Agenda

- Special Enrollment for Those Affected by Hurricanes and Fires
- Equitable Relief
- Costs in 2018
  - Parts B, C & D
  - IRMAA
  - Part D Utilization
  - Plan Finder
- Landscape of plans: MA & Part D
- Enrollment Opportunities
- New Medicare card
- QMB protections guidance
- Resources
Enrollment Opportunities for Those Affected by Hurricanes and Fires
Medicare Enrollment 2018

Medicare beneficiaries affected by Hurricane Harvey, Irma, or Maria, and the wild fires in California may be eligible for:

- Special open enrollment period to enroll, dis-enroll or switch Medicare health or prescription drug plans through December 31, 2017

- Special enrollment period that extends the Annual Open Enrollment (AOE) to December 31, 2017 to enroll, dis-enroll or switch Medicare health or prescription drug plans. CMS announcement 9/28/2017

- Contact 1-800-MEDICARE to request enrollment
Medicare Equitable Relief

Medicare beneficiaries affected by Hurricane Harvey, Irma, or Maria, and the wild fires in California may be eligible for:

- Initial Enrollment Period (IEP) or Special Enrollment Period (SEP) extension that runs through May 31, 2018 for individuals whose IEP or SEP was interrupted/impeded by the 2017 major disasters.

  CMS announcement 10/30/2017

- Contact Social Security at 1-800-772-1213 or visit a local Social Security office to make an enrollment request due to weather related events.
Federal Health Insurance Marketplace
Special Enrollment Period

- Individuals affected by **Hurricane Harvey, Irma, or Maria** who experienced a special enrollment period qualifying event between 60 days prior to the start date of the incident period and December 31, 2017, but were unable to complete the application, plan selection, and enrollment process due to a hurricane-related weather event in 2017
  - This special enrollment period will allow individuals impacted by the storms to select a new 2017 Exchange plan or make changes to their existing plan at any time through December, 31, 2017
  - Individuals affected by the storms may contact the Exchange Call Center at 1-800-318-2596 to enroll in a plan

- **CMS announcement 9/28/2017**
Extension of Time Limited Equitable Relief

- Time-limited equitable relief lasts until September 30, 2018.
- Time-limited equitable relief is possible if:
  - You delayed enrolling in Medicare Part B so that you could stay in your Marketplace plan.
  - Enrolled in Premium free part A
  - An IEP of 4/1/13 or later
  - Notified retroactive premium free part A after 10/1/13
  - Experienced confusion about QHPs and enrolling in Medicare
Medicare Costs in 2018
Medicare Part B Monthly Premium 2018

- Standard Part B premium estimated to be $134 according to the Medicare Trustees Report
- Substantial increase for Medicare beneficiaries previously protected by the hold harmless provisions
- Social Security COLA will be used to pay increased Part B premium
Part C & D Costs

- Medicare Advantage (MA) average premium submitted by health plans for 2018 was $30 (down $1.40 from 2017)
- The mandatory MOOP is $6,700, although plans can choose to have a lower voluntary MOOP (i.e., $3,400).
- Average 2018 Part D plan Premium is $33.50

Medicare Advantage coverage & costs: https://www.ncoa.org/resources/medicare-advantage-coverage-and-costs/
## 2017/2018 Standard Drug Benefit

<table>
<thead>
<tr>
<th>Benefit Parameters</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$400</td>
<td>$405</td>
</tr>
<tr>
<td>Initial Coverage Limit</td>
<td>$3,700</td>
<td>$3,750</td>
</tr>
<tr>
<td>Out of Pocket (OOP) Threshold</td>
<td>$4,950</td>
<td>$5,000</td>
</tr>
<tr>
<td>Catastrophic OOP Threshold</td>
<td>$7425</td>
<td>$7,508.75</td>
</tr>
<tr>
<td>Minimum Cost-Sharing in Catastrophic Coverage</td>
<td>$3.30/$8.25</td>
<td>$3.35/$8.35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extra Help Copayments</th>
<th>2017</th>
<th>2018</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>$1.20/$3.70</td>
<td>$1.25/$3.70</td>
</tr>
<tr>
<td>Full Extra Help – up to 135% FPL</td>
<td>$3.30/$8.25</td>
<td>$3.35/$8.35</td>
</tr>
<tr>
<td>Partial Extra Help (Deductible/Cost-Sharing)</td>
<td>$82/15%</td>
<td>$83/15%</td>
</tr>
</tbody>
</table>

