Big Review

Name	Office	Page #	Page Location
	AARP	10	Coverage and Cost Change Yearly - Top of Page
	AARP	10	Coverage and Cost Change Yearly - Top of Page
	AARP	10	Middle of page - box on annual enrollment period
	AARP	15-17	Signing up for Medicare
	AARP	17	Top of page - Initial Enrollment Period
	AARP	18	Top of page - employer or union coverage

Name	Office	Page #	Page Location
	AARP	19	Bottom of page - When can I get Medicare Supplemental Insurance (Medigap) policy?
	AARP	20	Top of page - Heading
	AARP	21	Top of page - What if I have other Insurance - 4th bullet
	AARP	23	Top of page - 2nd paragraph; 2nd sentence
	AARP	25	Top of page - Title
	AARP	27	Top of page - Hospice
	AARP	28	Bottom of page - Skilled Nursing Facilities (SNFs) care
	AARP	30	Top of page - Alcohol Misuse

Name	Office	Page #	Page Location
	AARP	30	Bottom of page - Ambulance Services
	AARP	31	Middle of page - Bone Density
	AARP	32	Middle of page - Cervical and Vaginal Cancer Screening
	AARP	33	Middle of page - Colorectal Cancer Screening
	AARP	41	Top of page - Pneumococcal Shot
	AARP	47	Middle of page - Yearly "Wellness" Visit
	AARP	48	Top of page - preventive services
	AARP	48	Top of page - preventive services

Name	Office	Page #	Page Location
	AARP	50	Top of page - Heading
	AARP	51	Top of page - Medicare Advantage column notes
	AARP	62	Top of page - Under "Important Facts"
	AARP	62-63	How does Medigap work with Medicare Advantage Plans?
	AARP	77	Top of page - PACE
	AARP	77	Bottom of page - Medicare Innovation Projects
	AARP	79	Bottom of page - 5-Star Special Enrollment Period
	AARP	81	Top of page - What Do I pay?

Name	Office	Page #	Page Location
	AARP	81	Top of page - Monthly Premiums
	AARP	82	Top of page - Coverage Gap
	AARP	82	Top of page - Coverage Gap
	AARP	83	Third column of table
	AARP	86	Top of page - What's Covered?
	AARP	86	Middle of page - note
	AARP	87	Top of page - third sentence

Name	Office	Page #	Page Location
	AARP	87-88	Medication Therapy Management Program
	AARP	91	Bottom of page
	AARP	93	Middle of page
	AARP	99	Bottom of page - bottom of 2nd to last paragraph

Name	Office	Page #	Page Location
	AARP	99	Bottom of page - 1st sentence of last paragraph
	AARP	111	Top of page - How Do I Pay for Long-Term Care? Long-term Care Insurance
	AARP	112	Top of page - How Do I Pay for Long-Term Care?
	AARP	114	What Are Advance Directives? What If I Already Have Advance Directives?
	AARP	118	How Do I Compare the Quality of Plans and Providers?
	AARP	119	Bottom of page - electronic prescribing
	AARP	124	
	AARP	125	

Medicare & You 2013 (2/17/12-2/27/12)	
Comment	DCD Action
Replace "Review your plan each year to make sure it will meet your needs for the following year." with "Always review your plan's materials for the upcoming year to make sure it will meet your needs."	
The difference between Original Medicare and MA has not yet been explained. Both can be thought of as Medicare health plans. If so, as drafted this could be read to mean that all Medicare coverage and costs, both Original or MA, can change coverage and costs each year. That is inaccurate as applied to Original Medicare.	
Dark ink makes it difficult to read "Open Enrollment" in middle row	
Add a paragraph in Section 2 that specifically speaks to people over 65 who are still working or are about to retire about how to enroll.	
Mention here that if they don't sign up for B when first eligible and are not eligible for special enrollment, that they may pay a penalty for as long as they are in Part B.	
This tells workers to ask their employer or union how their active worker coverage works w/ Medicare. That is reasonable advice if the employer is well versed in this, but not all employers, especially small ones, are. Some employers may incorrectly inform older workers who are age 65 or older that they have to enroll in Medicare when, depending on the size of the employer, they don't. Employers may try to push older workers into Medicare if they are costly, even if it's legally the worker's choice whether or not to enroll in Part B. Might be good to have another publication/fact sheet/Q&A to direct people to that works through the issues of who has a choice about enrolling in Part B when still working/covered by active worker, and the pros/cons of enrolling in B if one has other coverage. Other people don't seem to know that they are eligible for special enrollment period if they turn down B.	

