What’s New with Medicare in 2017

Audio Portion: 1-866-740-1260
Web Portion: www.ReadyTalk.com
Code: 4796976
Agenda

- Part D in 2017
- Extra Help/LIS Redeeming, Redeterminations, and Reassignment
- Medicare Advantage in 2017
- Hot Topics
  - MOON Notices
  - 2017 Premiums and Cost-sharing
  - Seamless Conversion
  - Limited Equitable Relief Part B Special Enrollment Period
  - MA Plan Finder Detailed Cost and Benefit Information
  - QMB Balanced Billing
Part D
Part D Prescriber Medicare Enrollment

- 2017 Part D Prescriber Enrollment
  - 2013 OIG Report found Medicare paid $5.4 million ordered by 14 prescribers with no authority to prescribe
  - Starts 2/1/2017, prescribers should enroll in or submit an opt out affidavit to the MAC by 8/1/2016
  - Applies to all physicians, dentist and other eligible professionals that write Part D prescriptions
  - 3-month Provisional Supply
    - 90-days or three separate one month supplies
    - Plan must notify beneficiary in writing within 3 months

Source: CMS MLN Matters #SE1434 Revised
Part D Monthly Premium IRMAA

- Income-related Monthly Adjustment Amount (IRMAA)
- Based on income above a certain limit
  - Fewer than 5 percent pay a higher premium
  - Uses same thresholds used to compute IRMAA for the Part B premium
  - Income as reported on your IRS tax return from 2 years ago
- Required to pay if you have Part D coverage
  - Withheld from SSA or RRB benefits check
  - Failure to pay may result in disenrollment
## 2016 IRMAA – 2017 Coming Soon

<table>
<thead>
<tr>
<th>If Your Yearly Income in 2014 was</th>
<th>In 2016 You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>File Individual Tax Return</td>
<td>File Joint Tax Return</td>
</tr>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
</tr>
<tr>
<td>$85,000.01 – $107,000</td>
<td>$170,000.01 – $214,000</td>
</tr>
<tr>
<td>$107,000.01 – $160,000</td>
<td>$214,000.01 – $320,000</td>
</tr>
<tr>
<td>$160,000.01 – $214,000</td>
<td>$320,000.01 – $428,000</td>
</tr>
<tr>
<td>Above $214,000</td>
<td>Above $428,000</td>
</tr>
</tbody>
</table>

*per month

IRMAA is adjusted each year, as it is calculated from the annual beneficiary base premium.

# 2016/2017 Standard Drug Benefit

<table>
<thead>
<tr>
<th>Benefit Parameters</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$360</td>
<td>$400</td>
</tr>
<tr>
<td>Initial Coverage Limit</td>
<td>$3,310</td>
<td>$3,700</td>
</tr>
<tr>
<td>Out of Pocket (OOP) Threshold</td>
<td>$4,850</td>
<td>$4,950</td>
</tr>
<tr>
<td>Catastrophic OOP Threshold</td>
<td>$7,062.50</td>
<td>$7,425</td>
</tr>
<tr>
<td>Minimum Cost-Sharing in Catastrophic Coverage</td>
<td>$2.95/$7.40</td>
<td>$3.30/$8.25</td>
</tr>
<tr>
<td>Extra Help Copayments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutionalized</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Receiving Home and Community-Based Services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Up to or at 100% Federal Poverty Level (FPL)</td>
<td>$1.20/$3.60</td>
<td>$1.20/$3.70</td>
</tr>
<tr>
<td>Full Extra Help – up to 135% FPL</td>
<td>$2.95/$7.40</td>
<td>$3.30/$8.25</td>
</tr>
<tr>
<td>Partial Extra Help (Deductible/Cost-Sharing)</td>
<td>$74/15%</td>
<td>$82/15%</td>
</tr>
</tbody>
</table>

Source: [CMS Final Call Letter 2017](#)
2017 Part D Landscape

- Fewer PDPs but still an average of 22 PDP choices
  - 5 new PDPs
  - 3 new local sponsors in AL/TN and MI regions and expansion of one sponsor into 2 additional plans
  - 134 PDPs exited: United American terminated its 91 plans; Stonebridge Life (Transamerica) terminated plans in 30 regions; 6 PDPs offered by local sponsors

- Part C & D Enforcement Action
  - PDP Sponsor Cigna banned from marketing and new enrollments
    - Plan information unavailable on Medicare Plan Finder
    - Must call plan or visit plan website for plan detail
Part C and Part D Enforcement Actions

CMS has the authority to take enforcement or contract actions when CMS determines that a Medicare Plan Sponsor either:

- substantially fails to comply with program and/or contract requirements,
- is carrying out its contract with CMS in a manner that is inconsistent with the efficient and effective administration of the Medicare Part C and Part D program requirements, or
- no longer substantially meets the applicable conditions of the Medicare Part C and D program.

