MEDICARE RIGHTS CENTER
Getting Medicare right

National Council on Aging

Helping clients understand Medicare notices

Medicare Rights Center

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through

Counseling and advocacy

Educational programs

Public policy initiatives

National Council on Aging

This toolkit for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) was made possible by grant funding from the National Council on Aging.

The National Council on Aging is a respected national leader and trusted partner to help people aged 60+ meet the challenges of aging. They partner with nonprofit organizations, government, and business top provide innovative community programs and services, online help, and advocacy.

National Council on Aging

Learning objectives

- Help beneficiaries understand the information included on Medicare Summary Notices (MSNs) and Explanations of Benefits (EOBs)
- Explain times when a beneficiary may receive an Advance Beneficiary Notice (ABN)
- Use Fall Open Enrollment Period notices to help beneficiaries decide if they need to make changes to their Medicare coverage

Medicare Summary Notice

Medicare Summary Notice (MSN)

- Original Medicare notice
- Summary of health care services and items beneficiary received during previous three months
- Not a bill
- May include name and address of private company that processes claims for Medicare

When does a beneficiary receive an MSN?

- Usually mailed four times a year (quarterly) after beneficiary receives health care services
- If beneficiary did not receive health care services during a particular quarter, they will not receive an MSN
- If beneficiary received services but did not receive an MSN, they should call 1-800-MEDICARE (633-4227) or access MSN online at www.mymedicare.gov

What information is included on an MSN?

- Health care services or items beneficiary received
- Amount providers billed Medicare for services
- Amount Medicare paid providers for each service
- Amount beneficiary may need to pay directly to providers
  - § Indicated in the "You May Be Billed" column
  - § Beneficiary will receive bill from their provider(s) and do not need to pay anything until they have received a bill
- Any non-covered charges
  - § If MSN shows that service or item is not covered, beneficiary should look for notes section to learn why

MSNs and secondary insurance

- Secondary insurance pays after Medicare
  - § Examples: Medigap policy, retiree insurance
  - § If beneficiary has Medigap policy, they may also receive notice from the Medigap company about what it paid as secondary
- Medicare or doctor may have already submitted the remaining bill to other insurance
- Beneficiary should check notes on MSN because they may indicate if claim has already been sent to another insurer
- If not, beneficiary may need to submit the claim
  - § Beneficiary should call their secondary insurance plan to learn what (if any) steps to take, and speak with provider to ensure that they have the most up-to-date insurance information

Sample MSN

This is the total amount that the provider can bill the beneficiary. They will receive a separate bill from their provider for any charges they owe. The MSN is not a bill.

January 21, 2020
Craig L. Secosan, M.D., (555) 555-1234
Looking Glass Eye Center PA, 1888 Medical Park Dr., Suite C, Brevard, NC 28712

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014)	Yes	$143.00	$107.97	$86.38	$21.59	
Destruction of skin growth (17000)	**NO**	$68.56	0.00	0.00	$68.56	A
Total for Claim #02-10195-592-390		$211.56	$107.97	$86.38	$90	

This column tells the beneficiary whether their claim was approved or denied.

Use this column to refer to footnotes at the bottom of the page for explanations of the services received.

Notes for Claims Above
A This service was denied. The information provided does not support the need for this service or item.

Explanation of Benefits

Explanation of Benefits (EOB)

- Medicare Advantage Plan notice
- Summary of health care services or items Medicare Advantage Plan or Part D prescription drug plan typically sends beneficiary after they receive services or items
- Not a bill

When does a beneficiary receive an EOB?

- Only sent to Medicare Advantage or Part D plan enrollees
  - § Not the same as Medicare Summary Notice, but serves similar function and contains similar information
- Usually mailed once per month or per service

What information is included on an EOB?

- Health care services or items beneficiary received
- Amount providers billed plan for services
- Amount plan paid providers for each service
- Amount beneficiary may need to pay directly to providers
  - § Indicated in the "Your Share" column
- Any non-covered charges
  - § If EOB shows that item or service is not covered, beneficiary should look for notes section to learn why
  - § Information may be included on next page
- All EOBs provide the same information, but layout and other specifics may vary by plan
- Beneficiary should contact plan with any questions

Part D plan EOB

- If beneficiary has Part D plan, their EOB will list:
  - § What the plan has paid for a prescription
  - § What beneficiary paid for prescription at pharmacy
  - § Any other payments made by programs or organizations.
  - § Total out-of-pocket costs for prescription drugs for the year
  - § Part D coverage phase (deductible, initial coverage, coverage gap, or catastrophic coverage)
- If beneficiary is unclear about any of these charges, or why their drug costs change from one month to the next, they should contact their plan
  - § Out-of-pocket costs for drugs may change depending on the coverage phase

Sample EOB

This column shows how much the beneficiary owes toward their deductible.

