Health & Retirement Services of Illinois
Newsletter October 2018

OUR NEWS LETTER

Bone mass measurement (bone density)

How often is it covered?

Medicare Part B (Medical Insurance) covers this test once every 24 months for people who meet the criteria below. This test may be covered more often if it's medically necessary. This test helps to see if you're at risk for broken bones.

Who's eligible?

All qualified people with Part B who are at risk for osteoporosis and meet one or more of these conditions:

- A woman whose doctor determines both of these (based on her medical history and other findings):
  - She's estrogen deficient
  - She's at risk for osteoporosis
- A person whose X-rays show possible osteoporosis, osteopenia, or vertebral fractures
- A person taking prednisone or steroid-type drugs or is planning to begin this treatment
- A person who has been diagnosed with primary hyperparathyroidism
- A person who is being monitored to see if their osteoporosis drug therapy is working

Your costs in Original Medicare

You pay nothing for this test if the doctor or other qualified health care provider accepts assignment.

In Our Newsletter

What if you didn't get your new Medicare card?

Your new Medicare card should have arrived in the mail by now. If you didn't get it, here's what to do:

- Remember that your new Medicare card will come in a plain white envelope from the Department of Health and Human Services.
- If the card didn't arrive, **call us at 1-800-MEDICARE.** Our call center representatives can check the status and help you get your new card.

In the meantime, **use your current Medicare card to get health care services.**

Avoid Scams

What should you do if someone calls and asks for your information, for money, or threatens to cancel your health benefits if you don't share your personal information? **Hang up! It's a scam.** Scam artists may try to steal your personal information by calling you and asking for your current Medicare Number to get your new Medicare card.

Medicare will never call uninvited and ask you to give personal information or money to get your new Medicare Number or card. Learn what to do if you get a suspicious call like this.

Remember: Your new Medicare card will automatically come to you in the mail. You don't need to do anything, as long as your address is up-to-date with the Social Security Administration. If you need to update or verify your address, visit your My Social Security account.

Preventive & screening services

What it's covered?

Medicare Part B (Medical Insurance) covers:

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings & counseling
- Bone mass measurements (bone density)
- Cardiovascular disease screenings
- Cardiovascular disease (behavioral therapy)
- Cervical & vaginal cancer screening
- Colorectal cancer screenings
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma tests
- Hepatitis C screening test
- HIV screening
- Lung cancer screening
- Mammograms (screening)
- Nutrition therapy services
- Obesity screenings & counseling
- One-time “Welcome to Medicare” preventive visit
- Prostate cancer screenings
- Sexually transmitted infections screening & counseling
- Shots:
    - Flu shots
    - Hepatitis B shots
    - Pneumococcal shots
- Tobacco use cessation counseling
- Yearly "Wellness" visit

Is Medicare's Latest Change A Step Too Far?

San Diego Union-Tribune (CA)

Though its name sounds like a trendy workout craze, Medicare's new "step therapy" policy has nothing to do with getting people in their 60s to move their feet.

Sometimes called "fail first," step therapy is the term used when a health insurance company forces doctors to prescribe the cheapest medication first, providing access to more expensive alternatives only if the first option doesn't get results.

The U.S. Centers for Medicare and Medicaid Services recently announced that privately administered Medicare Advantage plans will be allowed to create step therapy policies for drugs delivered in doctors offices and other outpatient settings. Such measures are already allowed in Medicare "Part D" medication plans.

Allowing step therapy for doctor-administrated drugs represents a significant change, especially since this class of medication often is used to treat serious illness such as cancer, said Juliette Cubanski, director of the Program on Medicare at the nonpartisan Kaiser Family Foundation.

"This is definitely a fundamental change in terms of giving plans more authority," Cubanski said. "I would think that health plans would tread carefully because they don't want to end up driving customers away."

Sarah Emond, executive vice president and chief operating officer for the Institute for Clinical and Economic Review in Boston, said it will be incumbent on health insurance companies to make sure that they're not ignoring evidence which shows that one drug can deliver better results than another even though it costs more.

"You would definitely want something like this to be anchored in solid evidence," Emond said.

The federal government touted the move as a positive for the millions of Medicare recipients nationwide who feel drug prices are too high, saying in a statement that the move "empowers patients with more choices" and that it shows that the Trump administration is taking "action to lower drug prices."

But many have been quick to say the change could slow down the often-frantic process of finding the right drug among many options to treat deadly diseases. In its own statement, the American Cancer Society said allowing step therapy for Medicare Part B plans "could erect barriers to care for cancer patients" while the American College of Rheumatology called the decision "an affront to America's sickest Medicare patients."

Those concerns, though, rub up against public outrage over drug prices. According to Health System Tracker, a service of the nonpartisan Kaiser Family Foundation, Americans continue to pay drastically-higher prices for drugs. For example, the average 2014 price for a 28-day supply of Humira, a drug used to treat rheumatoid arthritis and other conditions, was $2,669 in the United States, a sum that is 96 percent higher than the average paid in the United Kingdom.

Some private health plans already employ step therapy for some drugs on their formularies. A 2011 analysis in the Journal of Managed Care and Specialty Pharmacy, which examined the evidence in 14 different step therapy studies, found that forcing patients to take the cheapest drug, with the exception of antipsychotic medications used to treat conditions such as schizophrenia or bipolar disorder, does save money.

However, many have questioned the ethics of fail-first policies.