Enforcement and contract actions include:

- Civil money penalties (CMP)
- Intermediate sanctions (i.e., suspension of marketing, enrollment, payment), and
- Terminations.

Below is a list of recent CMP, Intermediate Sanction, and Termination notices issued by CMS.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action Taken</th>
<th>Organization Name</th>
<th>Basis for Action</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-09-08</td>
<td>Civil Money Penalty ($5,325)</td>
<td>Express Scripts Medicare</td>
<td>Required Beneficiary Notices</td>
<td>2016-09-08</td>
</tr>
<tr>
<td>2016-08-09</td>
<td>Civil Money Penalty ($102,820)</td>
<td>Blue Cross of Idaho Care Plus, Inc.</td>
<td>Required Beneficiary Notices</td>
<td>2016-08-09</td>
</tr>
</tbody>
</table>

Source: [CMS Part C & D Enforcement Actions Webpage](#)
2017 Part D Landscape

- 8 plan sponsors offering national, or near-national, plans
- Average PDP premium will increase by 9%, weighted by current plan enrollment
- Of 10 PDPs with highest enrollments
  - 4 will increase premiums by 18% or more
  - 1 will increase premiums by 10%
  - 5 will decrease premiums by 3 - 22%

Source: Kaiser Family Foundation Medicare Part D: A First Look at Plan Offerings
Figure 9

Medicare Part D Stand-Alone PDP Weighted Average Monthly Premiums by Region, 2017

National Average* = $42.17

$31<$37  6 regions
$39<$41  7 regions
$41<$43  12 regions
$43-$51  9 regions

NOTE: PDP is prescription drug plan. Average premiums are weighted by September 2016 enrollment, include premiums for both basic and enhanced PDPs, and assume current PDP enrollees remain in their same plan.

2017 Part D Landscape

- 85% of PDPs have Preferred Pharmacy networks
- All PDPs use tiered cost sharing; almost all PDPs will use 5 tier formulary
- 20% of PDPs use co-insurance for preferred brand tier
- 98% of PDPs use coinsurance for non-preferred drug tiers (or labeled non-preferred brand)
  - Typically co-insurance is 40%
- A few more LIS $0 premium benchmark plans than in 2016

Sources: Kaiser Family Foundation Medicare Part D: A First Look at Plan Offerings
Figure 15

Number of Medicare Part D Benchmark Plans by Region, 2017

Total Number of Benchmark Plans Across All Regions = 231

- 3-4 plans: 4 regions
- 5-6 plans: 9 regions
- 7 plans: 10 regions
- 8-10 plans: 11 regions

NOTE: Includes “de minimis” plans that can retain Low-Income Subsidy beneficiaries despite exceeding the benchmark premium by up to $2 in 2017. Includes 25 sanctioned benchmark plans closed to new enrollees as of September 2016.


Improving the lives of 10 million older adults by 2020

© 2016 National Council on Aging
## Improved Coverage in the Coverage Gap

<table>
<thead>
<tr>
<th>Year</th>
<th>What You Pay for Covered Brand-Name Drugs in the Coverage Gap</th>
<th>What You Pay for Covered Generic Drugs in the Coverage Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>47.5%</td>
<td>72%</td>
</tr>
<tr>
<td>2015</td>
<td>45%</td>
<td>65%</td>
</tr>
<tr>
<td>2016</td>
<td>45%</td>
<td>58%</td>
</tr>
<tr>
<td>2017</td>
<td>40%</td>
<td>51%</td>
</tr>
<tr>
<td>2018</td>
<td>35%</td>
<td>44%</td>
</tr>
<tr>
<td>2019</td>
<td>30%</td>
<td>37%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>
### Medicare Part D Prescription Drug Benefit in 2017

**Medicare's Basic Benefit:**
Besides the monthly premium, you pay...

- **Up to $400 annual deductible (You pay 100%)**
  - Medicare's Basic Benefit: Besides the monthly premium, you pay...

- **After the deductible, you pay 25% of prescription costs between $400 and $3,700 (or $825).**
  - After the deductible, you pay 25% of prescription costs between $400 and $3,700 (or $825).

