Don’t Be Spooked by Medicare in 2019

October 31, 2018

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Housekeeping Notes

- Slides are available at [www.ncoa.org/ncboewebinars](http://www.ncoa.org/ncboewebinars)
  - Webinar recording will be posted by end of the week
- All lines are muted
- Please enter all questions into chat (no need to raise hand)
  - We will attempt to answer as many as we can at the end of the webinar
  - Any unanswered questions will be posted to link above
Agenda

- Costs in 2019
  - Parts A, B, C & D
  - IRMAA
- Landscape of plans: D & MA
- 2019 Benefits Overview
- Medicare Tools Update
- QMB protections guidance
- Conditional Enrollment Guidance
- Special Enrollment for Those Affected a FEMA Declare Emergency
- Equitable Relief
- Resources
### Medicare Costs in 2019: Part A Cost Comparison

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A Deductible</td>
<td>$1,360</td>
<td>$1,364</td>
</tr>
<tr>
<td>Hospital Copay/day 61-90</td>
<td>$335</td>
<td>$341</td>
</tr>
<tr>
<td>Hospital Copay/day 91-150</td>
<td>$670</td>
<td>$682</td>
</tr>
<tr>
<td>SNF Copay/day 21-100</td>
<td>$167.50</td>
<td>$170.50</td>
</tr>
<tr>
<td>Part A Premium/month Less than 30 credits</td>
<td>$422</td>
<td>$437</td>
</tr>
<tr>
<td>Between 30-39 credits</td>
<td>$232</td>
<td>$240</td>
</tr>
</tbody>
</table>

2019 Part B Deductible and Premiums

- Part B deductible is $185
- Standard monthly Part B premium is $135.50
- The 2.8% increase in Social Security benefits will cover the increase in premiums for most people
- 3.5% of Medicare beneficiaries pay below the standard monthly Part B premium due to the statutory hold harmless provision

IRMAA (Income Related Monthly Adjustment Amounts)

- Based on income above a certain limit:
  - Fewer than 5% pay a higher premium
  - Same thresholds used to compute IRMAA for premiums for Parts B & D
  - Income as reported on your IRS tax return 2 years ago

- In 2019, a sixth tier has been added to the Part B and D IRMAA brackets for beneficiaries with income of $500,000 (individuals) and $750,000 (married couples) or more
  - The new tier requires high earners to cover 85% of Medicare premium

## 2018/2019 Standard Drug Benefit

<table>
<thead>
<tr>
<th>Benefit Parameters</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$405</td>
<td>$415</td>
</tr>
<tr>
<td>Initial Coverage Limit</td>
<td>$3,750</td>
<td>$3,820</td>
</tr>
<tr>
<td>Out of Pocket (OOP) Threshold</td>
<td>$5,000</td>
<td>$5,100</td>
</tr>
<tr>
<td>Catastrophic OOP Threshold</td>
<td>$7508.75</td>
<td>$7,653.75</td>
</tr>
<tr>
<td>Minimum Cost-Sharing in Catastrophic Coverage</td>
<td>$3.35/$8.35</td>
<td>$3.40/$8.50</td>
</tr>
</tbody>
</table>

### Extra Help Copayments

<table>
<thead>
<tr>
<th>Extra Help Copayments</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<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>$1.25/$3.70</td>
<td>$1.25/$3.80</td>
</tr>
<tr>
<td>Full Extra Help – up to 135% FPL</td>
<td>$3.35/$8.35</td>
<td>$3.40/$8.50</td>
</tr>
<tr>
<td>Partial Extra Help (Deductible/Cost-Sharing)</td>
<td>$83/15%</td>
<td>$85/15%</td>
</tr>
</tbody>
</table>

