Transcript for the October 2, 2012 Open Enrollment Webinar
Delivered by the CMS Partner Engagement team and the Division of Training

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Good afternoon and welcome to today's Open Enrollment webinar. I'm Susan Gustafson, and I'll be your webinar facilitator for today. Please use the little hand icon and wave it to let me know if the volume sounds okay. Okay. At least one of you can hear me. That is good.

There are a couple of things I wanted to share with you before we get started. If you will look at the left side of your screen, you will so that there is a chat Q&A box and can you send messages via the tool if you need to reach me. If you have a technical issue, can't hear the speaker, lose the sound, chat it in there and I'll be able to help you.

The file we're sharing today is available for to you download. Look in the download today's presentation box. If you click on the name, you can highlight it in yellow and save to the My Computer button and quick to download. You have a copy of that for future reference. There is also a box on your screen that says full screen. If you want to make today's presentation as wide as your screen, can you click on that to make it big and click on it again to go back. You may notice we have a closed caption pod at the bottom. We're trying to caption this and we'll capture a transcript. Now, I'm going turn the webinar over to John O'Brien. He's the Director of the CMS Division of Partner Engagement.

Thanks, Sue. Good afternoon. I'm John O'Brien and it's my pleasure to welcome to you today's call and to thank you for joining us virtually here in the lovely but not overly ostentatious building and to thank people outside of CMS who made this meeting happen, Particularly to Stacey Platte from our Division of Training. Janet Miller of the Division of Partner Engagement, and Marlene Erven, Executive Director of Alpha-1 Association.

This meeting is happening because of a meeting that they had about hosting an enrollment meeting for members of Marlene's organization. Janet did a great job of helping us appreciate the importance of working with you as Partners. We want to make sure everyone had the same opportunity. Janet, I hope this is not the last time we get to do this and this meeting speaks to the importance of innovative ideas from the field that come from our Partners.

We know all of you have suggestions for how we can better serve you. Keep them coming to Janet. On that note, it's my honor to turn the call over to Janet Miller. She leads our outreach to those who advocate for people with disabilities and chronic disease. Janet, take it away.

Thank you, John. Good afternoon and to those of out West Coast, good morning. I'm Janet Miller from the Centers of Medicare and Medicaid Services. I would like to thank

you for joining the webinar on Open Enrollment. This year, the Open Enrollment is October 15th and runs through December 7th. And Open Enrollment is really an important opportunity for all people with Medicare, including those with a disability or chronic illness to review the current Medicare health and prescription care options and to make sure you have the right health and prescription coverage for yourself.

Now, recently, CMS distributed the handbook and that contains all sorts of new information not only about the Medicare program but about information on specific health plans in your area. If you are already in a Medicare plan, the health plans are going to send out a plan annual notice of change. We call that an NOC and it's an important announcement document. It's going to include any changes in covering cost or service area that is going to be affect identify effective in January. If you got the notice, it's important that you review the changes because that is going to help you decide whether your plan is going to continue to meet your needs in the coming year. If you're Medicare and have not got this from your plan, call them now. Now o today's webinar, we'll be talking a lot of things and we're going to be looking carefully at how to review and compare plans so you that know how to provide and look at a plan to provide good coverage, lower costs and sometimes both.

Keep in mind that if you're happy with your current coverage, you don't have to do anything. Over the next 90 minutes, you will hear from Marlene Irvine, the executive director of the Alpha one association and she's going to talk about the importance of Open Enrollment from the perspective of an advocacy organization. And then the bulk of the time is to be spent with today's presenter, Miss Stacey Platte. Among other things, you will hear about the difference between service Medicare and Medicare Advantage plans, their roles and how they work. Important things for to you consider when you're choosing a plan, how to compare them a bit about Part D drug coverage. A very important thing is our Medicare Plan Finder and important tool, and we're going to talk about where to get information and other sources of help. To get started, it's my pleasure to introduce Marlene Irvine, the executive director of the Alpha one association. Marlene.

Thank you very much, Janet. On behalf of the Alpha One patient community, I would like to thank CMS for hosting this webinar today on Open Enrollment and we're delighted that CMS responded to the request to address the special needs of those living with chronic illness. The Alpha One association recognizes the education and outreach information about Medicare and that it's important to our community. We promote it on a dedicated section on our website in our newsletter and to hear our collaboration with the CMS regional office. It's our hope that individuals will have a better understanding about what kind of plans work best for them. It's our hope that individuals will have a better understanding about what kind of plans work best for them. The Alpha One Antirypsin Deficiency is a genetic disorder that can cause liver disease in children and lung and/or liver disease in adults. As with other genetic conditions, treatments and therapies can be expensive and heart hard to access. It's important for

patients to know which avenue of coverage will maximize their access care for their unique treatment and therapy.

This webinar will help Medicare and Medicaid recipients learn more about the assistance and resources available to them in their own community. And this collaboration and information sharing can benefit advocacy -- and will help their patients understand and advocate the Medicare coverage. And with those who have questions, CMS will take questions via a chatline during the webinar and questions will be handled on line and if there is not an immediate answer, CMS will get the information and they will post it along with the other questions and answers on today's call on our website at www.Alphaone.org. Again, our sincere thanks and for having us here today.

Thank you for the comments.

And before we get started, John or Sue, would you like to tell the folks how to submit the question?

Sure. Please type your question in the Chat Q&S box, and press return. We'll get your questions.

That was simple. Thank you.

And I would like to introduce today's presenter, Stacey Platte.