Provider: Main Street Cardiology **Claim Number: 87765**
Patient Account Number: 25303540

Date of service	Type of service	Notes	Amount billed	Your Plan Paid	Deductible	Copay	Non-covered	Your Share
1/10/20	Office visit		$150	$80	$0.00	$50	$0.00	$50

This column includes reference to notes section, when applicable. For example, if the plan did not approve coverage, this column would refer to section that explains why.

If plan denied coverage for the service, this column would list the amount that the plan did not pay for, and the beneficiary may be responsible for that cost.

This column shows how much the beneficiary owes for the cost of the service.

Reading MSNs and EOBs

Service approved

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Notes for Claims Above
A This service was denied. The information provided does not support the need for this service or item.

- MSN or EOB will show whether Medicare or plan approved coverage for health care service or item
- If coverage is denied, beneficiary can appeal

Appealing coverage denials

- If beneficiary is denied coverage for service that they believe should have been covered, they should appeal this decision
- MSN or EOB will include notes that explain the reason that Medicare coverage of an item or service was denied
  - § Common explanation for denial based on medical necessity is “The information provided does not support the need for this service or item”
  - § When beneficiary appeals, they and/or their provider will need to understand and address the reasons for denial
- The final page of MSN or EOB should include instructions for appealing this decision

Provider billed vs. provider paid

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- MSNs and EOBs may show different amounts for what provider charged, what approved amount was, and what Medicare or plan paid
- Medicare or plan pays provider based on **approved amount**, not based on what provider charged Medicare or plan

Provider billed vs. provider paid

If beneficiary has Original Medicare

- Medicare has set an amount that provider or supplier is paid for a particular service or item
  - § Known as Medicare-approved amount
- Medicare pays provider a percentage of the **Medicare-approved amount**
  - § Medicare pays 80% of approved amount for most Part B-covered services
  - § Medicare does not base its payment on amount charged by provider
- Coinsurance is based on the Medicare-approved amount
  - § 20% of approved amount for most Part B-covered services
  - § MSN will state the maximum amount the provider can bill in column labeled “Maximum You May Be Billed”

Provider billed vs. provider paid

If beneficiary has Medicare Advantage Plan

- Plan may have set an approved amount for the service in question
- Approved amount is the fee that health insurance plan and provider or supplier agree upon for particular service or item
- Beneficiary's EOB will show the amount the provider may bill you in the "Your Share" column
- If beneficiary follows plan's rules and uses providers in the plan's network, they will typically only owe set copayment or coinsurance (percentage of the plan's rate)

Beneficiary responsibility

- MSN or EOB may say beneficiary is responsible for an out-of-pocket cost
  - § MSN: "Maximum You May Be Billed" column
  - § EOB: "Your Share" column (EOB language may vary)

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Compare MSN or EOB with bill

- If beneficiary owes anything, they should receive bill directly from doctor or other provider who provided health care service or item
- MSNs and EOBs are not bills, so beneficiaries should wait for bill from provider before making any payment
- Beneficiary should compare bill with MSN or EOB to make sure billed amount matches what MSN or EOB says they owe

Reasons beneficiary owes out-of-pocket costs

- Some reasons a beneficiary may owe out-of-pocket costs include:
  - § **Beneficiary has not yet reached deductible**
    - » Deductible: Amount beneficiary must pay for health care expenses before health insurance begins to pay
    - » Once beneficiary reaches deductible, their plan will begin paying for part or all of the covered services
  - § **Beneficiary owes copayment**
    - » Copay: Set amount paid each time service is received
    - » Beneficiary may have already paid this when they were leaving the doctor's office

Reasons beneficiary owes out-of-pocket costs (continued)

- Some reasons beneficiary may owe out-of-pocket costs include:
  - § **Beneficiary is responsible for coinsurance**
    - » Coinsurance: Percentage of the cost of an item or service they received
  - § **Medicare or plan is denying coverage**
    - » Beneficiary can appeal according to instructions on MSN or EOB

Keeping health care records

- Beneficiaries should keep MSNs and EOBs
- They may need them in the future, for example:
  - § To prove that payment was made if a provider's billing department makes a mistake
  - § If they claimed medical deduction on their taxes
- If beneficiary lost their MSN or they need duplicate, they can:
  - § Call 1-800-MEDICARE
  - § Log in to or register for account at www.mymedicare.gov
- If beneficiary lost their EOB or they need duplicate, they should call their plan

Medicare fraud

Medicare fraud

- Medicare fraud occurs when someone knowingly deceives Medicare to receive payment when they should not, or to receive higher payment than they should
- Provider is committing fraud if they:
  - § Bill Medicare for services beneficiary never received
  - § Bill Medicare for services that are different from the ones beneficiary received (usually more expensive)
  - § Continue to bill Medicare for rented medical equipment after beneficiary has returned it
  - § Offer or perform services that beneficiary does not need in order to charge Medicare for more services
  - § Tell beneficiary that Medicare will pay for something when it will not
  - § Use another person's Medicare number or card

