BETTER MEDICARE

ALLIANCE

OPEN ENROLLMENT GUIDE

CONTENTS

UNDERSTANDING THE NEW MEDICARE CARD

New Cards

When Are the New Medicare Cards Being Mailed?

- CMS began mailing new Traditional Medicare cards to beneficiaries, state by state in April 2018.

What Is the Purpose of the New Medicare Card?

- The new Medicare cards replace the traditional red-white-and-blue Medicare cards.
- Instead of your Social Security Number, the new Medicare cards have a unique Medicare Number on the front.
- This change is intended to protect your privacy and prevent identity theft.

What Should I Do When I Receive My New Card?

1. Destroy your old Traditional Medicare card.

2. Medicare Advantage beneficiaries should continue using the card they received from their Medicare Advantage plan.

- However, you should also carry your new Medicare card in case your doctor's office or pharmacist asks to see it.

3. Protect your new Medicare Number by only giving it to doctors, pharmacists, other health care providers, your Medicare Advantage plan, or people you trust to work with Medicare on your behalf.

What if I Haven't Received My New Card Yet?

- If you haven't received your new Traditional Medicare card yet, you can sign into your MyMedicare.gov account to check the status of your card.
- You can also visit Medicare.gov/NewCard to check the status of card mailings in your state.
- If the map shows that your state has already completed the mailing of new cards and you still haven't received yours, please call 1-800-MEDICARE (1-800-633-4227).

UNDERSTANDING OPEN ENROLLMENT

When Is Open Enrollment?

- Open Enrollment for Medicare takes place each year from **October 15 to December 7.**

What Can I Do During The Open Enrollment Period?

During Open Enrollment, you can:

- Switch from a Medicare Advantage plan to a different Medicare Advantage plan
- Change from a Medicare Advantage plan to Traditional Medicare.
- Switch from one Medicare Advantage plan to another Medicare Advantage plan.
- Switch from a Medicare Advantage plan that does not offer drug coverage to a Medicare Advantage plan that offers drug coverage.
- Switch from a Medicare Advantage plan that offers drug coverage to a Medicare Advantage plan that does not offer drug coverage.

Medicare Advantage Open Enrollment Period will take place from January 1 to March 19 in 2019

What Can I Do During This NEW Open Enrollment Period?

- Switch to a different Medicare Advantage plan
- Drop your Medicare Advantage plan and return to Traditional Medicare, Part A and Part B
- Sign up for a stand-alone Medicare Part D Prescription Drug Plan (if you return to Traditional Medicare). Most Medicare Advantage plans include prescription drug coverage already. Usually you can't enroll in a stand-alone Medicare Prescription Drug plan if you already have a Medicare Advantage plan, but there are some situations where you can. Call your Medicare Advantage plan if you have questions.
- Drop your stand-alone Medicare Part D Prescription Drug Plan

When Can I Enroll In Traditional Medicare?

- If you did NOT sign up for Medicare Parts A and B when you were first eligible, you can do so each year from **January 1 to March 31,** with coverage effective July 1.

However, you may be subject to a late enrollment penalty.

The chart below summarizes the enrollment options, enrollment periods, and coverage start dates:

Enrollment Option	Start	End	Coverage Start
Traditional Medicare Part A/Part B Enrollment	January 1	March 31	July 1
Initial Medicare Advantage, and/or Medicare Prescription Drug Plan (if enrolled in Part B)	April 1	June 30	*see note
Initial Part D (if enrolled in Part B)	April 1	June 30	*see note
Medicare Advantage/Part D Annual Open Enrollment	October 15	December 7	January 1
Medicare Advantage Disenrollment Period	January 1	February 14	*see note
Medicare Advantage/Part D Annual Open Enrollment	October 15	December 7	January 1
Medicare Advantage Disenrollment Period	January 1	February 14	*see note

*Note: Your coverage will begin the first day of the month after you ask to join a plan. If you join during one of the 3 months before you turn 65, your coverage will begin the first day of the month you turn 65.

What Is The Difference Between Medicare Advantage And Traditional Medicare?