Source: CMS Final Call Letter 2018
# 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 2018**

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

1. **100% of your annual deductible** (max. $405)
2. **25% of prescription costs during your Initial Coverage Period** ($937 for someone with no deductible; $836.25 for someone in $405 deductible plan)
3. **You reach the $3,750 drug coverage limit — you’re headed for the donut hole.**
4. **Your drug costs have reached $7,508.75 and catastrophic coverage begins.** (You pay 5%, or $3.35 for generics and $8.35 for brand-name drugs, whichever is greater.)

---

**Need help paying for drugs?**
You may be eligible for Extra Help. Visit BenefitsCheckUp.org or ssa.gov/prescriptionhelp to apply.

---

Donut Hole/Coverage Gap = drug costs of $3,750 to $7,508.75

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After the Affordable Care Act: In 2018, you pay 35% for brand-name drugs and 44% for generics while in the donut hole.

**For more information, visit ncoa.org**

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**Source:** [NCOA Donut Hole: Coverage Gap Illustration](https://www.ncoa.org/medicare-drug-costs)

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True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward the out of pocket threshold ($5,000 in 2018)
- After threshold is met catastrophic coverage begins
  - Small copayment or coinsurance for covered drugs
- Plan Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if mid-year plan switch
  - Examples: move out of coverage area or use Extra Help Continuous Special Enrollment Period
## 2018 Gap Discount Ingredients

<table>
<thead>
<tr>
<th></th>
<th><strong>Brand Name</strong></th>
<th><strong>Generic Drug</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage</td>
<td>Counts to TrOOP?</td>
</tr>
<tr>
<td>Manufacturer discount</td>
<td>50%</td>
<td>Yes</td>
</tr>
<tr>
<td>Plan pays</td>
<td>15%</td>
<td>No</td>
</tr>
<tr>
<td>Beneficiary pays</td>
<td>35%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Learn more: [NCOA Coverage Gap Tip Sheet](#)
## 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</td>
</tr>
<tr>
<td>▪ Most charities (not if established or run by employer/union)</td>
<td>coverage)</td>
</tr>
<tr>
<td>▪ Indian Health Service</td>
<td>▪ Government-funded programs (including Medicaid, TRICARE,</td>
</tr>
<tr>
<td>▪ AIDS Drug Assistance Programs</td>
<td>VA)</td>
</tr>
<tr>
<td>▪ The discount you get on covered <em>brand-name drugs</em> in the coverage gap</td>
<td>▪ Patient Assistance Programs</td>
</tr>
<tr>
<td></td>
<td>▪ Other third-party payment arrangements</td>
</tr>
<tr>
<td></td>
<td>▪ Other types of insurance</td>
</tr>
</tbody>
</table>
• Income-related Monthly Adjustment Amount (IRMAA)

• 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

• Required to pay
  • Withheld from SSA or RRB benefits check
  • Failure to pay may result in disenrollment from Part D
**Medicare Part B IRMAA**

<table>
<thead>
<tr>
<th>Beneficiaries who file individual tax returns with income that is:</th>
<th>Beneficiaries who file joint tax returns with income that is:</th>
<th>IRMAA amounts added to Part B premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $85,000</td>
<td>Less than or equal to $170,000</td>
<td>?</td>
</tr>
<tr>
<td>$85,000.01- $107,000</td>
<td>$170,000.01 - $214,000</td>
<td></td>
</tr>
<tr>
<td>$107,000.01 - $133,500</td>
<td>$214,000.01 - $267,000</td>
<td></td>
</tr>
<tr>
<td>$133,500.01 - $160,000</td>
<td>$267,000.01 - $320,000</td>
<td></td>
</tr>
<tr>
<td>$160,000.01 - $214,000</td>
<td>$320,000.01 - $428,000</td>
<td></td>
</tr>
</tbody>
</table>
## 2018 Part D IRMAA

<table>
<thead>
<tr>
<th>If Your Yearly Income in 2016</th>
<th>In 2018 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 – $133,500</td>
<td>$214,000.01 – $267,00.01</td>
</tr>
<tr>
<td>$133,500.01 – $160,000</td>
<td>$267,000.01 – $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>

