Chapter Five

Other Medicare Options for Paying Health Care Costs Not Covered by Original Medicare

INTRODUCTION

Chapter 4 described Medicare as a federal health program that provides both major medical coverage and coverage for medical expenses when an eligible person becomes ill. However, Medicare is not intended to pay for all of a Medicare beneficiary's medical expenses. When Medicare does not cover a medical expense, the beneficiary must pay for it. Medicare beneficiaries are also responsible for paying Medicare out-of-pocket costs for premiums, deductibles, coinsurance and/or copayments, and excess charges. People on Medicare usually need another health plan, policy, or program to pay for the things Medicare won't pay for. Individuals are encouraged to contact the Health Information, Counseling and Advocacy Program (HICAP) benefits counseling program for more information about alternatives to cover the gaps in Medicare.

This chapter outlines recent changes in the Medicare program and provides an overview of the current options available to supplement Medicare.

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1. Delivery of Medicare services.

Beginning in 1996, the U.S. Congress directed the U.S. Centers for Medicare & Medicaid Services (CMS) to phase in new initiatives to encourage contracts with insurance companies and other health plans for the delivery of Medicare benefits. Previously, Medicare beneficiaries would receive their

Medicare benefits through traditional Medicare, also known as Original or fee-for-service Medicare. However, the Balanced Budget Act of 1997 made changes to fee-for-service Medicare and also authorized the creation of new Medicare contracts now referred to as Medicare Advantage (MA) plans.

2. **Sources of law.** Changes to the Medicare program were enacted through the following legislation that impacts the Social Security Act:

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Patient Protection and Affordable Care Act (PPACA) of 2010
- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Medicare Modernization Act of 2000
- Balanced Budget Refinement Act of 1999
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Social Security Act of 1965 (Title XVIII)

Although Medicare is under the general administration of CMS, rules resulting from these bills and amendments fall under the jurisdiction of various federal and state agencies and CMS subcontractors. Each section in the chapter identifies entities responsible for implementation, regulation, and enforcement.

3. **Original Medicare plan.** The changes that impact Original Medicare include reimbursement of services and Medicare supplement insurance plan benefits. Medicare supplement plans are sold by private insurance companies, but the benefits are set by federal and state law. These are commonly called "Medigap" or "Medsup" plans, and these terms are used interchangeably throughout this chapter. These plans are designed to work with Original Medicare. Medicare beneficiaries have the option to choose from Plans A, B, C, D, F, G, K, L, M, and N. Plan F also has a high deductible option which can potentially mean a lower premium for the beneficiary. Plan J also used to be an option for Medicare beneficiaries but effective June 1, 2010 as part of federal health care reform, Medicare discontinued the option. But, if a beneficiary has a Plan J in force prior to that date, they would be allowed to keep it. And keep in mind, there may be other plans such as H, I and L that are no longer being sold but, Medicare beneficiaries may still have one. Finally, the Medicare Access

and CHIP Reauthorization Act of 2015 ("MACRA") changed who can apply for Plans C and F. Accordingly, Section 401 of MACRA forbids the sale of Plans C and F to people who turn 65 on or after January 1, 2020 or to people who get free Part A due to ESRD or disability as of January 1, 2020 or later. Plans C and F are guaranteed renewable for those who already have effective plans in place. However, if the premiums are not paid, then the Medicare beneficiary will lose the plan and will not be able to re-enroll in the plan.

4. **Medicare basics.** To understand the gaps in Medicare, it is important to understand what Medicare covers under Medicare Part A (inpatient hospital insurance) and Medicare Part B (medically necessary medical services). Note: For purposes of this chapter we will not discuss Medicare Part D in detail. Medicare benefits are covered in Chapter 4. The CMS publication *Medicare & You* provides useful information about Medicare benefits. This brochure is mailed to all Medicare beneficiaries in the fall and provides a consumer-friendly description of what Medicare covers and any changes to Medicare benefits for the coming year. There is also an electronic version of *Medicare & You* at https://www.medicare.gov/medicare-and-you/medicare-and-you.html.

5. **Identifying the gaps in Original Medicare.** Generally, there are five categories of costs that Medicare beneficiaries have to pay out of their own pockets or paid for by other health coverage they have. These coverage gaps include premiums, deductibles, coinsurance/copayments, excess charges, and costs for services not covered by Medicare. The out-of-pocket costs in Original Medicare are different than those under Medicare Advantage plans and other coverages available to individuals vary depending on their situation. As an example, an individual might have Original Medicare, a retirement group plan, and be eligible for Veterans health benefits.

6. **Premiums.** Both Medicare Part A and Part B have a premium. The premium amounts apply to both Original Medicare and Medicare Advantage plans. Most people eligible for Medicare are not required to pay the Part A premium if they have accrued 40 credits. In some cases, people may be eligible for Medicare, but not qualified for premium-free Part A.

   An individual may earn up to four credits each year toward their goal of receiving 40 credits to qualify for Medicare coverage. The amount a person needs to make to earn one credit may change each year depending on cost-of-living adjustments. At the website www.ssa.gov, Social Security typically posts a press release during the last four months of the year, stating what the amounts will be for the

following year, to earn a credit, and other amounts pertinent to Social Security and Supplemental Security Income. Medicare posts its updated figures, also toward the end of the year, at www.medicare.gov.

People can purchase Medicare Part A by paying a premium. Anyone who chooses Medicare Part B pays a monthly premium. The Part B premium usually changes in January of each year. People who have health coverage through an employer and turn 65 or otherwise become eligible for Medicare should find out if they need to start their Medicare Part B coverage.

Most people have to pay Medicare premiums out of their own pockets because health plans that supplement Medicare do not pay the cost. However, people with limited income and resources may qualify for Medicaid by applying for and receiving Medicare Savings Programs (MSP) benefits to help pay these costs. MSPs, administered by the Texas Health and Human Services Commission, include the Qualified Medicare Beneficiary (QMB) Program, which pays the Part A premium, if there is one, and the Part B premium. The Specified Low-Income Medicare Beneficiary program (SLMB) and the Qualifying Individual (QI) program pay only the Medicare Part B premium, but allow individuals to have a higher income to qualify. The Qualified Disabled Working Individual (QDWI) program pays the Part A premium. See Chapter 6 for more information about MSPs.

Other premiums. In addition to Medicare premiums, Original Medicare beneficiaries may have to pay the premium for any supplemental health coverages they have or choose to buy. The cost of the added premium will be a factor in deciding how much additional coverage a person on Medicare will want to purchase. People who have a Medicare supplement policy for several years can expect significant increases in their premiums. Although these people may not have a special protection to buy a different Medicare supplement, it might be worthwhile to shop for another policy even if it means reducing their benefits.

7. **Deductibles.** Beneficiaries must also pay deductibles for both Medicare Part A and Part B before Medicare will pay. The amount of the deductible is usually a fixed amount. The amount can change annually in January. The Medicare Part A deductible is paid per benefit period. A benefit period begins when the person is hospitalized and ends when the person has been out of a facility for 60 consecutive days. Therefore, someone who has several hospitalizations in one year could pay more than one deductible in that year. The Medicare Part B deductible is paid annually. Some Medicare supplement policies and most group retirement plans cover Medicare deductibles. When selecting a

Medicare supplement plan, a person can choose a plan that covers only the more costly Medicare Part A deductible or a plan that covers both the Part A and Part B deductibles.

8. **Other deductibles.** Group retirement plans that supplement Original Medicare may also have deductibles. For example, a group plan might have an initial deductible that must be met before they cover the deductibles under Medicare Part A or Part B. Group plans may not be on the same calendar year as Medicare. Someone who sees the doctor infrequently may never reach their group plans annual deductible. On the other hand, someone who sees the doctor frequently will find that once the deductible has been met, the group plan will cover any other costs.

9. **Coinsurance and copayments.** Coinsurance is a percentage of the Medicare-approved costs that a beneficiary must pay. Both Medicare Part A and Part B require beneficiaries to pay coinsurance for covered services. Most Medicare Part B services require that the beneficiary pay 20 percent of the Medicare-approved amount. In Medicare Part A, the inpatient hospital copayment is a set daily rate for days 61 through 150 and for days 21 through 100 in skilled nursing home stays. These amounts can change in January each year. Since the change is not approved until after the printing of the annual *Medicare & You* publication, the coinsurance amounts for specific Medicare covered services will be out of date each January. Medicare coinsurance and copayments are a covered benefit if someone buys a Medicare supplement policy. By understanding how a Medigap policy covers these costs, it is easier to help someone review how their group retirement plan covers Medicare's coinsurance and copayments. Some Medicare supplement plans only pay the Medicare-approved coinsurance amount. This means that any excess charges beyond what Medicare approves would be the responsibility of the beneficiary. Medicare supplement plans F and G offer coverage for the excess charges, which is limited to 15 percent over the Medicare-approved charge.

