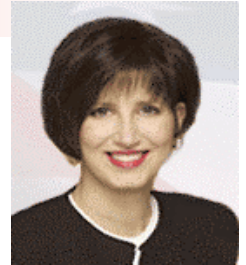


ELDERINFO NEWS

1-800-336-9500



DELAWARE'S NEW INSURANCE COMMISSIONER, KAREN WELDIN STEWART

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SPECIAL POINTS OF INTEREST:

- Statement from the newly elected Insurance Commissioner.
- 2009 Low-Income Subsidy and Resource limits.

The ELDERinfo department would like to welcome and introduce Mrs. Karen Weldin Stewart, the newly elected Insurance Commissioner for the State of Delaware, to the Delaware Medicare community. Commissioner Stewart has provided the following statement;

As I begin my tenure as the Commissioner of the Delaware Department of Insurance, I remain mindful of the pledges I have made to Delaware consumers in general and seniors in particular. A centerpiece of my administration will be to raise the bar and meet a higher standard for the quality, the coverage, the technology, the administration and the remuneration for providers of our state health care system.

In 2006, I drafted legislation that covers the "donut-hole" for senior citizens and persons with disabilities who qualify for enrollment in the Delaware Prescription Assistance Program and are on Medicare Part "D". The bill passed the House and the Senate unanimously and was promptly signed into law by then-Governor Minner.

As Insurance Commissioner, I want to take this legislation to the next level by expanding the Delaware Prescription Assistance Program to include a second tier that would cover seniors and disabled persons with slightly higher incomes, allowing them to pay a small premium and be part of the program.

Another priority for my administration will be to introduce legislation that will enable seniors on Medicare Parts A and B whose income is too high to be part of Medicaid to pay a premium to be part of Delaware's Medicaid Program in order to pay their co-pays and supplemental coverage.

From both the legislative and consumer service standpoints, my administration will be steadfast in its commitment to seniors. We are available to serve you as needed and encourage you to call our offices (Dover, 302-674-7300; Wilmington, 302-577-5280) with all your insurance concerns.

2009 LOW-INCOME SUBSIDY(LIS) AND RESOURCE LIMITS

On January 23, 2009 the Department of Health and Human Services (HHS) published in the *Federal Register* its annual update to the HHS poverty guidelines. These guidelines are used as the eligibility criterion for many Federal programs that HHS administers including the Extra

Help for Medicare Prescription Drug Programs (Part D).

The 2009 resource limits are \$8,100 (\$12,910 if married) for the full low-income subsidy and \$12,510 (\$25,010 if married) for other low-income subsidies.

The 2009 income limits are \$10,830 (\$14,570 if married) for

the full low-income subsidy and \$16,245 (\$21,855 if married) for other low-income subsidies.

You can apply for the extra help anytime during the year by calling our office at 1 (800) 336-9500 or online www.ssa.gov/prescriptionhelp.

WELLPOINT MEDICARE SANCTIONS

The Centers for Medicare & Medicaid Services (CMS) suspended marketing and enrollment for WellPoint Medicare Advantage and Prescription Drug Plan contracts, effective January 12, 2009. With these imposed sanctions, WellPoint will not be able to market several of its Medicare Advantage and Prescription Drug Plans and will not be able to enroll new beneficiaries.

Beneficiaries currently enrolled in WellPoint sponsored plans will continue to receive the same health care services and prescription drug coverage they have now. They will not lose any Medicare coverage. Beneficiaries who have questions should first

contact WellPoint. If they have additional questions, they should contact 1-800-MEDICARE or their specific plan.

Beneficiaries who have had difficulty getting services from WellPoint may have a special opportunity to enroll in a different Medicare plan. If they would like to learn more, they should contact 1-800-MEDICARE and explain their situation. The customer service representative will explain the next steps.

The sanctions were imposed because of widespread and continued failures by WellPoint to properly

administer their contracts in accordance with CMS requirements. Many of these failures have been reported by WellPoint.

WellPoint's compliance problems include, but are not limited to, failures in the following areas: enrollments and disenrollments; benefits administration, (including determining premiums, co-pays, administering the benefit for LIS eligible); grievances and appeals; marketing; claims processing; coordination of benefits; billing, and meeting call center and customer service requirements.

MEDICARE CLARIFIES "NEGOTIATED PRICES" UNDER PART D

Beginning January 1, 2010, individuals enrolled in Medicare's prescription drug benefit will pay lower prices at the pharmacy counter under a final rule announced January 6, 2009 by the Centers for Medicare & Medicaid Services (CMS). For beneficiaries with high overall drug expenditures, the change will slow their movement toward the initial coverage limit.

The rule revises Medicare's definition of negotiated prices by requiring drug plan sponsors under Part D to use the amount paid to a pharmacy as the basis for determining cost sharing for beneficiaries and for reporting a

plan's drug costs to CMS. The negotiated prices are the costs for prescription drugs agreed upon through direct negotiation between the Part D sponsor or an intermediary contracting organization, such as a pharmacy benefit manager (PBM), and the pharmaceutical manufacturer.