Good afternoon, everyone. I am happy to be with you here today to talk about Open Enrollment and the plan choices people with Medicare have. We going give an overview about Open Enrollment and what that means and relate some key dates to you related to Open Enrollment. By the end of the webinar, you should know how to compare the different Medicare plans and options. And what resources are available to help you make those comparisons and your important enrollment decisions.

You should also know how to join a new plan and the different options that you have for enrolling. We'll talk to you about LIS reassignment. That is related to folks to get Extra Help paying for their prescription drugs. There are some different kinds of things that happen with them during Open Enrollment, so we'll discuss that. We'll make you aware of the notices that beneficiaries may be receiving this fall. And then we'll give you some helpful resources that you can use to help you make planned decisions and consider your options during Open Enrollment.

We're going to start out with a high-level look of what the plans will look like for 2013. This first slide is talking about Medicare advantage plans and these are private health plans that are run through private insurance companies that you can choose to go with to provide your Medicare benefits. These plans are going to be available to you 99.6% of beneficiaries in 2013. Their premiums have stayed about the same, as from 2012. The average premium will go up by $1.47 and however, we know folks compare the

costs and benefits of the plan and make changes to the plan based on those costs. We expect once folks look at the costs of the different plans available in 2013, the average premium will increase by 50-cents and that will be on par by last year. The choices folks have available to them will go up by 7% and most of that increase will be in an additional number of coordinated care plans for beneficiaries, including things like HMOs and PPO options.

Here's a little bit of information about Part D, or the Medicare prescription drug benefit and how that will look for next year. The average premium is going to stay about the same again. The average monthly premium for prescription drug plan will be about $30 and in 2013 and in 2012, $29.67. Additionally, there are changes coming for 2013 for when people reach the donut hole. Or the coverage gap, as you may have heard it called. This is the portion of the Part D benefit where people had previously had to pay 100% of the cost of their drugs and now, as a result of the affordable care act, that amount decreased significantly. In 2013, you will see folks will receive 52.5% discount on covered brand name drugs while they're in the doughnut hole and also a 21% discount on covered generic drugs in the doughnut hole. All right, so as Janet mentioned, the Open Enrollment period is held every fall.

This is the opportunity that you have to go ahead and look at your current plan, review your other plan choices and decide what plan might work best for you. This period runs from October 15th through December 7th. You may notice the Open Enrollment period in previous year have been a little later and that has been moved up to move it away from the holidays and also give people a full seven weeks to go ahead and compare their plan.

Today we're going to talk about the plans you may consider the drug and healthcare plans available to you. Compare the plan that best fits your needs. Whatever plan, do you twos. If do you a change during that Open Enrollment period, the new coverage will be effective for you January 1st and that will give you some time after you make your choice to go ahead and get membership material in the mail to get everything you need for your drug and health coverage starting on January 1st.

And there are some few important dates you want to keep in mind this fall. The first is related to the Medicare and new handbook Janet mentioned and that was mailed out to households between September 16th and 30th. If you haven't received one already, you should receive one very shortly and it will give you a high Medicare view of your medications and in your area. By September 30th, if you have a current Medicare health or drug plan, they required to send you the annual notice of change.

Evidence of coverage documents that will tell you about any changes that are coming to costs or benefits for the upcoming 2013 plan year. Starting yesterday, October 1st, plans were allowed to begin their marketing. You might be receiving materials in the mail from some new plans that might want to solicit your business for the 2013 planned year and also yesterday, all of the 2013 plan information was added to the Medicare

Plan Finder and that is the tool on the Medicare.gov website where you compare the drug options available in your area.

And on October 11th, we're expecting the plan ratings to be updated on the Medicare Plan Finder. That is a tentative date, but we expect that to be around the 11th of October and for those of you who don't know, Medicare rates plans based on their quality and performance based on a variety of different measures so can you take a look at how the plan's rate and how they compare to one another and that information again is in the Medicare Plan Finder on Medicare.gov.

On October 15th, the Open Enrollment on period begins and ends on December 7th and any plan changes that you made or any changes to the current plan would begin January 1st. Each year, they can change their cost and coverage, their network of providers and a variety of different things and that is why it's important to check out the evidence of coverage documents and the annual notice of change that will give you all of the details about how your plan is changing for next year and also, some plans may choose to leave the Medicare program. After the end-of-the-year if that is the case.

If your plan is leaving the Medicare program, you will get a notice in the mail about now letting you know your plan won't be renewing with the contractor or Medicare program and if you fall into the circumstance, you will have an extended opportunity to choose a new plan. So you will have the period from October 15th through is the end of February to make a change into the new plans. If you choose a new plan during the Open Enrollment period, that coverage would be effective on January 1st. If you waited until after January, for instance, if you didn't realize your plan was leaving the Medicare program, your coverage would be effective the first of the next month after you made your enrollment choice. There are a variety of things to consider when looking at plans and comparing them to see which is best for you. Some of the things are listed here and you would want to look and see if the health services that you use most are covered by the plan. For instance, are the drugs that you need covered or on the formulary for that Particular plan, and if so, are there any restricts on the drugs? Are there any requirements for prior authorization and are there any quantity limits on the number of pills, for instance, that you can have per month with that plan. You want to look that at that and whether or not you have any other health or drug coverage currently.

