OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Training

Statewide Health Insurance Benefits Advisors (SHIBA)

New Medicare cards, Part D costs, IRMAA and Confidentiality update

October 2017 volunteer training

OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE SHIBA

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Learning objectives

Volunteers will learn and be able to explain:

- That new Medicare cards and numbers are coming between April 2018 and April 2019.
- Important messages to start sharing with clients about the new Medicare cards and numbers.
- Basic Part D plan structure and coverage periods:
    - Yearly deductible
    - Initial coverage
    - Coverage gap
    - Catastrophic coverage
- Not all Part D plans follow the standard structure and not all enrollees will experience all coverage periods each year.
- What is IRMAA (Income-Related Monthly Adjustment Amounts)?
- Clients can appeal IRMAA to the Social Security Administration (SSA).
- What kind of personal client & volunteer information you must send securely.
- When to use a Release of Information form.
- Our complaints process, which we are currently updating.

Troubleshooting and sharing time

Please take some time to share with your group:

- How Open Enrollment is going so far
- What questions and problems you're experiencing
- Any new things you've learned or problems you've solved

New Medicare cards are coming!

Starting April 2018, the Centers for Medicare & Medicaid Services (CMS) will start to mail new Medicare cards that include a new Medicare number. CMS will stagger the mailings with completion expected by April 2019. SHIBA will work to notify our clients about this. We've created a webpage "New Medicare cards are coming" in the Medicare section on OIC's public website: www.insurance.wa.gov/new-medicare-cards-are-coming. We want people to be informed and to protect themselves against possible fraud.

Current Medicare numbers – HICN - (Health Insurance Claim Number) include:

- Primary beneficiary account holder's Social Security Number (SSN) plus his or her Beneficiary Identification Code (BIC)
    - The BIC (such as A or B or M, etc.) indicates the type of benefits a Social Security claimant receives.
- HICN example: 123-45-6789 A1

New Medicare Beneficiary Identification (MBI) number includes:

- New Non-Intelligent Unique Identifier
- 11 characters- in a combination of letters and numbers
- Key characters 2, 5, 8, and 9 will always be alphabetic
- An MBI example: 1EG4-TE5-MK73

NEW MEDICARE CARDS ARE COMING!

As you help people with Medicare, here are some key messages to share about the new Medicare card:

- Medicare will mail new cards between April 2018 – April 2019.
- To help prevent identity theft, new cards won't include Social Security numbers. Instead, each person will get a new unique Medicare Number.
- You don't need to do anything to get a new card, but you should make sure your mailing address is up to date. Visit **ssa.gov/myaccount** or call **1-800-772-1213** (TTY: 1-800-325-0778) to correct your mailing address, if updates are needed.
- Medicare will never call and ask for personal information before sending new cards, so don't share your Medicare Number or other personal information if someone calls and asks for it.
- Medicare will mail more information with the new cards – check **Medicare.gov** for the latest updates.

CMS

CMS Product No. 12003-P
August 2017

Part D plan structure and coverage periods

Part D plans must all follow a basic structure or be able to show CMS their benefits are actuarially equivalent to the approved basic structure.

See the handout *CMS National Training Program 2017 – 2018 Standard Drug Benefit* chart to compare 2017 and 2018 parameters. As of this printing, we don't have the actual 2018 plan premiums. The Plan Finder will display these around October 1, 2017. We'll learn the income and asset limits for Extra Help sometime in early 2018 when the government announces the Federal Poverty Levels. Until that time, the Rainbow Chart, dated May 2017, contains accurate income and asset limits.

- The basic cost structure for Medicare outpatient drug coverage is the same in a Stand-Alone drug plan as it is when included in a Medicare Advantage (MA) plan. The Medicare Plan Finder shows these costs when you run a search, and it takes into account the differences in cost structures from plan to plan. The best way to show a client their estimated costs is to run the Plan Finder. Remember, Part D drug coverage is insurance against unexpected costs, and no one knows for sure what drugs they may need to take in the future.
- The Plan Finder breaks down results into four coverage levels:

  1. Deductible
  2. Initial coverage level
  3. Coverage gap
  4. Catastrophic coverage

National Training Program

2017 - 2018 Standard Drug Benefit

Benefit Parameters	2017	2018
Deductible	$400.00	$405.00
Initial Coverage Limit	$3,700.00	$3,750.00
Out-of-Pocket Threshold	$4,950.00	$5,000.00
Total Covered Drug Spending at OOP Threshold	$8,071.16	$8,417.60
Minimum Cost-Sharing in Catastrophic Coverage	$3.30/$8.25	$3.35/$8.35

Extra Help Copayments	2017	2018
Institutional (Level 3)	$0	$0
Receiving Home and Community-Based Services (under waiver only) (Level 3)	$0	$0
Up to or at 100% Federal Poverty Level (Level 2)	$1.20/$3.70	$1.25/$3.70
Full Extra Help (Level 1)	$3.30/$8.25	$3.35/$8.35
Partial Extra Help (Deductible/Cost-Sharing) (Level 4)	$82.00/15%	$83.00/15%

Source: Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information Table VI-1. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy, see page 48

Standard Part D plan structure

Refer to the example about Ms. Smith on the next page.