- Traditional Medicare includes Part A (hospital) and Part B (medical) coverage, if you enroll in both.
- Most people pay a monthly, income-based premium for Medicare Part B.
- Traditional Medicare does not cover visual, hearing, and dental benefits, and there is no limit on yearly amounts of out-of-pocket care costs.
- Under Traditional Medicare, you can go to any doctor or hospital in the United States that accepts Medicare.
- If you want Medicare drug coverage (Part D), you must purchase a separate Prescription Drug Plan (PDP) from a private insurance company.
- If you have Traditional Medicare, you may also choose to purchase a supplemental insurance policy to cover out-of-pocket physician costs, called Medigap.
- Under Medicare Advantage, you still pay Part B premiums.
- Over 97% of Medicare Advantage plans offer at least a vision, hearing, or dental benefit, and half of Medicare Advantage plans offer all three benefits.
- Medicare Advantage Plans have yearly limits on your out-of-pocket health care costs. Once you reach your maximum out-of-pocket spending, you pay nothing more out of pocket.
- Under Medicare Advantage, the providers you can visit depend on the plan you select. This is referred to as the "provider network" and plans offer information on which providers are in their plan.
- If you want a plan that includes Medicare drug coverage (Part D), you can sign up for a Medicare Advantage Prescription Drug Plan (MA-PD) which includes both health and drug coverage.

To learn more about Traditional Medicare and Medicare Advantage, please visit medicare.gov.

97%

Medicare Advantage plans offer at least a vision, hearing, or dental benefit and half of Medicare Advantage plans offer all three benefits

What Criteria Must I Meet If I Want To Enroll In A Medicare Advantage Plan?

- If you are eligible for Traditional Medicare, you generally are eligible to choose a Medicare Advantage plan.
- To be eligible for a Medicare Advantage plan, you must be enrolled in Medicare Parts A and B, and live in the Medicare Advantage plan service area.

When Can I Initially Enroll In Medicare Advantage Or A Drug Plan?

- If you are already enrolled in Medicare Part B, you can enroll in Medicare Advantage, a Medicare Advantage Drug plan, or Medicare Part D for the first time between **April 1 and June 30.**
- To clarify, the April 1 to June 30 enrollment period is for individuals who are enrolling in these plan types for the first time. If you already have one of these plans and would like to make changes, you can do so during Open Enrollment between **October 15 and December 7.**

What if I Am Already Enrolled In A Plan, And I Do Not Want To Make Changes?

- If you are already enrolled in a Medicare Advantage plan or a Medicare Part D prescription and you do NOT want to make changes to your coverage for 2019, you do not need to do anything during Open Enrollment.
- However, it is important to make sure your plan will still be available in 2019.
- If your plan is being discontinued and is not eligible for renewal, you will receive a non-renewal notice from your insurance carrier prior to Open Enrollment.

How Do I Change My Medicare Advantage Coverage After The Open Enrollment Period?

- If you are enrolled in a Medicare Advantage plan, you can leave your plan and return to Traditional Medicare between **January 1 and March 19** each year. This is known as disenrollment.
- After you leave your plan, you will have until February 14 to enroll in a Part D plan that will begin the first day of the following month that you enroll.
- You cannot switch to another Medicare Advantage plan after open enrollment unless you have a circumstance that affords you a **Special Enrollment Period**.
- For example, you can switch to a Medicare Advantage plan with a 5-star rating from December 8, 2018 - November 30, 2019. You can only use this Special enrollment period once during this timeframe.

UNDERSTANDING THE DIFFERENCE BETWEEN TRADITIONAL MEDICARE AND MEDICARE ADVANTAGE

What Is Medicare Advantage?

- Medicare Advantage, sometimes referred to as Medicare Part C, is the option in Medicare that allows beneficiaries to enroll in a health care plan offered through private companies.
- Medicare Advantage is an “all in one” alternative to Traditional Medicare. These “bundled” plans include Part A, Part B, and usually Part D.
- If you join a Medicare Advantage Plan, you still have Medicare. You will receive your Medicare Part A and Medicare Part B coverage from the Medicare Advantage Plan, instead of through Traditional Medicare.
- Under Traditional Medicare, the government pays for your Medicare benefits when you are eligible to receive them.
- Under Medicare Advantage Plans, Medicare pays private companies a set amount per person per month to cover your benefits.

WHAT ARE THE PARTS OF MEDICARE?

