MEDICARE: A MORE IN DEPTH KNOWLEDGE

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Overview

- Medicare and Medicaid
- Medicare and the Marketplace
- Coordination of Benefits
- Understanding Medicare Enrollment Periods
- Medicare Appeals
- Programs to Assist with Medicare Costs

MEDICARE AND MEDICAID

Medicare and Medicaid

- Dual Eligible = Medicare and Medicaid
- In 2016, Over 81,000 WV Medicare beneficiaries were dual eligible (National Council on Aging, 2017)
  - Has steadily increased since 2007, slight decrease in QMB, SLMB, QI-A 2015-2016 (National Council on Aging, 2017)
- Dual Eligibles may qualify for different levels of assistance with Medicare depending on type of Medicaid
  - Help with Medicare deductibles and coinsurance/copayments – Full Medicaid and QMB
  - Help with Medicare prescription costs (level of assistance varies depending on Medicaid type) – Also known as “Extra Help”
  - Medicare Premium assistance – only SSI, QMB, SLMB, QIA

Medicare and Medicaid

- Some types of Medicaid you can have along with Medicare
  - SSI related Medicaid
  - A/D, IDD, TBI Waiver Medicaid
  - Nursing Home Medicaid
  - Medicaid Spenddown
  - QMB, SLMB, QI-A
- Other types of Medicaid you cannot have once Medicare eligible
  - Expanded Medicaid (MAGI Medicaid) – sometimes can take a few months for this Medicaid to terminate once Medicare eligible
  - Breast and Cervical Cancer Medicaid

Transitioning Medicaid to Medicare

- Medicare is primary payer and Medicaid is secondary payer if Medicaid is still in effect
- Once Medicare eligible (meaning Part A and/or Part B is in effect), Medicaid is no longer allowed by federal law to pay for prescriptions.
- Must get a Part D prescription plan to assist with prescription costs
- Issues:
  - Consumer does not know Medicare has started
  - Medicaid information not submitted to Medicare until end of each month

What new Dual Eligible Beneficiary Should Do

- If Medicare Has Not Started
  - Apply for Extra Help (a prescription assistance program through Social Security), Medicaid automatically qualifies someone for Extra Help but Medicaid status may not be updated with Medicare until the end of the first month they are eligible for Medicare
  - Enroll into a Part D plan if Extra Help is approved
  - If it is known that Medicaid will be continuing once Medicare starts, client could wait and use LINET
  - LINET - Limited Income Newly Eligible Transition Program, temporary drug plan through Humana good for 60 days, can be used by someone who has Extra Help or has both Medicare and Medicaid
    - Immediate Need LINET – can get prescription coverage the day the person needs a medication if the person has Extra Help or Medicaid

What new Dual Eligible Beneficiary Should Do

- If Medicare Has Started and beneficiary has Part D
  - If beneficiary has Extra Help, there should be no issues
  - If beneficiary does not have Extra Help, must get proof of Medicaid to fax to Part D plan to ask to update co-pay assistance
- If Medicare Has Started and does not have Part D
  - If Medicaid is still active, can use LINET program to get prescriptions.
    - If beneficiary has Extra Help, Billing information can be called directly into the pharmacy
    - If beneficiary has Medicaid but it has not been updated with Medicare, must fax proof of Medicaid to LINET and get override codes to use LINET – immediate need LINET
  - If Medicaid not active, can apply for Extra Help and if approved can use LINET until Part D set up
  - Enroll into Part D once either LINET set up, Extra Help approved, or if not eligible for either enroll into Part D so the beneficiary will have drug coverage going forward

Auto-Enrollment

- Some beneficiaries are auto-enrolled into a Part D plan
  - If Medicaid is updated with Medicare before Medicare starts (rare)
  - If the beneficiary uses LINET, beneficiary will be auto-enrolled into Part D after 2 months
- Auto-Enrolled plan randomly selected from $0 premium eligible plans in state
  - May not cover all of beneficiary's prescriptions
  - Can change plans at any time during the year to another plan that better fits the beneficiary's needs

More Information about Dual Eligibles

- QMB (Qualified Medicare Beneficiary) recipients cannot be balanced billed (billed for Medicare cost sharing) for any services they receive regardless of if the provider accepts Medicaid or if the services are within the state.
  - "Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. See **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997"** (Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2016)
- QIA (Qualified Individual) recipients (receives assistance paying Part B monthly premium) cannot receive any other type of Medicaid at the same time as receiving QIA. Weigh pros and cons on what type to have, may be more beneficial to pay Part B premium but receive other type of Medicaid and its benefits such as Nursing Home Medicaid or A/D Waiver Medicaid

MEDICARE AND THE HEALTH INSURANCE MARKETPLACE

Medicare and the Marketplace

- If you have Medicare you don't need to do anything related to the Marketplace
  - Your benefits don't change because of the Marketplace
- Medicare isn't part of the Marketplace
- Medicare Part A is considered minimum essential coverage
- The Marketplace does not offer
  - Medicare Supplement Insurance (Medigap) policies
  - Medicare Prescription Drug Plans (Part D)