Noting that many states have limited step therapy amid doctor and patient stories of long waits for approval after first-step drugs fail or side effects appeared, researchers argued in a 2014 paper that step therapy can pose ethical problems when forcing a patient to take a cheaper drug could cause significant harm such as when treating "cancer, mental health, or seizure conditions."

Medicare's step therapy rule does give doctors and patients an out, allowing them to request an exception to a fail-first requirement and get a decision within 72 hours. Denied exceptions can be appealed to Medicare.

Any Medicare Advantage plan that decides to implement a step therapy program must notify all current policy holders of the change in writing, and Medicare has extended the amount of time that it will allow beneficiaries to change plans in 2019.

But the big picture remains a significant issue. The whole point of step therapy is to reduce drug costs and, while experts agree that the approach could cut costs somewhat, none predicted price shrinkage large enough that the average Medicare beneficiary would notice a significant difference.

A much more fundamental re-think of the way Medicare pays for drugs is necessary to start driving costs down closer to what the citizens of other countries pay, said Kristof Stremikis, director of market analysis and insight at the California Health Care Foundation.

Currently, he noted, Medicare uses a drug's average price in the wider market as a baseline for what it will pay. But the reasons why those prices are what they are are often murky. If the government truly wants to make a big dent in drug prices, unpacking those prices and demanding more transparency from drug companies will be necessary.

"The baseline we have today does not necessarily incorporate an objective assessment of a drug's value, and until that happens, the game isn't fundamentally changed. That's where significant savings are hiding," Stremikis said.

Cubanski, the Kaiser expert, agreed. She noted that the new step-therapy policy does require insurance plans to pass 50 percent of money saved by requiring the use of cheaper drugs onto patients, but, in the aggregate, she said, no one should expect a reversal of ever-increasing drug price trends.

"It's another opportunity to try and wring some savings out of Medicare, but, just because they're given this opportunity to use step therapy doesn't mean drug prices are coming down," Cubanski said.

Trump Has Opened Up Affordable Health Insurance Options

Commentary

All over our country, many Americans continue to struggle to pay for health insurance coverage. Premiums for Americans who buy their own insurance, rather than receiving it from an employer, have doubled since the implementation of Obamacare. Those increases have hurt our communities and put too much strain on the lives of our families, friends and neighbors.

Rising premiums have especially hurt the millions of middle-class Americans who aren't eligible for Obamacare subsidies. President Trump promised to help those left behind by Obamacare, and he's taken action. Earlier this month, the Trump administration finalized new regulations for a type of insurance plan that will help the 28 million forgotten men and women who remain uninsured under Obamacare.

In many states, these plans, known as "short-term, limited-duration" insurance, have for decades offered insurance for Americans for up to 12 months. The Obama administration limited the plans nationally to just three months, effectively eliminating this affordable option for many.

Subject to state regulation, the Trump administration will now allow these plans to last up to 12 months once again, and allow them to be renewed for up to 36 months in total.

These plans may be a welcome relief to consumers in states covered by Region I of the U.S. Department of Health and Human Services. In New Hampshire, for instance, premiums rose 32 percent from the implementation of Obamacare's major regulations through the end of President Obama's term in office. In Maine, they rose 55 percent.

Here are some things you should know about these plans:

What will they cost?: While state regulations can affect prices, short-term, limited-duration plans are expected to be 50 to 80 percent cheaper on average nationally than Obamacare plans.

How many people will buy them? Experts estimate that as many as 2 million or more Americans will enroll in one of these plans.

What do these plans cover? Coverage of medical services and levels of co-pays and deductibles will vary by insurer and depend on state regulation.

The Trump administration has instituted robust requirements for informing consumers about the limits of this option: Insurers offering short-term, limited-duration policies will be required to prominently display in the contract and in application materials that the policy is not required to comply with federal requirements for health insurance, including the rules created by Obamacare.

What kind of consumers do they make sense for? Short-term, limited-duration insurance makes sense for Americans who don't have or cannot afford other sources of coverage. That includes Americans who:

Don't have access to health insurance coverage through their employer, perhaps because they work multiple part-time jobs

Are independent contractors or self-employed in today's "gig economy" and can't afford Obamacare plans

Are between jobs or other sources of coverage, like young people who have graduated from college but aren't yet employed

Will I be able to keep these plans if I get sick? The federal government has said that consumers can be allowed to purchase plans with guaranteed renewability of up to 36 months. Based on this flexibility, consumers may be able to lock in their premiums at a certain level and keep their coverage for up to three years, protecting them from rate increases during this time in the event that they get sick. The availability of these options will depend on insurers' decisions and state regulation.

Do these plans satisfy the individual mandate for health insurance? No. However, beginning in January 2019, thanks to legislation signed by President Trump, the individual mandate for health insurance will no longer carry any penalty.

Eliminating the individual mandate penalty and expanding access to these short-term, affordable plans are just part of the Trump administration's efforts to ensure that as many Americans as possible have access to affordable health insurance. We have also expanded access to association health plans, which allow small businesses and self-employed Americans to band together to buy insurance, and continue to work with states to open up more affordable options and bring down premiums.

The Trump administration is working hard to ensure that health care is affordable and accessible for all Americans, and the recent news about short term plans is just one more example of President Trump living up to one of the promises he made to the American people.

(John McGough serves as New England regional director of the U.S. Department of Health & Human Services. He is responsible for the states of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, as well as the Region's 10 federally recognized tribes.)