

## Helping Clients Make Medicare Coverage Decisions during Fall Open Enrollment

### September 2019 Webinar Questions and Answers

**Question:** Can't you purchase Medigaps at other times without guaranteed issue right?

**Answer:** Yes. An individual can contact a Medigap insurer to purchase a Medigap even if the individual is not in their Medigap Open Enrollment Period or does not have a guaranteed issue right. However, outside of these periods, a Medigap insurer can refuse to sell the individual a policy. If they do sell the individual a policy, they do not have to offer the individual the best available rate.

**Question:** If you switch from a Medicare Advantage Plan to Original Medicare during the Medicare Advantage Open Enrollment Period (MA OEP), what do you do about a Part D plan?

**Answer:** During the MA OEP, if you switch to Original Medicare from an MA Plan, you will also be able to enroll in a stand-alone Part D plan.

**Question:** Will the new plan books for 2020 be available before open season?

**Answer:** Plan information for the upcoming year is usually released at the beginning of October, just before Fall Open Enrollment.

**Question:** I have a question regarding how private insurance plans contract with Medicare. I was told from numerous sources within the medical field that if you have a private insurance with Medicare, for example Humana, that Humana decides first and foremost what they will cover and refer then Medicare steps in to pay certain costs... how accurate is this?

**Answer:** Plans that contract with Medicare to provide Medicare benefits must cover all of the same services the Original Medicare does. Plans cannot choose, for example, whether to cover skilled nursing facility (SNF) care. However, a plan can choose to charge different cost-sharing for SNF care than Original Medicare does. A Medicare Advantage plan also makes coverage determinations, like if someone does not meet

the plan's requirement for a specialist referral, it can deny coverage. But a plan does not make a blanket decision about which Original Medicare-covered services it will cover or not—it has to cover all Medicare-covered services. If someone has a Humana Medicare Advantage plan, then that's the plan that provides their Medicare coverage. The individual does not also have Original Medicare coverage that steps in to pay certain costs. Medicare only steps in to pay as secondary if someone has other insurance that pays primary according to Medicare's coordination of benefits rules.

**Question:** Can you change from year to year between Original and Medicare advantage?

**Answer:** Yes, but you can only switch coverage during certain times of the year. You can use the Fall Open Enrollment Period to change between Original Medicare and Medicare Advantage. You can use the MA OEP to switch from one MA plan to another MA plan or to Original Medicare with or without a Part D plan.

**Question:** Does the Medicare Advantage maximum out-of-pocket limit include the cost/payment of the Part B premium?

**Answer:** No, the Medicare Advantage out-of-pocket limit does not include the Part B premium, or any other premiums.

**Question:** Will copays related to new supplemental services count toward MOOP (maximum out-of-pocket costs)?

**Answer:** Copays for covered services received from in-network providers count towards the MOOP. If a supplemental benefit is a covered service and a beneficiary sees an in-network provider, the copay for the benefit will count towards the MOOP.

**Question:** How long would the appeal process take re: coverage restrictions if you have step therapy?

**Answer:** The first step to appealing step therapy is an exception request. A beneficiary's doctor should contact the plan to request an exception. The plan should issue a decision within 72 hours for a standard request. If the beneficiary and their doctor feel the beneficiary's health would be seriously harmed by waiting the standard timeline, the doctor can request an expedited review and the plan should respond within

24 hours. If the plan responds favorably to the exception request, the beneficiary can get the drug without step therapy. If the plan responds unfavorably, the beneficiary can start their appeal. See this [Medicare Interactive answer](#) for more Part D appeals information.

**Question:** Are providers also held accountable for a window whereby they can join or leave the plan? What if I am seeing a physician and she decides to drop out of the plan in July. Will I use the special enrollment or are providers held to a window as well?

**Answer:** If your Medicare Advantage plan stops contracting with many providers in its network during the course of the calendar year and CMS determines these terminations are significant enough to impact plan enrollees, you will have a one-time Special Enrollment Period (SEP) to enroll in a different Medicare Advantage Plan (with or without Part D coverage) or switch to Original Medicare with or without a standalone Part D plan. Your plan will mail you a notice if CMS determines the terminations are substantial.