   Although most group retirement plans cover coinsurance amounts, people need to review their plans to know if there are any dollar limits or excluded services. In Original Medicare, someone could purchase a Medicare supplement policy even if they have a group retirement plan. Agents selling Medicare supplement policies are required to review an applicant's existing coverage to identify where there would be duplication of coverage.

   Sometimes the term "copayment" is used in place of coinsurance. This term used to be more common to Medicare Advantage plans but now these plans also include coinsurance. Like coinsurance, a copayment is an amount that the beneficiary pays out-of-pocket when receiving a covered medical service. In Medicare Advantage plans, copayments are fixed amounts that are unique to each plan

and are usually not covered by any other insurance or health plan. Medicare rules do not allow someone in a Medicare Advantage plan to buy a Medicare supplement policy or to be in two Medicare Advantage plans at the same time. In certain situations, it might be possible for someone to have a Medicare Advantage plan and their own group retirement plan. A benefits counselor assisting someone in this situation would probably want to encourage the client to contact the group plan administrator to determine how the two plans will work together. An example would be an employer who only offers a Medicare Advantage option. In this case, the retiree would need to join the Medicare Advantage plan versus Original Medicare.

Although some Medicare Advantage plans do not require payment of a premium other than the Part B premium (or Part A if applicable) all Medicare Advantage plans charge copayments and in some cases, coinsurance. The amount of the copayment is approved by the individual plan. Federal health reform requires Medicare Advantage plans to set annual caps on out-of-pocket costs paid by members. Most plans also set benefit periods for hospital stays with lower deductibles or copayments than Original Medicare. But, if someone returned to the hospital repeatedly, they might have to pay more than they would with Original Medicare. Similarly, most Medicare health plans also require inpatient hospital copayments. Remember that there are very limited options, if any, to finding alternate coverage for Medicare Advantage plan copayments and coinsurance.

10. **Excess charges.** Health care providers who participate in Original Medicare can choose to accept Medicare "assignment." These providers are listed in a directory maintained by the Medicare carrier in each state. Assignment means that the provider agrees to accept the Medicare-approved amount for a certain service or supply as payment in full. Doctors who do not accept assignment may charge up to 15 percent above the Medicare-approved amount when treating a person with Original Medicare. The charge above the Medicare-approved amount is called an excess charge. The beneficiary is responsible for paying the coinsurance amount and the excess charge. Medicare supplement plans F and G offer coverage for the excess charges. People with retirement group plans should check their policy to see if the plan will pay for the excess charge.

11. **Services not covered by Original Medicare.** In addition to Medicare premiums, deductibles and coinsurance/copayments, there are several services and medical costs that Medicare does not cover. A beneficiary is responsible for the full cost of those services. Some of the most common excluded services include emergency care while traveling out of the country, prescriptions, routine foot care, dental care, eye exams, and hearing aids. Some Medicare Advantage plans offer some coverage for

these excluded services. Since Medicare supplement policies are designed to coordinate with Medicare, Medicare supplement plans do not pay for most medical services that are not covered by Medicare. Some older Medicare supplement plans offer prescription benefits, emergency care while on foreign travel, and routine physicals. Medicare supplement plans that cover these services will cost more because the plan, not Medicare, is covering the benefit.

A benefits counselor can use the list of services not covered by Medicare to determine how an individual's retirement plan covers services Medicare doesn't cover. Some retirees complain that they can no longer afford the premiums for their group plan and have dropped their coverage knowing they might not get it back.

12. **Additional options to cover the gaps in Original Medicare.** Medicare premiums, deductibles, and coinsurance could cause financial hardship to people with Medicare, especially those with fixed incomes. Following is an overview of the available options that reduce the gaps in Medicare and provide additional benefits.

13. **Medicare supplement policies.** Medicare supplement insurance can help pay some of the gaps in health care costs that Original Medicare will not pay. Medicare supplement policies are sold through private insurance companies. To buy a Medicare supplement policy, a person must usually have both Medicare Part A and Part B.

    There are 10 standardized Medicare supplement insurance plans, labeled A through N. Each plan offers different benefits. Companies must use the same identifying letters for their plans. All companies selling Medicare supplement insurance must offer at least Plan A but do not have to offer any of the nine other plans. Companies are also allowed to offer plan F with a high-deductible. The Texas Department of Insurance (TDI) publishes the *Medicare Supplement Insurance Handbook*. The guide includes general information about Medicare supplement policies and shopping tips. This, and other insurance publications for consumers, is available on the TDI website at https://www.tdi.texas.gov/pubs/consumer/medsup.html.

    Centers for Medicare and Medicaid Services published a guide to help people choose a Medigap policy. If you go to https://www.medicare.gov/Publications/ and type in Medigap in the Keyword or ID field, then several publications will appear including the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

Medicare supplement policies help pay Medicare deductibles, coinsurance amounts, and excess charges. Medicare supplement policies only pay for services that Medicare deems medically necessary, and payments are generally based on the Medicare-approved amount. Medicare supplement policies will not cover either the Medicare Part A premium (if there is one) or the Part B premium.

Medicare supplement policies issued prior to 1992 were not standardized. Some pre-1992 policies offer better benefits for the premium charged. The second standardization of Medicare supplement policies took place on June 1, 2010, in accordance with federal health care reform. Someone with an older policy that they bought before either of these transitions does not need to switch plans.

14. **Medicare Select policies.** Medicare Select is a type of Medicare supplement policy that may provide a lower premium in exchange for using only providers on the insurance company's "network provider" list. An insurance company can issue Medicare Select coverage. If the beneficiary leaves a Medicare Select plan or the company stops offering the plan, the company must make available any non-Medicare Select policy it has on the market with comparable or lesser benefits.

15. **Regulation of companies.** Changes to standards for Medicare supplement policies may be issued as operation letters or as rules published in the *Federal Register*. TDI regulates companies selling Medicare supplement insurance in the state.

16. **Summary of Medicare supplement benefits.** Plans A, B, C, D, F, G, K, L, M, and N provide these basic benefits to cover gaps in Medicare:

    - Daily coinsurance for hospitalization expenses from the 61st through the 90th day of any Medicare benefit period; Medicare Part A coinsurance for any hospital confinement beyond the 90th day in a benefit period; and up to an additional 60 days during a beneficiary's lifetime. These are called inpatient "reserve days." Beneficiaries may use these days when they require more than 90 days in the hospital during a benefit period. When a reserve day is used, it is subtracted from the lifetime total and cannot be used again.
    - All Medicare-eligible hospital charges for a period of up to 365 additional days during the beneficiary's lifetime after all Medicare hospital benefit days are exhausted (benefits beyond what Medicare covers.)

- The reasonable cost of the first three pints of blood, or their equivalent, under Medicare Part A and Part B unless replaced. The covered period is the calendar year that runs January 1 through December 31.
- The 20 percent Part B coinsurance for Medicare-eligible expenses for medical services. This would include doctor bills, hospital or home health care, and outpatient hospital treatment, after the Part B annual deductible has been met.
- Hospice coinsurance for outpatient drugs and inpatient respite care.

17. Additional benefits in Medicare supplement policies B through N. Following is a brief description of the combinations of benefits that are added to the basic benefits in plans B through N:

- **Skilled nursing facility care:** Covers actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A. Available on plans C through G. This is not custodial care.
- **Part A deductible:** Pays the entire Medicare Part A inpatient hospital deductible amount per benefit period. Available on plans B through G and N.
- **Part B deductible:** Pays the Medicare Part B deductible amount per calendar year. Available on plans C and F.
- **Medicare Part B excess doctor charges:** Pays the entire medically necessary excess amount billed by providers who do not accept assignment. Plans F and G cover up to the 15 percent limit. Plan G covered 80 percent of the excess charge before the 2010 standardization; it is now 100 percent. If the doctor accepts Medicare assignment, this benefit is not needed.

Question:

Which of the following are considered Medicare out-of-pocket costs?

