

Medicare Part D for Professionals Overview and Updates for 2012

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What is Medicare?

- Based on work history and age or Disability (SSDI, Title II)
- Not comprehensive coverage
- Federal program.
- Some parts are administered by the Social Security Administration, some by Medicare.



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What is Part D?

- Part D is Medicare's prescription drug program.
- To get this benefit, you have to sign up for a prescription drug plan.
- These plans are private companies that contract with Medicare to provide this benefit.
- Medicare requires that all plans follow basic cost-sharing structures and include a certain level of coverage in their formularies.

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Part D

In 2012, 29 plans (32 in 2011)



- All plans cover Wisconsin residents, statewide
- Plan names with an asterisk on the 2012 plan list are national plans.
- The **only** way to choose a plan: www.medicare.gov
- Plans change each year. Costs, drugs covered on formulary, utilization management, etc.

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Part D income-based premiums

- Individuals with an income over \$85,000 for an individual or \$170,000 for a couple will have a higher Part D premium.
- Only approximately 5% of all Medicare Part D beneficiaries are subject to this premium increase.

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Part D types

- Stand alone prescription drug plans
- Prescription drug coverage included as a part of a Medicare Advantage plan or a special needs plan.
- The basic concepts of cost-sharing are the same whether the plan is a Part D plan or within a Medicare Advantage plan.

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Medicare Part D: Eligibility

- Eligibility to enroll:
 - Enrolled in either Part A or Part B or both
 - Must live in the service area of the prescription drug plan
 - Medicare shows that they are eligible for Part D
 - Must complete an enrollment form

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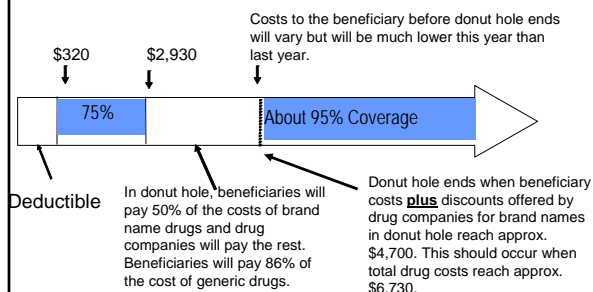


Medicare Part D costs

Medicare-only

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Medicare Eligible (No “Extra Help”) STANDARD BENEFIT - 2012



Brand Name Discounts

- In 2012, beneficiaries who reach the donut hole will pay 50% of the cost of their brand name drugs.
- The discounts **WON'T** extend the time the beneficiary spends in the donut hole because the pre-discounted cost of the brand name drug is what counts toward TROOP (true out of pocket costs).
- In other words, the \$4,700 TROOP includes BOTH what the *beneficiary* paid toward brand names AND the amount the drug companies paid for brand name drugs in the donut hole.
- Take home message for beneficiaries with brand name drugs: the amount of money you spend out of pocket before you get out of the donut hole will be significantly lower this year.
- Example: A beneficiary paid \$50 for his/her brand name drug in the donut hole. The discount from the manufacturer was therefore \$50. \$100 counts towards TROOP and getting out of the donut hole.

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Discount on Brand Name Drugs

- Although this is a discount to the consumer from the drug manufacturer, the beneficiary won't have to do any paperwork.
- There are no rebate checks, either.
- The savings will be seen right at the pharmacy.
- The rebate will only apply if Medicare Part D is the primary payer.
- If the plan already offers coverage during donut hole, the discount will apply to the cost the beneficiary would pay under the plan's donut hole coverage.
- Discounts only apply to portions of “straddle claims” in the donut hole.

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Generic drug subsidies in donut hole

- In 2012, beneficiaries will pay 86% of the costs of generics on donut hole.
- Only that 86% will count toward TROOP (help you get out of the donut hole)
- The % of the costs the beneficiary will pay toward generics will gradually decrease until 2020.
- Example: A beneficiary paid \$8.60 for a generic drug in the donut hole. The drug cost was \$10.00. Because this drug was a generic, only \$8.60 will count towards TROOP and getting out of the donut hole.

Closing the donut hole

- Started last year.
- 50% brand name discount in donut hole from drug manufacturers.
- In future years, the government will provide additional subsidies on top of the 50% discounts until the beneficiary out of pocket liability reaches 25% in 2020.
- Beneficiary liability for generics in donut hole is 86% this year, will continue to lower until 2020, when year-long coverage will look similar to initial coverage period.

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Costs: plans can vary from the standard plan

- Actuarially Equivalent Model:
 - Plans can shift costs in a number of ways as long as the coverage is actuarially equivalent to the standard benefit.
 - “Actuarially Equivalent” means that the plans can shift costs around using deductibles, formulary restrictions, and co-pays as long as the coverage, added up for a calendar year, is ON AVERAGE equivalent to the standard benefit.

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Medicare Part D: Benefits and Cost Sharing

- Enhanced Coverage
 - Plans can offer enhanced benefits which are a part of the plan but not a part of the Medicare Prescription drug benefit.
 - Enhanced plans can offer coverage that includes Part D excluded drugs, vitamins, or other benefits that are not a part of the Medicare Part D prescription drug benefit.
 - Costs associated with enhanced benefits do not count towards Part D out-of-pocket cost-sharing that is used to determine when someone meets their deductible, coverage gap, and catastrophic coverage.
 - Enhanced plans are not always cheaper than just buying the “enhanced” options at cost.

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What Part D Plans Cover



Drug Lists / Formularies

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“Part D Drugs” are...

Retail pharmacy prescription drugs

Except...

- Medicare Part B drugs: Outpatient drugs that require durable medical equipment
- Benzodiazepines / Barbiturates (Starting in 2013, Part D will cover benzodiazepines and in will cover barbiturates used in the treatment of epilepsy, cancer, or chronic mental disorders).
- “Off label” prescriptions, drugs not approved by FDA
- Prescription vitamins, weight control, over-the-counter drugs, “cosmetic” purposes (hair loss), erectile dysfunction drugs

Medicare Part B or Medicaid cover many excluded drugs.

(Prior authorization may be required)

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Part B vs. Part D

The same medication can be Part B or D depending on circumstances of the patient.

The following are Part B drugs:

- Anti-cancer:
 - Oral anti-cancer
- Immunosuppressants if transplant covered by Medicare
- Durable medical equipment supply drugs (DME)
 - When used in patient’s home
 - If the DME was covered by Medicare
- Parenteral nutrition for individual with non-functioning digestive tract
- Infusion/injectable drugs if administered by a physician

Other Part B covered items:

- DME: test strips, lancets, ostomy, etc.

