

## Medicare Advantage: Overview of Coverage and Costs

Generally, unless they qualify for a Medicare Savings Program (MSP), beneficiaries must continue to pay their Medicare Part B premium when they belong to a Medicare Advantage (MA) plan. For most, this just means their Part B premium will continue to be deducted from their monthly Social Security or Railroad Retirement benefit. However, some MA plans charge an extra plan premium that members must pay in addition to their Part B premium. Still other MA plans pay some or all of the Part B premiums for members as an extra benefit.

MA plans often require members to pay copayments or coinsurance when they receive medical care. The plans set how much these charges will be. It's important for Medicare beneficiaries to understand these charges, as they are likely to differ from Original Medicare Parts A and B charges.

In some instances, these out-of-pocket copayment or coinsurance costs may be less than the comparable costs in Original Medicare. For example, an MA member might pay a \$20 copayment to see a doctor for ongoing treatment of arthritis, whereas in Original Medicare he'd pay at least 20% of the Medicare charge. In other situations an MA plan copayment or coinsurance might cost the member more than the comparable cost if she were in Original Medicare. So, depending upon a beneficiary's health care needs, an MA plan's cost-sharing requirements could work in her favor, or not.

Keep in mind, however, some rules that help protect beneficiaries from high cost-sharing liabilities they may experience in MA plans:

- MA plans must provide all in-network preventive services *that are covered at zero cost-sharing under Original Medicare* at zero cost-sharing — this means no deductible, no copayment.
- Health care reform limits MA plans from charging its members copayments or coinsurance amounts for certain expensive services more than it would cost the beneficiary under Original Medicare. These services include chemotherapy, renal dialysis, and skilled nursing facility (SNF) stays.
- There is a mandatory maximum out-of-pocket (MOOP) limit on all Parts A and B services requirement of local and regional MA plans. In 2018, the mandatory MOOP is \$6,700, although plans can choose to have a lower voluntary MOOP (i.e., \$3,400).

### *What does a Medicare Advantage (MA) plan cover?*

MA plans must cover all medically reasonable and necessary care and services that are

covered by Medicare Parts A and B. Medicare Advantage plans with prescription drug coverage (MA-PDs) must also offer Part D prescription drug coverage.

Some MA plans offer extra coverage that isn't included in Original Medicare. For example, MA plans can cover over-the-counter medications like pain remedies or cough syrup, even though these are not Part D-covered drugs, or even health-related items such as hearing aids and glasses. They should check to see whether and how the MA plan offers limited extras, such as preventive dental benefits, or subsidizing part of the cost of membership in specific health clubs. They should also consider whether the extra benefits offered are ones they would use, such as health club membership.

### **MA Members with Limited Incomes**

Many individuals with both Medicare and Medicaid (or “dual eligible beneficiaries”) enroll in Medicare Advantage. Most dual eligible beneficiaries also may qualify for one of the Medicare Savings Programs (MSPs). MSPs help cover some of the costs in Medicare, such as premiums and cost-sharing amounts. There are four different MSPs, each with a different income and resource eligibility limit:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Beneficiary (SLMB)
- Qualifying Individual (QI)
- Qualified Disabled Working Individual (QDWI)

As more people with Medicare and limited incomes join Medicare Advantage plans (particularly Special Needs Plans or SNPs), it is important to understand the connection between MSPs and Medicare Advantage plans – that is, MSPs or Medicaid may pay certain Medicare Advantage charges on behalf of their members.

#### *Medicare Part A premium: Who pays?*

Some Medicare beneficiaries must pay a Part A premium because they (or their spouse) did not work long enough to qualify for premium-free Part A. These beneficiaries are called “voluntary” Medicare enrollees. The QMB program will pay the Medicare Part A premium on behalf of these “voluntary” Medicare beneficiaries if they are eligible for the program.

#### *Medicare Part B premium: Who pays?*

Three Medicare Savings Programs – QMB, SLMB, and QI – pay the Part B premium. MSPs pay the Part B premium for enrollees whether the beneficiaries are enrolled in Original Medicare or have joined a Medicare Advantage plan.

### *Who pays the monthly MA premium?*

Medicare Advantage plans, including Special Needs Plans (SNPs) for duals (D-SNPs), can charge their members monthly premiums. Medicaid law allows each state Medicaid agency to decide whether the QMB program will pay the Medicare Advantage plan premium for people enrolled in that program.

### *Who pays the MA copayments and coinsurance?*

CMS requires Medicaid to pay Medicare Advantage coinsurance or copayments to the plan on behalf of QMBs. You may hear from beneficiaries who are being charged copayments by their MA plan providers. They should file a complaint with their plan and you can help them, to be sure they are heard and this problem resolved. The MA plan should reimburse them, regardless of whether the plan has a contract set up with the state Medicaid agency.

Beneficiaries who have SLMB or QI should know that federal statutes governing these programs limits them to only pay for the Part B premium; therefore any additional Medicare Advantage plan premium is not covered by SLMB or QI.

Full duals who are not enrolled in a MSP should check with their state Medicaid agency; some states may opt to cover the MA premium, but they get no federal match for doing so.

For more information on MSP eligibility, consult our chart, [Medicare Savings Programs \(MSPs\) – Eligibility and Coverage](#).

## **Coverage Denials**

### *What can a beneficiary do if an MA plan denies coverage?*

Medicare beneficiaries can appeal if:

- They disagree with a plan’s decision to deny care or services that they think Medicare should cover, **OR**
- Their plan refuses to pay for care that they believe they should have.

Beneficiaries can start the appeal process by asking for a formal decision from the plan, called an “Organizational Determination”. They can ask by calling the plan’s toll-free call center number. Plans must issue their decisions within 14 days of a request. If the plan decides to stop home health, SNF, or certain rehabilitation services, beneficiaries are entitled to an expedited decision within 72 hours.

If the plan’s decision is to deny a request to approve a service, it must issue the member an [Integrated Denial Notice](#). In this notice, the plan must explain why it won’t cover the care or service or is discontinuing or reducing it. The notice must also include information on how the member can further appeal and request a “Reconsideration,” which is a review by the

MA plan of its initial decision to deny care or service. In addition, MA plans serving Medicare beneficiaries also enrolled in Medicaid must include Medicaid appeals information in the notice as well.

Beneficiaries dissatisfied with the customer service of their plan or plan providers can file a “grievance” (complaint) with the plan. The beneficiary can find information on how to file a grievance in their initial and annual enrollment packet (*Evidence of Coverage*), or by contacting the plan.

## References

Centers for Medicare & Medicaid Services (CMS) April 3, 2017 [2018 Final Call Letter](#) issued to all plans, which explains the 2018 Part D standard cost-sharing amounts (see page 48) and maximum out-of-pocket (MOOP) limits (see page 120).

See the Centers for Medicare & Medicaid Services (CMS) publication, [Dual Eligible Beneficiaries Under the Medicare and Medicare Programs](#), (revised November 2014) available from the Medicare Learning Network.

See [42 C.F.R. Section 1396a \(n\)](#) for legal authority that protects QMBs from being charged Medicare Parts A and B copayments and coinsurance.

See the *Patient Protection and Affordable Care Act (PPACA)* ([H.R. 3590](#)), Section 4103, 4104, and 4105 for statute that limits cost-sharing for preventive benefits under Medicare Advantage beginning in 2012.