Fraud protection

- MSN and/or EOB lists all services for which provider billed Medicare or Medicare health or drug plan
- Beneficiary can use these notices to ensure that provider is only billing for procedures they actually received
  - § Beneficiary can keep calendar or list of doctors' appointments and services and check it against MSN or EOB
  - § Beneficiary should call provider's billing department for more information if there are any services listed that beneficiary did not receive, or any providers whose names they do not recognize

Fraud protection (continued)

- Beneficiary can also compare EOB or MSN with bills they have received from or amounts they have paid at pharmacy or provider's office
  - § If provider is billing for more than the amount allowed by Medicare or Medicare Advantage or Part D plan, beneficiary should contact provider's office or plan to see if there has been a mistake
- To report fraud, beneficiary can contact:
  - § 1-800-MEDICARE
  - § Their local Senior Medicare Patrol (SMP)
    - » Call 877-808-2468 or visit www.smpresource.org

Advance Beneficiary Notice

When does a beneficiary receive an Advance Beneficiary Notice (ABN)?

- Original Medicare notice
- Beneficiary should receive ABN from provider before they receive a service if, based on Medicare coverage rules, provider has reason to believe Medicare will not pay for the service
- Providers are not required to provide ABN for services or items that are never covered by Medicare, such as hearing aids
  - § Example: Skilled nursing facilities are not required to provide ABN when beneficiary reaches the end of Medicare-covered days
- Providers are not permitted to give an ABN all the time, or to have a blanket ABN policy

What information is included on an ABN?

- Notice must list reason why provider believes Medicare will deny payment
  - § ABN might say, “Medicare only pays for this test once every three years”
- ABN may look different depending on the type of provider
- ABN allows beneficiary to decide whether to:
  - § Get the care in question and accept financial responsibility for the service (pay for the service out-of-pocket) if Medicare denies payment OR
  - § Decline the care

Financial protections: Problems with ABN

- Medicare has rules about when beneficiary should receive an ABN and how it should look
- If rules are not followed, beneficiary may not be responsible for denied charges if ABN:
  - § Is difficult to read or hard to understand
  - § Is given by the provider (except a lab) to every patient with no specific reason as to why claim may be denied
  - § Does not list the actual service provided, or is signed after the date the service was provided
  - § Is given to beneficiary during emergency or just prior to receiving a service (for instance, immediately before an MRI)
- Beneficiary may have to file appeal to prove there were problems with ABN

Financial protections: ABN not provided

- Beneficiary may not be responsible for cost of care if ABN was not provided when it should have been
- Beneficiary must meet all the following requirements
  - § They did not receive an ABN from their provider before they were given the service or item;
  - § Their provider had reason to believe the service or item would not be covered by Medicare;
  - § The item or service is not specifically excluded from Medicare coverage; and
  - § Medicare has denied coverage for the item or service

ABNs and appeals

- Even if provider gives beneficiary ABN, it is possible that Medicare will pay for the service
- To get an official coverage decision from Medicare, the beneficiary should:
  - § Sign the ABN, agreeing to pay if Medicare does not
  - § Receive the care
  - § Request that the provider submit the bill to Medicare
- If Medicare denies payment, beneficiary can file appeal
  - § Receiving an ABN does not prevent beneficiary from filing an appeal, as long as Medicare was billed

Fall Open Enrollment Period notices

Fall Open Enrollment Period

- Begins **October 15** and ends **December 7**
  - § Changes take effect January 1, 2021
  - § Beneficiary can make as many changes as they wish before December 7
- During Fall Open Enrollment, beneficiary can:
  - è Join a different Medicare Advantage Plan
  - è Join a different stand-alone Part D plan
  - è Switch from Original Medicare to a Medicare Advantage Plan
  - è Switch from a Medicare Advantage Plan to Original Medicare

Beneficiary notices

- During the fall, the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage Plans, Part D plans, and employer/union plans often send notices to Medicare beneficiaries
- Notice can go over changes for the approaching year, plan termination, or the loss of eligibility for certain programs
- Important to know what notice beneficiary has received to best help them make decisions during Fall Open Enrollment

Annual Notice of Change (ANOC)

- Sent by Medicare Advantage or Part D plan
  - § Explains how the plan's coverage and costs are changing for next year
  - § Must be received by September 30
  - § Lists changes to premium, deductible, copays
  - § Provides formulary changes, if any, and provides formulary summary
    - » Formulary: List of drugs Part D plan covers
  - § If plan is being consolidated or terminated, ANOC will indicate this
  - § May be sent via email; beneficiary can contact plan to request hard copy