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Drug Plan Cost-Controls

1. Formulary
2. "Utilization management" techniques
 - Prior authorization
 - Quantity limits : now they are on the planfinder!
 - Step therapy
3. Tiered cost-sharing
 - Most plans Tiers 1-4
 - Does not generally apply to low income subsidy co-payments

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Enrollment Periods



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Part D Enrollment

Medicare-only - Not automatic

- Must choose and enroll in a plan during an enrollment period.

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Enrollment Periods

- 1. Initial Enrollment Period (when first eligible for Medicare.)**
- 2. Annual Enrollment Period or Open Enrollment Period.**
- 3. Special Enrollment Periods.**

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1. Initial enrollment period (when first eligible for Medicare)

- 7 month window
 - 3 months before
 - The month first eligible (age 65 or 25th SSDI payment)
 - 3 months after
- Retroactive Medicare
 - Month notice received
 - 3 months after

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2. Annual Enrollment period (AEP) aka open enrollment period or annual coordinated enrollment period.

- **October 15 to December 7.**

EVERYONE with Medicare Part D should check their plan to see if it still works for them. This won't restrict LIS folks from enrolling through December 31 for January 1.

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What you can do during AEP

- You can sign up for a new PDP.
- You can switch PDPs.
- If you have a MAdvPD, you can switch to another MAdvPD.
- If you have a MAdvPD, you can go to an MAdv and a stand alone PDP (remember that not all MAdv allow you to have a stand alone PDP)
- If you have a MAdvPD, you can go back to original Medicare and a stand alone prescription drug benefit.
- You can disenroll from a PDP (for example if you want to take SeniorCare and drop PDP).

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What is an SEP?

Special Enrollment Period: In general, a special enrollment period gives you the ability to make one election or choice within a period of time. For example, some SEPs allow you one election choice within a three month period. Others allow this choice within a month long period, etc.

- Disenrollment is an election
- Enrollment is an election

Enrolling in a plan automatically disenrolls you from your previous plan!

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Special Enrollment Periods

- Low Income Subsidy (LIS): ongoing 1X/month SEP
- Change in residence
- Enter/leave long term care facility
- Loss of creditable coverage
- Enroll in Part B during annual enrollment (Jan-Mar): Part D SEP (April-June)
- Those enrolled in an SPAP (state pharmaceutical assistance program) have one SEP per calendar year (HIRSP, Chronic Renal Disease and Cystic Fibrosis Program, Hemophilia Home Care, SeniorCare if >200% FPL or levels 2&3, HIRSP.)
- Plan terminated/ non-renewed (latter have until last day of February)
- Other SEPs coordinate with Medicare Advantage (Part C) enrollment periods
- Loss of LIS at end of year: enrollment period between January 1 – March 31st
- Others on case-by-case basis

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5-star SEP

- Part D eligibles can enroll into a MAdv or PDP plan with a 5-star rating once a year.
- Ratings come out in October, and are good for January-December of the following year. There are no PDP 5 star plans in WI this year.
- The SEP starts on December 8 (when AEP ends) and runs through November 30
- Effective first calendar day of month following enrollment.

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5-star SEP continued

- Can use this to go from any type of plan to any 5-star plan (MAAdv, MAdv w/ PDP, PDP).
- If you go from MAdv w/ PDP and switch to a PDP, you will go back to original Medicare for basic medical coverage (A&B).
- Even if you are in a 5-star plan, you can use this to switch to a different one.

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SEP for MAdv-original Medicare conversions during MAdv disenrollment period

- From January 1, 2012 through February 14, 2012, individuals who disenroll from a Medicare Advantage plan (even one without drug coverage) to go back to original Medicare will have an SEP allowing a one-time enrollment into a stand alone PDP.
- The SEP will run from January 1, 2012 through February 14, 2012.
- This can be used to either enroll in a PDP which will automatically disenroll the beneficiary from the MAdv or MAdvPD or after the individual has disenrolled from the MAdv. Plan.
- New PDP enrollments will be effective on the first day of the calendar month following enrollment.

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2012 Plan Non-renewals

- Each year, some plans fail to renew and some are terminated. Some plans did terminate and/or nonrenew in Wisconsin for 2012.
- Individuals in these plans received a letter in early October informing them of this change and letting them know that they will need to choose a new plan for 2012.
- These individuals should choose the best plan for them.

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SEP for non-renewals

- Beneficiaries in non-renewed plans can sign up for a plan during the open enrollment period.
- If beneficiaries have not signed up for a new plan by December 7, they can sign up for a new plan up until the end of February.
- Their new plan is effective the first calendar day of the month following enrollment.
- Plan termination SEPs are handled differently.

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Plan Selection

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Plan Selection

- The only way to effectively choose a plan for most people is by using the computer.
- 1-800-medicare will help people over the phone.
- You can also use the plan finder and formulary finder on Medicare.gov to help individuals identify plan options.

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Pharmacy Selection

- You may need to run a planfinder with and without entering the pharmacy.
- Keep in mind that some plans give you an extra discount at a preferred pharmacy.
- Also, we are hearing that plans owned by BCBS (Blue Medicare Rx) and some Medicare Advantage Plan prescription drug plans don't yet have a contract with Walgreens for 2012.

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Preferred Pharmacies

- Plans are able to establish preferred pharmacies in addition to network pharmacies. Beneficiaries who go to those pharmacies are offered additional discounts.
- If you expand the list of pharmacies in the planfinder to the maximum allowable miles, it will tell you which pharmacies in that area have a preferred pharmacy.

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Preferred Pharmacies

- If you run a planfinder without a pharmacy and using a preferred pharmacy would result in additional savings, that plan will show up if there is one near the person and indicate that the costs estimated are based on a preferred pharmacy.
- This is why I recommend running a planfinder with and without the pharmacy listed.

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Preferred Pharmacies

- Some plans list the preferred pharmacy prices under the network pharmacy heading in the area of the planfinder under overview where you can click on “view important notes and drug cost sharing information.” This makes it look like there you get the preferred network costs at the preferred network pharmacies.

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Plan selection

- The vast majority of people do not select the lowest cost Part D plan.
- Fewer than 10% of all seniors picked the Med D plan that was best for them.
- Fewer than 15% picked one of two lowest cost plans for them.
- Even if you look at the cheapest 25% of plans available to a person in a particular state, only 50% of Medicare beneficiaries chose one of those plans.

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Why?

- Low premium may not be the lowest cost plan
- Low deductible may not be the lowest cost plan.
- Generic coverage during donut hole may not be the lowest cost plan
- Enhanced coverage may not save you money.
- Basing plan choice on coverage of one drug may not lead to best plan choice.
- Very few people change plans, even if the cost of that plan goes up and they would be better off in a different plan.
- Etc.