Under the new rule, plans must report to CMS the price actually paid to the pharmacy as the negotiated price. Any difference between the price paid by the plan to the PBM and the price paid by the PBM to the pharmacy must be reported as an administrative cost. This requirement helps

ensure that sponsors' administrative costs are not included in the drug costs used to determine how much the beneficiary will pay, as well as reinsurance and risk corridor payments made by CMS. This will also create a uniform definition of drug costs for all Part D sponsors.

ELDERinfo is looking to recruit more volunteer counselors in Sussex, Kent, and New Castle counties. If you know someone who would make a great counselor and who can commit some time each week, please have them call Lakia Turner, Director, at (302) 674-7366. ELDERinfo is dedicated to providing quality Medicare counseling to our Delaware beneficiaries.

OXYGEN DURABLE MEDICAL EQUIPMENT CLARIFICATION

The Medicare Improvements for Patients and Providers Act of 2008 implements new payment rules for oxygen suppliers effective January 1, 2009. It is important to note that Medicare has not changed coverage of oxygen for beneficiaries. There is a change of supplier responsibilities and ownership of equipment after 36 months of use mandated by recent changes in the Medicare law. Medicare is changing how it pays oxygen suppliers as follows:

- For the first 36 months, the supplier will receive rental payments for oxygen and equipment.
- After 36 months, the supplier is required to continue to furnish and maintain the equipment

without additional charge, but Medicare will continue to pay for oxygen contents furnished for use with liquid or gaseous oxygen systems.

- Also, after 36 months, the supplier is required to continue to furnish replacement accessories and supplies (e.g. masks, regulators, tubing) without additional charge.
- When the equipment is no longer needed, it goes back to the supplier; title is not transferred to the beneficiary after 36 months as was done previously.

This new payment method ensures continuity of provision of oxygen, prevents suppliers from continuing to receive payment for equipment long after Medicare payments have fully covered the cost of the equipment, and does not leave beneficiaries owning equipment to dispose of when it is no longer needed. Medicare continues to pay for needed oxygen and maintenance of the equipment for Medicare beneficiaries both during and after the 36 month rental period.

You can visit the DME/Oxygen page of the CMS website for more information at http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp

Attention counselors; if you are in need of any Medicare guides, pamphlets, or education material call ELDERinfo at 1-800-336-9500. We would be happy to provide you with the information.

CHANGES TO WELCOME TO MEDICARE VISIT

The Welcome to Medicare visit enables the beneficiary and provider to comprehensively review the patient's health, identify risk factors, and detect diseases early when outcomes are best. It also allows the provider to education the patients about Medicare covered services and make referrals or follow-up appointments for necessary care.

Beneficiaries enrolled in Medicare Part B with effective

dates that begin on or after January 1, 2009 will have one year from their Part B enrollment date to take advantage of this one-time visit. Previously, Medicare beneficiaries only had 6 months from their Part B enrollment date to access this important service. Several components of the Welcome to Medicare visit have changed, which include the following:

The comprehensive examination consists of:

a review of an individual's medical and social history with attention to modifiable risk factors; review of potential risk factors for depression; review of functional ability and level of safety; physical exam to include height, weight, blood pressure, visual acuity, body mass index; end of life planning; education, counseling, and referral based on the result of the review and evaluation services described

ELDERINFO

Delaware Department of Insurance
841 Silver Lake Blvd
Dover, DE 19904
Phone: 1-800-336-9500
Fax: (302) 739-6278



ELDERinfo provides free health insurance counseling for people with Medicare in Delaware. Our staff and volunteers are dedicated to providing answers and guidance to those tough questions and problems related to Medicare, Medigap, and other related issues. ELDERinfo is Delaware's State Health Insurance Assistance Program (SHIP). It is a public service of the Insurance Commissioner's Office and is funded in part by a grant from the federal Centers for Medicare & Medicaid Service (CMS).

ELDERinfo full time staff includes; Lakia Turner, Director; Alison Kirk, Assistant Director, Selinda Harris, Counselor. We also have volunteer counselors who can meet with individuals at various senior centers in New Castle, Kent, and Sussex counties. Contact our office to schedule an appointment.

MEDICARE VISIT, CONTINUED FROM PAGE 3

in the previous components; education, counseling, and referral, including a brief written plan such as a checklist for obtaining the appropriate screening and/or other Medicare Part B preventive services.

As of January 1, 2009 performance of an electrocardiogram (EKG) and interpretation of the EKG are no longer required as part of this service.

Coverage of the Welcome to Medicare visit is provided as a Medicare Part B benefit. For dates of service on or after January 1, 2009 the annual Part B deductible is waived if the Welcome to Medicare visit does not include the electrocardiogram. However, if the EKG is included as part of the Welcome to Medicare visit (performed with or without interpretation and report, or just its interpretation and report), the deductible will apply. The coinsurance or co-payment still applies regardless of the

type of Welcome to Medicare visit the beneficiary receives.

For more information on this rule change, visit the CMS website at

<http://www.cms.hhs.gov/WelcometoMedicareExam/>