Part A

Hospital Coverage

Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

Part B

Medical Coverage

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home Health care
- Durable medical equipment (like wheelchairs, walkers,
- Hospital beds, and other equipment and supplies)
- Many preventive services (like screenings, shots, and yearly “wellness” visits)

Part D

Prescription Drug Coverage

Helps cover:

- Cost of prescription drugs through private Part D plans
- Rules for coverage set by Medicare

Your Medicare options

TRADITIONAL MEDICARE

- This includes part A and B
- If you want drug coverage, you need to purchase a Part D plan separately.
- To pay your out-of-pocket costs in Traditional Medicare you would need help from a supplemental coverage.

Part A

Part B

You can add:

Part D

You can also add:

Supplemental Coverage

Such as coverage from former employer or union, or Medigap policies.

MEDICARE ADVANTAGE

- Medicare Advantage is an “all in one” alternative to Traditional Medicare. These “bundled” plans include Part A, Part B, and usually Part D.
- Medicare Advantage plans are required to place a limit on out-of-pocket costs (excluding Part D).
- Some plans offer extra benefits that Traditional Medicare doesn’t cover like vision, hearing or dental.

Part A

Part B

Most plans include:

Part D

Some plans also include:

- ☐ Lower out-of pocket costs
- ☐ Extra Benefits

Traditional Medicare vs. Medicare Advantage

Doctors and Hospital choice

Traditional Medicare	Medicare Advantage
You can go to **any doctor that accepts Medicare.**	In most cases, you'll need to use **doctors who are in the plan's network** (for non-emergency or non-urgent care). Ask your doctors if they participate in Medicare Advantage Plans.
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist or to have certain tests and procedures.

Costs

Traditional Medicare	Medicare Advantage
For Part B-covered services, **you usually pay 20% of the Medicare approved amount** after you meet your deductible.	**Out-of-pocket costs vary**—some plans have low or no out-of-pocket costs.
You **pay a premium (monthly payment) for Part B.** If you choose to buy prescription drug coverage, you'll pay that premium separately.	You may **pay a premium for the plan** (most include prescription drug coverage) **and a premium for Part B.** Some plans have a $0 premium or will help pay all or part of your Part B premium.
There's **no yearly limit** on what you pay out-of-pocket.	Plans have a **yearly limit** on what you pay out-of- pocket for Medicare Part A and B covered services. Once you reach your plan's limit, you'll pay nothing for Part A- and Part B covered services for the rest of the year.

You **can buy** supplemental coverage to help pay your out-of-pocket costs (like your deductible and 20% coinsurance).	You **can't buy or use** separate supplemental coverage

Coverage

Traditional Medicare	Medicare Advantage
Traditional Medicare covers medical services and supplies in hospitals, doctors' offices, and other health care settings.	Plans must cover all of the services that Traditional Medicare covers. Some plans **offer extra benefits that Traditional Medicare doesn't cover**— like vision, hearing, or dental.
You can join a **separate Medicare Prescription Drug Plan** to get drug coverage.	**Prescription drug coverage is included** in most plans.
In most cases, you don't have to get a service or supply approved ahead of time for it to be covered.	In some cases, you have to get a service or supply approved ahead of time for it to be covered by the plan.

Travel

Traditional Medicare	Medicare Advantage
Traditional Medicare generally **doesn't cover care outside the U.S**. You may be able to buy supplemental coverage that covers care outside the U.S.	Plans usually **don't cover care outside the U.S.** Also, plans usually don't cover non-emergency care you get outside of your plan's network.

UNDERSTANDING THE DIFFERENCES BETWEEN MEDICARE ADVANTAGE AND MEDIGAP

- If you are enrolled in Traditional Medicare, you may choose to purchase a supplemental insurance policy to cover out-of-pocket physician costs, called Medigap.
- Medigap provides supplemental coverage that pays for all or most of Medicare Parts A & B out-of-pocket costs including copayments, coinsurance, and deductibles.
- Under Medigap, beneficiaries must be at least 65 years old, and may enroll in Medigap in the first six months after they sign up for Medicare Part B.

