



Kansas Hospital
ASSOCIATION

MEDICARE ENROLLMENT HANDBOOK

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This handbook is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings. Information for this handbook was taken from www.medicare.gov and www.kdads.ks.gov (Senior Health Insurance Counseling For Kansas).

Table of Contents

Chapter 1 MEDICARE OVERVIEW	7
Who Runs Medicare?	7
The Centers for Medicare & Medicaid Services (CMS)	8
The Social Security Administration (SSA)	8
The Office of Medicare Hearings and Appeals (OMHA)	9
Sources of Medicare Eligibility, Coverage, and Payment Rules	10
Eligibility and Enrollment	10
Enrollment in General	11
Eligibility and Enrollment for Medicare Part A	11
Persons Entitled to Retirement Benefits	11
People with Disabilities or ESRD	11
Voluntary Enrollment in Medicare Part A.....	12
Eligibility and Enrollment for Medicare Part B	12
Persons eligible for Part B	12
Enrollment Periods	12
Initial Enrollment Period (IEP)	12
General Enrollment Period	13
Special Enrollment Period	13
Enrollment Procedures	13
Medicare Cards and Numbers	14
Chapter 2 MEDICARE PART A	16
Inpatient Hospital Coverage	16
Acute Care Hospitals	16
Inpatient Rehabilitation Facility (IRF)	18
Long-Term Care Hospitals (LTCHs)	18
Psychiatric Hospitals	18
Payments to Hospitals and the Right to Needed Care	18

What Are Your Hospital Rights?.....	19
Skilled Nursing Facility (SNF) Coverage	19
Skilled Nursing and Rehabilitation Services	20
Claims, Payment, and the Right to Needed Care.....	21
Home Health Care	22
Hospice Care	24
Your Rights as a Medicare Beneficiary	25
Medicare Outpatient Observation Notice (MOON)	26
Chapter 3 MEDICARE PART B	27
Part B Covered Services, Items, and Coverage Rules	27
Physician Services	27
Outpatient Hospital Services	28
Durable Medical Equipment (DME), Prosthetics, and Supplies	29
Competitive Bidding Program for DMEPOS	31
Drugs and Biologicals	31
Ambulance Services	32
Preventive and Screening Services.....	33
Excluded Services and Items	35
Part B Costs and Claims – Beneficiary Costs	35
Assignment	36
Private Contracts	37
Beneficiary Financial Liability Protections: Waiver of Liability	37
Advance Beneficiary Notice of Noncoverage (ABN)	39
Ambulance Transportation and ABNs	39
Other Things You Should Know About Medical Services Available	40
Coverage of Second Opinions	40
Medicare Outpatient Observation Notice Form (MOON)	40
Illegal Practices	41
Chapter 4 MEDICARE PART C (Medicare Advantage)	42
Types of Plans	42
Eligibility and Enrollment	47

Enrollment Periods and Effective Dates	50
Special Enrollment (Election) Periods	50
How to Enroll in a MA Plan	55
Post-Enrollment Actions	57
Coverage of Benefits and Access to Services	57
Supplemental Benefits and Guidelines	58
Relationship to Drug Coverage	63
Low-Income Assistance	66
Marketing Overview – Medicare Advantage and Medicare Part D	66
Special Guidelines	69
Agent and Broker Guidance	72
IMPORTANT REMINDERS	74
Chapter 5 MEDICARE PART D	75
The Standard Benefit Design	75
Creditable Coverage and Late Enrollment Penalties	75
Types of Drug Plans - Two Main Categories	76
Plan Variations	76
Eligibility and Enrollment	78
How to Select a Plan	80
Enrollment Periods	81
Special Enrollment Periods (SEPs)	82
How to Enroll	86
Disenrolling and Switching	86
Costs and Prices	87
Access to Drugs and Formularies	91
Cost-Containment Strategies	95
Transition Policies	96
Marketing	97
Help for Low-Income Beneficiaries	98
Eligibility	98
Applying for Low-Income Subsidy: Who Needs to Apply and Who Does Not?	99

Levels of Low-Income Subsidy	100
Institutionalized and HCBS Beneficiaries	101
Redeterminations and Redeeming	104
Prescription Drug Assistance Programs and Medicare Part D.....	107
Chapter 6 MEDICARE SUPPLEMENT (MEDIGAP) INSURANCE.....	108
Covered Gaps and the Basic Benefit	109
Medigap Modernization	110
The Standard Medigap Insurance Policies (June 1, 2010)	110
1990 Plans no longer sold	111
Other Policy Options	112
Explanation of Basic and Additional Benefits	112
Uncovered Gaps in Original Medicare	113
The Cost of Medigap Insurance	114
Consumer Rights and Protections	115
Other Policy Features & Limitations	116
30-Day Free Look	116
Suspension during Medicaid or QMB Eligibility	117
Underwriting	117
Pre-Existing Conditions Limitations	118
Coordination of Benefits	118
Sales Materials	119
Be a Wise Consumer	120
Chapter 7 COUNSELING TOOLS	123
List and contact of SHICK Agencies in Kansas.....	123
Toll Free Hotline.....	124
Getting Ready for Medicare Counseling Steps	125
Chapter 8 GLOSSARY	127
Chapter 9 APPENDIX	144
2022 Overview of Medicare A & B	144
Annual Medicare Premium and Cost-Sharing Amounts	145
Part A – Hospital Insurance	145

Part B -Medical Insurance146

Part B Late Enrollment Surcharges/Penalties:146

Part D – Medicare Prescription Drug Coverage147

Part D deductibles, copayments, & coinsurance148

Defined Standard Plan (Basic Benefit) in 2022148

2022 Monthly Poverty Guidelines148

2022 Resource Standards for Individuals/Couples149

Medicare Savings Programs (MSPs): Eligibility and Coverage (2022)150

 Medicare Drug Plan Costs if You Automatically Qualify for Extra Help150

 Medicare Drug Plan Costs if You Apply and Qualify for Extra Help151

Standard Medicare Supplement Policies at a Glance152

Medicare Prescription Drug Coverage Worksheet154

Chapter 1 - MEDICARE OVERVIEW

Medicare is a federal health insurance program which began in 1965. States are not involved in the program's administration. In general, the rules governing Medicare's operation are the same nationwide, though more detailed rules sometimes apply in specific states or regions and payments rates often vary from one region to another. Still, the program is virtually the same throughout the country.

Medicare is not free for the people, called beneficiaries, who benefit from the program. Congress designed the Medicare program so beneficiaries would share the total cost of health care with the federal government through:

- Premiums
- Deductibles
- Coinsurance charges, and
- Payment for non-covered (excluded) services and items

Eligibility for Medicare is available to three groups: those who are 65 and older, people with disabilities, and people with end-stage renal disease (ESRD). Medicare eligibility is open to people regardless of income. Eligibility is not based on financial need. In that respect, Medicare differs greatly from Medicaid, the state-sponsored health insurance program for low-income older Americans and others. Instead, Medicare is tied largely to employment. The financing for Medicare Part A's Hospital Insurance benefits, for example, derives from a FICA withholding tax applied to wages.

Medicare has a relatively comprehensive set of covered benefits. It also offers several service delivery options. Beneficiaries have the option to receive services through the "Original Medicare" program (Medicare Parts A and B, also called "Traditional Medicare") or through a variety of privately sponsored "Medicare Advantage" plans. Regardless of the choice they make between these options, beneficiaries have coverage for the Part A benefits that include inpatient hospital, skilled nursing facility, home health, and hospice care services. They also have coverage for Medicare Part B's benefits that include physician, outpatient hospital, home health, ambulance, and preventive services, along with medical equipment, supplies, and many other services and items.

The Medicare Advantage program is another name for Medicare Part C. Congress enacted Part C in 1998, and through it, set up several different systems for delivering Medicare-covered benefits and services through private contractors. These contractors, called "health plan sponsors" or Medicare Advantage Organizations (MAOs), offer Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private-Fee-for-Service (PFFS) plans, and more, to Medicare beneficiaries. These private plans must cover the same services and benefits that are available through the Original Medicare program.

In 2003, Congress enacted the Medicare Modernization Act (MMA) and created the Medicare Part D prescription drug program. From the start, the Original Medicare program did not cover most outpatient prescription drugs. Medicare Part D addresses this shortcoming by delivering drug coverage through privately-sponsored prescription drug plans (PDPs) and Medicare Advantage plans with Part D drug coverage (MA-PDs). The Part D program also offers assistance for low-income Medicare beneficiaries through a low-income subsidy (LIS), or "Extra Help" program.

Medicare covers health care services only when they meet Medicare's definitions for medical necessity. With some exceptions, a service must be "reasonable and necessary in the diagnosis or treatment of an illness or injury" to qualify for Medicare payments. Nonetheless, Congress has added many health care screening and preventive care services to Medicare's covered benefits since 1990.

Regardless of medical necessity, Medicare specifically excludes some services and items from its covered benefits. Medicare's exclusions include:

- Most care received outside the United States (with exceptions for emergencies along the Canadian and Mexican borders)
- Custodial care, including most long-term nursing home care
- Hearing aids
- Routine dental care
- Routine eye care
- Routine foot care
- Eyeglasses (except in connection with cataract surgery)
- Dentures
- Acupuncture for any condition other than chronic low back pain
- Homeopathic care
- Cosmetic surgery (except in connection with an illness or injury)
- Private duty nursing

Who Runs Medicare?

Medicare's administration is the combined work of federal agencies and contractors. Here are brief descriptions of the main actors:

The Centers for Medicare & Medicaid Services (CMS)

CMS is the federal agency that administers Medicare and Medicaid. Its headquarters are in Baltimore, with Regional Offices (ROs) in 10 cities around the country. It is the largest agency within the Department of Health & Human Services (HHS). CMS contracts with many private companies that handle aspects of Medicare's program operations including claims processing, monitoring the quality of care for patients, handling complaints, and reviewing appeals.

1-800-MEDICARE: CMS offers the agency's nationwide, toll-free, Medicare beneficiary Service Center. The Service Center is set up to answer questions about billing and claims, to provide information on Medicare health plans, to receive complaints, and to order publications. Customer service representatives are available 24 hours a day, seven days a week.

The Social Security Administration (SSA)

SSA handles Medicare eligibility and enrollment for Social Security recipients. SSA sends enrollment packets and Medicare cards to new Medicare beneficiaries. It also processes applications for Medicare Part D's low-income subsidy (LIS) program. The Railroad Retirement Board's (RRB) role is similar to SSA's. It handles Medicare eligibility and enrollment for Railroad Retirees.

Social Security replaces lost and damaged Medicare cards free of charge. Refer clients to SSA's toll-free phone number, 1-800-772-1213, or to their My Social Security account. SSA takes about 30 days to replace a Medicare card. Railroad retirees should call the RRB at 1-800-808-0772.

The agency's role in Medicare is limited mainly to eligibility and enrollment issues, including enrollment in the program that provides "Extra Help" in paying for prescription drugs for those with limited incomes.

The Office of Medicare Hearings and Appeals (OMHA)

OMHA is a separate agency within the federal Department of Health and Human Services (HHS). It employs Administrative Law Judges (ALJ) to provide hearings in the Medicare appeals process.

CMS' mission is to ensure health care security for beneficiaries.

Original Medicare's payment contractors currently include:

- **A/B Medicare Administrative Contractors (A/B MACs)** who contract with CMS to process Part A claims for hospitals and skilled nursing facilities and Part B claims for hospital outpatient services, physicians, ambulance providers, and others in a multi-state/territory region.
- **Home Health and Hospice Medicare Administrative Contractors (HH MACs)** who contract with CMS to process claims for home health agencies and hospice organizations in four multi-state regions.
- **DME Medicare Administrative Contractors (DME MACs)** who contract with CMS to process Part B claims for durable medical equipment (DME) and supplies, including Part B drugs, in four multistate regions. CMS has phased out the former Durable Medical Equipment Regional Carriers (DMERCs).

CMS also contracts with private companies to investigate quality of care complaints and to review coverage and payment decisions at certain points in the Medicare appeals process. These contractors include:

- **Quality Improvement Organizations (QIOs)** who contract with CMS to investigate complaints about poor care, review hospital discharge decisions, and handle expedited review requests for skilled nursing facility and home health service terminations. QIOs also work with providers on quality of care improvement projects. In 2014, CMS redesigned its QIO Program to further enhance the quality of services for Medicare beneficiaries. The new program structure maximizes learning and collaboration in improving care, enhances flexibility, supports the spread of effective new practices and models of care, helps achieve the priorities of the National Quality Strategy and the goals of the CMS Quality Strategy, and delivers program value to beneficiaries, patients, and taxpayers.
 - The QIO Program changes include separating case review from quality improvement, extending the contract period of performance from three (3) to five (5) years, removing requirements to restrict QIO activity to a single entity in each state/ territory, and opening contractor consideration to a broad range of entities to perform the work.
 - Now, one group of QIOs handles complaints while another group provides technical assistance to support providers and suppliers. QIOs have skills for transforming practices,

employing lean methodologies, assisting with value-based purchasing programs and developing innovative approaches to quality improvement.

- See <https://www.cms.gov/medicare/quality-initiatives-patient-assessmentinstruments/qualityimprovementorgs>.
- **Qualified Independent Contractors (QICs)** who contract with CMS to review coverage denials in the second stage of the Original Medicare appeals process called “reconsideration.” QICs handle Part A reconsiderations for east and west regions, Part B reconsiderations for north and south regions, and DME reconsiderations for all the states and territories. See <https://www.cms.gov/medicare/appeals-and-grievances/orgmedffsappeals>.

Sources of Medicare Eligibility, Coverage, and Payment Rules

Congress enacts the Medicare statutes in which the lawmakers broadly define Medicare’s terms and its scope of benefits. CMS, the federal Medicare agency, issues federal regulations, policy manuals, and other guidance documents that interpret the Medicare statute and gives details about CMS’s coverage and payment rules.

- The Medicare Statutes, known as Title XVIII of the Social Security Act and codified at 42 United States Code (USC) Section 1395, were enacted and are often amended by Congress.
- The Medicare Regulations are found at 42 Code of Federal Regulations (CFR), Parts 400-429. CMS publishes proposed regulations in the Federal Register and seeks public comment before finalizing the regulations that eventually appear in the Code of Federal Regulations.
- The Medicare Policy Manuals appear on-line at CMS’s website at <https://www.cms.gov/regulations-and-guidance/guidance/manuals>. The “Internet Only Manuals” contain CMS’s interpretation of the Medicare statute and regulations. They also include “Medicare National Coverage Determinations” that guide Medicare coverage decisions throughout the country on certain services, procedures, and devices.
- Medicare Program Transmittals, available at <https://www.cms.gov/regulations-and-guidance/guidance/transmittals> are sent by CMS to its contractors to put new or revised policies into action.
- Local Coverage Determinations that Medicare’s payment contractors create to clarify payment policy on some Medicare coverage issues.

Eligibility and Enrollment

Eligibility in General

Congress conceived Medicare as a health insurance program for workers who are no longer able to work due to age or disability. Hence close ties exist between Medicare eligibility and eligibility for Social Security benefits. Note, however, that Medicare coverage is available for some individuals who otherwise do not qualify for Social Security retirement payments.

Three groups of people are eligible for Medicare benefits. Those who benefit from the program are called beneficiaries. The three eligibility groups include:

- People 65 and older

- People with disabilities who have been receiving Social Security or Railroad Disability payments for 24 months, except for persons with Lou Gehrig’s disease (ALS)—they are eligible for Medicare in the sixth month of disability when they become eligible for disability benefit payments.
- People with end-stage renal disease (ESRD), that is, kidney disease that requires dialysis or transplant.

Most of those who are eligible for Medicare are entitled to benefits because they paid into the Medicare hospital insurance trust fund through FICA payroll deductions at work. However, a work record in the United States is not required for people 65 and older. Citizens of the U.S. who are 65 and older and did not pay long enough into Medicare trust fund, as well as permanent resident non-citizens aged 65 and older who have lived in the United States for five continuous years prior to applying for Medicare, are eligible for Medicare benefits. They must, however, pay monthly premiums for both Medicare Part A and Part B benefits.

Enrollment in General

The Social Security Administration (SSA) and Railroad Retirement Board (RRB) for railroad retirees determine eligibility for those entitled to Medicare benefits and handle enrollment. SSA uses both automatic and voluntary enrollment procedures. Many people are enrolled automatically in Medicare. Others must apply for Medicare coverage at a Social Security office or online. Note that some enrollment rules differ for Part A and Part B, including rules for some people who work beyond age 65.

SSA and RRB issue Medicare cards to enrolled beneficiaries. For more information about Medicare eligibility and enrollment, contact:

- The SSA at 1-800-772-1213, or go to <https://www.ssa.gov/>.
- The RRB at 1-800-808-0772, or go to <https://www.rrb.gov/>.

Eligibility and Enrollment for Medicare Part A

Persons Entitled to Retirement Benefits

Even though the age for full Social Security retirement benefits is later than age 65 for persons born after 1938, Medicare eligibility is still at age 65. Most people 65 and older are entitled to Part A benefits because they or a spouse have 40 credits (formerly “quarters of coverage”) in Social Security-covered employment. Those who choose to receive Social Security or railroad retirement benefits at age 65 or earlier do not need to apply separately for Medicare. Social Security enrolls them automatically in Medicare Part A. About 99 percent of Medicare beneficiaries do not pay a premium for Medicare Part A benefits. For more information on quarters of coverage, visit SSA’s website at <https://www.ssa.gov/OACT/COLA/QC.html>.

Those who wait past age 65 to apply for their monthly Social Security or railroad retirement benefit payments can apply for Medicare benefits at a Social Security office or online through <http://www.ssa.gov/>. They can apply for premium-free Part A anytime during the year. Their Part A benefits can take effect retroactively, up to six months before they applied.

People with Disabilities or ESRD

People of any age with disabilities who are entitled to Social Security or Railroad disability benefits for 24 months are also entitled to Medicare Part A without paying a premium. Their Medicare benefits start in the 25th month of receiving disability benefit payments.

People of any age who have end-stage renal disease (ESRD) and have had a kidney transplant or have received dialysis for three months are entitled to Medicare Part A benefits. People with ESRD must contact Social Security to apply for Medicare.

An exception to the 24-month disability waiting period applies to people who have Amyotrophic Lateral Sclerosis (ALS) (aka Lou Gehrig's disease). The law waives the waiting period. Because Social Security disability payments start after five months of the onset of a disability, Medicare coverage takes effect on the first day of the sixth month of the ALS disability.

Voluntary Enrollment in Medicare Part A

Those not entitled to Medicare through employment can enroll in Medicare voluntarily. This group includes certain people with disabilities and certain people aged 65 and older who do not have enough work credits to qualify for premium-free Medicare. They must, however, be willing to pay monthly premiums for the benefits. Seniors and people with disabilities who have fewer than 40 credits in Social Security-covered employment must pay a monthly premium for Part A benefits. The Medicare premium amount for the current year can be found in the Appendix. A late enrollment penalty may apply for those who enroll a year or more after their 65th birthday. Voluntary enrollees have three (3) time frames to enroll in the Part A program, just as with Medicare Part B.

Eligibility and Enrollment for Medicare Part B

Persons eligible for Part B

Those who are eligible for Part A benefits also are eligible for Medicare Part B. In addition, persons aged 65 and older who are U.S. citizens or permanent resident non-citizens for five years who are not entitled to Part A through Social Security-covered employment can enroll in Part B without enrolling in Part A.

Enrollment Periods

People who are eligible for Medicare Part B benefits must enroll in the program during an enrollment period. Original Medicare has three distinct enrollment periods. Note that Original Medicare does not have the seven-week Annual Enrollment Period (October 15 to December 7) that exists for Medicare drug plans (Part D) and Medicare Advantage plans (Part C).

Initial Enrollment Period (IEP)

The IEP is a seven-month time frame that includes the three months before and after the month of a person's 65th birthday.

- If a person enrolls (or is automatically enrolled) in Medicare during the first three months of the initial enrollment period, Medicare coverage starts on the first day of the month in which the person turns 65 (unless their birthday is on the 1st of the month, when their Medicare eligibility begins on the 1st of the month prior to their birthday month).

- If a person enrolls in the month of her 65th birthday, coverage starts on the first day of the next month.
- If a person enrolls in the fifth month of the IEP, coverage will start two months after enrollment.
- If a person enrolls in the sixth or seventh month of the IEP, coverage will start three months after enrollment.

General Enrollment Period

The General Enrollment Period is a three-month time frame at the beginning of each calendar year (January-March) during which a beneficiary who did not enroll during an initial enrollment period can enroll in Medicare Premium Part A and Part B.

- Coverage for Premium Part A and/or Part B takes effect on July 1.
- Premium penalties apply for those who enroll more than 12 months following their initial eligibility date.
- Part A Penalty: 10% premium surcharge for twice the number of years you could have had Part A, but didn't sign up.
- Part B Penalty: 10% premium surcharge for each 12-month period that had passed when a person could have been, but was not, enrolled in Part B.
 - Note that beneficiaries under the age of 65 currently paying this premium penalty will not have to pay that penalty upon turning 65.
 - Currently there is no cap on the penalty amount. For example, beneficiaries could be responsible for paying anywhere from 10% (1-year delay) to 300% (30-year delay) depending on how long they delayed enrolling.

Special Enrollment Period

The law requires employers with 20 or more employees to offer the same health coverage that it makes available to younger employees. In other words, these employers cannot force an older worker to get their health insurance through Medicare. Those who work beyond age 65 (the working aged) for employers with 20 or more employees, and who have continued health insurance coverage through an employer group health plan have an eight-month time frame to enroll in Medicare. The SEP starts in the month when a retiree is no longer working and/or their employee group coverage ends.

- Coverage takes effect on the first day of the month following enrollment.
- No penalties apply for late enrollment.
- A Special Enrollment Period is also available to spouses of the working aged.
- The Special Enrollment Period does not apply to those who continue their group plan coverage through COBRA rights and stopped working more than seven months ago.

Enrollment Procedures

Enrolling in Medicare Part B is optional. A person who enrolls in Medicare Part A is also enrolled in Part B unless they opt out of Part B.

- Most people do not opt out of Part B because they need the coverage.
- Social Security sends an enrollment packet that contains the red, white, and blue Medicare card.

- For automatic enrollees, Social Security enrolls them in both Part A and Part B, unless the beneficiary signs and returns an official post-card or other written statement to SSA in which they opt out of Part B coverage.
- The working aged (and their spouses) with employer group coverage can enroll in Part A (because they are entitled to it without premiums) and opt out of Part B. Part A Hospital Insurance pays second to the employer group plan. These beneficiaries can enroll in Part B later (as described above).
- Part B Premium - The standard Part B premium for the current year is listed in the appendix. However, the Hold Harmless rule that ensures that Social Security checks will not decline from one year to the next because of increases in Medicare Part B premiums. In some years, if there is no or little cost of living increase in the Social Security benefit, Medicare beneficiaries who had their Medicare Part B premium deducted from their Social Security or Railroad Retirement pensions will not have an increase in their Part B premium and will continue to pay the same premium in the next year. Some low-income persons may qualify for state assistance in paying the Part B premium through Medicaid or the Medicare Savings Programs.
- IRMAA - the law requires Medicare beneficiaries who have higher incomes to pay the monthly Part B premium along with an income-related adjustment to the premium. The income adjustment applies to beneficiaries who file individual tax returns and to beneficiaries who file a joint tax return, and have modified adjusted gross annual income above a certain amount. The monthly premium adjustment amounts for each level can be found in the *Medicare Premium and Cost-Sharing Amounts* in the appendix.

Medicare Cards and Numbers

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) replaced the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Between April 1, 2018 and April 1, 2019, CMS removed Social Security numbers from Medicare cards and mailed each person a new card. This helps keep people's information more secure and helps protect their identity.

The Medicare Number is unique and will only be used for Medicare coverage. The new number doesn't change coverage or benefits.

The new cards no longer include gender or a signature line. They are also smaller, the size of a standard credit card to fit in wallets easier and can be laminated.

The MBI is:

- Clearly different than the HICN and RRB number
- 11-characters in length
- Made up only of numbers and uppercase letters (no special characters)

Each MBI is unique, randomly generated, and the characters are "non-intelligent," which means they don't have any hidden or special meaning. MBI format specifications can be found in Chapter 14 – Appendix page 14-16.



MEDICARE HEALTH INSURANCE

Name/Nombre

JOHN L SMITH

Medicare Number/Número de Medicare

1EG4-TE5-MK72

Entitled to/Con derecho a

HOSPITAL (PART A)

MEDICAL (PART B)

Coverage starts/Cobertura empieza

03-01-2016

03-01-2016

Chapter 2 – MEDICARE PART A

Medicare Part A has four main benefits:

- Inpatient Hospital Care (including rehabilitation hospital and psychiatric hospital care) • Skilled Nursing Facility Care
- Home Health Care
- Hospice Care

Part A providers submit payment claims for their services to a Medicare claims contractor. Depending on the type of provider, they send claims to a Part A and Part B Medicare Administrative Contractor (A/B MAC), or a Home Health and Hospice Medicare Administrative Contractor (HH MAC). Afterwards, the claims contractor sends a *Medicare Summary Notice* to the patient that explains the coverage decision and the patient's share of the costs.

Part A providers have one calendar year from the date of service to submit claims to Medicare. Medicare Advantage plans may have different time frames.

Inpatient Hospital Coverage

Acute Care Hospitals

Medicare will pay for acute care hospital stays only when the services can be provided on an inpatient basis in a hospital. Hospital staff, including the internal Utilization Review (UR) Committee, reviews a patient's stay considering Medicare's coverage rules to decide if hospitalization admission is "reasonable and necessary," or if a patient's condition justifies an ongoing hospital stay. Hospital staff will assess if a patient can move safely to a lower level of care.

Medicare's inpatient hospital benefit covers:

- Semi-private room (Medicare covers the cost of private rooms when they are medically necessary)
- Regular nursing services (but not private duty nursing)
- Drugs, supplies, and equipment
- Physical therapy
- Medical social services
- Medical services provided by interns or residents

Medicare Part A generally does not cover the services that surgeons, anesthesiologists, or other physicians provide in the hospital. Physicians bill separately for their services and submit claims to Medicare Part B. When helping clients sort through their paperwork following a hospital stay, keep this difference in mind.

Medicare excludes some services from its inpatient hospital coverage.

Services Not Covered During Hospital Stays

- Physician services (covered by Medicare Part B)
- Personal convenience items such as television, radio, and telephone if billed separately • Private duty nurse
- Extra charges for private room unless required for medical reasons
- First three pints of blood
- Care received outside the United States.

Medicare Part A

- Exceptions: The following very limited situations involving qualified Canadian or Mexican hospitals are covered.
- The beneficiary is in the U.S. when an **emergency** occurs and Canadian or a Mexican hospital is closer than the nearest U.S. hospital which could provide needed emergency care.
- The beneficiary lives in the U.S. and a Canadian or Mexican hospital is closer to his or her home than the nearest U.S. hospital, regardless of whether an emergency exists.
- The beneficiary is in Canada traveling the most direct route to or from Alaska and a lower-48 state, and an emergency occurs that requires admittance to a Canadian hospital. Medicare *will not* pay for emergency situations in Canada while traveling as a tourist.

Covered Days and Costs for Inpatient Hospital Services

Medicare covers up to 150 days of inpatient hospital care within a benefit period if the covered days are medically necessary. With the start of each new benefit period, a Medicare patient has 90 renewable covered days. Medicare patients also have 60 non-renewable “lifetime reserve days.”

A benefit period starts on the first day that a Medicare patient enters a hospital as an inpatient and ends when the person has not received inpatient hospital or skilled nursing facility levels of care for 60 days in a row. The number of covered days remaining for a patient depends on the continuation—or end—of the benefit period (see examples below).

The costs that beneficiaries owe for inpatient hospital stays relate to the number of covered inpatient hospital days that they use in a benefit period. Part A’s cost-sharing charges include a first-day deductible for inpatient hospital services and coinsurance charges that apply to some hospital stays.

- Part A Deductible and Days 1 to 60: At the start of a hospital stay in a new benefit period, the patient owes a deductible. After a patient meets the deductible, Medicare covers in full the first 60 inpatient hospital days in the benefit period. The Part A deductible is **not** an annual deductible. Clients who have a series of hospital stays could multiple Part A deductibles in a calendar year if more than 60 days separate their repeated hospital stays.
- Coinsurance for Days 61 to 90: Patients owe a daily copay (1/4 of the Part A deductible) when they use days 61 through 90 in a benefit period. Medicare covers the balance of the hospital bill.
- Coinsurance for Days 91 to 150: Patients owe a daily copay (1/2 of the Part A deductible) when they use these “lifetime reserve days.” Medicare covers the balance of the hospital bill.
- Day 151 and Beyond: If the hospital stay continues beyond Medicare’s 150 covered hospital days in a benefit period, the patient is responsible for the entire hospital bill. But if the patient leaves the hospital for 60 days in a row and ends the benefit period, they have a new set of 90 covered hospital days if they enter the hospital again.

Medicare Part A and Part B have separate patient cost-sharing systems.¹ Part A’s deductible is tied to the benefit period. Part B has an annual deductible. While many beneficiaries are familiar with Part B’s costs, they may not know as much about Part A. What are the origins of the two deductibles? Congress

¹ Annual cost-sharing amounts are available in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.

Medicare Part A

patterned Part A and Part B on the Blue Cross (hospital) and Blue Shield (medical) plans of the early 1960's.

The fact that a person may owe more than one Part A deductible during the year may surprise some beneficiaries who often expect an annual deductible.

Inpatient Rehabilitation Facility (IRF)

Inpatient rehabilitation facilities, or rehabilitation hospitals, specialize in providing post-acute rehabilitative care for injured, disabled, or sick persons, including those who have had strokes, joint replacements, and injuries. Medicare treats rehabilitation hospital stays the same as acute care hospital stays for purposes of the Part A benefit period. The number of days spent in a rehabilitation hospital count toward the 150 Medicare-covered inpatient hospital days in a benefit period. Medicare covers rehabilitation hospital stays if:

- A physician certifies the need for the care;
- The patient needs a relatively intense, multi-disciplinary rehabilitation program;
- A team that includes speech therapists, physical therapists and/or occupational therapists, and rehabilitation nurses working under the supervision of a physician specializing in rehabilitation medicine provides the care; and
- The patient is progressing toward the goal of functioning as independently as possible.

Long-Term Care Hospitals (LTCHs)

Since 1999, Medicare has certified some facilities to operate as long-term care hospitals (LTCHs). Their average inpatient length of stay must be 25 days or longer. These hospitals typically provide post-acute extended medical and rehabilitative care for patients whose conditions are complex and who may have more than one acute or chronic condition. They provide services such as rehabilitation, respiratory therapy, cancer treatment, head trauma care, and pain management.

For purposes of covered days in a benefit period, Medicare treats LTCHs the same as acute care and rehabilitation hospitals. The number of days spent in a LTCH count toward Medicare's 150 covered inpatient hospital days in a benefit period. Where they exist, LTCHs provide an alternative to skilled nursing facilities for some patients.

Psychiatric Hospitals

Medicare covers inpatient psychiatric hospital stays when a physician determines that the patient, at the time of admission, needs and will benefit from the hospital stay. For Medicare coverage to continue, the patient must require a hospital level of care and receive active treatment.

Unlike acute care and rehabilitation hospital stays, Medicare covers 190 days of inpatient psychiatric hospital care in a patient's lifetime. The patient can use a maximum of 150 days in a benefit period. The lifetime limit applies only to services received in a psychiatric hospital, and not to services in the psychiatric unit of a general hospital.

Payments to Hospitals and the Right to Needed Care

Medicare pays hospitals based on a patient's diagnosis and condition using a Prospective Payment System (PPS). Thus, hospitals generally know in advance what their payment rates will be, given the patient's

Medicare Part A

principal diagnosis. Medicare's acute care hospital prospective payment system has different payment rates for more than 470 diagnosis related groups (DRG). CMS uses different prospective payment systems for acute care, rehabilitation, long-term care, and psychiatric hospitals.

The PPS creates cost-containment incentives for hospitals. Generally, they must provide all the medically necessary services that a patient needs within a fixed payment. If the care costs more, the hospital loses money. The PPS also establishes average lengths of stay for the various diagnoses that hospitals can use as guidelines. Medicare rules do not require hospitals to discharge patients after a certain number of days.

Under Medicare rules, hospitals must provide all the care that is medically necessary. Nevertheless, hospitals and physicians may sometimes decide to discharge a patient prematurely. When a patient disagrees with a proposed discharge, they or someone on their behalf should call the Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) no later than the planned discharge date to request a quick review. Instructions for this process appear on *An Important Message from Medicare from Medicare about Your Rights* that hospitals must give to all inpatients. After a person requests the QIO review, the hospital must give the patient a *Detailed Notice of Discharge* that contains specific information about the Medicare coverage policies upon which the hospital has based its decision.

The BFCC-QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient is ready to leave the hospital. It must make its decision within one day of receiving all the necessary information. Medicare continues to cover the hospital stay until noon of the day after the BFCC-QIO gives notice to the patient of its decision.

What Are Your Hospital Rights?

"You (the Medicare patient) have the right to receive all the hospital care necessary for the proper diagnosis and treatment of your injury or illness. According to Federal law, your discharge date must be determined solely by your medical needs, not by Medicare payment." (Excerpt from "An Important Message from Medicare.")

It cannot be emphasized enough that the Medicare patient's discharge date should be determined solely according to the individual's medical needs and not because of the DRG assignment.

Skilled Nursing Facility (SNF) Coverage

A skilled nursing facility (SNF) provides medical services under the direction of a physician that are performed by, or under the supervision of, licensed professionals that include Registered Nurses (RN), Licensed Practical Nurses (LPN), and rehabilitation therapists. SNFs typically are distinct units located within a nursing facility. Some hospitals designated a specific wing as the skilled nursing portion of the hospital. Other hospitals, generally in small towns, have a specific number of beds designated as "skilled nursing." In these situations, the term "swing bed" is used when a patient is transferred from inpatient hospital care to skilled nursing care. The patient may physically remain in the same bed.

Medicare will pay for services that can only be provided, as a practical matter, in a skilled nursing facility. The key issue is whether the patient needs skilled nursing or rehabilitation services daily, or not. SNF staff and the Utilization Review (UR) Committee reviews a patient's stay considering Medicare's coverage rules

Medicare Part A

to decide if SNF care is “reasonable and necessary,” or if the patient could safely move to a lower level of care in the nursing facility or to home. Medicare’s SNF benefit covers:

- Semi-private room (Medicare covers the cost of private rooms when they are medically necessary)
- Skilled nursing services
- Meals, including special diets
- Drugs
- Supplies and equipment for use during the SNF stay
- Rehabilitation services, including physical therapy, occupational therapy, and speech therapy services
- Medical social services

Medicare’s SNF benefit excludes these services from coverage:

- Private duty nursing
- Custodial care (where patient receives personal care services without daily skilled care)
- First three pints of blood for transfusions

To qualify for Medicare coverage of a SNF stay, these coverage rules or “conditions of coverage” must be met:

- The SNF must be Medicare certified.
- The patient must transfer to the SNF within 30 days of discharge from a hospital (there is an exception for cases in which it is medically necessary to start treatment later than 30 days).
- The hospital stay was three days or longer. To calculate the “three-day prior hospital stay,” Medicare counts the day of admission to the hospital, but not the day of discharge.
- The patient receives care in the SNF for a condition for which they received care in the hospital. • The patient needs skilled nursing or rehabilitation services on a “daily basis.”
- The patient’s physician orders the skilled services.

How does Medicare define daily basis? “Daily” means seven days per week for nursing services and five days per week for rehabilitation services. A patient meets the daily basis test if they receive a combination of skilled nursing and rehabilitation services over the course of a week.

Skilled Nursing and Rehabilitation Services

Skilled nursing services are those provided by, or under the supervision of, licensed nursing staff. Skilled rehabilitation services are those provided by, or under the supervision of, licensed physical therapists, occupational therapists, and speech therapists. Examples of skilled nursing services include:

- Patient education
 - Insertion, sterile irrigation, and replacement of catheters
 - Intravenous or intramuscular injections
 - Tube feedings
 - Applying dressings that involve prescription medications
 - Treatment of bed sores (decubitus ulcers)
 - Observation and assessment of a patient’s changing condition
- Examples of skilled

rehabilitation services include:

Medicare Part A

- Therapeutic exercises
- Gait evaluation and training
- Range of motion exercises
- Ongoing assessment of rehabilitation needs and potential.

Many people think that a patient must make significant improvement or show “rehabilitation potential” to qualify for Medicare SNF coverage. They think that when a patient’s condition stabilizes, or reaches a “plateau,” that Medicare coverage automatically ends. While rehabilitation potential is one among many factors to consider, Medicare’s rules say this: “When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient’s potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel.” Elsewhere, the rules say, “Even when a patient’s full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities.”

Covered Days and Costs for SNF Care

Medicare covers up to 100 days of SNF care within a benefit period, if the covered days are medically necessary. With the start of each new benefit, a Medicare patient has 100 renewable covered days.

- Days 1 to 20: Medicare payments cover the cost of the first 20 days of SNF care in full. There is no SNF deductible as with inpatient hospital stays.
- Coinsurance Days 21 to 100: The patient owes a copay² (1/8 of the Part A deductible) for each of these days. Medicare payments cover the balance of the bill.
- Day 101 and Beyond: Medicare coverage ends. The patient is responsible for the entire bill while SNF care continues. But if the benefit period ends with the patient’s absence from the SNF (or a hospital) for 60 days in a row, they receive a new set of 100 covered SNF days at the start of the next benefit period.

Claims, Payment, and the Right to Needed Care

SNFs send their bills for Medicare-covered stays to a Medicare Administrative Contractor (A/B MAC). Medicare pays them directly, and the payment contractor issues a Part A *Medicare Summary Notice (MSN)* to the patient explaining Medicare’s payment and detailing the beneficiary’s cost-sharing charges.