If You Have Medicare

- No one can sell you a Marketplace plan
  - Even if you only have Medicare Part A or Part B
  - Except an employer through the Small Business Health Options Program (SHOP) if you're an active worker or dependent of an active worker
    - The size of the employer helps determine who pays first
    - No late enrollment penalty if you enroll anytime you have SHOP coverage, or within 8 months of losing that coverage. Doesn't include COBRA coverage

If You Have a Marketplace Plan First and Then Get Medicare Coverage

- You may keep your Marketplace coverage but you lose eligibility for any advanced premium tax credits and/or reduced cost sharing for your Marketplace plan
- If you choose to drop your Marketplace plan, wait until the month before your Medicare begins to drop Marketplace coverage to avoid a gap in coverage, must contact both the Marketplace and Qualified Health Plan
- If you keep Marketplace coverage and are Medicare eligible, Marketplace coverage will only pay secondary costs regardless of if you have Medicare Part B because Marketplace coverage is always secondary to Medicare

Terminating Medicare for Marketplace Plan

- If you're enrolled in premium Part A and Part B, or Part B only
  - You can disenroll from Medicare and choose a Marketplace plan
  - You can qualify for advanced premium tax credit (APTC) or cost sharing reduction (CSR) if you meet eligibility requirements
- If you're enrolled in Medicare premium free Part A
  - Must withdraw the application for Social Security benefits
  - Pay back all Social Security and Medicare benefits received
  - Lose Advanced Premium Tax Credit and Cost Sharing Reduction
  - May owe a penalty for Medicare Part B if you enroll at a later time

Medicare for People with Disabilities and the Marketplace

- You may qualify for Medicare based on a disability
  - You must be entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
    - On the 25th month, you're automatically enrolled in Medicare Part A and B
- If you're getting SSDI, you can get a Marketplace plan to cover you during your 24–month waiting period
  - You may qualify for Medicaid or premium tax credits and reduced cost-sharing until your Medicare coverage starts
- Blue Cross Blue Shield is one of the Marketplace carriers currently in West Virginia. They will sell a Medigap/Supplement plan to people under 65 who are transitioning from one BCBS to another (people under 65 in West Virginia are normally not able to get a Medigap policy)

Medicare and Coverage through the Small Business Health Options Program (SHOP)

- Medicare Secondary Payer rules apply
- You may delay your Part B enrollment while covered by the Marketplace through your or your spouse's current employment
- You'll have a Special Enrollment Period (SEP) to sign up for Part B
  - Any time you're still covered by a group plan through your/your spouse's current employment
  - During 8-month period after current employment/coverage ends
- If you don't sign up for Part B during the SEP
  - You may have to pay a late enrollment penalty for as long as you have Medicare
  - You can only enroll during the General Enrollment Period

MEDICARE AND OTHER HEALTH INSURANCE

Coordination of Benefits

- When there's more than one payer, coordination of benefits rules decide which pays first
- There may be primary and secondary payers, and in some cases there may also be a third payer
- Medicare may be primary payer
  - In the absence of other primary insurance
- Medicare may be secondary payer
  - You may have other insurance that must pay first
- Medicare may not pay at all
  - For services and items other health insurance is responsible for paying

When Medicare Is Primary Payer

- If Medicare is your only insurance, or
- Your other source of coverage is
  - A Medigap policy
  - Medicaid
  - Retiree benefits
  - The Indian Health Service
  - Veterans benefits
  - TRICARE
  - Consolidated Omnibus Budget Reconciliation Act continuation coverage
    - Except 30-month coordination period for people with End-Stage Renal Disease

Benefits Coordination & Recovery Center

- Identifies health benefits available to people with Medicare
- Coordinates claims to ensure claims are paid by correct payer
- Responsible for identifying
  - Medicare Secondary Payer (MSP) situations
  - Claims that should cross over to supplemental insurers
- MSP Claims Investigation
  - Contractor learns about other insurance
  - Identifies which is primary

Employer Group Health Plans

- Coverage offered by many employers and unions
  - To current employees, spouse, and family members
  - To retirees, spouse, and family members
  - Includes Federal Employee Health Benefits Plans
  - May be fee-for-service plan
  - May be managed care plan
- Employees can choose to keep or reject
- Businesses with 50 or fewer employees can offer Small Business Health Options Program (SHOP) plans

Slide from Centers for Medicare and Medicaid Services, National Training Program

Employer Group Health Plans (EGHP)

If You Are	Medicare Pays First
65 or older and have retiree coverage	Yes
65 or older with EGHP coverage through current employment (yours or your spouse's)	If the employer has less than 20 employees
Under 65 with a disability and have EGHP coverage through current employment (yours or a family member's)	If the employer has less than 100 employees
Eligible for Medicare due to End-Stage Renal Disease (ERSD) and you have EGHP coverage	When the 30-month coordination period ends, or if you had Medicare primary before you had ESRD