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Planfinder issues this year

We are hearing reports that the planfinder is slow, the printing isn't working out, and that the sort function isn't working properly to show the lowest cost plans for mail order.

Please email me and let me know about any additional problems.

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Help learning planfinder

- <http://www.gwaar.org/images/stories/Medicare/SHIPVolunteer/SHIP-VolunteersPlanFinder-Training-2011final.ppt>
- http://www.youtube-nocookie.com/embed/iQQJ7ry_H6k

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Plan transitions 2011-2012

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2011 – 2012 Transition

- Different set of plans available every year.
- Plans change their list of covered drugs and cost structure.
- Plans can add prior authorization requirements or quantity limits.
- Plans can change drug tiers for particular drugs.

Even if you are happy with your 2011 plan – you still should evaluate whether it will work for you in 2012.

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Plan Transition 2011-2012

- Every Part D and Medicare Advantage plan member gets an Annual Notice of Change letter (explaining changes to a plan's benefits and costs for 2012) –by September 30.
 - Explains changes from 2011 to 2012
 - Remember a plan could have same name but different costs, formulary, and rules.

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Plan mapping

- Plans are allowed to merge plans or buy out other plans. When a parent company buys another plan or merges plans, they can ask Medicare to allow the individuals from the bought plan or previous plan to be blended with a parent plan- if they are similar enough. CMS grants many of these requests even when the plans don't seem similar to us. When someone goes from one plan into another in this way, it is called mapping or crosswalking. Individuals should receive notice of being mapped in the annual notice of change. It is very important this year to check to make sure that each beneficiary's plan is still working for him/her.
- The crosswalked plans are listed at the bottom of the plan list. There are far fewer than there were last year.

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Plan non-renewals cont.

- Individuals in MAdvPD plans that were non-renewed have a couple of additional options. These options must be weighed with an understanding of the related Medigap rights. Please attend a Medicare Advantage training to understand these options.

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SeniorCare

- SeniorCare is a state-administered prescription drug program available only to Wisconsin residents.
- There are some people who would benefit from SeniorCare to help with the donut hole or to cover otherwise uncovered drugs.
- After determining that someone is ineligible for any form of low income subsidy, if the person is a WI resident and 65 or older, s/he may want to consider SeniorCare to reduce costs as a replacement or supplement to Medicare Part D.
- SeniorCare is currently in effect until at least the end of 2012.

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Basic requirements

- \$30 annual application fee
- Must be 65 years of age or older
- No asset test
- Income test based on gross income of individual or couple.
- Benefit lasts 12 months, starts month after application, subject to yearly renewals.

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What Kind of Income Counts?

Just as with many other programs, the level of benefit for Seniorcare depends on income. There are rules regarding what counts as income. If a person applying for SeniorCare is married, keep in mind that the income of both spouses is counted if they are living together, with a few exceptions.

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How Does Gross Annual Income Determine Benefit?

- SeniorCare will place an applicant in 1 of 4 benefit levels depending on what his or her gross annual income is.

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SeniorCare Level One

SeniorCare level 1 participants have no spend-down or deductible and pay \$5 and \$15 for generic and brand name drugs. Once they pay their \$30 annual application/renewal fee they get immediate access to the \$5 and \$15 copays.

- Income at or below 160% FPL: \$17,424 per individual or \$23,536 per couple annually (\$1,452/month-\$1,961/ month).

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Level 2

- SeniorCare level 2a and 2b participants have no spend-down but do have a \$500 (2a) and \$850 (2b) deductible that must be met during each 12-month benefit period before they can participate at the \$5 and \$15 co-pay level. During the deductible period, the participant will pay the SeniorCare rate on most covered drugs. The SeniorCare rate is a discounted rate for most covered drugs.

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Level 2a

Income Limit	Annual Out-of-Pocket Expense Requirements and Benefits
Income greater than 160% but less than or equal to 200% of the FPL \$17,425 to \$21,780 per individual and \$23,537 to \$29,420 per couple annually (\$1,453 to \$1,815 per month individual; \$1,962 to \$2,451 per couple)	- \$500 deductible per person. -SeniorCare rate applies to cost of drugs until the deductible is met. -After deductible is met, \$5 and \$15 co-pays.

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Level 2b

Income Limit	Annual Out-of-Pocket Expense Requirements and Benefits
Income greater than 200% but less than or equal to 240% FPL \$21,781 to \$26,136 per individual and \$29,421 to \$35,304 per couple annually (\$1,816 to \$2,178 per month individual; \$2,452 to \$2,942 per couple)	- \$850 deductible per person. -SeniorCare rate applies to cost of drugs until the deductible is met. -After deductible is met, \$5 and \$15 co-pays.

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Level 3

- SeniorCare level 3 participants have a spend-down and an \$850 deductible that must be met during each 12-month benefit period before they can participate at the \$5 and \$15 co-pay level.

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What's a Spend-Down?

- The amount of the spend-down is equal to the difference between a participant's gross annual income and 240% of the current FPL (\$26,137/\$35,305). Participants in the spend-down phase pay the retail price on covered drugs. After the spend-down is met, each person will have an individual \$850 deductible requirement.

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Level 3

Income Limit	Annual Out-of-Pocket Expense Requirements and Benefits
Greater than \$26,137 per individual \$35,305 per couple annually. (Income greater than 240%) (\$2,179 per individual/\$2,943 per couple)	Pay retail price for drugs equal to the difference between \$26,137 per individual or \$35,305 per couple. This is called "spend-down." -Covered drug costs for spend-down will be tracked automatically. During the spend-down, there is no discount on drug costs. After spend-down is met, meet an \$850 deductible per person. -Pay SeniorCare rate for most covered drugs until the \$850 deductible is met. --After deductible is met, \$5 and \$15 co-pays.

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SeniorCare & Part D

- SeniorCare can either be used all by itself or in conjunction with Part D
- SC is creditable coverage
- SC coordinates with Part D (may provide coverage during the coverage gap)
- SC does not coordinate with Medicaid (cannot be on both)
- SC works in institutions as long as pharmacy accepts SeniorCare

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Why have SeniorCare & Part D?

- Depending on a beneficiary's circumstances, it will save them \$
- SeniorCare can provide coverage in the Part D donut hole
- SeniorCare can reduce the co-pay of a Part D drug
- Part D can provide drug coverage while someone is in the SeniorCare deductible or spend-down phase

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SeniorCare/Part D Coordination of Benefits

- When someone is enrolled in both Part D and SeniorCare, Part D is billed first and SeniorCare second. If a particular drug is covered by both Part D and SeniorCare then Part D will pay its share and, if the resulting Part D co-pay to the beneficiary is greater than \$5 or \$15, SeniorCare will then pay the difference between the applicable \$5 or \$15 co-pay and the Part D co-payment amount (assuming the enrollee has no SeniorCare spend-down or deductible--or has already satisfied the spend-down and/or deductible).