SNFs sometimes are hesitant, however, to submit claims to Medicare. There are many reasons for this. A key reason is that Medicare penalizes SNFs when they submit too many claims that Medicare denies for lack of medical necessity. If the SNF refuses to submit the bill to Medicare, the patient can ask for a “demand bill,” meaning that the SNF must submit a claim to Medicare on the patient’s behalf. There is no penalty for the patient or SNF when using this procedure. The A/B MAC then makes an official Medicare coverage decision on the claim.

As with hospitals, Medicare pays SNFs on a prospective basis under a system that groups patients according to their condition and the kind of facility resources they use.

² Annual cost-sharing amounts are available in the appendix under Annual Medicare Premium and Cost-Sharing Amounts.

Medicare Part A

SNF patients have the right to receive medically necessary care. SNFs must provide all the care that is medically necessary before discharging a patient to a lower level of care in the nursing facility or to home. Under Medicare rules, SNFs must give a written notice called a *Notice of Medicare Provider Non-Coverage* no later than two days before it intends to end a Medicare-covered stay. When a patient disagrees with a proposed discharge, they or someone on their behalf should call the BFCC-QIO immediately, but no later than noon of the planned service termination date, to request an immediate appeal. After a person requests the BFCC-QIO appeal, the hospital must give the patient a *Detailed Explanation of Non-Coverage* that contains specific information about the Medicare coverage policies upon which the SNF has based its decision.

The BFCC-QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient is ready to leave the SNF. If the BFCC-QIO decides that the patient still needs a skilled level of care, Medicare coverage for the SNF stay continues.

Home Health Care

A home health agency (HHA) is a public agency or private organization that provides skilled nursing services, therapy services, social services and other types of care in a patient's home or place of residence. One well-known example of an HHA is the Visiting Nurse Association (VNA). In some communities, home health agencies operate as affiliates of hospital systems.

Medicare home health benefit covers:

- Skilled nursing care on a part-time or intermittent basis
- Physical therapy
- Speech therapy
- Occupational therapy, if the patient initially received physical or speech therapy
- Medical social services
- Medical equipment and supplies provided by the HHA
- Home health aide services (e.g., bathing), if the patient also receives skilled care

Medicare's home health benefit excludes these services from coverage:

- Full-time care in the home
- Private duty nursing
- Home-delivered meals
- Homemaker services like cleaning, washing dishes, and shopping for groceries

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. In determining whether homebound criteria are met, it is necessary to look at the patient's condition over a period of time rather than for short periods within the home health stay.

CMS makes clear that the aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet the specific criteria outlined below.

Criteria for Homebound Status

CMS advises that an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

Criteria One: The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence or
- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two: There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

The definition and interpretation of the term “homebound” is often the key issue in Medicare coverage for home health care. A patient need not be bedridden to be considered homebound. Also, a patient may leave home if the absences are “of short duration,” or infrequent, or for medical purposes. The rules also say that an occasional trip to the barber, a walk around the block, attendance at worship services, or a drive would not require a finding that the person is not homebound so long as they are on an infrequent basis or are of relatively short duration.

Medicare defines “part-time” as 28 to 35 hours per week of combined skilled nursing and home health aide services. “Intermittent” means from once daily, for periods up to 21 days if there is a predictable end to the daily care, to once every 60 days.

Medicare will cover medically necessary home health services for patients with chronic conditions, such as diabetes and neuromuscular conditions, even though there is no chance for recovery. Medicare’s rules say that the decision about whether skilled care is medically necessary depends “solely upon the beneficiary’s unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.”

Covered Days for Home Health services

Unlike Medicare’s inpatient hospital and SNF coverage, there is no limit on the number of Medicare covered home health service days. Medicare coverage can continue indefinitely if the patient continues to need therapy or skilled nursing care on a part-time or intermittent basis and is homebound.

Patients do not owe a deductible or coinsurance charges for most home health care services, including the nursing, therapy, and home health aide services. Medicare payments to the home health agency cover the cost of these services in full. The one exception is that the patient owes a coinsurance charge of 20% of Medicare’s approved amount for any Durable Medical Equipment (DME) that the HHA provides.

Under Medicare’s home health prospective payment system, HHAs submit claims to a Home Health and Hospice Medicare Administrative Contractor (HH MAC) and receive payments for a 60-day episode of care. The payments reflect the complexity of a patient’s condition and her skilled care needs. A physician must recertify the patient’s need for home health care on a bi-monthly basis.

Medicare Part A

HHAs must provide all the care that is medically necessary before discharging a patient. Under Medicare rules, an HHA must give a written notice called a *Notice of Medicare Provider Non-Coverage* no later than two days before it intends to end Medicare-covered services. When a patient disagrees with a service termination decision, they or someone on their behalf should call the BFCC-QIO immediately, but no later than noon of the planned service termination date, to request an immediate appeal. Instructions for this process appear on the *Notice of Medicare Provider Non-Coverage*. After a person requests the BFCC-QIO appeal, the HHA must give the patient a *Detailed Explanation of Non-Coverage* that contains specific information about the Medicare coverage policies upon which the HHA has based its decision.

The BFCC-QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient no longer is homebound or needs skilled nursing or rehabilitation care. If the BFCC-QIO disagrees with the HHA's decision, Medicare coverage for home health services continues.

Medicare Part A and Part B both cover home health care. Since 1997, HHAs submit claims under Part A if the patient has been in a hospital for three days and starts to receive home health services within 14 days of discharge from the hospital or SNF. If the HHA cannot bill to Part A, they bill to Part B. Regardless of the payment source, the benefits are the same. Also, if a patient only has Part B coverage, the HHA submits claims exclusively under Part B.

Hospice Care

A hospice is a public agency or private organization that is primarily involved in providing "palliative care" to patients with a terminal illness. Hospice programs in the United States commonly offer home-based care, including care for beneficiaries who reside in nursing homes. The hospice benefit also has limited coverage for facility-based hospice care under certain conditions. Unlike Medicare's home health coverage, hospice programs often provide in-home care around the clock. There is no "part-time or intermittent" requirement for hospice.

Medicare's hospice benefit covers these services:

- Physician care (including the patient's personal physician who need not be affiliated with the hospice)
 - Nursing care
 - Counseling, including bereavement counseling
 - Medical social services
 - Physical, occupational, and speech therapy
 - Home health aide and homemaker services
 - Medications to manage the patient's pain and symptoms
 - Short-term inpatient care for pain control or acute or chronic symptom management
 - Respite care for five days or less to provide relief for the patient's caregiver
- Medicare's hospice benefit excludes these services from coverage:
- Treatment for the terminal illness that is not for symptom management and pain control
 - Care that another hospice provides that was not arranged by the patient's hospice
 - Care from another provider that duplicates the care that Medicare requires the hospice to give

Medicare Part A

To qualify for Medicare payments for hospice care, a patient must meet the following conditions of coverage:

- Be certified by a physician and the hospice director as having a terminal illness, meaning that they are expected to live six or fewer months if the illness runs its normal course
- File a written “hospice election” with the hospice agreeing to give up other Medicare coverage aimed at curing the terminal condition, except for physician services. A patient, however, can cancel hospice at any time and return to regular Medicare coverage. Also, in making this election, the patient only gives up regular Medicare benefits in connection with treatment for the terminal condition.
- Receive services from a Medicare-certified hospice

Covered Days and Costs for Hospice Services

Medicare covers an unlimited number of days, grouped into two 90-day “election periods” followed by an unlimited number of 60-day election periods, if the patient is terminally ill.

Hospice organizations submit claims to Home Health and Hospice Medicare Administrative Contractors (HH MAC). Medicare payments to the hospice cover the cost of most hospice services including the physician, nursing, therapy, and counseling services. There is, however, a nominal copayment for palliative drugs and respite care. Patients pay up to \$5 for each prescription and 5% coinsurance per day for respite care.

Your Rights as a Medicare Beneficiary

- Good quality medical care, including the right to make choices about the treatment you receive in hospitals, nursing homes, outpatient centers, and home health agencies.
- Written notice of any decision made by your hospital or Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) denying you Medicare coverage for hospital services.
- Reconsideration by your BFCC-QIO of a denial decision for hospital services.
- Notification and explanation of the final decision.
- Receiving a statement about your further appeal rights, including information on proper procedures.

What to do if you think you are being discharged from a hospital too soon, or if you are told Medicare will no longer pay for your continued stay in the hospital:

- Discuss your concerns with your doctor, your representative, or hospital discharge planner.
- Ask for a written statement that indicates when you will be responsible for the bill if you choose to remain in the hospital.
- If you are a resident of Kansas, telephone Livanta at 1-888-755-5580 (Monday-Friday: 9:00 a.m. - 5:00 p.m.) to file a complaint.

Your Rights If You Feel Quality Care Was NOT Delivered:

If you feel you did not receive acceptable quality of care in the hospital, nursing home, outpatient center or by a home health agency or Medicare Health Plan, and your care was received in Kansas, you may have your care reviewed by submitting a written complaint to:

Medicare Part A

Livanta LLC

BFCC-QIO

10820 Guilford Road, Suite 202

Annapolis Junction, MD 20701-1105

Medicare Beneficiary Help Line

Toll free: (888) 755-5580

(888) 985-9295 - TTY

Website: <https://livantaqio.com/en/states/kansas>

This help line is available to assist you with problems about the quality of medical care you receive in a hospital, hospital outpatient department, ambulatory surgery center, skilled nursing facility, or care provided by a home health agency or a Medicare Health Plan.

Medicare Outpatient Observation Notice (MOON)

The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH). The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. The NOTICE Act requires all hospitals and CAHs to provide written and oral notification under specified guidelines.

The MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin. The MOON may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.

Chapter 3 - MEDICARE PART B

Medicare Part B, officially called the Supplementary Medical Insurance (SMI) program (see the Medicare card), was designed to cover a wide range of medical services to complement Medicare's Part A hospital insurance benefits. Unlike Part A, which most beneficiaries receive automatically because they paid a Medicare tax through FICA payroll deductions, people must elect to enroll in Part B and pay a monthly premium.

The financing for Medicare Part B comes largely from federal general revenues, monthly premiums, and beneficiary cost-sharing charges that include the annual deductible and 20% coinsurance for most covered services and items. By law, the monthly premiums cover 25% of Part B program costs. FICA payroll taxes do not help finance Medicare Part B. The Part A and Part B trust funds are separate.

Some of the most common services that Medicare Part B covers are:

- Physician care
- Outpatient hospital treatment and surgery
- Home health care
- Durable medical equipment (DME) and supplies
- Ambulance services
- Prevention and screening services

The payment contractors for Medicare Part B services are the A/B Medicare Administrative Contractors (A/B MAC) for physician, ambulance, and many other covered services; the Home Health and Hospice Medicare Administrative Contractors (HH MAC) for Part B covered home health care; and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for medical equipment, prosthetics, and supplies. Providers submit claims to these contractors for Medicare payments.

Part B Covered Services, Items, and Coverage Rules

Generally, Medicare Part B covers medical services and items when they are medically necessary. This means that they must be reasonable and necessary in the diagnosis or treatment of an illness or injury. Since 1990, however, Congress has added many preventive and screening services to the list of Part B covered benefits. Part B covered services include physician, outpatient hospital, and ambulance services, along with durable medical equipment (DME) items. See the descriptions of these services, items, and coverage rules below.

Physician Services

Medicare Part B generally covers physician services, including diagnostic and surgical services. Medicare defines a "physician" as a licensed Medical doctor (MD), Osteopathic doctor (DO), Chiropractor (DC), Optometrist, Ophthalmologist, or Podiatrist (DPM). Medicare also covers services from other providers who include:

- Certified registered nurse anesthetist (CRNA)
- Clinical psychologist
- Clinical social worker
- Physician assistant (PA)

Medicare Part B

- Nurse practitioner and clinical nurse specialist
- Medicare covers a wide range of physician services that include:
 - Office, hospital, and home visits
 - Second opinions before surgery
 - Surgical services
 - Anesthesiology and radiology services
 - Mental health services
 - Chiropractic services under limited conditions
 - Podiatric services under limited conditions
 - Dental surgery under limited conditions

Medicare has limited coverage for some types of physician services, including chiropractic, podiatric, and dental care.

Chiropractic care: Medicare pays for the manual manipulation of a subluxation of the spine. It will cover chiropractic services for both acute and chronic subluxations with the short-term goal of improving the patient's condition or function. Rules state that chiropractic maintenance treatments are not "reasonable and necessary." Also, since 2000 Medicare has not required an x-ray to document the subluxation.

Podiatric services: Medicare pays for the debridement of mycotic toenails, ingrown toenails, bunions, and heel spurs. It pays for routine foot care only for patients with "systemic conditions" involving their circulation, nervous system, or metabolism, for example, diabetes.

Dental surgery: Medicare coverage is limited to paying dental surgeons to perform surgeries to set a fractured jaw, remove cancerous tissue, or to treat oral infections. It does not cover services in connection with the care, treatment, filling, removal, or replacement of teeth (although Part A pays for an inpatient hospital stay when a patient's medical condition requires inpatient care for the safe removal of teeth).

Outpatient Hospital Services

Medicare covers many outpatient hospital services. They include but are not limited to:

- Medical treatments, such as chemotherapy administration for cancer patients
- Emergency room services
- Outpatient surgical services, including many common "day surgery" procedures
- Rehabilitation services, such as physical therapy and cardiac rehabilitation programs
- Diagnostic services, such as x-rays, CT scans, and Magnetic Resonance Imaging (MRI)

Since 2000, Medicare has been using the Outpatient Prospective Payment System (OPPS) for many outpatient hospital services. Because of the OPPS, you may find that coinsurance charges for some outpatient hospital services, for example outpatient surgery, exceed 20% of the Medicare approved amount. You may also find that payment rates for the same outpatient service vary among hospitals. Note that the coinsurance charge for outpatient services in no case may exceed the Part A inpatient hospital deductible and that insurance rules require Medigap policies to cover the cost.

Durable Medical Equipment (DME), Prosthetics, and Supplies

Common examples of DME are wheelchairs, walkers, power operated vehicles, hospital beds, lift devices (e.g., Hoyer lift), and oxygen equipment. Medicare-covered DME includes customized equipment to meet

Medicare Part B

a beneficiary's unique medical needs. DME suppliers include pharmacies, home health agencies, and companies that specialize in the sale and service of medical equipment and supplies. Some large suppliers have nationwide mail order operations and advertise extensively.

Medicare defines DME as equipment that is:

- Able to withstand repeated use
- Used primarily for a medical purpose
- Generally not useful in the absence of an illness or injury
- Appropriate for use in the home

To qualify for payment, Medicare requires that:

- The equipment is reasonable and necessary for the treatment of a person's illness or injury or to improve the functioning of his malformed body part.
- A physician orders the DME and certifies the patient's need for DME through a prescription or, in some cases, a Certificate of Medical Necessity.
- The DME provider is Medicare enrolled and certified.

For purposes of Part B DME payments, a beneficiary's home may be her own house, apartment, a relative's home, a home for the aged, or some institutions. A home is not, however, a hospital or an institution (i.e., nursing home) that has a skilled nursing facility (SNF) unit. CMS assumes that Part A or Medicaid payments to hospitals and nursing facilities, or the private pay rates that residents pay to nursing facilities, should cover the cost of DME and supplies.

Even though an item serves a useful medical purpose and a physician has prescribed it, Medicare also considers if it is reasonable to pay for the DME. The Medicare Administrative Contractor (DME MAC) asks, for example, if the prescribed item is substantially more costly than other "appropriate and feasible alternatives." This analysis can result in coverage denials that may surprise some of your clients. DME denials usually are good cases to appeal.

Medicare excludes certain items from its list of covered DME. Because their purpose is not primarily medical, Medicare does not pay for:

- Air conditioners
- Humidifiers
- Stairway lifts
- Fitness equipment
- Safety grab bars
- Seat-lift chairs (but Medicare pays for the seat-lift device inside the chair)

Medicare has special coverage rules that CMS changed in 2005 for power-operated wheelchairs and scooters. In the past, Medicare required a patient to be "bed or chair confined" to show medical necessity. That is no longer the case. While coverage for such Mobility Assistive Equipment (MAE) is available only to meet a medical purpose in the home, Medicare has changed the rule to set up a function-based measure of medical necessity. Medicare now looks more broadly at the patient's inability to safely accomplish activities of daily living such as toileting, feeding, and dressing when deciding to cover MAE.

Prosthetics

Prosthetic devices are designed to replace all or part of a missing body organ or an inoperative or malfunctioning body organ. They include:

- Breast prostheses and reconstruction following a mastectomy
- Pacemakers
- Cataract lenses and glasses
- Artificial limbs and eyes
- Braces and trusses
- Therapeutic shoes for people with diabetes
- Urinary collection and retention systems

Medicare does not cover these items as prosthetic devices:

- Eyeglasses or contact lenses (except for cataracts)
- Hearing aids
- Dentures or dental implants
- Orthopedic shoes

Medicare rules allow for the rental or purchase of DME and prosthetics. Generally, beneficiaries decide whether to purchase or rent equipment, but CMS decides how to pay for an item. The agency categorizes DME, prosthetics, and supplies into six categories. It groups items, for example, that are inexpensive or routinely purchased, or that require frequent and substantial service, or that are customized. Based on the grouping, CMS decides whether to pay a monthly rental fee or a lump sum payment.

- For inexpensive items that cost less than \$150, like walkers, Medicare pays either a monthly rental fee or a lump sum.
- For expensive items, like hospital beds and wheelchairs, Medicare pays a monthly rental fee until payments reach the purchase price. Afterwards, Medicare pays the supplier a smaller monthly maintenance fee to cover repairs.
- For items that need frequent service, like ventilators and nebulizers, Medicare pays a monthly rental fee only.
- For customized equipment and prosthetics, Medicare pays a lump sum.
- For oxygen equipment, Medicare pays a monthly fee schedule amount only. It does not pay for the purchase of oxygen equipment.

With most rented DME, called “capped rental items,” Medicare gives beneficiaries the option to purchase the item in the tenth month of rental. If a beneficiary declines the purchase option, ownership of the DME stays with the equipment supplier after Medicare makes rental payments for 15 months. Afterwards, Medicare pays the supplier to service the equipment twice each year. If the beneficiary accepts the purchase option, they own an item after 13 months of rental payments. Medicare covers servicing as needed. Different rules apply to oxygen equipment where Medicare now makes rental payments for 36 months. Medicare no longer pays to maintain oxygen concentrators or trans filling equipment after the 36month rental period. The supplier of oxygen equipment in the 36th month of use must continue to furnish the oxygen and oxygen equipment for the remainder of the 5-year reasonable useful lifetime of the equipment.

Medicare Part B

Supplies

Medicare Part B pays for supplies that are furnished in connection with a physician's services or that are needed to use DME effectively. Some examples of covered supplies are:

- Oxygen
- Ostomy bags and supplies
- Heparin when used with a home dialysis system
- Surgical dressings, limited to primary and secondary dressings to treat surgical wounds
- Splints

Medicare does not cover chucks, diapers, and rubber sheets for persons with urinary or bowel incontinence.

Competitive Bidding Program for DMEPOS

Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program changes the amount Medicare pays for certain DMEPOS items. Under this program, suppliers submit bids to provide certain medical equipment and supplies to people with Medicare living in, or visiting, competitive bidding areas. Medicare uses these bids to set the amount it pays for each item. All suppliers are thoroughly screened to make sure they meet Medicare requirements (like eligibility and financial, quality, and accreditation standards) before they're awarded contracts.

Round 2021 of the Competitive Bidding Program began on January 1, 2021, and only includes off-the-shelf back and knee braces. If you have Original Medicare, the program requires you to get competitively bid off-the-shelf back and knee braces in competitive bidding areas from a contract supplier, unless an exception applies.

A CBA is an area where only Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program contract suppliers may furnish competitively bid lead and non-lead items to beneficiaries unless an exception is permitted by regulations. CBAs are based on metropolitan statistical areas, which are areas designated by the Office of Management and Budget, that include major cities and their surrounding suburban areas. In Kansas, the competitive bidding areas are Kansas City-Overland Park Ottawa, KS; and Wichita, KS.

More information on these CBAs can be found at <https://dmecompetitivebid.com/cba>.

Drugs and Biologicals

Medicare covers drugs that are given incident to a physician's services if the drugs are not usually self-administered by the patients who take them. Part B covered drugs and biologicals include:

- Erythropoietin for kidney failure
- Epoetin Alfa (Epoetin or Procrit) for severe anemia
- Blood clotting factors
- Immunosuppressive drugs, like cyclosporine, for transplant patients
- Certain oral medications for cancer patients, including anti-nausea drugs
- Osteoporosis medications for homebound patients

Medicare Part B

- Whole blood (except for the first three pints)

Medicare Part B uses the “self-administered drug rule” to determine medical necessity. Medicare looks at the usual method for taking a drug to decide if it is usually “self-administered.” If the usual method for taking a drug is orally by tablet or capsule, or by self-administered injection, like insulin, Medicare Part B does not pay. Coverage for these drugs often is available through a Medicare Part D drug plan.

When Medicare Part D drug coverage took effect in 2006, Medicare coverage for the drugs and biologicals listed above continued under Medicare Part B for those who meet the Part B coverage rules. Two advantages for beneficiaries who receive coverage for drugs under Part B is that there is no coverage gap and the coinsurance is 20% of Medicare’s approved amount.

Medicare Supplement insurance policies normally cover the coinsurance cost, leaving the patient with no out-of-pocket costs if they own one. Note that out-of-pocket costs connected with the Part B drug coverage do not count as True Out-of-Pocket (TrOOP) costs in the Part D drug program.

Ambulance Services

Medicare pays for ambulance services when the ambulance provider and the patient’s situation meet certain conditions of coverage. The ambulance service provider must be Medicare-certified, meaning that the equipment and personnel comply with federal standards. Medicare then considers such factors as the severity of the beneficiary’s condition and the distance to the nearest emergency facilities. Generally, Medicare only covers ambulance services in a locality (with some exceptions) to/from a hospital, skilled nursing facility (SNF), some other treatment facilities (e.g., dialysis centers), and the beneficiary’s home.

Medicare covers ambulance services when, given the patient’s condition, other transportation modes are “contraindicated,” meaning that the other transportation could endanger the person’s health. If a patient could use some other means of transportation without danger (even if that transport is not available), Medicare rules say that the ambulance trip is not medically necessary and cannot be covered.

EXAMPLE: *A beneficiary who fractures his collarbone in a fall may be able to travel safely to an emergency room in a car. But if he has other conditions or injuries that complicate the situation and endanger his health, Medicare may pay for an ambulance trip. Physician and ambulance service provider documentation is essential to Medicare payment.*

Medicare pays for ambulance trips to the “nearest appropriate facility,” i.e., the nearest institution (for example, hospital or skilled nursing facility) that is generally equipped to provide the care for the illness or injury involved. It makes no difference if a patient’s attending physician has staff privileges at the nearest hospital. If an institution has no bed available, however, it is not an appropriate facility and Medicare will pay for the trip to a more distant facility with an open bed. If an ambulance takes a patient to a facility beyond the nearest appropriate facility, Medicare limits its payment to the cost of transport to the nearer facility.

Non-emergency transportation will only be covered if the ambulance supplier obtains a physician’s certification indicating that ambulance transportation is necessary because other means of transportation are medically contraindicated. If the patient meets this condition, Medicare may pay for ambulance transport from a facility to the person’s home. This can include round trip transportation from a patient’s

Medicare Part B

home or skilled nursing facility to the closest facility that provides renal dialysis for patients living with end stage renal disease.

Medicare also covers air ambulance services when ground transport is not medically appropriate. This occurs when the time or instability involved in transporting a patient by ground ambulance threatens their survival or seriously endangers their health. Some examples of these serious situations are intracranial bleeding that requires immediate neurosurgery, multiple serious injuries, and treatment in a hyperbaric oxygen unit. The nearest appropriate facility rule applies to claims for air ambulance payment.

Preventive and Screening Services

Medicare Part B covers a growing array of screening and prevention services. Medicare began covering common screening procedures in 1991 after Congress added screening mammograms and other screening services to Medicare's covered benefits. In many cases, Medicare waives the Part B annual deductible, the 20% coinsurance charge, or both for these services.

Preventive Services and Screenings Covered by Original Medicare without a Coinsurance or Deductible

Currently, Medicare's covered screening services are:

- Abdominal Aortic Aneurysm (AAA) screening for those at high risk, once in lifetime.
- Alcohol misuse screening, once a year, and counseling, up to 4 times a year
- Bone mass measurements once every 24 months; more frequently if medically necessary
- Breast Cancer Screenings
 - Mammogram screening once every 12 months for women 40+; women between ages 35 and 39 an get one baseline mammogram
 - Breast examination once every 24 months, if at risk, once every 12 months
- Cardiovascular disease (behavioral therapy) once a year
- Cardiovascular disease screening for high-risk persons once every five years
- Cervical and vaginal cancer screening (Pap smear screening and pelvic exams every two years; more often for high-risk women)
- Colorectal cancer screening
 - Fecal occult blood tests once every 12 months for people age 50 and older
 - Multi-target stool DNA tests every 3 years
 - Colonoscopy once every 10 years
- Flexible sigmoidoscopy once every 48 months
- Depression screening once a year
- Diabetes Prevention Program
- Diabetes screening tests once every 12 months if you have a family history or are at risk for diabetes, twice a year if you have been diagnosed with pre-diabetes
- Hepatitis B Virus infection screening
- Hepatitis C Screening Test, one time
- HIV screening once every 12 months or up to three times during a pregnancy
- Immunizations

Medicare Part B

- Flu shots once a season
- Pneumococcal shot to prevent pneumococcal infections (like certain types of pneumonia). Also covers a different second shot if it's given at least 11 months after the first shot.
- Hepatitis B vaccine only for people at medium to high risk
- COVID-19 vaccines
- Lung Cancer screening once a year
- Medical nutrition therapy for people with diabetes or kidney disease – yearly
- Obesity Screening and Counseling
 - Requires a body mass index (BMI) of 30 or more
 - Medicare covers behavioral counseling sessions to help you lose weight.
- Prostate cancer screening - Prostate specific antigen (PSA) test: once every 12 months
- Sexually transmitted infections screening and counseling
- Tobacco Use cessation counseling – up to 8 visits in 12-month period
- “Welcome to Medicare” preventive visit for new Medicare beneficiaries (if received in the first 12 months of Medicare coverage)
- Yearly Wellness Visit every 12 months

Services Covered by Original Medicare WITH Coinsurances and/or Deductibles

- Glaucoma screening for persons at high risk (once every 12 months)
- Prostate cancer screening – digital rectal exam once every 12 months
- Colorectal Cancer screening - Barium enema once every 48 months or every 24 months if you are at high risk
- Diabetes testing devices and supplies
- Diabetes self-management training

Mental Health Services

Covered mental health services include counseling and therapy services from doctors, clinical psychologists, and clinical social workers. Medicare pays for outpatient mental health services at the same level as other Part B services, 80% of Medicare’s approved amount.

Other Covered Services

The list of other Part B covered services includes, but is not limited to:

- Acupuncture - up to 12 acupuncture visits in 90 days for chronic low back pain
 - Medicare doesn't cover acupuncture (including dry needling) for any condition other than chronic low back pain
- Physical, speech, and occupational therapy
- Laboratory, x-ray, and other diagnostic procedures
- X-ray, radium, and isotope therapy
- Devices for the reduction of fractures
- Comprehensive Outpatient Rehabilitation Facility (CORF) services
- Ambulatory surgical center services
- Rural health clinic outpatient mental health services

Medicare Part B

- Home health care
- Nutritional therapy for persons with diabetes or renal disease

Excluded Services and Items

Medicare excludes some services and items from its Part B benefits. These include:

- Immunizations unless they are related directly to the treatment of an injury or illness (except for flu, pneumonia, and hepatitis B vaccines)
- Routine eye exams
- Most dental care, such as cleaning, fillings, extractions, and dentures
- Routine foot care, except for those with systemic conditions like diabetes or neuropathy
- Cosmetic surgery
- Homemaker services
- Meals on Wheels
- Private duty nursing
- Services that are not reasonable and necessary

Part B Costs and Claims – Beneficiary Costs

Along with the monthly premium, Part B beneficiary cost-sharing charges generally are the:

- Annual deductible; a certain amount paid first in Medicare approved charges. The deductible adjusts each year to account for inflation in Medicare spending.³
- 20% coinsurance charge; 20% of Medicare's approved amount
- Excess charge
 - Physicians who do not "accept assignment" can bill for no more than 115% of Medicare's approved amount. This is called the Limiting Charge, or Excess Charge.
 - The Limiting Charge does not apply to all Part B providers. DME suppliers who do not accept assignment, for example, can bill the patient for the entire difference between the approved amount and the actual charge for an item.
- Part B Premium
 - The standard Part B premium.
 - *IRMAA (Income Related Monthly Adjustment Amount)* Higher-income beneficiaries will pay higher premiums for Part B and prescription drug coverage. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

After the beneficiary meets the annual Part B deductible, Medicare Part B typically pays 80% of the approved amount for physician, DME, ambulance and other covered services, and the beneficiary owes 20% of the approved amount (the Part B coinsurance charge). But there are some exceptions to the usual 20% coinsurance charge.

³ Annual cost-sharing amounts are available in the appendix under Medicare Premium and Cost-Sharing Amounts.

Medicare Part B

Medicare bases its payment for physicians and many other providers on national “fee schedules” that CMS adjusts for differences in costs among the nation’s geographic areas. CMS also adjusts its fee schedule payments to address cost increases.

Exceptions to Part B Cost-Sharing Norms

Outpatient hospital coinsurance charges and beneficiary costs for preventive and screening services often depart from the usual Part B cost-sharing rules. Under the Outpatient Prospective Payment System (OPPS), patient coinsurance charges often exceed 20% of Medicare’s approved charge. The copayment for a single service can't be more than the amount of the inpatient hospital deductible. If you get hospital outpatient services in a critical access hospital, your copayment may be higher and may exceed the Part A hospital stay deductible.

Part B Billing and Claims

Most Part B providers, including physicians, must submit claims for services and items directly to the A/B Medicare Administrative Contractor (A/B MAC). Medical equipment, prosthetics, and supply providers send their claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MAC). Afterwards, the payment contractors send a Part B *Medicare Summary Notice* to the patient (normally every three months) that explains its coverage decision(s) and the patient’s share of the costs. Keep in mind that providers have one calendar year from the date of service to submit claims in Original Medicare.

Because nearly all providers submit claims to Medicare, it is unlikely that you will ever help a client complete a Medicare claim form officially called the Beneficiary Request for Medicare Payment Form 1490S. But, it may come up in connection with covered care in Canada and Mexico, or when a provider refuses in rare cases to submit a claim to Medicare.

Assignment

Providers who accept assignment agree to accept Medicare’s approved amount as payment in full. The term itself means that a patient assigns her claim on Medicare’s payment over to the provider. When that happens, Medicare pays the provider directly. Providers can only bill the patient for the annual deductible and the coinsurance charge. While physicians have the option to accept assignment, many agree to accept assignment in all cases. They are called “Medicare Participating Physicians.” In recent years, physicians nationwide have accepted assignment on nearly 99 percent of their claims.

Non-participating providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. These providers are called "non-participating."

If the doctor, provider, or supplier doesn't accept assignment:

- The beneficiary might have to pay the entire charge at the time of service. The doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to the beneficiary.
- They can't charge for submitting a claim. If they don't submit the Medicare claim once asked to, call 1-800-MEDICARE.

Medicare Part B

- In some cases, the beneficiary might have to submit their own claim to Medicare using Form CMS1490S to get paid back.
- They can charge the beneficiary more than the Medicare-approved amount, but there's a limit called "the limiting charge." The provider can only charge up to 15% over the amount that nonparticipating providers are paid. Non-participating providers are paid 95% of the fee schedule amount.

The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.

Medicare requires some Part B providers to accept assignment in all cases. The mandatory assignment rule applies to:

- Ambulance suppliers
- Outpatient hospital facilities
- Ambulatory Surgical Centers
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Outpatient physical, occupational, and speech therapy providers
- Clinical laboratories

The law requires providers and suppliers to submit claims on behalf of Medicare beneficiaries for both assigned and unassigned claims. Since October 2003, Medicare in most cases also requires doctors, suppliers, and other providers to submit claims electronically to the Carriers and MACs.

Private Contracts

The law allows Medicare beneficiaries and physicians to enter private written contracts in which the physician agrees to provide services and the beneficiary agrees to pay whatever the physician charges.

Providers who enter private contracts cannot receive Medicare payments for two years. Neither the provider nor the beneficiary can submit the claim to Medicare or to a Medicare supplement (Medigap) insurance plan, meaning that the beneficiary pays the entire bill out-of-pocket. Physicians, however, cannot require beneficiaries to enter a private contract in emergency situations. Physicians who enter private contracts must forgo Medicare payments for all Medicare patients for two years.

Beneficiary Financial Liability Protections: Waiver of Liability

Under the Original Medicare plan, there are protections under both Medicare Part A and Medicare Part B for beneficiary if Medicare decides that they received care that was not medically necessary or that is not covered by Medicare.

When Medicare denies payment for services because they are not reasonable and necessary in an individual case, under certain conditions the patient is not liable for the bill. Under this "waiver of liability" rule, the provider cannot collect payment from the patient. The rule does not apply to services that Medicare excludes from coverage (for example, cosmetic surgery and non-covered services or procedures that CMS describes in a National Coverage Determination, or NCD), or to services that Medicare denies for technical reasons as when a claim does not meet all coverage requirements.

Limitation on Liability

In certain cases, even if Medicare denies your claim, you will not be held responsible for paying the doctor or other health care provider. These cases fall under the “limitation on liability” (waiver of liability) provision of the Medicare law. This limitation on liability applies only when the following three requirements are met:

- The services are furnished by an institutional provider, such as a hospital, skilled nursing facility, or home health agency that participates in Medicare, or by a doctor or other supplier who “accepts assignment.”
 - Medicare denied the claim for one of the following reasons:
 - ✦ The care provided was custodial care.
 - ✦ The care was not “reasonable and necessary” under Medicare program standards for diagnosis and treatment.
 - ✦ For home health services, the patient was not homebound or did not require skilled nursing care on an intermittent basis.
 - ✦ The only reason for the denial is that, in error, the beneficiary was placed in a Skilled Nursing Facility bed that was not approved by Medicare.
- The beneficiary did not know, or could not reasonably be expected to know, that Medicare does not cover the services given. (For example, the beneficiary did not know because they did not receive a written notice, Advance Beneficiary Notice – ABN.)

In certain situations, Medicare law will protect the beneficiary from paying for doctor services provided on a non-assigned or assigned basis that are denied because they are “not reasonable or necessary.” If the doctor knows or should know that Medicare will not pay for the service, the doctor is required to give the beneficiary written notice in advance that tells them why Medicare will not pay for it. If they do not get this written notice, they will not have to pay for the service or they may be entitled to a refund from the doctor.

When Medicare waives liability for a patient on a denied claim, the provider is liable for the bill unless he or she could not be expected to know that Medicare would deny coverage. Thus, providers have an incentive to notify patients in writing when there is any doubt that Medicare will cover a service or item. These notices are called *Notice of Medicare Provider Non-Coverage* and *Advance Beneficiary Notices* (ABNs). Note that if both patient and provider did not know that Medicare might deny payment, Medicare pays the provider for the service.

A patient generally is not liable for the charges on a denied claim if a provider does not give her proper written notice. This means that providers must clearly describe the services or items in question and explain why they think the services are not reasonable and necessary considering Medicare coverage rules. If a provider gives a blank ABN to your client and bills her for non-covered services, appeal the denial and send a copy of the improperly completed form along with the appeal request.

How do you find out if Medicare waived your client’s liability for non-covered services? Look at the MSN. If Medicare’s approved amount is \$0.00, a separate note will say, “It appears that you did not know that Medicare would not pay for this service, so Medicare does not hold you liable.”

Without a written notice, Medicare assumes that a beneficiary could not know about the chance of a claim denial, and it waives the beneficiary’s liability to pay the claim. But if a physician or other health care

provider gave an ABN that properly explains why Medicare might deny coverage, Medicare assumes that the beneficiary has notice about the chance of a denial. The provider then is free to bill the beneficiary for the unpaid bill.

Advance Beneficiary Notice of Noncoverage (ABN)

An *Advance Beneficiary Notice (ABN)* is a standard CMS form that, when a provider completes it properly, gives written notice to a patient that Medicare may not pay for a service or item. Medicare guidelines instruct providers to use ABNs only when there is a legitimate doubt about the medical necessity of a service or item. Providers should not give them to everyone. Here are some key points about ABNs:

- Medicare considers a patient who receives a properly completed ABN to know that the service or item would not be covered if Medicare later denies payment on the claim.
- The practical effect of an ABN is to shift financial liability for a denied claim from the provider to the patient.
- After issuing an ABN, the provider must submit the bill to Medicare for an official coverage decision if the patient decides to receive the services or items and asks the provider to bill Medicare.

There are two situations where a doctor or health care provider must give a written notice (called an Advance Beneficiary Notice of Noncoverage – ABN), in advance, that the care **MAY NOT** be paid by Medicare:

1. Before the doctor or provider gives you a service that they believe Medicare doesn't consider medically necessary;
2. When they know or believe that Medicare will not pay for the service.

If the beneficiary is not given an ABN before they receive the service, they are not responsible for paying for the service. But if they do receive a written notice, sign an agreement, receive the service and Medicare does not pay for the service, the beneficiary must pay for it.

Laboratories may give ABNs to patients because Medicare often denies payment for tests when the diagnosis does not fit the procedure. The problem arises because physicians order tests when they are not yet sure of the patient's diagnosis, or when they want to rule out a condition. When your clients face coverage denials for lab tests, they can either ask the lab to resubmit the claim with additional information from the physician or appeal the denial.

Example: It is not appropriate for a laboratory to give an ABN to a patient who has a condition that clearly makes a lab test medically necessary. For example, a test for warfarin (Coumadin) levels in a patient's blood typically would be reasonable and necessary for someone who has a mitral heart valve replacement.