A. _____ Medicare Part A and Part B premium

B. _____ Copayments and coinsurance

C. _____ Deductibles

D. _____ Cost of services that Medicare does not cover

E. _____ All of the above

Other Medicare supplement benefits:

- **Foreign travel emergency**: Covers 80 percent of the billed charges for emergency care that Medicare would cover in the United States. Care must begin during the first 60 days outside the United States. There is a calendar year deductible of $250. The lifetime maximum benefit is $50,000. (Available on plans C, D, F, G, J, M, and N. Although plans E, H, I and J are no longer for sale, they still provide foreign travel emergency health care coverage.)
- **At-home recovery**: Covers doctor-approved, short-term, at-home assistance with activities of daily living while recovering from an illness, injury, or surgery. Limited to seven visits per week by a qualified care provider. Pays actual charges up to $40 per visit, with a maximum of $1,600 per year. (Available on pre-2010 plans D, G, I, and J.) This only applies to existing policies because these benefits have been dropped from plans available after the June 1, 2010 standardization of Medicare supplement policies.
- **Preventive medical care**: Includes an annual physical examination, certain lab tests, and other preventive measures deemed appropriate by a physician. Maximum benefit is $120 per year. This only applies to in force policies because these benefits have been dropped from plans available after the June 1, 2010 standardization of Medicare supplement policies. Preventive medical care was only available on plans E and J.
- **Prescription drug benefits***:* Existing policies will continue to offer prescription coverage to the policyholder. Medicare supplement policies sold after January 1, 2006, were not allowed to include this benefit.

18. **Plans K, L, M, and N**: These plans are cost-sharing Medicare supplement policies. All of them cover Medicare Part A hospital coinsurance and additional costs after the original 365 days have been used. Plans K and M cover 50 percent of the annual deductible of Medicare Part A. Plan L covers 75 percent of the Part A deductible, and Plan N covers 100 percent.

19. **Understanding the cost of Medicare supplement policies.** Medicare supplement plan benefits are identical but the premiums can still vary among companies. Medicare supplement policies in Texas are either issue-age rated or attained-age rated. Issue-age premiums are based on the person's age when they purchase a policy. Attained age premiums will automatically increase as the beneficiary gets older. The increase is in addition to any general annual premium increase. Companies sell

Medicare supplement insurance to qualified individuals or groups. A beneficiary must be a member of a particular group, association, or organization to get group insurance coverage.

Other factors that affect Medicare supplement rates include the person's gender, whether the person smokes or not, where the person lives, and whether the policy has an elimination period before it covers a preexisting condition.

20. **Consumer protections when buying Medicare supplement insurance.** A beneficiary does not need a Medicare supplement policy if the beneficiary has group health insurance through an employer or former employer; if the beneficiary receives Medicaid or qualify for the Qualified Medicare Beneficiary Medicaid or if the beneficiary belongs to a Medicare Advantage plan.

Open enrollment rights to buy a Medicare supplement (persons 65 or older): Insurance companies must sell a Medicare supplement policy to people who are at least 65 and who apply within six months after enrolling in Medicare Part B, even if they have preexisting conditions. These six months are called the "open enrollment" period. During open enrollment, an insurance company must allow the person to choose among all the Medicare supplement policies it offers. Open enrollment rights may be used more than once during this six-month period. For instance, people may change their minds about a policy, cancel it, and still have the right to buy any other Medicare supplement policy during the six months after the person first enrolled in Medicare Part B.

Questions:

Which is true of Medigap policies?

A. _____ There are 10 standard plans.

B. _____ There are high deductible versions of all 10 plans.

C. _____ Medigap policies are sold and regulated by the federal government.

D. _____ Medigap policies are guaranteed renewable which means the price can never increase.

Before buying a Medicare supplement policy, the beneficiary should:

A. _____ Make sure that they have Medicare Part A and Part B.

B. _____ Determine if they are entitled to group insurance through their employer or through a retirement plan from their former employer.

C. _____ Find out if they might qualify for the Medicare savings programs.

D. _____ Find out if there is a Medicare Advantage option available.

E. _____ All of the above

Texans with disabilities under age 65: In Texas, people under 65 who become eligible for Medicare because of a disability also have a six-month open enrollment period beginning the day they enroll in Medicare Part B. This open enrollment right is applicable to Medicare supplement Plan A only, although there are companies that offer people who are under 65 and eligible for Medicare additional plans. When the beneficiary turns 65, the beneficiary will have a six-month open enrollment period during which any of the 10 plans may be purchased.

Questions:

The Medicare supplement high-deductible plan F requires that the beneficiary first pay the annual deductible before the plan pays any of the costs.

True _____ False _____

In Texas, a person with disabilities under age 65 may buy any Medicare supplement plan regardless of preexisting conditions during a six-month open enrollment period.

True _____ False _____

Guaranteed issue protection: A beneficiary may have a right to buy a Medicare supplement policy outside of the six-month open enrollment period due to the following situations:

- A Medicare Advantage health plan or private-fee-for-service plan ends its Medicare contract; ○ The beneficiary moves outside a Medicare Advantage plan's area; ○ The Medicare Advantage plan fails to meet its contractual obligations; ○ An employer group plan that supplements Medicare ends its coverage; ○ A plan ends through no fault of the beneficiary; ○ The beneficiary buys a Medicare Select

plan for the first time or drops a Medicare supplement policy to join a Medicare Advantage plan, and then leaves the plan or policy within one year;

- A beneficiary joined a Medicare Advantage plan when they first became eligible for Medicare at age 65 and decides to leave the plan within one year of joining.

This right to buy a Medicare supplement policy requires companies to issue a policy without regard to the beneficiary's health or claim history. The protection allows a qualified beneficiary to purchase Medicare supplement plans A, B, C, or F (including high-deductible F), K and L within a 63-day period. The 63-day period begins the earliest of the day the beneficiary lost coverage or the date of notice that the coverage will end. Similar to the open enrollment period, this protection applies differently to Medicare beneficiaries under age 65. Beneficiaries under age 65 have the right to purchase Plan A, but may also purchase plans B, C, or F. Because the company cannot deny the plan or charge more because of health or claim history, a beneficiary could get better coverage than during their initial open enrollment period.

Group Medicare supplement insurance rights. The rights of group Medicare supplement policies and individual policies are essentially the same. Because the group might make decisions that are out of the person's control, members have the following protections:

- If the group changes insurance companies, the new company must offer coverage to everyone previously covered. The new policy must cover preexisting conditions that were covered by the old policy; ○ If a person leaves the group, the insurance company must offer to provide unbroken Medicare supplement coverage with an individual policy or continuation of the group insurance; ○ If the group cancels its coverage, the insurance company must offer the person either an individual policy continuing the benefits they had before or a different policy meeting Texas requirements.

Free Look: A policyholder can return a policy within 30 days from the date they purchased it and receive a full refund. Encourage a beneficiary to use this "free look" period to review the policy carefully.

Renewability*:* All Medicare supplement policies are guaranteed renewable. A company cannot cancel a policy or refuse to renew it, unless the beneficiary made material false statements on the application or failed to pay the premium. However, the amount of the premium is not guaranteed. An

insurance company may raise premiums, but may do so only once each year. If the person purchased an attained-age policy, a company may also raise the premium on the beneficiary's birthday.

21. Other information about Medicare supplement insurance:

- **Medicare supplement claims.** Doctors and other health care providers must submit Medicare claims to the appropriate Texas Medicare contractor. Doctors and other health care providers generally know who the current contractor is. Medicare changes contractors from time to time. In most cases, these Medicare contractors send the Medicare claim directly to the Medicare supplement insurance company.
- **Coordination with Original Medicare, appeals, and complaints.** Medicare supplement policies won't pay for services that Medicare does not deem medically necessary. If the Medicare contractor denies the claim as medically unnecessary, the Medicare supplement company won't pay it. A beneficiary has the right to appeal a claim denial. The appeal process is described in the Medicare Summary Notice that is mailed to the beneficiary. If the Medicare supplement company refuses to pay a claim for a Medicare-approved charge or delays payment of a claim, the beneficiary can file a complaint with the Texas Department of Insurance.
- **Elimination period.** Even though a company must sell a policy during an open enrollment period, the company can require a waiting period of up to six months before covering a preexisting condition.