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SeniorCare/Part D Coordination of Benefits

- If the beneficiary's drug is not covered by their Part D plan (either because it is never covered by that plan or they are in their Part D deductible or donut-hole) and is covered by SeniorCare then SeniorCare will cover the cost (again assuming the enrollee has no SeniorCare spend-down or deductible--or has already satisfied the spend-down and/or deductible) and the enrollee will pay the applicable \$5 or \$15 SeniorCare copay.

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Medicare Part D Special Enrollment Periods Related to SeniorCare

- Individuals can use multiple SEPs for Med D to enroll or disenroll in SeniorCare and thus take advantage of SeniorCare during different times in Med D coverage.
- Useful SEPs include SPAP (only for 2b or 3 SeniorCare plans) and SEP to disenroll from Part D/Advantage Plan to enroll in or maintain other creditable coverage.

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SEPs Are Useful

- These Special Enrollment Periods are important because they allow beneficiaries to buy (for \$30) their way into or out of a Part D plan once during any part of the year when they would otherwise have to wait until the Part D Annual Enrollment Period to do so.

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SeniorCare/Part Coordination of Benefits: TROOP

- Only SeniorCare level 2b and 3 costs paid by SeniorCare count towards TROOP costs for Med D. For levels 1 and 2a, ONLY what the SeniorCare beneficiaries actually paid for drugs counts toward TROOP.

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Part 2: The Low Income Subsidy

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Low Income Subsidy

- Low Income Subsidy (LIS)
 - A person with a subsidy has lower Part D costs than a person without a subsidy. The Med D coverage is “subsidized.”

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Help with Costs: the Low-Income Subsidy

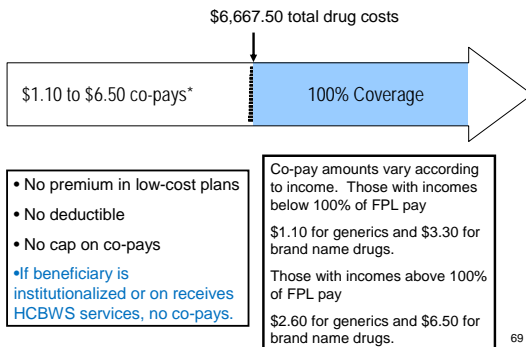
3 groups of people have LIS:

1. Those who apply for and are found eligible for a program called “Extra Help” have a subsidy. This is a program through the Social Security Administration. Your subsidy will be full or partial depending on your income and assets.
2. Full dual eligibles (have both full Medicaid card services and Medicare) automatically have the full subsidy.
3. MSP (Medicare Savings Program) recipients automatically have the full subsidy.

Once you have LIS, it lasts until at least Dec. 31st of the calendar year with very few exceptions.

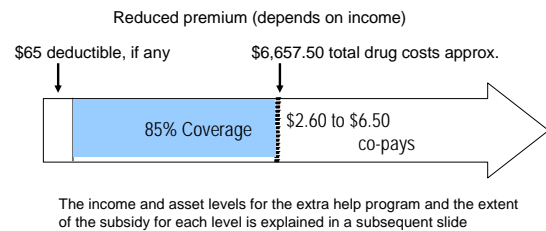
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Full Subsidy 2012



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Partial Extra Help 2012



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LIS avenue #1: Extra Help through Social Security

- Must have assets and income below certain amounts.
- A few assets are treated more generously by Social Security than Medicaid (MAid).
- Assets shown are for 2011. These will stay in effect until new numbers are released, usually mid-November. Income is dependent on the Federal Poverty Levels. Income will be assessed at current levels until new levels are released. Typically, new FPLs aren't released until the first few months of the calendar year.

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Income for SSA extra help

- Full extra help: Income at or below 135% of poverty
 - Income: Single: \$1,225.13, Couple \$1,654.88
 - Assets: Single \$6,680, Couple \$10,020
 - SSI income and asset counting rules apply with a few exceptions. Also, these asset limits do not include an allowable \$1,500 per person burial allowance, nor do they include life insurance policies.
- Partial Extra Help: Income at or below 150% of poverty
 - Income: Single: \$1,361.25, Couple \$1,838.75
 - Assets: Single: \$11,140, Couple \$22,260
 - Again, there is an allowable \$1,500 burial allowance per person allowed as an asset exclusion.

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Partial Extra Help benefits

- How much help will I get?
 - Below 150% FPL
 - Premium for subsidy
 - 135%-140% FPL: 75% premium subsidy
 - 140%-145% FPL: 50% premium subsidy
 - 145%-150% FPL: 25% premium subsidy
 - \$65 deductible
 - 15% co-insurance

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Applying for the Extra Help

- Social Security processes the application.
 - Apply in person at office
 - Apply by mail: Call Social Security and ask them to mail the most recent version of the paper application.
 - Apply online <https://secure.ssa.gov/apps6z/i1020/main.html>
- You can make referrals to the MIPPA outreach program in your county.
- GWAAR has some good resources available to do an initial assessment of eligibility and help individuals identify what information they need for an application.

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LIS avenue #2: Medicaid

- Needs based (SSI or low income/assets)
- Comprehensive coverage
- State and Federal program; but apply with county human services office or by using ACCESS.



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Medicaid programs that give the LIS

- SSI-related
- EBD
- MAPP
- BadgerCare Plus for families with children.
- Institutional MA
- Any full benefit Medical Assistance

All these programs qualify a Medicare beneficiary for the full subsidy automatically

BadgerCare Plus and MAPP have income limits and asset limits more generous than the SSA Part D subsidy program

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Medicaid Purchase Plan (MAPP)

- Available to those with a disability determination who are working.
- The work requirement is met through monetary earnings OR receiving in-kind income for services rendered.
- The asset limit for this program is \$15,000, much higher than the usual Medicaid limit.
- If you are on MAPP, you automatically receive the full subsidy.
- You can start MAPP even before starting work if you work with a HEC screener to develop and implement a work plan.
- Many individuals are not informed, nor do they know about this program, which can drastically lower costs under Medicare Part D.

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Avenue to LIS #3: Medicare Savings Programs

Assist low income Medicare beneficiaries with some of their Medicare costs.

- Use the same income & asset counting rules as Medicaid programs.
- Appeals are handled in the same way as any other Medicaid appeal.
- Sometimes called Medicare Buy-ins.
- MSPs include QMB, SLMB, SLMB+ and QDWI.