- **You reach the $3,700 drug coverage limit - you're headed for the donut hole.**
  - You reach the $3,700 drug coverage limit - you're headed for the donut hole.

- **Your drug costs have reached $7,425 and coverage begins again. (You pay 5%, or $3.30 for generics and $8.25 for brand-name drugs, whichever is greater.)**
  - Your drug costs have reached $7,425 and coverage begins again. (You pay 5%, or $3.30 for generics and $8.25 for brand-name drugs, whichever is greater.)

**Drug costs of $3,700 to $7,425**

- **Before the Affordable Care Act:**
  - You paid 100% out-of-pocket while in the donut hole.

- **After the Affordable Care Act:**
  - In 2017, you pay 40% for brand-name drugs and 51% for generics while in the donut hole.

**Source:** [NCOA Donut Hole: Coverage Gap Illustration](#)
## 2017 Gap Discount Ingredients

<table>
<thead>
<tr>
<th></th>
<th>Brand Name</th>
<th>Generic Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage</td>
<td>Percentage</td>
</tr>
<tr>
<td>Counts to TrOOP?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Counts to TrOOP?</td>
<td>NA</td>
<td>No</td>
</tr>
<tr>
<td>Manufacturer discount</td>
<td>50%</td>
<td>NA</td>
</tr>
<tr>
<td>Plan pays</td>
<td>10%</td>
<td>49%</td>
</tr>
<tr>
<td>Beneficiary pays</td>
<td>40%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Learn more: NCOA Coverage Gap Tip Sheet
True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out of pocket threshold ($4,950 in 2017)
- After threshold you get catastrophic coverage
  - You pay only small copayment or coinsurance for covered drugs
- Plan Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if you switch plans mid-year
## What Payments Count Toward TrOOP?

<table>
<thead>
<tr>
<th>Payments That Count</th>
<th>Payments That Don’t Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Payments made by you, your family members, or friends</td>
<td>▪ Your monthly plan premium</td>
</tr>
<tr>
<td>▪ Qualified State Pharmacy Assistance Programs</td>
<td>▪ Share of the drug cost paid by your Medicare drug plan</td>
</tr>
<tr>
<td>▪ Medicare’s Extra Help</td>
<td>▪ Group Health Plans (including employer/union retiree coverage)</td>
</tr>
<tr>
<td>▪ Most charities (not if established or run by employer/union)</td>
<td>▪ Government-funded programs (including Medicaid, TRICARE, VA)</td>
</tr>
<tr>
<td>▪ Indian Health Service</td>
<td>▪ Patient Assistance Programs</td>
</tr>
<tr>
<td>▪ AIDS Drug Assistance Programs</td>
<td>▪ Other third-party payment arrangements</td>
</tr>
<tr>
<td>▪ The discount you get on covered <strong>brand-name drugs</strong> in the coverage gap</td>
<td>▪ Other types of insurance</td>
</tr>
<tr>
<td></td>
<td>▪ The discount you get on covered <strong>generic drugs</strong> in the coverage gap</td>
</tr>
</tbody>
</table>
AEP/OEP Choices

- Part C & D Plans
  - Shop and compare plans
  - Enroll or disenroll
  - Switch to another plan

- Medicare Supplemental Policy (Medigap)
  - Can apply to change any time during the year, not limited to AEP/OEP
    - Outside Medigap Open Enrollment and Guarantee Issue may be subject to medical underwriting and therefore charged more or denied a policy
Pharmacy Part D vs. Out-of-pocket Payments

- Pharmacy requesting direct payment
  - Pharmacy claims losing money when run Part D plan
  - Coerce beneficiaries to pay directly vs. using Part D plan
  - Reports from IL, WI, OK, WV and NC
Extra Help: Three R’s

Extra Help With Medicare Prescription Drug Plan Costs

What help can I receive?

Medicare beneficiaries can qualify for Extra Help with their Medicare prescription drug plan costs. The Extra Help is estimated to be worth about $4,000 per year. To qualify for the Extra Help, a person must be receiving Medicare, have limited resources and income, and reside in one of the 50 States or the District of Columbia.