Any change that you make, for instance, by joining a Medicare plan, could affect the coverage that you already have and I would want to make sure any decisions wouldn't affect your current coverage. You want to, of course, compare the premiums and coinsurance amounts and copayment amounts and deductibles to plans you're considering. There might be networks for certain plans and you would want to see and make sure if your doctors, specialists or hospitals that you use most are in the network for that plan or if you would have to pay an out-of-network cost. You want to look and see if your pharmacy is in a network for a Particular drug plan and you may want to consider whether or not you travel during the year. If you do, you would want to make sure you have coverage through your plans and the location you're traveling to during the year.

There are a variety of options to learn about plans and enroll in the plans that you choose during Open Enrollment. We'll talk about each of these separately.
The first is the Medicare Plan Finder. That is the tool I mentioned on the Medicare.gov website. You can enter your zip code and find out about the different health plans and drug plans in your area and you will be asked to enter the precision drugs you're taking to make sure the option plans you're looking at would provide you with coverage for the drugs. You'll be asked to select the pharmacy or pharmacies that you use most often, and once you do, that you will be provided with a list of plans and can you compare them based on cost and coverage. How do you get there? Go to the Medicare.gov website. There is button on the left hand side of the page. It says find health and drug plans.

When you click on that button, it will take to you an option where can you enter your zip code and see the plan option or go ahead and enter your full Medicare information like your Medicare number and affective date and birth date and some other key pieces of information and to see a more personalized plan search for you. There are plan ratings information available on that website, Particularly you may notice any plans in your area that are highly rated or lowly rated and who rate the plans based on a star from 1 being the lowest and five stars being the highest. We have a couple of icons on the screen to show you what that will look like if you have a highly or lowly rated plan in your area. If you have a five-star plan in the area, it will have the school's star with December 5 in it and if there is a low rated plan, there will be a triangle with the exclamation point in it.

One other thing is an additional option that folks have a five-star rated plan in their area. This is an additional opportunity people have to enroll aside from the Open Enrollment period. If folks have a five-star rated plan in their area, they have one opportunity per year to switch to that plan, if they would like to do so. They're able to make that change even if they are a five-star rated plan as well.

Again, to find the planned ratings information, it's the Medicare website. That is different set of information that is included there the next slide is to tell but the low performing plans you might see in the Medicare Plan Finder and they for plans that have received a rating of less than three stars for three years in a row. They're consistently low performing plans and there are changes coming for the plans for 2014 we want to you be aware of. One change, there won't be online enrollment available for the low performing plans or enrollment through 1-800-Medicare. You will need to go ahead and call the plan directly to enroll in one plan. And FBIs have the option to call 1-800-Medicare and ask to be moved into a higher quality plan if they would like to do so. This is an option throughout the year not just during Open Enrollment. In addition to the Medicare enrolling through the Plan Finder, folks can call the plan you have and get more information about changes or go ahead and go to their website. They have the most comprehensive information available on their website and for instance, can you see the full summary of benefits, full formulary, information about network providers or pharmacies the plan works with and that would be available through the plan website. The difference is that unlike with the Plan Finder, you won't be able to compare plans to

one another. You will be able to see the information about the plan you're looking at and that can be helpful if you're looking for details and you can call the plan or check the website. If you need contact information, find that in your Medicare handbook mailed out to you or on the Medicare Plan Finder as well again, another option you have is the Medicare & You handbook that will have a basic overview of the plans available in your area, including the monthly premium you would pay for the plan, the annual deductible and basic information about how the plan rated over the past year.

This information would be good for a quick comparison and might not give you the full details you would need to decide whether or not the plan would be best for you and we encourage you to take additional steps to research the plan networks and benefits to make sure it will provide good coverage for the conditions you may have and that should be reaching your household shortly, if it has not already. Another option you have for plan information and comparisons is 1-800-MEDICARE. This is the number for the Medicare program. When you call, you have a couple of options. You can enter the Medicare number if you have it and that will take you to an automated response station and if not, they'll provide the customer service representatives with information right away to bring up some information about you quicker. You can be connected to a customer service representative 24 hours seven days a week and you can receive assistance in other languages other than English if you have a need for that. Just let the folk at 1-800-Medicare know what language you spoke and they will be able to provide translation assistance.

The last option we wanted to make you aware of is the state health insured assistance programs or SHIP. There is one in each state and their purpose is to provide assistance to people with Medicare and their families with questions they might have about Medicare, plan comparisons, and help with enrollment if you need it. They do provide free personalized counseling and assistance. Sometimes it's over the phone. Sometimes it's in person. They also do outreach and presentation, so you may see them in your community as well and to find your local SHIP contact, you have a few obligations. If you look back in the Medicare & You handbook, the information is there. You can go to the website listed on the slide here and the view the contact section or if you call 1-800-MEDICARE they will give you that information as well.

All right. You might be wondering once you compared your plans and listed all of the plan information, how would you join a new plan? You have a few options. You can complete a paper application and enroll over the phone. You can call a plan to be enrolled or 1-800-MEDICARE. You can enroll online, or perhaps use the plan website directly if they have that option available. And there is a TTY number there for folks who may need that. The last thing to note here is that if you do enroll in a new plan that will go ahead and disenroll you from the current plan. You need to take one action here and just make a new enrollment to switch plans and that will disenroll you from the plan that you have right now.
Again, we want to stress if you have some other coverage such as coverage through employment or spouse's employment, check on that coverage and your benefits administrator before making the change and adding the Medicare prescription drug plan

or health plan. The decision that you make could affect your coverage as well as the coverage that you may have for other depends or family member -- dependents or family members. Please go ahead and check on that before making the actual enrollment decision.

