

MEDICARE OPEN ENROLLMENT



Understanding Your Medicare Plan
and Your Cost-Sharing Responsibilities

Choosing an appropriate Medicare plan is an important decision that can affect your health and financial stability. Once you understand the basic components of a Medicare plan and how out-of-pocket costs are calculated, you will be better equipped to select a plan that meets your needs.



What is Medicare?

Medicare is a federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD).¹ Medicare plans cover a comprehensive set of health services, but different sets of services are split among the different parts of Medicare, including Medicare parts A, B, C, and D.

What is Original Medicare?

Original Medicare is managed by the federal government and includes Medicare Parts A and B.² Medicare Part A covers inpatient care, such as treatment received in a hospital, nursing facility, and limited home health services.³ Medicare Part B covers services and supplies that are provided in an outpatient setting.⁴ It also covers prescription medications that are administered in a doctor's office or hospital.⁵ It does not cover prescription medications that are typically taken at home.⁶

To qualify for Original Medicare, you must be 65 or older, have a qualifying disability, or have ESRD.⁷

What is Medicare Advantage?

Medicare Advantage (MA), also referred to as "Part C," is a Medicare health plan offered by private insurers, rather than the government. MA plans generally must offer coverage benefits equal to those provided by Original Medicare (i.e., inpatient care and outpatient services, supplies, and prescriptions).⁸

To qualify for an MA plan, you must be 65 or older or have a qualifying disability and live within the plan's service area. If you have ESRD, you may not qualify for most MA plans.

What is Medicare Part D?

Medicare Part D is managed by private insurers and provides prescription drug coverage.⁹ A Medicare beneficiary must have a Part A or Part B plan to qualify for Part D coverage.¹⁰ While most medications are covered under Medicare Part D, there are some drugs that are only covered by Medicare Part B (e.g., antigens, hemophilia clotting factors).¹¹

What are the differences between Original Medicare and MA plans?

Cards

- With Original Medicare plans, you will receive a red, white, and blue card that you should present to your health care provider when seeking care.¹²
- With MA plans, you will have a membership card that you will present to your health care provider. This card is different from the red, white, and blue card that Original Medicare enrollees receive.

Network

- With Original Medicare plans, enrollees will be able to see any provider that participates in the Medicare program.¹³

- With MA plans, enrollees will only be able to see in-network providers, but a referral may be needed before an enrollee can see a specialist.¹⁴ However, MA preferred provider organizations (PPO) plans generally allow enrollees to see an in-network specialist without a referral.¹⁵

Services Covered

- Both Original Medicare and MA plans cover the same types of services and benefits provided under Medicare Part A and Part B; however, they may have different rules, costs, and restrictions.¹⁶

Costs

- Original Medicare plan enrollees are charged for standardized Part A and Part B costs, including monthly Part B premiums. Enrollees must pay a 20 percent coinsurance for Medicare-covered services if they see a participating provider and after meeting their deductible.¹⁷
- The cost-sharing in MA plans varies based on the type of plan selected. Enrollees are typically responsible for copayments for in-network care. Plans may also charge a monthly premium in addition to the Part B premium.
- If your health care costs are unaffordable, you may consider enrolling in a Medigap plan, which is detailed below in the Supplemental Insurance section.

Out-of-Pocket Limit

- Original Medicare plans do not have annual out-of-pocket limits.¹⁸
- MA plans do. As a result, MA enrollees cannot be required to spend more than a specific amount of money out-of-pocket each year.¹⁹

Prescription Medications

- Original Medicare plans require enrollment in a separate prescription drug plan through Part D.²⁰
- MA plans incorporate prescription drug coverage into the standard benefit package; however, many plans charge a higher premium for this coverage.²¹

Travel

- Original Medicare provides coverage of services when you travel anywhere in the United States.²²

- MA typically only provides coverage of services offered within your plan's service areas, except in emergencies.²³

Supplemental Insurance

- If you have Original Medicare, you can sign up for a Medicare supplement policy, referred to as Medigap, to help cover some of the costs that Original Medicare will not cover.²⁴ This includes copayments, coinsurance, and deductibles. Enrollees will be required to pay a separate premium for the Medigap policy. Medigap policies are guaranteed to be renewable.²⁵
- MA enrollees are ineligible for Medigap policies.