Ambulance Transportation and ABNs

CMS does not expect ambulance providers to issue Advance Beneficiary Notices (ABNs) to beneficiaries in some cases where Medicare is likely to deny payment. The main reason is that Medicare does not want providers to ask beneficiaries to sign ABNs when they are in an emergency situation or under great duress, that is, where someone would feel forced to sign the form. Medicare's concern is that a beneficiary will not be able to make an informed decision under such conditions.

Medicare Part B

However, the ambulance company must give you an “Advance Beneficiary Notice of Noncoverage (ABN)” when **both** apply:

- You got ambulance services in a non-emergency situation.
- The ambulance company believes that Medicare may not pay for your specific ambulance service.

Beneficiary Notices can be found at <https://www.cms.gov/medicare/medicare-general-information/bni>

Other Things You Should Know About Medical Services Available

Coverage of Second Opinions

Sometimes your doctor may recommend surgery for the treatment of a medical problem. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

If the second doctor doesn't agree with the first, you may feel confused about what to do. In that case, you may want to do the following:

- Talk more about your condition with your first doctor
- Talk to a third doctor (Medicare helps pay for a third opinion) Getting a second opinion doesn't mean you have to change doctors. You decide which doctor you want to do your surgery.

Medicare Part B helps pay for a second opinion just as it helps pay for other doctors' services that are medically necessary. If you have Medicare Part B and are in the Original Medicare Plan,

- Medicare pays 80% of the Medicare-approved amount for a second opinion.
- Your share is usually 20% of the Medicare-approved amount after you have paid your yearly Part B deductible. The Part B deductible may increase each year.
- If the second opinion doesn't agree with the first, Medicare pays 80% of the Medicare-approved amount for a third opinion.
- If you decide to have the surgery, Medicare Part B covers the doctor's services, and Medicare Part A (Hospital Insurance) covers other hospital services.

If you are in a Medicare Health Plan (MA), you have the right to get a second opinion. Some MA plans such as HMOs will only help pay for a second opinion if you first get a referral from your primary care doctor. (A referral is a written OK). After you get a referral, you must get the second opinion from the doctor named in the referral. If you want to get a second opinion from a doctor who doesn't belong to your plan, talk to your plan first. In some cases, HMO plans will help pay for this. If your plan won't pay, you could still get the second opinion from the doctor who doesn't belong to your plan, but you would have to pay the full cost. Call your plan for more information.

If you are in a Medicare Preferred Provider Organization (PPO) or a Medicare Private Fee-for-Service Plan, your plan will help pay for a second opinion. You don't need a referral. If you are in a PPO, you may have to pay more if you get a second opinion from a doctor who doesn't belong to your plan.

If you belong to any of the above plans, and the first two opinions are different, these plans will help pay for a third opinion. Call your plan for more information.

Medicare Outpatient Observation Notice Form (MOON)

Beginning on March 8, 2017, hospitals and critical access hospitals must provide the Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries receiving observation services as an outpatient for more than 24 hours. This notice educates Medicare beneficiaries on the effect of outpatient status, particularly as it pertains to cost-sharing requirements and skilled nursing facility (SNF) eligibility. The MOON must be provided no later than 36 hours from the time the beneficiary begins receiving outpatient observation services (or, if sooner, upon release). The MOON must be accompanied by an oral explanation of the information in the form and must be signed by the beneficiary or the beneficiary's representative.

Failure to provide the MOON to applicable beneficiaries is considered a violation of the hospital's Medicare provider agreement and could result in termination of the hospital's Medicare provider agreement.

Illegal Practices

Medicare beneficiaries need to be aware that these practices are specifically prohibited by federal law:

Waiver of excess charges

A physician asks/requires beneficiary sign a waiver agreeing to pay for more than the fee schedule amount.

Retainer

A physician asks/requires a retainer be paid before accepting a Medicare beneficiary as a patient.

TO REPORT ANY OF THESE ACTIVITIES or ANY Medicare Fraud, Abuse, and Health Care Error:

Kansas SMP - 1-800-432-3535

Chapter 4 - **MEDICARE PART C (Medicare Advantage)**

Medicare Advantage is a system for delivering Medicare benefits to beneficiaries who enroll in plans offered by private health insurance organizations. Private Medicare plans agree to coordinate the care received by beneficiaries and reduce costs by emphasizing prevention and limiting the use of services. The Original Medicare program, in contrast, typically pays for care on a fee-for-service basis.

Eligible beneficiaries must choose to enroll in a MA plan. That is, eligible beneficiaries must enroll in a MA plan during an applicable enrollment period, and generally agree to stay in the plan for a calendar year, to receive coverage through the Medicare Advantage program. After enrollment in a MA plan takes effect, beneficiaries typically must receive all the care according to plan rules, respecting provider network, prior authorization, and other limits that plans may use to control spending.

The Centers for Medicare and Medicaid Services (CMS) pays private MA plans a fixed amount per beneficiary to provide care. The amount CMS pays to the plans is not directly related to the quantity or cost of health services they deliver. This payment method is called capitation. It contrasts with Original Medicare's fee-for-service system in which Medicare pays physicians and other healthcare providers for each service they provide to Medicare beneficiaries.

In 2020, an average of 39% of Medicare beneficiaries were enrolled in Medicare Advantage plans. In Kansas, an average of 19% of Medicare beneficiaries were enrolled in MA plans. Since enrollment into a Medicare Advantage plan changes fundamental aspects of how Medicare beneficiaries receive their health care, it is more important than ever for people to have access to timely, accurate, and useable information about these plans before they enroll. SHIPs have an important role in providing thorough counseling and information to Medicare beneficiaries about all their Medicare options so that they can make informed decisions about their benefits.

Types of Plans

In order to receive health coverage through a Medicare Advantage (MA) plan, beneficiaries need to enroll in an available plan. While all MA plans are set up under the Medicare Part C program, the law allows plan sponsors to take very different approaches to structures for coverage, provider networks, and payment. Plan sponsors offer several types of plans. These include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans, Special Needs Plans, Cost Plans, and PACE plans. This section provides in-depth descriptions of the different MA plans available across the country.

Medicare Advantage plans are offered in a specific geographical area, with exceptions for some employer/union sponsored MA plans that have retirees living in different areas. Generally, beneficiaries must live within a plan's service area to be considered eligible for enrollment in the MA plan. A service area may be as small as one county or as large as multiple MA regions. Within a MA plan's service area, the plan must provide all enrollees an identical package of benefits with an identical cost-sharing structure.

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are a type of Coordinated Care Plan (CCP) that operates through a network of health care providers. HMOs contract with hospitals, physicians, laboratories, and

Medicare Part C

other providers to create their provider networks. Plans may offer incentives to network providers to help in the effort to contain costs or to meet certain quality of care standards. Most HMOs require people who enroll in the plan to choose a primary care provider (PCP). The PCP is often a physician who is expected to act as a gatekeeper to health care services. HMO plan members, or “enrollees,” generally must contact their PCP to obtain referrals to see specialists or to receive some services, such as expensive diagnostic procedures. Many HMOs also require prior approval for elective surgeries and post-acute care admissions, for example, to rehabilitation hospitals. HMOs cannot, however, require enrollees to obtain referrals for emergency medical care or urgently needed care, though most plans expect enrollees to contact the plan within a certain time frame after receiving such care. Each HMO can have different provider networks and different rules for referrals and prior approval, so it is important to understand the specifics of a plan before enrolling in one.

In HMO plans, enrollees usually must obtain health care services through network providers. The HMO will not cover services that plan enrollees obtain when they see physicians or go to hospitals or other providers outside of the network (except for necessary emergency or urgent care).

Some HMO plans have developed a more lenient approach, called a Point of Service (POS) benefit option. The HMO-POS benefit allows enrollees to obtain certain health care services without following the plan’s standard network or prior authorization rules. Often, services obtained through the POS benefit will cost an enrollee more than services provided according to the standard rules. HMO plans with a POS benefit may limit the POS portion of the benefit to specific services or to a fixed dollar benefit amount. As with all MA plans, it is important to understand the POS benefit, if offered, before enrolling in an HMO plan.

HMO plans may or may not offer Medicare Part D drug coverage through the HMO, although most do. ***Enrollees in HMO plans with no Medicare drug coverage (MA-only) may not enroll in a stand-alone Prescription Drug Plan (PDP).*** Enrollees who select an HMO plan with Medicare drug coverage (MA-PD) must accept the drug coverage portion of the plan.

Preferred Provider Organizations (PPOs)

Preferred Provider Organizations (PPOs) are a type of Coordinated Care Plan that operates through a network of health care providers. Unlike HMOs, PPOs generally pay for out-of-network care. Also, they do not require enrollees to choose a primary care provider (PCP) nor do they require referrals to see specialists or receive certain types of health services. Enrollees in PPOs usually pay lower cost-sharing amounts for services provided by the PPO’s network of “preferred” health care providers. Even in routine circumstances, PPOs provide coverage for services received out-of-network, but cost-sharing (deductibles and copayments) is generally higher for out-of-network care.

A Regional Preferred Provider Organization (RPPO) is a type of PPO plan that offers coverage throughout one of the 26 CMS-established MA regions. These plans are the result of the government’s effort to expand and support Coordinated Care Plans even in rural areas. By contrast, other PPOs (local PPOs) provide a benefit package to a service area of only one or more counties. RPPOs offer a number of incentives and changes from local PPOs, including a standard benefit package (that includes a set premium) across the region, an annual out-of-pocket limit, or “cap,” on enrollee out-of-pocket cost sharing, and a combined Part A and Part B deductible. Furthermore, the health care provider network of

Medicare Part C

RPOs is spread throughout the MA region, providing access to more health care providers across a broader area than local PPOs and most HMOs.

PPO plans may or may not offer Medicare drug coverage. **Enrollees in PPO plans without Medicare drug coverage (MA-only) may not enroll in a stand-alone Prescription Drug Plan (PDP).** Enrollees who select a PPO plan with Medicare drug coverage (MA-PD) must accept the drug coverage portion of the plan.

Private Fee-for-Service (PFFS) Plans

Private Fee-for-Service (PFFS) Plans are a type of Medicare Advantage (MA) plan that is very different from Coordinated Care Plans. Beneficiaries don't need to choose a primary care doctor in PFFS Plans. PFFS plans resemble Original Medicare in that the plans pay providers for each service they deliver to plan enrollees. They are also similar in that enrollees are not limited to a network of health care providers and do not need referrals to see a specialist. On the other hand, unlike Original Medicare, PFFS plans set their own payment rates for health care providers. Thus, enrollees may see any provider who agrees to accept the plan's payment terms, but CMS does not require providers to accept these terms. Because of this, it is critical to know that any Medicare provider, including physicians, home health agencies, and equipment suppliers, **may choose to accept, or not accept, the terms of the PFFS plan each time a patient visits the provider.** This means that enrollees cannot trust that their preferred doctors and hospitals will remain PFFS providers even if they received covered services through these providers previously.

Starting in 2011, non-employer/non-union PFFS plans that are operating in areas with more than one MA network-based plan must meet the access standards of other MA network-based plans. Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before. Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before. For each service you get, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms. In an emergency, doctors, hospitals, and other providers must treat you. You only need to pay the copayment or coinsurance amount allowed by the plan for the type(s) of service you get at the time of the service.

Private Fee-for-Service plans may or may not offer Medicare drug coverage through the PFFS. Unlike many other types of MA plans, enrollees in PFFS plans without Medicare drug coverage (PFFS-only) may enroll in a stand-alone Prescription Drug Plan (PDP).

Special Needs Plans (SNPs)

- Special Needs Plans (SNPs) are a type of Coordinated Care Plan (HMO or PPO) that exclusively provides coverage for beneficiaries with special medical needs or health care situations. Special Needs Plans must offer Medicare Part D drug coverage. A SNP may serve one of the following three subgroups of Medicare beneficiaries:
- Institutionalized individuals
 - Those residing in or expected to reside for 90 days or longer in a long-term care facility (including skilled nursing facility (SNF), nursing facility (NF), intermediate care facility (ICF), or inpatient psychiatric facility)
 - Those living in the community but requiring an equivalent level of care (LOC) to those residing in a long-term care facility
- Dual-eligible individuals
 - Those entitled to Medical Assistance under a state plan under Title XIX (Medicaid)

Medicare Part C

- Some SNPs may enroll all or a portion of dual-eligible beneficiaries, including those with Medicaid and those in Medicare Savings Programs
- Individuals with a chronic or disabling condition
 - These plans must be designed to serve 15 severe and chronic conditions:
 - ✦ Chronic alcohol and other drug dependence
 - ✦ Autoimmune disorders—including polyarthritis nodosa, polymyalgia rheumatica, polymyositis, rheumatoid arthritis, and systemic lupus erythematosus
 - ✦ Cancer excluding pre-cancer conditions
 - ✦ Cardiovascular disorders—including cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorder
 - ✦ Chronic heart failure
 - ✦ Dementia
 - ✦ Diabetes mellitus
 - ✦ End-stage liver disease
 - ✦ End-stage renal disease (ESRD) requiring dialysis.
 - ✦ Severe hematologic blood disorders—including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait), and chronic venous thromboembolic disorder
 - ✦ HIV/AIDS
 - ✦ Chronic lung disorders—including asthma, chronic bronchitis, emphysema, pulmonary fibrosis, and pulmonary hypertension
 - ✦ Chronic and disabling mental health conditions—including bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, and schizoaffective disorder
 - ✦ Neurologic disorders—including amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington’s disease, multiple sclerosis, Parkinson’s disease, polyneuropathy, spinal stenosis, and stroke-related neurologic deficit
 - ✦ Stroke
- SNPs also must apply one of the following structures:
 - The plan may target one chronic condition from the list of approved chronic conditions (see above).
 - The plan may target a group of commonly co-morbid and clinically linked chronic conditions from a list of approved common multi-condition groupings in which the eligible beneficiary has at least one condition. The groupings include diabetes mellitus and chronic heart failure; chronic heart failure and cardiovascular disorders; diabetes mellitus and cardiovascular disorders; diabetes mellitus, chronic heart failure, and cardiovascular disorders; and stroke and cardiovascular disorders.
 - The plan may target a plan-designed grouping of multiple chronic conditions from the list of approved chronic conditions in which the eligible beneficiary has all conditions

Medicare Part C

Medicare Medical Savings Account (MSA) Plans

A Medicare MSA Plan is a consumer-directed Medicare Advantage Plan. These plans are like Health Savings Account Plans available outside of Medicare. You can choose your health care services and providers.

Medicare MSA Plans have two parts. They combine a high-deductible insurance plan with a medical savings account that you can use to pay for your health care costs.

High-deductible health plan: The first part is a special type of high-deductible Medicare Advantage Plan (Part C). The plan will only begin to cover your costs once you meet a high yearly Deductible, which varies by plan.

Medical Savings Account (MSA): The second part is a special type of savings account. The Medicare MSA Plan deposits money into your account. You can use money from this savings account to pay your health care costs before you meet the deductible. Medicare MSA plans cover the Medicare services that all Medicare Advantage Plans must cover.

Medicare MSA Plans do not cover Medicare Part D prescription drugs. If you join a Medicare MSA Plan and need drug coverage, you'll have to join a Medicare Prescription Drug Plan.

Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan available in certain, limited areas of the country. A Medicare cost plan doesn't replace your original Medicare coverage. Instead, it offers other benefits in addition to those of original Medicare.

- In general, you can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, Original Medicare covers the services. You'll pay the Part A and Part B coinsurance and deductible.
- You can join anytime the Medicare Cost Plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can join a separate Medicare drug plan or you can get drug coverage from the Cost Plan (if offered). Even if the Cost Plan offers drug coverage, you can choose to get drug coverage from a separate Medicare drug plan.

You can add or drop Medicare drug coverage only at certain times.

Another type of Medicare Cost Plan only provides coverage for Part B services. These plans never include Part D. Part A services are covered through Original Medicare. These plans are either sponsored by employer or union group health plans or offered by companies that don't provide Part A services.

Programs for All-Inclusive Care for the Elderly (PACE)

The Program for All-Inclusive Care for the Elderly (PACE) is a model that provides community-based medical, psychosocial, long-term care, and chronic care to frail older adults. An interdisciplinary team manages participants' care to keep them out of nursing homes as long as possible by providing adult day center and home-based care services. PACE is a Medicare Health Plan, but not a Medicare Advantage Plan.

Medicare Part C

To qualify for PACE services, an individual must be age 55 or older, certified by the state to need nursing home care, have the ability to live in the community safely and live within a PACE service area. PACE programs receive monthly Medicare and Medicaid capitation payments for each qualifying participant, and those who are not eligible for these benefits must privately pay the capitation amount. Capitation allows PACE programs to provide a variety of services, even some that Medicare or Medicaid may not typically cover, through a determined monthly payment for each individual.

PACE delivers most of its services from a day health center which members attend several times a week. The day health center provides primary medical care, physical, occupational and recreational therapies, personal care, social services, and transportation to and from the center. Home-based services often supplement the center-based services.

Eligibility and Enrollment

Given the many choices that Medicare beneficiaries face in terms of receiving their health insurance and drug coverage, it is essential for SHICK counselors to help clients assess if a Medicare Advantage (MA) plan will meet their health insurance needs. The first step in that process is to determine if a client is eligible to enroll in a MA plan. Here are three key questions counselors should ask to assess a client's eligibility for enrolling in a MA plan.

- **Is your client enrolled in Medicare?** Generally, to be eligible to enroll in a Medicare Advantage plan, a Medicare beneficiary must be enrolled in both Medicare Part A and Part B.
- **Does your client live in the MA plan's service area?** Beneficiaries must permanently reside in a Medicare Advantage plan's service area to be able to enroll in the plan. Service areas differ among the various types of MA plans. Service areas may be no larger than a few counties in a metropolitan area or they may encompass an entire state or a multi-state region. Since provider network rules vary by plan as well as by plan type, it is especially important for beneficiaries who live out of a plan's service area for some part of the year to consider this factor.

When eligible beneficiaries decide to join a MA plan, they must complete an enrollment form to elect, or enroll in, a MA plan. It is very important to note that Medicare beneficiaries who choose to enroll in a Medicare Advantage plan remain "in Medicare." Often beneficiaries think that they are leaving Medicare when they join a MA plan. Counselors may need to address the sources of this confusion, which may include marketing materials and a MA plan's use of its own membership card instead of a beneficiary's regular Medicare card. While MA coverage through a private plan replaces the Part A Hospital Insurance and Part B Supplemental Medical Insurance that provide coverage to beneficiaries in Original Medicare, MA enrollees retain the rights of all Medicare beneficiaries, including the right to return to Original Medicare.

Finally, except for beneficiaries enrolled in Medicare Medical Savings Account (MSA) plans and those enrolled in Private-Fee-for-Service (PFFS) plans and Cost plans that do not offer qualified prescription drug coverage, individuals may not be enrolled into both a MA plan and a stand-alone Medicare Prescription Drug Plan (PDP) at the same time.

Deciding to Enroll in a MA Plan

MA plans may help some Medicare beneficiaries lower their out-of-pocket spending and gain access to benefits beyond those in Original Medicare.^{ee}

Medicare Part C

SHICK counselors provide a unique and essential service for clients when guiding them through a process to reach sound decisions about MA plan enrollment. To continue the assessment process that began with determining eligibility, counselors should learn as much as possible about a client's interest in particular MA plans. Here are some likely reasons for that interest:

- **Low premiums:** Some MA plans have very low monthly premiums. When compared to the cost of Medicare Supplement (Medigap) insurance policies or retiree group health plans, some of your clients could save several hundreds of dollars annually on insurance premiums by enrolling in a MA plan. The prospect of lower monthly health insurance premiums alone motivates many people to consider MA plans.
- **Extra Benefits:** Most MA plans offer benefits that the Original Medicare program excludes from coverage. Typically, these extra benefits can include routine dental and vision care.
- **Simplicity:** MA plans often combine the benefits that Original Medicare and Medicare Part D make available, along with some features of supplement insurance, in a complete package with one monthly premium. Some people prefer this to Original Medicare in which beneficiaries often pay separate premiums for Medigap insurance and Part D prescription drug benefits. Many MA plans also use set copayment amounts, such as \$10 or \$20 for each physician visit instead of Original Medicare's less predictable Part B 20% coinsurance charge.
- **An Affordable Alternative to Medicare Supplement Insurance:** Because MA plans cover some of the benefit gaps in Original Medicare, and because they are billed as a modern insurance option with more "advantages," some of your clients may believe that MA plans take the place of Original Medicare and supplement insurance, or that the MA plans and Medigap insurance are equivalent. This is a misimpression that SHICK counselors must address with patience and the use of case examples that illustrate how the out-of-pocket costs in MA plans and Medigap insurance differ.

After taking some time to listen to the reasons for a client's interest in a MA plan, it is important next for counselors to address several factors that beneficiaries should consider before joining a Medicare Advantage plan. Here are some considerations:

- **Plan Rules:** Enrollees in MA plans must follow the rules of the Medicare Advantage plan to receive coverage and payment. For example, a common rule in Medicare HMOs is one that requires the use of network providers, including doctors, hospitals, and diagnostic facilities. Another common rule in HMOs requires patients to get referrals to see specialists. Many MA plans, including HMOs and Private Fee-for-Service (PFFS) plans, also have prior authorization or prior notification rules that apply, for example, to medical equipment and elective surgery. Enrollees who do not follow their MA plan's rules may be responsible for the entire cost of care.
- **Lock-In:** Beneficiaries who opt to join a MA plan should understand the concept of lock-in. Individuals may make changes only during limited enrollment periods (e.g., the OEP and MA OEP). Once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year. This lock-in feature does not apply to beneficiaries who have a SEP.
- **Out-of-Pocket Costs:** Since many Medicare beneficiaries have moderate incomes, it is tempting for some people to compare MA plans and Original Medicare with a Medigap policy by premiums alone. But the true cost of a MA plan includes the monthly premium plus the cost-sharing charges for various

Medicare Part C

services. MA plans set their own cost structure, so a plan could offer a low monthly premium and offset it by charging more for individual covered services. While MA plans commonly use defined copayments for inpatient hospital and physician services, many use percentage-based coinsurance charges for outpatient hospital care and medical equipment and supplies. In some plans, beneficiaries owe out-of-pocket 20% of the cost for outpatient surgery and other treatments. In contrast, those in Original Medicare may purchase a Medigap policy that pays all the beneficiary's cost-sharing for inpatient and outpatient hospital services, and the entire coinsurance charge for medical equipment and supplies.

- **Beneficiary Liability for Cost-Sharing:** MA plan members must be prepared to cover the plan's out-of-pocket costs with their own income or financial resources. Thus, it is critical for people to examine a MA plan's cost-sharing structure and for counselors to show through case examples how the cost sharing system works, before your clients enroll in a MA plan.
- **Access to Providers:** Some MA plans have health care provider networks with restricted access to "out-of-network" providers. Provider networks are common in Medicare HMOs and PPOs. Some HMO and PPO plans' networks are very large, while others are more limited. Medicare PFFS plans, on the other hand, make payments to any health care provider who is willing to accept the plan's payment terms. Doctors, hospitals, and other service providers can pick and choose among the PFFS plans whose payments they will accept. With respect to providers, counselors should encourage clients to think about a MA plan's ability to ensure access to the hospitals, doctors, home health agencies, and diagnostic centers they prefer to use.
- **Peace of Mind:** Some people who enroll in MA plans face surprisingly large out-of-pocket costs when an unexpected illness or accident requires a series of outpatient hospital visits for treatment or rehabilitation. Others are stunned when an out-of-town diagnostic center does not accept a MA plan's payments, leaving them to foot the entire bill for expensive procedures. To promote peace of mind, counselors can help clients weigh the benefit of a MA plan's potential savings with some of its inherent uncertainties and risks. With clients who are "on the fence," counselors should recall that those who enroll in MA plans can return to Original Medicare during an annual Open Enrollment Period (OEP), the MA Open Enrollment Period (MA OEP), or a Special Enrollment Period (SEP). In limited cases, clients have special rights to return to Original Medicare and purchase Medigap insurance.

CMS has an online tool that provides information about Medicare Advantage plans, called the Medicare Plan Finder. It is available at <https://www.medicare.gov/>. Coverage and cost information about each plan is in the Medicare Plan Finder by clicking on the plan's name. Through this online tool, SHICK counselors can help beneficiaries narrow the list of available MA plans in their state. The tool allows you to further limit the list of MA plans in a state with additional screening criteria—including but not limited to:

- Plan benefits
- Insurance carrier
- Drug coverage
- Star Rating

Medicare Part C

While the Medicare Plan Finder gives a lot of information about the coverage and cost features in MA plans in summary and detailed forms, even the detailed information may not provide all the specifics that a client needs to make an informed decision, such as contracted providers. Thus, further research may be required. Typically, you can find more information about a MA plan through its website or toll-free number.

The Medicare website also has a comparison tool for Medigap policies available in the state. Since beneficiaries sometimes enroll in a Medicare Advantage plan as an alternative to buying Medigap insurance, this tool can provide a method to evaluate both sets of options.

Enrollment Periods and Effective Dates

CMS does not allow continuous open enrollment for the Medicare Advantage program. While some low-income beneficiaries may make enrollment changes more often, most beneficiaries have limited time frames to enroll in, disenroll from, or switch MA plans. Most people who enroll in MA plans are “locked in” to their plans for a calendar year. Beneficiaries must complete an enrollment form to elect, or enroll in, a MA plan.

There are three enrollment period categories: initial, yearly, and special enrollment. A beneficiary’s first chance to enroll in Medicare, and thus to choose a Medicare Advantage plan, is called the Initial Enrollment Period (IEP). The IEP usually coordinates with a beneficiary’s Part D Initial Enrollment Period (IEP). Yearly scheduled enrollment periods (including the annual Open Enrollment Period and MA Open Enrollment Period) are set times of year when the law permits beneficiaries to make changes to their Medicare coverage. Special Enrollment Periods (SEPs) enable beneficiaries with special situations to make plan changes outside of initial or yearly opportunities. For example, SEPs permit beneficiaries who move out of a plan’s service area or who lose other health coverage to make changes to their Medicare benefits.

Initial Coverage Election Period (IEP)

The Initial Coverage Election Period (IEP) is the seven-month time frame during which a person who is newly eligible for Medicare (enrolled in both Medicare Part A and Part B) may choose to enroll in a Medicare Advantage plan for the first time. The IEP begins three months before entitlement to both Part A and Part B and ends either on the last day for the beneficiary’s Part B initial enrollment period or the last day of the month preceding entitlement to both Part A and Part B, whichever is later.

Generally, a person becomes eligible for Medicare on the first day of the month of his or her 65th birthday or the 25th month of disability. Part B enrollment may not occur upon entitlement to Part A for a variety of reasons; thus, the IEP typically coordinates with Part B entitlement or enrollment.

Yearly Opportunities for Enrollment: OEP and MA OEP

The MMA permits Medicare beneficiaries to make changes to their Medicare enrollment during the annual Open Enrollment (or Election) Period (OEP) each year. Medicare Advantage-eligible beneficiaries may use the OEP as an opportunity to enroll in or disenroll from a MA plan. They can use the OEP to switch from one MA plan to another or to leave the MA program for Original Medicare. The OEP runs from October 15 through December 7 each year. The new coverage choice becomes effective on January 1 of the upcoming year. Beneficiaries who make more than one enrollment choice during the OEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change

Medicare Part C

their minds throughout the OEP. While this may be helpful for some individuals, keep in mind that unscrupulous plan sales agents can undo the results of a counseling session with SHICK’s clients. Note that employer/union sponsored MA group plans need not conform to the OEP rules that apply to other MA plans.

The OEP is also a chance for all Medicare beneficiaries to enroll in or disenroll from a Medicare drug plan. A decision to enroll in or disenroll from Medicare drug coverage during the OEP is effective for the following calendar year, beginning on January 1. Only beneficiaries who have a Special Enrollment Period (SEP) opportunity may change their Medicare drug plan enrollment during the plan year.

Medicare Advantage Open Enrollment Period (MA OEP)

The Medicare Advantage open enrollment period (MA OEP) takes place from January 1st through March 31st annually. This OEP allows individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or Original Medicare. Individuals using the MA OEP to make a change may make a coordinating change to add or drop Part D coverage. An MA organization has the option to voluntarily close one or more of its MA plans to MA OEP enrollment requests. If an MA plan is closed for MA OEP enrollments, then it is closed to all individuals in the entire plan service area who are making MA OEP enrollment requests. All MA plans must accept MA OEP disenrollment requests, regardless of whether it is open for enrollment. Individuals with enrollment in Original Medicare or other Medicare health plan types, such as MSAs and cost plans, are not able use the MA OEP to enroll in an MA plan, regardless of whether they have Part D.

The types of changes beneficiaries can make during the MA OEP are listed in the table below. An enrollment choice made during the MA OEP is in effect for the entire remaining calendar year starting on the effective date of coverage, unless a beneficiary has a SEP opportunity.

Important: If the beneficiary disenrolls from a Medicare private health plan (Medicare Advantage), federal law does not give the beneficiary the right of guarantee issue to buy a Medigap plan.

Type of Coverage on January 1	Allowed During MA OEP
MA-PD MA-only	<ul style="list-style-type: none">• MA-PD• MA-only• Original Medicare + PDP• Original Medicare w/o PDP
Original Medicare only or with a PDP	<ul style="list-style-type: none">• No changes allowed

Another OEP enrollment opportunity, called the OEPI, exists for people in institutions. The OEPI is a continuous enrollment period for all Medicare beneficiaries who move into, reside in, or move out of an institution. The OEPI permits them to make unlimited changes to their MA or Original Medicare enrollment. For the OEPI, the term “institutionalized” includes those residing in the following facilities:

- Skilled nursing facilities (SNFs)
- Nursing facilities (NFs)
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Psychiatric hospitals
- Rehabilitation hospitals
- Long-term care hospitals

Medicare Part C

- Swing-bed hospitals

Special Enrollment (Election) Periods

Special Enrollment (Election) Periods (SEPs) enable Medicare beneficiaries to make certain enrollment changes in several special situations. As a SHICK counselor, it is important to keep in mind that these SEP opportunities exist because they may enable some of your clients to make changes in their MA enrollment outside of the OEP and MA OEP.

CMS's enrollment guidance describes a SEP this way:

Special election periods constitute periods outside of the usual IEP, OEP, or MA OEP when an individual may elect a plan or change his or her current plan election. Depending on the nature of the special election period, an individual may:

- Discontinue an enrollment in a MA plan and enroll in Original Medicare
- Switch from Original Medicare to a MA plan
- Switch from one MA plan to another MA plan

Certain SEPs are limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may subsequently elect a new MA plan within the SEP time frame. Once the individual has elected the new MA plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. **In other words, the SEP for the individual ends when the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.**

In addition to MA-specific SEPs, there are certain other SEPs that correspond to Prescription Drug Plans (PDPs).

Change in Residence

Two circumstances give persons the right to a SEP for a change in residence. This includes those who have a change in permanent residence that places them outside of their MA plan's service area and those who have new MA and/or Part D plans available because of a change in permanent residence.

This SEP has certain notice procedures. For people who notify their plan in advance of their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months.

When individuals do not notify their plan of their move, and the plan learns from CMS or otherwise that they have lived outside of their plan's service area for more than six months, their SEP begins in the sixth month and continues through the eighth month after the move. Persons may request that the effective dates of their SEP enrollments to be up to three months after the notification but not earlier than the date of the move.

Contract Violation

MA plan enrollees who demonstrate to CMS that the MA organization violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another MA plan or to Original Medicare. SHICK can help plan enrollees submit requests for Contract Violation SEPs to their CMS Regional Office. CMS will process some of these enrollment requests as

retroactive disenrollments/enrollments. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS.

Non-Renewals or Terminations

People whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 of the prior year to January 31 of the following year. CMS requires these plans to give 90 days' notice to enrollees. The effective date of the enrollment may be on January 1, or February 1, but not before the plan receives the enrollment request.

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month past the termination effective date. These plans are required to give 60 days' notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

Exceptional Conditions

- **SEP EGHP:** Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect a MA plan or vice versa during the period when the EGHP allows plan changes. The effective date of the enrollment may be up to three months after the request for enrollment or disenrollment but not before the plan receives the request.
- **Disenrollment Connected to a CMS Sanction:** If CMS sanctions a MA organization and enrollees disenroll due to the issue that led to the sanction, CMS may authorize a SEP on a case-by-case basis for those enrollees.
- **PACE Enrollees:** MA enrollees may disenroll at any time to join a PACE program. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join a MA plan.
- **Dual-Eligible and LIS-eligible Beneficiaries:** Beneficiaries can join, switch, or drop Medicare prescription drug coverage one time per calendar quarter between January through September. The effective date of the change is the first of the month following the request for the change. They can also make a change from October 15–December 7, and the change will take effect on January 1.
- **Trial Period SEP:** People who drop a Medigap policy to enroll in a MA plan for the first time are entitled to a guaranteed right to purchase their own Medigap policy back or buy a new one, if the one they had is not available, within the "trial period," usually twelve months. The Trial Period SEP permits them to disenroll from a MA plan at any time during this trial period to return to Original Medicare and to purchase the Medigap policy. The SEP begins upon disenrollment from the MA plan and continues for two additional months, with an effective date depending on the situation.
- **Retroactive ESRD Entitlement**
- **Retroactive Medicare Entitlement**
- **Part D Coordinating:** These SEPs permit eligible persons to make an election into or out of an MA-PD plan (or as it applies below).

Medicare Part C

- **Involuntary Loss of Creditable Coverage:** Medicare beneficiaries who experience an involuntary loss of creditable coverage or a reduction in such coverage that makes it no longer creditable have a SEP to permit enrollment into a Part D plan (including an MA-PD plan). The SEP begins upon notification of the loss (or reduction) and ends two months after the loss (or reduction) or the notice, whichever is later. The effective date is the first of the month following the request or may be up to three months prospective.
- **Not Informed of Creditable Coverage:** Those not adequately informed of a loss of (or that they never had) creditable coverage have a SEP to enroll in a Part D plan (including an MA-PD plan). Established on a case-by-case basis, this SEP begins upon approval from CMS and continues for two additional months.
- **Error by Federal Employee:** On a case-by-case basis, CMS may grant a SEP to those whose enrollment or non-enrollment in a Part D plan (including an MA-PD plan) is not valid due to the action, inaction, or error of a Federal employee. This SEP begins upon approval from CMS and continues for two additional months. SHIPs can help plan enrollees submit requests to their CMS Regional Office.
- **Disabled Medicare Beneficiary Turning 65:** Beneficiaries eligible for Medicare due to a disability have an additional IEP for Part D upon turning 65. The coordinating SEP with this IEP may be used to disenroll from an MA-only or MA-PD plan and return to Original Medicare, or to enroll in an MA only plan (regardless of whether the Part D IEP to enroll in a PDP is used). The SEP begins and ends concurrently with the additional Part D IEP.
- **Beneficiaries Losing Special Needs Status:** Those enrolled in a Special Needs Plan (SNP) who no longer meet the specific special needs status are eligible for a SEP. The SEP begins upon the change in status and continues for three more months.
- **Beneficiaries no longer eligible for Medicaid or LIS upon Losing LIS:** Beneficiaries can join a Medicare Advantage or Medicare Prescription Drug Plan, switch from their current plan to another Medicare Advantage or Medicare Prescription Drug Plan, drop their Medicare Advantage Plan and return to Original Medicare, or drop their Medicare prescription drug coverage. The effective date of the change would be the first of the month following the request for the change. Their chance to change lasts for 3 full months from either the date they are no longer eligible or notified, whichever is later.
- **Enrollment in a Chronic Care SNP:** A SEP exists for individuals who qualify for a Chronic Care Special Needs Plan (SNP) to enroll in an SNP. The SEP applies to all beneficiaries who qualify for these SNPs and ends upon enrollment into a plan.
- **Beneficiaries Who Require a New Chronic Care SNP:** An additional SEP exists for beneficiaries currently enrolled in a Chronic Care SNP who require a new SNP due to a new chronic care focus. The SEP ends upon enrollment into the new SNP.
- **Disenrollment from Part D to enroll in or Maintain Creditable Coverage:** Any enrollee in a Part D plan (including PDPs and MA-PDs) may disenroll at any time from the plan to obtain or maintain other creditable coverage. The effective date of disenrollment would be the first of the month following the request. This SEP permits those leaving MA-PD plans also to enroll in an MA-only plan.
- **Beneficiaries who are released from jail.** Beneficiaries who are released from jail have a SEP to join a MA plan or Part D plan for two full months after the month they are released from jail.

SEP65

Beneficiaries who enroll in a MA plan (excluding an MSA plan) during their Initial Enrollment Period for Part B (the seven months around their 65th birthday) have a SEP65 to try out the Medicare Advantage program. These individuals may disenroll from the MA plan into Original Medicare at any time during the first twelve months of enrollment in the MA plan. They have a guaranteed issue right to any Medigap policy (not just plans A, B, C, F, K, or L; or A, B, D, G, K, or L if Medicare eligible after 1/1/2020).

5-Star SEP

Under the 5-Star Special Enrollment Period, a beneficiary can join or switch to a 5-Star MA plan (with or without drug coverage) or a 5-Star PDP in their service area. This SEP is from December 8 through November 30 of the next year, with an effective date of the first of month following the enrollment request. It can only be used to enroll in plans given an overall 5-star rating for the current calendar year. The Star rating is from the ratings on the Plan Finder. Beneficiaries can only use the 5-star SEP one time during the year. If the beneficiary joins an MA-only plan which allows a stand-alone PDP, they also have a coordinating Part D SEP and can join a PDP for the same month. The PDP doesn't have to be a 5-star plan. However, if they are switching from one MA-only plan to another MA-only plan, they do not have an SEP to switch PDPs.

How to Enroll in a MA Plan

Beneficiaries eligible for the Part D low-income subsidy, and thus have auto or facilitated enrollment, may occasionally be auto or facilitated enrolled into a Medicare Advantage plan with drug coverage. This process only occurs in certain exceptional instances when a beneficiary is enrolled into an MA-only plan upon becoming eligible for the LIS. At that point, these beneficiaries would be facilitated into MA-PD plans to ensure their access to Medicare drug coverage. ***Who Can Help a Medicare Beneficiary Enroll?***

In most cases, Medicare beneficiaries themselves must complete applications to enroll in MA plans. CMS's MA Enrollment and Disenrollment Guidance explains that anyone other than the beneficiary who completes an enrollment request must state that he or she has the legal authority under state law to execute the enrollment.