- Information on the Extra Help program
- See if you qualify for Extra Help and apply
- Extra Help forms and publications
- Extra Help information for caregivers and organizations
- Extra Help information in other languages
- Information on the review of your eligibility
- The official U.S. Government site for people with Medicare
- Understanding Medicare enrollment periods

Apply for Extra Help With Medicare Prescription Drug Plan Costs

Additional Resources

- State Health Insurance Counseling and Assistance Program (SHIP)
- Getting help with your Medicare costs
- Medicare Savings Programs (MSP)
- Model Application for Medicare Premium Assistance
- National Center for Benefits Outreach and Enrollment
- Medicare Rx - Connect

MyMedicare.gov

Sign In
Create an Account
LIS Redeeming and Redetermination

- **Redeeming for LIS**
  - List from State Medicaid covered Jul.-Dec. all on the list are redeemed for LIS the following year
  - No notice from CMS

- **Redetermination**
  1. Initial- applied and awarded between May-Apr. with a reported or suspected change in circumstance receive a form in Aug./Sept.
  2. Cyclical- random sample receive a form in Aug./Sept.
  3. Subsidy Changing- marriage, divorce, separation, annulment, or death of spouse
LIS Plan Reassignment

- Newly Eligible Full Extra Help/LIS are auto-enrolled in low-income benchmark plans with $0 premium
- Reassignment when a plan is no longer a benchmark plan
- Receive blue notification letter in Oct./Nov. and again mid-Dec.
- Choosers are not reassigned but receive tan letter about premium due
# CMS and SSA mailings - CMS version

## CMS’s Guide to CMS, SSA & Plan 2016/2017

<table>
<thead>
<tr>
<th>Mail date</th>
<th>Sender</th>
<th>Mailing/color</th>
<th>Main message</th>
<th>Consumer action</th>
</tr>
</thead>
</table>
| Early November | CMS | LIS Choosers Notice (Product No. 11267) (TAN Notice) | Informs people who get Extra Help and chose a Medicare drug plan on their own that their plan’s premium is changing, and they’ll have to pay a portion of their plan’s premium in 2013 unless they join a new $0 premium plan. | • Keep the notice.  
• You may want to look for a new plan for coverage for 2013 with a premium below the regional low income subsidy benchmark. (Notice includes list of local plans with no premium liability.)  
• Change plans in early Dec. if you choose. |
| November | CMS | CMS Non-Renewal Reminder Notice (Product No. 11433 & Product No. 11438) | Reminds people who don’t get Extra Help and whose plan is leaving the Medicare Program that they need to choose a new plan for 2013. | You must look for a new plan for coverage in 2013. |
| November | Social Security | Social Security Part B & Part D Income-Related Adjustment Amount Notice | Tells higher-income consumers about income-related Part B and Part D premium adjustments. Includes the information in the December BRI notices (see below). | Keep the notice. |
| November | Social Security | Social Security LIS Redetermination Decision Notice Begins | Social Security begins mailing notices letting people know whether they still qualify for Extra Help in the coming year. | • Keep the notice  
• If you believe the decision is incorrect, you have the right to appeal it. The notice explains how to appeal.  
• If you have questions, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. |
| Late November | Social Security | Social Security LIS and MSP Outreach Notice (Form SSA-L441) | Informs people who may be eligible for Qualified Disabled Working Individual (QDWI) about the Medicare Savings Programs and the Extra Help available for Medicare prescription drug coverage. | • If you think you qualify for Extra Help, you should apply.  
• For more information about the Extra Help or if you want to apply, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. |
| December | Social Security | Social Security Benefit Rate Change (BRI) Notice | Tells people about benefit payment changes for the coming year due to cost of living increases, variations in the premiums that are withheld, etc. | Keep the notice. |
CMS and SSA mailings - NCOA version

NCOA’s Guide to Mailings and Key Events in 2017

- Page 3 contains a one page color coded chart with links to model notices (Spanish too)
- Detailed explanation of the mailer and actions the beneficiaries need to take

**Redetermination Packets**

*What:* Low-Income Subsidy (LIS)/Extra Help Redetermination Packets  
*When:* Late August/early September  
*From Whom:* Social Security Administration (on SSA Letterhead)  
*Publication No.:* SSA Form No. 1026B

*Why did your client get this packet?*  
The Social Security Administration mails LIS/Extra Help redetermination of eligibility packets to a sample of those who were found eligible by SSA for LIS/Extra Help between May 2015 and April 2016. This sample includes a random selection of people along with those who reported a change in their income between January and August 2016.

*What do your clients need to do if they receive a redetermination packet?*  
The packet contains a questionnaire entitled “Review of Your Eligibility for Extra Help” ([Form SSA-1026B](#)), which must be completed, signed, and returned in the pre-addressed, stamped envelope to SSA, within 30 days. Failure to return a completed form results in termination of LIS/Extra Help shortly after the beginning of 2017. LIS/Extra Help awards are good for a year, so any changes to LIS/Extra Help status or level are generally effective on January 1, 2017.