- The calculations start on January 1 of the year and end on December 31. The calculations start over again each new year.
- If someone starts drug coverage mid-year, the calculations start on their first day of coverage and end on December 31.
- Not all plans will have a deductible and some deductibles will be less than $405 for 2018.
- Some people may not experience every coverage level. This depends mostly on the costs of their drugs. People with very inexpensive drugs may never get out of the deductible level during the year, while people with extremely expensive drugs might move from deductible to catastrophic coverage in one or two months.

Notes

Standard Part D Plan Structure 2018*

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year. Costs in this chart do not include the premium.

1. Yearly deductible	2. Initial Coverage	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first $405 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $3,750.	Once Ms. Smith and her plan have spent $3,750 for covered drugs, she's in the coverage gap. Brand-name: • Manufacturer pays 50% • Plan pays 15% • Ms. Smith pays 35% Generic: • Plan pays 56% • Ms. Smith pays 44%	Once Ms. Smith has spent $5,000 out of pocket for the year, her coverage gap ends. Now she pays for each covered drug until the end of the year: Either a 5% coinsurance or copayment of Brand-name: $8.35 Generic: $3.35 *Whichever cost is higher

*Most Part D plans are not standard plans. The Medicare Plan Finder is the best way to estimate enrollee costs.

2018 PART D PLAN COVERAGE PERIODS & COSTS

Standard Part D Plan Structure*

(Begins January 1, 2018. Ends December 31, 2018.) Costs do not include plan premiums.

1 Yearly Deductible

- Enrollee pays $405

2 Initial Coverage

- Enrollee pays 25%
- Coverage limit paid by plan & enrollee: $3,750

3 Coverage Gap

- Generics: Enrollee pays 44%
- Brands: Enrollee pays 35%

4 Catastrophic Coverage

- After enrollee has paid total $5,000
- Enrollee pays 5% or $3.35 Generics $8.35 Brands

*Most Part D plans are not standard plans. www.medicare.gov/part-d/costs/part-d-costs.html
The Medicare Plan Finder is the best way to estimate enrollee costs.

IRMAA (Income-Related Monthly Adjustment Amount)

Since 2011, single people with Medicare who earn over $85,000, and married couples who earn more than $170,000, pay an extra amount in addition to any Part B and Part D premiums.

- This amount depends on their income bracket and how they file his or her taxes (for example, single or jointly).
- Social Security determines the amount, using Internal Revenue Service (IRS) data.
- Based on Federal Income Tax return from two years prior.
- Clients will get letter from Social Security each fall with information about his or her premium and also what to do if he or she disagrees.
- Clients can request Social Security reconsider if she or he had changes since they filed taxes, such as:
    - Death of a spouse
    - Marriage, divorce, annulment
    - Reduced work hours or no longer working
    - Other loss of income, etc.

- Clients should read their letter from Social Security and contact Social Security if they have questions.
- For detailed information and links, see the Social Security publication *Medicare Premiums: Rules for Higher-Income Beneficiaries at*: www.ssa.gov/pubs/EN-05-10536.pdf

Medicare Income-Related Monthly Adjustment Amount (IRMAA)

The **Medicare Income-Related Monthly Adjustment Amount (IRMAA)** is the additional amount an individual must pay on top of their Medicare Part B and/or Part D premium to have Medicare coverage if the income they reported two years ago was above $85,000 per year ($170,000 for couples). See the chart below to know the current IRMAA Part B and/or Part D amounts.

Part B IRMAA

If beneficiary filed an individual tax return with income that was:	If beneficiary filed a joint tax return with income that was:	What beneficiary pays to have Medicare Part B (premium)
Equal to or below $85,000	Equal to or below $170,000	Standard 2017 Premium = $134
$85,001-$107,000	$170,001-$214,000	Standard premium + $53.50
$107,001-$160,000	$214,001-$320,000	Standard premium + $133.90
$160,001-$214,000	$320,001-$428,000	Standard premium + $214.30
Above $214,000	Above $428,000	Standard premium + $294

Part D IRMAA

If beneficiary filed an individual tax return with income that was:	If beneficiary filed a joint tax return with income that was:	What beneficiary pays to have Medicare Part D (premium)
Equal to or below $85,000	Equal to or below $170,000	Part D plan premium
$85,001-$107,000	$170,001-$214,000	Part D plan premium + $13.30
$107,001-$160,000	$214,001-$320,000	Part D plan premium + $34.20
$160,001-$214,000	$320,001-$428,000	Part D plan premium + $55.20
Above $214,000	Above $428,000	Part D plan premium + $76.20

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Note: These numbers are for 2017. As of the printing of this material, all of the 2018 numbers are not yet available.

Sharing personal information and confidentiality – Update

In the July 2017 Training, we discussed personally identifiable information and protecting client confidentiality. In response to many questions we received and new information we've learned, please review the following three items:

1. Encrypted emails

- These are one way to share confidential information about clients and volunteers. You can also share this information by fax or US Mail.
- If information includes protected personally identifiable information, we all must send it securely by one of the above methods.
- These pieces of information (without anything else added) are OK to share non-securely:
  - Name
  - Phone number
  - The fact that they are a SHIBA client

- If volunteers or staff need information about how to access and use encrypted emails, contact Liz Mercer at LizM@oic.wa.gov or at 360-725-7225.