22. Unfair trade practice in the sale of Medicare supplement policies. Agents and companies may not engage in any of the following illegal activities:

- Knowingly making any misleading statement that causes someone to drop a policy and buy a replacement from another company. This is called "twisting";
- Suggesting that a client replace or buy a new policy from the same company. Replacing or buying a new policy is not always a good idea because of preexisting conditions, costs, and other potentially negative outcome. This is called "churning";
- Using high-pressure tactics, including the use of force, fright, or threat to pressure someone into buying a policy;
- Obtaining sales leads by using advertising that doesn't say an agent or company is trying to sell insurance. This is called "cold lead advertising";

- Posing as a representative of Medicare or a government agency; o Selling a Medicare supplement policy that duplicates a person's existing Medicare benefits or health insurance coverage. An agent is required to ask if the person has other health policies;
- Suggesting that the beneficiary lie about something on the application. For example, telling an applicant not to mention a recent diagnosis;
- Using mail advertisements that appear to be from a government agency. These ads often have eagles or similar graphics and official-sounding government bureaus on the return address.

23. Money-saving tips:

- Standardized benefit plans make price shopping easier. o Consider other factors. Price should not be the only consideration. Learn a company's complaint record by calling TDI's Consumer Help Line. Both are important indicators of the service a policyholder can expect from a company. Family and friends are other sources of information about a company's customer service. Consumers should get to know the independent agents in their area, and ask if they have any experience with the companies they're considering.
- Remind people to ask if their doctor accepts assignment. If the doctor accepts assignment, the person would not need the excess charge benefit offered by plans F and G.

24. Other resources and Medicare supplement-related information. Consumer publications that address Medicare supplement insurance include the CMS annual publication *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* and the TDI publication *Medicare Supplement Insurance Handbook.* CMS also has publications on its website that provide more details about Original Medicare. These publications can assist the member in appealing a claim or denial of services.

25. Employer-related health plans and other health coverage that supplements Medicare. Some people who are eligible for Medicare may also have the option to receive health coverage from a group health plan sponsored by an employer, union, or association. A group plan may cover employees, dependents, and retirees. People with employer-related coverage may not need to enroll in Medicare even though they are eligible for it. Additionally, a retiree who no longer works but is still eligible for group health coverage may not need to purchase other insurance coverage beyond Medicare.

26. Sources of law. Employer-related health insurance is not mandated by federal or state law. When an employer does offer it, there are Medicare rules that will determine which plan (Medicare or the employer plan) pays first. There are also federal laws that protect people from losing health coverage. This section relates to Medicare's secondary payer rules and also the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Depending on what type of insurance a person has there may be additional protections through other federal or state agencies.

An employer-related plan (sometimes referred to as private group insurance) may change how Medicare pays a claim and will affect when someone should enroll in Medicare Part B. Employer related plans may also coordinate coverage obtained either through a Medicare supplement policy or Medicare Advantage plan. As a benefits counselor, you will need to determine if there is a duplication of coverage and whether to suggest that someone consider additional coverage.

Each employer-related plan is unique and the benefits will vary from plan to plan. Before discussing how employer-related coverage coordinates to fill the gaps in Medicare, it is important that a benefits counselor understand certain aspects of this type of coverage. The benefits offered by an employer related plan are not standardized like Original Medicare or a Medicare supplement policy. To understand what protections a group plan offers, you will have to contact the plan sponsor or review the actual policy or contract.

27. When does a person with employer-related coverage NOT need to enroll in Medicare? If a person has coverage from a group plan – either because they are still working or covered as a dependent by a working spouse – the person needs to decide whether to enroll in Medicare Part B. The two sources for verifying this information are the Social Security Administration and the benefits coordinator for the group plan. Federal rules define the responsibility of a small versus large employer group. The importance of reviewing this information will affect the individual in two ways. First, if Medicare will not be the primary payer (group plan pays first), the individual could pay the annual premium for Medicare Part B and find that no benefits are paid by Medicare. Second, the person could face either a monetary penalty for delayed enrollment into Medicare, or could lose the open enrollment right protection for buying a Medicare supplement policy. For more information about these issues, refer to the CMS publications *Medicare and Other Health Benefits: Your Guide to Who Pays First* and *A Guide for Persons on Medicare.*

28. How employer-related plans work to cover the gaps in Medicare. Employer-related plans do not abide by Medicare supplement rules and are not required to coordinate with Medicare. Yet, in many

cases, a group plan will cover both the deductibles and coinsurance gaps in Medicare. Some plans also cover services that Medicare does not offer such as outpatient prescriptions, routine eye care, and dental care. Most group plans will not pick up the costs of the Medicare Part A and Part B premiums or offer coverage for long-term care. Be aware that some group plans completely cover the benefits available under Medicare Part B. The group might advise retirees that they do not need Medicare Part B since the group plan pays the coinsurance. Retirees need to be informed that should the group ever stop offering a health retirement plan, the retiree would be subject to the late penalty for each year that they delay enrollment.

29. **Understanding the cost of group plans.** Most people eligible for group coverage pay a premium for this coverage. The premium amount is set by the group, as are any increases. Traditionally, group insurance is a value when the group includes both active employees and retirees. The premium for the group will be based in part on the number of claims submitted. A key attraction to group plans is the fact that most plans offer coverage for dependents that are not yet eligible for Medicare. The person eligible for Medicare must pay both the Medicare premiums and the group plan premium.
Recent trends indicate employers are having difficulty covering the cost of health insurance for their employees. Many have had to pass on part of the increases to their covered members. Benefits counselors can help the client compare the cost of the group premium against the premium for a comparable Medicare supplement plan. In addition, the benefits counselor can review how many of the Medicare gaps the plan covers, the copayments (amount paid by the policyholder) and what added benefits the plan provides, including what it covers for dependents. If the person with the group plan ever has to drop it because of cost or because the plan ends, the person would have the guaranteed protection to buy Medicare supplement plans A, B, C, F, K or L.

30. **How employer-related plans work with Medicare.** The contractors that process Medicare claims and employer-related plans are able to communicate with each other. The Medicare guide "Who Pays First" also has pertinent information.

31. **Doctors and health care providers that work with Original Medicare** know who the Medicare administrative contractors (MAC) are for the type of claim to be submitted. The Medicare administrative contractors change from time to time due to rebidding of the contracts by Medicare.

32. **Denial of services or complaints.** If Medicare denies a claim, a beneficiary can appeal to Medicare as outlined in the MSN. If Medicare pays its portion of the claim and the group insurance plan denies or delays payment, a benefits counselor would need to suggest that the client review the group

member handbook or the policy for recourse. Depending on the type of plan, a complaint can be submitted by the client to the Texas Department of Insurance. The Texas Department of Insurance can advise the complainant of what other recourse is available.

33. **More about how group plans work.** The following is a list of information that a person should be familiar with regarding his or her group plan:

- How retirement or the death of the employee will affect coverage for dependents;
- Does the plan have a lifetime maximum? See the policy for a definition of lifetime benefit and find out what has been used to date;
- The policy's benefits coordination, limitations and exclusions. **Read the policy**;
- If it's possible to further supplement a group plan with a Medicare supplement policy or Medicare Advantage plan; Annual enrollment periods and whether it's possible to drop the group plan and get it back during the next enrollment;
- How frequently the employer changes plans or companies. This might require the policyholder to change doctors or to update his or her insurance information with Medicare.

34. **Consumer rights under an employer-related plan.** To assist a client who has a complaint or question about their employer-related plan the client and you will need to review the employer plan's benefit booklet. The following resources may offer further assistance related to state and federal monitoring of employer-related health plans.

Question:

A person who is still working when they become eligible for Medicare can delay enrollment in Medicare if their employer allows them to.

True _____ False _____

- **ERISA - U.S. Department of Labor**

Some employment-related benefit plans are subject to federal regulation under ERISA. ERISA has authority over how plans are administered and who is eligible.

Division of Technical Assistance and Inquiries
2000 Constitution Ave. NW, Room N-5619

Washington, D.C. 20210 1 (866) 487-2365
www.dol.gov/dol/pwba/public/pubs/mwguide.pdf

- **COBRA - Consolidated Omnibus Budget Reconciliation Act**

  COBRA is a federal law that requires employers with 20 or more employees to allow employees and their dependents to continue their group coverage under certain conditions. Some states extend the COBRA benefits beyond federal laws. COBRA interacts with Medicare secondary payer rules and also impacts eligibility between Medicare and COBRA coverage. See the CMS publication, *Guide to Health Insurance for People on Medicare* for more information about Medicare and COBRA coverage.