Employer Group Health Plans Cont'd

- Beneficiary should always check with employer and insurance to get accurate employer size if unsure whether it would be considered small employer
- For small employers who are in a multi-group plan, the largest group in the multi-group determines if considered large employer and therefore primary. Ex. PEIA

Health Savings Accounts (HSA)

- Account funds used for qualified medical expenses
- High-deductible health plan (HDHP) and tax-sheltered account Not a group health plan
- Funded by any eligible individual Eligibility based on the type of HSA
- Account can accumulate tax-deferred interest
- Used to pay current and future qualified medical expenses
- Can’t have another source of health insurance including Medicare
  - You can use funds after retirement to pay Qualified medical expenses including Medicare premiums, deductibles and cost-sharing
- You can’t use funds after retirement for Medigap (Medicare Supplement Insurance) policy premiums
- A person with Medicare may only withdraw funds
  - Can no longer contribute to the account or will have penalties 6% tax penalty on any contributions and their interest until they withdraw the amount from their account

Delaying Part B

- If EGHP is based on active employment is primary payer, beneficiary may want to delay Part B
  - Medicare doesn't pay as much as secondary payer
  - No penalty for delaying enrollment into Part B as long as have active EGHP
  - Can sign up for Part B at anytime while have insurance through active employment
  - Special Enrollment Period to get Part B within 8 months of retiring/losing active employer health insurance. Must complete 2 forms and return to SSA:
    - Application for Enrollment in Part B form – CMS-40B
    - Part B Request for Employment Information form – CMS-L564
  - Initial Enrollment Period rules supersede Special Enrollment Period rules
- If beneficiary delays Part B, also delays Medigap Open Enrollment

When Employer or Union Coverage Ends

- When your employment ends
  - You may get a chance to elect COBRA – not considered creditable coverage
  - You may get a Special Enrollment Period
    - Sign up for Part B without a penalty

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Allows certain former employees, retirees, spouses former spouses, and dependent children the right to temporary continuation of health coverage at group rates.
- Coverage is only available when coverage is lost due to certain specific events.
  - Generally for 18 months, but can be longer in special circumstances
- Person must pay the entire insurance premium.

Consolidated Omnibus Budget

If You	Medicare Pays First	Part D Plan Pays First for Medically-necessary drugs
Are 65 or older or have a disability and have **COBRA** continuation coverage	In most cases	In most cases
Have **COBRA** continuation coverage and are eligible for Medicare due to End-Stage Renal Disease	When your 30-month coordination period ends	When your 30-month coordination period ends

No-Fault Insurance

- Pays regardless of who is at fault
- Medicare is secondary payer
- Medicare may make conditional payment
  - If claim not paid within 120 days
  - Person won’t have to use own money to pay bill
  - Must be repaid when claim is resolved by the primary payer

Liability Insurance

- Protects against certain claims
  - Negligence, inappropriate action, or inaction
- Medicare is secondary payer
  - Providers must attempt to collect before billing Medicare
- Medicare may make conditional payment
  - If the liability insurer won’t pay promptly (within 120 days)
  - Medicare recovers conditional payment

Workers' Compensation

- Medicare won't pay for health care related to workers' compensation claims
- If workers' compensation claim is denied, claim may be filed for Medicare payment
- Workers' compensation claims can be resolved by settlements, judgments, or awards.

Federal Black Benefits Lung Program

- Covers lung disease/conditions caused by coal mining
- Services under this program
  - Considered workers' compensation claims
  - Not covered by Medicare
- For more information call
  - 1-800-638-7072
  - TTY 1-877-889-5627

Veterans Affairs (VA) Coverage

- If you have Medicare and VA benefits
  - Can get treatment under either program
- Medicare pays first when you choose to get your benefits from Medicare
- To receive services under VA benefits
  - You must get your health care at a VA facility or
  - Have the VA authorize services in a non-VA facility

TRICARE for Life Coverage (TFL)

- Military retiree coverage for services covered by Medicare and TFL
  - Medicare pays first/TFL pays remaining
- For services covered by TFL but not Medicare
  - TFL pays first and Medicare pays nothing
- For services received in a military hospital or other federal provider
  - TFL pays and Medicare generally pays nothing

Important Retiree Coverage Considerations

- Most retiree plans offer generous coverage for the entire family
  - Employer/union must disclose how its plan works with Medicare drug coverage
  - Talk to your benefits administrator for more information
- If you lose your creditable prescription drug coverage, you have 63 days to enroll in a Part D plan without penalty
- People who drop retiree drug coverage may
  - Lose other health coverage
  - Not be able to get it back
  - Cause family members to lose their coverage

Retiree Health Reimbursement Accounts

- Employers dropping retiree coverage
  - Offer a reimbursement account to help retiree (and spouse) pay for coverage options such as: Supplement, Advantage, Part D, Dental
  - Must Enroll Through Broker to keep funding:
    - OneExchange
    - Aon Hewitt
  - Must continue to enroll through broker for following years unless no more funding for reimbursement account
  - Guaranteed issue right for Supplement plan when employer coverage ending