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Medicare Savings Programs

- QMB: available to those with incomes up to 100% of FPL.
- SLMB: available to those with incomes up to 120% of the FPL.
- SLMB+: available to those without other types of Medicaid if incomes up to 135% of FPL.
- QDWI: available to those with incomes up to 200% of FPL.

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MSP benefits

- QMB: Pays Medicare Part B premium, A premium if applicable, and all Medicare Parts A & B copays, deductibles, coinsurances, etc., and confers full LIS.
- SLMB: Pays the Medicare Part B premium and automatically confers full LIS.
- SLMB+: Pays the Medicare Part B premium and automatically confers full LIS.
- QDWI: Pays the Medicare Part A premium for those who must pay a Medicare Part A premium.

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MSPs Asset Limits

- The asset limit for the MSPs are the same as the asset limits for Social Security's full extra help program.
 - In 2011, the asset test for a single person is \$6,680 for an individual and \$10,020 for a married couple.
 - Whenever the asset levels for SSA's full extra help program go up, so will those for the MSPs.
 - These figures are usually released in November.

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State treatment of extra help data received from Social Security

- The state receives information from Social Security regarding all extra help applications who didn't opt out. It is required to treat these individuals as applicants for MSPs.
- When the state receives the extra help data from Social Security, it mails all of these individuals a letter explaining the MSPs and asking them to use ACCESS or to contact their county to complete their application. Applications are not complete until the state receives the EBD Medicaid applications.
- The Office of the SHIP Director sends those not likely to qualify a letter informing them of where they can go for assistance with benefits. Further, the Office forwards the data on beneficiaries who are likely eligible to MIPPA agencies who will follow up with beneficiaries and help them access the MSPs and other benefits.

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Cont.

- Application date is the date that the individual filed the application with SSA.
- See MEH 2.6.5 for information.
- <http://www.dhs.wisconsin.gov/em/ops-memos/2010/pdf/10-07.pdf>.
- <http://www.dhs.wisconsin.gov/em/ops-memos/2010/pdf/10-07attachment1.pdf>.

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Applying for the MSP

- Can do it with the county.
- There is no separate MSP-only application.
- You can ask that the person be considered for an MSP in the regular Medicaid application or on a food stamp / food share application.
- ACCESS applications collect the information necessary to assess for the MSP but there is no specific request that it be assessed for MSPs in ACCESS.
- Workers are now required to toggle the CARES system to check for MSPs unless the beneficiary specifically states that they do not want to be tested.
- The CARES system does give an alert when SSA provides information re: extra help to the State, triggering a screen for MSP.
- SLMB+ determinations must still be made manually in the CARES system.

84

How to find out if the beneficiary has the LIS

- 1-800-Medicare
- www.medicare.gov: personalized plan search.
- If they have Medicaid or an MSP, they should have the LIS, but it might not be reflected on the Medicare system. Each month, and, hopefully, starting soon, each week, WI sends an upload to Medicare with a list of its Medicaid and MSP recipients with Medicare.
- Social Security knows who has extra help from Social Security.
- It is not a good idea to rely on CARES or the ForwardHealth Portal. This can confirm Medicaid eligibility, but only Medicare can tell whether Medicare believes the person has the subsidy.

85

Enrollment in Part D for LIS beneficiaries

86

Low Cost or Benchmark Plans

- To maximize savings with a subsidy, a LIS beneficiary must be in one of these plans.
- A low cost plan, sometimes called a benchmark plan, is one with a premium that falls below the benchmark dollar figure for your state and is a “basic” – not “enhanced” plan.
- Full subsidy individuals have no premium in one of these plans.
- Please use our list of low cost plans. CMS has a process to allow some plans over the benchmark limit to receive LIS members with no premium. Using the benchmark limit to define these plans yourself could result in error.

87

Low Cost or Benchmark Plans 2012

- This year, there are 10 low cost plans in WI.
- Last year, there were 10, but two of them are different.
- Of last year's plans, some didn't renew. These are:
 - AARP Preferred is no longer a low cost plan.
 - Bravo PDP is no longer offering a PDP in Wisconsin.
- New LIS plans include:
 - United American Select
 - Envision Silver (was a PDP last year, but not a low cost PDP).
- Plans that will remain the same
 - First Health Part D premier
 - Health Spring Prescription Drug Plan Reg 16
 - CVS Caremark Value (formerly SilverScript)
 - Community CCRX Basic
 - Cigna Medicare Rx Plan One
 - Health Net Orange Option 1
 - Humana WalMart
 - Aetna CVS which was formerly called Aetna Essentials.

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Enrollment in LIS

- If you begin Medicare with the LIS in place (extra help, MAid, or MSP), or you have Medicare but not a Med D plan when you get the LIS, you will be put in a plan by Medicare.
- This assignment will be random!
- You **can** decline this enrollment choice.
- You can also choose your own plan. This will impact your future treatment under the Medicare part D program.
- If you had a Medicare Part D plan when you became eligible for LIS, or you were in certain types of MAdv plans, you will stay in your old plan (with some premium relief and cost-sharing relief) unless you choose a new low cost plan.

89

LIS plan effective date: new to Medicare

- For full benefit duals: it will be the first day of Medicare eligibility, if possible.

90

Low Cost Plan Effective Date: LIS eligibility established after Medicare eligibility begins

- When Medicare puts a LIS beneficiary into a plan, the effective date will be the first day of the second month following the month Medicare received the confirmation that the beneficiary is eligible for the LIS (either from WI through data sharing or from Social Security).

91

BUT...

- The date Medicare puts you in a plan may not match the date you became eligible for the MSP, extra help, or Medicaid.
- How does that work?

92

Treatment of full benefit dual eligibles

- Full benefit dual eligibles:
 - enrollment retroactive to 1st day of Medicaid - do not expect timeliness due to data sharing delays.
 - Medicare will place you in a low cost plan prospectively.
 - For the retro period, you will be automatically enrolled in the LINET (point of sale) plan (covered later) and will be reimbursed for out of pocket costs you already paid. For some periods of retroactivity, you may have to submit receipts to LINET.
 - If you have the LIS, but Medicare hasn't received the information from the state yet, you can always use the LINET process to start receiving these discounts immediately.
 - You can also choose a plan. As with any enrollment, it will be effective on the first calendar day of the month following the month of enrollment.

93

For all other LIS recipients

- Enrollment effective prospectively as previously described.
- Ex. CMS receives notice a beneficiary is eligible in July. Enrollment into LIS plan will be effective on September 1.
- These individuals can use LINET before enrollment becomes effective.
- This group can also become choosers.
- Further, these beneficiaries may also be able to get reimbursements from LINET for some of the period of time in which they were eligible for subsidy but not yet in a plan.