- **U.S. Department of Labor, Pensions and Welfare Benefits Regional Office**

  525 S. Griffin St., Suite 900
  Dallas, TX 75202
  1-972-850-4500 (not a toll free number) www.dol.gov/dol/pwba/public/health.htm

- **Texas Department of Insurance**

  TDI licenses agents and companies that sell health and life insurance. It also issues rules regarding payment of claims, and processes consumer and provider claims complaints. TDI also monitors insurance fraud and abuse.

  Consumer Protection, Life, Accident and Health Complaints Resolution
  P.O. Box 149091 M.C. 111-1A
  Austin TX 78714-9091 1-800-252-
  3439 www.tdi.state.tx.us

- **Health Insurance Portability and Accountability Act (HIPAA)**

  Contact TDI or CMS.

  HIPAA Help Line: 410-786-1565 (not a toll-free number, second option on recording) www.hhs.gov/ocr/privacy

- **The Centers for Medicare and Medicaid Services Health Insurance Hotline**

The Centers for Medicare and Medicaid Services Health Insurance Hotline: 410-786-1565 (this is Not a toll-free number).

The Centers for Medicare and Medicaid Services Health Insurance Hotline is sponsored by an agency of the United States federal government. This hotline fields questions about: the Health Insurance Portability and Accountability Act (HIPPA Title 1), the Women's Health and Cancer Rights Act, the Mental Health Parity and Addition Equity Act, Newborns and Mothers Health Protection Act, the Genetic Information Nondiscrimination Act, and COBRA as it applies to public sector Employers. Calls are returned within five business days.

- **TRICARE (formerly CHAMPUS)**

TRICARE FOR LIFE (TFL)

Provides medical and prescription coverage for Medicare-eligible retirees and their qualified Medicare-eligible dependents. Must meet eligibility defined by the U.S. Department of Defense.

1-888-363-5433 www.TRICARE.osd.mil

35. Former federal employee retirement plans. Not all former federal employees are eligible for Medicare. Retirees should first contact their former employing office or retirement system. Information about current health plan options is also available from the U.S. Office of Personnel Management, Retirement and Insurance Services.

- **Other retirement plans**
- **Railroad Retirement Board (RRB)**

1-800-808-0772 for enrollment, lost RRB Medicare Card or address change.

RRB Medicare Part A intermediary – TrailBlazers Health Enterprises

1-800-442-2620

RRB Medicare Part B carrier – Palmetto GBA

1-800-833-4455 www.opm.gov

- **Employees Retirement System of Texas**

  ERS administers retirement, health and other insurance benefits, TexFlex, a tax-savings flexible benefit program, and 401(k) and 457 investment accounts as part of the Texa$aver Program.

  1-877-275-4377 or (512) 867-7711 in Austin www.ers.state.tx.us/home/default.aspx

- **Teacher Retirement System of Texas**

  TRS-Care and TRS-Active Care. This is mainly for retirees who worked for independent school districts. State colleges and public universities should contact their former employer or the state retirement system.

  1-800-223-8778 (for enrollment and eligibility) 1-800-367-3636
  (for complaints and claims) www.trs.state.tx.us/

Other health insurance options

Texas Health Options

Texas Health Options maintains a website where consumers can obtain information pertinent to shopping for health insurance.

www.TexasHealthOptions.com

- **TexCare Partnership**

  Offers two health care coverage options for Texas children: Medicaid, and the Children's Health Insurance Program (CHIP). Both programs cover children from birth through age 18. Individuals can apply for both programs with a single application through TexCare Partnership.

  1-800-647-6558
  https://www.dshs.texas.gov/region4-5/chips.shtm

36. **Medicare health care options, Medicare Advantage health plans.** To give Medicare beneficiaries more options to receive their health benefits, the federal government may enter into contracts with health plans that sell insurance to large groups. Medicare Advantage (MA) health plans, also referred

to as coordinated care plans, contract with Medicare to serve a specific geographic area usually designated by ZIP code or county. MA health plans offer their members, people who are eligible and choose to join these plans, all of their Medicare benefits through a network of doctors, hospitals, and other related health care providers. A person who joins a MA health plan is no longer in Original Medicare and must follow the procedures and rules of the plan to receive their Medicare benefits.

When CMS contracts with a MA health plan, it agrees to pre-pay a monthly fee for each Medicare beneficiary that enrolls in the plan. Contracts are usually for one year, and each year CMS will approve the benefits and any fees that the plan passes on to its members. Most MA health plans charge their members a monthly premium (separate from the Medicare Part B premium) and copayments. The amount of these premiums is usually lower than what might be paid with a Medicare supplement policy.

Copayments in Medicare have usually been defined as a set amount that the beneficiary pays as a shared cost for an approved service. The term copayments is used mainly with Medicare Advantage health plans (MA) and the amounts have traditionally been low. In Original Medicare, this shared cost is called coinsurance and is a percentage of the approved amount for a service. Medicare now uses the term copayment in both Original Medicare and Medicare Advantage plans. Many people think that the copayments in MAs continue to be small amounts such as $5 or $10. In reality, most MAs have increased the amount of their copayments. In addition, new copayments for certain services needed as treatments for chronic illnesses such as radiation therapy are often higher than the coinsurance amount that a person would be responsible to pay under Original Medicare.

Each year these plans make a business decision of whether to continue their contracts or to terminate them.

To find out if a Medicare Advantage health plan is available in a specific area call Medicare's toll-free hotline available 24 hours a day at 1-800-633-4227 or visit the interactive Medicare website tool, Plan Finder at www.medicare.gov.

37. **Regulatory authority and sources of law**. Medicare Part C, or Medicare Advantage health plans, must meet the contracting requirements of 42 United States Code §1395w-27.

Sources of law. Changes to the Medicare program were enacted through the following legislation that impacts the Social Security Act:

- Patient Protection and Affordable Care Act (PPACA) of 2010
- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Medicare Modernization Act of 2000
- Balanced Budget Refinement Act of 1999
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act (HIPAA) of 1996

CMS is authorized to enter into contracts with federally qualified managed care plans to arrange or deliver services to Medicare beneficiaries. Legislation under the Balanced Budget Act of 1997 expanded the types of health plans that CMS could contract with as part of the federal campaign to expand Medicare choices.

The contract with CMS requires that a plan have sufficient administrative capacity to assure against fraud, provide adequate provider networks, and to develop processes for quality care improvement, appeals and grievances. They are also subject to external quality monitoring by independent CMS contractors called independent review organizations (IRO), state level contracts, and a national agent for reconsideration of managed care plan denials known as the Center for Health Dispute Resolution or CHDR. CMS regional offices are responsible for state monitoring of managed care plans and the review of marketing and advertising materials.

In addition to meeting federal requirements, managed health plans must meet state licensure requirements. However, state laws cannot conflict with or be more stringent than federal rules. TDI does not have a formal role in the application review process although federal law requires the plan to submit their application to TDI. As a state-licensed entity, the managed care plan is under the oversight of the insurance department related to solvency issues.

State laws regarding managed care patient protection rules and consumer complaints do not apply to a Medicare health plan. TDI does not track or maintain copies of Medicare health plan complaints. Since Medicare health plan coverage has a direct impact on Medicare supplement insurance policies, which are under the regulation of TDI, the agency frequently issues news releases and insurer directives as they relate to what is happening in the Medicare HMO market.

38. How a Medicare Advantage health plan covers the gaps in Medicare. Medicare plans referred to as Medicare Advantage plans (MA) agree to provide all Medicare-approved services to Medicare beneficiaries that join the MA. CMS pays the MA a monthly fee for each Medicare beneficiary

enrolled in the plan. People who join the plan, may or may not pay a plan premium and only pay copayments when they access a service or provider. The copayments have usually been less than what the beneficiary would pay as coinsurance under Original Medicare. In addition, Medicare Advantage plans usually cover benefits like preventive care and prescriptions. The added services may also have copayments. The beneficiary continues to pay the Medicare Part B monthly premium which is usually withheld from their Social Security check.

39. **Medicare Advantage (Part C) health plans.** CMS is authorized to contract with different health care plans including health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider sponsored organizations (PSOs), special needs plans (SNPs), and religious fraternal plans. The central and regional offices of CMS are responsible for MA subcontracts. CMS must approve annual benefit plans, premiums, and cost-sharing amounts.