*What you should know as a benefits counselor?*  
- The form must be completed and returned to SSA even if your client experienced no changes to income or resources that would affect her LIS/Extra Help eligibility or level of subsidies.

Read more about [Redeterminations](#).
LINET

- Limited Income Newly Eligible Transition
  - For those with no Part D and Awarded Extra Help
- Administered by Humana
- Stay in up to 6 months
- $0 premium
- Enroll at pharmacy with Best Available Evidence
What does Part C cover?

Part C covers hospital, doctor’s visits and prescriptions.*

Part C MAY COVER vision, hearing and dental

*Most Part C plans include prescription drug coverage
2017 Medicare Advantage (MA) Landscape

- Medicare Advantage (MA) average premium submitted by health plans for 2017 was $31.40 (down $1.19 from 2016)
- 67 percent of beneficiaries enrolled in MA will not have a premium increase
- More MA plans will offer supplemental benefits (like dental and vision)
Payments to private Medicare Advantage (MA) Plans tied to plans’ quality of coverage

- More high-quality plans were available in 2017 than in 2014 (38%)
- More beneficiaries enrolled in higher quality plans

<table>
<thead>
<tr>
<th>MA Plans</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA contracts with 4 or more stars</td>
<td>48.5%</td>
<td>Around 49%</td>
</tr>
<tr>
<td>MA enrollees in plans with 4 or more stars</td>
<td>71%</td>
<td>68%</td>
</tr>
</tbody>
</table>
MA-PD Quality

- Approximately 68% of MA-PD Enrollees are in 4 or 5 star plans
- 12 MA-PD and 3 MA only contracts have 5 star ratings
- Two plans have low-performing icon
- Average star rating is slightly lower
  ➢ 4.03 in 2016 to 4.00 in 2017

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html
Star Special Enrollment Period (SEP)

- Use Medicare Plan Finder tool at medicare.gov to see quality and performance ratings
- Star ratings given once a year, assigned in October of the previous year
- Use 5-star SEP to switch to any 5-star plan one time
  - December 8 - November 30 of following year
  - Coverage starts first day of month after enrolled
  - Be careful not to switch from Part D coverage to no Part D
CPP Special Enrollment Period (SEP)

- SEP detailed in Continuously Poor Performer (CPP) Notice
  - One-time change after Jan. 1
  - Must enroll in a plan with 3 stars or more
  - Call 1-800-Medicare to change
    - Prospective = no retroactive changes
    - Can move to Original Medicare and enroll in Part D
Hospital Observation Status (MOON Notice)

- What’s in MOON?
  - Explain reason for outpatient status
  - Explain implications of outpatient status on cost-sharing and eligibility for SNF care
  - Requires patient or caregiver signature

- Timeline
  - Delayed from original implementation date Aug. 6, 2016
  - MOON public comment period ended 9/1/16
  - Effective 90 calendar days from final OMB approval

Source: CMS Beneficiary Notices Initiative page and PRA MOON Listing
Held Harmless

- SSA benefit amount cannot decrease year-to-year as result of Part B premium increase
- About 70% of beneficiaries because Part B premium is withheld from SSA benefit

Not Held Harmless

- About 30% of beneficiaries
  - IRMAA paying beneficiaries with higher incomes
  - New Medicare beneficiaries
  - Pay Part B directly (not SSA withholding)
    - Medicaid paid premiums through MSP
    - Not yet receiving SSA benefit
COLA and Part B Premiums

- **2016 no COLA**
  - 2016 Medicare Trustee Report estimated Part B premium of $159.30/mo.
  - Congress added safeguard for those not held harmless = $121.80/mo. ($118.80 + $3 trust fund loan repayment)

- **2017 COLA = SSA announced 0.3% on 10/18/16**
  - Anticipate CMS announce premiums and cost-sharing early Nov. (happened 11/10/15)
  - 2017 Medicare Trustee Report estimated 0.2% COLA
    - Part B estimate = $149/mo. (+ $3 trust fund loan repayment)
  - Need Congressional action for those not held harmless
**2017 Scenario:** SSA COLA = 0.3% (actual)
Part B premium = $149.00 (trustee projection)

