Topical Brief:

Illinois Cares Rx Elimination - Frequently Asked Questions

July 23, 2012

Due to funding cuts in the state budget signed by the Governor in June 2012, **the Illinois Cares Rx program (ICRx) was eliminated effective July 1, 2012.** ICRx provided prescription drug assistance to more than 160,000 older adults and people with disabilities in the state of Illinois who met the program's income and eligibility criteria.

As of July 1, 2012, ICRx will no longer assist individuals to pay for their Medicare Part D plans and prescriptions. This means that individuals are now responsible for their monthly Part D plan premium (if the plan had one – some of the coordinating Medicare Advantage plans did not), higher prescription drug co-pays and any portion of the annual deductible not met prior to July 1st.

The Make Medicare Work (MMW) Coalition hosted a webinar on June 15, 2012 on the elimination of the ICRx program and received follow-up questions related to assisting clients navigate the changes. This Frequently Asked Questions (FAQ) Brief was created in response to those questions and organized into the following topics:

- ICRx Special Enrollment Periods and Switching Plans
- Medicaid Spenddown
- Circuit Breaker, Ride Free, and License Plate Discount Programs
- Medicare Part D Premium Issues

Illinois Cares Rx Special Enrollment Periods (SEPs) and Switching Plans

Will individuals who lost ICRx coverage be allowed to switch Medicare Part D plans now that ICRx will no longer be helping them pay for their Part D plan and prescription drugs?

Yes. All individuals who lost ICRx coverage effective June 30, 2012 will receive a **loss of ICRx special enrollment period (SEP)**. This is a one-time SEP that can be used to change, enroll or disenroll from a Part D plan. **This SEP will be available through August 31, 2012.** If an individual decides to use this SEP, the new plan choice or change will take effect the first day of the following month. For example, if Ms. Green changes to a new plan in July, her new plan will go into effect August 1st.

Can an ICRx member switch plans more than once during the special enrollment period (SEP)?

Yes. ICRx members also have a second SEP for being a member of a state pharmaceutical assistance program (SPAP) such as ICRx. Each year, ICRx members would receive a one-

time a year SEP to switch or enroll Part D plans just for being a member of a SPAP. This SEP is different than the one listed above and is still in effect through August 31, 2012 even though the ICRx program was eliminated on July 1st.

However, this SEP cannot be used to disenroll or drop a Part D coverage and should be used carefully if the loss of ICRx SEP has already been used. It is not recommended to use both SEPs within the same month. If it is necessary to use this second SEP, for example because a client switched plans prematurely without researching it, it is recommended to do so through 1-800-MEDICARE.

Could the SEP be extended to September 2012?

No. According to Medicare's rules, the SEP for an individual losing assistance from a state pharmaceutical assistance program (ICRx coverage) begins the month the beneficiary is notified and lasts for two months after. ICRx members were notified by mail in June that that ICRx was ending; therefore, the SEP lasts only until the end of August.

Can people use the SEP to drop Part D coverage altogether?

This depends on which SEP they decide to use. If an individual uses the loss of ICRx SEP, then yes, they can disenroll from his or her Part D plan. Usually, beneficiaries can only disenroll from a Part D plan during the Part D open enrollment period (October 15 – December 7 of each year) but an individual who is losing his or her ICRx coverage will receive a one-time SEP to enroll into a Part D plan, switch to another plan or disenroll from a Part D plan.

An individual cannot drop Part D coverage if he or she uses the regular annual SEP they receive for just being a member of ICRx. This SEP can only be used to switch or enroll in a Part D plan.

Remember! Individuals who choose to disenroll or "drop" their Part D plan may be subject to a late enrollment penalty if they go longer than 63 days without a Part D plan or other creditable prescription drug coverage and then decide to enroll in a Part D plan at a later time.

Are costs in the online Medicare prescription drug plan finder (www.Medicare.gov) accurate if you select a pharmacy?

Medicare's online prescription drug plan finder is a tool that allows counselors and beneficiaries to enter their prescription drug information and compare and enroll in a Part D plan that best suits their needs. The plan finder lists drug costs during the different phases of Medicare Part D (deductible, initial coverage, coverage gap and catastrophic) in addition to providing premium, deductible and plan rating information. The tool is meant to allow individuals to compare Part D plans without having to contact each Part D plan separately. Entering a pharmacy will provide a more accurate estimate of drug costs with a specific plan. It is important to remember the drug costs displayed on Medicare's online prescription drug plan finder are estimates. Drug prices fluctuate and may vary even when a pharmacy is selected. It is always a good idea to contact any plan(s) an individual is interested in directly

to confirm drug prices. You should also print out or save a plan analysis in the instance prices are drastically different once the beneficiary enrolls in and uses the plan at the pharmacy.