Additional Benefits

- MA plans may provide additional benefits, such as routine vision or dental services, routine hearing services, and membership in fitness programs.²⁶
- Original Medicare plans do not offer these additional benefits.²⁷

How do I sign up for an Original Medicare or MA plan?

You can sign up for an Original Medicare or MA plan as soon you first become eligible. Your initial eligibility for Medicare begins three months before your 65th birthday and lasts for seven months.²⁸ For every year after that, you can sign up or make changes to your Medicare coverage during the Fall open enrollment period. If the open enrollment period has passed, you still may be able to sign up for a plan under certain circumstances referred to as special enrollment periods (SEPs).²⁹

Open Enrollment

Fall open enrollment for 2020 Medicare plans runs from October 15 to December 7, 2019.³⁰ During this time, you can enroll in a Medicare or a MA plan. Any changes made during this period will take effect on





January 1.³¹ During this period, you can make various changes to your coverage, including the following:

- Switching from Original Medicare to an MA plan or vice versa;
- Switching from one MA plan to another;
- Switching from one Medicare Part D plan to another; and
- Signing up for a Medicare Part D plan if you did not do so when you were first eligible (although a late enrollment penalty may apply).

If you are dissatisfied with the MA plan you chose during fall open enrollment, you can change your plan during the MA open enrollment period, which runs from January 1 to March 31.³² During this time, you can make the following changes:

- Leave your MA plan and return to Original Medicare;
- Buy a Part D prescription drug plan to supplement your Original Medicare; and
- Switch to a different MA plan.

Changes made during this time will become effective on the first day of the following month.³³ For example, if you enroll in a MA plan in February during the MA Open Enrollment Period, your coverage will become effective on the first day of March.

If you did not sign up for Medicare Part B when you were first eligible, you have a chance to do

so each year from January 1 to March 31, with coverage effective July 1.³⁴ You may have to pay a late enrollment penalty, however. For Part B, the penalty is an additional 10 percent of the premium for each 12-month period that you were eligible but not enrolled.³⁵

Special Enrollment Periods

You can also make changes to your MA and Medicare prescription drug coverage under special circumstances.³⁶ These circumstances trigger special enrollment periods.³⁷ Special circumstances include the following:

- You changed where you live (e.g., moved to a new address that is not in your plan's service area, moved back to the U.S. after living outside the country, or were released from jail);
- You lost your current coverage (e.g., no longer eligible for Medicaid or left coverage from your employer);
- You have a chance to get other coverage (e.g., to enroll in other coverage offered by your employer or are enrolled in other drug coverage as good as Medicare prescription drug coverage, such as TRICARE);
- Your plan changes its contract with Medicare; or
- Other special situations (e.g., you are eligible for both Medicare and Medicaid).

A full list of special circumstances are available at <https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances-special-enrollment-periods>.





Fall Open Enrollment

If you are already enrolled in an Original Medicare plan, MA plan or Medicare Part D plan, and you would like to keep your plan without making any changes to it, you do not need to take any action during the Fall Open Enrollment period.³⁸ You will be auto-enrolled. If, for some reason, you are not eligible for auto-enrollment, you should receive notice from your plan. At that point, you should select a new plan.³⁹

It is important to note that while a plan may be renewed, the benefits and costs associated with the plan could change from one year to the next. If you are interested in renewing a plan you already have, be sure to review the coverage details to ensure it is the right fit for you.

What should I consider when selecting a Medicare plan?

Health Plan Structure

Original Medicare has a defined benefit structure and cost-sharing responsibilities that are established and regularly updated by the federal government. Enrollees in Original Medicare have the option of supplementing their coverage with a Medicare Part D plan or with MediGap, but Medicare coverage generally will not vary between beneficiaries.

For more information about Original Medicare's benefit structure, visit <https://www.medicare.gov/what-medicare-covers>.