PEIA Medicare Retiree benefits

- Have the option to keep PEIA as secondary when you first retire or immediately go onto Humana PEIA plan
- All PEIA Medicare retirees are switched onto Humana PEIA plan January 1st of following year
- Humana PEIA plan has different costs and network than other Humana plans available to public
- Humana PEIA plan premium depends on years of service/how long you worked for state; receive discounts on premium for tobacco free
- Open Enrollment for Medicare PEIA retirees October 1st – October 31st; plan year January 1st – December 31st
- PEIA offers Benefit and Premium assistance program to some retirees depending on years of service and income.
- Benefits are expected to change for 2017

Federal Employee Health Benefits (FEHB)

- Administered by OPM – Office of Personnel Management
- Open Enrollment November 1st – November 30th
- If still working, may not need Part B/D because FEHB coverage will be primary payer
- If you are retiring or retired, you may want to get Medicare Part B if you have a fee for service FEHB plan such as the basic or standard plan with Blue Cross Blue Shield. These FEHB plans pays secondary to Medicare and there are little out-of-pocket costs when you have both Medicare A and B and this type of FEHB plan. For more information see handout on USB – Medicare, Blue, and You
- If you have a FEHB HMO plan, you may not need Medicare Part B
- If you do not sign up for Medicare Part B when you are first eligible and not actively employed, you may have to pay a penalty for Medicare Part B. You may sign up for Part B during the General Enrollment Period January 1st – March 31st
- The FEHB's drug coverage is credible (as good as or better than Medicare Part D). You do not have to get Part D, unless you qualify for low-income assistance with drug costs.
- If you want to get a Part D plan after your initial enrollment, you can during Medicare's Open Enrollment between October 15th and December 7th with no penalty.

MEDICARE AND ESRD

Eligibility for Medicare Part A (Hospital Insurance) Based on ESRD

- Eligibility requirements
  - Any age
  - Kidneys no longer function, and
  - Must have worked the required amount of time or
  - Getting or be eligible for Social Security, Railroad Retirement, or federal retirement benefits or
    - An eligible child or
    - An eligible spouse (including through same-sex marriage)

Medicare Part B (Medical Insurance) Eligibility

- You can enroll in Part B if entitled to Part A
  - You pay the monthly Part B premium
  - You may pay a penalty if you delay taking Part B
- You need both Part A and Part B for complete coverage
- Enrollment based on ESRD may eliminate your Part B penalty if you already had Medicare due to age or disability
  - If you didn't enroll when you were first eligible
- If you have Medicare due to ESRD and reach 65
  - You have continuous coverage
  - Those not enrolled in Part B will be enrolled
  - You can decide whether or not to keep it

How to Enroll in Part A and Part B

- Enroll at your local Social Security office
- Get doctor/dialysis facility to fill out Form CMS-2728
  - If Social Security gets the form before you enroll, they may contact you to see if you want to enroll
- If you have a group health plan, you may want to delay enrolling
  - Near the end of the 30-month coordination period
  - Won't have to pay Part B premium until you need it
- Get facts before deciding to delay
  - Especially if transplant is planned

Medicare and Group Health Plan (GHP) Coverage (30-Month Coordination Period)

- If enrollment is based solely on ESRD
  - Your GHP/employer coverage is the only payer during first 3 months
- Medicare is the secondary payer during the 30-month coordination period
  - Begins when first eligible for Medicare even if not enrolled
- Separate coordination period each time enrolled based on ESRD
  - No 3-month waiting period
  - New 30-month coordination period if you have GHP coverage

Enrollment Considerations—30-Month Coordination Period

- You might want Medicare during the coordination period
  - To pay the group health plan deductible/ coinsurance
  - If you're getting a transplant soon
    - Affects coverage for immunosuppressive drugs
    - Coverage for living donor
- Delaying Part B or Part D could mean
  - Waiting for applicable enrollment period to enroll
  - Possible penalty for late enrollment

Enrollment Considerations — Immunosuppressive Drugs

If You	Your Immunosuppressive Drugs
Are entitled to Part A at time of transplant **and** ▪ Medicare paid for your transplant and the transplant took place in a Medicare-approved facility **or** ▪ Medicare was secondary payer but made no payment	Are covered by Part B ▪ Medicare pays 80% ▪ You pay 20% • Coinsurance costs don't count toward catastrophic coverage under Part D
Didn't meet the transplant conditions above	May be covered by Part D (unless you would be covered by Part B, but you haven't enrolled in Part B) ▪ Costs vary by plan ▪ Helps cover drugs needed for other conditions

When Medicare Coverage Based on ESRD Starts

Your Coverage Starts	Under the Following Circumstances
1st day of the 4th month	You get a regular course of dialysis in a facility
1st day of the month of the 1st month of dialysis	You participate in a home dialysis training program during the first 3 months of your regular course of dialysis (with expectation of completion)
1st day of the month	You get a kidney transplant
1st day of the month	You're admitted to a Medicare-approved transplant facility for a kidney transplant or procedures preliminary to a kidney transplant if transplant takes place in the same month or within the following 2 months
2 months before the month of your transplant	Your transplant is delayed more than 2 months after you're admitted to the hospital for the transplant **or** for health care services you need for the transplant