All right, that is a little bit about Open Enrollment and the process that is going to happen and where can you look for more information. We're going to spend now some time talking about the different Medicare choices that you have in the Medicare program. These are the options we're going to talk about and we're going to start off with the original Medicare program. This is the Medicare option that you will be enrolled in unless you take an action to join another planned option. This is the original Medicare run by the Federal Government. This is where you get your hospital benefits, also called Part A, and outpatient medical or doctor benefits called Medicare Part B through the Federal government plan and this is the plan that 75% of folks with Medicare have.

Unless you made another decision previously, this is the plan that you will be in and you go ahead with this plan and see any doctor or hospital or specialist or provider that accepts Medicare. You don't have a network here for say and this is a fee-for-service plan. You can see anyone who accepts the Medicare program across the country. With your Part A coverage, to let you know, this would include things like hospital coverage, skilled nursing coverage, home healthcare coverage and hospice coverage. Most people have worked and paid into taxes for at least 10 years and won't have to pay a premium, generally speaking, for the Part A coverage. Although there are copayments and coinsurance amounts and deductibles, that would apply for the services. Part B on the other hand, or your outpatient medical services and procedures and medical equipment that you may use in your home like walkers and wheelchairs, they are paid for differently.

You would pay a monthly premium to be enrolled in the Part B program and for most folks, that amount is $99.90 and you would have a co-insurance amount, which is 20% and an annual deductible of $120 in 2012. You have the option with all of those costs mentioned there, the deductible and coinsurance and copayment amounts to buy a supplemental policy to help pay for the costs. In some cases, you may have the option. We're going to talk about that more on the coming slides. You will get a Medicare Summary Notice if you’re in the Medicare program and will that'll list all of the services you received if they were covered by Medicare, what was paid for them and if they were denied. If they were denied for coverage, that Medicare Summary Notice will include information about the appealing options that you have to go ahead and get the services covered.

The next few slides are going to talk about the Medigap policies that will help you. There are the gaps in original Medicare, such as the deductibles, coinsurance or copayment amount for your hospital or outpatient services that you may need help paying for and if that is the case, you may have the option to chase a private health insurance policy through a private insurance company. The options will vary by state and that depends on what area you live in, what options are available to you. This will be supplemental

insurance, again, to help supplement that original Medicare coverage. One thing to know if you have existing coverage through employment or spouse's employment, you may not need one of those policies anyway. The current employer coverage or retiree coverage might work with the Medicare coverage to provide you with most of the benefits and cover most of your costs. If you're in that situation, you may not need a Medigap policy.

If you do, we'll let you know a few things about them. They may not be available to all states to folks under 65. Folks who have Medicare because of a disability or end-stage renal disease, permanent kidney failure requiring dialysis or a kidney transplant, Medigap may not be available and it depends on which state you live in. There are 29 states that require the Medigap policies to be sold to people under 65. But if you live in a state other than that, it's not a requirement for those companies to sell you a policy. They may decide to sell you one if you would like to do so and you would be subject to underwriting and your Medigap monthly premium would reflect the underwriting.

Another thing to note, if you turn 65 if you're in that situation, you're under 65 with Medicare even if you don't have access to one of the policies to help you supplement your Medicare ?. Once you do turn 65, you will have an additional opportunity to go ahead and make a choice. Specifically related to Open Enrollment. If you have a Medicare advantage plan right now, so you have a private health plan giving you Medicare coverage, you decide to go ahead and go back to original Medicare during the Open Enrollment period, there is not a guarantee an insurance company would sell you a Medigap policy to supplement the original Medicare coverage you going back to.

If the company will sell you a policy, you may have to, again, meet the medical underwriting requirements unless you fall into certain circumstances. Such as if your Medicare Advantage plan decides to leave the Medicare program entirely. In all cases, can you contact the Medigap insurance companies in your area to see what plans are available to you and also what the cost would be for those plans. Gets that information by contacting the state Department of Insurance or look on the Medicare.gov website to see the Medigap policies that are available in your area and get information about the companies can you contact to talk about the Medigap policies they offer.

All right. For folks who were in the last circumstance who had Medicare Advantage plan that did not review for the following year, and you do go ahead and join original Medicare. If you're age 65 or older, you would have a special right to buy a Medigap policy, called a guaranteed issue right and that right would last from 60 days before you lose your Medicare Advantage coverage all the way until 63 days after that coverage ends and you would have the right to go ahead and buy certain Medigap policies from any insurer in your state. The difference to note here, though, is for folks under age 65, even if you fall in the circumstance, you may not be able to buy a Medigap policy again until you turn age 65. We do really encourage folks to contact their state health insurance assistance programs or SHIPs, if you're interested in researching your Medigap options available to you. They can provide with you a lot of guidance on what is available and what it might cost you in your area.

All right. Moving on to Medicare Advantage plans. This is the alternative to Original Medicare. You can either choose to get your Medicare benefits in a fee-for-service way through the Federal government plan, which is Original Medicare, or you can go ahead and choose a Medicare Advantage plan which is a health plan offered by a private insurance company. It's still part of the Medicare program and that works a little bit differently.

Medicare would go ahead and pay a set amount per -- to this private health plan to provide you with your coverage and that would provide with you your Medicare Part A benefits and Part B benefits. They would provide prescription drug coverage or Part D coverage as well and there are different types of plans. And option plans available to you. The options that you can have could be HMO plans, would have a network and may require authorization for going out of network, for instance. You may have PPO plans available to you that might have a little bit wider networks than the HMOs and may allow to you go out of network at a higher cost. There might be private fee-for-service plans available to you where can you go to any providers that will accept the plan's payment amount. There may be special needs plans, plans specifically designed to meet the needs of folks with certain conditions and such as plans for folks with chronic conditions, like diabetes, or end-stage renal disease. There are also plans specifically for people who have both Medicare and Medicaid or people who have Medicare and live in institutions. And then there are Medicare and medical savings accounts available in your area and this would work like a regular health savings account to combine a high deductible health plan with a saving account where Medicare will send you money to help pay for your care.