### 2017 projection for **70% held harmless**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017 if no &quot;hold harmless&quot; provision</th>
<th>2017 with &quot;hold harmless&quot; provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Social Security benefit</td>
<td>$1,500.00</td>
<td>$1,504.50</td>
<td>$1,504.50</td>
</tr>
<tr>
<td>Monthly Part B premium</td>
<td>-$104.90</td>
<td>-$149.00</td>
<td>-$109.40*</td>
</tr>
<tr>
<td>Net Social Security benefit</td>
<td>$1,395.10</td>
<td>$1,355.50</td>
<td>$1,395.10</td>
</tr>
</tbody>
</table>

* Part B Premium amount specific to individual to avoid reduction in SSA benefit

### 2017 projection for **30% not held harmless**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017 if no Congressional safeguard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Social Security benefit</td>
<td>$1,500.00</td>
<td>$1,504.50</td>
</tr>
<tr>
<td>Monthly Part B premium</td>
<td>-$118.20</td>
<td>-$149.00</td>
</tr>
<tr>
<td>Loan repayment surcharge</td>
<td>-$3.00</td>
<td>-$3.00</td>
</tr>
<tr>
<td>Net Social Security benefit</td>
<td>$1,381.80</td>
<td>$1,352.50</td>
</tr>
</tbody>
</table>
MA Seamless Conversion

- Converting newly-eligible beneficiaries into MA
  - CMS Medicare Managed Care Manual guidance Chp. 2 Section 40.1.4
  - Transition from enrollment in non-Medicare plan into MA plan from same organization
  - MA organization (MAO) must apply to CMS Regional Account Manager no later than 90 days before individuals IEP
  - Minimum notice: opt-out notice to beneficiary 60 days in advance of Medicare effective date
  - Washington Post/KHN story and CMA Case Study
MA Seamless Conversion

- 10/21/16 CMS **Seamless Moratorium Memo**
  - Temporary suspension of proposal acceptance
  - Clarifying memo out soon for 29 currently approved

- **Policy Data and Chart of Approved Seamless MA Organizations**
  - No data on number of beneficiaries seamlessly enrolled

<table>
<thead>
<tr>
<th>Region</th>
<th>State (MAO Approvals)</th>
<th>State (MAO Approvals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>None</td>
<td>Region 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NM (1), OK (1), TX (1)</td>
</tr>
<tr>
<td>Region 2</td>
<td>NY (1), PR (2)</td>
<td>Region 7</td>
</tr>
<tr>
<td>Region 3</td>
<td>PA (1)</td>
<td>Region 8</td>
</tr>
<tr>
<td>Region 4</td>
<td>FL (3), KY (2), TN (3)</td>
<td>Region 9</td>
</tr>
<tr>
<td>Region 5</td>
<td>IL (1), IN (1), MI (4), MN (1)</td>
<td>Region 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR (1)</td>
</tr>
</tbody>
</table>
Unwanted Seamless Conversion Options

- Enroll in another plan prior to MA effective date

- Special Enrollment Periods
  - MA Trial Right Period if age 65 or older and join MA for the first time (and get Medigap Guarantee Issue)
    - Disenroll within 12 months
    - Managed Care Manual 30.4.5 SEPs for Beneficiaries Age 65 SEP65
  - Potentially, use the fraudulent/misleading marketing complaint in Complaint Tracking Module (CTM) or to CMS Regional Office (RO)
    - Can make retroactive enrollment request in CTM or CMS RO for consideration
    - Managed Care Manual 60.5 Retroactive Disenrollments
Marketplace/Medicare Data Matching Pilot Notice

- August 2016, CMS sends notices to beneficiaries 65 and older enrolled in both Minimum Essential Coverage (MEC) Medicare and Marketplace with financial assistance
  - Premium-free Medicare Part A = MEC Medicare
  - Marketplace financial assistance = Advanced Premium Tax Credit (APTC) or Cost-sharing Reduction (CSR)
    - Letter warns may have to repay tax credits received while enrolled in both MEC Medicare and Marketplace
Avoiding Gaps in Coverage from Marketplace to Medicare Transitions

- Misunderstanding of Medicare Part B enrollment and Marketplace financial assistance (APTC or CSR)
  - Marketplace likely unaffordable without APTC or CSR

- **Equitable Relief** (as of 9/29/16) for Part B Special Enrollment Period
  - Beneficiary must make request between **9/1/16-3/31/17**
  - No late enrollment penalty will apply
  - Must have (or “recently” had) MEC Medicare and Marketplace
  - Part B effective month of enrollment or retroactively during previous two months (retro premium payment)
Equitable Relief Part B SEP Criteria