When Coverage for ESRD Ends, Continues, or Resumes

When Coverage Ends	When Coverage Continues	When Coverage Resumes
Entitlement based solely on ESRD • Coverage ends 12 months after the month you no longer require a regular course of dialysis **or** • Thirty-six months after the month of your kidney transplant	• No interruption in coverage if you start a regular course of dialysis again within 12 months after regular dialysis stopped **or** • You have a kidney transplant **or** • Regular course of dialysis starts within 36 months after transplant **or** you received another kidney transplant within 36 months after transplant	Must file new application and there's no waiting period if • You start a regular course of dialysis again or get a kidney transplant more than 12 months after you stopped getting a regular course of dialysis • You have another kidney transplant > 36 months later

MEDICARE ENROLLMENT PERIODS

Medicare Enrollment Periods

- Initial Enrollment Period (IEP)
- Special Enrollment Period (SEP)
- General Enrollment Period (GEP)
- Open Enrollment Period (OEP)

Initial Enrollment Period (IEP)

- 7 month window – 3 months before month of eligibility, Month of eligibility (month Medicare starts), 3 months after month of eligibility
- Month of eligibility is either 1st day of 65th birthday month (unless birthday is on 1st of month, then month of eligibility month before 65th birthday month) or 25th month of receiving Social Security Disability Cash benefits
- If already have Medicare due to disability, receive another IEP when turning 65
- IEP applies to enrolling into Medicare Part A and B if not auto-enrolled (meaning not drawing Social Security cash benefits); enrolling into Medicare Part D prescription coverage; and enrolling into Medicare Part C Advantage plan coverage

Initial Enrollment Period Cont'd

- If you have to actively enroll into Medicare Parts A and B during IEP, if you enroll in first 3 months prior to turning 65, Medicare starts 1st day of 65th birthday month, if enroll in birthday month or 3 months after there is a delayed start to when Part B starts. (See Next Slide)
- If enrolling into Medicare Advantage or Part D prescription coverage during 3 months prior to month of Medicare eligibility, coverage begins month of eligibility, if enroll during month of eligibility or in 3 months after coverage begins the first of the following month

If Not Automatically Enrolled
Your 7-Month Initial Enrollment Period

	No Delay			Delayed Start			
If you enroll in Part B	**3 months before the month you turn 65**	**2 months before the month you turn 65**	**1 month before the month you turn 65**	***The month you turn 65***	**1 month after you turn 65**	**2 months after you turn 65**	**3 months after you turn 65**
Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.				If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.			

Special Enrollment Period (SEP)

- Ability to apply for Medicare coverage due to special circumstances
- For Medicare Part B, SEP applies to beneficiaries who have active employer coverage while eligible for Medicare. If someone has active employer coverage through self or spouse, can sign up at any time the beneficiary has active employer coverage or within 8 months of coverage ending or switching to retiree status (Centers for Medicare and Medicaid Services, National Training Program, 2015)
- For Medicare Advantage or Part D, there are many SEP opportunities to sign up for coverage outside of IEP and OEP such as: move to a new plan service area; recently moved into, currently reside, or recently moved out of an institution (i.e. skilled nursing, long-term care); released from jail; lose Extra Help, losing coverage from employer; plan terminates contract with Medicare; continuous SEP for those receiving Extra Help or Medicaid (Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2015)

Medicare Advantage Special Enrollment Period

- January 1st – February 14th
- May choose to switch back to Original Medicare and pick up a stand-alone Medicare Part D prescription drug plan
- Cannot switch from on Advantage plan to another or switch from Medicare to Advantage plan

General Enrollment Period (GEP)

- January 1st through March 31st
- Time to enroll into Part B (and Part A if not eligible for Premium free Part A) if you did not sign up when first eligible and did not have active employer coverage
- Coverage does not start until July 1st
- Penalty 10% of Part B premium for every 12-month period eligible for Part B but not enrolled, i.e. go 2 12-month periods you will pay an additional 20% on top of base Part B premium.

Medicare and Incarceration

- Medicare does not generally cover health care costs while incarcerated
- Must still pay Part B premium while incarcerated, pay directly since not drawing Social Security while incarcerated
- If you become eligible for Medicare while incarcerated best to go ahead and enroll into coverage even though not using
- If you do not pay your Part B premium while incarcerated or enroll into Medicare when eligible while incarcerated may have to wait until General Enrollment Period to enroll, have a gap in coverage, and owe a penalty.
- If you are under 65 and receiving Social Security Disability benefits and in the middle of your 24 month waiting period for Medicare before incarceration, the time you spend in prison will not count towards the 24 month waiting period. Once your SSDI benefits restart after your release, you will resume your 24 month waiting period.