If you're considering a Medicare Advantage plan, you would like to look at which type of plan you're considering and what that would mean for the network of providers of doctors and hospitals and specialists that you would be able to use with that particular plan.

Again, you could get the information about the plan network about contacting the plan directly, through the website or by calling. You can get that information also through the Medicare Plan Finder. There is some information on what is called the health plan benefits tab that has details about that as well. Who can join one of these Medicare advantage plans? You have to live in the plan's Particular service area. As I mentioned, the options vary by area and you need to be within the plan's network, so you do need to live in that service area. You need to have both Medicare Part A and B. So if you have one or the other, you are not eligible to join the Medicare advantage plan. And there is also a requirement that you not have end-stage renal disease at the time you enroll in the plan and the exceptions to this requirement include, for instance, if you develop kidney failure while a member of the plans, you are able to stay in that plan and there are certain special needs plans as I mentioned for folks who have certain conditions like end-stage renal disease. If that is the case, you can go ahead and join the plan. To be in one of these plans, you would have to pay the plan's premium. There

may be a monthly premium to get your health coverage and drug coverage through this plan. That would be in addition to your Medicare Part B premium.

And there may also be not be plans with an incentive get you to join and that is great. If you didn't have to pay an additional amount there, I would recommend you that look at the plan's network and the benefits to make sure you can get the coverage and access the care through that plan. You, of course, need to follow the plan's rules and provide them information and you can only belong to one at a time. And that will be your plan until you make a choice. As mentioned, you receive the services through the plan and that is Part A and Part B and some of the plans may offer additional benefits to you, like hearing coverage, dental coverage or some cases gym memberships and that might be a reason to consider a plan if you need the additional services.

If I join work, have a separate plan membership card and in addition to your regular red, white, and blue Medicare cards, you would get that in the mail and that is once you join the plan. They might be different. So while the plan does have to provide you with the same cover benefits, they can do that to structure the benefits differently or require different cost sharing for benefits. You want to look at the copayment amounts and the deductibles. They can be different. If you're comparing two different plans, you want to look at the amounts and the services that you would use most and what the different cost-sharing amounts would be for them soy, as I mentioned, you have to pay the monthly Part B premium of $99.90. There might be some plans that will pay some of that amount for you, but that is not too common.

Generally, you will have to pay for that Part B premium. Again, your cost-sharing might be different from original Medicare. And also, Medigap plans don't work with Medicare Advantage plans. You can't have a Medigap policy with a Medicare Advantage plan to pick up some of the costs. It doesn't work like that. You would be paying whatever the out of pocket costs are for that Medicare Advantage plan out of pocket. If you don't have Medigap plans available to you in your state, if you're under 65, Medicare Advantage plans can be a good option for folks to provide you with some additional benefits and maybe some different cost sharing than original Medicare.

You want to be careful and look at the benefits and see which you would utilize the most based on you current cost sharing conditions and compare what to what you're used to now and under original Medicare, make sure that would work for and you make sure that your providers and most important doctors that you go see are included in the plan's network.

All right. During Open Enrollment, you do have some options if you're currently in a Medicare Advantage plan. You can go ahead and switch to another Medicare Advantage plan. You would go ahead and be switching from your old plan into a new plan and if you did that, you would be automatically disenrolled from your old plan, again. You can also switch back to Original Medicare coverage if would like to do that by joining a standalone Medicare prescription drug plan, which we're going to talk about in a few minutes. If you did that, though, you would have original Medicare again and

you may want to consider getting the Medigap policy if that is available to you to help fill the gaps in the Original Medicare cover affect there is an additional opportunity if you have it available to you.

If you join and for whatever reason you realized it didn't work for you. You want to leave the plan and go back to original Medicare. You would have a chance every January from January 1st through February 15th to go ahead and leave a Medicare advantage plan and go back to the Original Medicare program. So, for instance, you may decide to do that if had joined the Medicare Advantage plan and realized after the first of the year that it didn't cover some of your prescription drugs or it didn't work with the providers that you needed it to work with and you have this opportunity to go back and choose Original Medicare and choose a prescription drug if you would like to do that.

All right. The last part of Medicare we're talking about here is the Medicare prescription drug coverage. You may have heard that called Medicare Part D and this is for folks, anyone who has Medicare can join a Medicare Part D plan. All you have to do have is either Medicare Part A or Part B and you can get it through a Medicare Advantage plan and that -- with the plan to add to your original Medicare coverage.

Something to note about the plans include that they must include a range of drugs in each different category of drugs and for each category, they have to cover at least two of the drugs to make sure you have different options for the drugs that you're able to take. There are some categories of drugs, though, where the plans have to cover all or substantially all of the medications in the categories and those categories include things like cancer drugs, HIV or aids drugs, antidepressants, antipsychotics and immunosuppressant drugs to help with transplants. They're categories where they required to cover all of the drugs. Aside from that, the plans can choose what is on their list of covered drugs and their formulary and neigh can decide who there are restricts on the drugs. Whether you might need prior authorization from the plan before you can fill the drug or whether need to go through step therapy, trying a less expensive generic drug before you are approved to use a brand nape name drug or that depending on what you're looking at. When you're comparing them, you want to look at the formulary and see whether there are any restrictions on the prescriptions that you currently taking. And can you find that information through the plan. And can you find it through the Medicare.gov website. That information is available through the Medicare Plan Finder if do you enter the precisions that you're taking. Plan Finder will tell you if your drugs are covered and what the restrictions may or may not be on the drugs. If there are any restrictions on your drugs, we want to emphasize you're able to file an extension to ask for coverage of the prescriptions without any restrictions if medically necessary and that is an option available to you. For whatever reason the request is denied, go ahead and go through different levels. You can appeal up to five different levels to get coverage for that drug.