CMS Annual Part C & D Benchmark Memo on 7/31/17, page 4
Part D Utilization

- PDP can limit the initial fill to a 30 day supply for designated drugs
- PDPs should not restrict tiering exception request to a single lower tier if multiple lower tiers contain alternative drugs
- Monitoring for opioid over utilization
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>Benefits</th>
<th>Ambulance</th>
<th>In-network: $250</th>
<th>Out-of-network: $250</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doctor's office visits</td>
<td>Primary Physician</td>
<td>In-network: $15 per visit</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (wheelchairs, oxygen, etc.)</td>
<td>In-network: 20% per item</td>
<td>Out-of-network: 45% per item</td>
</tr>
<tr>
<td></td>
<td>Emergency care</td>
<td>$75 per visit (always covered)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>In-network: You pay nothing</td>
<td>Out-of-network: 50%</td>
</tr>
<tr>
<td></td>
<td>Mental health care</td>
<td>In-network: $335 for days 1 through 4 $0 for days 5 through 90</td>
<td></td>
</tr>
</tbody>
</table>
In 2018, provides more extensive benefits information.

### Care Improvement Plus Medicare Advantage (Regional PPO) (R3444-012-0)

- **Organization:** UnitedHealthcare
- **Plan Type:** Preferred Provider Organization
  - **In-Network:** Yes

#### Benefits Highlights

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly health plan premium</td>
<td>$13.00</td>
</tr>
<tr>
<td>Health plan deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Other health plan deductibles?</td>
<td>In-Network: No</td>
</tr>
<tr>
<td>Maximum out-of-pocket enrollee responsibility</td>
<td>$6,700 In and Out-of-network</td>
</tr>
<tr>
<td>(does not include prescription drugs)</td>
<td>$6,700 In-network</td>
</tr>
<tr>
<td>Optional supplemental benefits?</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient hospital coverage</td>
<td>In-Network: $360 for days 1 through 5</td>
</tr>
<tr>
<td></td>
<td>$0 for days 6 through 90</td>
</tr>
<tr>
<td></td>
<td>$0 for days 91 and beyond</td>
</tr>
<tr>
<td></td>
<td>Out of Network: $360 for days 1 through 5</td>
</tr>
</tbody>
</table>

#### Additional Information

- **Organization:** UnitedHealthcare
- **Plan Type:** Preferred Provider Organization
- **In-Network:** Yes
- **Monthly health plan premium:** $13.00
- **Health plan deductible:** $0
- **Other health plan deductibles:** In-Network: No
- **Maximum out-of-pocket enrollee responsibility:** $6,700
- **Optional supplemental benefits:** Yes
- **Inpatient hospital coverage:** In-Network: $360 for days 1 through 5
- **Out of Network:** $360 for days 1 through 5

#### Health Plan Details

- **Members:**
  - 1-800-204-1002
  - 711 (TTY/TDD)
- **Non Members:**
  - 1-800-555-5757
  - 711 (TTY/TDD)

- **Location:** 3315 Central AVE, Hot Springs, AR 71913
- **Overall Star Rating:** 3.5 out of 5 stars
### 2018 MA Detailed Costs and Benefits View

#### Emergency care/Urgent care
- **Emergency**: $80 per visit (always covered)
- **Urgent care**: $30-40 per visit (always covered)

#### Diagnostic procedures/lab services/imaging
- **Diagnostic tests and procedures**:  
  - **In-Network**: 20%
  - **Out-of-Network**: 20%
- **Lab services**:  
  - **In-Network**: $10
  - **Out-of-Network**: $10
- **Diagnostic radiology services (e.g., MRI)**:  
  - **In-Network**: 20%
  - **Out-of-Network**: 20%
- **Outpatient x-rays**:  
  - **In-Network**: $14
  - **Out-of-Network**: $14

#### Mental health services
- **In-Network**: $360 for days 1 through 4  
  - $0 for days 5 through 90  
  - **Out-of-Network**: $360 for days 1 through 4  
  - $0 for days 5 through 90
- **Outpatient group therapy visit with a psychiatrist**:  
  - **In-Network**: $30
  - **Out-of-Network**: $30-40
- **Outpatient individual therapy visit with a psychiatrist**:  
  - **In-Network**: $40
  - **Out-of-Network**: $30-40
- **Outpatient group therapy visit**:  
  - **In-Network**: $30
  - **Out-of-Network**: $30-40
### Benefits Services