If an individual switches from a plan without a deductible to a new plan with a deductible, does the person have to meet it?

When an individual in a Part D plan switches from one plan to another at any time during a calendar year, the individual's True Out of Pocket (TrOOP) costs are transferred to the new plan. This includes the co-pays the individual has paid out of his or her pocket in **and** what ICRx has paid on his or her behalf

If your current coordinating plan (like AARP Medicare Rx Preferred) has no ($0) deductible, and you switch to a plan that has a deductible, you will be responsible for paying any amount of the deductible that has not been paid on your behalf, up to the new deductible amount.

For example, if the new deductible is $320, and ICRx and you together have already paid for $220 worth of drugs, you would owe $100 in deductible before benefits begin in the new plan. If $320 or more has been paid, you owe no deductible.

Please note TrOOP costs only include costs for drugs covered on the plan's formulary or drugs covered through a plan exception or appeal. The following is a list of what can be included in TrOOP costs.

- Any costs the member has paid out of his or her own pocket including the deductible or co-pays
- Amounts paid by
    - ICRx and/or Extra Help
    - a family member or friend
    - brand name drug discounts provided by drug manufacturers during the coverage gap (donut hole)
    - the AIDS Drug and Assistance Program (ADAP)
    - Indian Health Services
    - Charities unless they are administered by an employer or union group health plan

To determine an individual's TrOOP costs, the member may consult his or her most current Explanation of Benefits (EOB) or contact the current Part D plan directly. **Please note TrOOP costs do not include what is paid by the plan.**
The total amount of drug expenses with the plan will include what is paid by the plan, the member and ICRx. The total amount in drug expenses is what is used to determine which phase of coverage the individual is in such as initial coverage limit, donut hole or catastrophic.

If someone is in the donut hole (also referred to as the Part D coverage gap) before they switch plans, are they still in the donut hole if they switch to a new plan?

When an individual switches from one Part D plan to another during the coverage year, his or her TrOOP amounts transfer over to the new plan. This means if a beneficiary was in the coverage gap with the old plan, he or she will still be in the coverage gap with their new plan.

Do individuals with ICRx coverage who also have Extra Help (also known as the Low Income Subsidy or LIS) also receive a SEP?

Individuals with Extra Help can use the SEP for losing ICRx coverage but also have another SEP through Extra Help. The Extra Help SEP gives them a continuous SEP that allows them to switch plans at any time during the year up to once a month for as long as they receive Extra Help. This means that individuals who were on ICRx **and** Extra Help will be able to switch plans at any time they choose.

Medicaid Spenddown

I heard on the June 15th MMW webinar that a client who meets his or her Medicaid spenddown at least once for any month between July and December 2012 will automatically qualify for Extra Help for the rest of 2012 and for all of 2013. Is this true?

Yes. MMW has created a topical Brief that explains how this process works. Please visit http://ageoptions.org/whatwedo/mmw.cfm for more information on using Medicaid Spenddown to qualify for Extra Help.

For clients who receive home and community-based services through the Department of Rehabilitation Services (DRS) or the Community Care Program (CCP), what counts toward their spenddown – their copayments, or the total value of the services? If it is the latter, how do we obtain proof of that amount?

The total amount that is paid for these services is what counts toward spenddown. If the amount meets spenddown, eligibility for Medicaid will begin on the 1st of the month the application was submitted. The amount paid by Illinois Department on Aging (IDOA) or DRS for these services should be provided by these two agencies without the client having to do anything.

The Community Care Program (CCP) is administered by IDOA. CCP provides case management, chore, homemaker and adult day services to frail older adults age 60 and older at home who might other needs nursing home care. Click here for more information about the Community Care Program. Division of Rehabilitation Services (DRS) are administered through the Department of Human Services (DHS) and assist people with disabilities in Illinois to live independently. Click here to learn more about DRS services.

Will Medicaid cover "incurred" bills that were used to qualify for spenddown? (Incurred bills are from when the client was not on Medicaid.) Does the person need to pay those bills eventually or apply for charity care?

No, Medicaid will not pay any bill that was used to qualify for spenddown. However, it will pay any part of the bill that was not needed to meet spenddown or carry it over to the next month to meet spenddown. It is up to the enrollee. This is called a "split bill."

Any bill or portion of a bill not covered by Medicaid is subject to whatever legal collection procedures the provider chooses to utilize. The individual is still legally obligated to pay this

bill. The applicability of charity care will depend on the procedures of the provider. Presumably, this bill would be treated like any other outstanding bill.