NOTE: SHICK counselors who assist clients with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. Instead, SHICK counselors who help clients with Medicare Advantage plan enrollment are merely facilitating the process. Counselors can avoid problems by making sure that they do not indicate that they represent their clients, or sign enrollment forms on a client's behalf.

Plan Must Provide Certain Information to Enrollee

Prior to the effective date of enrollment (or within 10 calendar days of enrolling) a MA plan must provide all enrollees with the following documents:

- A copy of the enrollment form, where applicable
- A notice acknowledging receipt of the completed enrollment election showing the effective date of coverage
- Proof of health insurance coverage, including, where applicable, the data necessary to access prescription drug benefits

Medicare Part C

Materials must explain the following information to new enrollees:

- The costs associated with the MA plan, including but not limited to the premium, coinsurance, copayments, or fees and the amount that the plan contributes to the Medicare premium and deductible, if applicable.
- The lock-in requirement, including an acknowledgement from enrollees that they understand about the plan's provider network requirements.
- The effective date of coverage and steps to take to obtain services prior to the receipt of an ID card, if necessary.

Disenrollment

Medicare beneficiaries who are currently enrolled in a Medicare Advantage plan may only disenroll from that plan during certain periods: the annual Open Enrollment Period (OEP) from October 15 through December 7; during the MA Open Enrollment Period (MA OEP) from January 1 through March 31; and any applicable Special Enrollment Period (SEP).

There are a few ways for a Medicare beneficiary to disenroll from a MA plan:

- By enrolling in another plan
- By sending or faxing a signed written notice to the MA organization
- By requesting disenrollment online to the MA organization (if the MA organization offers this option)
- By calling 1-800-MEDICARE

CMS's disenrollment policy guidance states that "if a member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above. [...] The disenrollment request must be dated when it is initially received at the MA organization's business offices."

The effective date of most disenrollment requests is the first of the month following the request for disenrollment. There are certain exceptions to this rule based on the enrollment period during which enrollees request the disenrollment. Plans must send written acknowledgement of the disenrollment request to the enrollee within ten days of the request.

MA plans may also process involuntary disenrollments in certain circumstances. Examples of situations where plans have the option to disenroll individuals include the following:

- Failure to pay premiums timely
- Engaging in disruptive behavior
- Providing fraudulent information to the plan

There are also certain situations when CMS requires a plan to process an involuntary disenrollment:

- Moving out of a MA plan's service area
- Losing entitlement to Medicare Part A and/or Part B
- Losing special needs status, for Special Needs Plans
- Death
- Plan terminating or discontinuing

Post-Enrollment Actions

Even after a beneficiary requests enrollment or disenrollment, there are certain changes that may be made related to the enrollment or disenrollment.

Cancellations

Both enrollment and disenrollment requests may be cancelled before the effective date of the change. Those wishing to request such a cancellation must request this directly from the MA organization.

Reinstatements

Enrollment in a MA plan may be reinstated if a disenrollment was processed and the disenrollment was not legally valid. CMS processes reinstatements on a case-by-case basis, but common reasons for reinstatements include the following circumstances:

- Disenrollment due to mistaken death indicator
- Disenrollment due to mistaken loss of Medicare Part A or Part B
- Mistaken disenrollment

Retroactive Enrollments

If a MA organization does not process a valid request for enrollment within the appropriate time frame, then CMS may perform a retroactive enrollment.

Retroactive Disenrollments

If an enrollment in a MA plan was never legally valid or if a beneficiary makes a valid disenrollment request and it is not processed, a retroactive disenrollment may be performed by CMS. Enrollments that are not legally valid could include the following:

- An incomplete enrollment request
- An attempted enrollment for an individual who did not meet eligibility requirements at the time of enrollment
- If the member or his/her legal representative did not intend to enroll in the MA organization. Evidence of a lack of intent to enroll could include:
 - An enrollment form signed by the individual when a legal representative should have signed,
 - A request by the individual for cancellation of enrollment before the effective date, ○ An enrollment in a supplemental insurance program after enrolling in the MA plan, or ○ Receiving services out-of-network after enrolling in a MA plan.

Coverage of Benefits and Access to Services

Basic Benefits

Generally, the law requires Medicare Advantage plans to cover, at a minimum, all Original Medicare covered services, except hospice care. This means that MA plans must provide coverage of all Part A and Part B services by furnishing these services directly or through payment arrangements with providers of certain services. MA organizations must submit to CMS their coverage of benefits package before CMS approves the MA plan.

Medicare Part C

Before approving a MA organization to offer a MA plan to beneficiaries, CMS reviews the proposal to ensure that the plan meets the following conditions:

- Medicare-covered services are provided and meet CMS guidelines under Original Medicare
- Cost-sharing structure does not discriminate against beneficiaries, promote discrimination, discourage enrollment, encourage disenrollment, steer certain subsets of beneficiaries to the plan, inhibit access to services, or design cost-sharing differentials that limit choices
- Benefits meet other MA program requirements

As with Original Medicare, coverage of services depends on several conditions:

- The service must meet a benefit category
- The service must not be specifically excluded from coverage
- The item or services must be considered “reasonable and necessary”

CMS’s policy guidance provides this information about the term “reasonable and necessary”:

Section 1862(a)(1)(A) of the Act states that, subject to certain limitations, no payment may be made for expenses incurred for items or services that are not “reasonable and necessary” for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

Medicare Advantage Organizations must abide by National Coverage Determinations, general Medicare coverage guidelines, and written coverage decisions of local Medicare Administrative Contractors (MACs). In the absence of national or local coverage determinations, Medicare Advantage organizations may follow the coverage policies of other MA organizations, or make their own coverage determinations and provide a rationale for the decision. While MA plans must provide coverage for all Medicare-covered services, they may use their flexibility to encourage cost-effective use of these services.

Supplemental Benefits and Guidelines

Coverage of supplemental benefits by a Medicare Advantage plan falls into two categories—mandatory supplemental benefits and optional supplemental benefits.

Mandatory Supplemental Benefits

These benefits include services not covered by Original Medicare (excluding Medicare prescription drug coverage) that some MA plans may offer to all enrollees as an automatic part of the MA plan’s package. If a MA plan offers mandatory supplemental benefits, all enrollees in that plan must accept these benefits. MA plans submit their mandatory supplemental benefits to CMS as part of the benefits package that CMS reviews before it approves the plan.

MA plan enrollees pay for these benefits through the MA plan’s premium and cost sharing. The MA plan may use rebate dollars to pay for a part of or all mandatory supplemental benefits.

Examples of mandatory supplemental benefits include:

- Coverage for emergencies outside the United States
- Annual physical examinations
- Routine hearing and vision examinations
- No three-day prior hospital stay before Skilled Nursing Facility (SNF) admission

Medicare Part C

- Acupuncture
- Transportation to plan provider appointments
- Point of Service (POS) option in Medicare HMOs

Optional Supplemental Benefits

These benefits include services not covered by Original Medicare (excluding Medicare drug coverage) that a MA plan offers as an option to all enrollees. If enrollees opt to take these benefits, they must pay the full cost of the coverage, typically through an extra premium. The optional supplemental benefits must be offered to all beneficiaries equally upon enrolling in the MA plan and for a set time afterwards. Plan enrollees may voluntarily drop this coverage at any time during the plan year by giving notice to the plan.

Examples of optional supplemental benefits packages include:

- Dental care that covers visits, x-rays, and semi-annual cleanings
- Vision care that covers optometry visits, eyeglasses, or contact lenses
- Hearing care that covers audiology tests and the partial costs of hearing aids
- Point of Service (POS) option in Medicare HMOs

Design of Supplemental Benefits

While MA plans have significant flexibility in designing their benefits packages, they must follow certain guidelines for their supplemental benefits package:

- All benefits generally must be health-related. Health-related means that the primary purpose of the item or service is to prevent, cure, or diminish an illness or injury that is actually present or expected to occur in the future. If the primary purpose of the item or service is comfort, cosmetic, or daily maintenance then it may not be classified as a health benefit.
- Beginning in 2019, MA plans are now allowed to offer some non-health related supplemental benefits, though the number of plans offering these benefits are still limited.
- All benefits must be offered in the same way to all enrollees.
- All benefits must be priced in the bid to CMS.
- All benefits must be specified in the appropriate marketing vehicles.

Value-Added Items and Services (VAIS)

Value-Added Items and Services (VAIS) are items and services that do not meet the definition of benefits. MA organizations may not use Medicare program dollars to pay for VAIS, and the cost associated with these items and services must be intrinsically administrative for CMS to consider them VAIS.

There are certain rules associated with plans offering VAIS:

- VAIS must be offered for the entire contract year
 - VAIS must be offered in the same way to all enrollees
 - Plans must maintain the privacy and confidentiality of enrollee records
 - Plans must comply with applicable HIPAA laws
 - Plans must comply with relevant fraud and abuse laws
- Examples of VAIS include:
- Fitness programs
 - Health club memberships or membership discounts
 - Discounts on items such as nutritional supplements
 - Meals on Wheels following hospital discharge

Service Areas

Medicare Advantage plans have a specific geographic area that CMS approves with some exceptions for retiree group MA plans. According to CMS's policy guidance:

The basic requirement of service area is that each MA plan offered by a MA organization must be offered to all beneficiaries in a MA plan's service area with a uniform benefit package and uniform cost sharing arrangements.

Beneficiaries must live within a plan's service area to be able to enroll in the MA plan. A service area may be as small as one county or as large as multiple MA regions. A regional MA plan (like a Regional PPO plan) must have a service area that encompasses the entire MA region. (Nationally, there are 26 MA regions. Kansas is in Region 18 with Oklahoma.) Within a MA plan's service area, the plan must provide all enrollees an identical package of benefits with an identical cost-sharing structure.

The following features are affected by a MA plan's service area:

- **Access Requirements:** a MA plan's service area defines the geographic area in which a coordinated care plan's covered services must be available and accessible.
- **Eligibility:** a MA plan's service area determines which Medicare beneficiaries are permitted to enroll in the plan. Other than Special Needs Plans (which may restrict their enrollment to certain populations of beneficiaries), MA plans must allow any eligible Medicare beneficiary residing in a plan's service area to enroll in that plan during an applicable enrollment period.
- **Payment Rate:** a MA plan's service area determines CMS's payment rate to the MA plan. CMS pays MA plans a set amount of money per beneficiary who enrolls in the plan. Several factors affect the set amount, including, for example, the plan's service area and the health status of enrollees. **Required Benefits:** a MA plan's service area sometimes determines which benefits must be covered by the plan. All benefits offered by MA plans in a service area must be uniform throughout the service area; so the service area will establish, to some extent, the benefits that a MA plan must offer.

Medicare Part C

- **Urgently-Needed Services:** a MA plan's service area determines the boundaries beyond which a coordinated care plan must cover urgently-needed services.

Disclosure Requirements

MA plans can be most beneficial to enrollees who are able to understand and follow the plans' rules for receiving covered services and benefits. To achieve this end, plans are required to provide certain information to enrollees at specific times during a plan contract year.

Upon Enrollment and Annually Thereafter

MA plans must provide the following information to all plan enrollees upon enrollment and annually thereafter:

- **Service area:** The MA plan's service area and enrollment continuation area, if relevant
- **Benefits:** The MA plan's benefits, including conditions and limitations and the premiums and cost sharing related to these benefits
- **Access:** Information about the MA plan's network providers, out-of-network coverage, and POS option (if applicable)
- **Out-of-area coverage:** The MA plan's rules for coverage of services outside of the plan's service area
- **Emergency coverage:** The MA plan's coverage of emergency services, including what constitutes an emergency, appropriate use of emergency services, process and procedures for obtaining these services, and locations where emergency services can be obtained
- **Supplemental benefits:** The MA plan's mandatory and optional supplemental benefits (if applicable) and the premiums for those benefits
- **Prior authorization and review rules:** The MA plan's prior authorization rules that must be met to ensure the plan provides coverage for the services
- **Grievance and appeals procedures**
- **Quality Improvement program:** Except for PFFS and MSA plans, a description of the required Quality Improvement program
- **Catastrophic caps and single deductible:** Plans' information about their out-of-pocket limit (also known as "catastrophic stop-loss coverage") and combined Medicare deductible (if applicable) • **Disenrollment rights and responsibilities**

Upon Request

All beneficiaries eligible to enroll in a MA plan have a right to receive the following information from MA plans:

- **Original Medicare-covered benefits:** Information about Part A and Part B covered benefits, including cost-sharing
- **Enrollment procedure:** Information and instructions for potential enrollees on how to enroll in the MA plan
- **Rights:** Information about grievance and appeal procedures and the right to be protected from discrimination
- **Potential for contract termination:** Information about potential changes to a MA plan, including contract termination, non-renewal of a contract, or a reduction in a plan's service area

Medicare Part C

- **Benefits:** The MA plan's benefits, including conditions and limitations, the premiums and cost-sharing related to these benefits, out-of-pocket limits, out-of-network coverage policies, and coverage of emergency and urgently-needed care
- **Premiums:** Information about any monthly basic premium, any monthly supplemental premium, and any reduction in the Part B premium • Plan's service area
- **Quality and performance indicators:** To the extent they are available, information about the following indicators: disenrollment rates, enrollee satisfaction, health outcomes, plan-level appeal data, and record of plan compliance
- **Supplemental benefits:** The MA plan's mandatory and optional supplemental benefits (if applicable) and the terms, conditions, and premiums for those benefits
- **Utilization management techniques**
- **Aggregated number and disposition of disputes:** Information about submissions for plan grievances and appeals
- **Physician compensation methods**
- **Financial information:** Information on the financial condition of the MA organization

Ensuring Continuity of Care

All MA organizations must show they have met standards to ensure continuity of care for enrollees. MA organizations must meet the following requirements, among others, to satisfy CMS's expectation that the plan is ready and able to secure continuity of care for enrollees:

- The MA plan must describe its method for coordinating care, including which services are coordinated, under which circumstances they are coordinated, methods of coordination, and who coordinates the care.
- The MA plan must provide enrollees with a source of primary care.
- The MA plan must integrate services with community and social service programs through contracts or otherwise.
- The MA plan must establish processes that ensure effective and continuous patient care and quality review, including an initial health assessment for all new enrollees, an enrollee health record that is maintained, and a proper exchange of clinical information throughout the network of providers.
- The MA plan must use practices to inform enrollees of preferred follow-up care, training methods for self-care, and other health care promotion.
- The MA plan must have set treatment regimens to address common barriers to compliance for enrollees.

Access and Availability Rules for Coordinated Care Plans

Coordinated Care Plans (CCPs), such as HMOs and PPOs, also are required to demonstrate they have met access and availability standards for enrollees. MA organizations must meet the following requirements to obtain CMS approval for the plan sponsors:

The CCP must maintain and monitor a network of providers that is sufficient to provide adequate access to covered services to meet the needs of all enrollees. The plan must maintain a provider network that is distributed throughout the service area to ensure enrollees must not travel unreasonable distances to receive care. Unreasonable distance is understood to be an average

Medicare Part C

travel time of 30 minutes for commonly used services. Acceptable travel times may be longer for less common services or in rural areas.

- The CCP must establish standards for timeliness of access to care. This means that adequate numbers of providers are available all day, every day, for medically necessary service.
- The CCP must maintain a cohort of primary care providers (PCPs) from which enrollees may select a personal PCP.
- The CCP must provide access to necessary specialists. Female enrollees should have direct access to women's health specialists. If a MA plan's network of specialists does not sufficiently serve the plan's enrollees, the MA plan must arrange for care outside of the network to meet the needs of enrollees.
- The CCP must establish medical necessity determination standards, including coverage rules, practice guidelines, payment policies, and utilization management.
- The CCP must ensure that it provides coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services as required.
- The CCP must have criteria for chronic care improvement programs, including the identification of enrollees appropriate for such programs and systems for monitoring enrollees' participation in such programs.

Relationship to Drug Coverage

Drug coverage under the Medicare Advantage program falls into several categories: Part B drug coverage, Part D drug coverage, and over-the-counter drug coverage. Medicare Part A provides coverage for some drugs received during a Medicare-covered inpatient hospital stay.

Part B Original Medicare Drug Coverage

Since Medicare Part D drug coverage took effect on January 1, 2006, all Part B-covered drugs and biologicals continue to be covered through Original Medicare. Thus, MA plans cover Part B drugs and biologicals outside of their Part D drug benefit because the plans must cover the benefits in Part A and Part B of Original Medicare.

Some examples of Part B-covered drugs and biologicals are:

- Injectable drugs that are considered "not usually self-administered" and are given to beneficiaries in connection with physician services
- Drugs that beneficiaries take through durable medical equipment authorized by a MA plan
- Clotting factors for beneficiaries diagnosed with certain blood clotting disorders
- Immunosuppressive drugs following a Medicare-covered organ transplant
- Injectable osteoporosis drugs for beneficiaries who have had bone fractures related to postmenopausal osteoporosis
- Antigens
- Certain oral anti-cancer drugs
- Certain anti-nausea drugs
- Injectable erythropoietin for beneficiaries who have end-stage renal disease (ESRD) and related anemia

Part D Medicare Drug Coverage

There are different rules that govern whether Medicare Advantage plans offer Part D benefits as a MA plan with drug coverage (MA-PD). All Medicare Advantage organizations offering coordinated care plans (e.g., HMOs and PPOs) in a service area must offer at least one MA-PD plan within that area. This rule affects both local and regional coordinated care plans. All Special Needs Plans, a type of coordinated care plan, are required to provide prescription drug coverage.

Private Fee-for-Service (PFFS) plans, Medicare Medical Savings Accounts (MSAs), and Program for All Inclusive Care for the Elderly (PACE) are not coordinated care plans. Medicare law does not place the same requirements on them as it does on coordinated care plans. PFFS plans are not required to provide drug coverage, and therefore many PFFS plans exist as MA-only plans. Also, MSA plans are prohibited from offering drug coverage, so all MSA plans are MA-only plans. Like Special Needs Plans, however, PACE plans must provide prescription drug coverage to all enrollees.

Generally, Medicare beneficiaries who want drug coverage and the benefits of a Medicare Advantage plan must enroll in a MA plan with Part D prescription drug coverage (MA-PD). An exception applies to beneficiaries who are enrolled in certain types of MA plans that do not offer drug coverage, including some PFFS plans, and all Medical Savings Account (MSA) plans. The MMA permits people who are enrolled in a PFFS, Cost, or MSA plan without Part D drug coverage, to enroll in a stand-alone Prescription Drug Plan (PDP) to receive prescription drug coverage. Otherwise beneficiaries who enroll in MA coordinated care plans that do not offer Part D drug coverage may not enroll in stand-alone PDPs.

Monthly Premiums

All Medicare beneficiaries have costs associated with their Medicare coverage, whether they are in Original Medicare or Medicare Advantage. The costs of a Medicare Advantage (MA) plan, though, can be different from those in Original Medicare.

Beneficiaries in MA plans must continue to pay the Medicare Part B premium.

The plan may have an additional premium, sometimes called a Part C premium. It covers the Medicare Part A and Part B benefits as well as any mandatory supplemental benefits. Enrollees pay the plan's Part C premium in addition to the Part B premium. Low monthly Part C plan premiums attract many Medicare beneficiaries to the Medicare Advantage program. Many MA plans eliminate the Part C premium entirely. SHICK counselors can help their clients make sound MA enrollment decisions by showing them how to balance a plan's low premiums with its other out-of-pocket costs.

Some Medicare Advantage plans may offer optional supplemental benefits to their enrollees. Only those enrollees who choose this optional coverage must pay an extra premium to receive the benefits. Optional benefits packages are similar to "riders" in other kinds of insurance. Medicare Advantage plans cannot use rebate dollars to reduce the actual costs of the optional supplemental premium.

Costs for Health Care Services

Federal law gives Medicare Advantage (MA) plans flexibility to create cost-sharing structures that differ from Original Medicare's. MA plans may use percentage coinsurance charges, fixed copayment charges, or a combination of the two, depending on the service. Keep in mind that plans can change their cost-sharing

Medicare Part C

structures and payment amounts yearly. CMS requires plans to notify plan members of these changes through an “Annual Notice of Change,” or ANOC.

While beneficiaries in Original Medicare may purchase a Medigap policy to pay for some of the out-of-pocket costs—or gaps—in Original Medicare, the law prohibits Medigap policies from coordinating with MA plans. At this time, there are no Medicare-approved policies, like a Medigap, to cover the out-of-pocket costs for Medicare Advantage enrollees. Enrollees in MA plans must be prepared to pay out-of-pocket for any and all deductibles, copayments, and coinsurance amounts. In 2011, CMS implemented regulations making total out-of-pocket spending more predictable by requiring annual spending caps for all MA plans. The caps limit plan members’ financial exposure to set dollar amounts. After a person reaches a spending cap, the MA plan covers the full cost of care for the rest of the year.

Billing for Services

Medicare Advantage billing is a process very similar to other commercial health insurance products. When a MA plan enrollee receives a covered service, the health care provider collects the copayment, if applicable, from the enrollee. Then the provider submits the claim to the plan. If the MA plan agrees to cover the service, the plan sends the provider a payment. If the MA plan declines to cover the service, the plan notifies the provider. It issues a written Notice of Denial of Payment to explain the reasons for its denial. In such cases, the provider may bill the enrollee for the full cost of the service. An enrollee who disagrees with a plan’s coverage denial (i.e., a plan’s “organization determination”) may initiate the appeals process.

Medicare Advantage plans may have restrictions on certain health services. For example, they may require enrollees to receive prior authorization for some services. If the physician requests prior approval for such a service and the MA plan denies the request, the plan issues a written Notice of Denial of Medical Coverage to explain its decision. When this happens, enrollees have a few options. First, they can start the appeals process. Second, they may file a grievance with the MA plan. Third, the physician may provide more information to meet the plan’s coverage requirements.

The prior authorization process is quite different from the way that beneficiaries in Original Medicare receive covered services. In Original Medicare, the beneficiary receives a service from a Medicare provider. At that point, Medicare decides whether the service is covered. If the service is not covered, the beneficiary may pay the bill or appeal the denial if he believes Medicare should have covered the service. In Medicare Advantage, an enrollee may have to request coverage for a service before receiving it. If the plan denies coverage the enrollee may pay out-of-pocket for the service or start an appeal. The key difference between these two delivery mechanisms is that under Original Medicare a beneficiary may have to appeal to receive payment for a service received. Under Medicare Advantage a beneficiary may have to appeal to receive the service itself.

In Original Medicare, beneficiaries receive a Medicare Summary Notice (MSN) every three months if Medicare has paid a claim on their behalf. The MSN outlines all of the services a beneficiary received, how much Medicare paid for the service, and the amount providers may bill the beneficiary for each service. Medicare Advantage does not have an official, standard, system like the MSN for providing notice to enrollees about services they received. CMS instead expects plans to “give the beneficiary prompt notice of acceptance or denial of claims in a format specified by CMS.” Most plans send an Explanation of

Medicare Part C

Benefits (EOB) after they have paid for a service. For denials, they issue a form captioned *Notice of Denial of Payment*.

Low-Income Assistance

Some Medicare beneficiaries with limited income receive benefits from the state Medicaid program to pay some of the out-of-pocket costs associated with Medicare coverage. There are several levels of assistance, including full Medicaid benefits and the different categories of Medicare Savings Programs (MSPs).

Medicare beneficiaries who qualify for full Medicaid benefits are known as full dual-eligible beneficiaries (or “full duals”). Because full duals have few, if any, out-of-pocket expenses associated with their Medicare and Medicaid coverage, most of them have coverage through Original Medicare. However, some full dual beneficiaries may choose to enroll in a MA plan.

Some Medicare beneficiaries may qualify for the Medicare Savings Program called “Qualified Medicare Beneficiary,” or QMB. Similar to the full dual-eligible beneficiaries, those with QMB have lower out-of-pocket costs associated with their Medicare coverage, and most of them have coverage through Original Medicare. However, some QMBs may choose to enroll in a Medicare Advantage plan.

Both full duals and QMBs receive assistance from Medicaid to pay for certain costs associated with Medicare Advantage plans. These costs include:

- Medicare premiums
- Deductibles
- Coinsurance and copayments (except for Part D copayments)

Enrollment of full duals and QMBs into some Medicare Advantage (MA) plans can be problematic. Not all MA plans have a contract in place with the state Medicaid office. Without such a contract, payment to providers for services received by enrollees may not occur as it should. When these beneficiaries receive covered services from a provider, the provider bills the MA plan for the services. If the plan does not have a contract with Medicaid, the claim is not always submitted by the provider to Medicaid for payment. The provider then may end up billing the beneficiary for the copayment charges that, for other Medicare beneficiaries, would be associated with the service. **Many times beneficiaries pay out-of-pocket for these charges, not realizing that they are protected by law from being charged these cost-sharing amounts and that Medicaid should cover these costs.**

Marketing Overview – Medicare Advantage and Medicare Part D

The Centers for Medicare & Medicaid Services (CMS) has set Marketing Guidelines for Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). Providers, such as pharmacies and all other entities that contract with MA plans, must also follow a set of Marketing Guidelines.

Congress took steps in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 to address several problematic marketing activities. MIPPA and related CMS rules and guidance deal with unsolicited contacts with Medicare beneficiaries, providing meals to prospective enrollees, and the use of unlicensed sales agents. CMS also issued new guidance on co-branding, appointments to market MA plans

Medicare Part C

to prospective enrollees, and agent and broker compensation. The entire list of requirements is available at <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>.

It is important for SHICK counselors and Medicare beneficiaries to recognize and report to CMS activities or behaviors that do not meet the Marketing Guidelines.

Marketing for the next plan year may not begin until MA organizations and Medicare drug plan sponsors receive notice from CMS that they have an approved contract to offer in the coming year, but not before October 1 of the current year. Prior to this marketing period, plans may only provide educational material or presentations to eligible Medicare beneficiaries, that is, with no intent to enroll potential members.

Co-Branding with Providers or Downstream Entities

Plans/Part D sponsors that choose to co-brand with providers/pharmacies may include the name and/or logo of co-branded providers/pharmacies on materials other than enrollee ID cards as long as the Plan/Part D sponsor makes it clear to beneficiaries that the providers/pharmacies are part of the plan's network. In addition, Plans/Part D sponsors must include the appropriate model disclaimer on co-branded materials.

Names and/or logos of co-branded providers on the plan's enrollee ID card are prohibited, unless the provider names and/or logos are in the name of the plan name and/or are related to an enrollee's selection of a specific provider/provider organization, (e.g., physician, hospital, medical group).

Part D sponsors are prohibited from displaying the names and/or logos of co-branded pharmacies on the Part D sponsor's enrollee ID card.

Cross-Selling

A CMS rule prohibits MA and Part D drug plans and their representatives from marketing non-health care related products (such as annuities and life insurance) to prospective plan enrollees during sales activities or presentations. The rule's purpose is to prevent confusion that Medicare health plans and non-health related financial products are part of the same package. Plans may, however, sell non-health related products on inbound calls when a beneficiary asks for information about them.

Marketing Materials

All materials used in promoting and selling a MA plan or a Medicare drug plan and for enrollment are subject to CMS rules and restrictions on marketing. Separate CMS rules govern the materials that plans use for different phases of the marketing process.

- Advertising
- Advertising, as governed by CMS rules, includes the following methods:
 - Television ads
 - Radio ads
 - Banner ads
 - Outdoor advertising
 - Print ads
 - Internet advertising
 - Direct mail (including enrollment forms or materials)

Pre-Enrollment Materials

CMS has a specific set of rules to govern the marketing materials that MA organizations and Medicare drug plans use prior to enrollment. These are called "pre-enrollment materials."

Summary of Benefits

The Summary of Benefits (SB) is the main means that a MA organization or Medicare Drug Plan uses to provide current enrollees and eligible individuals wide-ranging information about a plan's structure, coverage, benefits, and costs.

The SB is a standardized document with four sections:

- An introduction and beneficiary information: This section includes standard language that applies to all MA organizations and Medicare Drug Plans and must be included verbatim in the SB.
- A benefit comparison matrix: This section of the SB includes a chart of benefits offered by the MA or Drug plan. The benefits included on the chart are pulled from a list of commonly available benefits.
- An optional free-form text area: This section includes information about the plan's benefits not included elsewhere in the SB.
- Special Needs Plans (SNPs) for dual-eligible beneficiaries must provide each prospective enrollee a written statement describing
 - Benefits the individual is entitled to under Medicaid
 - Cost-sharing protections the individual is entitled to under Medicaid
 - Which of these benefits and cost-sharing protections are covered under the SNP

Dual-Eligible Outreach

MA organizations have the option to conduct outreach to enrollees about the Medicaid and Medicare Savings Programs (MSPs) which assist Medicare beneficiaries who qualify for the programs with some health care costs. MA organizations providing such outreach programs must submit plans to CMS for approval.

If a MA organization chooses to provide such outreach to enrollees, it must follow CMS-established guidance to be effective and to protect enrollees. MA plans must:

- Provide outreach for all levels of assistance
- Clarify that providing financial information is optional
- Clarify that MSPs are part of the Medicaid program
- Confirm the plan will protect the privacy of information provided to the plan
- Explain that the plan's initial assessment of eligibility is not final; the State Medicaid Agency makes the final determination
- Provide follow up information for enrollees that the MA plan determines are not eligible for assistance
- Adequately train staff to conduct outreach
- Provide alternate sources of information for assistance
- Ensure privacy guidelines are followed
- Coordinate with CMS's regional offices MA plans providing such outreach may:
 - Conduct outreach to a portion of enrollees rather than the entire enrollee population
 - Provide hands-on assistance to the enrollee in completing applications
 - File an Authorization of Representative form to help enrollees apply for assistance with the state

Medicare Part C

- Follow up with enrollees who do not respond to initial attempts to contact for such outreach
- Assist enrollees to reapply for benefits when necessary
- Subcontract outreach to another entity

MA plans providing outreach to enrollees may not:

- Solicit potential enrollees door-to-door or through other means of direct contact including cold calls, without an enrollee initiating the contact
- Share private financial information with other entities not involved in the outreach process
- Use enrollees' financial information for any purpose other than to provide an initial screening for assistance programs
- Continue to contact enrollees who have refused outreach assistance
- Imply to enrollees that the plan has final authority to decide eligibility for such programs

Marketing Review

With few exceptions, MA plans and Medicare drug plan sponsors must submit all of their marketing materials to CMS for review and approval prior to use.

Special Guidelines

Requirements for Marketing to Populations with Special Needs

Organizations offering MA and Medicare drug plans must make marketing materials available in any language spoken as a primary language by more than ten percent of residents within a plan's service area. Plans also must provide a service through their toll-free call centers to assist beneficiaries who speak a language other than English.

Plans must accommodate enrollees with visual impairment by providing appropriate basic enrollee information materials. Any Medicare beneficiary eligible to enroll in a MA or Medicare drug plan, including those with disabilities, must have appropriate assistance from the plan to access information.

Plans must submit materials in languages other than English (including Braille) with an English translation as well as a signed and certified letter to demonstrate that the translation is suitable.

Anti-Discrimination

The law prohibits Medicare Advantage organizations and Medicare drug plan sponsors from discriminating on the basis of:

- Race
- Ethnicity
- Religion
- Gender
- Sexual Orientation
- Health Status
- Geographic Location

With a few exceptions, a plan's services must be offered to all enrollees in the plan. A few examples of these exceptions include gender-specific services and certain services for those with specific diagnoses.

Promotional Activities

CMS has established specific rules about many aspects of MA and Medicare drug plan promotion. It is important to note that CMS guidance issued in September 2008 clarified a distinction between “educational events” and “marketing (or sales) events.” Several important restrictions on sales activities apply to plans involved in educational events. CMS’s marketing rules, designed to protect beneficiaries from undue sales pressure and misleading information, apply to the following activities:

Nominal Gifts

Plans may provide small gifts of nominal value (\$15 retail) to potential enrollees who attend a marketing or sales presentation. Plans must provide any nominal gift to any eligible beneficiary and cannot make the gift conditional on enrollment in the plan. Plans advertising any free gifts must include disclaimers that there is no obligation to enroll in the plan. Nominal gifts may not be in the form of cash or other monetary rebates even if their worth is \$15 or less.

If a nominal gift is a chance to receive one large gift or a communal experience (e.g., a concert, raffle, drawing), the total fair market value must not exceed the nominal per person value based on anticipated attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than \$150 (\$15 for each of the 10 anticipated attendees). Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation.

Hold Time Messages

An MA plan or Medicare drug plan may use health-related information as part of the messages played while on hold with the plan’s toll-free call center. Information may not be presented during these messages about non-health related services, for example, other lines of insurance.

Referral Programs

Plans may offer small, nominal gifts to plan members who refer potential enrollees to the plan. The rules limit these gifts to one per year for any plan member, and are subject to the same limitations as other nominal gifts (e.g., retail value less than \$15). Plans may solicit such referrals from their enrollees during the year.

Educational Events

MA and Medicare drug plans cannot engage in sales activities, including the distribution of marketing materials or the collection of plan applications, at educational events. Typically, educational events include health information fairs and other state or community-sponsored events that the event sponsors promote as being educational in nature. MA and Medicare drug plans and other organizations may sponsor educational events. According to CMS, the purpose of an educational event is to provide objective information about the Medicare program and issues such as wellness and prevention. CMS guidance says that the plans should not use educational events to steer or attempt to steer beneficiaries “to a specific or limited number of plans.”

Organizations that sponsor or participate in educational events must add a notice on advertising materials saying that the event is “educational only and information regarding the plan will not be available.” In contrast to educational events, sales events are those that have the purpose of marketing to potential members or steering potential members to a specific or limited number of plans.

Health Fairs and Health Promotion Events

MA organizations or Part D plan sponsors may take part in health fairs either as a sole-sponsor or as a cosponsor. At sole-sponsor events, such plans may offer door prizes, or similar items, with a value less than \$15. At multiple-sponsor events, plans may exceed the \$15 limit if they contribute to a larger prize offered by multiple contributors. CMS prohibits sales presentations and enrollment at health fairs and health promotion events.

CMS-Sponsored Health Information Fairs

CMS is required to sponsor informational events about MA and Part D plans. The agency permits MA plans and Part D plans to participate. At these health fairs, plans may assist in planning, distribute information and applications, have a booth, distribute nominal gifts, contribute funding to the cost of the fair, and market multiple lines of business. CMS does not, however, permit plans to make sales presentations, collect enrollment forms, collect names or addresses of beneficiaries, compare benefits to other plans, use third-party materials, or provide gifts larger than \$15.

Exclusion of Meals as a Nominal Gift

Plans/Part D sponsors may not provide or subsidize meals at sales/marketing events. Refreshments and light snacks may be provided. Plans/Part D sponsors should ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being “bundled” and provided as if a meal. Meals may be provided at CMS-defined educational events and other events that would fall under the definition of communications.

Provider Promotional Activities

Providers may be involved in some activities to promote MA and Part D plans. This section refers to providers, including pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

Providers in the Health Care Setting

- Providers may have general discussions with beneficiaries about potential plan options.
- Providers may make available marketing materials to their patients as long as they make them available for all MA plans with which a provider participates.
- Providers cannot accept enrollment applications.
- Providers may not persuade beneficiaries to join a MA plan.
- Providers may not offer anything to a beneficiary in return for enrolling in a MA plan.
- Providers may refer their patients to other sources of information, including SHICK.

Plans in the Health Care Setting

- MA and Part D plans may not conduct sales activities in health care settings, except in common areas such as hospital and nursing home cafeterias, community or recreational rooms, or conference rooms.
- Plans cannot conduct sales presentations and distribute or accept enrollment applications in areas where patients primarily receive health care services, including waiting rooms, exam rooms, hospital patient rooms, dialysis center, and pharmacy counter areas.
- Plans may not mislead or pressure beneficiaries into participating in the presentation.

Medicare Part C

- Plans may only schedule marketing appointments with long-term care nursing facility residents when a beneficiary requests it.

Provider Affiliations

- Providers may announce new affiliations for specific MA and Part D plans through general advertising.
- Any materials found within the provider's location that list a provider's MA or Part D plan affiliations must include all such plans.

Health Fairs

- Providers may distribute marketing materials (not including MA or Part D enrollment applications) at health fairs.
- Providers may present general education about MA and Part D plans at health fairs.

Agent and Broker Guidance

People employed by or contracting with a Medicare Advantage organization or Part D sponsor are governed by a set of rules concerning their behavior and activities. The organization employing or contracting such sales agents is responsible for the activities of these agents. State insurance departments also regulate agents and brokers. This means that agents are subject both to plan and state oversight. One variable in this arrangement is that the effectiveness of oversight often depends on the strength of a state's insurance department.

No person marketing a MA or Part D plan may choose to market to or selectively enroll healthier beneficiaries. This discriminatory practice is called "cherry picking" and is not allowed in the marketing of MA or PDP plans.

Licensed and Trained Marketing Representatives

CMS requires MA and Part D plans to use only those agents, brokers, and sales representatives who are licensed, certified, or registered under state law to market their products. CMS further expects plan sponsors to follow a state's appointment process to inform the state insurance regulators of the representatives they have appointed to market plans on their behalf, as well as to report the termination of any agents or brokers. In addition, plan sponsors must ensure each year that brokers and agents who sell Medicare products are trained on Medicare rules, regulations, specific plan details, and that they pass a test with a score of 100%.

Agent and Broker Compensation

CMS is aware that MA and Part D plans offer compensation to agents and brokers who market these plans to beneficiaries, and that some plans' compensation structures have led to "churning," a prohibited sales practice in which an agent or broker enrolls a beneficiary in a new MA or Part D plan each year to take advantage of higher first year commissions. While compensation structures may differ among types of plans (e.g., MA versus MA-PD), Medicare law now requires plans to create compensation systems that create incentives for agents and brokers to enroll beneficiaries in the MA or Part D plan that best meets their health care needs. In short, compensation systems that create incentives for agents or brokers to move beneficiaries between different MA and/or PDP plans are prohibited. CMS rules limit agent or broker compensation for a beneficiary's annual renewal in a MA or Part D plan to half the compensation

paid for the beneficiary's first year as a plan member. The rule also requires that compensation paid to agents and brokers reflect fair market value based on commissions paid in past years (with inflation adjustments allowed). CMS will review the plans' compensation structures annually, and plans cannot change their commission rates or compensation structures without CMS approval.