Review ANOC

- Beneficiary should review ANOC to make sure:
  - § Their drugs will still be covered next year
  - § Their providers and pharmacies are still in the plan's network
- If beneficiary is unhappy with any of plan's changes, they may wish to enroll in new plan
- Even if beneficiary is happy with current Medicare coverage, they should check to see if there is another plan in their area that will offer better health and/or drug coverage at more affordable price
  - § Beneficiary could lower their costs by shopping among plans each year
  - § There could be another Part D plan in their area that covers the drugs they take with fewer restrictions and/or lower prices

Creditable coverage notice

- Sent by employer/union plans
- Plan must inform Medicare-eligible individuals whether their drug coverage continues to be creditable
  - § Creditable coverage: prescription drug coverage considered to be as good as or better than Medicare Part D
  - § Beneficiaries with creditable coverage can delay enrollment in a Part D plan without incurring a late enrollment penalty
- Must be sent by October 15
- Beneficiaries should keep the notice as proof of creditable coverage
- Beneficiaries who no longer have creditable coverage should consider enrolling in a Part D plan during Fall Open Enrollment

Loss of deemed status

- Sent by CMS in September
- Explains that beneficiary no longer automatically qualifies for Extra Help in the approaching calendar year
  - § Extra Help: Federal program that helps pay out-of-pocket costs of Medicare prescription drug coverage
- Beneficiary gets this notice after they no longer:
  - § Qualify for Medicaid
  - § Have a Medicare Savings Program (MSP)
  - § Or, get Supplemental Security Income (SSI)
- These beneficiaries may still qualify for Extra Help and should apply
  - § Application is included in the mailing

Part D plan reassignment

- Sent by CMS in late October
- Informs beneficiaries enrolled in Extra Help that Medicare will enroll them in a new Part D plan as of January 1 of the approaching year because:
  - § Their current plan is leaving the Medicare program at the end of the year (i.e. plan termination)
  - § Or, their plan's premium is increasing above their state's benchmark
    - » Extra Help pays for Part D premium up to state-specific benchmark amount
- Beneficiaries can also choose their own new plan
  - § Selection must be made by December 31, otherwise CMS will assign them to a new plan staring January 1

Medicare Advantage Plan reassignment

- Sent by CMS in late October/early November
- Informs beneficiaries enrolled in Extra Help that Medicare will enroll them in a new Part D plan as of January 1 of the approaching year because:
  - § Their Medicare Advantage Plan is leaving the Medicare program at the end of the year (i.e. plan termination)
- Beneficiaries can also choose their own new plan
  - § Selection must be made by December 31, otherwise CMS will assign them to a new plan staring January 1

Other notices

- Change in Copays Notice
  - § Sent by CMS in October
  - § Informs beneficiaries that they still qualify for Extra Help, but their copay amounts will be different in 2021
- Low-Income Subsidy Choosers Notice
  - § Sent by CMS in November
  - § Sent to beneficiaries who chose their plan when they enrolled in Extra Help
  - § Informs beneficiaries that their premium will go up in 2021
  - § If they do not choose a new plan, they will have to pay a portion of the premium in 2021

Other notices (continued)

- CMS Non-renewal Action notice
  - § Sent in January
  - § Reminds beneficiaries who don't receive Extra Help and whose plan terminated at the end of the year that they need to join a new Part D plan by February 28
- Deemed status notice
  - § Sent ongoingly by CMS
  - § Informs beneficiaries they'll automatically get Extra Help

Resources for information and help

State Health Insurance Assistance Program (SHIP)

- www.shiptacenter.org
- www.eldercare.gov

Social Security Administration

- 800-772-1213
- www.ssa.gov

Medicare

- 1-800-MEDICARE (633-4227)
- www.medicare.gov

Medicare Rights Center

- 800-333-4114
- www.medicareinteractive.org

National Council on Aging

- www.ncoa.org
- www.centerforbenefits.org
- www.mymedicarematters.org
- www.benefitscheckup.org

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Medicare Interactive

- www.medicareinteractive.org

- Web-based compendium developed by Medicare Rights for use as a look-up guide and counseling tool to help people with Medicare
  - § Easy to navigate
  - § Clear, simple language
  - § Answers to Medicare questions and questions about related topics
  - § 3+ million annual visits

Medicare Interactive Pro (MI Pro)

- Web-based curriculum that empowers professionals to better help clients, patients, employees, retirees, and others navigate Medicare
  - § Four levels with four to five courses each
  - § Quizzes and downloadable course materials
- Builds on 30 years of Medicare Rights Center counseling experience
- For details, visit www.medicareinteractive.org/learning-center/courses or contact Jay Johnson at 212-204-6234 or jjohnson@medicarerights.org