MA plans offer different options. Each plan structure has its own benefits and drawbacks:

- **Health Maintenance Organization (HMO):** a plan that provides all health services through a network of health care providers (e.g., physicians, nurses, therapists) and facilities (e.g., hospitals, medical offices, clinics).⁴⁰
 - Pros: Premiums and copays are relatively low in comparison to other plans. There is also typically less paperwork as compared with other plans.⁴¹
 - Cons: The plan will limit your ability to obtain services outside of your plan's network. You may not be able to choose your health care provider. You will need a referral from your primary care provider (PCP) before you can see a specialist.⁴²
- **Preferred Provider Organization (PPO):** a plan that includes a network of doctors, hospitals, and other providers and institutes that have agreed to charge less for plan members.⁴³
 - Pros: You do not need a referral from your PCP to see a specialist. You can also see out-of-network providers.⁴⁴
 - Cons: You will have to pay more if you go outside of your plan's network. You may have to meet your plan's deductible before it will cover the cost of out-of-network services. You may have higher premiums than with an HMO.⁴⁵



- **Private Fee-for-Service (PFFS):** a plan that privately contracts with providers on certain payment terms.

- Pros: Enrollees will not need to select a primary care provider and they will not be required to obtain a referral to see a specialist.⁴⁶

- Cons: Only the providers who have accepted the plan's payment rates can deliver care to an enrollee in a PFFS plan. There is no guarantee that an enrollee will be able to see providers outside of this network.⁴⁷

- **Special Needs Plans (SNPs):** a plan that limits coverage to individuals with specific health conditions.⁴⁸

- Pros: These plans will be tailored towards that specific condition including specialized benefits, provider choices, and formulary coverage. If eligible, individuals may enroll in an SNP at any time.⁴⁹

- Cons: Enrollees in SNPs are required to see providers that participate in the plan's network, except for emergency care or for out-of-area dialysis for enrollees with ESRD.⁵⁰

If I enroll in an MA plan or a Medicare Part D plan, how do I determine how much I owe for my prescription?

You will need to locate your health plan's formulary. Once you find the formulary, look to see if your medication is listed. If it is listed, then you will then need to determine whether your medication is on a tier. Medications may be grouped together in different tiers based on their costs. If it is on a lower tier, such as the first tier, you may have a small copay. If your medication is on a higher tier, you may owe a coinsurance, which is a percentage of the drug cost. You may need to cross-reference the formulary with your plan's Evidence of Coverage document.⁵¹ This document will provide additional information about how much medications cost based on which tier they are on. If you do owe a co-insurance, you may not be able to tell how much you will pay out of pocket based on the plan documents. In that case, you should call the plan directly and find out.

If you cannot find your medication on the formulary, look for a formulary exclusion list. If your medication is on the exclusion list, that means your medication is not covered and you will be required to pay 100 percent of the cost of your medication.⁵² You may be able to get your plan to cover an excluded drug by filing for a request for a formulary exception.⁵³

Is there a limit on how much my health care plan can make me pay out of pocket?

Original Medicare plans do not have a maximum out-of-pocket limit, but MA plans do.⁵⁴ These limits vary based on the type of health plan (HMO vs. PPO). For 2020, the maximum out-of-pocket limits for MA plans range from \$3,401 to \$10,000. Plans can have different maximum out-of-pocket limits for in-network and out-of-network services.⁵⁵

Can my plan change whether it will cover my medication mid-year?

You should be aware that Medicare Part D and MA plans can adjust their formularies in the middle of the plan year.⁵⁶ However, enrollees have certain rights when this occurs. If a plan makes a maintenance change to its formulary, enrollees must be given 60-days' notice before the change takes effect or a 60-day refill of the medication.⁵⁷ Maintenance changes occur when a plan covers a generic medication in place of a brand medication, adding coverage restrictions to a medication, removing a medication from the formulary that was unintentionally included, and making coverage changes based on new clinical guidelines or safety concerns from the U.S. Food and Drug Administration (FDA). If a plan makes a formulary change for any other reason, it must allow enrollees to continue receiving that medication for the remainder of the plan year as long as it is medically necessary.⁵⁸ Your plan will communicate with you by mail if there are any coverage changes that affect you.

How do I determine if my doctor is covered and how much I owe for doctors' visits?

To calculate the costs you will be responsible for, you will need to know whether your doctor is in-network or out-of-network, whether your plan covers out-of-network providers, whether you owe a copay or coinsurance, and what costs your plan will cover before you meet your deductible. When seeking health care services, it is best to visit an in-network provider to ensure you pay the least out-of-pocket. Visiting an out-of-network provider will likely incur increased out-of-pocket costs for you, which may not be necessary.