Almost

90%

of Medicare Advantage plans include drug coverage

- Medigap policies are regulated by states, so rules of coverage differ
- After that period, people in most states can be turned down by Medigap, or charged extra for pre-existing conditions.
- Medigap plans are not necessary if you chose a Medicare Advantage plan because Medicare Advantage plans typically include the coverage offered by Medigap.
- You are not permitted to enroll in both a Medicare Advantage plan and a Medigap plan simultaneously.
- Medigap does not cover Part D (drug) coverage.
- Almost 90% of Medicare Advantage plans include drug coverage.
- Medicare Advantage plans have yearly limits on your out-of-pocket health care costs. Once you reach your maximum out-of-pocket spending, you pay nothing.
- Medigap plans do not have a limit on out-of-pocket health care costs.
- Medicare Advantage plans and Medigap plans are both provided through private insurance companies.
- Click here to learn more about the Medigap program
- Click here to learn more about the Medicare Advantage program
- Click here to learn more about Traditional Medicare

The following chart highlights the key differences between Medigap and Medicare Advantage.

Medigap	Medicare Advantage
• Optional supplemental coverage for Traditional Medicare beneficiaries. • Pay additional premium to cover services not covered under Traditional Medicare such as copays, coinsurance, and deductibles. • Medigap plans are provided by private companies regulated by states. • There are 10 different types of Medigap plans that vary by design. • Does not have an annual limit on out-of-pocket spending. • Medigap is only purchased as a supplement to Traditional Medicare, after you have enrolled in and paid for Parts A and B.	• Covers Traditional Medicare Parts A (hospital) and B (medical) benefits. • Almost 90% of Medicare Advantage plans also include Part D (prescription drug) coverage. • Over 97% of Medicare Advantage plans offer at least a vision, hearing, or dental benefit. • Approximately 50% of Medicare Advantage plans offer all three additional benefits. • There is an annual cap limit on out-of-pocket spending. This limit changes each year. • Medicare Advantage is provid.d through private insurance companies. • Services are provided by an HMO, PPO, or FFS plan. In HMO and PPO plans you are expected to use a defined network of providers. • The government sets quality standards, known as star ratings, for Medicare Advantage plans. • Under Medicare Advantage, you are still required to pay Part B premiums. • Some Medicare Advantage plans do not have an additional premium, whereas other Medicare Advantage plans require an additional premium. • These premiums may differ in cost due to zip code and plan type.

97%

of Medicare Advantage plans offer extra benefits

UNDERSTANDING THE NEW FLEXIBILITIES AND IMPROVEMENTS TO MEDICARE ADVANTAGE

What Are the New Improvements to Medicare Advantage?

- In April 2018, CMS made changes to Medicare Advantage by allowing Medicare Advantage plans to offer new supplemental benefits to beneficiaries with certain clinical conditions.
- The supplemental benefits available include services that address physical impairments, health conditions, and avoid Emergency Room visits.

Adult Day Care Service

This includes Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Examples are eating, toileting, bathing, getting dressed, housecleaning, shopping for groceries, managing money and taking prescribed medication.

Home-Based Palliative Care

Home-based specialized medical care services to diminish symptoms for terminally ill beneficiaries with a life expectancy of more than 6 months.The services offered under this benefit are not covered by Medicare, such as nursing and social work services.

In-Home Support Services

In-home support services to assist beneficiaries with disabilities or physical impairments to reduce hospital visits.

Support for Caregivers of Enrollees

Emotional support, such as counseling, for patients, family members, and caregivers.

Medically-Approved Non-Opioid

Medically-approved non-opioid pain treatment alternatives such as therapeutic massage to improve pain, stiffness, and loss of range of motion from an injury or illness.

Stand-alone Memory Fitness Benefit

Prevention, treatment, or improvement of the psychological impact of conditions like memory loss and dementia.

"Home & Bathroom Safety Devices & Modifications"

The purchase, installation, and inspection of safety devices to prevent injuries in the home and bathroom. Allowable modifications include shower stools, grab bars and temporary mobility ramps.

Transportation

Transportation for doctor's visits. Transportation must be arranged by the health plan and may include a health aide to assist.

Over-the-Counter (OTC) Benefits

Health-related items and medications available without a prescription and not covered by Medicare Parts A, B, or D such as pill cutters, crushers, and bottle openers are permitted. In addition, electronic activity trackers such as an Apple Watch or a Fitbit may also be covered under this benefit.

When Can I Start Using These New Benefits?