94

Notices

- Beneficiaries who get extra help through Social Security will get an award letter and instructions on what to do.
- Beneficiaries who are found eligible through MAid or MSPs who are "deemed" eligible for LIS and will get a purple letter informing them of this and instructions on what to do.

95

Notices cont.

- Beneficiaries who are not already in a plan when they get the LIS will get a yellow or green notice informing them that they will be placed in a part D plan, which plan, and the effective date of that plan. These notices will be either yellow or green.
- These yellow and green notices will tell the beneficiary how to use the LINET process to obtain coverage in any uncovered or retroactive period of eligibility.

96

Effective dates of LIS when already in a Part D plan

- Your cost sharing will go back to when your LIS status was established.
 - It can't go back earlier than when you are eligible for Medicare.
 - The first day of the month in which you submitted an application to social security for extra help, or
 - The first day you were found eligible for an MSP or MAid.
- Your plan should affirmatively reimburse you.

97

LIS enrollment

- LIS recipients have a special enrollment period once a month.
- Remember that a disenrollment is an enrollment choice, so just enroll in the new plan rather than disenroll from the old plan.
- The new plan choice will be effective on the first day of the month following enrollment.

98

I have Medical Assistance. Do I have to take Part D?

- In Wisconsin, if you have Medical Assistance and don't sign up for Part D, MAid will no longer include drug coverage.
- Because you have MAid, when you sign up for a Part D plan, you will maximize your Medicare prescription drug savings because you will be eligible for LIS.
- Further, those drugs excluded by law from coverage under Part D but covered by MAid will continue to be covered by MAid once you sign up for a Part D plan.
- But, you won't have the cap on copays you did with MAid.

99

Drugs excluded by law from Medicare but covered by Medicaid

- If you are a dual eligible, when you sign up for a Medicare Part D plan, your Forward card will cover drugs covered by your Medicaid program, but excluded by Medicare.
- Therefore, when you select a Part D plan, you should exclude these drugs when you search for a plan - it will skew your results because it will include in your plan choices enhanced plans that provide coverage for those drugs that you can have covered by the Forward Card.
- Remember, however, the Forward Card will only cover drugs excluded BY LAW from the Medicare program, not simply drugs that are not on the formulary of the plan you chose.

100

Plan Selection

Be careful about plan selection if the person is taking benzodiazepines and doesn't have MAid. The cost estimates for OOP costs are wildly varying across plans

Also, use planfinder to determine premiums for LIS person in a non-low cost plan.

The planfinder defaults to the <100% copay levels and the >100% copays in others – this may not accurately reflect that person's situation.

The planfinder also won't show \$0 copays for waiver recipients.

101

LIS transitions 2011-2012

- CMS puts out an LIS mailing calendar with all of the mailings and links to them every year. It can be found at
- <https://www.cms.gov/LimitedIncomeandResources/Downloads/2011Mailings.pdf>

102

The LIS rider

- Everybody with the low income subsidy – starting last year- gets a letter informing them how changes to the plan will affect them. It is due the same time as the Annual Notice of Change so most plans sent it with the ANOC.
- This year, due to a computer error by CMS, some beneficiaries won't get this notice until the end of October.

103

Re-deeming

- Many people who have LIS for 2011 will automatically be eligible for LIS in 2012.
- Dual eligibles and MSPs: CMS looks at Medicaid data from states in July 2011 and uses that data to determine LIS eligibility for 2012: it will *re-deem* those people for LIS for the full year of 2012. These folks will not get a letter telling them that they will still be eligible in 2012 (no news is good news). They should get the LIS rider.
- Those not re-deemed got a letter in September from CMS on GRAY paper stating that the individual will lose LIS in 2012 and will be given a form to fill out to apply for extra help.
- Cont. on next slide

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Re-deeming cont.

- Those who lost eligibility and were not on the state upload files in July, but regain MAid/MSP status before the end of 2011 should also be re-deemed to receive the LIS for the full year of 2012 and will receive a purple letter to that effect.
- This means that those who receive MAid, even for one month, after the July window, will be deemed eligible for the subsidy for the remainder of 2011 and for 2012.
- No news is good news

105

What about Social Security?

- For those with extra help through Social Security:
 - Social Security periodically checks some of its extra help beneficiaries to determine whether they remain eligible.
 - Social Security identified some people who may no longer be eligible and sent them a letter in early September asking them to fill out the eligibility review form. The letter asked individuals to submit the review form within 30 days and allowed for a 30 day extension. Beneficiaries who did not fill out this form can still reestablish eligibility through an application. If you missed either deadline, call Social Security and ask for either an extension or for a new application, whatever they deem necessary.
 - If the beneficiary did not get this letter, s/he will get extra help in 2012.
 - It is very important to fill out any forms. Doing nothing will result in the loss of extra help. Submitting the forms in a timely manner will ensure no LIS coverage gap.
 - Again, no news is good news.

106

Reassignment

- Two plans that were low cost plans last year are no longer low cost plans this year - Bravo and AARP Preferred.
- If Medicare put you into this plan, Medicare will automatically reassign you to a new plan.
- Individuals can supercede this selection and choose their own plan.
- Individuals reassigned get a **blue letter** that is supposed to have some information about how the change will affect them.

107

The Tan Letter: Choosers

- LIS beneficiaries who originally chose a plan that is no longer a low-cost plan will stay in that plan and have premiums or increased premiums in 2012 if they do nothing.
- These choosers will get a tan letter informing them that if they switch plans, they could save premium costs.
 - This includes those who chose to enroll in AARP Preferred, which was a low cost plan last year, but is no longer a low cost plan this year.
 - This also includes any LIS person who is not in a low cost plan.
- CMS will now send this tan letter twice a year, once in preparation for open enrollment and once again in May.

108

Orange Letter

- You get this letter if you still have the copays but they are changing due to a change in your income.

109

Part 3: Problem Solving

- Drug not covered
- Point of Sale Facilitated Enrollment
- Best Available Evidence
- Transition policies/ plan changes
- Retroactive Enrollment
- Premium Withholding
- Late enrollment penalties
- Coordination of Benefits
- Marketing Violations

110

Drug not Covered

- If it is a Part D drug, but is not on beneficiary's formulary, try to use a transition policy, then ask for a coverage determination.
- If Part D drug is on formulary, but denied because it is an off-label use, these are never successful, except for anti-cancer drugs, which now have own compendia.
- If it is a Part D drug, but it exceeds the quantity limit or requires PA, ask for an emergency fill under the transition policy and ask for a coverage determination.
- If it is not a Part D drug, see if
 - Covered by Forward Card if beneficiary is on Medical Assistance?
 - Is there a therapeutically appropriate alternative?
 - Is there a prescription assistance program?
- If you are LIS, you can always change plans, effective the first day of the calendar month after your enrollment date.