If you are enrolled in Original Medicare, you will have access to most health care providers. CMS maintains a provider directory for Medicare that you can use online. Visit the following website to access this directory: <https://www.medicare.gov/physiciancompare/>. Your cost-sharing responsibilities will differ depending on the type of service you receive. For services covered by Medicare Part A, you will be responsible for a \$1,364 deductible for each coverage period. After you meet your deductible, you will be responsible for greater coinsurance amounts the longer you stay in the hospital. For services covered under Medicare Part B, you will be responsible

for a \$185 deductible for the full year. After you meet your deductible, you will be responsible for a 20% coinsurance for most covered services.⁵⁹

If you are enrolled in an MA plan, your choices could be more limited. To determine whether your doctor is in-network or out-of-network, you will need to locate your health plan's provider directory and search for your doctor. You should be able to find your plan's directory online. If you cannot find it, you should call your health plan to ask whether your doctor is in-network. If your doctor is not in-network and you are comfortable seeing a different doctor, you can ask your health plan for the name of another doctor who is in-network.

For MA plans, copayment and coinsurance rates may vary based on plan type and whether your provider is in-network or out-of-network. For example, if your doctor is out-of-network and your plan is an HMO, then you may have to pay 100 percent of the cost for that visit. You can determine what your plan's rates are for in-network and out-of-network providers by looking at your plan's Evidence of Coverage document, which is a brief overview of your plan's benefits cost-sharing requirements. Your plan's Evidence of Coverage document should be delivered to you by mail and also available online. If you cannot locate it, call your health plan and ask for a copy.

Your plan may also charge you different rates based on whether you are seeing your primary care provider or a specialist. If you are seeing a specialist, you may need a referral from your primary care provider before your plan will cover your visit to the specialist. This information will also be provided in the Evidence of Coverage document.

If your plan charges you co-insurance, you will need to know how much each service costs so you can calculate how much you owe. You may want to contact your doctor to find out what his or her rates are. For example, if your doctor charges \$200 per visit, and you owe a 20 percent coinsurance, you will have to pay \$40 per visit once your deductible is met.





Finally, you will need to know whether you must meet your deductible before any portion of your visit will be covered. Both traditional Medicare and Medicare Advantage will cover preventive services without any cost-sharing requirements prior to the completion of your deductible. However, you must see an in-network provider to receive these services without any cost-sharing requirements.⁶⁰

How do I determine how much I owe for my prescription?

The costs for your medications will vary depending on the part of Medicare that provides coverage for them. For medications covered under Medicare Part B, you will be responsible for a \$185 annual deductible. After the annual deductible is met, you will be responsible for 20% of the medication's price.⁶¹

For medications covered under Medicare Part D, your costs will fluctuate depending on the phase of coverage you are currently in. Once you start filling prescriptions using your Part D benefit, you will be responsible for a 100% of the cost of your medications until you reach the \$435 initial deductible. After that deductible is met, you will be responsible for a copay or coinsurance for your medications until you reach the initial coverage limit, which is \$4,020. After you reach the initial coverage limit, you will enter the "donut hole" phase of coverage, which persists until you spend \$6,350 out-of-pocket.⁶² While you are in the "donut hole" phase, your cost-sharing for your

medications will be 25% of the medication's retail price. After you spend \$6,350 out-of-pocket, you will enter the catastrophic coverage phase. While in this phase, your cost-sharing for medications will be the greater of a fixed price for that medication or 5% of the retail price. Once you reach this point, your cost-sharing responsibilities will remain steady for the rest of the plan year. At the beginning of each year, your progress through the coverage phases will reset and you will have to fulfill your initial deductible again before the plan begins sharing the costs of your medications with you.

What other restrictions might I face when trying to obtain a medical service or prescription?

Your plan's formulary should tell you whether there are any restrictions on your medication. For example, you may see "QL," "ST," or "PA" next to your medication on the formulary. "QL" stands for quantity limits. It means that the plan will only cover a certain amount of the medication or cover a certain number of days. "ST" stands for step therapy, which means you may be required to try and fail on a less expensive drug first before your plan will cover your prescribed medication. New rules allow MA plans to require you to try and fail on a Part D medication before covering a Part B medication.⁶³ "PA" stands for "prior authorization," which means that you or your doctor must get your insurer to approve of the medication before the plan will cover it.