### 2019 Coverage Gap Components

<table>
<thead>
<tr>
<th></th>
<th>Brand Name</th>
<th>Generic Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage</td>
<td>Counts to TrOOP?</td>
</tr>
<tr>
<td>Manufacturer discount</td>
<td>70%</td>
<td>Yes</td>
</tr>
<tr>
<td>Plan pays</td>
<td>5%</td>
<td>No</td>
</tr>
<tr>
<td>Beneficiary pays</td>
<td>25%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

## 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 brand-name drugs in the coverage gap</td>
<td>Other types of insurance</td>
</tr>
</tbody>
</table>

*brand-name drugs*
2019 Part D Plan Landscape

- Significant increase in number of PDPs over 2018
- 901 PDPs will be offered in the 34 regions, an additional 11 PDPs in territories
- Increase is probably due to elimination of meaningful difference limit for enhanced benefit PDPs by same sponsor in region
  - 61% of plans will offer enhanced benefits
- An average of 27 PDP choices in each of the 34 regions
  - 22 PDP plans in Alaska to 30 PDPs in Pennsylvania/West Virginia and California

2019 Part D Plan Landscape (cont.)

- Average monthly PDP premiums range from $34 (Hawaii) to $46 (CA, NJ and NY)
- All 34 regions have at least one PDP available for under $20
- Premium trends of 10 PDPs with highest enrollments
  - 5 will increase premiums by $1 - $7
  - 3 will decrease premiums by $1 - $9
  - 2 will have no change in premiums
- Average PDP premium will increase by 2%, weighted by current plan enrollment

All PDPs use tiered cost sharing; almost all PDPs will use 5 tier formulary

23% of PDPs use coinsurance for preferred brand tiers. Median coinsurance is 20%; median copay is $40)

Virtually all of PDPs use coinsurance for non-preferred drug tiers (or labeled non-preferred brand)
  - Median co-insurance is 40%

Fewer LIS $0 premium benchmark plans than in 2018 or any preceding year – range from 2 PDPs in Florida to 10 PDPs in AZ

Estimated 1 million LIS enrollees in benchmark plans in 2018 that will not be benchmark in 2019

2019 Medicare Advantage (MA) Landscape

- 18% increase in the number of Medicare Advantage plans since 2018. Total = 2,743
- Medicare Advantage (MA-PD) average premium submitted by health plans for 2019 was $40
- The mandatory maximum MOOP is $6,700, although plans can choose to have a lower voluntary MOOP (i.e., $3,400)
- 14 new sponsors entering MA market for first time; five insurers are leaving the MA market
- More MA plans will offer standard supplemental benefits (like dental and vision) and targeted supplemental benefits

Quality Ratings and MA-PD

- Payments to private Medicare Advantage (MA) plans tied to plans’ quality of coverage
  - One fewer high-quality plans were available in 2019 than in 2018
  - More beneficiaries enrolled in higher quality plans

<table>
<thead>
<tr>
<th>MA-PD</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA-PD contracts with 4 or more stars</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>MA-PD enrollees in plans with 4 or more stars</td>
<td>74%</td>
<td>73%</td>
</tr>
</tbody>
</table>
Approximately 74% of MA-PD Enrollees are in 4 or 5 star plans

14 MA-PD and 1 MA only contracts have 5 star ratings and four PDP contracts have 5 stars

There are four contracts (C and/or D) identified on MPF as plans with the low-performing icon

Average star rating for MA-PD is down
• 4.07 in 2018 to 4.05 in 2019

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html
E-Medicare Digitization

- Initiative is designed to provide a more personalized customer experience, modernize the way beneficiaries get information and make the best decisions on Medicare
- New tools can be found on medicare.gov homepage
E-Medicare Digitization Tools

- **Coverage Options Quiz** is a five question quiz to help beneficiaries determine if Medicare Advantage or Original Medicare is the right option.

- **Out-of-Pocket Cost Calculator** compares estimated premiums & out-of-pocket costs for original Medicare and Medicare Advantage (MA) based on service area and health status.
  - Users can add a Medigap policy and drug plan to their estimate for original Medicare.