Open Enrollment Period (OEP)

- Part D Prescription Coverage and Medicare Advantage
  - October 15th – December 7th each year
  - Time to review coverage for the following year – HIGHLY RECOMMENDED
  - Plans can change every year
  - Beneficiary can enroll into a new plan for following year or enroll into a plan for the first time
- Medigap/Medicare Supplement
  - First 6 months of being 65 or older AND having Medicare Part B
  - If delay Part B enrollment, delay Medigap Open Enrollment
  - If under 65, have the same 6 month opportunity when turn 65.
  - Can enroll outside of OEP but may be subject to pre-existing condition questions unless qualify for guaranteed issue right

MEDICARE APPEAL RIGHTS

Appeal Rights in Original Medicare

- File an appeal if
  - A service or item isn't covered
    - And you think it should've been
  - Payment for a service or item is denied
    - And you think Medicare should've paid for it
  - You question the amount Medicare paid for a service

How to Appeal in Original Medicare

- "Medicare Summary Notice" will tell you
  - Why Medicare didn't pay
  - How to appeal
  - Where to file your appeal
  - How long you have to appeal
- Collect information that may help your case
- Keep a copy of everything you send to Medicare

Original Medicare Appeals Process

Initial Decision

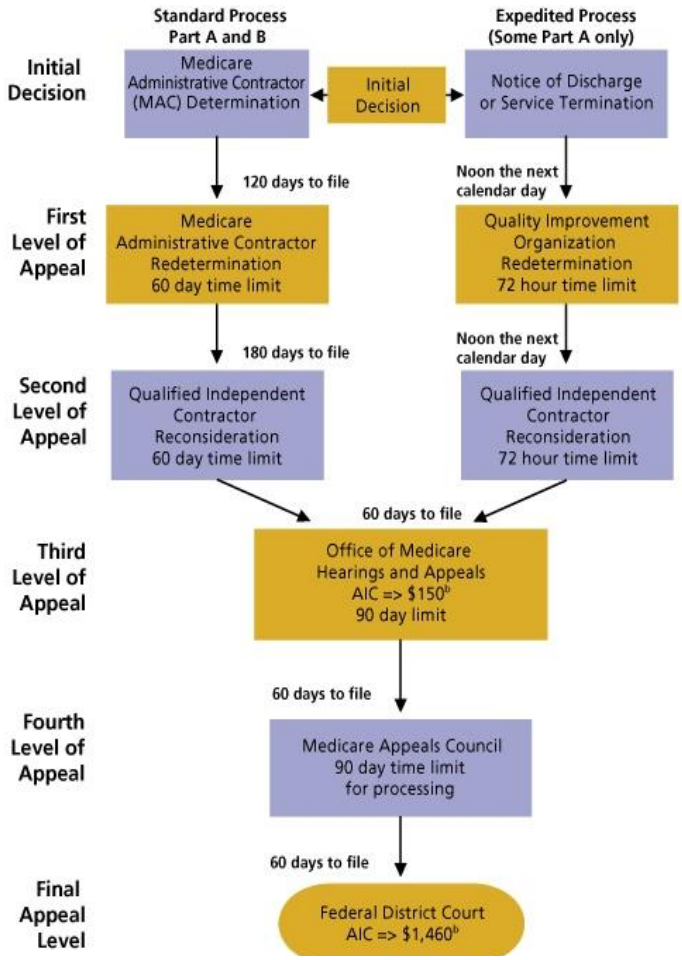
Redetermination by Medicare

Reconsideration by Qualified Independent Contractor

Hearing with Administrative Law Judge

Review by Medicare Appeals Council

Review by Federal District Court



a: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days; **b**: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.; **c**: A request for a coverage determination includes a request for a tiering exception or a formulary exception; **AIC** = Amount in Controversy; **ALJ** = Administrative Law Judge; **MA-PD** = Medicare Advantage Prescription Drug ; Medicare Administrative Contractor (MAC); **MMA** = Medicare Prescription Drug, Improvement & Modernization Act of 2003; A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, PDP = Prescription Drug Plan or the enrollee's physician; The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins ; **IRE** = Independent Review Entity ; **QIC** = Qualified Independent Contractor when the plan sponsor receives the physician's supporting statement. This chart reflects the **CY 2015 AIC** amounts.

Fast Appeals in Original Medicare

- Ask your provider for information related to your case
- Call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
  - To request a fast (expedited) appeal
  - No later than listed on the notice
- If you miss the deadline
  - You still have appeal rights
    - Contact your BFCC-QIO for late appeals
- West Virginia BFCC-QIO is KEPRO 1-844-455-8708

Coverage and Appeal Rights in Medicare Advantage Plans

You have the right to

- Know how your doctors are paid
- Get a coverage decision or coverage information
- A fair, efficient, and timely appeals process
  - Five levels of appeal
  - Decision letter sent explaining further appeal rights
  - Automatic review of Part C plan reconsideration
    - By Independent Review Entity (IRE)
- File a grievance about concerns or problems