111

New pharmacy counter denial notices

- Individuals who are denied coverage for a drug should start getting notices right at the pharmacy.
- The denial notices are scheduled to start on 1-1-2012.
- This notice will inform the beneficiary of his or her right to ask for a coverage determination, but it won't be specific to the individual.

112

Exceptions / Coverage Determinations

- Contact the drug plan to request
- Decision:
 - 72 hours from request
 - expedited process: 24 hours
- Further appeals available....
 - Step 2: Redetermination
 - Step 3: Reconsideration
 - ALJ or federal court



113

Tiering exception

- The coverage determination process can also be used to ask for a tiering exception
- In this process, you ask that a drug in a higher tier be treated as if it were in a lower tier for you.
- You cannot do this with specialty tier drugs.
- Some have done this when drugs went to a higher tier from one year to the next.
- Others have argued financial hardship.
- Please let me know if you receive one of these and on what grounds!

114

Point-of-Sale Facilitated Enrollment

- Works when the individual has the low income subsidy and the individual is not enrolled in a plan.
- Humana is the provider.
- Humana will place the person in its Humana POS/LINET plan.
- Works until the person either enrolls in a plan or is enrolled into a plan by Medicare.
- The plan has an open formulary and no restrictions.
- Doesn't always work.

115

POS process

- Designed to give immediate coverage for individuals.
- Many pharmacists will only attempt POS enrollment if they check the Medicare computer and it shows that the individual has the LIS, but it CAN be used for anyone who currently has the LIS.
- If a pharmacist will attempt enrollment into the POS/LINET plan, s/he needs certain information and/or documentation.

116

LINET

- Individuals will not get a card from the Humana POS/LINET plan, but they will get a letter.
- Individuals will also be able to submit receipts to the Humana POS/LINET plan and ask pharmacists to submit outstanding claims to the POS/LINET plan for periods in which they were LIS eligible but not enrolled in a plan. The reimbursement process is more expansive for full benefit dual eligibles than other LIS recipients.

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LINET

- Four steps for pharmacists document: includes the BIN and PCN numbers
 - There is no PCN for CVS, they use something called a Condor code and it is 23530
- <http://apps.humana.com/marketing/documents.asp?file=1680692>.
- The BIN number is new, but the old one worked for me this week.....

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Humana LINET #s

1-800-783-1307 (phone)

1-877-801-0369 (TTY)

1-877-210-5592 (Fax)

119

Best Available Evidence

- If a person is enrolled in a plan that doesn't know the person has the LIS, the plan is required to take the best available evidence that the person receives the LIS, and structure cost-sharing accordingly.
- This could include award letters, emails from ES workers, Cares Notice, etc, showing the MAid status during relevant time.
- Experience on the helplines shows that few of the front-line workers know about the best available evidence policy. You may have to ask for a supervisor.
- A good description is found here: <http://www.cms.gov/partnerships/downloads/11325-P.pdf>.
- If the regular plan number doesn't result in help, you can find the plan's BAE contact person here: https://www.cms.gov/PrescriptionDrugCovContra/17_Best_Available_Evidence_Policy.asp.

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Best Available Evidence and \$0 copays for HCBWS recipients

- Starting January 1, if a beneficiary receiving home and community based waiver services with both Medicare and Medicaid is being charged a co-pay for drugs, the BAE policy can be used to show that the individual receives the HCBWS.
- We believe that the BAE document will be updated or supplemented with information about using BAE with HCBWS.

121

Last ditch help for LIS beneficiaries

- The CMS regional office.
- The regional office only wants to hear from the beneficiary or advocate if they have **TRIED the POS facilitated enrollment and it failed AND they are out of necessary medications.**
- Call a helpline or a benefit specialist for help with retroactive enrollment.

122

Pharmaceutical Assistance Programs

- Various options depending on income
- Some allow coverage once a certain amount has been spent on Part D
- www.needymeds.org
- www.pparx.org
- www.medicare.gov
as part of Drug Plan Finder

Peg Nugent GWAAR-MIPPA Summer 2009

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Transition Policies

- Provides a 30-day *one-time* fill for individuals new to a plan who didn't know about plan restrictions or non-formulary Part D drugs or who need the fill in order to comply with PA requirements.
- In effect for individuals 90 days into a new plan year or 90 days after enrollment.
- A good resource for this is <http://www.nsclc.org/areas/medicare-part-d/part-d-transition-requirements-issued-for-2011/2011%20Part%20D%20Transition%20Rights.pdf>.

124

Formulary Changes

- Plan changes formulary during the year
 - It can immediately stop refilling if the change is for a safety reason (FDA black box).
 - If change is for approved reasons (generic substitution, e.g.), it must provide a 60-day notice, and if no notice is provided, a 60-day supply (if beneficiary is not affected by change, no notice is required).
 - If the change is for any other reason, if approved by CMS, the plan must fill the medication for current enrollees for the rest of the plan year.
 - Plans can add drugs to their formularies, reduce costs, lower tiers, or delete utilization management requirements at any time without notice.

125

Resolving Part B v. Part D Issues

- Try billing both and see what works.
- Determine which you think it is and ask for an expedited coverage determination.
- Contact one of the helplines or a benefit specialist.
- These can be complex.

126

Billing Problems

- Billing problems are involved and not easily solved.
- Premium withholding problems are difficult and can take months to resolve.

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Failure to Pay Premiums

- Individuals with premium liabilities who fail to pay can be disenrolled.
- The plan can choose to do nothing and allow members to remain enrolled, but must apply such policies to all members consistently.
- It must have a grace period of no less than two months, but can have longer grace period.
- Must make a reasonable effort to collect past due amounts and must give notice.

Failure to pay premiums: SS withholding

- Plans cannot disenroll for failure to pay premiums where the member requested the premiums be withheld from social security check until the plan hears that it can't be taken out of the check.
- In these cases, the notice and grace period must occur AFTER this rejection.
- If the beneficiary is in withholding status, but it is not being withheld due to SSA/CMS error, disenrollment is improper.

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- Payment of past due premiums does not create a SEP
- Individuals must still wait for a regular enrollment period to get back into a plan.

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Reinstatement for failure to pay premiums for good cause (as of 1-1-12)

- Must make the request for good cause reinstatement. It includes:
 - Federal government error caused the payment to be missed or late;
 - Prolonged illness, hospitalization or institutionalization of the beneficiary;
 - Death or serious illness of spouse or other family member; or
 - Loss of the beneficiary's home or severe impact by fire, or other exceptional circumstance outside the beneficiary's control (e.g. affected individual resides in a federal disaster area).