    - HMO – A type of health plan that is run by an insurance company or corporation that contracts with a network of doctors, hospitals, and other health care providers. The HMO contracts with Medicare to provide all Medicare services to Medicare beneficiaries that join the plan. The HMO receives a set amount of money from Medicare for each member of the plan.
    - PSO – A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of health plan is run by the doctors and providers themselves, and not by an insurance company.
    - PPO – You pay less if you use doctors, hospitals, and other health providers that belong to the plan's network. You pay more if you use similar services outside of the established network.
    - SNP – SNP's provide focused and specialized health care for specific groups of people. Typically, those that have both Medicare and Medicaid, those who live in nursing homes, or have certain chronic medical conditions.

Medicare Advantage plans have become significantly more popular and there are generally more plans available to choose from. Additionally, any out of pocket costs will vary from plan to plan and can depend on a number of variables. For example, will the plan charge a premium or help with Medicare Part B premiums? Will the plan have a yearly deductible and / or how much will the copayment or coinsurance will be for each service visit in the plan? There are other variables to consider too such as the pan's yearly limit on out of pocket costs for all medical services. With that being said, benefits

counselors need to review how the MA plan defines terms and what the amounts are in order to better help a person compare costs between plans.

Question:

Medicare Advantage health plan refers to any Medicare plan option that is a contract between a private insurance company or corporation and the Medicare program. If a person joins a Medicare Advantage health plan, they are considered to be out of Original Medicare.

True _____ False _____

40. **How Medicare Advantage health plans work.** To join a MA plan, the beneficiary must reside in the MA's service area (designated by county or ZIP code), must have both Medicare Part A and Part B, and must not have end stage renal disease (ESRD.) If a beneficiary develops ESRD after enrolling in the MA, coverage would continue and that person would have a right to continued coverage with another Medicare Advantage plan should their plan decide to end coverage. A Medicare Advantage plan cannot exclude an otherwise eligible applicant because of preexisting conditions other than

ESRD. To find out if a Medicare Advantage plan is available in a given area, contact TDI at 1-800252-3439, or Medicare at 1-800-633-4227 or www.medicare.gov.

To control costs, the MA plan contracts with health care providers to furnish all necessary services. These providers make up the MA's "network." Generally, members must obtain services from providers in their MA's network. Members choose a primary care physician (PCP) from the MA's network list of participating doctors. The PCP either delivers or authorizes all of the member's care. This means a member must have a referral from their PCP to see a specialist. In most cases, the specialist must also be in the MA's network. Members who obtain medical care from providers not in the MA's network or without a referral from their PCP may have to pay the full cost of the care they receive themselves. Exceptions are made for emergency care.

41. **Out-of-pocket costs with Medicare Advantage health plans**. The beneficiary must continue paying the Medicare Part B premium, which usually is deducted from the beneficiary's Social Security check. Some Medicare Advantage plans then charge an additional monthly premium while others charge nothing. There is also a fixed copayment each time a medical service is provided.

Although assignment relates only to Original Medicare, some of the Medicare Advantage plans have additional excess fees that can be charged to the member. Similarly, there is a significant shared copayment for durable medical equipment for failure to pre-notify the plan. While most Medicare health plans do not charge excess fees, they can deny payment of a service if it was not medically necessary or if the service was a non-emergency and obtained from an out-of-network provider. Like the copayments in MA plans, members must pay for these excess charges out of their own pockets.

42. Identifying Medicare Advantage benefits. The companies that contract with Medicare can change benefits and copayments each year. The Medicare website allows consumers to compare benefits amounts, copayments, and deductibles for Medicare Advantage plans in their area. To learn which providers are in a MA plan network, consumers must obtain an application packet from the plan or

may in some cases, visit the plan's website. The Medicare website provides a toll-free number for each MA plan option available and may list a web address if one is available.

43. More about how Medicare Advantage plans work. When a Medicare beneficiary joins a MA, the beneficiary leaves Original Medicare. Medicare Advantage plans differ from Original Medicare in several ways, including:

- Medicare Advantage plan withdrawals - Medicare Advantage plans decide each year whether to stay in or withdraw from the Medicare market. If a plan withdraws from the market, its members are automatically returned to Original Medicare at the end of the fiscal year. Members may join another health plan, if one is available in their area. If another plan is not available, beneficiaries can consider purchasing a Medicare supplement policy to cover the gaps in Original Medicare. When a MA plan withdraws from the market, it must notify its members in writing about options available through remaining MA plans and their right to buy Medicare supplement insurance plans A, B, C, F, high deductible F, K or L. If a member has not moved into another Medicare Advantage plan by January 1, the beneficiary is automatically returned to Original Medicare. The right to buy Medicare supplement policy plans A, B, C, F, high deductible F, K or L, lasts for 63 days and requires that the companies sell the policy without regard to preexisting conditions or wait periods.
- Words like "assignment," "excess charge," and "Medicare-approved rate" that apply to Original Medicare do not apply to MA plans. The application packet for a MA plan and the member's

"evidence of coverage," sometimes referred to as the member handbook, will include definitions and terms that apply to the MA plan.

- When the beneficiary is outside of the service area, MA plans pay only for emergency care and urgently needed care. Be aware that there are review procedures in place for services that may be initially denied coverage. This could be a problem if the member travels frequently. A member can be dropped from the plan if they leave the service area for 90 consecutive days.
- Although a MA plan might offer prescription coverage, this does not mean that a member can get any brand name prescription they choose. MA plans have lists of prescriptions that they will cover. This list is called the plan's "drug formulary." Upon request, the plan must disclose whether a specific drug is on its formulary. The plan must pre-notify members about change to its formulary, which can take place during the year.
- Since health care in a MA plan must be provided or authorized by a member's PCP, the member cannot see a specialist without a referral from the PCP. If a specialist is not available in the network, the plan may refer the member to a specialist outside the network. The plan would be responsible for covering the costs of the specialist.
- Medicare Advantage plan members do not have to file claims when they receive care. The member is only responsible for paying the copayment amount. The provider, not the member, is responsible for collecting reimbursement from the plan for the services.
- Medicare Advantage plan members do not need other insurance to supplement their MA plan.
- **Additional benefits.** Some Medicare Advantage plans may provide more benefits than Original Medicare. These could include dental care, prescriptions, hearing aids, and eyeglasses. The MA plan may charge an additional premium for added benefits. Also, remember that MA plans can change their benefits each year when their contract with CMS is renewed. A MA plan that offers an added benefit, such as prescription drug coverage, can later drop that benefit.

44. How to get the most from a Medicare Advantage health plan. Members should:

- **Read the plan booklet.** Tell consumers to keep the HMO telephone numbers handy (usually located on the back of their member card) and to learn how regular appointments, referrals, and emergency care are handled.
- **Be clear about coverage for emergency care received at non-MA facilities ("out-of-plan facilities").** A MA must pay for emergency care wherever it is received. Members must make

sure they understand how the plan defines emergency care. Ultimately, however, the member is the judge of whether a situation is an emergency. The plan must approve or deny requests from a treating doctor within one hour for services following emergency treatment and stabilization. The plan should be notified as soon as possible that a member is receiving emergency care in an out-of-plan facility. Outside the service area, care for life-threatening conditions and other urgently needed care is covered. "Urgently needed care" will be defined in the member handbook.

- **Know how to file a complaint.** Members should first try to resolve any issues or concerns with their primary care physician. If the issue cannot be resolved at the doctor level, the member should file a written complaint with the MA plan administrator or customer service representative. Recent trends show that network provider problems have included limited access to doctors, greater travel distances for specialists or other services, and delayed appointments for referrals to specialists. While some of these issues can impact the quality of care, at times it may be necessary to address the issue from the perspective of access to care. MA plans are required to have adequate provider networks. Frequently, having the member or a benefits counselor question an action, or asking for a review, can change the response of the plan. A member also has the right to change their PCP. Inpatient hospital complaints regarding services would be processed through the IRO. Although TDI does not have authority over Medicare Advantage complaints, a HICAP representative may be able to assist the benefits counselors who have questions about complaints.
- **Know how to file an appeal.** Federal regulations require that Medicare Advantage plans provide appeals procedures for members. The member should ask the doctor to explain why a service was received or not received. If treatment was denied, find statements in the member handbook (evidence of coverage) that would lead the member to believe it should be covered. A denial of service outside the hospital setting would be filed directly with the plan.

  Benefits counselors can seek the assistance of the Legal Hotline for Texans to assist members with an appeal.
- **Know how to disenroll from a Medicare Advantage Plan.** To withdraw (disenroll) the member should notify the plan. It is important that alternate coverage be secured before leaving a Medicare Advantage plan. Additionally, health plans can close enrollment outside of the mandated annual open enrollment period under certain circumstances. There are special circumstances under which the above rules can be waived for a beneficiary. In addition to the new fall open enrollment dates, there is a new Medicare Advantage disenrollment period from January 1 through February 14.