You have the right to

- Access your case file
  - Call or write your plan
  - Plan may charge you a reasonable fee for
    - Copying
    - Mailing
- Present evidence to support your case
- Ask for an expedited appeal
  - When supported by a doctor

Medicare Part C Appeals Process

Initial Determination

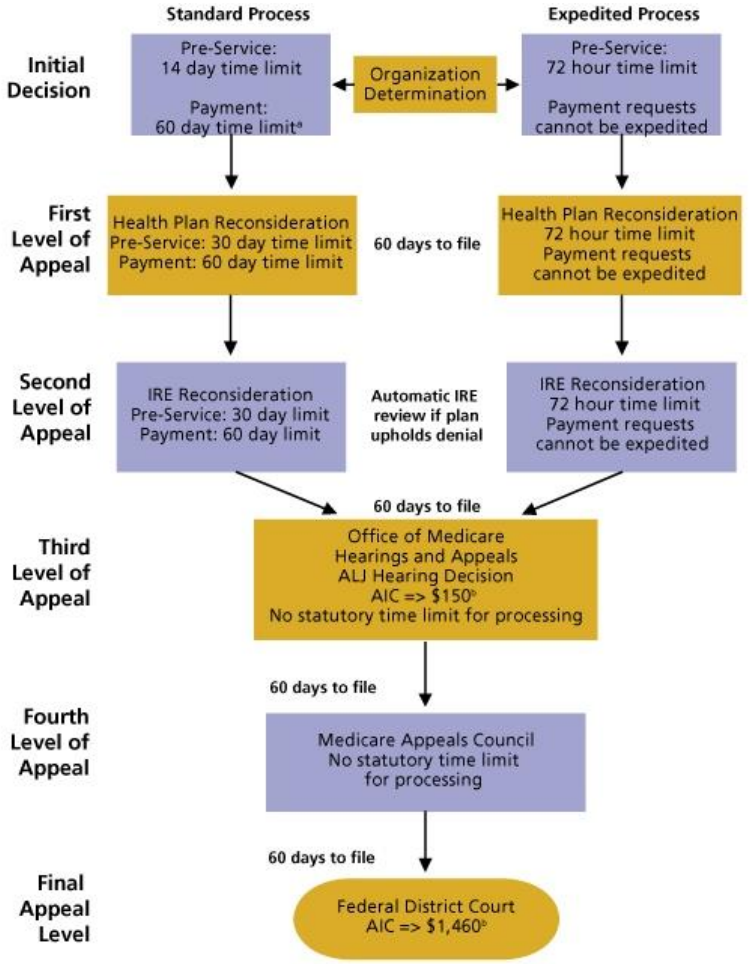
Plan Reconsideration →

Independent Review Entity (IRE) →

Administrative Law Judge (ALJ) →

Medicare Appeals Council (MAC) →

Judicial Review →



*These pre-service time frames include a possible extension of up to 14 days.

a: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days; **b**: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.; **c**: A request for a coverage determination includes a request for a tiering exception or a formulary exception; **AIC** = Amount in Controversy; **ALJ** = Administrative Law Judge; **MA-PD** = Medicare Advantage Prescription Drug ; Medicare Administrative Contractor (MAC); **MMA** = Medicare Prescription Drug, Improvement & Modernization Act of 2003; A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, PDP = Prescription Drug Plan or the enrollee's physician; The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins ; **IRE** = Independent Review Entity ; **QIC** = Qualified Independent Contractor when the plan sponsor receives the physician's supporting statement. This chart reflects the **CY 2015 AIC** amounts.

Request a Part D Coverage Determination

- A coverage determination is the initial decision made by a plan
  - Which benefits you're entitled to get
  - How much you have to pay for a benefit
- You, your prescriber, or your appointed representative can request it
- Time frames for coverage determination request
  - Standard (decision within 72 hours)
  - Expedited (decision within 24 hours)
    - If life or health may be seriously jeopardized

Request an Exception

- Two types of exceptions
  1. Tier exceptions
  2. Formulary exceptions
- Need supporting statement from prescriber
- You, your appointed representative, or prescriber can make requests
- Access to Part D drugs
  - Not included on the plan's list, or
  - On the list but with special coverage rules
    - Prior authorization
    - Quantity limits
    - Step therapy
- Plan can determine the level of cost sharing

When Plans Must Grant Formulary Exceptions

- Plan must grant a formulary exception if
  - All formulary alternatives aren't as effective and/or
  - Drug would have adverse effects
- Plan must grant an exception to a coverage rule
  - If coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or
  - It has caused, or is likely to cause, harm to enrollee

Part D—Approved Exceptions

- Exception valid for remainder of the plan year if
  - You're still enrolled
  - Prescriber continues to prescribe drug
  - Drug stays safe to treat your condition
- Plan may extend coverage into new plan year
- Plan must notify you in writing
  - If coverage not extended
  - The date coverage will end
  - The right to request a new exception

Requesting Part D Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, you must make your appeal requests in writing
  - Plans must accept verbal expedited (fast) requests
  - Limited timeframe to file an appeal request (within 60 days or later with good cause)
- An appeal can be requested by
  - You or your appointed representative
  - Your doctor or other prescriber
- There are 5 levels of appeals