How can I identify and avoid a Medicare scam?

Medicare beneficiaries are often the targets of fraud and scams. If you receive a communication, such as





a call or an email, from someone who is claiming to be a representative of Medicare, it is likely a scam. These communications often request personal information from you or claim to be able to secure new benefits for you. If you receive a communication like this, disengage from it immediately. You should never give your personal information to someone claiming to represent Medicare. Medicare, or a Medicare representative, will never contact you for your Medicare Number or other personal information unless you have given them permission in advance.⁶⁴ To ensure that you are speaking to an actual representative from Medicare, initiate the communication yourself by calling 1-800-Medicare (1-800-633-4227).⁶⁵ If you suspect that you have been targeted by a Medicare scam, you should report it to the Federal Trade Commission using the following link: <http://www.ftc.gov/complaint>.⁶⁶

What can I do if my plan does not cover a service or medication that I need?

Medicare Part B

If a treatment or service is not covered by Medicare Part B, you can file an appeal, which could allow you to receive these treatments and services as if they were covered by your plan.⁶⁷ Medicare has five levels of appeals.⁶⁸ If your plan does not cover a medical service or medication that you need, you can work with your doctor to request an exemption or to file an appeal with a Medicare Administrative Contractor (MAC). If you are not satisfied with the results of this first-level appeal, you can elevate the appeal to a Qualified Independent Contractor (QIC). If you are not satisfied with the results

of this second-level appeal, you can elevate the appeal to the Office of Medicare Hearings and Appeals (OMHA). If you are not satisfied with the results of this third-level appeal, you can elevate the appeal to the Medicare Appeals Council. If you are not satisfied with the results of this fourth-level appeal, you can request judicial review before a Federal District Court.

Medicare Part D

If a medication is not covered by your Part D plan, you can file a request for an exception, which could allow you to receive these medications without being responsible for their full cost. There are two types of exceptions for Part D plans: tiering exceptions and formulary exceptions. A tiering exception can be used to have a medication covered at a lower cost-sharing tier, which will reduce the costs you are responsible for. A formulary exception can be used to have your plan cover a medication that is excluded from the plan's formulary altogether. Exception requests are handled by the Part D plan sponsor and you must prove that the medication is medically necessary to have the exception request approved. Your prescriber will need to provide a supporting statement to the plan sponsor that attests to the medication's medical necessity.⁶⁹

MA Plan

If you are enrolled in an MA plan, you can request an appeal within 60 days of being notified by your plan that certain treatments or services will not be covered.⁷⁰ The plan must act on the appeal within 30 days if the appeal is a request for a service before it is rendered or 60 days if the appeal is a request for



payment after a service has been rendered.⁷¹ If your appeal is urgent, you can request an expedited appeal, which will require the health plan to act on it within 72 hours.⁷² If the plan decides against your appeal or if the plan does not act on the appeal within the required timeframe, the appeal will be automatically be elevated to a second-level appeal. After this point, the appeals process will be identical to the five-level appeals process for Medicare Part B appeals.

What if I have additional questions about my Medicare plan?

If you have additional questions about your insurance coverage, you should call Medicare's 24-hour help line at 1-800-Medicare (1-800-633-4227).⁷³ Be sure to take detailed notes about what the agency tells you. You

should also write down the name of the representative that you spoke to and the date of your conversation. If you are not satisfied that the representative has fully answered your question, ask to speak with a supervisor. Alternatively, you can contact Aired Alliance at policy@aimedalliance.org or (202) 559-0380, and we will do our best to help you.

About Aired Alliance

Aired Alliance is a 501(c)(3) not-for-profit organization that seeks to protect and enhance the rights of health care consumers and providers. We advance our mission by conducting legal research and analysis, developing economically sound policy recommendations, educating the public, and advocating for the enforcement of laws and professional ethics.

About National Organization of Rheumatology Managers

The National Organization of Rheumatology Managers (NORM) is a forum that promotes education, expertise and advocacy for rheumatology managers and their practices. NORM provides value across the nation by cultivating a thriving community of rheumatology managers and physicians. Together, we are focused on supporting our patients and pursuing excellence in medical practice management.



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