.

Your costs at the pharmacy temporarily increase when you're in the doughnut hole. In the past, people were usually responsible for the full cost of their prescriptions during this period. However, because of health reform, people now get discounts on drugs they buy while in the doughnut hole. In 2012, people in the doughnut hole get a 50 percent manufacturer's discount on covered brand-name drugs and a 14 percent government subsidy on covered generic drugs. These discounts will increase every year until 2020, when the doughnut hole will be gone (in

2013, the brand name discount increases to 52.5 percent and the generic discount increases to 21 percent of the full drug cost).

You get out of the coverage gap in 2012 when you have paid \$4,700 out-of-pocket for covered drugs since the start of the year. When you reach this out-of-pocket limit, you get catastrophic coverage. The costs that help you reach catastrophic coverage are mostly the costs you have spent out of your own pocket: your deductible, what you paid during the initial coverage period and what you paid during the coverage gap. It also includes the 50 percent discount on brand-name drugs that you received in the coverage gap. If someone else pays for your drugs on your behalf, this will also count toward getting you out of the coverage gap. This includes drug costs paid for you by family members, most charities, state pharmaceutical assistance programs, AIDS drug assistance programs and Indian Health Services.

When you reach catastrophic coverage, you pay either a 5 percent coinsurance for covered drugs or a co-pay of \$2.60 for covered generic drugs and \$6.50 for covered brand-name drugs, whichever is greater.

(Medicare)



**“Be of service. Whether you make yourself available to a friend or co-worker, of you make time every month to do volunteer work, there is nothing that harvests more of a feeling of empowerment than being of service to
someone in need.”**

Gillian Anderson

Preferred pharmacies vs. network pharmacies

Network pharmacies are any pharmacies that are contracted with a specific prescription drug plan to provide beneficiaries medications with agreed upon co-pays or co-insurance rates. Some of those pharmacies may be considered “[referred]” pharmacies and if so, have special relationships built into their contracts with PDPs so that they can offer medications at lower prices than regular network pharmacies. Problems occur if beneficiaries don’t offer any pharmacies when doing comparisons with Plan Finder.

If you do not select a pharmacy and a plan offers preferred pharmacies, the cost estimates on the Plan Finder will reflect the preferred pharmacy pricing. If a beneficiary decides to go to a network pharmacy instead of a preferred pharmacy, the pricing would then be higher than listed on the comparison. For this reason, it’s important to select one or two pharmacies to get the most accurate cost estimates.

A recent update to Plan Finder requires that if medications are entered into the system a pharmacy must be accepted. This should address the issue of confusion caused by the preferred pharmacy pricing.

(CMS)

Health Savings Accounts

When an individual becomes entitled to Medicare they are not longer able to contribute to the Health Savings Account (HSA); therefore, if the Employer Group Health Plan is covering self and family, the family member will be affected since the policy holder is losing the plan. However, the employer cannot force an active employee to enroll in Medicare. Hence, if the individual does not enroll in Medicare at age 65, they can keep the HSA with a high-deductible plan until they retire.

To be an eligible individual and qualify for an HSA, you must meet the following requirements.

- You must be covered under a high deductible health plan (HDHP), on the first day of the month.
- You have no other health coverage except what is permitted under other health coverage.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else’s tax return.

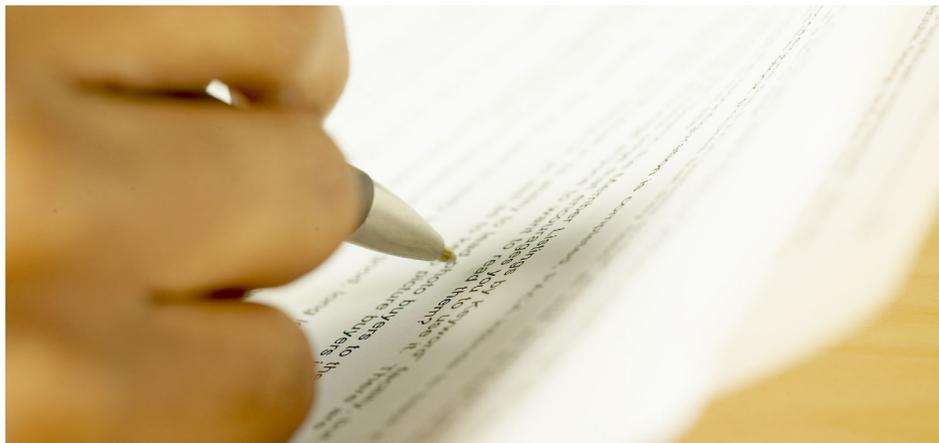
So upon enrolling in Medicare they cannot contribute any more, but they can still use the money to pay the Medicare deductibles and copayments, Medicare Part C and D premiums and coinsurance. Or you could transfer the funds to the HRA (health reimbursement account).

While we can answer very basic questions about Medicare and HSA, questions related to rules about contributions or detail information should be directed to the IRS. HSAs are tax-favored accounts created by the IRS, and therefore subject to IRS rules. Click here to see the IRS brochure with more detailed information.

(CMS)

Director's corner

Dave Zimmerman



Greetings!

SHIC training opportunities have been scheduled for this fall. Please plan to join us.

Initial Training for New Counselors

- Sept. 25-26, 2012
- 8 a.m.-4:30 p.m. both days
- Comfort Inn, Bismarck; call 701-223-1911 before Sept. 7 for reservations—mention the North Dakota Insurance Department block to receive state rate

Update Training for Existing Counselors

- October 11, 2012
- 8 a.m.-4:30 p.m.
- Comfort Inn, Bismarck; call 701-223-1911 by Sept. 25 for reservations (some rooms also available at Comfort Inn Suites, 701-223-4009)—mention the North Dakota Insurance Department block to receive state rate

The Insurance Department currently has 10 people who have indicated interest in becoming new SHIC counselors. Do you know anyone who you think would be a great addition

to the SHIC family of counselors? Please ask them to reach out to us.

Are you looking for an easy way to get support when you are dealing with tough or unusual beneficiary issues, to register for SHIC training, to order North Dakota Insurance Department or SHIC publications, to update your contact information or to recommend future counselors? Just call toll-free 1-888-575-6611 or email us at ndshic@nd.gov.

Sincerely,

Dave Zimmerman

For more information

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