<table>
<thead>
<tr>
<th>Item</th>
<th>In-Network: $20</th>
<th>Out-of-Network: $20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine eye exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Contact lenses</td>
<td>In-Network: $0 copay</td>
<td>Out-of-Network: $0 copay</td>
</tr>
<tr>
<td>Eyeglasses (frames and lenses)</td>
<td>In-Network: $0 copay</td>
<td>Out-of-Network: $0 copay</td>
</tr>
<tr>
<td>Eyeglass frames</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Eyeglass lenses</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Upgrades</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

### Optional Supplemental Benefits

**Package #1**
- Comprehensive dental services
- Preventive dental services
- Monthly Premium: $35.00
- Deductible: $100.00

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2018 MA Detailed Costs and Benefits View
Landscape of Plans
2018 Part D Plan Landscape

- Increase in number of PDPs over 2017 with an average of 23 PDP choices
  - No new plan sponsors offering PDPs in 2018 but new plan offerings by existing plans
  - 19 PDP plans in Alaska to 26 PDPs in Pennsylvania/West Virginia

Source: Kaiser Family Foundation (KFF) Medicare PDP First Look at Part D
2018 Part D Plan Landscape

- In contrast to previous years, there is no PDP available nationally for under $20
- Premium trends of 10 PDPs with highest enrollments
  - 4 will increase premiums by 20% or more
  - 4 will increase premiums by 4 - 18%
  - 2 will decrease premiums by 5 - 9%
- Average PDP premium will increase by 9%, weighted by current plan enrollment

Source: Kaiser Family Foundation (KFF) Medicare PDP First Look at Part D
2018 Part D Coverage Landscape

- Most PDPs have Preferred Pharmacy networks
- All PDPs use tiered cost sharing; almost all PDPs will use a 5-tier formulary
- 24% of PDPs use coinsurance for preferred brand tiers
- 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 2017 or any preceding year

Sources: Kaiser Family Foundation Medicare Part D: A First Look at Plan Offerings
The number of benchmark PDPs in 2018 varies across regions from 2 PDPs in Florida to 10 PDPs in Delaware/D.C./Maryland and Arizona.

NOTE: Includes “de minimis” plans that can retain Low-Income Subsidy beneficiaries despite exceeding the benchmark premium by up to $2 in 2018.
SOURCE: Authors’ analysis of Centers for Medicare & Medicaid Services 2018 PDP landscape source file.
2018 Medicare Advantage (MA) Landscape

- 14% increase in the number of Medicare Advantage plans since 2017
- Medicare Advantage (MA) average premium submitted by health plans for 2018 was $30 (down $1.40 from 2017)
- 77% of beneficiaries enrolled in MA will have the same or lower premium
- More MA plans will offer additional benefits (like dental and vision)

Kaiser Family Foundation Medicare Advantage 2018 Data Spotlight
CMS 2018 MA PDP Landscape
MA Enrollment and Disenrollment Guidance 2018

- CMS continues its suspension of any new seamless enrollment proposals.
- Streamlines the enrollment process to ease the premium payment selection process and eliminates the requirement to mail a copy of a completed paper enrollment request back to the individual.
Payments to private Medicare Advantage (MA) Plans tied to plans’ quality of coverage

- Fewer high-quality plans were available in 2018 than in 2017
- More beneficiaries enrolled in higher quality plans

<table>
<thead>
<tr>
<th>MA-PD</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA-PD contracts with 4 or more stars</td>
<td>44%</td>
<td>49%</td>
</tr>
<tr>
<td>MA-PD enrollees in plans with 4 or more stars</td>
<td>73%</td>
<td>69%</td>
</tr>
</tbody>
</table>
2018 MA-PD Quality

- Approximately 73% of MA-PD Enrollees are in 4 or 5 star plans
- 15 MA-PD and 1 MA only contracts have 5 star ratings
- For the first time no contracts will receive the plans the low-performing icon
- Average star rating is up slightly
  - 4.02 in 2017 to 4.06 in 2018