Scope of Appointments (Sales Meetings) with Beneficiaries

MA and Part D drug plans' sales representatives, including agents and brokers, may not market any health care related product during an individual marketing appointment beyond the scope of topics that the beneficiary agrees to discuss. This rule requires plans and their sales representatives to document, in advance of a personal sales meeting, the scope of the beneficiary's interest in discussing different MA and Part D plan options. The rule applies to marketing appointments with both current and prospective plan members. CMS expects plans to confirm that a beneficiary wants to talk about stand-alone Part D prescription drug plans or Medicare Advantage plans, or both. Plans may document a beneficiary's consent through a signed appointment form, a recording, and other verifiable means.

Marketing through Unsolicited Contacts

CMS rules prohibit MA and Part D plans from making unsolicited contact with prospective enrollees outside of advertised educational or marketing events. The rules apply to both door-to-door and telephone marketing activities.

Door-to-Door Solicitation

MA organizations and Medicare Part D sponsors cannot market their plans door-to-door without a beneficiary's invitation to do so. Similarly, agents and brokers cannot visit or call beneficiaries who attended an event unless the beneficiary gave permission for the follow-up contact at the event.

Unsolicited Email Policy

Generally, MA and Part D organizations may not send unsolicited emails to beneficiaries. If beneficiaries request email from a plan, the organization is permitted to do so.

Outbound Marketing Calls

Rules prohibit MA and Part D plans and their sales representatives from making outbound calls to potential enrollees, without the beneficiary first initiating the contact. Plans may not conduct or allow unsolicited contacts under the guise of selling another product such as Medicare Supplement policies, a needs assessment, or a review of Medicare coverage options to which CMS's unsolicited contact rules do not directly apply. The prohibition on outbound calls does not apply, however, to Medicare Supplement marketing. Thus, the plan sponsors must walk a fine line because the rules allow sales representatives to make outbound calls specifically to market Medicare Supplement policies and to discuss MA and Part D products if the beneficiary expresses an interest in them.

CMS, however, allows plans to contact beneficiaries who are already plan members to discuss other products. In the same way, agents and brokers may contact beneficiaries who they previously enrolled in a MA or Part D plan to discuss plan issues and to market other plan options. Agents also can initiate phone calls to confirm an appointment to which a beneficiary has already agreed. Otherwise, agents cannot make unsolicited phone calls to other beneficiaries or plan members, and plans cannot make unsolicited

Medicare Part C

contacts with former plan members who have disenrolled or with current members who are in the process of disenrolling voluntarily.

Enrollment via Inbound Telephone

MA organizations and Part D plan sponsors may not enroll beneficiaries during outbound calls (telemarketing). Furthermore, they cannot transfer outbound calls to inbound lines to proceed with enrollment. During an appropriate enrollment call, the plan may not collect (or request) credit card or bank account numbers.

Beneficiaries who would like to enroll in a MA or Part D plan during an appropriate enrollment period may call the plan directly to do so.

IMPORTANT REMINDERS

People in Medicare Advantage plans are:

- Still in Medicare program
- Still have Medicare rights and protections
- Still get all regular Medicare-covered services
- May get extra benefits like routine vision, hearing, dental care
- May be able to get prescription drug coverage

Chapter 5 - MEDICARE PART D

The Medicare Modernization Act (MMA) of 2003 created the Medicare Part D prescription drug program, with coverage first available in 2006. The MMA's main purpose is to provide prescription drug coverage to Medicare beneficiaries through private insurance companies called plan sponsors. People with Medicare Part A, Part B, or both, are eligible to join a Part D drug plan of some kind.

Plan Sponsors

There are two ways to get Medicare drug coverage through these plan sponsors:

- Through stand-alone Prescription Drug Plans (PDPs).
- Through a Medicare Advantage (MA) plan, or health plan, that operates under Medicare Part C.

The Standard Benefit Design

The federal government does not sponsor its own standard benefit drug plan. Rather, the MMA establishes a standard prescription drug coverage benefit design. The standard coverage design has an annual deductible, a 25% coinsurance amount, and a coverage gap which are established by law. Few plan sponsors offer a Part D drug plan that conforms exactly to the standard coverage model. The MMA also allows Part D plan sponsors to use the standard coverage design as a baseline for other Part D drug plans with many different coverage features. These include plans that are actuarially equivalent to the standard coverage benefit but have tiered copayments instead of the 25% coinsurance charge. Some plan sponsors also offer Part D plans, called alternative prescription drug coverage, that go beyond the coverage of standard plans. The plan sponsors, within broad guidelines, set the premiums, cost-sharing amounts, and coverage limits for their Part D plans. The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicare, approves these private drug plans for inclusion in the Part D program using the standard coverage model as a baseline for coverage.

Access to Drugs

The MMA requires all Part D drug plans to provide access to medically necessary medications including generic and brand name drugs. Under Medicare rules, Part D drug plan formularies must cover at least two drugs within each diagnostic or therapeutic class. Many plans cover more than two drugs in each class, though most plans do not have open formularies that cover all possible prescription medications.

The MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs that are covered by Medicare Part A or Part B, such as chemotherapy drugs. Other drugs that are generally excluded from Part D coverage are in the section on formularies.

Creditable Coverage and Late Enrollment Penalties

Enrolling in the Part D program is voluntary. The MMA established defined time frames when beneficiaries can enroll in and/or disenroll from a Part D drug plan. A decision not to join a Part D plan during an available enrollment period may result in late enrollment penalties added to the monthly premium for those who do not have existing creditable coverage. Creditable coverage is drug coverage that is financially equal to or better than Medicare's standard drug benefit. This means people without creditable coverage who are eligible to join a Part D drug plan but choose not to do so may pay higher monthly premiums when they eventually sign up. In contrast, people with creditable coverage can keep their current coverage without penalty if they join a Part D drug plan later.

Low-Income Subsidy or Extra Help

For people with limited financial means, the MMA established the low-income subsidy (LIS) or “Extra Help” program to help pay the premiums and other out-of-pocket costs connected with the Part D plans. The LIS is available for Medicare beneficiaries receiving Medicaid benefits, for those enrolled in one of the Medicare Savings Programs (MSPs), and for those whose monthly income is at or below 150% of the Federal Poverty Level (FPL). All who meet the income criteria must meet also certain guidelines in countable assets from all sources. The Social Security Administration (SSA) processes applications for the LIS program. When beneficiaries are found eligible for the LIS program, Medicare directly pays their drug plans for some or all of their Part D costs, including premiums, deductibles, and coinsurance charges or copayments.

Types of Drug Plans - Two Main Categories

The Part D prescription drug benefit is available only through Medicare-approved plans from private insurance companies called “plan sponsors.” The MMA authorizes the plan sponsors to offer two major types of Medicare Part D drug plans. These are Prescription Drug Plans (PDPs) and Medicare Advantage plans with Part D (MA-PDs). The law gives plan sponsors significant room to design PDPs and MA-PDs with varied cost-sharing and formulary features. This section describes the two main types of plans and some of the variations federal law allows.

Prescription Drug Plans (PDPs)

PDPs are stand-alone plans that offer only prescription drug benefits under Medicare.

- Beneficiaries in Original (traditional, fee-for-service) Medicare for their Part A and Part B coverage and those in certain Medicare health plans such as PFFSs, MSAs, and Cost plans, would use this option.

Medicare Advantage Plans with Part D (MA-PDs)

- MA-PDs offer a Part D prescription drug benefit along with other Medicare-covered benefits including physician, hospital, diagnostic, home health care, and durable medical equipment services, through contracted provider networks. Beneficiaries still must pay their Part B premiums and they do have Medicare. Enrolling in Medicare Advantage essentially is an alternative to Original Medicare. The MAPD delivers Medicare benefits and serves as a primary insurer.

Plan Variations

Standard and Alternative Coverage Designs

Guidelines for the four varieties of Medicare Part D plans are set forth in CMS’s *Medicare Prescription Drug Benefit Manual (PDBM)* – <https://www.cms.gov/medicare/prescription-drugcoverage/prescriptiondrugcovcontra/partdmanuals.html>.

1. ***Defined Standard*** prescription drug coverage benefit design. CMS approves all other drug plan benefit designs based on the value of this standard, defined coverage.
2. ***Actuarially Equivalent*** standard plan. Both this plan and the defined standard plan have the same annual deductible. The main difference between these two types is the actuarially equivalent plans have tiered copayments rather than a 25% coinsurance charge. In its *PBDM*, CMS refers to both of these standard designs as “basic” drug benefit types.

3. **Basic Alternative** plan. The basic alternative plans must be equal in value to standard plans but may have lower deductibles and different cost-sharing structures.
4. **Enhanced Alternative** plan. This plan has supplemental benefits that may include reduced cost-sharing amounts and broader formularies. Monthly premiums for alternative and enhanced plans are sometimes higher than those for standard plans.

The drug plans themselves vary considerably in terms of monthly premiums and cost-sharing structures—some use set copayments and others have percentage-based coinsurance charges. It is important to note that many specific features of these plans change from year to year, including the premiums, annual deductible, and coverage limits. Plan sponsors also can alter the cost-sharing structures, the scope of their formularies, and their cost-control systems. CMS and the plan sponsors agree to their Part D contracts on an annual basis.

Defined Standard Plan (Basic Benefit)⁴

The MMA defines the costs of the standard benefit as a plan with:

- A monthly premium
- An annual deductible
- A 25% coinsurance for the cost of covered drugs up to an initial coverage limit
- A coverage gap (“doughnut hole”) in costs for covered drugs
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year

Defined Standard Plan (Basic Benefit)			
<input checked="" type="checkbox"/>	What you pay		
<input type="checkbox"/>	What Medicare pays		
		25% brand names	5%
		25% generics	
100%	25%	5% brand names	95%
	75%	75% generics	
Deductible	Initial Coverage Level	Coverage Gap	Catastrophic Coverage

Actuarially Equivalent Standard Plan (Basic Benefit)

The MMA defines the costs of the actuarially equivalent standard benefit as a plan with:

- A monthly premium
- An annual deductible
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to the initial coverage limit

⁴ Annual cost-sharing amounts are available in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.

Medicare Part D

- A coverage gap (“doughnut hole”) in costs for covered drugs
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year

Basic Alternative Plan (Basic Benefit)

The MMA defines the costs of the basic alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit.
- A coverage gap (“doughnut hole”) in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year

Enhanced Alternative Plan (Enhanced Benefit)

The MMA defines the costs and coverage of the enhanced alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit.
- If included, a coverage gap (“doughnut hole”) in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans. Some enhanced alternative plans will offer some coverage throughout the coverage gap
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copay for a generic or preferred drug and a higher copay for other drugs for the rest of the year
- Formularies may be broader, and may cover drugs that are generally excluded from Part D coverage

When counseling clients about which type of plan to choose, it is important to understand the major differences between these four Part D plan designs. This information about each plan is available each year on the Landscape of Plans. Note that the *Medicare Prescription Drug Plan Finder* (Plan Finder), available at <http://www.medicare.gov>, does not distinguish plans in this way.

Eligibility and Enrollment

Given all the choices available for Medicare prescription drug coverage, it is essential for SHICK counselors to help clients determine whether they can enroll, whether they want to enroll, how to enroll, and when to enroll in a Medicare drug plan. The first step in the process is to ask if your client is enrolled in Medicare. Anyone who has Medicare Part A and/or Part B is eligible for a Part D plan.

Deciding to Enroll in a Part D Plan

Everyone who is eligible for Part D has a choice to make about whether to enroll in a Part D drug plan. That choice depends largely on whether they have other health insurance that covers prescription drugs.

Medicare Part D

For clients who currently have no coverage for prescription drugs, enrolling in Part D can save them money over time. On the other hand, clients who already have prescription drug coverage face a different set of options based on if and how their current coverage works with Part D.

It is important for all Medicare beneficiaries to make informed decisions about their drug coverage.

Medicare beneficiaries with the following types of coverage have special considerations:

- Retiree or union coverage
- Veterans Administration (VA) and/or TRICARE for Life
- Federal Employee Health Benefit Program (FEHBP)
- Medicaid
- Medicare Savings Programs (QMB, LMB, ELMB)

Creditable Coverage

- For beneficiaries with existing insurance coverage for prescription drugs, it is important to learn if that coverage is “creditable.” Creditable coverage means that the insurance benefit is as good as—or better than—the coverage in Medicare’s basic benefit.
- The drug coverage in many retiree or union health plans, TRICARE for Life, the VA, and the Federal Employee Health Benefit Program (FEHBP) is creditable coverage. The drug coverage in three standardized Medigap insurance policies (Plans H, I, and J) sold between 1992 and 2004 is not creditable, but the drug coverage in some Medigap policies that pre-date 1992 is creditable. Similarly, the drug coverage in some Medigap policies sold through 2005 in Massachusetts, Minnesota, and Wisconsin is creditable. If the policy was issued before 1992 (or before 2006 in the three states), contact the benefits administrator at the insurance company to ask whether the benefit is considered creditable.
- The MMA requires insurers to notify people annually about the creditable status of their health plans. This notice may be an official letter, or it may appear in a health plan update, such as a newsletter. It is important for your clients who have creditable coverage to keep these notices in a safe place for possible future reference. Another way to get information on creditable coverage is to call the benefits office for the retiree health plan.
- People who have creditable coverage for prescription drugs do not need to enroll in a Part D drug plan, perhaps ever. It is also important to know that some people who have creditable coverage through an employer or union health plan could permanently lose their retiree health benefits if they enroll in a Part D drug plan. Under the terms of some group insurance contracts, retirees may lose all their health benefits and forfeit their creditable coverage (along with spousal coverage) by enrolling in other coverage, like a Medicare drug plan.

Late Enrollment Penalty (LEP)

CMS charges a late enrollment penalty to Part D-eligible beneficiaries when they do not have a Part D plan or creditable coverage. The penalty is assessed if, and when, these beneficiaries enroll in Part D. CMS calculates the penalty based on the number of months an eligible beneficiary was not enrolled in Part D or other creditable coverage.

Some people choose not to enroll in Part D because they have no prescription drug costs now, or they are overwhelmed by the process. Because of the potential for penalties, it is very important for you and your

clients to know whether their current coverage is creditable. One group exempt from the penalty is those eligible for the low-income subsidy—they will not have a late enrollment penalty.

ENROLLMENT: CONSIDER THE THREE C's

Coverage – What are the beneficiary's drug needs NOW? Medicare drug plans cover generic and brand name drugs. All plans must cover the same categories of drugs, but plans can choose which specific drugs they will cover in each drug category. Beneficiaries should check to see which plans cover their prescription drugs.

Cost – What will the beneficiary pay out-of-pocket, including premiums? Monthly premiums and beneficiaries' share of the cost of prescriptions will vary depending on which plan they choose. If they have limited income and resources, they may qualify for extra help from Medicare in paying their drug plan costs.

Convenience – What pharmacies does the beneficiary want to use? Do they honor the plan that has the coverage the beneficiary needs at a cost he/she can afford? Drug plans must contract with pharmacies in each area. Beneficiaries should check with the plan to make sure the pharmacies in the plan are convenient to them. Some plans will also allow them to get their prescriptions through the mail.

How to Select a Plan

There are many factors to consider for beneficiaries who decide to enroll in a Part D plan. Dozens of plans are available in most areas of the country. SHIPs use a number of factors to help narrow down the list of possible plans for each person they assist. This keeps the process more manageable and also helps beneficiaries choose a plan because the list of appropriate plans is often a good deal shorter than the list of all plans. To help them choose the most appropriate plan, bear in mind the following categories:

Access to Needed Drugs

One factor to consider when selecting a Part D drug plan is the extent to which the plan provides coverage for needed drugs. It is important to compare the beneficiary's prescribed medications to Part D plans' formularies (i.e., lists of covered drugs). Because many Part D plans are available to most beneficiaries, using the formulary to narrow down that list of plans is a helpful practice.

After filtering out Part D plans that do not include all of a beneficiary's medications on their formularies, there are other factors to consider related to the formulary. Specifically, Part D plans may apply utilization management tools to certain drugs on their formularies. Some examples of these tools include prior authorization, step therapy, and quantity limits. Since utilization management may make it more difficult for enrollees to access their needed prescriptions, it is important to consider this factor when comparing the plans' formularies.

Access to Pharmacies

Another factor to consider is the plans' pharmacy networks. It is important to check if a beneficiary's preferred pharmacy is in the plan's network, and if not, to make sure that convenient alternatives exist. Plan networks are important because Part D plans will not pay for prescriptions at non-network pharmacies, except in emergencies. A drug plan's network pharmacies may change from year to year. Some drug plans also have "preferred pharmacies" within the network that offer lower prices than other network pharmacies.

Medicare Part D

Other pharmacy access concerns include alternative methods of getting prescriptions. Many plans offer a mail-order program, though the law does not require it. All plans must allow access to home infusion pharmacies and to long-term care (LTC) pharmacies for those who reside in LTC facilities.

Plan Costs

Most beneficiaries will consider costs and prices when selecting a Part D plan. The total yearly costs of being enrolled in a Part D plan depend on the monthly premium, annual deductible, copayments or coinsurance for each drug, and any drug costs that the beneficiary will owe in the coverage gap. Monthly premiums range significantly. Deductibles will also range in cost annually. A deductible is the amount that an enrollee must spend out-of-pocket on formulary drugs before the plan begins to pay its share of the costs for each prescription filled. Finally, the Plan Finder lists the cost of each drug covered by Part D plans.

Beneficiaries who qualify for LIS have different cost considerations. Most of these beneficiaries have access to premium-free plans with no annual deductible, reduced or eliminated cost-sharing for each drug, and no coverage gap. Remember, though, that plan formularies will vary, so not all premium-free plans are appropriate for all LIS beneficiaries.

Other Considerations

Beneficiaries in the process of selecting appropriate Part D plans may consider other factors before enrolling in a plan. One consideration for these beneficiaries is service area. A plan's service area includes the counties, states, regions, or territories in which an enrollee may use the plan. Some plans are national, meaning their service area is nationwide. Others are regional and have geographic limitations on their pharmacy networks.

Another factor beneficiaries consider is the quality information that CMS makes available about each plan. The Plan Finder shows quality information for the following categories: drug plan customer service, member complaints and staying with drug plan, member experience with drug plan, and drug pricing and patient safety. These quality measures offer beneficiaries a source of objective information which they can use to compare plans.

An additional factor for beneficiaries to understand is the concept of lock-in. Beneficiaries who opt to join Part D plans should understand that after enrollment, they may have only limited opportunities to make changes to their coverage. Once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year. This lock-in feature does not apply to beneficiaries who have a Special Enrollment Period.

Enrollment Periods

The MMA does not allow most beneficiaries to enroll in or disenroll from Part D plans at any time. Most beneficiaries have limited time frames to enroll in, disenroll from, or switch Part D plans. Two notable exceptions are beneficiaries who qualify for LIS and beneficiaries living in long-term care facilities. Beneficiaries with LIS may make quarterly changes. Beneficiaries in LTC facilities may make monthly plan enrollment changes.

There are three enrollment period categories: initial, annual, and special. A beneficiary's first chance to enroll in Medicare, and thus to join a Medicare drug plan, is called the Initial Enrollment Period (IEP). The

Medicare Part D

yearly scheduled enrollment period, annual Open Enrollment Period (OEP), is a set time of year when the law permits beneficiaries to change their Part D plans. Special Enrollment Periods (SEPs) enable beneficiaries under specific circumstances to make plan changes outside of initial or yearly opportunities. SEPs are designed, for example, to permit beneficiaries who move out of a plan's service area or into a long-term care facility to make changes.

Initial Enrollment Period (IEP)

Generally, an individual becomes eligible for Medicare on the first day of the month of the individual's 65th birthday or the 25th month of disability. The three months before, the month during, and the three months after this eligibility date are known as the Part B Initial Enrollment Period (IEP). This time frame is also the IEP for Part D benefits. Beneficiaries who do not enroll in a Medicare drug plan during their IEP generally will not be able to enroll in a plan until the following annual Open Enrollment Period (OEP), unless they qualify for a special enrollment period, or SEP. Note that if a beneficiary does not have creditable drug coverage and does not enroll in a Medicare drug plan during the IEP, he will likely have a late enrollment penalty added to his Medicare drug plan's premium if and when he enrolls.

Initial enrollment for Medicare works differently for some people with disabilities. For those with end stage renal disease (ESRD), beneficiaries must file a written application for those benefits when they become eligible. Those who have had a kidney transplant and those who have had kidney dialysis for three months are entitled to Medicare Part A. Part D eligibility begins upon entitlement to or enrollment in Medicare Part A and/or Part B. Thus, upon filing an application for Medicare Part A coverage, beneficiaries are entitled to enroll in a Part D plan.

Part D eligibility and enrollment for those with Amyotrophic Lateral Sclerosis, (ALS), is more like the process for those with disabilities. The 24-month waiting period that applies to most beneficiaries with disabilities does not apply to those with ALS. These individuals have a 5-month waiting period; their Part A coverage begins on the sixth month of the ALS disability. Thus, these beneficiaries have seven months of a Part D IEP. Their IEP begins in the second month of ALS disability and continues to three months past the month their Part A benefits begin.

Yearly Opportunity for Enrollment: AEP

Beneficiaries who already are enrolled in Medicare may enroll in a plan, change plans, or disenroll from their current plan during the annual Open Enrollment Period (OEP). The OEP runs from October 15 through December 7 each year. A decision to enroll or disenroll during the OEP is effective usually for the entire calendar year starting on January 1. Beneficiaries who make more than one enrollment choice during the OEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change their minds throughout the OEP. While this may be helpful for some individuals, keep in mind that other insurance sales agents can undo a plan selection made during an earlier SHICK counseling session with a client.

Special Enrollment Periods (SEPs)

Special Enrollment Periods (SEPs) enable Medicare beneficiaries to make Part D plan enrollment changes in special situations. Special enrollment periods constitute periods outside of the usual IEP for Part D or AEP when an individual may elect a plan or change his or her current plan election. There are various

Medicare Part D

types of SEPs, including SEPs for dual-eligible individuals, for individuals whose current plan terminates, for individuals who change residence and for individuals who meet exceptional conditions.

Change in Residence

Beneficiaries have the right to a SEP under the four following circumstances related to a change in residence:

- Those with a change in permanent residence that places them outside of their Part D plan's service area
- Those with new Part D and/or MA plans available due to a change in permanent residence
- Those not eligible for Part D because they have been living outside of the U.S. and have returned to the U.S.
- Those not eligible for Part D because they were incarcerated (in jail) and are now released

This SEP has certain notice procedures. For people who notify their plan before their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months. People may request for the effective date of this SEP enrollment to be up to three months after they notify their plan but not earlier than the date of the move.

There are other procedures for those who do not notify their plans of their moves. If the plan learns from CMS (or otherwise) that an enrollee has lived outside of the plan's service areas for more than six months, the enrollee's SEP begins upon discovery of that move and continues for two months after the move.

Dual-Eligible Beneficiaries and Upon Losing Dual-Eligibility

All dual-eligible beneficiaries (including those with both Medicare and Medicaid and those who are in Medicare Savings Programs) have a SEP that begins upon becoming dual-eligible and ends up to two months after losing such eligibility. This SEP allows beneficiaries to enroll in or disenroll from Part D plans, including PDPs and MA-PD plans. The beneficiary is limited to a onetime per calendar quarter election between January through September (three opportunities to change plans). The effective date of the change is the first of the month following the request for the change.

Contract Violation

Part D plan enrollees who demonstrate to CMS that the PDP sponsor violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another Part D plan. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS. CMS also may approve retroactive disenrollment in these cases, depending on the severity of the situation. In considering cases for retroactive disenrollment, CMS will consider certain factors in each case.

Non-Renewals or Terminations

Beneficiaries whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 to January 31 of the next year. In these circumstances, CMS requires these plans to give a 90-day notice to enrollees. The effective date of the enrollment may be on January 1, or February 1, but not before the plan receives the enrollment request.

Medicare Part D

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month past the termination effective date. These plans are required to give a 60-day notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

Involuntary Loss of Creditable Coverage

Beneficiaries who involuntarily lose creditable prescription drug coverage are eligible for a SEP. An involuntary loss includes a reduction in the amount or type of coverage that makes it no longer creditable. A loss of coverage because an individual failed to pay premiums does not constitute an involuntary loss.

This SEP permits enrollment in a PDP and begins with the month in which the individual is advised of the loss of creditable coverage and ends two months after either the loss (or reduction) occurs or the individual received the notice, whichever is later. The effective date of this SEP may be the first of the month after the request or, at the beneficiary's request, may be no more than two months from the end of the SEP.

Not Adequately Informed about Creditable Coverage

Those not adequately informed of a loss of (or that they never had) creditable coverage have a SEP to enroll in a Part D plan (including an MA-PD plan). Established on a case-by-case basis, this SEP begins upon approval from CMS and continues for two additional months.

Error by a Federal Employee

On a case-by-case basis, CMS may grant a SEP to those whose enrollment or non-enrollment in a Part D plan (including an MA-PD plan) is not valid due to the action, inaction, or error of a federal employee, including customer service representatives (CSRs) at 1-800-MEDICARE. This SEP begins upon approval from CMS and continues for two additional months.

5-Star SEP

Under the 5-Star Special Enrollment Period, a beneficiary can join or switch to a 5-Star MA plan (with or without drug coverage) or a 5-Star PDP in their service area. The time frame for this SEP is December 8 through November 30 of the next year, with an effective date of the first of month following the enrollment request. It can only be used to enroll in plans given an overall 5-star rating for the current calendar year. The Star rating is from the ratings on the Plan Finder. Beneficiaries can only use the 5-star SEP one time during the year. If the beneficiary joins an MA-only plan which allows a stand-alone PDP, they also have a coordinating Part D SEP and can join a PDP for the same month. The PDP doesn't have to be a 5-star plan. However, if they are switching from one MA-only plan to another MA-only plan, they do not have an SEP to switch PDPs.

Exceptional Conditions

- **SEP EGHP:** Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect a Part D plan or vice versa during the period when the EGHP allows plan changes. The effective date of the enrollment may be up to three months after the request for enrollment or disenrollment but not before the plan receives the request.
- **Disenrollment Connected to a CMS Sanction:** If CMS sanctions a Part D plan sponsor and enrollees disenroll due to the issue that led to the sanction, CMS may authorize a SEP on a case-by-case basis for those enrollees.
- **PACE Enrollees:** Part D plan enrollees may disenroll at any time to join a PACE plan. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join Original Medicare and a PDP or an MA plan.
- **Trial Period SEP:** People who drop a Medigap policy to enroll in a Medicare Advantage plan for the first time are entitled to a guaranteed right to return to the Medigap policy they had or if the policy they had is not available, to purchase another Medigap policy within the “trial period,” usually 12 months. The Trial Period SEP permits them to disenroll from an MA plan at any time during this trial period to return to Original Medicare and to purchase the Medigap policy and a PDP. The SEP begins upon disenrollment from the MA plan and continues for two additional months, with an effective date depending on the situation.
- **Retroactive ESRD Entitlement**
- **Retroactive Medicare Entitlement**
- **SEP for Institutionalized Individuals:** Beneficiaries who move into, reside in, or move out of a long-term care (LTC) facility have a SEP that begins upon moving into the LTC facility and lasts through up to two months after moving out of the facility.
- **SEP for Individuals Who Enroll in Part B during the Part B General Enrollment Period (GEP):** Those individuals who are not entitled to premium-free Part A and who enroll in Part B during the GEP (January – March). The SEP begins April 1 and ends June 30, with an effective date of July 1.
- **Beneficiaries Losing Special Needs Status:** Those enrolled in a Special Needs Plan (SNP) who no longer meet the specific special needs status are eligible for a SEP. The SEP begins upon the change in status and continues for three more months.
- **Enrollment in a Chronic Care SNP:** A SEP exists for individuals who qualify for a Chronic Care Special Needs Plan (SNP) to enroll in an SNP. The SEP applies to all beneficiaries who qualify for these SNPs and ends upon enrollment in a plan.
- **Beneficiaries no longer eligible for Medicaid or LIS upon Losing LIS:** Beneficiaries can join a Medicare Advantage or Medicare Prescription Drug Plan, switch from their current plan to another Medicare Advantage or Medicare Prescription Drug Plan, drop their Medicare Advantage Plan and return to Original Medicare, or drop their Medicare prescription drug coverage. The effective date of the change would be the first of the month following the request for the change. Their chance to change lasts for 3 full months from either the date they are no longer eligible or notified, whichever is later.
- **Disenrollment from Part D to enroll in or Maintain Creditable Coverage:** Any enrollee in a Part D plan (including PDPs and MA-PDs) may disenroll at any time from the plan to obtain or maintain other creditable coverage (such as TRICARE or VA coverage). The effective date of disenrollment would be

Medicare Part D

the first of the month following the request. This SEP permits those leaving MA-PD plans also to enroll in an MA-only plan.

How to Enroll

After beneficiaries determine they are eligible for the Part D drug benefit, decide to enroll in a plan during an available enrollment period, and choose an appropriate plan, the next step is to start the process of enrolling. There are several ways to enroll in a Part D drug plan. These include mailing an enrollment form to the plan sponsor, enrolling online, enrolling by phone, and enrolling with a sales representative.

CMS makes it easy for beneficiaries to compare and enroll in Part D plans on the Plan Finder located online at <http://www.medicare.gov>.

Who Can Help a Medicare Beneficiary Enroll?

In most cases a Medicare beneficiary must complete the application to enroll in a Medicare drug plan. CMS's PDP Guidance on Eligibility, Enrollment and Disenrollment explains that anyone other than the beneficiary who completes an enrollment request must state that he or she has the legal authority under state law to execute the enrollment and that the documentary proof of such legal authority will be made available to CMS or the plan upon request.

SHICK counselors who assist Medicare beneficiaries with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. SHICK counselors who assist beneficiaries with Part D plan enrollment are merely facilitating the process. ***Counselors can avoid problems by making sure that they do not indicate that they represent their clients or sign enrollment forms on a client's behalf unless the client is unable to write.*** If clients are not able to write, counselors should follow the standard rules for such cases. This means that the client should make an "X" in the signature box and the witness should write "By" and his name and address with a short description of reason the patient cannot sign.

Disenrolling and Switching

Most Medicare beneficiaries who currently are enrolled in a Part D drug plan may only disenroll from that plan during certain periods: the OEP from October 15 through December 7, certain situations during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31, and applicable SEPs. Generally, once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year.

There are a few ways for a Medicare beneficiary to disenroll from a Part D plan:

- By enrolling in another plan
- By giving or faxing a signed written notice to the PDP sponsor
- By requesting disenrollment online to the PDP sponsor (if the sponsor offers this option)
- By calling 1-800-MEDICARE

Annual Open Enrollment Period (OEP)

During the OEP, Medicare beneficiaries can make only one choice among two options affecting their drug plan enrollment. They either can enroll in a different Part D plan (PDP or MA-PD) or disenroll from their

Medicare Part D

current plan. Enrolling in a different Part D plan effectively switches the beneficiary from one plan to the other.

Medicare Advantage Open Enrollment Period (MA OEP)

A separate yearly open enrollment period for changes related to Medicare Advantage plans is called the Medicare Advantage Open Enrollment Period (MA OEP). It lasts from January 1 to March 31 each year. During the MA OEP, Medicare beneficiaries currently enrolled in a MA-PD or a MA-only have an opportunity to change their Medicare Advantage plan coverage. Enrollment in an MSA plan does not qualify beneficiaries for the MA OEP. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage. Any change made during the MA OEP takes effect on the first of the following month.

Special Enrollment Period (SEP)

During any applicable SEP, a beneficiary may disenroll from a Part D plan. Beneficiaries need only enroll in a new Part D plan to be disenrolled from a previous one. A disenrollment during the SEP does not prevent a beneficiary from subsequently enrolling in another plan if the SEP's timeframe has not expired. The length of an SEP varies according to the situation. People who move out of their drug plan's service area, for example, can have a SEP of up to four months. In contrast, people who move out of a certain type of nursing facility have a SEP that lasts up to two months after discharge.

MA Plans and Part D

Generally, Medicare beneficiaries who want drug coverage and the benefits of a Medicare Advantage plan must select an MA plan that offers Part D prescription drug coverage (MA-PD). This rule is absolute for all coordinated care plans (i.e., HMOs, PPOs, and SNPs). Those beneficiaries enrolled in coordinated care plans who want Part D coverage must enroll in coordinated care plans that have a Part D component—an MA-PD plan. This means that enrollees in coordinated care plans without Part D coverage—MA-only plans—will not have access to drug coverage through Medicare. Furthermore, Special Needs Plans (SNPs) must provide Part D coverage. Thus, all SNPs are MA-PDs, and enrollees have access to Medicare drug coverage through their SNPs.

An exception applies to beneficiaries who are enrolled in certain types of MA plans that do not provide drug coverage, including some PFFS plans, Medicare Cost Plans, and all Medical Savings Account (MSA) plans. Private Fee-for-Service plans may or may not have Part D coverage. For those PFFS plans that are MA-PDs, enrollees must take the Part D coverage that comes with the plan. For those PFFS plans that do not offer drug coverage, enrollees may also enroll in stand-alone Prescription Drug Plans (PDPs) to receive Part D coverage. Additionally, MSAs and Cost plans are not permitted to offer drug coverage, so enrollees in these plans also may enroll in stand-alone PDP plans.

Costs and Prices

Beneficiaries enrolled in both types of Part D plans—PDPs and MA-PDs—will have costs associated with enrollment in those plans. The costs will differ from beneficiary to beneficiary and from plan to plan.

Those who qualify for the low-income subsidy (LIS) receive assistance from Medicare to help cover some or all of these costs that others pay out-of-pocket. ***Throughout this section, for the sake of simplicity, the costs and prices discussed will apply to those beneficiaries who do not qualify for LIS.***

Beneficiary Cost-Sharing

Beneficiaries who are enrolled in Part D plans almost always have cost-sharing responsibilities. These costs generally include the monthly premium, an annual deductible, and copayments or coinsurance for each prescription filled. Above a certain level of out-of-pocket spending, beneficiaries also will have costs in the coverage gap, also known as the “donut hole.” Once beneficiaries have spent to another set level, costs are minimal as there is a level of catastrophic coverage in the Part D plan design.

Monthly Premiums

A premium is a set amount of money beneficiaries must pay each month to a Part D plan to be enrolled in a plan. Monthly premium amounts range widely. Plans with higher premiums sometimes offer enhanced benefits, such as a broader formulary with more access to brand-name medications or coverage for some drugs in the coverage gap.

Beneficiaries have several options to pay the monthly premium to their plan. They can choose to pay the premium directly to the plan by check, money order, a savings or checking account deduction, or electronic payment by phone or through the Internet by using credit cards. Beneficiaries may also elect to have the premium deducted from their Social Security checks. ***Data transfers from the drug plans to CMS and then to SSA can take a few months to process, which can result in up to three months of premiums taken out of a Social Security check at once.***

IRMAA (Income Related Monthly Adjustment Amount) Beginning 2011, the Affordable Care Act required Part D enrollees whose incomes exceed the same thresholds that apply to Part B enrollees to pay an income-related monthly adjustment amount, in addition to their Part D plan premium.⁵

Annual Deductible

A deductible is the amount a beneficiary owes out-of-pocket before the drug plan starts to pay for medications on its formulary. The allowed deductible amount increases each year. Plan deductibles range from \$0 to a maximum amount which changes each year, depending on the type of plan. Some plans have a structure in which certain tiers of their formularies are exempt from the deductible. For example, a plan could allow enrollees to pay reduced cost-sharing for generic drugs, but brand-name drugs are full price until the enrollee reaches the deductible.

Copayments and Coinsurance Amounts

After plan enrollees spend the full amount of a plan’s deductible, they enter the period of coverage known as the “initial coverage period.” During the initial coverage period, Part D plans charge either a copayment or coinsurance amount for each medication that enrollees fill at pharmacies. Each plan sponsor sets the copayment or coinsurance amount, and the amount differs according to the drug plan’s design. Typically, beneficiaries pay this out-of-pocket cost at the time they receive each filled prescription.

Copayments are a flat-rate amount, such as \$5 or \$25, charged to beneficiaries for each prescription. Coinsurance charges are based on a percentage of the total negotiated price of a prescription, such as 25% (as in the case of a basic standard plan). Negotiated prices are the costs for prescription drugs agreed

⁵ Annual cost-sharing amounts are available in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.

Medicare Part D

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. In effect, the negotiated price is the amount paid by Part D plans to pharmacies for each prescription drug filled by a plan enrollee.

True Out-of-Pocket (TrOOP) Costs

True Out-of-Pocket (TrOOP) costs are those that a beneficiary incurs when paying the cost-sharing amounts for covered drugs under a Medicare Part D drug plan. Plans calculate these costs for each enrollee to determine which level of coverage to provide (i.e., deductible, initial coverage period, coverage gap, or catastrophic coverage). TrOOP includes the total amount of any annual deductible paid plus the price paid for each formulary prescription filled. ***Note that the monthly premium does not count towards TrOOP costs.***

It is important for SHICK counselors to understand the relationship between TrOOP costs and the initial coverage limit and catastrophic coverage. As beneficiaries incur costs under their Part D plans, they move closer to the initial coverage limit.

After plan enrollees reach the initial coverage limit measured by total drug spending, they enter the coverage level known as the coverage gap. During the coverage gap, beneficiaries pay a 25% copay for covered drugs unless their plan offers additional benefits in the coverage gap level.

Important Note about TrOOP:

The total amount spent in the gap on plan-covered drug costs includes: the drug costs paid by the beneficiary, the discount on brand-name drugs paid by the drug manufacturer if applicable, and the amount paid by the plan, i.e. Medicare.