We have a question that came in asking if you will repeat the categories for all drugs.

Those categories are cancer medication, drugs for HIV/aids, antidepressants, antipsychotic aspect convulsive drugs and immunosuppressant drugs. Two other categories of drugs that I wanted to make note of because there is changes coming for 2013, are benzodiazapene and barbiturates and these are prescribed for insomnia, anxiety and pain and those have traditionally been excluded from coverage under the Medicare program in 2013, they'll be covered for folks. If you're taking them into the categories and obtained out of pocket for them, they will be covered in 2013 and those would be all types of benzodiazepine, and barbiturates, including epilepsy, cancer, and chronic mental health disorders.

All right, the last thing I will mention before we move away from this screen is that even if you are taking prescription drugs that are not on the formulary for a new plan that you switched to for 2013, and they required to give you a transition fill of that prescription while you are waiting to either switch to a different prescription that is on the formulary or to tide you over while going through the exceptions process to request coverage for the prescription. The new plan is required to give you a temporary fill of the prescription to tide you over after the first procedure.

Who can join a Part D plan? You have to have Medicare Part A or Part B. One or the other is fine and can you have both. You have to live in the plan service area. The plan options may vary from area to area and the networks are different, so you have to live in that particular area. As with Medicare Advantage plans, in order to get into one of these drug plans, you would have to go and take a proactive action to enroll in the plan. The last thing to note there is you have to live inside the U.S. if you're outside of the U.S., either permanently or for an extended period of time, you're not eligible to join a Part D plan. If you’re incarcerated you are not eligible until you come back out from being incarcerated. So, related to Open Enrollment if you switch prescription drug plans or enroll in a new plan or if you join a Medicare Advantage plan with some drug coverage, again, you will automatically be disenrolled from a drug plan and enrolled into the new plan. If you drop a Medicare Advantage plan and join Original Medicare, you would have an option to join one of these standalone precision drug plans as well, and there is a late enrollment penalty for folks who might be joining now during Open Enrollment who have been eligible for Medicare prescription drug coverage but were not enrolled and this is for folks who didn't have coverage as good as Medicare Part B.

For instance, there is prescription coverage out there that is good such as some employer coverage or Federal coverage and if you fall into one of those categories, you won't have a late enrollment penalty if you enroll later. For folks who didn't have that kind of coverage, you may have to pay a penalty equal to 1% for each month that you were eligible to join a medical prescription drug plan and didn't join and that would be in addition to your regular monthly planned premium. The last thing to note here is that folks who received the Extra Help to pay for their prescription drugs, they're not subject to this particular penalty.

With Open Enrollment moved up now, the odds are very likely that you will have your membership materials in hand by January 1st. By the time you do need to go ahead and fill a new prescription. If you don't, if by January 1st you have not received your

membership card in the mail, you would want to bring whatever information can you to the pharmacy or doctor for them to help process your claims. For instance, your red, white, and blue Medicare card or health plan membership card if you have one of those. Your photo I.D. driver's license, if you have a confirmation letter from the plan, or even just the name of the plan and the plan's information. That would be helpful to the pharmacy or provider and for whatever reason based on the information you are to provide, they're not able to confirm your enrollment information, you may have to pay out-of-pocket for services and can you request to be reimbursed for anything that you have paid out of pocket during that time. Also, if you do have Medicaid or if you get Extra Help paying for your prescriptions, bring that information with you as well to help with the progressing of your claims.

So I mentioned briefly that there is Extra Help available for folks with limited income and resources to help them pay for their Medicare Part D premiums, the copayments and deductible amounts. All right, so for folks who fall into that category, Medicare may end up reassigning them for a different drug plan and only if they fall into certain circumstances. So, if they if is they receive 100% Extra Help to help pay for their prescription drugs, they could be reassigned to a new Medicare plan. If their plan is terminating for the next plan year if for instance, it increases over the amount that Medicare is able to reimburse with that Extra Help, then they might be reassigned. They will be reassigned to a new plan the next year they come in bask form, which are eligible for the Extra Help and then there are plans to offer enhanced benefits not eligible for the Extra Help. If someone is in a plan and that changes from a basic plan to enhanced plan, that person would be reassigned to a new Medicare drug plan for the following year to make sure that they do still have access to their prescription drug benefits. In a particular area, someone would be reassigned on into a basic Medicare drug plan with a monthly premium below a certain regal Extra Help premium amount and that would help those put into the Medicare drug plans by Medicare spokes may come across some plans that don't renew for the following year. The plan was losing money and it was not viable and ended up losing the Medicare program. Sometimes there are plans under CMS sanctions for violating a rule or set of rules about benefit area access to prescriptions or services, for instance, and the circumstances the plan may be asked to leave the Medicare program.

As I mentioned, folks can join another Medicare Advantage plan or prescription drug plan, whichever the case might be, and they have to let folks know by the beginning of October anoint days before the change would take effect and these people get the special enrollment period I mentioned earlier interest October 15th to next year and folks can make a change to their coverage.