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

Example: Kaiser Permanente Medicare Plus Std w/Part D (AB) (Cost) (H2150-009-0)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Annual: $25.20</td>
<td>$15.00 Drug: $2.10</td>
<td>Annual Drug Deductible: $0 Health Plan Deductible: $0</td>
<td>Doctor Choice: Plan Doctors Only All Your Drugs on Formulary: N/A</td>
<td>Drug Restrictions: N/A No Additional Gap</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Rest of 2014: $23.10*           | Health: $12.90        | Drug Copay/                                        | Out of Pocket Spending Limit: $2,420 | $2,420

This plan got Medicare’s highest rating (5 stars)
Medicare Cards
New Medicare Card

- The new cards are designed to decrease Medicare beneficiary vulnerability to identity theft by removing the SSN from their Medicare identification cards and replace it with a Medicare Beneficiary Identifier (MBI).
- The MBI is
  - Unique alpha numeric non-intelligent identifier
  - 11 bytes in length
Other Key Points

- New cards start mailing in April 2018 and continue through April 2019. Cards will arrive at different times.
- Ensure mailing address is up-to-date. Contact social security at 1-800-772-1213 or www.ssa.gov/myaccount.
- Gender and signature line won’t appear on the new card.
- The Railroad Retirement Board will issue new cards to RRB beneficiaries.
Tips to Prevent Fraud

Clients are reminded:

- Medicare will **never** request personal or private information when mailing out the new Medicare card/number and beneficiaries should be wary of anyone contacting them about the new card or MBI.
- Destroy old Medicare card upon receipt of the new one.
- Protect MBI like any other personal information.
- CMS anticipates that the MBI won’t be changed for an individual unless the MBI has been compromised.
Qualified Medicare Beneficiary (QMB) Protections
Improper Billing

- 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
### 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

- Starting October 2, 2017, 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)

Resource: QMB Indicator in the Medicare Fee-For-Service Claims Processing System
### Part B Medicare Summary Notice: Page One

**Notice for Jennifer Washington**

<table>
<thead>
<tr>
<th>Medicare Number</th>
<th>XXX-XX-1234A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of This Notice</td>
<td>September 16, 2017</td>
</tr>
<tr>
<td>Claims Processed Between</td>
<td>June 15 – September 15, 2017</td>
</tr>
</tbody>
</table>

**Your Deductible Status**

Your deductible is what you must pay for most health services before Medicare begins to pay.

**Part B Deductible:** You have now met **$85.00** of your **$109.00** deductible for 2017.

**Be Informed!**

This notice contains claims covered by the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. When you’re enrolled in the QMB program, providers and suppliers who accept Medicare aren’t allowed to bill you for Medicare deductibles, coinsurance, and copayments.

**Your Claims & Costs This Period**

<table>
<thead>
<tr>
<th>Did Medicare Approve All Services?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Services Medicare Denied</td>
<td>0</td>
</tr>
</tbody>
</table>

See claims starting on page 3.

**Total You May Be Billed**

$0.00

**Providers with Claims This Period**

- **June 18, 2017**
  - Susan Jones, M.D.
- **June 28, 2017**
  - Craig I. Secosan, M.D.
- **June 29 – June 30, 2017**
  - Edward J. Mcginley M.D.
### Medicare Summary Notice for Part B: Detail Line

**June 18, 2017**  
**Dr. Susan Jones, M.D., (555) 555-1234**  
Brevard County Physical Therapy Center, 32 Main Street, Brevard, NC 28712-4187

<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>
</tbody>
</table>

**Total for Claim #02-10195-592-677**  
- $45.00  
- $28.54  
- $22.83  
- $0.00

**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)
  • The Medicare Benefits Contact Center (BCC) will refer the unresolved beneficiary inquiry to 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 a explanatory cover letter
  • Copies of the MAC instructions and compliance letters can be found in Transmittal 1757 - CMS Manual System

▪ Contact the Consumer Financial Protection Bureau (CFPB) at www.consumerfinance.gov or call the CFPB at 1-855-411-2372
Resources
Resources from NCOA

- Guide to Mailings & Key Events: https://www.ncoa.org/resources/medicare-open-enrollment-guide-to-mailings-key-events/
- My Medicare Matters® educational site and personalized decision support tool: www.mymedicarematters.org
- BenefitsCheckUp®: www.BenefitsCheckUp.org
Contact

Ann Kayrish: Ann.Kayrish@ncoa.org
Leslie Fried: Leslie.Fried@ncoa.org

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www.twitter.com/NCOAging

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