When the amount spent on Plan-covered drugs reaches the catastrophic limit, the beneficiary reaches the catastrophic coverage threshold. Beneficiaries with catastrophic coverage pay the greater of five percent of the plans' negotiated drug costs or lower copayments for generics and preferred brand-name drugs and a higher copayment for other brand-name drugs for the remainder of the calendar year. The Part D plan covers 95% or the balance of the cost.

Beneficiaries with LIS also incur TrOOP costs. Their TrOOP includes the amount Medicare pays for formulary drugs for LIS beneficiaries in Part D plans. For those with LIS, Part D plans use TrOOP to determine the point when beneficiaries enter catastrophic coverage. The catastrophic limit is the same for all enrollees' in Part D plans.

A plan must send a statement, called an "Explanation of Benefits" (EOB), to every enrollee at the end of each month showing how much the plan and the enrollee have paid in TrOOP costs. Part D plans are responsible for calculating and reporting TrOOP costs.

TrOOP costs for each Part D enrollee follow enrollees throughout the plan year. If a beneficiary switches Part D plans, his TrOOP costs are transferred to the new Part D plan. For this reason, beneficiaries cannot switch Part D plans to "reset" their TrOOP costs and avoid the coverage gap. Because TrOOP follows Part D enrollees from plan to plan, there is no way to "game the system."

Certain out-of-pocket expenses count towards TrOOP costs, and other out-of-pocket spending does not count.

Medicare Part D

TrOOP Includes	TrOOP Does NOT Include
Out-of-pocket expenses including the annual deductible and all coinsurance and copayment amounts for drugs on the plan's formulary	Monthly premiums paid to the plan
Spending from health savings accounts (HSAs), flexible spending accounts (FSAs), and medical savings accounts (MSAs)	Amount paid by other insurance plans in addition to the beneficiary's Part D coverage (e.g., an employer or retiree group plan's drug benefit, VA, or TRICARE)
Contributions or payments for drugs on the plan's formulary paid by friends or relatives on a beneficiary's behalf	Amount paid by Medicaid or by state programs that receive federal or public funds
Contributions or payments for drugs on the plan's formulary paid by certain charitable foundations on a beneficiary's behalf	Amount spent for prescription drugs that are non-Part D drugs or that are not on the plan's formulary (unless the enrollee received a formulary exception for a drug)
Unadvertised, individualized waivers or reductions of plan cost-sharing amounts by pharmacies due to a beneficiary's inability to pay	Amount spent for prescription drugs that are purchased from a pharmacy that is not in the pharmacy network of the plan (except for drugs received due to a plan's out-of-network policy)
TrOOP Includes	TrOOP Does NOT Include
Payments by Qualified State Pharmaceutical Assistance Programs (SPAPs)* (not available in Kansas)	Total cost of a drug that a private Patient Assistance Program (PAP) provides to a beneficiary
Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are on their plan's formulary	Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are not on their plan's formulary

Late Enrollment Penalty

The late enrollment penalty (LEP) affects those without Part D or creditable coverage who delay enrolling in a Medicare drug plan. Creditable coverage is insurance coverage that is at least equal to or better than the coverage in the Part D basic benefit. Beneficiaries without creditable coverage for more than 63 days may face an LEP if they decide to enroll in a Part D plan later.

Most beneficiaries who do not have creditable coverage and delay enrolling in a Part D plan will owe an LEP. The penalty is added to their plan's monthly premium. The penalty will continue as long as they are enrolled in a Part D plan and, for many, this means that they will pay the penalty for the rest of their lives. Plans are not permitted to charge an LEP to beneficiaries with LIS.

The penalty is calculated as one percent of the Part D base beneficiary premium for each month the beneficiary does not have creditable coverage and is not enrolled in Part D plan.

Medicare Part D

Another category of beneficiaries will not face an LEP, in one specific situation. The under-65 Medicare population, like all Medicare beneficiaries, who are not enrolled either in Part D or in creditable coverage for more than 63 days have an LEP if they later choose to enroll in Part D. These beneficiaries receive a new Initial Enrollment Period (IEP) upon turning 65. With the new IEP comes an exemption from past or current LEP. The exemption is in effect for beneficiaries who were paying an LEP as well as those who never enrolled in Part D and otherwise would have an LEP. The subsequent IEP, in effect, erases any previous record of months without creditable coverage.

Penalty Calculation

The LEP is not calculated as a percentage of the premium of the enrollee's chosen drug plan. The penalty amount will change each year because CMS calculates the penalty based on the Part D base beneficiary premium for a current calendar year. The final amount is rounded to the nearest \$.10 and added to the monthly premium of the plan that the beneficiary selects. See the chart below for information on calculating the LEP, assuming the base premium is \$34.10.

(18%)	x	\$34.10	=	\$6.20	+	\$20.00	=	\$26.20
1% x 18 months (the number of months without creditable coverage)		Base Beneficiary premium amount		Penalty amount		Monthly premium		Total Monthly premium including the penalty

Access to Drugs and Formularies

Each Part D plan has a network of pharmacies from which enrollees routinely can access their Part D drugs. Additionally, each Part D plan covers the prescription drugs that it places on a formulary, or list of covered drugs. Formularies may vary greatly among the plans. Plans also may encourage enrollees to use certain drugs on their formularies to control costs. These factors may affect a beneficiary's access to prescription drugs, and thus are important to consider when selecting a plan.

Pharmacy Networks

The Part D plans vary in the extent of their pharmacy networks. A pharmacy network is a group of pharmacies under contract with a Part D plan to provide its enrollees access to prescription drugs. In addition to network pharmacies, some drug plans also designate preferred pharmacies that offer the lowest prices and out-of-pocket costs among all the plan's network pharmacies. The Plan Finder lists all network pharmacies by name and location and further notes those which are preferred pharmacies. It is important to learn if a beneficiary's pharmacy of choice is in the plan's network, and if it is not, to make sure that convenient alternatives exist. Because the drug plans renew their contracts annually, network pharmacies may change from year to year.

A Medicare drug plan may not pay for prescriptions at pharmacies that are not in the plan's network. Exceptions apply, however, in emergencies and some other situations. CMS requires Part D plans to ensure that their enrollees have adequate access to covered drugs at out-of-network pharmacies when someone "cannot be reasonably expected to obtain covered drugs at a network pharmacy, or when such access is not routine." CMS expects the drug plans to cover prescriptions filled at out-of-network pharmacies when a plan enrollee loses his or her covered drugs or becomes ill, needs a covered drug, and cannot get to a network pharmacy.

Medicare Part D

Similarly, drug plans should cover prescriptions that a hospital or clinic-based pharmacy fills when someone is an emergency or outpatient surgery patient. Since Medicare Part B covers these types of hospital and clinic visits, Part D covers the prescriptions received during those visits. Many hospital affiliated pharmacies are not in the network of Part D plans, so this type of coverage would be provided by the plan's out-of-network policy. Since the plan's negotiated price for a drug is often less than the price charged by a hospital pharmacy, beneficiaries should keep in mind that they will have to pay the difference between the two prices.

It is also important to know that the MMA allows pharmacies to waive or reduce the cost-sharing amount (i.e., copayment, coinsurance) for beneficiaries who are otherwise unable to afford their prescription drugs. Pharmacies, however, cannot do this on a routine basis. The amount the pharmacy pays counts toward the beneficiary's true out-of-pocket costs (TrOOP).

Formularies

Medicare drug plans use formularies—that is, comprehensive lists of the drugs they cover—to define their drug benefits. The MMA allows each drug plan to develop its own formulary within certain limits. CMS reviews formularies to make sure that they comply with federal law. It evaluates the formularies to ensure adequate access to medically necessary drugs and to make sure that no formulary excludes drugs in such a way as to discourage particular groups from joining a plan. For example, CMS would not approve a formulary if it did not include insulin and oral anti-glycemic agents, as such a formulary would discriminate against people with diabetes.

The MMA requires all Part D drug plans to provide access to medically necessary medications including generic and brand-name drugs. Plans' formularies must include at least two drugs in each treatment category and class that a drug plan sponsor designates, although CMS may require plans to include more than two drugs for some categories and classes. Medicare rules require the plans to cover all drugs in six categories. CMS refers to these classes as "classes of clinical concern."

- Anti-neoplastics (anti-cancer drugs)
- Anti-convulsants
- Antidepressants
- Antipsychotics
- Immunosuppressants
- Anti-retrovirals

CMS established the requirement for plans to cover all drugs and dosage forms within these six classes with only limited exceptions. Those exceptions include:

- Multi-source brands of the identical molecular structure
- Extended release products when the immediate-release product is included
- Products that have the same active ingredient or moiety
- Dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals)

Drugs Excluded from Part D Coverage

Aside from requiring coverage for drugs in certain categories, the MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs when they are covered by Medicare Part A or Part B, including some chemotherapy drugs. Other drugs that the law generally excludes from Part D coverage are:

- Drugs prescribed for anorexia, weight loss, or weight gain
- Drugs prescribed to relieve the symptoms of coughs and colds. This exclusion does not include medications used to treat a cough that results from a medical condition that is not a cold or cough.
- Prescription vitamins and minerals, with the exception of prenatal vitamins and fluoride. (Vitamin D analogs such as calcitriol, doxercalciferol, paricalcitol, and dihydrotachysterol are not considered prescription vitamins. Prescription niacin products, such as Niaspan and Niacor are Part D drugs and are not considered vitamins.)
- Over-the-counter drugs, with the exception of insulin • Drugs when used for cosmetic purposes or hair growth.
- Fertility drugs
- Drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications
- Sexual or erectile dysfunction (ED) drugs, when prescribed for the treatment of sexual or erectile dysfunction

Drugs Not Excluded from Part D Coverage:

- Prescription drug products that otherwise satisfy the definition of a Part D drug are Part D drugs when used for AIDS wasting and cachexia due to a chronic disease, if these conditions are medically-accepted indications as defined by section 1927(k)(6) of the Act for the particular Part D drug. Specifically, CMS does not consider such prescription drug products being used to treat AIDS wasting and cachexia due to a chronic disease as either agents used for weight gain or agents used for cosmetic purposes.
- Part D drugs indicated for the treatment of psoriasis, acne, rosacea, or vitiligo are not considered cosmetic.
- Vitamin D analogs such as calcitriol, doxercalciferol, and paricalcitol when used for a medically accepted indication as defined by section 1927(k)(6) of the Act, are not excluded because CMS interprets the exclusion of prescription vitamin D products as being limited to products consisting of ergocalciferol (vitamin D2) and/or cholecalciferol (vitamin D3).
- Prescription-only smoking cessation products.
- Prescription Niacin Products (Niaspan, Niacor).
- Cough and cold medications are eligible to meet the definition of a Part D drug in clinically relevant situations other than those of symptomatic relief of cough and/or colds. For example, when “cough” medications are used to treat a medical condition that causes a cough, such as the use of bronchodilators for the treatment of bronchospasm in asthma, CMS does not consider these “cough” medications as excluded drugs and, therefore, these medications may be covered under Part D. However, antitussives used to treat cough symptoms, and not the underlying medical

Medicare Part D

condition causing the cough, are excluded from basic Part D coverage regardless of the medical condition causing the cough

Formulary Changes

Part D plans can change their formularies within certain limits. Medicare drug plans may only change the therapeutic categories and classes in their formularies once each year. These changes must occur between plan years. That is, a plan can change the categories and classes on its formulary for the next plan year, but the change cannot be effective prior to January 1 of the next year.

Medicare drug plans typically may not remove drugs from their formularies at any time during the plan year. A few exceptions to this general rule exist. First, Part D drugs may be removed from formularies when the Food and Drug Administration (FDA) pronounces a Part D drug unsafe. Plans may also remove drugs from formularies if the manufacturer removes the Part D drug from the market.

Medicare drug plans also may not make any change in cost-sharing status of formulary drugs from the start of the Annual Enrollment Period to **60 days after the beginning of the plan year**. Plans also must provide a 60-day notice to affected beneficiaries including those who are currently taking a drug that is removed from the formulary or whose costs are changing because of a shift in a drug's tier placement. If the plan does not provide prior notice, it must authorize a 60-day fill of the drug and provide notice at the point of sale.

Part D plans usually must follow these general rules about mid-year formulary changes:

- Plans may remove or place in a higher tier brand-name drugs when generic or multi-source brand name equivalents enter the market.
- Plans may remove non-Part D drugs included on their formularies by mistake.
- Plans may add utilization management tools based on new FDA warnings.
- Plans may remove drugs based on new FDA market withdrawal notice.
- Plans may remove or place in a higher tier drugs based on new clinical guidelines or recommendations. An example is following CDC's recommendation against using older antivirals for treatment and prevention of the flu.
- Plans may add utilization management tools in the following cases:
 - To respond to other approved formulary changes. One example is adding prior authorization to a brand name drug when a generic version is on the market.
 - To help determine B vs. D coverage
 - To promote the safe utilization of a Part D drug based upon new clinical guidelines or information

Medically Accepted Indications and Off-Label Use

Part D plans must ensure that physicians and other health providers prescribe Part D covered drugs for medically accepted indications. In some cases, providers prescribe drugs for a purpose other than the one originally approved by the FDA. This is called an "off-label use" of the drug. Sometimes physicians prescribe a drug to treat a medically accepted indication that is an off-label use. CMS does not require Part D plans to approve off-label use but does expect them to refer to common medical practice in determining that a prescribed drug effectively deals with a medically accepted indication.

Medicare Part D

Because plans can differ in their decisions about medically accepted indications, it is important to check with a plan about its policies for approving off-label use. One plan, for example, may consider peer reviewed literature in deciding on an acceptable use, while another may limit its consideration to the uses described in a CMS-approved drug compendium. Plans may deny coverage for off-label drug use for lack of medical necessity. If the client's physician is willing to help make the case that an off-label use is within common medical practice, SHICK counselors can assist their clients to appeal these coverage denials.

Cost-Containment Strategies

The Part D program relies on competition among drug plans and limits on the use of some covered drugs, often called utilization management tools, to help contain costs and control government spending on the prescription drug program.

Price Competition

The federal government does not regulate the drug prices that plan sponsors charge in the Medicare Part D program. Part D plan sponsors individually negotiate prices with drug manufacturers. Thus, drug prices vary from plan to plan. The plans' negotiated drug costs affect the length of time it takes enrollees to reach the initial coverage limit, as well as the prices they pay for drugs once in the coverage gap.

Utilization Management Tools

Along with price competition, the MMA allows drug plans to control costs through drug utilization management systems that may have an impact on a beneficiary's ability to access prescribed medications. The common elements in these utilization management systems are:

- Cost tiers
- Prior authorization
- Step therapy
- Quantity limits

As a SHICK counselor, keep in mind that even though a drug plan lists a client's medication as a covered drug on its formulary, a utilization management tool may restrict access to that drug. It may be necessary to ask the prescribing physician to make the case to the plan that your client's medical condition creates a medical need for the drug. When a Part D plan uses a utilization management tool to deny coverage for a formulary drug that your client needs, SHIPs can play an important role in assisting through the exceptions or redetermination appeals processes.

Cost Tiers

Many plan sponsors assign the covered drugs on a plan's formulary to different cost-sharing tiers. The MMA allows plan sponsors to design plans with as many as six tiers. Plans usually assign generic drugs to a low cost-sharing tier. For example, a plan's copayments for generic furosemide and brand-name Lasix might be \$5 and \$40, respectively. The smaller copayment in the lower tier works as an incentive for beneficiaries to select less costly drugs instead of the more expensive alternatives placed in higher tiers.

Prior Authorization

Prior authorization requires an added step in filling a prescription. Plans typically use prior authorization requirements to control the use of higher cost medications. The MMA gives plan sponsors considerable latitude to design their prior authorization systems. The plans can use different forms and may ask

Medicare Part D

physicians to provide documentation to establish the need for a drug. Thus, it may be easier for prescribing physicians to secure prior authorization in one plan as opposed to another. SHICK counselors may be able to help clients with information about the exceptions and appeals process following an unsuccessful request from the plan for prior authorization.

Step Therapy

Step therapy is a cost-control method that requires beneficiaries to use a less expensive medication, long-established as effective in treating a condition, before moving on to the next “step” in the process, involving a higher cost or newer, brand-name drug. Drug plans that require step therapy for a particular drug will not pay for the more expensive drugs, in the second and third steps, until the beneficiary tries the less expensive first step, and it proves to be ineffective or harmful. When beneficiaries have already tried the less expensive drug unsuccessfully, the doctor should contact the drug plan to request an exception.

Quantity Limits

Plans may limit the amount of medication that they pay for over a certain time period. The Kaiser Family Foundation reported that quantity limits are the most common utilization management tool that national PDPs use with ten frequently prescribed brand-name drugs. It is not unusual to find plans only paying for a limited supply of a brand-name medication, even though a physician prescribes more.

The MMA allows Part D plans to use any of these cost-containment strategies. SHICK counselors can expect that their clients will encounter one or more of them as potential road-blocks to access their prescribed drugs. Thus, it is important for clients to understand their rights, and know how to exercise them, when a drug plan’s cost-control requirements impede needed care.

Medication Therapy Management Programs (MTMPs)

All Part D plans (including MA-PD plans) must offer a Medication Therapy Management Program (MTMP) to eligible enrollees. MTM programs are intended to reduce the risk of adverse medication events and improve medication use by participants.

Transition Policies

All Part D drug plans have transition policies through which enrollees sometimes can obtain a temporary fill of their prescription drugs. Transition policies cover new Medicare beneficiaries’ enrollment in Part D plans, a switch from one Part D plan to another, level of care changes affecting long-term care facility residents, and formulary changes from one contract year to the next affecting current plan enrollees.

When a transition policy is in effect, a Part D plan must cover an enrollee’s prescription drugs even if they are not on the plan’s formulary. While CMS has set forth minimum transition policy requirements to address the needs of new and current drug plan enrollees, the agency allows plans to craft their own transition policies. Because the policies may vary from plan to plan, with some exceeding the minimum requirements, it is important for your clients to check with their drug plans to learn how the transition policies might affect them.

New Enrollees

Under the MMA, Part D plans must offer a transition process for beneficiaries who are either enrolling in a Part D plan for the first time (i.e., new Medicare beneficiaries and beneficiaries who recently lost

Medicare Part D

creditable coverage) or are enrolling in a different plan. This includes beneficiaries who are joining a Part D plan through a Special Enrollment Period (SEP). Under the transition process, plans must provide new enrollees with a temporary, 30-day supply of a non-formulary drug, including a drug dispensed under a utilization management restriction (e.g., prior approval) that they were taking before enrolling in new Part D plans. Plans may choose to extend the 30-day supply for new enrollees, but at a minimum they must provide a 30-day supply. Plans must cover this temporary supply, or transition fill, when beneficiaries go to pharmacies to fill prescribed medications within 90 days of drug coverage becoming effective.

The transition process also is an opportunity for enrollees to work with their physicians to find alternative drugs on the plan's formulary or to file an exception to request coverage for the drug. Medicare rules require plans to give new enrollees a written notice that states that they must either switch to a therapeutically equivalent drug that is on formulary or request an exception from the plan to continue taking the drug for the remainder of the calendar year. Plans work with pharmacies to distribute the notice to enrollees when they receive a transition fill. In the event that a prescription is not filled and such a notice is not distributed, it is best to contact the plan for further information on the plan's reasons for denying coverage and the appropriate next steps. The transition letter should explain the reason that the plan is providing a temporary fill, e.g., that the drug is not on the formulary or that the plan places a utilization management restriction on the drug.

Current Enrollees

CMS expects Part D plans to have a meaningful transition process in place for current plan enrollees whose drugs are no longer on the plan's formulary in the change from one contract year to the next. CMS expects plans to select one of two options.

1. Plans can provide for current enrollees a transition process that is consistent with the process for new enrollees. Under this option, CMS requires plans to provide enrollees with a temporary supply of the requested prescription drug (where it is not medically contraindicated) and with written notice that states how they must either switch to a drug that is on the plan's formulary or request an exception to continue taking the drug.
2. Alternatively, plans can establish and implement a transition process for current enrollees prior to the start of a new contract year (January 1, in most cases). This option requires plans to prospectively transition current enrollees to a therapeutically equivalent drug on the formulary or complete requests for formulary and cost-sharing exceptions before prior to the start of a new contract year. If a plan does neither, it must provide a temporary fill until the beneficiary has transitioned to a new drug on the formulary or until it has granted an exception.

Marketing

The rules governing marketing Medicare Part D are the same as those for Medicare Part C, Medicare Advantage. Please refer to Chapter 5, Marketing Overview – Medicare Advantage and Medicare Part D section.

Help for Low-Income Beneficiaries

Eligibility

Medicare beneficiaries with limited income and resources have access to substantial financial help with the costs of Part D. A program called the low-income subsidy (LIS), or “Extra Help,” provides this assistance to beneficiaries with limited means. The subsidy helps to pay a portion of Part D plans’ costs—including the monthly premium, the annual deductible, and copayments or coinsurance amounts for covered drugs. The MMA sets forth several subsidy levels that differ based on the amount of a beneficiary’s income and resources (or assets).

The Social Security Administration (SSA) manages the following processes related to the low-income subsidy:

- Provides general information to the public about LIS
- Supplies applications for LIS
- Makes LIS eligibility determinations for Medicare beneficiaries who apply for LIS. SSA works in conjunction with CMS on the LIS program. In short, CMS is responsible for administering the program, while SSA makes determinations about who is eligible for the program.

In general, LIS is available to Medicare beneficiaries whose:

- Income is below 150% of the federal poverty level (FPL)
- Resources (sometimes called assets) amounts are lower. There are two levels of allowable resources.
- The amounts are listed in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.
- Also note that SSA does not count all sources of income and resources when determining eligibility for LIS.

SSA and CMS also work with state Medicaid agencies to determine LIS eligibility for another group of Medicare beneficiaries—individuals who qualify for Medicaid or for a Medicare Savings Program (MSP). These beneficiaries are considered “deemed eligible” and will automatically receive the subsidy. All other individuals must apply to receive the subsidy. Except in limited circumstances, those who are eligible for LIS receive the subsidy at least throughout the calendar year.

Countable and Excluded Income

The degree of help available to low-income beneficiaries depends in part on the amount of income they receive. In general, SSA uses Supplemental Security Income (SSI) rules to calculate countable income in determining if beneficiaries meet the income limits for the low-income subsidies. Common sources of countable income are:

- Social Security benefits
- Railroad Retirement benefits
- Pensions or annuities (including veterans’ pensions)
- Alimony
- Rental income (net)
- Workers compensation

Medicare Part D

- Wages (gross) or earnings from self-employment (net)

If beneficiaries receive Social Security benefits for a disability or blindness and have work-related expenses that are not reimbursable by their employers, these expenses will be deducted before earned income is counted. Some sources of income do not count in LIS eligibility determinations. They include food stamps, home energy assistance, stipends paid to ACTION program volunteers (e.g., Senior Companion Program workers), some victim compensation payments (e.g., war reparations), and some tribal payments to Native Americans. More details about countable income are available in the Social Security booklet, *A Guide to SSI for Groups and Organizations*.

Countable and Excluded Resources

The amount of help available to low-income beneficiaries also depends on their resources or assets. Only certain resources count in determining eligibility for the Extra Help program. Some examples of countable resources are:

- Bank accounts (checking, savings or certificates of deposits or CDs)
- Stocks, bonds, savings bonds, mutual funds, individual retirement accounts (IRAs)
- Cash at any other financial institution or at home
- Real estate other than a primary home

Other resources, such as the beneficiary's primary home or a car, do not count in determining one's eligibility for LIS. These excluded resources include:

- Cash value of a life insurance policy
- Property one needs for self-support, such as rental property
- Jewelry and home furnishings
- Burial spaces owned by a beneficiary and spouse

Beneficiaries can exclude from their countable resources up to \$1,500 per person that they designate for funeral and burial expenses.

Applying for Low-Income Subsidy: Who Needs to Apply and Who Does Not?

Some low-income beneficiaries do not need to apply for LIS (Extra Help) because they are "deemed eligible." Other low-income beneficiaries must apply.

Individuals who are deemed eligible for the Extra Help and do not need to apply include those Medicare beneficiaries who receive Medicaid benefits, including full and partial benefits. Individuals with Medicare and full Medicaid benefits are referred to as "full duals," in that they are enrolled in both programs and are eligible for Medicaid's full set of benefits. Full-duals also include residents of nursing facilities who are on Medicare and Medicaid and Medicare beneficiaries who reside in the community and are enrolled in a Medicaid Home and Community-Based Services (HCBS) waiver program. This also includes SSI recipients who automatically receive full Medicaid benefits.

Medicare beneficiaries who are enrolled in one of three Medicare Savings Programs (MSPs) sometimes are referred to as "partial duals." The state, through its Medicaid program, pays at least the Part B premiums for beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB), Low-income Beneficiaries (LMB), and Expanded Low-income Beneficiaries (ELMB) programs. For those in the QMB programs, the state also covers Medicare's deductibles and coinsurance costs.

Medicare Part D

Medicare beneficiaries who must apply for the extra help are those with limited financial means but who are not a full or partial dual. All beneficiaries who think they may be eligible for the extra help can apply, but only those who meet the income and resource limits will be found eligible.

Levels of Low-Income Subsidy

There are different levels of subsidies that depend on eligible beneficiaries' income and resources. The descriptions below use the standard federal poverty level (FPL) for individuals living in the 48 contiguous states and the District of Columbia. Income amounts are higher for those living in Alaska and Hawaii.

The descriptions below refer to the benchmark premium. CMS calculates the benchmark premium each year using premium and enrollment information for all plans with enrollment in the past year. CMS uses the following premium amounts for plans:

- The total monthly premium for standard plans
- The portion of enhanced plans' premiums attributed to standard Part D coverage
- The monthly prescription drug beneficiary premiums for MA-PD plans

CMS calculates the average of these amounts and uses actual enrollment information to weight the average. This weighted average is called the "benchmark subsidy." Each year, CMS calculates the benchmark for each plan region. Those with the full premium subsidy do not have to pay a monthly premium if they enroll in standard plans with premiums below this benchmark amount.

Full Dual-Eligible (Medicare and Full Medicaid) with Income up to 100% FPL

Full dual-eligible beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
- Those who enroll in a standard plan with a premium above the benchmark amount must pay a portion of the premium
- Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay an annual deductible
- Pay a low copay for generic and preferred brand prescription drugs and a slightly higher copay for all other drugs on the plan's formulary
- After beneficiaries in this group reach the out-of-pocket threshold, all prescription drugs on the plan's formulary are free

Full Dual-Eligible (Medicare and Full Medicaid) with Income above 100% FPL and Partial Dual Eligible with Income up to 135% FPL

Beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region

Medicare Part D

- Those who enroll in a standard plan with a premium above the benchmark amount must pay a portion of the premium
- Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay an annual deductible
- Pay a higher copay than full-dual eligible for generic and preferred brand prescription drugs and again a slightly higher copay for all other drugs on the plan's formulary
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold

Institutionalized and HCBS Beneficiaries

Special LIS rules apply for full-duals who reside in certain long-term care (LTC) facilities including: skilled nursing facilities, nursing facilities, inpatient psychiatric hospitals, and intermediate care facilities that are residential facilities for developmentally disabled adults (called "ICF/MRs"). Regardless of their income, Medicare beneficiaries who receive full Medicaid benefits and reside in these LTC facilities receive maximum subsidies, and therefore do not incur any out-of-pocket costs for prescription drugs on their plans' formularies. They do not pay monthly premiums, annual deductibles, or copayments for their prescriptions. Medicaid Home and Community-Based Services (HCBS) waiver recipients also have no copays.

Residents of assisted living facilities, group homes, and board and care homes may qualify for LIS but are subject to some cost-sharing in line with their income and resources.

Non-Deemed

Income up to 135% FPL

These beneficiaries have applied for and been approved for LIS by SSA. There are two subsidy levels available for beneficiaries within this income range depending upon the amount of their countable resources.

Fewer Resources

Beneficiaries in this income group have a lower resource level and:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark amount must pay a portion of the premium
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay an annual deductible
- Pay a higher copay than full-dual eligible for generic and preferred brand prescription drugs and again a slightly higher copay for all other drugs on the plan's formulary
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold

More Resources

Beneficiaries in this income group have a higher countable resource level (assets):

Medicare Part D

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
- Those who enroll in a standard plan with a premium above the benchmark must pay a portion of the premium
- Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Have an annual deductible, unless their plan has a lower deductible. In that case, they would pay the plan's deductible, which could be as low as \$0
- Pay a coinsurance of 15% for each prescription drug on the plan's formulary
- Pay a low copay for generic and preferred brand prescription drugs and a slightly higher copay for all other drugs on the plan's formulary, after reaching the out-of-pocket threshold

Income between 135% FPL and 150% FPL

Beneficiaries whose countable income is between 135% and 150% of FPL (see chart below) and who have countable resources (assets) no higher than the maximum allowable resources are eligible for a subsidy. Beneficiaries who meet these income and asset requirements receive the following subsidies:

- Medicare pays a portion of the monthly premium based on their income:
 - Those with income between 135% and 140% FPL receive a premium subsidy of 75% of the benchmark premium
 - Those with income between 140% and 145% FPL receive a premium subsidy of 50% of the benchmark premium
 - Those with income between 145% and 150% FPL receive a premium subsidy of 25% of the benchmark premium
- Have an annual deductible, unless their plan has a lower deductible. They would pay the plan's lower deductible, or \$0 in plans with no deductible
- Pay a coinsurance of 15% for each prescription drug on the plan's formulary
- Pay a low copay for generic and preferred brand prescription drugs and a slightly higher copay for all other drugs on the plan's formulary, after reaching the out-of-pocket threshold ***How Do Beneficiaries Apply for LIS?***

Those beneficiaries who are not deemed eligible and want to apply for Extra Help must complete an application for SSA to make an eligibility determination. Beneficiaries can access the SSA application in four ways:

- Go to the SSA website at <http://www.ssa.gov> and complete the application online
- Call SSA at 1-800-772-1213 and ask a customer service representative to send an application through the mail
- Call SSA at 1-800-772-1213 and ask a customer service representative to help them complete the application over the phone
- Go to a local SSA office and pick up an application form SSA Form 1020

Once paper applications are complete, they must be mailed to the Social Security Administration. The application comes with a self-addressed, postage-paid envelope.

SSA verifies elements of eligibility (e.g., income, resources, residency, and Medicare entitlement) by comparing the information on the application form to Social Security records and records from other federal agencies, including CMS. SSA asks applicants to submit proof of income or resources in limited circumstances. Two examples of such instances are if there are discrepancies between the information on the application and the government records or if applicants report ownership of non-home real property.

Who Can Help Beneficiaries Complete the Application?

Three categories of helpers, called personal representatives, may act on behalf of beneficiaries for the purpose of applying for LIS. These include:

- Those asked to help (such as a family member or friend)
- Those authorized by state or other law
- Someone acting responsibly on behalf of an “incapacitated” beneficiary

CMS expressly declined to limit “acting responsibly” in any way, stating that it assumes the good intentions of everyone who wants to help get people into the LIS program. Also, SHICK counselors are able to help beneficiaries complete applications.

How Long Does SSA Take to Process an Application?

The law does not require the SSA to process applications and notify applicants about subsidy determinations in any particular time frame. The SSA states only that applications remain “in effect” until a decision is reached regarding subsidy eligibility and has further indicated that it expects routine processing time to be two to three weeks.

What Rights Do Beneficiaries Have if Their Subsidy Applications Are Denied?

The SSA has an appeal process that low-income beneficiaries can use if they disagree with a decision to deny, reduce, or discontinue the LIS. Beneficiaries who wish to appeal a decision by SSA must complete a form called Appeal of Determination for Help with Medicare Prescription Drug Plan Costs

Eligible for Low-Income Subsidy: What Happens Next

CMS auto-enrolls and facilitates enrollment of certain LIS beneficiaries into PDPs. “Auto-Enrollment” is the process that refers to full-benefit dual eligible individuals. “Facilitated Enrollment” is the process that refers to other LIS beneficiaries. The primary differences between the two are the populations and the enrollment effective date. Beneficiaries who qualify for LIS must be enrolled into Part D plans to receive the subsidy.

All auto/facilitated enrollments generated by CMS into qualifying PDPs have prospective effective dates. Specifically, the effective date will be the first day of the second month after CMS identifies the person. Full-benefit dual eligible individuals and SSI-only beneficiaries may qualify to be retroactively auto/facilitated enrolled by CMS into the Limited Income NET contractor. Partial dual eligible individuals and LIS applicants do not qualify for retroactive assignments.

Limited Income Newly Eligible Transition (LI NET) Program

The Limited Income Newly Eligible Transition (LI NET) program is administered by Humana and offers those with the low-income subsidy (LIS) immediate, but temporary, access to prescription drug coverage.

Medicare Part D

LI NET provides this coverage for beneficiaries who qualify for Extra Help and go to a pharmacy to have a prescription filled, but are not enrolled in Medicare drug plans.

The LI NET program serves three functions:

1. When full dual-eligible beneficiaries have some period of retroactive eligibility with no Part D plan, the LI NET plan through Humana provides retroactive coverage of their prescription drugs. These beneficiaries are auto-enrolled prospectively into a standard Part D plan with a premium below the regional benchmark.
2. All beneficiaries with the low-income subsidy (LIS) who are not enrolled in a Part D plan are eligible to use the LI NET plan for immediate coverage of their prescription drugs at the pharmacy. Beneficiaries must provide evidence of their eligibility for the LIS. Other than the group eligible for LI NET auto-enrollment, all other beneficiaries with LIS will still have access to the existing facilitated enrollment process.
3. Finally, the LI NET program also provides retroactive reimbursement for out-of-pocket expenses paid by beneficiaries with LIS who were not enrolled in a Part D plan at the time of the expenses.

Humana has established a toll-free number for assistance with the LI NET program. This number is 1-800783-1307.

Medicaid's Role with Non-Part D Drugs

The MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs that are covered by Medicare Part A or Part B, such as some chemotherapy drugs. Other drugs that are generally excluded from Part D coverage are listed in the section on formularies. Some Part D plans with enhanced benefit designs, however, may provide coverage for some of the drugs in these categories.

A state's Medicaid program may cover some of these excluded drugs or Part D drugs that are not on Medicare drug plan formularies for full dual-eligible beneficiaries, including residents of nursing facilities and recipients of HCBS waivers. To access specific information about which non-Part D drugs state Medicaid programs are covering for full-dual beneficiaries, check with the state Medicaid agency.

Redeterminations and Redeeming

Agencies reassess eligibility for the LIS on a regular basis. This process involves three agencies: the SSA, CMS, and the state Medicaid agency (KDHE). The agency that initially determined a beneficiary's eligibility for the LIS is responsible for reassessing their eligibility for the following calendar year.

Redetermination: SSA uses a process called "redetermination" to assess the continued eligibility of LIS recipients who applied for and were found eligible for LIS through the SSA.

Redeeming: CMS reviews the eligibility status of all beneficiaries who were deemed eligible for LIS (in the previous calendar year) because they receive Medicaid benefits (full or partial) or Supplemental Security Income (SSI) benefits.

SSA Redeterminations

The Social Security Administration (SSA) conducts three types of redeterminations:

- Initial

Medicare Part D

- Cyclical
- Subsidy changing events (SCE)

The following SSA redetermination processes only pertain to beneficiaries who applied for the LIS (or Extra Help) through the SSA.

Initial Redeterminations

To redetermine eligibility the next year, the SSA selects a group of beneficiaries who were eligible for Extra Help during the previous year and who the SSA believes have experienced a change in their circumstances that may have affected their eligibility for extra help. These beneficiaries receive a redetermination form in the mail in September. The form, Social Security Administration Review of Your Eligibility for Extra Help (SSA-1026), must be completed and returned within 30 days of receipt, **even if nothing has changed**. If the beneficiary does not complete and return the form, SSA may terminate his eligibility for Extra Help, effective January 1 of the following year.

Cyclical Redeterminations

Each year the SSA also will select a random group of Extra Help recipients for redetermination to evaluate their eligibility for the next year. These beneficiaries receive a redetermination form in the mail in September. The form is the same form sent to those selected for the initial redetermination. Beneficiaries must respond to the form within 30 days of receipt, **even if nothing has changed**. If a beneficiary does not complete and return the form, SSA may terminate their eligibility for Extra Help, effective January 1 of the following year.

Subsidy Changing Event (SCE) Redeterminations

Beneficiaries with LIS who experience subsidy-changing events — including marriage, divorce, separation, annulment, and death of spouse — must report the event to SSA. Upon notification, SSA sends these beneficiaries a special SCE redetermination form. Beneficiaries are required to complete and submit the form within 90 days of receipt. Beneficiaries who do not respond will no longer receive Extra Help. For those that do respond, their Extra Help status will reflect the change the month after SSA receives the completed form.

Beneficiaries may appeal a reduction or termination of their subsidy. According to SSA, “It may be more advantageous to the individual to file an appeal than to file a new application. This is because the individual may lose one or more months of Part D subsidy by filing a new application. An appeal would preserve the retroactivity of the subsidy while a new application would not” (20 CFR 418.3605 - 418.3680).

Beneficiaries should use the SSA appeals form for this process.

Redeeming

Based on data that state Medicaid agencies send to CMS, individuals with Medicare and Medicaid are deemed eligible for the LIS. These beneficiaries automatically qualify for LIS, and therefore, do not need to complete an application. CMS redeems for the following year all individuals who were full or partial duals in or after July of the current year.

Medicare Part D

Starting each year in July, state Medicaid agencies begin sending transmissions to CMS containing data on all dual-eligible beneficiaries. Individuals whose data is transmitted to CMS automatically are redeemed eligible for LIS for the following year.

If their LIS status has not changed, they will not receive any notice informing them that they will continue to receive Extra Help in the following year. If they remain LIS eligible, but a change in their finances requires a change to their subsidy amount, they will receive an orange letter from CMS. The letter explains that although they still qualify for the Extra Help in the next year, their costs will change as of January 1.

Some people who were deemed eligible for LIS in the current year will not be deemed eligible for the following year because they no longer qualify for Medicaid. These beneficiaries receive a grey letter from CMS in September. The letter explains that they will not automatically receive Extra Help to pay for their Part D costs effective January 1. The letter explains they can apply for the LIS through the SSA. It also contains an application for the LIS with a postage-paid envelope.