All right, our last section of the presentation will be about notices that are listed here. We'll go through them one-by-one. The first is for folks whose prescription drug plan premium would be increasing for 2013 on ever about the benchmark amount that Medicare is able to reimburse for the coverage. And that is converting to that enhanced benefit. They'll receive a letter letting them know they will be assigned unless they take an action on their own and lets them know what the plan will be for 2013 and they have

the plan information and what action would they want to take. They can compare the plan they were randomly reassigned to otherwise, they will have that reassigned plan to fall back on if they don't make any other enrollment election. They would get that letter later this month or early in November letting them know the current plan is leading the Medicare program and they will go back to the original Medicare coverage and unless they make their own drug choice. They would want to keep that notice and again compare that stand alone bring drug plan that they would be reassigned to or prescription drug plan obligations they have available.

There are drug plans terminating, and that would come in late October from CMS on blue paper again and again, just like with the other letters, they would want to compare the reassignment plans to the 2013 options they have available. Things are different, though, for the folks that I mentioned who went ahead and previously chose the plan that they are enrolled in. They might be folks with the low-income subsidy or have the Extra Help paying the prescription drugs. They chose the current plan and neigh have even if they didn't have to pay any monthly premium this year in 2012, based on how their plan changes for 2013, they may now have a premium amount they would be responsible for paying for they won't be reassigned but they will be by CMS so they are for the situation. Negotiations won't receive a notice, though -- folks won't receive a notice, though, if they're in plans below the benchmark amount and won't have an additional premium liability and also folks who get Partial extra help won't receive this notice. Neigh choose the can rent plan and they'll be responsible for pay something portion of the premium, they will get a letter that is new this year.

Starting next year, it will be sent out and reminding folks there are plans available and they would like to switch to another plan again, the notice is on tan paper and lets them know about the premium liability for the following plan year and letting them know that they would be responsible for whatever portion of that premium over that benchmark amount. Change plans to meet their needs. And one of the ways I previously mentioned. If folks are affected by reassignment and are being reassigned to a new drug plan, they will get a notice later in December letting them know which drugs they took in 2012 will be covered by the new plan they are reassigned to for 2013 and folks can look at the letter. They have until December 31st to choose another plan starting in January.

That provides information available and for instance, by state and in a particular area. This is where you go online about the plans available in your area and there is the Medicare & You handbook. While you may have received this in the mail to your home, can you read it online, if you would like to do that. If you would like a to talk with a person there is 1-800-MEDICARE as well, and we put together a web page for the call with resources that you might be interested in, excuse me, and utilizing including a variety of publications those are available through the website and that is the CMS.gov website. There would be a tab in the upper right-hand corner that says Outreach and Education. You can click there. And then in the middle of the page, click on the link that says National Medicare Training Program and that is who we work with and from that section look in the Training Library. You'll find a link to today's call. You can learn about

the special needs plans or appeals and exceptions and how that works for Medicare and choosing a Medigap policy and you can get them through the Medicare.gov website as well and the next slide will show us -- there are Open Enrollment resources available and can you download and order publications and posters and stickers related to Open Enrollment and on the next slide, shows the publications I was trying to mention. They're available on Medicare.gov and can you search for the CMS product number on the right-hand side of the screen to find the publication. I mentioned the one about Medigap policies and they find them to be helpful and there are things to think about when you're looking at Medicare drug coverage. How to do your yearly Medicare plan review, understanding the different enrollment period options you have available to you and so forth and there is a lot of materials on Medicare.gov you might find helpful as well.

This is an appendix we have made available to you and that describes all of the different mailings the folks may receive from CMS or Social Security about the plans, throughout the plan year. So the details are available to you if you want to download the presentation through the webinar feature here. The last thing I'm going to mention is, you know, we know how important it is for everyone to get the serves they need covered, whether they're in original Medicare or Medicare Advantage plan, and if for whatever reason your plan has denied your service, you know, whichever plan you're in, original Medicare or Advantage Plan, you receive your Medicare summary notice or your explanation of benefits from your plans saying that a service has been denied, just know that you do have always an exceptions process to get coverage for the services medically necessary that you do need.

So, for each of the different parts of Medicare, there is a standard and an expedited appeals process to get you timely access to the coverage and the services that you need. It includes an initial decision about whether or not something will be covered and five whole levels of appeal if you need to go that far to get the services. If you're in the situation where you need to request an exception rock at your appeals and summary notice and from the plan to get more details about how to begin the process and who to contact.

Okay. We have had a couple of question comes in and we'll see if we can take these quickly. Have the premiums for 2013 been announced yet?

It's not announced yet. It comes out around this time each fall and we're expecting it shortly. Not released yet, though.

Are there any restrictions after you signed up for the year and the plan to modify the formulary to eliminate a drug you're taking?.

That is a good question. On plans, they can make changes to the formularies mid-year. They do have to be approved by CMS, though, and there are some restrictions on what plans can do mid-year. For instance, though, they can remove the drugs mid-year if it has been determined to be unsafe by the FDA. They can completely remove the drug

from the formulary and they can also add generics, if the generic is approved midyear and, for instance, add a preferred status to the generic and require an additional restriction on the planned name and they're required to have the notice of the changes and if you're taking the drug, that would be effective to give you some time to consider an exception or consider taking a different drug covered by the plan.

Okay, and if someone goes into the Plan Finder tool and look at their plan, how can they tell what the plan rating is?

