

## Questions and Answers from the 2020 Medicare Changes Webinar

*The following questions and answers were submitted during the November 2019 webinar, What's Happening with Medicare in 2020. To access a recording of this webinar and download the slides, visit: <https://www.ncoa.org/resources/medicare-in-2020-webinar/>*

### **Part D Drug Benefit**

**Please clarify how the cost for drugs can be different in the initial coverage phase and the coverage gap phases of the Part D benefit.**

In the initial coverage phase plans and beneficiaries pay for a portion of the cost for each prescription drug. Beneficiary cost can either be a copayment (a set dollar amount) or coinsurance (a percentage of the drug's cost). The copayment or coinsurance amount will vary by plan and tier assigned to the drug and is not required to be 25% of the cost of a drug. The initial coverage phase ends when the amount spent by both the plan and the beneficiary on covered drugs reaches \$4,020. Beneficiaries' costs may change when they reach the coverage gap phase which requires that beneficiary costs are limited to 25% of the cost of the drug.

**Will utilization management for Part D require beneficiaries to seek treatment at Outpatient Treatment Programs (OTP)?**

The Medicare 2020 Medicare Advantage and Part D Final Rule and Call Letter does not currently identify any utilization management requirements.

**If a beneficiary is in a skilled nursing facility (SNF) are they eligible to change drug plans once per month if medicines change or are they only able to change plans once a quarter?**

Currently no exceptions have been made to the Part D Low-Income Subsidy (LIS)/Extra Help Special Enrollment Period which limits the ability of beneficiaries with LIS to change prescription drug plans to once per quarter for the first 9 months of the year. Beneficiaries who move into, reside in, or are discharged from certain long-term care facilities may utilize a Part D Institutionalized individuals SEP to join or disenroll from a PDP or an MA-PD. See the [NCOA Part D special enrollment fact sheet](#) for more information.

**When a person changes Part D plans from one to another during open enrollment, do they need to notify the old plan?**

No, enrollment into the new plan cancels enrollment in the old plan. Beneficiaries would be wise to arrange with their bank or credit union to stop automatic payments to the old plan after the December premium is paid.

**There were changes to the protected drugs for certain medical conditions. Can you review them?**

While several changes to protected classes were proposed for 2020, no changes to the six protected classes were adopted. Part D plans are required to cover all drugs in the protected classes: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastic.

## **Plan Finder**

### **What steps need to be taken to show LIS eligibility and pricing on the new Plan Finder if my clients do not wish to create a My Medicare account?**

CMS has repeatedly confirmed that My Medicare.gov accounts are required to access, create and save personal drug lists and to access low-income subsidy information.

### **In helping a client with a drug plan comparison this year, the plan prescription drug cost went from \$1000 in 2019 to \$138,000 in 2020. Is this possible?**

Drug costs do change every year and it could be that one or more of the beneficiary's drugs may have been removed from plan formularies this year. Additionally, NCOA has received numerous reports that dosage and quantity amounts for many drugs such as cremes, nasal sprays, and insulin are not accurate on Plan Finder. Carefully check the dosage and quantity amounts for all the drug lists comparisons.

## **Telehealth Benefits**

### **Can telehealth be used for face to face for homecare orders?**

In general, Medicare regulation requires that telehealth services be medically appropriate. Provided is a link to payable telehealth/communication technology-based services codes for 2020 which provides insight into the types of services will be covered: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

### **Will MSNs reflect telehealth versus in person office visit charges?**

The Medicare Summary Notice (MSN) currently displays a brief description of services delivered and associated billing codes submitted by the provider. Some evaluation and management codes used by providers are the same whether a beneficiary is seen in the office or remotely. However, CMS has created a list of codes which are specific to communication technology-based services /telehealth service. While an MSN may show an indistinguishable office visit code, the code would likely be paired with another which designates a telehealth service. The complete list of payable telehealth services can be found in the answer to the question above.

## **Medicare Advantage**

### **Can you review the regulations on seamless and passive enrollment by MA plans?**

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 another comparable plan. The enrollment process must be done in consultation with Medicaid.

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. See the linked resources for more guidance on passive and/or facilitated enrollments:

- [Medicare Managed Care manual](#)
- [CMS 2019 Enrollment Guidance memo](#)

### **Can beneficiaries get a surprise bill if they see a doctor while in an in-network hospital, but that doctor is not an in-network doctor for a MA plan?**

Medicare Advantage enrollees who use out-of-network services in nonemergency situations may not have any coverage or may be liable for out-of-network cost sharing, depending on the rules of their plan. Enrollees can use the plan organizational determination process to seek coverage for items or services they believe should be covered. Federal regulations require plans to apply in-network cost sharing when enrollees use out-of-network providers for emergency services, recognizing that beneficiaries do not have the ability to select in-network versus out of network care during a medical emergency.

### **Do all co-pays and co-insurance cost go in the total OOP costs on a MA plan?**

Medicare Advantage plan premiums and prescription drug costs do not count toward your out-of-pocket (OOP) maximum for your Medicare Advantage plan. Generally, the plan deductible, copayments, coinsurance for Medicare covered services count toward your plan's out-of-pocket maximum.

## **Medicare (Medigap) Supplement Plans**

### **Is there an easier way to compare and or choose a supplement plan?**

Medicare Plan Finder does not include complete information on Medicare supplement plans. Most state Departments of Insurance provide a complete list of all Medigap policies sold in the state.

### **What can you tell me about Medigap pre-existing condition policies in my state?**

States have the flexibility to institute consumer protections for Medigap that go beyond the minimum federal standards. For example, 28 states require Medigap insurers to issue policies to eligible Medicare beneficiaries whose employer has changed their retiree health coverage benefits. Four states (CT, MA, ME, NY) require either continuous or annual guaranteed issue protections for Medigap for all beneficiaries in traditional Medicare ages 65 and older, regardless of medical history. See the report from the Kaiser Family Foundation, which outlines how consumer protections vary by state:

<https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>

**Are individuals who become Medicare eligible on January 1, 2020 able to purchase Medigap Part C and F plans after January 1, 2020?**

The Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) prohibits the sale of Medigap policies that cover Part B deductibles to “newly eligible” Medicare beneficiaries defined as those individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

Therefore, someone whose 65<sup>th</sup> birthday is January 1 would not be eligible to purchase Plans C or F.