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Cont.

- Not good cause includes:
 - Allegation that bills or warning notices were not received due to unreported change of address, out of town for vacation, visiting out of town family, etc;
 - Authorized representative did not pay timely on member's behalf;
 - Lack of understanding of the ramifications of not paying plan premiums or Part D-IRMAA;
 - Could not afford to pay premiums at the time of delinquency/disenrollment

You can call 1-800-Medicare to request this good cause reinstatement. If you need help accessing this system, please call a helpline.

132

Part D's late enrollment penalty

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Late Penalties

- If you decline Part D, you may have a penalty when you sign up later.
- People who are LIS or who become LIS eligible will not have a penalty.
- The penalty increases annually.

134

When is a Part D Penalty assessed?

If it has been 63 days or longer since either: the individual's initial enrollment period ended, or since the individual was last enrolled in a Part D plan, and the individual:

- Was eligible for Part D,
- Not enrolled in Part D,
- Not enrolled in creditable coverage, and
- No exception to the penalty applies

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The last day of an individual's initial enrollment period (IEP) will be:

- May 15, 2006 if eligible for MC Jan 2006 or earlier;
- 3 months after first month of MC eligibility;
- If Medicare was awarded retroactively, 3 months after the month the Medicare beneficiary receives notice of retroactive Medicare;
- 3 months after the month beneficiary becomes age 65 (if eligible for Medicare before age 65); or
- 3 months after the month the enrollee moved out of incarceration or moved into the US after living abroad.

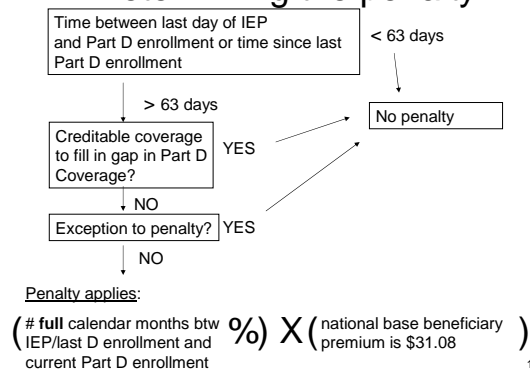
136

Exceptions to the penalty

- Awarded extra help (whether due to Medicaid entitlement or approval by SSA)
- Katrina Evacuees if qualified for FEMA assistance and enrolled in Part D before Dec 31, 2006.
- Otherwise as determined by CMS.

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Determining the penalty



138

Appeals Process

- Beneficiary will get a LEP notice
- After that, the beneficiary gives the individual 60 days to request reconsideration (on a form supplied w/ LEP notice)
- Decided by IRE – Maximus: Decisions of IRE are final and not subject to appeal
- Good cause extension available

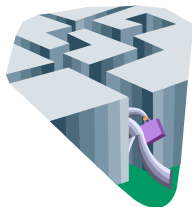
139

Reminder...

- Part D penalty is different from Part B Penalty.
 - Part B penalty does not factor “creditable coverage” but insurance coverage tied to active employment instead.

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Other insurance & Part D



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Coordination of Benefits

- Medicaid & Part D coordinate well.
- Part D coordinates well with HIRSP. If you have HIRSP, you are required to take the HIRSP Medicare supplement plan.
- Part D does coordinate with SeniorCare mostly.
- Part D can coordinate with private insurance.

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HIRSP

HIRSP (“Health Insurance Risk Sharing Plan”)
See www.hirsp.org for more info on HIRSP

- If you have Medicare and HIRSP, you are required to take the HIRSP Medicare Supplement Policy (this is not the same as a Medigap Supplement policy).
- HIRSP and Medicare Part D are designed to coordinate.
- Before making a decision to altering current insurance, please make sure that you fully understand the implications of dropping other coverage and taking HIRSP.
- Available to those who start HIRSP before 65 even after age 65.

143

Should a person with other employer-based or private drug coverage keep Part D?

- Those with other “creditable coverage” for prescriptions can decline D with no risk of a penalty later.
- The beneficiary can get a certificate of creditable coverage from your employer each year to prove that the coverage you have is creditable.
- SeniorCare is creditable coverage.
- * Careful!!! Rules are **very** different for Medicare **Part B** coverage. Part B enrollment & penalty depends on coverage tied to *current employment* – not “creditable coverage.”
- Always make sure that the beneficiary understands the implications of declining any private insurance before a final decision is made to alter existing coverage.

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Private Prescription Insurance and/or COBRA

- If the COBRA plan or private plan allows you to have both that plan and Medicare Part D, they should coordinate, but sometimes the meshing of insurances doesn't go well.
- If you have COBRA and you go on Medicare, you must notify the plan administrator.

* * Careful!!! Rules are **very** different for Medicare **Part B** coverage. Part B enrollment & penalty depends on coverage tied to *current employment* – not “creditable coverage” and the treatment of coverage under COBRA is different!

145

Marketing

- CMS has marketing guidelines due to widespread reports of fraudulent and misleading marketing practices.
- These practices often caused beneficiaries to join plans that weren't right for them.
- Marketing occurs whenever a beneficiary is encouraged to join a specific plan or is steered toward one of several plans offered by a company.

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Marketing Violations

- Misrepresenting benefits available under a plan
- Providing meals as part of marketing activities
- Telemarketing, door-to-door solicitation or other “cold calling”
- Cross-selling non-health related products during marketing or sales of Medicare plans
- Selling, marketing, or accepting applications in locations where health care is delivered
- Selling, marketing, or accepting applications at an educational event
- SEPs may be available for beneficiaries enrolled through marketing violations.

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Resources



- Part D and Age 60 and older:
 - Elderly Benefit Specialists:
<http://dhs.wisconsin.gov/aging/Genage/BENSPECS.HTM>
 - Prescription Drug Helpline (CWAG) (866)456-8211 www.wismedrx.org

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Resources, cont.

- Part D and Under age 60:
 - Disability Benefit Specialists: A list of disability benefit specialists can be found at <http://dhs.wisconsin.gov/disabilities/benspecs/counties.htm>
 - Disability Drug Benefit Helpline (DRW): (800)926-4862
 - Disabilityrightswi.org (click on “Part D” on the left)
 - HEC, Independent Living Centers

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Resources cont.

- Medicare Advantage / Medigap:
 - Medigap Helpline: 1(800)242-1060
 - <http://oci.wi.gov/> for publications
- GWAAR:
 - Peg Nugent, Medicare Trainer and Counselor:
www.GWAAR.org, Peg.Nugent@gwaar.org