- Medicare Advantage beneficiaries can start using some or all these new benefits as of April 2019. If offered by your health plan. Not all Medicare Advantage plans will offer all benefits.
- These benefits are available to beneficiaries based on their health status or circumstances.
- If you have a question about a particular benefit, please contact your Medicare Advantage plan to learn more.

UNDERSTANDING MEDICARE ADVANTAGE SPECIAL NEEDS PLANS (SNPs)

What Is A Medicare Special Needs Plan (SNP)?

- Special Need Plans (SNPs) are a type of Medicare Advantage plan designed to provide coordinated care to individuals with special needs.
- SNPs are designed to address complex conditions by providing better access to coordinated care to low income beneficiaries, beneficiaries with disabling chronic conditions, and beneficiaries in need of long-term care.
- SNPs tailor benefits, providers (i.e. physicians, nurses, other health professionals), and prescription drug coverage to best meet the needs of the beneficiaries they serve.
- In addition to providing all Medicare Part A and B benefits, SNPs also provide reduced cost sharing and enhanced benefits related to mental health, social services, and wellness.
- Under SNPs, plans will coordinate the services and providers you need to help you stay healthy and follow doctors' or other health care providers' recommendations.
- By law, all SNPs must have an evidence-based model of care in place with an appropriate network of providers and specialists.
- SNPs use care coordinators or care managers to help beneficiaries follow doctors recommendations to stay healthy. Care coordinators make sure beneficiaries receive the right care and information.

For example, if you have diabetes, a care coordinator may help you check your blood sugar, keep track of your diet, schedule eye and foot exams, and help you get proper exercise.

- A care coordinator for someone who is low-income and eligible for both Medicare and Medicaid may help beneficiaries gain access to community resources to coordinate their different Medicare and Medicaid benefits and services.
- Under SNPs, each beneficiary must receive an annual assessment, a personalized care plan to address goals and objectives, and a care management team.
- A beneficiary in an SNP is still in the Medicare program and therefore, has all the Medicare rights and protections.

How can I learn more about SNPs?

- Visit Medicare.gov's page on SNPs.
- Use the Medicare Plan Finder Tool.
- Call 1-800-MEDICARE (63342273) to speak with a representative.
- Contact your local SHIP counselor to discuss your specific needs.

- SNP beneficiaries get complete Medicare Part A (hospital) and Part B (medical) coverage. SNPs are also required to provide Part D (prescription drug) coverage.

What are the three types of Medicare Special Needs Plans (SNPs)?

Chronic Condition Special Needs Plans (C-SNPs)

- C-SNPs are designed for beneficiaries with a severe or disabling chronic condition such as cancer, dementia, or history of stroke. Over 339,000 Medicare Advantage beneficiaries are enrolled in a Medicare C-SNP.
- C-SNPs focus on monitoring health status, managing chronic diseases, and avoiding unnecessary hospitalizations.
- For example, a C-SNP for a beneficiary with congestive heart failure (CHF) would include a network of providers who specialize in treating CHF, case management programs specializing in CHF, and a drug formulary designed for treating CHF.

Institutional Special Needs Plans (I-SNPs)

- I-SNPs are designed for beneficiaries who live in a nursing home or in the community but require skilled nursing care at home. Over 65,000 beneficiaries are enrolled in a Medicare I-SNP.
- I-SNPs focus on providing care for beneficiaries who, for 90 days or longer, have needed the level of services provided under long-term care, a skilled nursing facility (SNF), a facility for individuals with certain intellectual/learning disabilities, or an inpatient psychiatric facility.

Dual-Eligible Special Needs Plans (D-SNPs)

- D-SNPs are designed for low-income beneficiaries who are eligible for coverage under both Medicare and Medicaid (known as dual-eligible beneficiaries). 1.9 million beneficiaries are enrolled in a Medicare D-SNP.
- D-SNPs contract with states to provide both Medicare and Medicaid benefits, as well additional services that may be covered under Medicaid in their state.
- D-SNPs focus on helping beneficiaries gain access to coordinated benefits and community services from both Medicare and Medicaid.