- Beneficiary cannot:
  - Be uninsured and filing for Part B or premium Part A for the first time
  - Be in their Initial Enrollment Period (IEP)
  - Have an IEP (or retro Part A entitlement) that ended 9/30/13 or earlier
Equitable Relief Part B SEP Criteria

- Beneficiary must:
  - Be entitled to premium-free Part A and not enrolled in Part B
  - Have an IEP starting 4/1/13 or later (or retro Part A entitlement on 10/1/13 or later)
  - Mention to SSA Field Office their issues/concerns about Marketplace coverage, APTC, or CSR coverage or allege misinformation about APTC or CSR
    - May provide MEC Medicare/Marketplace letter, if available, but not required
Social Security Process for Equitable Relief

- Verify meets eligibility requirements
- Collect beneficiary statement and available evidence (letter, etc.)
- Complete SSA-5002 Report of Contact form with recommendation and supporting evidence
- Forward case to Processing Center or Office of Disability Operations for review and final decision
  - If decision on equitable relief is necessary, submit to the SSA Regional Office
### Overview

| Care Improvement Plus Medicare Advantage (Regional PPO) | P.O. Box 29675
| Hot Springs, AR 71903 |
| Plan Type: Preferred Provider Organization |

| Organizations: Care Improvement Plus |

| Members: 1-800-204-1002 |
| Non-Members: 1-800-204-1007 |

### Costs and Other Important Information

#### Benefits

<table>
<thead>
<tr>
<th>Ambulance</th>
<th>In-network: $250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-network: $250</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor's office visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Physician</td>
</tr>
<tr>
<td>In-network: $30 per visit</td>
</tr>
<tr>
<td>Out-of-network: $30 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: $50 per visit</td>
</tr>
<tr>
<td>Out-of-network: $50 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Durable medical equipment (wheelchairs, oxygen, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: 20% per item</td>
</tr>
<tr>
<td>Out-of-network: 50% per item</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency care</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75 per visit (always covered)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: You pay nothing</td>
</tr>
<tr>
<td>Out-of-network: 50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: $395 for days 1 through 3</td>
</tr>
<tr>
<td>$0 for days 4 through 90</td>
</tr>
<tr>
<td>Out-of-network: $395 for days 1 through 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: 20% per visit</td>
</tr>
<tr>
<td>Out-of-network: 20% per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Renal dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: 20% per visit</td>
</tr>
<tr>
<td>Out-of-network: 20% per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient hospital care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: $395 for days 1 through 4</td>
</tr>
<tr>
<td>$0 for days 5 through 90</td>
</tr>
<tr>
<td>$0 for days 91 and beyond</td>
</tr>
<tr>
<td>Out-of-network: $395 for days 1 through 4</td>
</tr>
<tr>
<td>$0 for days 5 and beyond</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skilled Nursing Facility (SNF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: $0 for days 1 through 20</td>
</tr>
<tr>
<td>$150 for days 21 through 62</td>
</tr>
<tr>
<td>$0 for days 63 through 100</td>
</tr>
<tr>
<td>Out-of-network: $0 for days 1 through 20</td>
</tr>
<tr>
<td>$150 for days 21 through 62</td>
</tr>
<tr>
<td>$0 for days 63 through 100</td>
</tr>
</tbody>
</table>
Care Improvement Plus Medicare Advantage (Regional PPO) (MAPD) (R3444-012)

Monthly premium, deductible, and limits on how much you pay for covered services

How much is the monthly premium? $29.00 per month. In addition, you must keep paying your Medicare Part B premium.

How much is the deductible? $220 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.

Is there any limit on how much I will pay for my covered services? Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your yearly limit(s) in this plan:

- **$6,700** for services you receive from in-network providers.
- **$6,700** for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Is there a limit on how much the plan will pay? Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

**Covered Medical and Hospital Benefits**

Note:

- Services with a ⁹ may require prior authorization.
Transportation

Not covered

Urgently needed services

$30-40 copay, depending on the service

Vision services

Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):
  - In-network: $0-50 copay, depending on the service

Routine eye exam (for up to 1 every year):
  - In-network: $25 copay

Contact lenses:
  - In-network: You pay nothing

Eyeglasses (frames and lenses):
  - In-network: You pay nothing

Eyeglasses or contact lenses after cataract surgery:
  - In-network: You pay nothing

Our plan pays up to $100 every year for contact lenses and eyeglasses (frames and lenses) from any provider.
  - Out-of-network: $25 copay