Comment	DCD Action
Third sentence says that it is a 6 month period when they have a guaranteed right to buy regardless of their health. Consider adding "one-time" 6 month period to emphasize that if they don't act in their period, they may not have the same guaranteed right to buy again.	
Might be clearer to say "What if I have Medicare and Other Insurance?"	
This bullet could be confusing. Haven't seen the word "secondary" before. Following from chart on p. 20, maybe say, If you have coverage, see above, where Medicare pays first, you may have to . . . What happens to retirees or older workers of small employers if they don't enroll in Part B? Does their other coverage reject the claim?	
Can you give a time-frame when Social Security will notify a beneficiary if they have to pay more than the standard Part B premium? We get a number of questions from members about this and it would be helpful if the information was in the handbook up in the front section.	
Since you talk about services first, tests second, and items last. Please edit the title to reflect the order of coverage category as they are introduced in the text that follows the title page. Also, consumers might not understand what you mean by "Item":. Suggested edit "Services, Tests or Medical Supplies".	
In the sentence on respite care, does "caregiver" refer to a family caregiver, direct care worker, either or both? It may be helpful to clarify.	
It is good the language is clear about the 3 day inpatient hospital stay requirement for Medicare SNF coverage. However, a patient may be in observation and not realize they have not been formally admitted as a hospital inpatient. The handbook should suggest that beneficiaries inquire about whether they are in observation or admitted as an inpatient and note that time spent in observation does not count toward the 3 day inpatient hospital stay requirement. Also, define "custodial care" if not defined earlier.	
Need to define the difference between alcohol "misuse" and "not alcohol dependant"	

Comment	DCD Action
What does it mean to say that Medicare will pay for the ambulance if "transportation in some other vehicle could endanger your health?" What if the person thought they were having a heart attack, but it turns out they didn't.	
Says that a person can get a bone density test more often that once a year if medically necessary. Does this mean that people pay nothing if they get the test more than once a year? Needs to be more clear.	
It says that if a person is at high risk, they can get cervical/vaginal cancer screening every year at no cost. The policy is inconsistent with the colonoscopy screening rules, where if someone has a polyp, they incur cost sharing	
Colonoscopy is a good example of ancillary costs. The colonoscopy itself may be "free" but if one has it in a hospital and receives sedation, there may be associated cost sharing for those other services. Beneficiaries need to be made aware of this.	
What if a person is at high risk and needs a second pneumonia shot…do they incur cost sharing for the second shot.	
The document should do a better job of explaining when a person will incur a cost for the wellness visit and when they won't incur a cost.	
Overall, the prevention section does not make clear that although some screenings may be "free", beneficiaries my incur ancillary cost sharing (e.g., infusion fees, facility fees, etc.). Also, what happens if a person does a AAA screen and something is found and the person needs watching...is this considered screening. The section should make it clear what screening is and what it isn/t. AARP has been at the forefront of touting "free" prevention benefits in Medicare. However, we need to make sure that people understand the difference between not being charged for the actual service and being charged for ancillary services.	
We are getting a lot of questions about the colonoscopy as a preventive benefit vs. when a physician finds or removes a growth during the colonoscopy. Consumers are asking if there is a growth do they then have to pay a copay? Can you put a notation about this as to help minimize the confusion around preventive vs. diagnostic services.	

Comment	DCD Action
Change to "How Can I Get My Medicare Prescription Drug Coverage?"	
While this says you can only use a Medigap policy if you disenroll from your MA plan, it fails to say that their options for buying a Medigap policy if they disenroll are guaranteed in only limited situations.	
Replace "You can't have prescription drug coverage in both your Medigap policy and a Medicare drug plan. See page 89." with "Medigap policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Medigap policy, you can keep it."	
What this section does not tell people is that if they want to drop their MA plan beyond their first 12 months and return to Original Medicare, they are not guaranteed the right to buy a Medigap plan. This is a point that many people don't understand. They think they can choose to return to Original Medicare during the annual enrollment period sometime in the future and pick up Medigap when they do. Except in a few states, this isn't the case. Federal law does not guarantee access to Medigap beyond the 6 month open enrollment period and the few guarantee issue situations. People need to be told this. MA plans tend to highlight that they can return to Original Medicare but don't mention that Medigap may not be available.	
The document should clearly let people know that if they join a PACE program, they are essentially in a managed care program and do not have access to any provider. In addition, they may have to give up their current providers if they join a PACE program.	
The document should clearly tell people what they may gain and lose if they sign up for a Medicare Innovation Project.	
Under "5-Star Special Enrollment Period," the paragraph should indicate: "If you are already enrolled in a Medicare prescription drug plan, you can switch to a Medicare 5-star plan."	
Bold "What you pay for Part D coverage could be higher based on your income." Consider adding a table that shows the income thresholds and monthly adjustment amounts.	