339K

Over 339,000 Medicare Advantage beneficiaries are enrolled in Medicare C-SNPs

65K

Over 65,000 beneficiaries are enrolled in Medicare I-SNPs

1.9M

1.9 million beneficiaries are enrolled in Medicare D-SNPs

UNDERSTANDING CARE COORDINATION IN MEDICARE ADVANTAGE

What is coordinated care?

- Coordinated care is the organization of patient care between two or more health professionals to provide the most appropriate delivery of health care services.

How does care coordination work in Medicare Advantage?

- In Medicare Advantage, early identification of illness is a priority, and early intervention is the goal.
- Most Medicare Advantage plans use Health Risk Assessments to identify early illness and various factors that may affect health.
- Medicare Advantage is improving the interaction between providers, building new partnerships, and engaging patients where they are.
- Care coordination often involves a primary care team of professionals who manage patients with complex conditions or care managers who follow-up with patients who have chronic conditions.
- In-home and community-based care is essential to patient-centered, high-value care.
- Flexibility in care delivery allows care to be provided to you in the most appropriate setting and most appropriate provider.

UNDERSTANDING THE MEDICARE DIABETES PREVENTION PROGRAM

What Is the Medicare Diabetes Prevention Program?

- The Medicare Diabetes Prevention Program (MDPP) is designed to prevent the onset of Type 2 diabetes in pre-diabetic Medicare beneficiaries.
- The MDPP includes a series of in-person, group-based sessions focused on promoting healthier lifestyles through wellness, nutrition, and exercise support to meet healthy behavior goals.
- MDPP was added as a new benefit under Medicare as of January 2019 and is available in both Traditional Medicare and Medicare Advantage.

Is the MDPP Available to Medicare Advantage Beneficiaries?

- Medicare Advantage plans offer MDPP to all eligible beneficiaries at no additional cost.
- Medicare Advantage plans are able to partner with community-based organizations like the YMCA and Silver Sneakers to offer the MDPP services.
- Medicare Advantage plans engage health care providers to identify pre-diabetic patients who may benefit from participating in the MDPP.

Risk of diabetes was reduced by 71% in people age 60 and older

Is the MDPP Effective?

- A study of the MDPP found that participants' risk of diabetes was reduced by 71% in people age 60 and older.
- Evidence shows programs that include exercise, nutrition counseling, support, and social engagement have a positive impact on reducing disease progression.

UNDERSTANDING MEDICARE ADVANTAGE RETIREE COVERAGE

What is Medicare Advantage Retiree Coverage?

- If you have retiree health coverage and are over 65 years old, you may be automatically enrolled in a Medicare Advantage plan that is similar to the coverage you received before you retired.
- This type of Medicare Advantage Retiree Coverage is known as an Employer Group Waiver Plans (EGWPs). This is an option selected by some employers, including state and local governments, industries, and unions to offer their retirees' health coverage through Medicare Advantage.
- Over four million retirees across the country are enrolled in a Medicare Advantage health plan offered by a former employer.

What Are the Benefits of Medicare Advantage Retiree Coverage?

- Employers report that Medicare Advantage retiree coverage gives them the ability to continue coverage that offers the comprehensive, coordinated care their retirees expect.
- Retirees in employer-sponsored Medicare Advantage plans also have cost protections that are not available in Traditional Medicare, such as an annual cap on out-of-pocket costs and lower premiums.

How do I find Out if This Type of Coverage Is Available to Me?

- If you are approaching retirement age, ask your employer or human resources department if Medicare Advantage Retiree Coverage is available to you.

UNDERSTANDING MEDICARE ADVANTAGE STAR RATINGS

What Are Medicare Advantage Star Ratings?

- In Medicare Advantage, quality is measured by a Stars Rating System.
- Ratings range from 1 to 5 stars, with five being the highest and one being the lowest score.
- Medicare Advantage plans that receive 4+ stars receive a bonus that is used to provide enhanced benefits and better care to beneficiaries.
- More than 70% of Medicare Advantage beneficiaries are in 4-star or higher rated plans.
- Plans receive an annually updated Star Rating each October, which is public to beneficiaries.
- Star Ratings incentivize quality improvements in care and services received by beneficiaries and support quality goals in Medicare.

What Determines a Plan's Start Rating?