2. Authorization for release of information (See revised form)

- These are mainly designed for SHIBA staff and/or volunteers to use in carrying out assistance and advocacy for clients, when the client can't be there (i.e. on the telephone) to give permission to share information.
- Examples are: SHIBA staff/volunteer calls provider office about a billing question or problem, contacts Dept. of Social & Health Services or the Health Care Authority about an application for benefits, contacts an insurance company about enrollment or claim questions.
- You should use it when a provider asks for it in order to work with you.

3. Complaints and release of information

The recent change in state law about this will change some of our processes, but not to the extent we originally thought. We very recently received updated advice from our Attorney General that even though the notice of confidentiality and opt-out are always required, they must be in writing only when a complaint is submitted in writing. (This notice is already printed on the paper OIC Complaint forms.)

- Starting immediately, you do NOT need to have the client sign an Authorization for release of information to submit a complaint to SHIBA via SHIBA Online.
- We all still need to give notification to the client about the confidentiality and their right to opt out. Notification can include sending the client a printed or electronic document or sharing the information verbally. We're working on the details of this process and will share more information as soon as it is available.

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SHIBA

Authorization for release of information

**Indicates a required field*

*I _____ (Medicare beneficiary or representative's
Please print clearly

name), hereby authorize _____ (SHIBA staff or
Please print clearly

volunteer advisor's name) to obtain records and related information about:

_____

_____

*1. State problem/issue

This release includes medical, business, financial records and other related information. The purpose for the release of this information is:

_____

_____

(***Note:*** *State purpose, such as to assist with a medical billing or coverage question, to help enroll in or use a Medicare health and/or drug plan, help get an insurance claim paid, or to request help applying for benefits (i.e., Extra Help.)*

*2. Release of medical information by other entities

I authorize any insurance company, health service contractor, health maintenance organization, or medical and dental providers, that has any record of, or knowledge about the insured named on this form, to provide that information to the Washington State Office of the Insurance Commissioner. They may share copies of any records or any other information, including medical records and claim files. A photocopy of this complaint form authorization is as valid as the original.

***Medicare beneficiary or representative signature:**

_____

Date: ___/____/_____

Nature of representation (parent, guardian, power of attorney, etc.):

_____

NOTE: This authorization expires six (6) months from the date on which it was signed.

Scenarios

1. You're working with a client who wants to compare his drug plan choices for 2018. He is 69 and you think he has Extra Help for his drug costs, but you're not completely sure.

   What is the easiest way for you to find out if he has Extra Help, and also how to get the most accurate drug plan pricing for the new year?

_____

_____

2. Samantha calls you for help. She has Medicare and she heard about the low-cost health plans she can get on the Washington Healthplanfinder. She saw an ad that says she has from November 1, 2017 through January 15, 2018 to choose a plan.

   What do you tell her?

_____

_____

3. Carline's sister has a United Healthcare/AARP Medicare Advantage prescription drug plan (MAPD). Carline currently has a Humana/Walmart Medicare prescription drug plan. Carline would like to switch to her sister's United Healthcare/AARP Medicare Advantage plan during Medicare's Open Enrollment Period, since her sister said she's had great experiences with that particular plan this past year.

   What is it that you want to tell Carline to know or consider before she makes this change?

_____

_____

4. Ben is 68, and has been in a Medicare Advantage plan since he started Medicare at age 65. He comes to you during Open Enrollment and says he's noticing his out-of-pocket costs for health care rise each year. His friend told him she has a plan that covers all of her out-of-pocket costs and Ben wonders if he can get one of these. What kind of plan do you think Ben's friend has? Can Ben get one during Open Enrollment?

   What information should he know before making any changes?

_____

_____

5. You help your client Nora by running the Plan Finder for her. She has Original Medicare, a Medicare Supplement and a stand-alone Part D plan, and wants to compare her coverage for 2018. She takes 17 medications and every plan you look at for her has some kind of restrictions on at least some of her drugs, such as Prior Authorization, Step Therapy or Quantity Limits.

   What information do you want her to consider when she's choosing her plan for 2018?

_____

_____

6. **(Note: This scenario is only for counties that are experiencing MA plans leaving in 2018)** In early October, Melissa got a letter from her Medicare Advantage plan telling her they won't provide coverage after December 31, 2017. She is age 70 and angry about the change.

   What can you tell her about her options at this point?
   How long does she have to make her decisions?

_____

_____

Training Course Evaluation

Date of Training: _____

Training Location: _____

How can SHIBA improve the monthly trainings?

_____
_____
_____

What additional trainings within our SHIBA scope would you like to see?

_____
_____
_____

What SHIBA training materials (including QRCs) would you like to see added to My SHIBA?

_____
_____
_____

Other:_____
_____
_____

If you prefer to give electronic feedback about curriculum, please contact:
Liz Mercer: lizm@oic.wa.gov or Judith Bendersky: judithb@oic.wa.gov