Individuals who receive this letter include Medicare beneficiaries who:

- No longer qualify for full Medicaid benefits
- Are no longer eligible for a Medicare Savings Program (MSP)
- No longer receive Supplemental Security Income (SSI) and do not qualify for Medicaid

Anyone who receives the grey letter and subsequently re-qualifies for Medicaid would be redeemed for the LIS for the following year.

Part D Plan Reassignment by CMS

In the fall of each year, CMS reassigns certain groups of Medicare beneficiaries who are eligible for LIS into Part D plans for the coming year. Typically, CMS reassigns two groups of Medicare beneficiaries who were deemed eligible for the Extra Help in the past year and will continue to be deemed eligible in the following year:

- Medicare beneficiaries with the full subsidy who stayed in the plan into which they were auto assigned by CMS, and their plan premium for the following year is more than the regional low-income premium subsidy benchmark.
- Medicare beneficiaries with the full subsidy whose plans are leaving the Medicare program in the following year.

Some Part D plans that were LIS benchmark plans in the past year will have a premium above the following year's regional LIS benchmark. As a result, full LIS recipients would be responsible to pay a portion of the plan premium if they remain in such plans. Therefore, CMS reassigns certain LIS-eligible individuals to different Part D plans with premiums that are at or below the regional LIS benchmark for their area.

Specifically, CMS reassigns only those full subsidy LIS beneficiaries who accepted their auto-assigned plans.

By early November, reassigned Medicare beneficiaries should receive blue letters from CMS with information about their reassignment. Those who are reassigned because their plan is leaving the Medicare program will receive Version 1 of the blue letter. Those who are reassigned because their

Medicare Part D

current, assigned plan's premium will be above the next year's regional LIS benchmark will receive Version 2 of the blue letter.

Notably absent from those reassigned are all full subsidy LIS beneficiaries who enrolled in plans other than the one to which they were auto-assigned. CMS will not reassign these Medicare beneficiaries who were deemed eligible but switched plans. CMS refers to this group of beneficiaries as "choosers." CMS does not reassign one other group of LIS beneficiaries—those with partial LIS subsidy (which includes those with LIS who are charged a deductible).

These beneficiaries, the "choosers," should receive a tan letter from CMS by early November informing them that they will owe a portion of the premium if they remain in their plans.

Prescription Drug Assistance Programs and Medicare Part D

Generally two types of prescription drug assistance programs are available to help Medicare beneficiaries with limited financial resources access their medications:

- State Pharmaceutical Assistance Programs (SPAPs) – not available in Kansas
- Private Pharmaceutical Assistance Programs (PAPs)

Beneficiaries must meet certain eligibility criteria to qualify for the benefits offered under these programs. These programs coordinate their benefits with Part D in different ways.

Private Pharmaceutical Assistance Programs (PAPs)

Some private pharmaceutical companies offer their products to low-income individuals for free or reduced prices through pharmaceutical assistance programs (PAPs) and drug discount programs. Due to Medicare Part D coverage, many of these programs either no longer offer their services to Medicare beneficiaries who are eligible for or enrolled in a Medicare Part D plan, or require some attempts to have the Part D plan pay for a medication before they will assist a beneficiary. There is a separate application process for each medication. This process varies from company to company.

PAPs are not comprehensive insurance plans and therefore are not considered creditable coverage. Some programs may provide only one free sample or supply of a medication; others may provide ongoing assistance. The application process sometimes requires the participation of a physician who will receive and administer or deliver the drug to her patient.

It is important to know that the total cost of the drug that a PAP provides to a beneficiary in the coverage gap does not count towards True Out-Of-Pocket costs (TrOOP). Therefore, assistance from a PAP extends the time that a beneficiary spends in the coverage gap, and, hence, delays the Part D catastrophic benefit. However, if a beneficiary must pay a copayment or coinsurance amount to receive a PAP-provided medication, the copayment or coinsurance amount counts towards TrOOP if the medication is on the plan's formulary.

Chapter 6-MEDICARE SUPPLEMENT (MEDIGAP) INSURANCE

Medicare Supplement insurance is health insurance sold by private insurance companies that fill some of the cost and benefit “gaps” in the Original Medicare program. The official name for these policies is “Medicare Supplement Insurance,” but it is often referred to as Medigap Insurance. State insurance departments regulate the companies and agents that sell this insurance.

Before 1990, Medigap insurance policies were not standardized in many states. As a result, it was hard for consumers to compare one plan to another as to how well they filled Medicare’s gaps. Since 1991, insurance companies in most states must sell Medigap insurance policies that conform to minimum standards set by the National Association of Insurance Commissioners (NAIC). Massachusetts, Minnesota, and Wisconsin had their own Medigap standardization laws in place before the NAIC developed its national model law and regulation and are exempt from the NAIC rules. From 1991 to 2005, the NAIC model had 10 standard Medigap plans lettered A-J. The Medicare Modernization Act of 2003 added plans K and L to the array of standard plans. Plans K and L took effect on January 1, 2006, the same day that Medicare began its Part D prescription drug program.

A revised NAIC model law and rule took effect on June 1, 2010. After that date, insurers can no longer sell some of the original standardized Medigap plans (E, H, I, J, and high deductible J) because, when Medigap drug benefits were removed from plans H, I, and J in 2006, the result was that the plans duplicated other plans. The revised NAIC model also eliminated the preventive care, at-home recovery, and 80% payment for excess charge benefits. This is because, with changes in Original Medicare’s coverage and claims procedures, they are now outdated. The revised NAIC model also created two new Medigap plans, M and N, and added a new hospice cost-sharing benefit to the core benefit of all plans effective June 1, 2010. The revised NAIC model law calls these Medigap policies (A, B, C, D, F, high deductible F, G, K, L, M, and N) that conform to the new rules “2010 plans.”

Since Congress authorized the model law in 1990, the NAIC refers to the plans issued under the old model rules as “1990 plans.” These plans will remain in effect if their policy holders pay premiums. They may, however, become more expensive over time as the number of policy holders declines.

In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was passed. It states that Medicare Supplement plans with Part B deductible coverage (Plans C, F and high deductible F) cannot be purchased by “newly eligible” Medicare recipients. Section 401 of MACRA prohibits the sale of Medigap policies that cover Part B deductibles to “newly eligible” Medicare beneficiaries defined as those individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020. Since Plan F High Deductible cannot be sold to those “newly eligible” Medicare beneficiaries, a new Plan G High Deductible was created.

Here are some key points about Medigap insurance that apply to both the 1990 and 2010 plans:

- Beneficiaries who have Original Medicare and a Medigap policy have access to most hospitals, physicians, and other providers in the country.
- Medigap coverage is tied to Original Medicare’s coverage. If Medicare approves payment on a claim, so does the Medigap policy. If Medicare denies a claim, generally so does the Medigap policy.

Medicare Supplement (Medigap) Insurance

- A person generally must have Medicare Part A and Part B to purchase a Medigap policy.
- Medigap policies do not work with Medicare Advantage plans, that is, Medicare HMOs, PPOs, Private-Fee-for-Service (PFFS) plans, Special Need Plans, and Medicare Savings Accounts (MSA). Medicare Advantage plan members should not buy Medigap insurance.
- Many companies have “crossover claim” agreements with Medicare. Medicare shares its coverage and payment information electronically with the Medigap insurer. The company in turn automatically pays its share of the claim. When providers accept assignment, this enables bills to be paid in full with no paperwork for the beneficiary.
- All companies in the state of Kansas that wish to sell Medicare Supplement insurance must make Plan A available to their customers. In addition, they must offer Medicare Supplement Plan C or Plan F for those eligible for Medicare prior to 01/01/2020, or Plan D or Plan G for those eligible for Medicare on or after 01/01/2020. Plan A features the core benefits of a Medicare Supplement policy. All other plans build on those benefits.

Covered Gaps and the Basic Benefit

Each of the standard Medigap policies covers the same gaps regardless of the company that sells it. Thus, for example, Medigap Plan C from Mutual of Omaha covers the same gaps as Plan C from Golden Rule. This means that clients can make “apples to apples” comparisons among the standard policies. Prices for Medigap insurance tend to increase based on the number of gaps the policies fill. Plan A which covers a basic, or core, benefit is usually the cheapest.

Medigap policies are designed to cover some or all of these gaps in Original Medicare: ⁶

- Part A deductible per benefit period
- Part A hospital daily coinsurance
- No hospital coverage after 150 days in a benefit period
- No psychiatric hospital coverage after 190 days in a lifetime
- SNF daily coinsurance charge
- Hospice coinsurance charges for palliative medications and respite care
- First three pints of blood
- Part B annual deductible
- Part B coinsurance charge (20% of the approved amount in most cases, but more for many outpatient hospital services, and for outpatient mental health)
- Part B excess charge (the difference between Medicare’s approved amount and Medicare’s 15% limiting charge for physician services)
- Emergency care received outside the U.S.A.

The basic, or core, benefit includes coverage for the:

- Part A inpatient hospital coinsurance charges
- 365 days of hospitalization after Medicare coverage ends (starting on the 151st medically necessary inpatient hospital day in a Part A benefit period)
- Hospice coinsurance charges for palliative medications and respite care

⁶ Medicare cost-sharing can be found in the Appendix under Annual Medicare Premium and Cost-Sharing Amounts/

Medicare Supplement (Medigap) Insurance

- Preventive care coinsurance
- Part B 20% coinsurance charge
- First three pints of blood

Medigap Modernization

Beginning June 1, 2010, insurance companies must offer Medigap policies that comply with a new set of Medigap standards. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the states to adopt a revised NAIC model for Medigap modernization that had been in development since 2005. States enacted legislation and adopted regulations in 2009 to give effect to the revised model standards. Companies began selling policies that comply with the new standards in June 2010.

The revised model eliminated some policies altogether. After June 2010, companies no longer sell Medigap Plans H, I, J, and high-deductible Plan J because, since they no longer offer the former limited prescription drug benefit, they now duplicate other plans. The new rules also eliminated Plan E because its 80% coverage of the Part B excess charge is not needed.

The revised model also eliminated some benefits from all Medigap plans. Companies no longer offer the at-home recovery, preventive care, and 80% of excess charges benefit. Given changes in Medicare since 1990, these benefits are outdated and little used.

Two new Medigap policies—Plans M and N—joined Plans A, B, C, D, F, high deductible F, G, K, and L. Plan M includes the basic benefit, 50% coverage for the Part A deductible, full coverage for the Part B coinsurance charge, and foreign travel emergency coverage. Plan N includes the basic benefit, full coverage for the Part A deductible, coverage for the Part B coinsurance charge, except for a \$20 copayment for office visits and a \$50 copayment for emergency room visits, and foreign travel emergency coverage.

The Standard Medigap Insurance Policies (June 1, 2010)

Medigap Plan A covers only the core benefit. The other Medigap plans build on this core benefit to cover different combinations of coverage gaps. Keep in mind that the basic benefit does not include coverage for the Part A inpatient hospital deductible or the Part B annual deductible. Several of the 1990 and 2010 plans, however, cover the Part A deductible in full. Note that Plans K, L, M, and N take a slightly different approach to covering the features of the basic benefit. Here are the main features of the standard Medicare Supplement Insurance (Medigap) policies:

- Plan A covers the basic benefit. It does not cover the Part A or Part B deductibles, the Part A SNF daily coinsurance charge, foreign travel emergencies, or Part B excess charges.
- Plan B covers the basic benefit and the Part A inpatient hospital deductible. It does not cover the Part A SNF daily coinsurance charge, the Part B deductible, foreign travel emergencies, or the Part B excess charges.
- Plan C covers the basic benefit, the Part A inpatient hospital deductible, the Part B deductible, the SNF daily coinsurance charge, and foreign travel emergencies. It does not cover the Part B excess charge.
- Plan D covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies.

Medicare Supplement (Medigap) Insurance

- Plan F covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the Part B deductible, and 100% of the Part B excess charge. Note that physicians in the United States accept assignment in 99% of the cases, meaning that very few doctors bill for the excess charge. Other Part B providers, such as medical equipment suppliers, may bill for excess charges more often. Some companies offer a high deductible Plan F with an annual deductible.
- Plan G covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, and 100% of the Part B excess charge. It does not cover the Part B deductible.
- Plan K covers 100% of the Part A inpatient hospital coinsurance charges but it departs from the basic benefit by paying 50% (not 100%) of Part B coinsurance charges. It also covers 50% of the Part A inpatient hospital deductible and the SNF daily coinsurance charge. It has an annual out-of-pocket cap and is adjusted each year for inflation.
- Plan L covers 100% of the Part A inpatient hospital coinsurance charges but it departs from the basic benefit by paying 75% (not 100%) of Part B coinsurance charges. It also covers 75% of the Part A inpatient hospital deductible and the SNF daily coinsurance charge. It has an annual out-of-pocket cap and is adjusted each year for inflation.
- Plan M covers 100% of the Part A inpatient hospital coinsurance charges and 50% of the Part A deductible. It also fully covers the SNF daily coinsurance charge.
- Plan N covers 100% of the Part A inpatient hospital coinsurance charges and 100% of the Part A deductible. It fully covers the SNF daily coinsurance charge. This plan covers the 20% coinsurance charge for most Part B services (e.g., ambulance and outpatient hospital services), except for physician office visits and emergency room (ER) visits. The policy holder is responsible for \$20 copayments for office visits and \$50 copayments for ER visits.

1990 Plans no longer sold

While these plans are no longer being sold, you may counsel beneficiaries who still have one of these policies in force.

- Plan E (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, and preventive services that Medicare Part B does not cover (e.g., an annual physical examination).
- Plan H (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge and foreign travel emergencies. It is almost identical to Plan D, except that it has no at-home recovery benefit. Before 2006, this policy had a limited prescription drug benefit.
- Plan I (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the at-home recovery benefit, and 100% of the Part B excess charge. It does not cover the Part B deductible. Before 2006, this policy had a limited prescription drug benefit.
- Plan J (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the at-home

Medicare Supplement (Medigap) Insurance

recovery benefit, the preventive care benefit (e.g., for annual physical examinations), the Part B deductible, and 100% of the Part B excess charge. Before 2006, this policy had a limited prescription drug benefit. Some companies offer a high deductible Plan J with an annual deductible.

- If you encounter a beneficiary with H, I, or J that still includes drug coverage, you will need to consider their options carefully as this drug coverage is not creditable.

Other Policy Options

- Medicare Select Policies: Some insurance companies also offer “Medicare Select” policies for Medigap Plans. Medicare Select policies cover the same gaps as regular plans, except that they require beneficiaries to use certain providers, typically hospitals, in non-emergency situations. A beneficiary can switch to a plan with equal or lesser value at any time with the same company.
 - Because the insurers negotiate directly with specific providers, sometimes called “preferred providers,” premium costs for Medicare Select plans are generally lower than a standard Medicare Supplement policy. When you choose to use a preferred provider, Medicare pays its share of the approved charges and the Medicare Select policy pays for the full supplemental benefits provided for in the policy. If you do not want to use the preferred provider, Medicare will still pay its share of approved charges. However, the Medicare Select policy would not be required to pay any benefits.
- High Deductible Plans F & G: The law allows insurance companies to sell Medigap plan F (or Plan G for those eligible after January 1, 2020) with a high deductible option. After the beneficiary pays the annual deductible, the policies start to fill the same gaps as the regular plans F or G. CMS updates the deductible amount each year based on the consumer price index. The monthly premiums for high deductible policies are also usually less than those for regular policies.

Explanation of Basic and Additional Benefits

Part A Deductible (All Plans except A)

Medicare will pay for the first 60 days of hospitalization in a benefit period after the beneficiary pays a “deductible.” This benefit pays the full deductible amount each time it is charged to the beneficiary. It is included in all policies except Plan A, although on Plans K, L, & M, only a varying percentage is covered. The amount usually goes up each year, and the deductible is charged based on a benefit period rather than a calendar year.

Part B Deductible (Plans C & F)

Medicare has an annual deductible for Part B covered services. This amount of Medicare-approved Part B charges each year is the responsibility of the beneficiary. This benefit pays the deductible each year.

Beginning January 1, 2020, Medigap plans sold to new people with Medicare are not allowed to cover the Part B deductible. Plans C and F are no longer available to people new to Medicare on January 1, 2020 and after. If you already have either of these two plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you’ll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

Skilled Nursing Facility Coinsurance (All Plans except A & B)

Medicare covers only approved skilled nursing care in a Medicare approved facility. These benefits are available when you satisfy the guidelines as defined by Medicare. This type of care is usually for a limited number of days.

All standardized policies except A & B include the “Skilled Nursing Facility Coinsurance Benefits” that pays the actual billed charges up to the Medicare coinsurance amount for days 21-100. Standardized policies cannot pay benefits beyond 100 days. The average stay in skilled care is below 100 days.

Excess Charges (Plans F & G)

One of the gaps in Medicare is medical charges that are in “excess” of approved amounts. Physicians who don’t accept assignment (non-participating physicians) can charge more than the approved amounts.

They can charge you more than the Medicare-approved amount, but there's a limit called “the limiting charge.” The provider can only charge you up to 15% over the amount that non-participating providers are paid. Non-participating providers are paid 95% of the fee schedule amount.

The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.

Foreign Travel Emergency (Plans C, D, F, G, M, & N)

Medicare covers you only while in the United States and its possessions (Guam, Puerto Rico, and Virgin Islands). If someone is traveling outside the covered areas, Medicare will not pay for health care (except in rare emergency situations when the nearest care is across the border in Canada or Mexico.) Covered Cost under This Benefit

- Only for emergency care needed immediately because of an injury or an illness of sudden and unexpected onset
- Care must begin during the first 60 consecutive days of each trip outside the U.S.
- \$250 calendar year deductible
- \$50,000 lifetime maximum
- 80% of billed charges paid for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country.

Uncovered Gaps in Original Medicare

There are some gaps in Original Medicare that the standard plans cannot fill. Foremost among the gaps is prescription drug coverage.

Other gaps in Original Medicare include:

- SNF coverage after 100 days in a benefit period
- Private duty nursing
- Hearing aids
- Dentures and dental implants
- Eyeglasses (except for cataracts)
- Custodial care

Medicare Supplement (Medigap) Insurance

Many people cover these additional gaps out-of-pocket. Some, however, purchase other types of insurance, such as long-term care insurance to help with the costs of custodial level care in nursing facilities and at home. Some buy dental insurance to help pay for dental care. These “other” gaps are among the main reasons that Medicare beneficiaries pay on average about 18 percent of their total health and long-term care costs out-of-pocket.

The Cost of Medigap Insurance

Because each standard policy must cover the same benefits, the main point of comparison between one insurance company and another is price. Generally, Plan A is the least expensive plan among an insurance company’s array of Medigap insurance policies. Policies that fill more coverage gaps usually cost more. Policies with a guaranteed issue feature also tend to cost more. But insurers set their own prices for Medigap policies and monthly premiums vary from company to company, sometimes dramatically. It pays to shop around.

Many factors contribute to the difference in pricing among companies for the same insurance policy. One factor is the number of people the company insures. If it insures many Medicare beneficiaries, it may be easier to spread the cost of insurance around. Another factor is the approach the company takes to marketing and customer service. Some use local agents for sales and service. Others rely on direct mail and toll-free customer service lines.

Insurance companies also use different methods to set or “rate” their prices. When buying a Medigap policy, it is good to know which method the company uses because it may have a big impact on future premium costs. The three most common rating methods are:

- Issue-age rating where the premium is based on the beneficiary’s age at the time the company issued the policy. Premiums will not increase based on age, although they can rise due to inflation.
- Attained-age rating where the premium is based on a beneficiary’s current age and goes up with age. Premiums start out low but increase over time.
- Community rating where the premium is the same for everyone who has the Medigap policy regardless of age. (Kansas does not have any community-rated policies on the private market.)

Most insurance companies use one of the age-rating methods to set their premiums. Relatively few use the community rating method.

The Kansas Insurance Department publishes a Medigap insurance cost comparison guide. It’s a great tool for evaluating insurance options. If you’re helping someone from another state, check the SHIP or insurance department website for state-specific guide premium comparisons.

One important service that counselors provide is helping clients compare the cost of Medigap insurance with the cost of Medicare Advantage (MA) plans. Many MA plans have low monthly premiums, including some with no premiums at all. But comparing Medigap insurance and MA plans on premium prices alone can lead to problems. It is also important for people to understand where the potential for out-of-pocket costs exists.

Example: Glenn is new to Medicare. As he decides about enrolling in a Medicare Advantage plan, he asks about the difference in price between Medigap Plan C and a Medicare PPO. The monthly premium for the Medigap policy is \$170 (\$2,040 annually). The monthly premium for the Medicare PPO is \$50 (\$600

annually). Glenn wants to make sure, however, that he has good coverage for cancer care because the illness runs in his family. With Medigap Plan C, if he needs hospital outpatient services and chemotherapy drugs, he would have no additional out-of-pocket costs. Plan C covers all the coinsurance charges. But with the Medicare PPO, he would owe 20% of the cost of chemotherapy drugs with the potential for many thousands of dollars in out-of-pocket costs that would add to the cost of the PPO's low premiums.

Consumer Rights and Protections

Medicare beneficiaries have several important consumer rights when purchasing Medigap insurance. Some of the main protections are:

Open enrollment and guaranteed issue rights for new Medicare beneficiaries: In Kansas, all people with Medicare have a six-month Medigap open enrollment period after they become eligible for Medicare and enroll in Medicare Part B. This also protects older workers when they first enroll in Part B later. A beneficiary has the right to purchase any Medigap policy during this frame. Insurance companies must issue the policy and cannot turn down the applicant based on poor health status.

Guaranteed issue and open enrollment for people under 65: Kansas requires insurance companies to sell all types of Medigap policies to Medicare beneficiaries who are under age 65, including those with disabilities. The companies must issue the policies regardless of age or health status. Guaranteed issue plans for beneficiaries eligible prior to January 1, 2020 are: A, B, C, F, K, or L. Guaranteed issue plans for beneficiaries eligible after January 1, 2020 are: A, B, D, G, K, or L.

Guaranteed issue rights for those who lose coverage: Medicare beneficiaries who lose their coverage from a Medicare Advantage plan when they move away from the plan's service area, or those who lose coverage when an employer or union group plan ends, have a right to enroll in one of six Medigap policies (A, B, D, G, K, or L) or (A, B, C, F, K, or L) during a 63-day window after their previous coverage ends.

Losing Medicare Advantage (MA) coverage

- MA terminates or stops providing care in the area.
- Beneficiary moves outside the MA service area.
- Beneficiary leaves the plan because it failed to meet its required obligations to them.
- The beneficiary is eligible to return to Original Medicare and purchase a Medigap policy, (A, B, C, F, K, or L or (, B, D, G, K or L) from any company selling these policies.

Medicare Advantage/Medicare Select Trial Right

- The beneficiary initially enrolls in an MA plan or Medicare Select plan when they first become eligible for Medicare and decide within the first 12 months they do not like it, they can go to Original Medicare, and they have the right to purchase any Medigap policy from any insurance company selling these policies (excluding Plans C or F if eligible after January 1, 2020).
- if the beneficiary decides to try an MA plan or Medicare Select, they drop their Medigap coverage, and then decide they don't like the MA, they may return to Original Medicare if they meet these requirements:
 - This must be the first time they are enrolled in an MA plan or Medicare Select plan;
 - They must decide to leave the plan within one year after joining;

Medicare Supplement (Medigap) Insurance

- If they meet these requirements, they will return to their original Medigap policy, if it is still offered, or choose from one of the guaranteed policies (A, B, C, F, K, or L, or A, B, D, G, K, or L).

Employer Group Health Plan Benefits

If the beneficiary is enrolled as an employee, retiree, or dependent under a group health plan and the plan terminates their health benefits they have the right to purchase one of the six guaranteed Medigap policies (A, B, C, F, K, or L or A, B, D, G, K or L) from any insurance company selling these policies.

Medigap Insurance Coverage

If the beneficiary loses their Medigap insurance coverage due to one of these reasons:

- Insurance company is insolvent or goes bankrupt.
- Involuntary termination of coverage or enrollment.
- Company substantially violates material provision of the policy
- Representative of company materially misrepresents policy provisions in marketing the policy.
- The beneficiary is eligible to return to Original Medicare and purchase a Medicare supplement policy, (A, B, C, F, K, or L or A, B, D, G, K or L) from any company selling these policies.

Medicaid eligibility

If the beneficiary loses their eligibility for health benefits under Title XIX of the Social Security Act (Medicaid), the beneficiary is eligible to purchase any Medigap policy from any company selling these policies in Kansas, (excluding Plans C or F if eligible after January 1, 2020).

Guaranteed Renewability: Insurance companies cannot cancel Medigap insurance policies except for failure to pay premiums. Older policies (prior to 1992) may allow the company to refuse to renew on an individual basis.

- If a supplement is canceled due to non-payment of premium, it shall be reinstated in the event of lapse, if the insurer provides proof of cognitive impairment or the loss of functional capacity within five months after termination. The beneficiary (or their representative) may pay past due premium and keep the policy in force. The standard of proof of cognitive impairment or loss of functional capacity shall be established by clinical diagnosis by a person licensed to practice medicine and surgery and qualified to make such diagnosis.

Prohibited marketing practices: It is against the law for an insurance company or agent to sell duplicate Medigap policies, to sell a Medigap policy to someone who has Medicaid (with some exceptions), and to use high-pressure sales tactics.

Other Policy Features & Limitations

30-Day Free Look

Kansas requires a minimum 30-day “free look” period for Medigap insurance beginning when the policy is received by the insured. If the policy is reviewed and returned to the insurer during the free look period, a full premium refund must be given. Policies should be returned with a letter of explanation directly to the insurer’s home office using certified mail. To verify the date of receipt, keep the envelope in which the policy was received, and keep a copy of all correspondence. For practical purposes, the date of receipt is the postmark date plus 7-10 days.

Suspension during Medicaid or QMB Eligibility

In some situations, eligibility for Medicaid or QMB assistance may be for a short period only. Under these circumstances a suspension provision enables the insured to immediately return to using the Medigap policy without having to go through the application process and possible denial because of health conditions.

Suspending (Freezing) a Medigap Policy

- When a policyholder or certificate holder is entitled to Medicaid or QMB, the benefits and premium may be suspended at the request of the insured for a period not to exceed 24 months. The insured must notify the company within 90 days after the date they become entitled to Medicaid/QMB coverage and explain why they want their policy suspended. Upon receiving the notice, the company must return that portion of the premium applicable to the period of Medicaid/QMB eligibility.
- When a policyholder or certificate holder loses Medicaid or QMB, his/her insurance coverage can automatically be reinstated (effective with the termination date) if the company is notified within 90 days and pays the premium attributable to the period.
- There can be no pre-existing condition waiting period when the policy is reinstated. Coverage must be equivalent to coverage in effect before the date it was suspended. Premiums must be paid back to the date the policy is reinstated, which is the date Medicaid or QMB ends.

Underwriting

Underwriting is the process through which insurance companies decide whether to issue insurance to an applicant. Each company has its own guidelines for underwriting. Some companies are very conservative and insure only relatively low-risk individuals. Other companies will insure people with a higher potential risk because of health problems. A higher risk usually requires a higher premiums rate.

Underwriting may be limited to asking health-related questions on an application, or it may entail a thorough review of an individual's medical history including obtaining copies of medical records from the applicant's physicians. There is no limit on how far back into one's medical history the insurance company can search while they are doing underwriting. Conditions for which the applicant has received no advice or treatment in the six months before a policy's effective date cannot be considered pre-existing for any required waiting period.

Pre-Existing Conditions Limitations

Some people who know or suspect that they might require medical treatment in the future attempt to purchase health insurance to defray the cost of that future treatment. This form of "adverse selection" may involve fraudulently concealing information from an application or may occur because basic insurance principles are not understood. One of the ways companies defend against this form of adverse selection by applicants in poor health is the pre-existing condition exclusion or waiting period. There is no limit on what health history is considered for underwriting purposes as earlier described; however, there is a limit on how long benefits can be denied for pre-existing conditions once a policy has been issued.

Pre-Existing Condition Defined

Medicare Supplement (Medigap) Insurance

Under the Kansas insurance code, “a pre-existing condition is one for which medical advice was given or treatment was recommended by or received from a physician within the six months before the effective date of coverage.” Treatment for this definition includes prescription medication. The waiting period for a Medicare supplement policy cannot exceed six months after the policy becomes effective.

Waiting Period for Pre-existing Conditions

Limits can apply only to those conditions identified as pre-existing, according to the definition above. Benefit payments on a claim can be denied for treatment of pre-existing medical condition for up to six months after the effective date of a health insurance policy. During the waiting period, any eligible claims for conditions that are not pre-existing will be paid.

The six-month time frame before and after policy issue is the maximum allowed. A company can use a shorter period or have no limitation for pre-existing conditions. Obviously, an accident that occurs after a policy is issued could not be a pre-existing condition.

Credit for Pre-Existing Conditions

If you have a Medigap policy and you replace it with another Medigap policy, you get up to six months “credit” for the time you were covered by the old policy. The company cannot refuse to cover pre-existing conditions if you have at least six months of “creditable coverage.” Creditable coverage includes:

- Group health plan (like an employer plan);
- Health insurance policy;
- Medicare Part A or Part B;
- Medicaid;
- Medical program of the Indian Health Service or tribal organization;
- A Healthcare Marketplace plan;
- TRICARE (health care program for military dependents & retirees);
- Federal Employees Health Benefit Plan;
- Public health plan; or
- Health plan under the Peace Corp Act.

Coordination of Benefits

The Medigap Policy and Medicare

Medigap insurance always coordinates with Medicare. This means Medicare pays first (is primary), and the Medigap policy helps pay amounts not paid by Medicare. If a claim is not approved for Medicare coverage, the Medigap policy usually does not cover the claim unless the policy specifically includes a benefit in addition to Medicare-approved coverage.

The Medigap Policy & Other Health Insurance

Medigap policies are not allowed to coordinate benefits with other health insurance (except for Medicare). In other words, the Medigap policy will pay its normal benefits regardless of any other insurance you may have.

Group Health Insurance Policies

Medicare Supplement (Medigap) Insurance

Common types of group health insurance policies are employer-provided retirement policies, accident policies, and specific-disease policies (such as a plan that pays in case of cancer or stroke).

Group insurance policies can **have a coordination of benefits** provision. This provision allows them to reduce their benefits if another group insurance plan or Medicare pays benefits. The result may be that the **group** policy ends up paying little or nothing on the claim.

More than One Medicare Supplement Policy

It is against the law for an insurance company or agent to knowingly sell a Medigap policy to someone who already has a Medigap policy, unless the new one is to replace the old one. Applications ask if the applicant has another Medigap policy or if it is the intent to replace coverage currently in force. If the applicant indicates coverage is in force and there is no intent to terminate the current coverage, the insurance company will not issue the policy.

If you had a supplement policy prior to 1991, it is possible for you to have two supplements. However, after 1991, you can only have ONE Medigap policy. If someone does have multiple Medicare supplement policies, each policy must pay full benefits due. Claims should be filed separately for each policy.

Other Health Insurance Policies

The law allows the sale of additional insurance policies such as hospital indemnity, cancer, stroke, and accident even though benefits may duplicate benefits from Medicare. However, such policies must pay all benefits due regardless of any payments the insured receives from other coverage.

A disclosure statement explaining possible duplication of benefits must be provided to the applicant along with the application.

Consumer Protection

The way insurance companies and agents conduct the business of selling insurance and the design and use of written material is substantially regulated by federal and state laws and regulations. Any violation of those laws and regulations may be addressed in a written complaint which, upon investigation by the Kansas Insurance Department, may lead to fines, restriction on future activity, or loss of the right to do business in the state.

Sales Materials

Outline of Coverage

This must be provided to the client at the time of solicitation. It shows the features of each plan being offered and includes premium information.

Acknowledgement of Non-duplication

This must be provided at the time of **application** (or issuance if a mail order policy). The agent, or insurance company for a direct mail sale, must offer to review all health insurance policies for a client. Both the client and agent must sign the "Acknowledgement of Non-duplication" which states that the offer to review had been made and that the intended sale will not duplicate other benefits to which the client is entitled.

Replacement Notice

Medicare Supplement (Medigap) Insurance

This must be provided at the time of application (or policy delivery if a mail order policy) when a Medigap policy being purchased will be replacing another Medigap policy. The replacement notice must be signed by the client and agent, and it must state that the client intends to terminate existing coverage. The agent must indicate why the replacement policy is being purchased (additional benefits; lower premiums, but no change in benefits, fewer benefits and lower premium; or other).

Questionable Behavior of Insurance Agents

The Kansas Insurance Department (KID) has rules and regulations regarding what is required and expected on the part of agents as they sell insurance. KID has enforcement authority through the Agents and Brokers Division, which licenses all agents selling insurance in Kansas. Any questionable behavior of an agent can be passed along to this division at any time and it will be put in the file of the agent and if necessary, disciplinary action will be taken.

To take administrative action of any kind, KID needs the person observing the behavior to file a complaint with the department including the name of the agent and the company that he/she represents, either online at <https://insurance.kansas.gov/complaint>, or written using the consumer complaint pdf form available at https://insurance.ks.gov/documents/department/Complaint_Form.pdf. The formal complaint must be signed by the person who has observed the questionable behavior.

WARNING! It is important to remember that any personal views on an agent or company are just that - personal views. Expressing such a view in public is contrary to the most basic principle of the SHICK program - “**unbiased**” assistance. This is also a fundamental principle of the Kansas Insurance Department and the Kansas Department for Aging and Disability Services. Any prejudicial statements made that are not based on administrative action taken specifically by the department toward certain individuals is strictly prohibited.

KID takes its role of supervising agents very seriously because it has a direct relationship regarding protecting Kansas insurance consumers. Any information about any agent forwarded to KID is always helpful. Formal complaints are even more helpful because they can then investigate the matter.

Be a Wise Consumer

Shop Around

Decide which of the 10 standardized policies best meets your needs. Then shop around for price, customer service, and financial stability. Group insurance is not necessarily less expensive than individual coverage.

Medigap Open Enrollment Period

During the first six months a person is enrolled in Medicare Part B, *whether 65 or under 65 (in Kansas)*, all insurance companies must accept the person for Medigap coverage under any policy currently being marketed. Past health history may not be considered. If the beneficiary waits until after the open enrollment period, they may be refused coverage under some policies if they do not meet the company’s insurability requirements.

Companies May Have a Waiting Period (Up to six months)

Medicare Supplement (Medigap) Insurance

Pre-existing conditions would not be covered during the waiting period. If you have pre-existing conditions, look for a company that does not have a waiting period.

Does the Person with Medicare have Creditable Coverage?

If the answer is yes, there is no need to worry about the pre-existing condition waiting period – but first they must understand creditable coverage AND not have a gap of more than 63 days without coverage.

The Phrase “No Medical Examination Required” may be misleading

The beneficiary might not have to go to a physician for an exam, but medical statements they make on the application could prevent them from getting coverage after their open enrollment period.

Take Time

A beneficiary should not feel pressured into buying a policy if they have questions or concerns. They should involve a friend or relative whose judgment they can trust. If they need more time, tell the agent to return at some future date. They should not fall for the age-old excuse, “I’m only going to be in town today, so you had better buy now.”

Generally, it takes at least 30 days to be approved

They are not insured by a new Medigap policy on the day they apply for it.

A policy should be delivered within a reasonable time (usually within 30 days after application)

If they haven’t received the policy or had their check returned in 30 days, contact the company and obtain in writing the reason for delay. If problems continue, contact the Kansas Insurance Department.

Consider carefully before replacing a policy with a new one

The beneficiary should not cancel a policy until they have been accepted by the new insurer and have policy in hand.

Do not pay with cash

They should/can pay by check, money order, or bank draft payable to the insurance company only, not the agent. They should completely fill in the check before presenting it to the agent.

If they are eligible for Medicaid, generally, they do not need a Medigap policy

There are exceptions to this. To find out if they are eligible for Medicaid or if they are a Qualified Medicare Beneficiary (QMB) or a Low Income Beneficiary (LMB), ask the beneficiary or the KanCare Clearinghouse.

Use Their 30-Day “Free Look” Period

The beneficiary should review their new Medigap policy and get a premium refund if they decide not to take the coverage.

Refunds Aren’t Available After the “Free Look” Period

Insurance companies are not required to return an unused premium if the beneficiary decides to drop the policy before its next premium due date, but after the free look period has passed. If an agent tries to sell them a new policy saying they can get a premium refund for their current policy, report the agent to the Kansas Insurance Department.

Medigap Policies Are Not Sold by Federal or State Governments

Medicare Supplement (Medigap) Insurance

Advertising or suggesting that a policy is government sponsored is illegal. These practices should be reported to the Kansas Insurance Department.

Complete the Application Carefully

Before the beneficiary signs an application, they should read the health information recorded by the agent. They should not sign it until all health information is presented correctly. If they leave out medical information requested, the insurer could deny coverage for that condition or cancel their policy.

Review Retiree Policies Carefully

The beneficiary should carefully compare benefits and cost of retiree plans before replacing a retiree benefit with a Medigap policy. It will be necessary to have a copy of the outline of coverage to make this comparison. It may be necessary to call the Employer's Plan or Human Resources Administrator. Without this information, it is not possible to make an accurate comparison.

Outline of Coverage

An Outline of Coverage must be provided at the time of solicitation. When presented by an agent, an acknowledgment of receipt of such outline shall be obtained. This is often in the form of a question on the application requiring a yes or no answer.

The information that must be included and the format in which it must be presented are spelled out in the insurance regulations. In general, an Outline of Coverage will have the following:

- An illustration of premium information with all possible premiums for the prospective applicant.
- Disclosures about other aspects of the policy and how coverage will be administered.
- Charts displaying the features of each benefit plan being offered.