Will the new Medicaid rule of a four prescription limit apply for dual eligibles who use spenddown to qualify for LIS?
Dual eligibles (people who qualify for Medicare and Medicaid) receive their prescription drugs through Medicare Part D and automatically qualify for Extra Help. Medicare Part D coverage is not subject to a four prescription limit. However, in the month of Medicaid eligibility, the individual will be able to use their Medicaid card to access those Medicare Part D excluded drugs that Medicaid covers. There are very few Medicare Part D excluded drugs, but the most common are benzodiazepines and barbiturates. These drugs, if covered by Medicaid, would be subject to the new four prescription limit.

If someone uses spenddown to qualify for LIS, will they be forced into a managed care plan during the Medicaid transition?

No. At this time, the Managed Care Pilot Program, also referred to as the Integrated Care program does not include dual eligibles (people with Medicare **and** Medicaid). The Integrated Care Program currently applies to people only with Medicaid who live in suburban Cook (not Chicago), DuPage, Kane, Kankakee, Lake and Will Counties.

How do you indicate what month you want to receive Medicaid?
Usually, once a Medicaid application is approved, the Medicaid caseworker will make the Medicaid eligibility month the same as the month of application. An applicant should make it clear what month he or she wants eligibility to the caseworker when the application is taken. *Whenever possible, this request should be made in writing* either by including a letter along with application specifying the month the client would like a Medicaid card or writing the month at the top of the application. You should always keep a copy of the application and request.

The MMW webinar mentioned writing in the client's Social Security number on every page of a Medicaid application submitted including additional documentation. I am concerned about putting a client's Social Security number on every page of documentation. How secure is this information, especially since applications are not done in real time?

We agree with your concern. Unfortunately, papers are lost within the local offices all the time. The Medicaid application also requires an applicant to submit additional documentation. Without this identifier on every page, it is likely that lost pages will never be re-matched with the application. That might slow down an eligibility determination, particularly if one of the separated pages is a bill needed to meet spenddown.

What community-based resources are available to help clients manage spenddown (both private pay and subsidized/free)?

There are no particular resources that we are aware of that manage spenddown except the usual suspects that assist with all types of benefits issues: Area Agencies on Aging, Centers for Independent Living, Senior Centers, and all the other wonderful community service providers that keep this system operating!

What about clients who have an extraordinarily high spenddown or refuse to apply for Medicaid altogether?

As much as possible, you want to demonstrate to people, even with high spenddown amounts, how much this could save them on a yearly basis. Individuals with Medicare who meet the spenddown amount at least for one month will automatically qualify for the Low-Income Subsidy. For some, even a meeting a spenddown of over $1000 would be cheaper than what they will pay out of pocket without the Low Income Subsidy. Remember that Medicare beneficiaries already have almost $700 already incurred toward a spenddown just by counting their monthly Medicare Part B premiums ($99.90 a month x 6 months).

As for those who refuse to apply, we would suggest trying to see what their fear is about applying for Medicaid. You might find that they have inaccurate information about the impact of qualifying for Medicaid for a month. For example, many seniors are concerned with potential property liens or estate claims if they enroll in Medicaid. If the person only uses the Medicaid card as a mechanism for qualifying for the Low Income Subsidy and does not use the card to pay for any actual medical services, no attempts at recovery will take place. There is nothing to recover as Medicaid only attempts to recover the amount of the Medicaid assistance received.

Do the local Department of Human Services (DHS / Medicaid offices) host meetings for agencies in the community assisting clients? How can we find out when they are scheduled?

Local DHS offices host Community Quality Council (CQC) meetings to update community agencies about what is going on at that local Medicaid office and to let you interact with DHS staff. The local office administrator at your local DHS office should be able to tell you when these meetings take place.

If a client is eligible for spenddown in July 2012 and therefore qualifies for LIS through all of 2013, when will they need to reapply for spenddown in order to get LIS again?

They will need to re-apply for spenddown in July - December of 2013 to assure eligibility for the Low Income Subsidy is secure and in place for 2014. Basically, meeting and applying for spenddown will replace completing the yearly Illinois Cares Rx application, except that it will be done in the second half of the year. We suggest offices use the same strategies and procedures for this new spenddown strategy as they had for assuring applications were completed for continued Illinois Cares Rx coverage.

How can we know that the local DHS offices will be able to handle the increase in Medicaid applications? Is there anything we can do to make things more tolerable for DHS caseworkers?

We all realize that the DHS local offices are overwhelmed as it is without the added burden of an influx of spenddown cases. The best we can do now is to accurately complete the applications, gather all the evidence needed to meet spenddown, and submit that evidence with the application. That will make the applications easier for the caseworkers to process.

When calling a Part D plan to alert them to the fact that a beneficiary has qualified for LIS via Medicaid spenddown, is there a specific department to ask for or terminology to use?