If a provider decides to stop accepting a plan partway through the year, there is no SEP. The provider should alert the patient that they will no longer be accepting their plan.

**Question:** As a volunteer SHIP counselor, I have learned that one Medigap plan in my area comes with an "enrollment discount" of 3% per year for 10 years in my state. I was shocked that they claim community rating. It feels like a bait and switch--esp. in most states where there is no guaranteed issue right to switch plans. Does this violate any rules since it doesn't conform with CMS definition of community rating?

**Answer:** CMS does not define community rating or oversee or regulate Medigap; that's done on the state level. The entity that may require community rating, and who regulates the sale of Medigap and pricing limitations, is the state insurance agency. It doesn't seem like this type of discount "violates" community rating, though. It's more so setting up the pricing so that it decreases as someone gets older, rather than increases as is the case with attained age.

**Question:** Doesn't it make sense we have a federal fix to the MACRA legislation getting rid of the Part B deductible? My 67-year-old sister will have to go underwriting in order to change her F plan to a G plan. Perhaps Congress could require states have a Special Enrollment Period for these beneficiaries to switch plans.

**Answer:** Since your sister is 67, that means she was eligible for Medicare before January 1, 2020. She can keep her Medigap Plan F and is not required to change to Plan G. If she decides later on to switch to Plan G, then she would be subject to underwriting unless her state provides additional protections.

**Question:** As MA plans' networks become more and more limited, will these beneficiaries be subjected to "surprise bills"?

**Answer:** Surprise billing protections generally do not expressly apply to Medicare-covered transactions. However, beneficiaries are protected from many, if not all of the situations these surprise billing protections aim to address. These situations include:

- Emergency and urgently needed services. If a beneficiary receives emergency or urgently needed services out-of-network, these services are covered as if in-network.
- Services referred by/provided through network providers. If a beneficiary's in-network provider refers them to an out-of-network provider, the services are covered as if in-network.
- Improper billing protections for individuals with the Qualified Medicare Beneficiary (QMB) Medicare Savings Program (MSP). Beneficiaries with the QMB MSP cannot be billed for Medicare cost-sharing, like deductible, copays, or coinsurance charges.

**Question:** Don't MA plans have to provide urgent/emergent care if a person travels outside of their region?

**Answer:** Yes. MA plans must cover emergency room services anywhere in the country. They must cover the services as if they were in-network, even if a beneficiary was out-of-network at the time. If the condition was not an emergency but appeared to be one at the time, the MA plan must still cover the care.

**Question:** What does it mean that beneficiaries can make multiple changes during the Fall OEP but only the last one will take effect on 1/1?

**Answer:** Because a beneficiary can make multiple changes during the Fall Open Enrollment Period, I wanted to clarify that the last change they make is the one that becomes effective. For example, if a beneficiary enrolls in a new MA plan in October, but then in November decides they want to enroll in Original Medicare with a stand-



alone Part D plan, their choice to enroll in Original Medicare will take effect in January, since that was the last choice they made.

**Question:** Will there be something offered for ESRD in 2020?

**Answer:** Beginning in 2021, Medicare-eligible individuals with end stage renal disease (ESRD) will be allowed to enroll in Medicare Advantage plans. Currently, people with ESRD can enroll in an MA plan if it is a Special Needs Plan for people with ESRD. [Here are the other exceptions](#) for MA Plan enrollment for people with ESRD.

**Question:** Do people with an MA have to pay the Part B deductible each year?

**Answer:** People with an MA plan do not have to pay the Original Medicare Part B deductible each year. If their MA plan has a deductible for outpatient services, they will owe that deductible.

**Question:** If a beneficiary is not computer literate and prefers to set up a MyMedicare.gov account how is their information saved?

**Answer:** Their information is only saved if they make a MyMedicare.gov account. If a beneficiary does not use computers, they can ask a friend or family member to make an account for them. A professional may choose to make an account for a beneficiary, but how they store the beneficiary's username and password would depend on the organization's policies with regard to storing a client's personal information.