Try the tools and give us your feedback!
2019 Changes to Medicare Plan Finder

- Home page has been updated
- Prominence of basic and MyMedicare search
- MyMedicare.gov logins testing a web chat option
- Personalized search by Medicare Beneficiary Identifier (MBI) and SSN
Locating “Targeted Supplemental” Benefits on MPF

- Health & Drugs Benefits tab
- Benefits Highlights: Additional benefits or reduced cost sharing for enrollees with certain health conditions
- Targeted benefits not listed on MPF
Expanded Scope of Supplemental Benefits

- MA plans are permitted to cover a broader array of items and services so long as they are used to: *Diagnose, prevent, or improve the effects of injuries or health conditions, or reduce avoidable emergency department visits.*

As defined in the CMS 2019 Call Letter and Final Rule

- **Standard:** Offered to all enrollees, i.e., dental, vision and hearing benefits/services
- **Targeted:** (new in 2019) Available to enrollees being treated for a health condition or diagnosis
- **Chronic:** (beginning in 2020) Limited to chronically ill, tailored, may include social support
Re-Interpretation of Supplemental Benefit Uniformity

Health care benefits may be targeted to specific groups of beneficiaries based on their health status or disease state to improve quality of life.

Example: MA plans may provide a diabetes patient with access to low- or no-cost transportation and/or reduced or eliminated copays for visits to the endocrinologist.
2019 MA Targeted Supplemental Benefits Parameters

- Target populations must be identifiable based on health status, disease state (diabetes, COPD, hypertension)
- Reduced cost-sharing or additional benefit must be medically related to the target condition
- Reduced Part C cost-sharing if seen by high value providers (hospitals, physicians, home health)
- Reduced cost sharing flexibility does not apply to MA plan premiums, Part D benefits or cost-sharing
- Benefits and flexibilities must be identified in the 2019 EOC and on MPF
2019 Meaningful Difference

Part C Plans
- Unlimited variety of plans in the same service area (change)

Part D Plans
- Two enhanced alternatives (EA) and one basic plan in a service area (same)
- The PDP enhanced alternative and basic plan meaningful difference requirement remains (same)
- EA offerings are free to be similar premium, cost sharing and benefits (change)
Step Therapy for Part B Drugs

MA plans may apply step therapy requirements for physician administered Part B drugs.

- Plans utilizing step therapy provide enrollees drug management care coordination plans
- Plans may offer incentives to enroll in beneficiary engagement/care coordination programs
- Exception/appeals process available

Medicare Advantage Open Enrollment Period (MA OEP)

Medicare Advantage Open Enrollment Period January 1- March 31 each year

MA Open Enrollment Period allows:

- Switch from one MA /MA-PD plan to another MA/MA-PD
- Disenroll from their MA to join original Medicare and utilize coordinating Part D SEP
- May drop Part D when switching plans

MA OEP does not allow:

- Disenroll from Original Medicare to join an MA plan
- Changes from one stand alone PDP to another stand alone PDP
- Changes in enrollment in other types of Medicare health plans i.e. cost plans, Medicare Savings Accounts, PACE

Marketing to MA enrollees during the MA OEP is prohibited
### Who Can Use the MA OEP:

<table>
<thead>
<tr>
<th>Who Can Use the MA OEP</th>
<th>MA OEP occurs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals enrolled in MA as of January 1</td>
<td>Annually January 1 – March 31</td>
</tr>
<tr>
<td>New Medicare beneficiaries who are enrolled in an MA Plan during their Initial Coverage Election Period</td>
<td>The month of entitlement to Part A and Part B – the last day of the 3rd month of entitlement</td>
</tr>
<tr>
<td>The effective date for an MA OEP election is the first of the month following receipt of the enrollment request</td>
<td></td>
</tr>
</tbody>
</table>