There are a variety of different places to look for the Plan Finder. If you looking at, for instance, the planned results page, the first page where you would start to see some of the plan information, there is the column there that says overall ratings and that would show you what the overall star rating for the plan is on a scale from 1-5 stars. And if you click on the name of the plan, though, can you find all of the detail you would want to know about that plan's rating, excuse me, by going the plans rating tab to let you know how the plan rated.

If a person has a chronic illness and usage, can that plan refuse to accept them or charge them more? Yes, they can. I was originally from Michigan. Before I came here, I worked with the Michigan healthcare state insurance assistance program N. Michigan, because it varies by state, there was a plan available in Michigan where people of any age could get that plan and pay the same amounts without medical underwriting. Depending on your state, it could be available. Check request with your own state to find out the obligations there.

This is another plan question for you. How can a person be sure a provider is in their plan? Someone had an issue last year when they called the plan and called the providers and both said yes, your plan, and after the sum of the first, it turned out that neither one was. Networks can change during the year. It's not ideal or convenience, but they're able to come in and out of the network. The plan has to provide with you access to an adequate number of providers. But it's public that one particular provider could leave your plan during the year and you may have to go see another provider until such a time you that are able to switch plans into one that your provider will use.

There is a question about had having drugs covered under the Medicare Advantage plan and Part B. How would that compare, if you have a Medicare Advantage plan, would you that coverage be the same as Part B?

They're required to cover the drugs covered under Medicare Part B because you're receiving your Part A and Part B benefits through the Medicare Advantage plan. They are required to provide you with coverage for those drugs. Yes.

And earlier you mentioned 29 states that were required to give Medigap plans to people under sage 65. Can you go through that again?

Sure. Depending on the state you live in, there might be state-specific protections that allow you the opportunity to purchase a Medigap policy even if you're under age 65, if you have Medicare for a disability or end-stage renal disease or permanent kidney failure. If they do afford you with that option, it's possible that they can charge you more for medical underwriting but they may choose to make the policies available to you. Those states that require Medigap insurance to be offered to people under 65 - I'm going to read them here – are: Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, and Wisconsin. So if I read your name there, those states are required to sell to folks under 65. There are some special cough yachts for folks, for instance, Medigap is not available to people who have ESRD under 65 and three states, California, Massachusetts, and Vermont. And in one state, Medigap is available to people under 65 and with ESRD and that is with Delaware. Depends on where you live and the different options available to you and even if one of your states is not in the list there that I listed, Medigap companies can choose to sell you a policy if you're under 65 they may charge you more. It's their option to sell to you. Companies are required to sell to you.

How would someone find out if they're not in one of the 29 states and if there is a company to offer them a Medigap plan?

And I would recommend contact the state insurance and they should be able to provide that to you. If they were not able to provide that to you for some reason, I would contact the SHIP, the state health insurance assistance program. They had have that to preside to you. Call the insurance company and ask them as a last resort, but try one of the other ways first so you don't have to call a bunch of companies.

Can someone listening in is confused about the five-star plans. Can you provide clarification on changing from a lower star plan to a five star plan?.

Okay. You have to change to an actual five-star plan. And you may not have any in your area and they available in certain parts of the country, depending on where the plan is and how they rated the past year. You may not have them available. If you do and have a five-star plan available to you, can you make a change into that plan once at any point during the plan this year.

Okay. And someone else was concerned about questioning when an enrollee change plans. Can they do it in midyear?

Someone could change plans mid-year if they were eligible for a special enrollment period. For instance, with the Medicare drug plan. There are a variety of different circumstances that could entitle you to a special opportunity to enroll. For instance, if someone becomes eligible for Extra Help paying for their prescription drugs, they have a special enrollment period to change plans during the year. If you move out of the service area for your current plans and since you can also have an opportunity to

choose a new plan or if you live in a long-term care facility or leave a long-term care facility, that would give you a special enrollment opportunity as well. And so anything midyear, you would need to be eligible for a special enrollment period and another would be if you lose your drug coverage steer in the year and such as the coverage you would have through your employer and that would give you a special opportunity as well.

There is another between the special enrollment period question.

Uh-huh.

Is there a special enrollment period if the plan changes its name, or merges with another plan?

No, I am not aware of special enrollment period.

If a person is disabled and under age 65 in Massachusetts, can they purchase a Medigap plan?

Let's see. In notes that I have here, it's not available to people with ESRD under age 65 in Massachusetts. That would lead me to believe that people under 65 in Massachusetts who do not have ESRD may be able to purchase a policy. But I would contact the insurance department to be sure.

Okay. And then has been a couple of questions asking if we were going repeat this webinar or if recorded it. And I will say unfortunately, our recording technology is not great so we did not record it, but we did have a transcript of it, which we will post online. At this point, we don't have any plans to repeat it, but things change. We do offer another session, we will get an e mail out to everyone participating in this call.

That is great. Are those all of the questions?

That is it.

Well, we are just about out of time. I wanted to remind you that the information is going to be on the national medication training library and I will read that off to you. That is a very long link. We have one at www.cms.gov/nationalMedicaretraining program. That is all one word. And that should get you there we asked for a transcript of this recording and it's going to be post on the toolkit page. It will probably take 24 hours, maybe a little bit more to get that up. And we are also going to post the questions and answers on that as well. I would just want to thank, first of all, Marlene for her initiative and anything this and putting it together. Certainly, I want to thank Stacy who has done a yeoman's job in bringing us a lot of wonderful information and sue for keeping us on track, and I would like to thank you for joining us today. It was our pleasure. Have a good day.