Comment	DCD Action
Identify exact income amounts that qualify one for the higher premiums, instead of saying, "If your income is above a certain limit…."	
"In 2013, once you enter the coverage gap, you pay 47.5% of the plan's cost for covered brand-name drugs and 79% of the plan's cost for covered generic drugs until you reach the end of the coverage gap"	
This section should acknowledge that MOST people with Medicare Part D who do not receive extra Help DO NOT EXPERIENCE the coverage gap. Then add, "But if you do, in 2013, for prescriptions you fill in the gap, you will pay 47.5% on covered brand-name drugs....." Delete this sentence: "Not everyone will enter the coverage gap."	
"In 2013, she pays 47.5% of the plan's cost for her covered brand-name prescription drugs and 79% of the plan's cost for covered generic drugs"	
End of 1st paragraph, acknowledge that one cannot request an exception for drugs assigned to the "Specialty Tier" to reduce the required cost-sharing.	
There's a reference to "except for vaccines covered under Part B. Identify, by name, the most common vaccines that are covered under Part B. The whole B/D jurisdiction split is very confusing for Medicare beneficiaries and clinicians, so specific examples would help.	
Define "observation services"	

Comment	DCD Action
This section opens by noting that if you qualify for medication therapy management services, you can get them for free. However, the specific list of eligibility criteria do not appear until p. 88 -- instead, this list should appear immediately under the first sentence of this section on p. 87. Also, the dollar threshold (currently the third item on the list) should be listed first. Following the list of eligibility criteria, then provide a list of MTM services (which are now in paragraph form, and hard to grasp). Further, add a statement that if you are eligible for your plan's MTM program, you will receive a letter from your plan that explains how to access these free services. Add a statement that these services may be provided to you in a face-to-face meeting with a pharmacist, or over the phone. Add a statement that the pharmacist (or other person who provides MTM services) will ask for your help in talking about how your medicines are working, and if you have experienced any problems. Add a statement, "Your feedback about your medicines is essential to get the most benefit from the medication therapy management services."	
The sentence that starts, "Resources include money in a checking or savings account ……. " needs to be in closer proximity to the previous paragraph that discusses LIS eligibility by income and resources. Be consistent: the income eligibility criteria are listed in bulleted fashion; list the "resources" criteria with bullets, too. Also on this page, there's a reference that persons who qualify for Extra Help have "no coverage gap." This is false: LIS enrollees fall into the coverage gap at a much higher rate than non-LIS enrollees. What's unique is that Extra Help enrollees will NOT have any additional cost-sharing (beyond their regular LIS co-payments) on prescriptions they fill in the gap.	
The sentence that states what the specific LIS co-payment amounts are should be moved to p. 91, and incorporated into the bulleted list on the bottom of p. 91 that identifies the benefits of LIS. This is very important information, and should not be buried at the end of the Extra Help section.	
"In these cases, the plan will send you a letter about your options before the fall open enrollment period…"	

Comment	DCD Action
"If you want uninterrupted coverage from Medicare prescription drug coverage (Part D) or a Medicare Advantage Plan (like an HMO or PPO)…"	
Most policies include coverage for a range of services (i.e. more than "Others may include..."). Define "informal home care" - not everyone will know what that means.	
Consider mentioning Older Americans Act programs here or the Eldercare Locator, which is located on page 113.	
Say how to contact your local Area Agency on Aging or give the Eldercare Locator number to do so	
Note that visiting a facility, such as a nursing home, is a good way to find out about the quality of care.	
Discussion of "electronic prescribing," 2nd bullet point, notes "….. and prescribe a drug that costs you less." This should be changed to read, "and may be able to prescribe a drug that costs you less."	
Add a definition for "Medication Therapy Management"	
Add a definition for "Star Ratings"	