*Medicare Managed Care Manual. Chapter 2*
Transition of Medicare Cost Plans to MA

- Cost plans will not be renewed if there are 2 or more competing MA plans with a minimum of 5,000 enrollees (urban area) or 1,500 enrollees (rural area) in the service area

- Plan members may enroll into:
  - MA plan (by 2/28/19) or
  - Original Medicare and Part D plan (by 2/28/19) and a Medigap plan (by 3/4/19) guarantee issue (no health history review)
Easing Enrollment in MA Plans

Opt-Out Action

- Medicaid managed care enrollees newly eligible for Medicare may be seamlessly enrolled into a D–SNP or FIDE-SNP administered by the same sponsor organization. CMS must approve the default enrollment.

- Full-benefit duals enrolled in a non-renewing integrated D-SNP may be passively enrolled into comparable plan. Process is done in consultation with Medicaid.

Opt-In Action

- Simplified enrollment/election process for non-Medicare members (commercial, Marketplace, Medicaid) into MA plans offered by same organization.
SEP for CMS or State Initiated Enrollments

- Individuals enrolled through passive enrollment, auto-enrollment, facilitated enrollment, and reassignment have a 3 month SEP to disenroll from their new plan or enroll into a different plan.
- The SEP allows individuals to make an election before the enrollment is effective or after the coverage starts.
- SEP ensures the mandatory “opt-out” right provided to the enrollee as part of the CMS or state-initiated enrollment.

SEP for Duals & LIS Eligible

- SEP can be used once per calendar quarter:
  - January – March
  - April – June, and
  - July – September

- Can **not** be used in the 4th quarter of the year (October – December)

- Dual eligibles and LIS recipients retain the same right to utilize other SEPs such as change of LIS status, AEP, moving out of a service area, when initially auto-enrolled
SEP for Dual and LIS Eligible (cont.)

- The effective date of an enrollment request made using this SEP is the first of the month following receipt of an enrollment request.

- The SEP is considered “used” based on the month in which the individual makes the election (date of the enrollment request).

- For example: Plan receives an application in March
  - April 1 is the effective date
  - SEP is “used” for the 1st quarter, not the 2nd quarter.
Implementation of CARA Provisions

- Identifies opioids and benzodiazepines as frequently abused drugs
- Defines an “at risk” beneficiary as someone that reaches or exceeds a specific dosage of opioids and/or obtaining them from multiple prescribers and multiple pharmacies
- “At risk” determinations will be subject to the existing beneficiary appeals process
Limits for All Medicare Part D Enrollees

- Plans will limit the initial opioid prescription fills for the treatment of acute pain to no more than a 7 days’ supply
- Plans must implement an edit when a beneficiaries reaches or exceeds an established MME (morphine milligram equivalent) per day that requires the pharmacist to consult with the prescriber before filling the prescription
- The consultation requirement may delay prescription readiness
Limitations on Beneficiaries Deemed “At Risk”

- Plans may limit or **lock in** an at-risk beneficiary’s access to frequently abused drugs to a selected prescriber(s) and/or pharmacy(ies)
  - Plans must engage in prescriber and beneficiary case management before lock-in provisions can be implemented
  - Beneficiaries may submit prescriber and pharmacy preferences

- Plans may limit the use of the SEP for dually or other LIS eligible beneficiaries
Exempt Beneficiaries

- Receive hospice care or is receiving palliative or end-of-life care
- Resident of a long-term care or other facility where residents receive drugs through a contract with a single pharmacy
- Receiving treated for active cancer-related pain
QMB Protections: Improper Billing

- Federal law does not allow Medicare providers to charge Qualified Medicare Beneficiaries (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
## Improper Billing Occurs