Each Part D plan handles these situations with their own procedures. However, the magic words to use are "Best Available Evidence Rule." Click here to learn more about the Best Available Evidence rule. The phone operators should be trained to recognize that this triggers a specific procedure. If it does not, please report this to us so we can follow up with the plan.

I have a client who is part owner of the home in which she lives. Would she be eligible for Medicaid since she owns a home (she would have a spenddown) and if so, would they put a "lien" on her home?

Medicaid does not count the home in which you reside as an asset for eligibility purposes. The State of Illinois does have the legal right to recover assistance received through Medicaid and can file a lien on a person's property. But, as was explained above, if the client here only enrolls in Medicaid to secure Low Income Subsidy status and never uses the card, there is nothing to recover.

Circuit Breaker

Was the Circuit Breaker program eliminated?

Yes. The Circuit Breaker property tax and rental grant program was eliminated July 1, 2012.

If someone filed a Circuit Breaker application by June 30, 2012, will they still get the Circuit Breaker grant check?

The Illinois Department on Aging is continuing to use funds from the last fiscal year to pay out Circuit Breaker grant checks to people who applied before June 30, 2012. They will continue to process applications submitted before June 30, and they will issue grant checks as long as funds are available. In practice, this means that many people who applied before June 30 will receive a grant check if they qualify. However, it is possible that some people who applied before June 30 will not receive a grant check if the funding is exhausted before their application is processed.

Does the elimination of Circuit Breaker mean that all senior property tax reduction programs have been eliminated?

No. The Circuit Breaker program is **not** related to any other property tax assistance programs, such as Homeowners Exemption, Senior Homestead Exemption, or Senior Freeze. These programs will continue to be administered by the same agencies that have always overseen those programs.

Will the Seniors and People with Disabilities Ride Free Transit Card and License Plate Discount programs continue? If so, what will be the process for applying for these programs?

The Illinois Department on Aging is continuing to process applications for these programs, but there is no funding allocated for them. The fate of these programs is unclear at this point. Clients who currently have Ride Free cards can continue using them. They are good for two years. We encourage people to continue to apply for the programs (using the IL-1363 application) if they wish to obtain the benefits.

Medicare Part D Premium Issues

When will the coordinating Part D plans begin sending bills for monthly premiums? Will individuals receive a bill, or will the premium be deducted from their Social Security check?

Part D plans that coordinated with ICRx should send out monthly premium bills to beneficiaries who lost ICRx benefits. If an individual has not received a premium bill from her/his Part D plan, the person should contact the Part D plan and tell the plan how s/he would like to pay the monthly premiums. People may request to pay their premiums in one of the following ways:

- Automatic deduction from a Social Security check
- Automatic deduction from a bank account
- Sending a monthly payment to the plan with the statement or coupon book issued by the plan

Please note: Part D plans will not automatically deduct premiums from a person's Social Security check. The individual must set that process up with the Part D plan.

If someone does not pay their Part D plan premiums and does not switch plans before August 31, what will happen? Will they be given a chance to pay past-due premiums and be reinstated in their plan if they are disenrolled?

A client has the option to stay in the Part D plan that he or she already has and does not have to switch. However, he or she is responsible for paying the monthly premium after July 1st. Prior to July 2012, ICRx was paying the monthly premium for individuals enrolled in an ICRx coordinating stand-alone prescription drug plan. ICRx was also paying the drug portion of the monthly premium for individuals enrolled in coordinating Medicare Advantage plan with drug coverage (MA-PD).

Beginning July 1, 2012, individuals will be responsible for paying the monthly drug plan premium. Part D plans have the choice of disenrolling individuals who do not pay the premium but must first follow certain guidance created by Medicare. Plans are required to do the following before disenrolling a member:

- Send the member a bill with the amount due and a due date.

- If the individual does not pay this bill, the plan must send a notice no later than 10 days after the due date of the premium. The notice must explain that the individual will be disenrolled from the plan beginning the month following the grace period. Plans are required to give their members a grace period of at least one month but may choose to provider longer grace periods. Plans with a grace period of 2 months or more have up to 15 days to send a notice.

Individuals who fail to pay the premium after this procedure may be disenrolled the first of the month following the end of the grace period. Individuals who are disenrolled from a plan will have to wait until the Part D open enrollment period (October 15 - December 7) to re-enroll in a plan even if they pay the past due premiums to the plan. Individuals who are disenrolled from Medicare Advantage plans for not paying premiums will go back to original Medicare (Medicare Part A and Part B only). It is best to call the plan to find out their policy.

As always, feel free to contact us with any comments or questions. If you would like to unsubscribe and not receive updates and information from the Make Medicare Work Coalition, please contact Georgia Gerdes by calling (708)383-0258 or emailing Georgia.Gerdes@ageoptions.org