Chapter 7 - COUNSELING TOOLS

SHICK (Senior Health Insurance Counseling of Kansas) RESOURCES

There are 11 Area Agencies on Aging (AAA) in Kansas, each covering a specific geographical area. These agencies coordinate service and programs for persons age 60 and over in each area. Of the 11 AAA's, 10 are SHICK Sub-grantees. Johnson County AAA (11) is not a SHICK Sub-grantee. The SHICK program for Johnson County is coordinated through the East Central Kansas AAA. **SHICK counselors are trained to walk a beneficiary through their Medicare options and help them complete the needed paperwork.** If you are unsure how to enroll or dis-enroll a beneficiary in Medicare coverage, contact a SHICK counselor to meet with the individual.

SHICK Sub-grantees

Wyandotte/Leavenworth County Area Agency on Aging

913-573-8545 / 1-888-661-1444 / (fax) 913-573-8577

849 N 47th St., Kansas City, Kansas 66102 **Counties:**

Leavenworth, Wyandotte

Sedgwick County Extension & SHICK Call Center

316-660-0100/ ext. 0117 / 316-722-1432 (fax)

7001 W. 21st North, Wichita, KS 67205 **County:**

Butler, Harvey, Sedgwick

Central Plains Area Agency on Aging

316-660-5120 / 800-367-7298 ext. 5132

271 W 3rd St N Suite 500, Wichita 67202 **County:**

Butler, Harvey, Sedgwick

Northwest Kansas Area Agency on Aging

785-628-8204 / 800-432-7422 / 785-628-6096 (fax)

510 West 29th, Suite B, P O Box 610, Hays, KS 67601

Counties: Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Norton, Osborne, Phillips, Rawlins, Rooks, Russell, Sheridan, Sherman, Smith, Thomas, Trego, Wallace

Senior Resource Center for Douglas County

785-842-0543 / 877-295-3277 / 785-842-0562 (fax)

745 Vermont, Lawrence, KS 66044 **County:**

Douglas

Jayhawk Area Agency on Aging

785-235-1367 / 800-798-1366 (outside Topeka) / 785-354-5346(fax)

2910 SW Topeka Boulevard, Topeka, KS 66611

County: Jefferson, Shawnee

Counseling Tools

Southeast Kansas Area Agency on Aging

620-431-2980 / 800-794-2440 / 620-431-2988 (fax)

1 West Ash, P. O. Box J, Chanute, KS 66720

County: Allen, Bourbon, Cherokee, Crawford, Labette, Montgomery, Neosho, Wilson, Woodson

Southwest Kansas Area Agency on Aging

620-225-8230 / 800-742-9531 / 620-225-8240 (fax)

236 San Jose Dr., P. O. Box 1636, Dodge City, KS 67801

County: Barber, Barton, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearny, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Rush, Scott, Seward, Stevens, Stafford, Stanton, Wichita

East Central Kansas Area Agency on Aging

785-242-7200 / 800-633-5621 / 785-242-7202 (fax)

117 South Main, Ottawa, KS 66067

County: Anderson, Coffey, Franklin, Johnson, Linn, Miami, Osage

North Central Flint Hills Area Agency on Aging

785-776-9294 / 800-432-2703 / 785-776-9479 (fax)

401 Houston, Manhattan, KS 66502

County: Chase, Clay, Cloud, Dickinson, Ellsworth, Geary, Jewell, Lincoln, Lyon, Marion, Mitchell, Morris, Ottawa, Pottawatomie, Republic, Riley, Saline, Wabaunsee

Northeast Kansas Area Agency on Aging

785-742-7152 / 800-883-2549 / 785-742-7154 (fax)

1803 Oregon, Hiawatha, KS 66434

County: Atchison, Brown, Doniphan, Jackson, Marshall, Nemaha, Washington

South Central Kansas Area Agency on Aging

620-442-0268 / 800-362-0264 / 620-442-0296 (fax)

P. O. Box 1122, 304 S Summit, Arkansas City, KS 67005

County: Rice, McPherson, Reno, Kingman, Harper, Sumner, Cowley, Chautauqua, Elk, Greenwood

TOLL-FREE HOTLINE: 1-800-860-5260

SHICK WEB SITE <http://www.kdads.ks.gov/shick>

How to Find SHIPs Outside the state of Kansas

- **Call 1-800-MEDICARE - (1-800-633-4227)**
- **Ask the SHICK Call Center Operator at 1-800-860-5260**
- **Go to: <https://www.shiptacenter.org/> ○ Find “Looking for help? Find your local SHIP here:” Click on the box “SHIP**

Locator”

- ✦ Click on the preferred state’s name

The state’s SHIP Profile page will open

Getting Ready for Medicare – Enrollment Steps

Counseling Steps for assisting a beneficiary who is new to Medicare due to turning 65 or qualifying for Medicare due to disability.

Step 1: Identify if the client has Medicare and find out which parts of Medicare they have.

Step 2: Identify if the client has any other health care coverage.

Step 3: Identify if the client has low income and assets.

- General questions are best.
- Is your income above or below this amount?
- Are your assets above or below this amount?
- More specific income and asset information is not needed unless the beneficiary qualifies for Extra Help or the Medicare Savings Program.

Step 4: Identify if the client is eligible for Medicare or will be soon.

Step 5: If needed, explain to the client the different parts of Medicare (A-D) and what each part covers.

Step 6: Tell client points to think about for each part of Medicare:

- Cost and programs to help with cost (Medicare Savings Programs, Part D Extra Help)
- Penalties and gaps
- Effective start dates, and impact on current or past bills or treatment needs
- Impact to other health care coverage for client and family (such as will other coverage continue or end, which insurance will be primary, etc.)

Step 7: Identify whether Social Security Administration (SSA) will automatically enroll client in any parts of Medicare, or if client will need to enroll self in to join.

- Options for enrolling in Medicare – www.ssa.gov, apply online or go to their local Social Security office.
- Let client know about any parts of Medicare client will need to enroll self in to join.
- If client must enroll to have Medicare, ensure client knows how and when he or she may enroll.

Step 8: Identify if client may defer enrolling in any parts of Medicare without a penalty.

Step 9: Ensure client understands Medicare billing process, including:

- Finding providers who take their coverage
- What happens if providers don't accept assignment under Original Medicare
- What to expect with Medicare billing

Counseling Tools

Step 10: Make sure client knows how to protect self against fraud (give SMP brochure).

Step 11: If client needs help with the costs or gaps of Medicare, give explanation of supplemental insurance. Refer to Medicare Supplement Shopper's Guide from the Kansas Insurance Department or refer to the Kansas Insurance Department website: <https://insurance.kansas.gov> .

Step 12: Provide appropriate referrals, publications, and Web references.

Other reminders

- Tell clients points to think about with each option.
- Help clients compare choices with resources provided in SHICK training, Kansas Insurance Department publications or information found on www.medicare.gov website Provide related publications and referrals.
- Find out if clients have other questions.
- Warn clients about fraud. The SMP brochure and SMP Personal Healthcare Journal are good resources.
- Summarize next steps.
- Complete the Beneficiary Contact Form or data enter your contact on STARS.

Chapter 8 - GLOSSARY

A

Abuse – A range of the following improper behaviors or billing practices including, but not limited to: Billing for a non-covered service; Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or Inappropriately allocating costs on a cost report.

Activities of Daily Living (ADL) - Activities you usually do during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.

Administrative Law Judge (ALJ) - A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.

Advance Beneficiary Notice of Noncoverage (ABN) - In Original Medicare, a notice that a doctor, supplier, or provider gives a Medicare beneficiary before furnishing an item or service if the doctor, supplier, or provider believes that Medicare may deny payment. In this situation, if you aren't given an ABN before you get the item or service, and Medicare denies payment, then you may not have to pay for it. If you are given an ABN, and you sign it, you will probably have to pay for the item or service if Medicare denies payment.

Advance Coverage Decision - A notice you get from a Medicare Advantage Plan letting you know in advance whether it will cover a particular service.

Advance Directive - A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a Living Will and a Durable Power of Attorney for health care.

Aging and Disability Resource Center (ADRC) – The ADRC is a trusted source of information where people of all ages, abilities and income levels - and their caregivers - can go to obtain assistance in planning for their future long-term service and support needs.

Allowed Charge (Medicare) – An individual charge determination made by a Medicare carrier on a covered Part B medical service or supply. In the absence of unusual medical circumstances, it is the lowest of: 1) the physician's fee schedule amount in most cases; or 2) the actual charge made by the physician or supplier.

ALS - Amyotrophic lateral sclerosis, also known as Lou Gehrig's disease.

Ambulatory Services – Medical services provided to patients who are not hospitalized.

Ambulatory Surgical Center - A facility where simpler surgeries are performed for patients who aren't expected to need more than 24 hours of care.

Ancillary Services - Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

Annual Coordinated Election Period (AEP) - The Annual Coordinated Election Period for Medicare beneficiaries begins in October 15 through December 7 each year. Also called the Open Enrollment Period.

Appeal - An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. Appeals involve money – Medicare paid too much, Medicare didn't pay enough, Medicare denied the claim.

Approved Amount - The fee Medicare sets as reasonable for a covered medical service.

Area Agency on Aging (AAA) - A nationwide network of State and local programs that help older people plan and care for their life-long needs. Services include information and referral for in-home services, counseling, legal services, adult day care, skilled nursing care/therapy, transportation, personal care, respite care, nutrition and meals.

Assignment (Medicare) – An agreement by your doctor or other supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

B

Beneficiary - A person who has health care insurance through the Medicare or Medicaid programs.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) - A type of QIO (an organization of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care for people with Medicare. The BFCCQIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.

Benefit Period - The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Benefits - The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Benefits Coordination & Recovery Center - The company that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have, and determine whether the coverage pays before or after Medicare. This company also acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment, and the other payer is determined to be primary.

Biologicals - Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.

C

Capped Rental Item - Durable medical equipment (like nebulizers or manual wheelchairs) that costs more than \$150, and the supplier rents it to people with Medicare more than 25% of the time.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs.

CHAMPVA - A health care benefit for dependents of qualifying veterans.

Claim - A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.

Clinical breast exam - An exam by your doctor or other health care provider to check for breast cancer by feeling and looking at your breasts. This exam isn't the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.

Cognitive Impairment - A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

Coinsurance – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Complaint (of Fraud or Abuse) - A statement, oral or written, alleging that a provider or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.

Conditional Payment - A payment made by Medicare for services for which another payer is responsible.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - A law that lets some people keep their employer group health plan coverage for a period of time after: the death of your spouse, losing your job, having your working hours reduced, leaving your job voluntarily, or getting a divorce. You may have to pay both your share and the employer's share of the premium.

Coordinated Care Plan - A plan that includes a CMS-approved network of providers that are under contract or arrangement with the MA organization to deliver the benefit package approved by CMS. Coordinated care plans include plans offered by health maintenance organizations (HMOs), preferred provider organizations (PPOs), as well as other types of network plans (except network MSA plans).

Coordination of Benefits - A way to figure out who pays first when two or more health insurance plans are responsible for paying a medical claim.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Cost Sharing - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. This amount can include copayments, coinsurance, and/or deductibles.

Coverage gap (Medicare prescription drug coverage) - A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the "donut hole") starts when you and your plan have paid a set dollar amount for prescription drugs during that year.

Creditable Coverage (Medigap) - Health coverage you have had in the past, such as group health plan (including COBRA continuation coverage), an HMO, an individual health insurance policy, Medicare or Medicaid, and this prior coverage was not interrupted by a significant break in coverage (more than 63 days). The time period of this prior coverage must be applied toward any pre-existing condition exclusion imposed by a new health plan. Proof of your creditable coverage may be shown by a certificate of creditable coverage or by other documents showing an individual had health coverage, such as a health insurance ID card.

Creditable Prescription Drug Coverage - Prescription drug coverage (like from an employer or union), that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

Critical Access Hospital (CAH) - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Custodial Care - Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

D

Deductible - The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or other insurance begins to pay.

Deemed Status - A provider or supplier earns this when they have been accredited by a national accreditation program (approved by the Centers for Medicare & Medicaid Services) that they demonstrate compliance with certain conditions.

Demonstrations - Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas.

Department of Health and Human Services (HHS) - A Federal agency that administers programs for protecting the health of all Americans, including the Medicare, Medicaid, and Children's Health Insurance Programs.

Disability - For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for continuous period of not less than 12 months. Special rules apply for workers aged 55 or older

Glossary

whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare for most applicants.

DME Medicare Administrative Contractor (MAC) - A private company that contracts with Medicare to pay bills for durable medical equipment.

Drug List - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. This list is also called a formulary.

Durable Medical Equipment (DME) – Certain medical equipment, such as a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Durable Power of Attorney - A legal document that enables you to designate another person, called the attorney-in-fact, to act on your behalf, in the event you become disabled or incapacitated.

E

Emergency Care - Care given for a medical emergency when you believe that your health is in serious danger when every second counts.

Employer or Union Retiree Plans - Plans that give health and/or drug coverage to employees, former employees, and their families. These plans are offered to people through their (or a spouse's) current or former employer or employee organization.

End-Stage Renal Disease (ESRD) - Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Enrollment Period - A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Exception - A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You must request an exception, and your doctor or other prescriber must send a supporting statement explaining the medical reason for the exception.

Excess Charge – If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

Exclusions - Items or services that Medicare does not cover, such as most routine services like eye exams, hearing exams, annual physical, long-term care, and custodial care in a nursing or private home.

Extra Help - A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

F

Federally-Qualified Health Center - Federally-funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services even if you can't afford it. Services are provided on a sliding scale fee based on your ability to pay.

Fee-For-Service Payment – A method of paying for medical care in which each service performed by an individual provider can bear a related charge.

Formulary - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Fraud - The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Fraud and Abuse - Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.

Free Look (Medigap Policy) - A period of time (30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled. If you cancel, you will get your money back.

G

Gaps - The costs or services that are not covered under the Original Medicare Plan.

General Enrollment Period (GEP) - The General Enrollment Period is January 1 through March 31 of each year. If you enroll in Premium Part A or Part B during the General Enrollment Period, your coverage starts on July 1.

Generic Drug - A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Grievance - A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.

Group health plan - In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Guaranteed Issue Rights (Also Called “Medigap Protections”) - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of a past or present health problem.

Guaranteed Renewable Policy - An insurance policy that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud, or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

H

Health care provider - A person or organization that's licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Health coverage - Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

Health Insurance Claim Number (HICN) – The ten (10) to eleven (11) digit number assigned by Medicare to each beneficiary. Also referred to as your Medicare Claim Number.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - The "Standard for Privacy of Individually Identifiable Health Information (also called the "Privacy Rule")" of HIPAA assures your health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Health Maintenance Organization (HMO) (Medicare) – A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency.

Health Savings Account (HSA) - A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.

Health Reimbursement Arrangement (Account) (HRA) - an employer-funded plan that reimburses employees for medical expenses and, sometimes, insurance premiums.

Home - Location, other than a hospital or other facility, where the patient receives care in a private residence.

Home and Community-Based Service Waiver Programs (HCBS) - The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, intellectually disabled, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.

Home Health Care - Health care services and supplies a doctor decides you may receive in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

Homebound - Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent

absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

Hospice - A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well.

Hospital Care (Inpatient) - Treatment you get in an acute care hospital, critical access hospital, inpatient rehabilitation facility, long-term care hospital, inpatient care as part of a qualifying research study, and mental health care.

Hospital Outpatient Setting - A part of a hospital where you get outpatient services, like an emergency department, observation unit, surgery center, or pain clinic.

I

Independent Reviewer - An organization (sometimes called an Independent Review Entity or IRE) that has no connection to your Medicare health plan or Medicare Prescription Drug Plan. Medicare contracts with the IRE to review your case if you appeal your plan's payment or coverage decision or if your plan doesn't make a timely appeals decision.

Initial Coverage Limit - Under Part D, once you have met your yearly deductible, you will pay a copayment or coinsurance for each covered drug until you reach your plan's out-of-pocket maximum (or initial coverage limit). You will then enter your plan's coverage gap (sometimes called the "donut hole").

Initial Enrollment Period (IEP) - The Initial Enrollment Period is the first chance you have to enroll in Medicare Part B & buy a Medicare Part D Prescription Drug plan. Your Initial Enrollment Period starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months.

In-Network - Doctors, hospitals, pharmacies, and other health care providers that have agreed to provide members of a certain insurance plan with services and supplies at a discounted price. In some insurance plans, your care is only covered if you get it from in-network doctors, hospitals, pharmacies, and other health care providers.

Inpatient Care - Health care that you get when you're admitted to a health care facility, like a hospital or skilled nursing facility.

Inpatient Hospital Services - Services you get when you're admitted to a hospital, including bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Inpatient Prospective Payment System (IPPS) - Hospitals that have contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.

Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Inpatient Rehabilitation Facility - A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

L

Large Group Health Plan (LGHP) - In general, a group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

Liability Insurance - Liability insurance is insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.

Lifetime Reserve Days - In Original Medicare, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Limiting Charge - In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Living Wills - A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent.

Long-Term Care - Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Long-Term Care Hospital - Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Long-Term Care Insurance - A private insurance policy to help pay for some long-term medical and nonmedical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies."

Long-Term Care Ombudsman - An independent advocate (supporter) for nursing home and assisted living facility residents who works to solve problems between residents and nursing homes or assisted living facilities. They may be able to provide information about home health agencies in their area.

Low-Income Medicare Beneficiary (LMB) - A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

M

Medicaid - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary- Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare - The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medicare Administrative Contractor (MAC) - A company that processes claims for Medicare.

Medicare Advantage Plan (Medicare Part C) (MA) - A type of Medicare health plan offered by a private company which contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Advantage Open Enrollment Period (MA-OEP) - January 1 through March 31 every year. Available only for beneficiaries who are enroll in a Medicare Advantage plan as of January 1. Beneficiaries have a one-time opportunity to switch MA plans or drop their MA plan and return to Original Medicare, Part A and Part B.

Medicare Advantage Prescription Drug (MA-PD) PLAN - A Medicare Advantage plan that offers Medicare prescription drug coverage (Part D), Part A, and Part B benefits in one plan.

Medicare Health Plan - A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Outpatient Observation Notice (MOON) - The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH).

Medicare Part A (Hospital Insurance) - Coverage for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance) - Coverage for certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Preferred Provider Organization (PPO) PLAN - A type of Medicare Advantage Plan (Part C) available in some areas of the country in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Prescription Drug Coverage (Part D) - Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medicare Private Fee-for-Service Plan - A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare, if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals, and how much you must pay when you get care. A Private Fee-For-Service Plan is very different than Original Medicare, and you must follow the plan rules carefully when you go for health care services. When you're in a Private Fee-For-Service Plan, you may pay more or less for Medicare-covered benefits than in Original Medicare.

Medicare Savings Program (MSP) - A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.

Medicare Select - A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Summary Notice (MSN) - A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare approved amount, how much Medicare paid, and what you must pay.

Medicare Special Needs Plan (SNP) - A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

Medicare Supplement Insurance - Medicare supplement insurance are health insurance policies that coordinate with Medicare as the primary payer. This could be a Medigap policy, an employer group plan, TRICARE for Life, and Medicaid, to name a few. Most are sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage.

Medicare-Approved Amount - In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount charged by a doctor or supplier.

Medigap Insurance – Private standardized supplementary medical insurance covering out-of-pocket expenditures of Medicare beneficiaries such as deductibles and coinsurance.

Medigap Open Enrollment Period - A one-time-only six month period when you can buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems. Kansas law has provisions for people under 65, on SSA disability.

Military Treatment Facility - A medical facility operated by one or more of the Uniformed Services. A Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

MIPPA - Medicare Improvements for Patients and Providers Act of 2008 - On July 15, 2008, Congress overrode President Bush's veto and enacted this law. It is perhaps best known for blocking scheduled cuts in Medicare's payments to doctors as well as changes in three key areas: 1) improvements to Medicare

benefits, especially for low-income beneficiaries; 2) new policies to reduce racial and ethnic disparities among people with Medicare; and 3) reining in rapidly-growing and inefficient private Medicare Advantage plans.

Multi-Employer Plan - In general, a group health plan that's sponsored jointly by two or more employers.

N

Network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Network Pharmacies - Pharmacies that have agreed to provide members of certain Medicare plans with services and supplies at a discounted price. In some Medicare plans, your prescriptions are only covered if you get them filled at network pharmacies.

No-Fault Insurance - No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Non-Covered Service - The service: does not meet the requirements of a Medicare benefit category, is statutorily excluded from coverage on ground other than 1862(a)(1), or is not reasonable and necessary under 1862 (a)(1).

Non-Formulary Drugs – Drugs not on a plan-approved drug list.

Non-Participating Physician - A doctor or supplier who does not accept assignment on all Medicare claims.

Non-Preferred Pharmacy - A pharmacy that's part of a Medicare drug plan's network but isn't a Preferred Pharmacy. You may pay higher out-of-pocket costs if you get your prescription drugs from a Non-Preferred Pharmacy instead of a Preferred Pharmacy.

O

Occupational Therapy - Treatment that helps you return to your usual activities (like bathing, preparing meals, and housekeeping) after an illness.

Open Enrollment Period - See Annual Coordinated Enrollment Period

Original Medicare - Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Out-of-network - A benefit that may be provided by your Medicare Advantage plan. Generally, this benefit gives you the choice to get plan services from outside of the plan's network of health care providers. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

Out-of-pocket costs - Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.

Outpatient Prospective Payment System - The way that Medicare pays for most outpatient services at hospitals or community mental health centers under Medicare Part B.

Outpatient Hospital CARE- Medical or surgical care you get from a hospital when your doctor hasn't written an order to admit you to the hospital as an inpatient. Outpatient hospital care may include emergency department services, observation services, outpatient surgery, lab tests, or X-rays. Your care may be considered outpatient hospital care even if you spend the night at the hospital.

P

Participating Physician or Supplier - A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts. (See Assignment.)

Penalty - An amount added to your monthly premium for Medicare Part B, or for a Medicare Prescription Drug Plan, if you don't join when you're first able to. You pay this higher amount to Medicare as long as you have Medicare. There are some exceptions.

Personal Care - Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. The Medicare home health benefit does pay for personal care services.

Physical Therapy - Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Point-of-Service Option - In a Health Maintenance Organization (HMO), this option lets you use doctors and hospitals outside the plan for an additional cost.

Power of Attorney - A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care.

Pre-Existing Condition - A health problem you had before the date that a new insurance policy starts.

Preferred Providers – Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services - -Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Doctor - The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Prior Authorization - Approval from a Medicare drug plan that may be required before you fill your prescription for the prescription to be covered by your plan.

Primary Payer - An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

Programs of All-Inclusive Care for the Elderly (PACE) A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically-necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

Prospective Payment System - A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

Provider - Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Public Health Emergency – an emergency need for health care [medical] services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack or other significant or catastrophic event.

Q

Qualified Disabled and Working Individuals (QDWI) Program - A state program that helps pay Part A premiums for people who have Part A and limited income and resources.

Qualified Individual (QI) Program - A state program that helps pay Part B premiums for people who have Part A and limited income and resources.

Qualified Medicare Beneficiary (QMB) Program - A state program that helps pay Part A premiums, Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) for people who have Part A and limited income and resources.

R

Railroad Retirement - A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services - Services that help you regain abilities, such as speech or walking, that have been impaired by an illness or injury. These services are given by nurses, and physical, occupational and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

Respite Care – Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.

S

Secondary Payer - The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Self-Insured – An individual or organization that assumes the financial risk of paying for health care.

Service Area - A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Care - Care such as intravenous injections that can only be given by a registered nurse or doctor.

Skilled Nursing Facility (SNF) - A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Special Enrollment Period - A set time when you can sign up for Medicare Part B if you didn't take Medicare Part B during the Initial Enrollment Period, because you or your spouse were working and had group health plan coverage through the employer or union. You can sign up at any time you are covered under the group plan based on current employment status. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.

Specified Disease Insurance – This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of disease. Specified Disease Insurance doesn't fill gaps in your Medicare coverage.

Specified Low-Income Medicare Beneficiary (SLMB) Program - A state program that helps pay Part B premiums for people who have Part A and limited income and resources.

Speech-Language Therapy - Treatment that helps you strengthen or regain speech, language, and swallowing skills.

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. The SHIP in Kansas is SHICK (Senior Health Insurance Counseling for Kansas).

State Insurance Department - A state agency that regulates insurance and can provide information about Medigap policies and other private insurance.

Step Therapy - A coverage rule used by some Medicare Prescription Drug Plans that requires you to try one or more similar, lower cost drugs to treat your condition before the plan will cover the prescribed drug.

Supplemental Security Income (SSI) - A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits aren't the same as Social Security retirement or disability benefits.

Supplier - Generally, any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

Swing Bed – Bed approved for multiple patient use, i.e. hospital and Skilled Nursing Facility.

T

Telemedicine - Medical or other health services given to a patient using a communications system (like a computer, telephone, or television) by a practitioner in a location different than the patient's.

Tiers - Groups of drugs that have a different cost for each group. Generally, a drug in a lower tier will cost you less than a drug in a higher tier

TRICARE - A health care program for active duty and retired uniformed services members and their families. Previously known as Civilian Health And Medical Program (CHAMPUS).

TRICARE for Life (TFL) - Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

TTY - A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

U

Underwriting - The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Urgently Needed Care - Care that you get outside of your Medicare health plan's service area for a sudden illness or injury that needs medical care right away but isn't life threatening. If it's not safe to wait until you get home to get care from a plan doctor, the health plan must pay for the care.

W

Waiting Period - The period that must pass before an employee or dependent is eligible to enroll (becomes covered) under the terms of the group health plan. If the employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before the late or special enrollment is not a

Glossary

waiting period. If a plan has a waiting period and a pre-existing condition exclusion, the pre-existing condition exclusion period begins when the waiting period begins. Days in a waiting period are not counted toward creditable coverage unless there is other creditable coverage during that time. Days in a waiting period are not counted when determining a significant break in coverage.

Workers Compensation - Insurance that employers are required to have to cover employees who get sick or injured on the job.

World Health Organization – An organization that maintains the International Classification of Diseases (ICS) medical code set.

Chapter 9 - APPENDIX 2022 Overview of Medicare A & B

Key: Shaded areas – Medicare Pays
White areas – You Pay

A	B																								
Premium: <i>40 work quarters = zero less than 30 quarters = \$499 30 - 39 quarters = \$274</i>	Premium: \$170.10 unless individual income over \$91,000 or couple \$182,000.																								
Each benefit period* In-patient Hospital	\$233 Deductible (per calendar year, January 1 to December 31)																								
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100% Services Home Health Hospice	Preventive Services PAID 100%: Welcome to Medicare Physical Exam, Screening Mammograms, Annual Pap Tests, Diabetes Screening, Bone Mass Measurement, Flu Shots, some Colorectal Cancer Screening, Screening & Counseling for Obesity, Medical Nutrition Therapy, Tobacco Use Cessation, Yearly Wellness Visit WITH CO-PAY OR DEDUCTIBLE: Abdominal Aortic Aneurysm Screening, Diabetes Supplies & Self-Management, Prostate Cancer Screening, Glaucoma Screening, CCS - Barium enema, HIV Screening																								
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* Benefit period ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.	Excess Charges (15% over Medicare Allowed Charge)																								

Annual Medicare Premium and Cost-Sharing Amounts 2022

Part A – Hospital Insurance

Part A Standard Premium – No charge for most people (at least 40 work credits)
 \$499.00 per month for people with less than 30 work credits
 \$274.00 per month for people with 30 to 39 work credits

Part A – Hospital Insurance – Covered Services (Per Benefit Period)

Part A Deductible for Each Benefit Period	\$1,556.00
Hospital Inpatient	\$0 for days 1 - 60 \$389.00 a day for days 61 to 90 \$778.00 a day for days 91 – 150 (lifetime reserve days) All costs for days after 150
Skilled Nursing Facility	\$0 for days 1 – 20 \$194.50 a day for days 21 – 100 All costs for all days after 100
Home Health Care	\$0 for home health care services 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	\$0 for hospice care You may need to pay a copayment of no more than \$5 for each prescription drug and other similar products for pain relief and symptom control while you're at home. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D. You may need to pay 5% of the Medicare-approved amount for inpatient respite care. Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Blood	Blood Transfusion

Part A Late Enrollment Surcharges/Penalties:

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

Part B -Medical Insurance

Part B deductible -\$233 per year

Part B coinsurance -After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you’re a hospital inpatient), outpatient therapy, and durable medical equipment.

Part B Standard Premium -\$170.10 per month (or higher depending on your income)

You'll pay a higher premium amount in 2022 if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount.

If

You’re in 1 of these 5 groups, your 2022 Part B monthly premium rates are listed below.

If Your Yearly Income in 2020 (for what you pay in 2022) was			You pay (in 2022) *
File Individual Tax Return	File Joint Tax Return	File married and separate tax return	
\$91,000 or less	\$182,000 or less	\$91,000 or less	\$0.00
Above \$91,000 up to \$114,000	Above \$182,000 up to \$228,000	Not applicable	\$68.00
Above \$114,000 up to \$142,000	Above \$228,000 up to \$284,000	Not applicable	\$170.10
Above \$142,000 up to \$170,000	Above \$284,000 up to \$340,000	Not applicable	\$272.20
Above \$170,000 up to \$500,000	Above \$340,000 up to \$750,000	above \$91,000 and less than \$409,000	\$374.20
Above \$500,000	Above \$750,000	\$409,000 and above	\$408.20

*If beneficiary pays a late-enrollment penalty, this amount is higher.

Part B Late Enrollment Surcharges/Penalties:

If you don’t sign up for Part B when you’re first eligible, or if you drop Part B and then get it later, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could’ve had Part B, but didn’t sign up for it.

Part D –**Medicare Prescription Drug Coverage**

Part D Base Beneficiary Premium -\$33.37 (Used to determine any late enrollment penalty amount).

Listed below are the 2022 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

If Your Yearly Income in 2020 (for what you pay in 2022) was			You pay (in 2022) Income related monthly adjustment amount + your plan premium (YPP)
File individual tax return	File joint tax return	File married and separate tax return	
\$91,000 or less	\$182,000 or less	\$91,000 or less	\$0.00 + YPP
Above \$91,000 up to \$114,000	Above \$182,000 up to \$228,000	Not applicable	\$12.40* + YPP
Above \$114,000 up to \$142,000	Above \$228,000 up to \$284,000	Not applicable	\$32.10* + YPP
Above \$142,000 up to \$170,000	Above \$284,000 up to \$340,000	Not applicable	\$51.70* + YPP
Above \$170,000 up to \$500,000	Above \$340,000 up to \$750,000	above \$91,000 and less than \$409,000	\$71.30* + YPP
Above \$500,000	Above \$750,000	\$409,000 and above	\$77.90* + YPP

Part D deductibles, copayments, & coinsurance

The amount you pay for Part D deductibles, copayments, and/or coinsurance varies by plan. Look for specific Medicare drug plan costs, and then call the plans you're interested in to get more details.

Defined Standard Plan (Basic Benefit) in 2022

What you pay	100%	25%	25% brand names 25% generics	5%
What Medicare pays	0%	75%	75% brand names 75% generics	95%
Costs	\$0 - \$480	\$480 - \$4430	\$4431-\$7050	Drug costs > \$7050 OOP Max \$7050
Coverage Level	Deductible 1	Initial Coverage Level 2	Coverage Gap 3	Catastrophic Coverage 4

2022 Monthly Poverty Guidelines

Guidelines for the 48 contiguous states and the District of Columbia

Persons in family/ household	100%	120%	135%	140%	145%	150%
1	\$1,133	\$1,359	\$1,529	\$1,586	\$1,642	\$1,699
2	\$1,526	\$1,831	\$2,060	\$2,136	\$2,212	\$2,289
3	\$1,919	\$2,303	\$2,591	\$2,687	\$2,783	\$2,879
4	\$2,313	\$2,775	\$3,122	\$3,238	\$3,353	\$3,469
5	\$2,706	\$3,247	\$3,653	\$3,788	\$3,923	\$4,059
6	\$3,099	\$3,719	\$4,184	\$4,339	\$4,494	\$4,649
7	\$3,493	\$4,191	\$4,715	\$4,890	\$5,064	\$5,239
8	\$3,886	\$4,663	\$5,246	\$5,440	\$5,634	\$5,829

Federal poverty level guidelines at: <https://aspe.hhs.gov/poverty-guidelines>.

2022 Resource Standards for Individuals/Couples

	With Burial Exclusion	Without Burial Exclusion
Lower Resources Level	\$9,900/\$15,600	\$8,400/\$12,600
Higher Resources Level	\$15,510/\$30,950	\$14,010/\$27,950

Medicare Savings Programs (MSPs): Eligibility and Coverage (2022)

Type of MSP	Financial Eligibility	Benefits Covered by MSP
Qualified Medicare Beneficiary (QMB)	Monthly Income*: At or below 100% FPL Resources: Lower resource level	Part A hospital deductible (\$1,556/per benefit period) Part A hospital copays: days 61-90 (\$389 daily), days 91-150 (\$778 daily) Part A SNF copays: days 21-100 (\$194.50 daily) Part A premium if owed (\$499 for most voluntary enrollees) Part B annual deductible (\$233) Part B monthly premium (\$170.10) Part B coinsurance (amount varies)
Specified Low-Income Medicare Beneficiary (SLMB)	Monthly Income*: Between 100-120% FPL Resources: Lower resource level	Part B monthly premium (\$170.10)
Qualifying Individual (QI) or Expanded LMB (ELMB)	Monthly Income*: 121-135% FPL Resources: Lower resource level	Part B monthly premium (\$170.10)
Qualified Disabled Working Individual (QDWI)	Monthly Income**: \$4,339 if single \$5,833 if married Resources: \$4,000 if single, \$6,000 if married	Medicare Part A premium (for people with Medicare who are under age 65, disabled, and no longer qualify for free Medicare Part A or Medicaid because they returned to work and their income exceeds the limit)

Medicare Drug Plan Costs if You Automatically Qualify for Extra Help

If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until \$7,050)	Your cost per prescription (after \$7,050)
Full Medicaid coverage & for each full month you live in an institution, like a nursing home or HCBS	\$0	\$0	\$0	\$0
Full Medicaid coverage & yearly income below 100% FPL	\$0	\$0	\$1.35 for generic & certain preferred drugs; \$4.00 for brand-name drugs	\$0
Full Medicaid coverage & yearly income above 100 % FPL	\$0	\$0	no more than \$3.95 for generic & certain preferred drugs; no more than \$9.85 for brand name drugs	\$0
Medicare Savings Program – all levels	\$0	\$0		\$0
Get Supplemental Security Income (SSI) but not Medicaid	\$0	\$0		\$0

Medicare Drug Plan Costs if You Apply and Qualify for Extra Help

If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until 7,050)	Your cost per prescription (after \$7,050)
a yearly income at or below 135% FPL Lower resource level	\$0	\$0	\$3.95 for generic & certain preferred drugs; \$9.85 for brand-name drugs	\$0
a yearly income below 135% FPL Higher resource level	\$0	\$99	up to 15% of the cost of each prescription	no more than \$3.95 for generic & certain preferred drugs; no more than \$9.85 for brand-name drugs
a yearly income between 135% and 140% FPL higher resource level	25%			
a yearly income between 140% and 145% FPL higher resource level	50%			
a yearly income between 145% and 150% FPL higher resource level	75%			

Notes:

*Income limit does not include \$20 “unearned income disregard.” States may disregard other income as well.

**This includes additional earned income exclusions

Note: There are plans with no monthly premium. There are other plans where the beneficiary will have to pay part of the premium even when qualifying for full extra help. The beneficiary should tell the plan that he/she qualifies for extra help and ask how much the monthly premium will be.

Standard Medicare Supplement Policies at a Glance

	A	B	C	D	F*	G*	K	L	M	N
Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess Charges					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
							Out-of-Pocket Limit**			
							\$6,620	\$3,310		

Plans C & F are not available for individuals who are new to Medicare on or after 1/1/2020. People new to Medicare are those who turn 65 on or after January 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after January 1, 2020.

*Plans F and G also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of \$2,490 in 2022 before your Medicare supplement plan pays anything.

**After you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$233 in 2022), the Medicare supplement plan pays 100% of covered services for the rest of the calendar year. Out-Of-Pocket Annual Limit will increase each year for inflation. The Out-Of-Pocket Annual Limit DOES NOT include “excess charges.” The beneficiary is responsible for these charges.

Appendix

***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

Medicare Prescription Drug Coverage Worksheet

1. What is your name as it appears on your Medicare card? ①

2. What is your Medicare Claim Number? ②

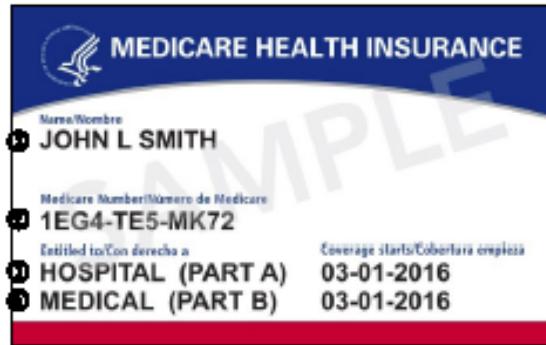
3. What is your date of birth?

Month/Date/Year

4. What is the coverage start date for your Medicare?

③ Part A _____
④ Part B _____
Month/Date/Year
Month/Date/Year

5. What is your Zip Code? _____ County? _____
 Address, City, State _____
 Phone # _____



*Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.

6. Check the **ONE** box that best describes your **INCOME**.*

Single, widowed, divorced or live apart from my spouse and: <input type="checkbox"/> My annual gross income is less than \$20,385 <input type="checkbox"/> My annual gross income is greater than \$20,385	Married and: <input type="checkbox"/> Our annual gross income is less than \$27,465 <input type="checkbox"/> Our annual gross income is greater than \$27,465
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7. Check the **ONE** box that best describes your **LIQUID ASSETS**. Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions.*

Single, widowed, divorced or live apart from my spouse and: <input type="checkbox"/> My assets are \$15,600 or less <input type="checkbox"/> My assets are greater than \$15,600	Married and: <input type="checkbox"/> Our assets are \$30,950 or less <input type="checkbox"/> Our assets are greater than \$30,950
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8. List the pharmacy or pharmacies you use. (Required)

Appendix

9. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

DRUG NAME	DOSAGE	30- DAY QUANTITY	MONTHLY COST