<table>
<thead>
<tr>
<th>Difficulties for Providers</th>
<th>Difficulties for Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion about the billing rules</td>
<td>Confusion and lack of awareness regarding QMB status and rules</td>
</tr>
<tr>
<td>Difficulty in identifying QMB status</td>
<td>Many pay improper charges</td>
</tr>
<tr>
<td></td>
<td>Unpaid balances sent to collections</td>
</tr>
</tbody>
</table>
Medicare Summary Notice Changes

As of July 2, 2018, the Medicare Summary Notice (MSN) will:

- Clearly identify when the beneficiary was enrolled in the QMB program
- Accurately reflect the beneficiary’s cost-sharing liability ($0 for the period enrolled in the QMB program)

<table>
<thead>
<tr>
<th>Service Provided &amp; Billing Code</th>
<th>Service Approved?</th>
<th>Amount Provider Charged</th>
<th>Medicare-Approved Amount</th>
<th>Amount Medicare Paid</th>
<th>Maximum You May Be Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 min (97110)</td>
<td>Yes</td>
<td>$45.00</td>
<td>$28.54</td>
<td>$22.83</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total for Claim #02-10195-592-677</strong></td>
<td></td>
<td>$45.00</td>
<td>$28.54</td>
<td>$22.83</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Notes for Claims Above**

A You’re in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can’t bill you for the Medicare costs for this item or service, but you may be charged a small Medicaid copay.
Action Plan for Wrongly Billed QMBs

- Advise provider or debt collector of the QMB protections and/or provide copies of MSN showing $0 copayment
- Contact 1-800-MEDICARE (TTY-1-800-633-4227)
  - Unresolved beneficiary inquiry forwarded to the Medicare Administrative Contractor (MAC)
  - MAC will issue a compliance letter to named provider(s) or supplier and send a copy of the compliance letter to the beneficiary with an explanatory cover letter
- Contact the Bureau of Consumer Financial Protection at www.consumerfinance.gov or call 1-855-411-2372
Part A Conditional Enrollment update

- June 2018: SSA issued guidance clarifying the process to obtain conditional Part A
- The revised POMS provisions provide specific instructions and wording to ensure that a conditional Part A application is processed as “conditional”

- SSA Guidance on part A conditional enrollment: [https://secure.ssa.gov/poms.nsf/lnx/0600801140](https://secure.ssa.gov/poms.nsf/lnx/0600801140)
New Medicare SEP for FEMA Declared Emergency

Medicare beneficiaries affected by a FEMA declared emergency are eligible for a Special Enrollment Period (SEP):

- Unable to enroll, dis-enroll or switch Medicare health or prescription drug plans during their valid election period.
- The SEP lasts from the start of the incident period to four full calendar months after the incident period.
- Contact 1-800-MEDICARE to request enrollment

NCOA Post-Disaster Resources for Seniors: https://www.ncoa.org/blog/finding-post-disaster-resources-seniors
Extension of Equitable Relief for Marketplace Enrollees

Time limited equitable relief will last until **September 30, 2019** for individuals enrolled in a QHP who delayed enrolling in Medicare Part B

Eligibility requirements:

- Current or past enrollment Marketplace plan, enrolled in premium-free Part A, and:
  - Part A entitlement date after 7/1/13 OR
  - Retroactive premium free part A after 10/1/13 OR
  - Have and SEP that ended after 10/1/13
Marketplace Equitable Relief (cont.)

Equitable relief for Marketplace enrollees allows eligible individuals to:

1. Enroll in Part B without penalty or
2. Eliminate or reduce Part B late enrollment penalty for those enrolled during the 2015-2019 General Enrollment Periods


Resources from NCOA

- Open Enrollment compendium:

- My Medicare Matters® educational site and personalized decision support tool: [www.mymedicarematters.org](http://www.mymedicarematters.org)

Contact

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Leslie Fried: Leslie.Fried@ncoa.org

Visit us online at:
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www.ncoa.org/centerforbenefits
www.facebook.com/NCOAging
www.twitter.com/NCOAging

Educational resources for SHIPs: www.shiptacenter.org
Questions?