- **Medicare Advantage plans must have procedures for continued coverage of "special circumstance" patients if the plan terminates its contract with a provider.** The plan must continue to pay the provider to treat the special circumstance patient for up to 90 days after the termination date. Special circumstances include acute or life-threatening conditions and terminal illness as determined by the treating physician.
- **Patient rights under a Medicare Advantage health plan**. Federal law requires that health plans inform their members about the grievance and appeals process. Specific information about grievances and appeals is contained in the member handbook.
- As advocates, benefits counselors can help members navigate getting services from their plans by helping them understand the importance of following the plan's rules for obtaining services. When a problem arises the first thing to do is to determine if the issue is a complaint/grievance (such as a fraudulent enrollment) or an appeal for denied services. The next step is to follow the process to address the problem.
- The Medicare Advantage appeal process is different from Original Medicare in that it allows for expedited appeals. Both grievances and appeals are most effective when in writing. Benefits counselors who establish contacts with MA plans operating in their area can frequently help resolve complaints or grievances on behalf of their clients without going through the written process. Health Law Program staff at Texas Legal Services Center will assist benefits counselors with difficult cases or will help elevate a complaint to the plan or CMS.
- There are various resources offered by CMS to address complaints. Besides calling 1-800MEDICARE, there is also an online complaint form that can be submitted to CMS.
- Once a complaint is submitted electronically, it is sent to the member's plan. The plan, not CMS, is supposed to follow-up with the member. Both consumers and benefits counselors get better responses from CMS if it is documented that the member followed the plans process and the plan did not address the problem in a timely manner or that the response was not adequate.

45. Other information and resources regarding Medicare Advantage health plans.

To find out if a MA health plan is available and to review benefits and costs use the Medicare website tool known as the Plan Finder. It will allow you to enter a ZIP code or county. You can also call 1800-MEDICARE, give them the ZIP code, and ask them for the toll-free telephone number for each plan available. You would then call each plan and ask for a prospective member packet.

Questions

The Medicare website tool known as the Plan Finder can be sued to find out if a MA health plan is available and to review benefits and costs. True _____ False _____

Which does not apply within a Medicare Advantage health plan?

A. _____ A person must have Medicare Part A and Part B to enroll.

B. _____ An enrollee must use the plan's network of providers and needs a referral to see a specialist.

C. _____ A person needs to review their plan every year during the open enrollment period.

D. _____ A person should use the Medicare Summary Notice to review if charges were correctly billed.

E. _____ All of the above.

46. Medicare private fee-for-service plans. A private fee-for-service (PFFS) plan is another option for some Medicare beneficiaries. PFFS is different from Original Medicare or a Medicare Advantage health plan. With a PFFS plan, CMS contracts with a private insurance company that agrees to provide all Medicare approved services to Medicare beneficiaries who join the plan. The contract defines a geographic service area by county or ZIP code. PFFS plans are different from managed care plan options because they allow beneficiaries to go to any doctor, hospital, or provider, as long as the provider agrees to the terms and conditions for reimbursement outlined by the PFFS plan. A beneficiary who joins the PFFS plan is no longer in Original Medicare and must follow the procedures and rules of the plan to receive their Medicare benefits. Members don't have a primary care physician to oversee their care, so they don't need a referral to go to a specialist.

CMS enters into a one-year contract with the PFFS contractor and approves the plan's benefits, premiums, and any other out-of-pocket costs that will be passed on to beneficiaries. CMS pre-pays a monthly fee for each beneficiary that enrolls in the PFFS. The PFFS plan assumes all claims processing to health providers that agree to Medicare approved services to members of the plan. The

amount of reimbursement to providers may be different from the Medicare approved amounts under Original Medicare. Additionally, the rules allow for PFFS plans to balance bill members.

47. **Regulatory authority and sources of law**. Medicare PFFS plans have as their source of law 42 United States Code §1395w-28(b)(2). The Balanced Budget Act of 1997 authorized HHS and CMS to enter into contracts with insurance companies. As a Medicare Advantage option, the PFFS must develop a process for quality care improvement, appeals, and grievances. The plan is subject to the external quality monitoring by the same independent CMS contractors and the national agent for reconsideration of denials that monitors the Medicare Advantage managed care plans. The CMS regional office is responsible for state monitoring of the PFFS plan and the review of marketing and advertising materials is approved at the CMS central office.

Similar to Medicare Advantage managed care plans, PFFS plans must meet federal contracting requirements and be state-licensed entities. TDI does not have a formal role in the review of the PFFS application process, although the company offering the plan must meet licensing requirements as a company selling insurance in Texas. Beneficiary complaints, grievances, or appeals regarding the PFFS plan must be submitted through the process outlined by the PFFS plan. Issues related to excessively delayed payment of claims can be directed to TDI as these might be indicators of solvency issues which are under the authority of TDI.

48. **How the PFFS plans cover the gaps in Medicare.** The PFFS plans agree to provide all Medicare approved services to beneficiaries that join the plan. The member will pay a monthly premium to the PFFS plan. The premium is different from the Medicare Part B monthly premium which the beneficiary continues to pay directly to Medicare.

The beneficiary will pay Medicare Part A and Part B copayments (fixed amounts dependent on the service received) and coinsurance (a percentage of the cost for each service). These costs are applied differently in PFFS plans than in Original Medicare. For example, inpatient care in Original Medicare, a deductible applies to each benefit period. In the PFFS plan, the same inpatient care applies a per admission copayment without regard to benefit period. Additionally, the PFFS plan requires pre-notification of any inpatient admission. The coinsurance in Original Medicare is 20 percent of the Medicare-approved cost. In the PFFS plan, the coinsurance can range from 20 to 70 percent of the PFFS approved amount. As with the copayment, there is an increased amount that can be applied for failure to notify the plan in advance of receiving service.

49. **How does the Medicare PFFS plan work?** To join the PFFS plan, a person must reside in the plans service area, have both Medicare Part A and Part B, and cannot have ESRD. The PFFS plan's contract with CMS is for one year. Each year, the PFFS plan decides whether to stay in or leave Medicare. If the plan leaves Medicare, members must either return to Original Medicare or join another Medicare Advantage plan. The PFFS plan is available in rural areas that most Medicare health care plans would not traditionally serve. The monthly premium, copayments, and coinsurance change at the start of each year.

The PFFS plan cannot exclude an otherwise eligible applicant because of preexisting conditions other than ESRD.

Enrollees can obtain services from any provider that accepts the plan's terms and conditions. The PFFS plan is responsible for payment directly to the physician or provider. The beneficiary pays a set copayment to the provider. Providers are reimbursed at different rates dependent on whether they decide to work with the plan as a contracted provider, also referred to as a "deemed" provider or provide a service as a "non-contracted" provider. Responsibility to identify providers willing to accept the plan currently falls to the member. The member is also liable for paying any non-covered Medicare services received from providers. The PFFS plan uses prior notification rules as a way to control cost. The beneficiary will be charged a higher copayment or coinsurance if they fail to get prior approval before receiving certain services. In some instances, if the PFFS plan determines that a service received was not "medically necessary," they will deny payment. An enrollee may appeal the denial.

50. **Identifying the out-of-pocket costs for the PFFS option.** The beneficiary pays a fixed monthly premium. In addition, there are different copayment amounts based on the service received. A member could pay a higher copayment amount if they do not comply with the prior notification rules.

The PFFS plan could be costlier than other Medicare options for certain beneficiaries. People who require frequent hospitalization or use durable medical equipment, outpatient mental health services or home health services (50 percent coinsurance) would pay significantly higher out-of-pocket cost then some of the other Medicare options. A screening questionnaire that identifies the beneficiary's insurance coverages and needed medical service would help a person decide if this option is appropriate for their situation.

In general, this plan may be a suitable option for someone who is fairly healthy and does not use the higher cost services such as hospitalization and durable equipment. The premium for the PFFS plan is now comparable to the premium for a Medicare supplement Plan A for someone who just turned 65. A more important aspect of this plan is assuring that the doctors and other health providers become familiar with how the plan reimburses providers and that those providers are willing to work with the PFFS plan.

51. Identifying Medicare PFFS benefits. The PFFS plan will cover all required Medicare services that are provided as medically necessary. This includes new preventive health exams. The only benefit enhancements beyond what Medicare covers is reimbursement for emergency care outside the United States and increased inpatient hospital days beyond what Medicare covers.