Plans receive their overall Star Rating based on how they perform in the categories including:

- Staying healthy: screenings, tests, and vaccines
- Managing chronic (long-term) conditions
- Plan responsiveness and care
- Member complaints
- Health plan customer service

More than 70% of beneficiaries are in Medicare Advantage Plans with 4-star or higher rating.

How Do Star Ratings Impact Beneficiaries?

- Star Ratings can help inform your decision-making as you research the Medicare Advantage options available in your area.
- The Star Ratings for Medicare Advantage plans can be found in the Medicare Plan Finder tool (www.medicare.gov/find-a-plan) or by calling 1-800-MEDICARE.
- There is a Special Enrollment Period (SEP) for Medicare Advantage plans with 5-star ratings.
- From December 8, 2018 – November 30, 2019, you can switch to 5-star Medicare Advantage plan. You can only use this SEP once during this timeframe.

UNDERSTANDING MEDICARE PART B PREMIUMS

What Does The Medicare Part B Premium Cover?

Medicare Part B generally covers two types of services:

- Medically necessary services, which include services or supplies necessary to diagnose or treat your medical condition.
- Preventive services, which include services to prevent illnesses (i.e. the flu or pneumonia), or to detect illnesses at an early stage.
- Examples of services covered by Medicare Part B include: lab tests, surgeries, doctor visits, and supplies such as wheelchairs and walkers.

How Is The Medicare Part B Premium Paid?

- Most people pay a monthly, income-based premium for Medicare Part B to the Social Security Administration.
- If you receive Social Security, Railroad Retirement Board, or Office of Personnel Management benefits, your Part B premium will be automatically deducted from your benefit payment.
- If you do not receive these benefit payments, you will receive a monthly bill called a “Notice of Medicare Premium Payment Due.”
- Once you begin collecting retirement benefits from Social Security, your Part B premiums will automatically shift to Social Security deduction.
- You must pay your Part B premium every month for as long as you have Part B (even if you don’t use it). There are panelties for non-payment unless you have continous coverage elsewhere.
- If you are dually enrolled in Medicare and Medicaid, Medicaid covers the Medicare Part B premium.
- Under Medicare Advantage, you are still responsible for paying the Part B premium.
- Your Medicare Advantage plan must cover the same Part B services and supplies covered under Traditional Medicare.

What Is The 2019 Part B Premium?

- The Part B premium for 2019 is $135.50 (or higher depending on your income).
- There is a special rule for Social Security recipients called the "hold-harmless" provision, which prevents your Social Security check from decreasing one year to the next if Part B premiums increase.
- An estimated 2 million Medicare beneficiaries (about 3.5 percent) are subject to the "hold harmless" provision in 2019 and pay less than the $135.50 premium.

See the chart below to compare annual income brackets in 2019 with last year's brackets.

Tax Filing Status	Annual Income 2019	Standard 2019 Part B Premium
Single Married	Less than $85,000 Less than $170,000	$135.50/month
Single Married	$85,000 - $107,000 $170,000 - $214,000	$189.60/month
Single Married	$107,000- $133,500 $214,000- $267,000	$270.90/month
Single Married	$133,500 - $160,000 $267,000- $320,000	$352.20/month
Single Married	$160,000 - $500,000 $320,000 - $750,000	$433.40/month
Single Married	More than $500,000 More than $750,000	$460.50/month

UNDERSTANDING PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE

What is Prior Authorization?

- Prior authorization, sometimes referred to as preauthorization, is a process used to determine whether certain prescriptions, procedures, or services will be covered by your health insurance.

Why is Prior Authorization Necessary?

- There are several reasons prior authorization may be required including age, medical necessity, possible drug interactions, or availability of a generic drug alternative.

What Is The Purpose of Prior Authorization in Prescription Drugs?

- The goal of prior authorization is to provide cost savings to patients by preventing unnecessary procedures or avoiding use of expensive prescription drugs when a clinically equivalent alternative, generic or biosimilar drug is available.

How Does Prior Authorization Work Under Medicare Advantage?

- Under Medicare Advantage, some services, procedures, or prescriptions may require prior authorization.
- This means you may need your clinician to approve a referral for a test, visit, procedure or prescription drug before you go for that service.
- As of January 2019, Medicare Advantage is authorized to use a type of prior authorization for certain medications, known as ‘step therapy,’ as part of a patient-centered care coordination program.
- Under step therapy plans may require beneficiaries to first use a clinically equivalent, often lower cost alternative for treatment before use of a more expensive drug.