  - Out-of-network: You pay nothing

  - Out-of-network: You pay nothing

  - Out-of-network: You pay nothing
Hearing services

Exam to diagnose and treat hearing and balance issues:
- **In-network:** $20 copay

Routine hearing exam (for up to 1 every year):
- **In-network:** $20 copay

Hearing aid:
- **In-network:** $390-450 copay for each hearing aid, depending on the type
- **Out-of-network:** $20 copay
- **Out-of-network:** $20 copay
- **Out-of-network:** $390-450 copay for each hearing aid, depending on the type

Optional Benefits (you must pay an extra premium each month for these benefits)
Optional Supplemental Package #1

**Package 1: Dental Platinum Rider**
Benefits include:
- Preventive Dental
- Comprehensive Dental

How much is the monthly premium?
Additional $34.00 per month. You must keep paying your Medicare Part B premium and your $29 monthly plan premium.

How much is the deductible?
This package does not have a deductible.

Is there a limit on how much the plan will pay?
Our plan has a coverage limit for certain benefits.
Finding 2017 MA Detailed Coverage Information

- Obtain Summary of Benefit documents from plans
- Visit plan websites
- Create a list or spreadsheet comparing

<table>
<thead>
<tr>
<th>Care Improvement Plus</th>
<th>Overall Star Rating: 4.5 out of 5 stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>(Regional PPO)</td>
</tr>
<tr>
<td>(R3444-012-D)</td>
<td></td>
</tr>
<tr>
<td>Organization: United Healthcare</td>
<td></td>
</tr>
<tr>
<td>Plan Type: Preferred Provider Organization</td>
<td></td>
</tr>
</tbody>
</table>

3315 Central Ave
Hot Springs, AR 71913

Members: 1-800-234-1002
711 (TTY/TDD)

Non Members: 1-800-555-5787
711 (TTY/TDD)

- Ambulance
  - In-network: $250
  - Out-of-network: $250

- Doctor's office visits
  - Primary Physician
    - In-network: $15 per visit
    - Out-of-network: $15 per visit
  - Specialist
    - In-network: $50 per visit
    - Out-of-network: $50 per visit

- Durable medical equipment (wheelchairs, oxygen, etc.)
  - In-network: 20% per item
  - Out-of-network: 45% per item

- Emergency care
  - $75 per visit (always covered)

- Home health care
  - In-network: You pay nothing
  - Out-of-network: 50%

- Mental health care
  - In-network: $335 for days 1 through 4
  - $0 for days 5 through 30
Polling Question

Which of the following best describes the impact of removing the detailed cost and benefit information to you?

I don’t assist with MA comparisons
I hadn’t noticed
I spend more time making MA comparisons
I spend significantly more time making MA comparisons
Balance Billing Prohibition

- Federal law does not allow Medicare providers to charge QMBs for Medicare cost sharing ("balance billing")
  - Social Security Act Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A)
  - Applies to all Medicare providers:
    - Original Medicare
    - Medicare Advantage
    - Medicare-only and Medicaid
    - Out-of-state
State “Lesser-of” policies

- Balanced Budget Act of 1997 allows States to limit their payment of Medicare deductibles and coinsurance
  - Apply the Medicare or Medicaid reimbursement rate, whichever is “lesser of”
  - Usually eliminate or reduce the Medicare cost-sharing reimbursement
- Most states apply “lesser of” policies to physician services as of Jan. 2015 except:
  - AR, IA, ME, MO, MS, NE, OH, OK, SD, VT, WY are “full payment” states
  - ID & TX use “other” payment limits

(MACPAC 2015)
CMS efforts to address QMB Balanced Billing

- Medicare Learning Network (MLN)
  - At-a-Glance Chart

- Proposed Physician Fee Schedule Rule reminder

- CY 2017 MA Call Letter

- Updated MA Policy Guidance: Section 10.5.2
QMB Balanced Billing Resources

- CMS Medicare Medicaid Coordination Office
  - Access to Care Issues Among Qualified Medicare Beneficiaries July 2015
  - Medicare-Medicaid General Information FAQ list
  - 8/4/16 MMCO PPT presentation “Key Issues for Dual Eligible Beneficiaries”
Contact Us

Melissa Simpson: Melissa.Simpson@ncoa.org
Leslie Fried: Leslie.Fried@ncoa.org

Visit us online at:

www.ncoa.org
www.ncoa.org/centerforbenefits
www.mymedicarematters.org
www.facebook.com/NCOAging
www.twitter.com/NCOAging

Locate a SHIP for local Medicare help
www.shiptacenter.org