The member must pay an annual deductible before the plan pays for emergency care. In addition, there is a coinsurance of 20 percent that the member must also pay. There is a maximum annual limit for emergency care while out of the United States. The PFFS plan's benefits and costs are also available on the Medicare Plan Finder website. If a person resides in a PFFS area, the PFFS plan will be included in the comparison of plans.

52. More about how Medicare PFFS plans works. When a beneficiary joins the PFFS plan, they leave Original Medicare. Following are aspects of the PFFS plan that are different from Original Medicare:

- Eligibility, enrollment, and disenrollment guidelines in the PFFS plan are the same as those in Medicare Advantage managed care plans. New dates and rules concerning changing from a Medicare Advantage plan to Original Medicare were effective January 2011;
- Since doctors and other providers can choose not to accept the plan's terms of payment, members should tell their provider before a service is rendered that they are in the PFFS plan. If a particular physician or provider does not accept the plan, the member will have to find another provider;
- Like in Medicare health care plans, it is important that members become familiar with the plan's member handbook that defines terms unique to the plan and outlines procedures for accessing services. Some members could be liable for paying higher costs if they frequently need services that have higher copayments, if they fail to comply with prior notification rules or cannot find providers that accept the PFFS plan;

•People who require treatment from specialists or other providers should confirm that the specialist and facility they use is also willing to accept the PFFS plan;

•Members in a PFFS plan may not have to file claims when they receive care. The legislation that authorized the PFFS plan allows plans the option to require enrollees to pay providers in advance and then to submit claims to the plan for reimbursement back to the member. The member is responsible for paying the copayment amount. PFFS plans allow "balance billing," which means that the beneficiary can be asked to pay up to 15 percent more than the plan's payment for that service;

•PFFS plan members cannot be in another Medicare Advantage plan or have a Medicare supplement policy while they are in the PFFS plan. If the member has group insurance, they will want to review how their group plan will coordinate with the PFFS plan.

53. Members should know how to get the most from the PFFS plan. To get the most from the PFFS plan, members should:

- **As with any new program, members should do their homework.** Find out by talking to friends, physicians, and providers if the PFFS plan is accepted in your area. If no one is familiar with the plan, ask the plan representatives to tell you which providers in your area have agreed to accept the plan.
- **Members should be clear about coverage for emergency and inpatient hospital care.** The PFFS plan cannot restrict enrollees to use a provider network or require a referral to see a specialist. The plan does require prior notification defined as an "advance coverage decision" before certain services are accessed. The plan can charge a higher copayment for not receiving prior notification or could deny coverage as not "medically necessary."
- **Members should know how to file a quality of care, or access to care complaint.** PFFS enrollees have the same grievance and appeals rights as Medicare health care plans. The member handbook that the plan must provide each enrollee will outline and identify how to file a complaint. Medicare Advantage options do not follow procedures used in Original Medicare. Providers can file complaints directly to the PFFS plan for non-payment of claims. The provider cannot collect reimbursement from the member unless the member continues to see a provider that will not contract with the plan. Any undue delay in payment to providers for what would otherwise be an approved Medicare claim, may be filed with the Texas Department of Insurance as nonpayment and could be an indication of solvency problems.

- **Members should know how to appeal decisions.** The PFFS plan must follow the appeals process for all Medicare Advantage plans. This process has three components and is detailed in the member handbook. The categories of appeals are: regular appeal for denial of service or payment; expedited appeal, which requires a determination within 72 hours; and hospital-related appeal, which is handled by the state's IRO. Benefit counselors can seek the assistance of the Health Law Program at Texas Legal Services Center as well as the Legal Hotline for Texans to assist members with an appeal.
- **Members should know how to get out of the PFFS.** To withdraw (disenroll) from the PFFS plan the member must notify the plan or the local Social Security office in writing. Before leaving a MA plan, it is important that alternate coverage be secured. The insurance company that offers the PFFS plan also sells a Medicare supplement insurance policy. The company has promoted the option to begin in the PFFS plan with the understanding that if the beneficiary ever wanted to get out of the PFFS plan they would have an automatic right to buy a Medicare supplement policy from this company.

54. Members can access more information and resources on the PFFS plan. To find out if the PFFS plan is available and details about the costs and benefits a member can visit the Medicare Plan Finder website. More limited information can be obtained by calling the Medicare toll-free hotline (800) 633-4227.

Question:

Which of the following individuals would not be a good candidate for the PFFS plan?

A. _____ Newly enrolled beneficiary who is very healthy, does not have access to employer or group insurance, and is budgeting because there is a spouse who is not yet Medicare eligible.

B. _____ A beneficiary who has frequent hospitalizations and is beginning to have memory loss.

55. CMS Reading Resources:

- *Medicare & You* - Annual publication that outlines available Medicare Advantage plans and new changes to Medicare.
- *Choosing a Medicare Health Plan*: *A Guide for People with Medicare* – Worksheet-type brochure that describes different Medicare Advantage plans. The brochure is organized in a question

and answer format and requires the client to gather information that will help them make an informed choice about options. It is recommended as a training overview on how to assist client's to review their options. It is available at: https://www.mymedicare.gov/.

- *Medicare Health Plan Nonrenewal Fact Sheet* – General overview on the Medicare HMO termination process and steps to follow.
- *Your Medicare Rights & Protections* – This brochure outlines Medicare basic benefits and rights needed to better understand if an issue should be considered a justified denial, a complaint, or a grievance. This publication is recommended as a training overview to help benefits counselors research steps to follow to resolve a client's concern.

Other print resources and contacts

- **Publications and periodicals from the Medicare Rights Center.** The MRC is a national nonprofit organization devoted to advocacy on behalf of Medicare beneficiaries. MRC has served as the state SHIP for the state of New York, making their information very timely on current issues related to Medicare. Learn more at their website: http://www.medicarerights.org/ or call the toll- free number 1(800) 333-4114.

Chapter 5
Questions

1. Which of the following are considered Medicare out-of-pocket costs?

A. _____ Medicare Part A and Part B premiums.

_____ B.Copayments and coinsurance.

_____ C.Deductibles.

_____ D. Cost of services that Medicare does not cover.

_____ E.All of the above.

2. Which is true of Medigap policies?

A. _____ There are 10 standard plans.

_____ B. There are high deductible versions of all 10 plans.

_____ C. Medigap policies are sold and regulated by the federal government?

D. Medigap policies are guaranteed renewable which means the price can never increase.
_____

3. Before buying a Medicare supplement policy, the beneficiary should:

A. Make sure that they have Medicare Part A and Part B.
_____

B. _____ Review their entitlement to group insurance through their employer or to a retirement plan from their former employer.

_____ C.Find out if they qualify for the Medicare Savings Programs.

_____ D. Find out if there is a Medicare Advantage option available.

_____ E.All of the above.

4. The Medicare supplement high deductible Plan F requires that the beneficiary first pay the annual deductible ($2,300 in 2019) before the plan pays any of the costs.

True _____ False _____

5. In Texas, a person with disabilities under age 65 has a six-month open enrollment period, just like people over 65, and may buy any Medicare supplement plan regardless of any preexisting conditions.

True _____ False _____

6. A person, who is still working when they become eligible for Medicare, can delay enrollment in Medicare if their employer allows it.

True _____ False _____

7. A Medicare Advantage health plan refers to any Medicare plan option that is a contract between a private insurance company or corporation and the Medicare program. If a person joins a Medicare Advantage health plan, they are no longer in Original Medicare.

True _____ False _____

8. The Medicare Plan Finder can be used to find out if a MA health plan is available and to review benefits and costs

True _____ False _____

9. Which does not apply to a Medicare Advantage health plan?

A. _____ A person must have Medicare Part A and Part B to enroll.

B. An enrollee must use the plan's network of providers and needs a referral to see a specialist.

C. A person needs to review their plan every year during the open enrollment period.

D. A person should use the Medicare Summary Notice to review if charges were correctly billed

E. All of the above.

10. Which of the following individuals would <u>not</u> be good candidates for the PFFS plan?

A. A newly enrolled beneficiary who is very healthy, does not have access to employer or group insurance, and is budgeting because their spouse is not eligible for Medicare.

B. A beneficiary who has frequent hospitalizations and is beginning to have memory loss.

Chapter Six Answers

1. E
2. A
3. E
4. True
5. False
6. True
7. True
8. True
9. D

10. B