How Can I Find Out When Prior Authorization Is Required?

- The Medicare Plan Finder can help beneficiaries determine whether prior authorization is necessary.
- In the “Health and Drug Plan Benefits” tab, if there is a letter ‘A’ in a circle by a drug or benefit, the plan requires prior authorization.
- Beneficiaries are able to request prior authorization from their Medicare Advantage plan to find out if a service or procedure is covered beforehand. This could help reduce out-of-pocket costs.
- If you would like to learn more about prior authorization in your plan, please contact your Medicare Advantage plan.

UNDERSTANDING COST SHARING IN MEDICARE ADVANTAGE

What Is Cost Sharing?

Individuals who have health insurance, including Traditional Medicare, Medicare Advantage, or other types of coverage, generally pay for their healthcare two ways:

1. Premiums

- A premium is a fixed amount paid in advance for an insurance policy. The standard monthly premium for Medicare Part B in 2019 is $135.50.

2. Cost Sharing

- Cost sharing refers to the out-of-pocket payments that beneficiaries are required to make when they receive health care.
- Cost sharing occurs when a portion of beneficiaries' health care costs are not covered by health insurance.
- The term "cost sharing" generally includes deductibles, coinsurance, and copayments. Cost sharing does not include premiums, amounts billed for non-network providers, or the cost of non-covered services.

What Do I Need to Know About the 3 Methods of Cost-Sharing in Medicare?

Deductible	Copayment	Coinsurance
• A deductible is the amount of money that a beneficiary must pay before an insurance company will begin to pay. • The Part B deductible for 2019 is $185.	• A copayment is payment made to a provider by a beneficiary in addition to that made by an insurer. • For example, a doctor's visit may require a co-payment of $20 by the beneficiary with the rest of the cost of the doctor's visit covered by the insurance provider.	• Coinsurance is the percentage of a covered health care service beneficiaries pay after they have paid their deductible. • Under Traditional Medicare, after the deductible is met, you typically pay 20% of Medicare approved services or goods.

What Is The Out-Of-Pocket Limit?

- Medicare requires Medicare Advantage plans to have a mandatory out-of-pocket limit on all Part A and B services. This limit is imposed on an annual basis.
- In 2018, the out-of-pocket limit for Medicare Advantage plans is $6,700, but plans may choose to have a lower limit (i.e. some Medicare Advantage plans have an out-of-pocket limit of $3,400).
- Once a beneficiary reaches their out-of-pocket limit, his or her Medicare Advantage plan pays for all the covered services for the remainder of the year.

How Is Cost Sharing Structured Under Medicare Advantage?

- Medicare Advantage plans may require beneficiaries to pay copayments or coinsurance when they receive medical care.
- Each Medicare Advantage plan determines how much these charges will be.
- These out-of-pocket payments are likely to differ from the out-of-pocket charges under Traditional Medicare.
- In some instances, Medicare Advantage out-of-pocket copayment costs may be less than the comparable costs in Traditional Medicare.
- Services covered under Traditional Medicare at zero cost-sharing must also be covered under Medicare Advantage at zero cost sharing.

Example Of Cost Sharing Under Medicare Advantage:

*Disclaimer: The following is ONLY an example. Please do not expect this example to be applicable to your Medicare Advantage plan type.

Meet Robert

Robert, a Medicare Advantage beneficiary, needs to have a medical procedure that costs a total of $12,000.

Under his particular Medicare Advantage plan, he has the following deductible, coinsurance, and out-of-pocket maximum:

- Deductible: $750
- Coinsurance: 30%
- Out-of-pocket limit: $6,700

First, Robert would need to pay all of his deductible, which is $750.

Then, Robert would have to pay his coinsurance which is 30% of the remaining cost after paying his deductible.

- $12,000-$750 = $11,250
- $11,250 x 30% = $3,375 coinsurance

Therefore, Robert's total out-of-pocket cost for his $12,000 medical procedure would be $4125 (his $750 deductible plus his $3,375 coinsurance).

When Robert's total out-of-pocket spending reaches $6,700, his Medicare Advantage plan will pay for all of his covered services for the remainder of the year.