Medicare Part D Levels of Appeal

Initial Decision

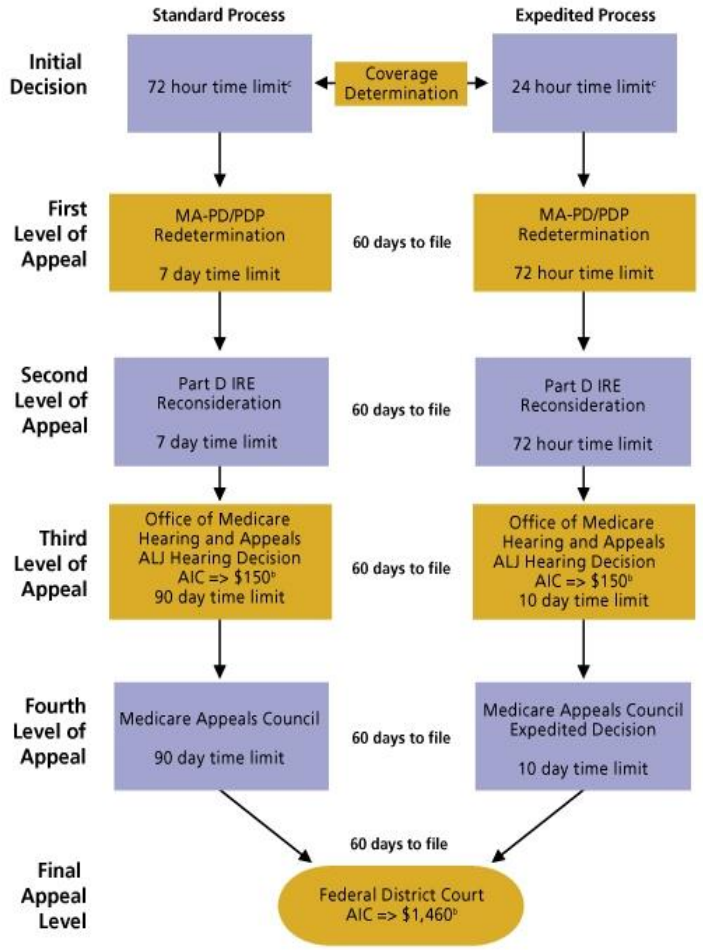
Redetermination from the Part D plan (sponsor) →

Reconsideration by an Independent Review Entity (IRE) →

Hearing before an Administrative Law Judge (ALJ) →

Review by the Medicare Appeals Council (MAC) →

Review by a federal district court →



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MEDICARE LOW-INCOME ASSISTANCE PROGRAMS

Programs to Assist with Medicare Costs

- Extra Help
- Medicare Savings Programs
- LINET

What is Extra Help?

- Help paying prescription drug costs
- Social Security program
  - Determined by either an application through Social Security or by receiving Medicaid
- Some groups automatically qualify*
  - People with Medicare and Medicaid
  - Supplemental Security Income (SSI) only
  - Medicare Savings Programs
- You or someone on your behalf can apply

- * Because Medicaid is only updated with Medicare once a month at end of month in WV, these individuals may still want to apply for Extra Help through Social Security Application

2017 Extra Help Income and Resource Limits

- Income
  - Below 150% of the Federal poverty level (FPL)
    - $1,508 per month for an individual*, or
    - $2,030 per month for a married couple*
    - Based on family size
- Resources
  - Up to $13,820 for an individual, or
  - Up to $27,600 for a married couple
    - Includes $1,500/person for funeral or burial expenses
    - Counts savings and investments
    - Does not count home you live in

*Higher amounts for Alaska and Hawaii

Redetermination Process

- People who applied and qualified for Extra Help
  - Four types of redetermination processes
    1. Initial
    2. Cyclical or recurring
    3. Subsidy-changing event (SCE)
    4. Other event (change other than SCE)

- People who qualified for Extra Help due to having Medicaid (deemed)
  - SSA reviews each year in July for the following year

2017 Extra Help Copayments

Institutionalized	$0
Receiving Home and Community-Based Services	$0
Up to or at 100% Federal Poverty Level (FPL)	$1.20/$3.70
Full Extra Help – up to 135% FPL	$3.30/$8.25
Partial Extra Help • 100% assistance on premium (if at or below benchmark) - Below 135% FPL but above $7,390/$11,090 in resources but not above maximum resource limit • 75% assistance on premium (if at or below benchmark) – Between 136% and 140% FPL • 50% assistance on premium (if at or below benchmark) – Between 141% and 145% FPL • 25% assistance on premium (if at or below benchmark) – Between 146% and 150% FPL	$82/15% (Deductible/Cost-Sharing)

Extra Help Benchmark

- The regional benchmark amount is the maximum premium subsidy that can be provided to people who get the *full* Part D low-income subsidy (LIS)/Extra Help. People who get the full subsidy *and* who are enrolled in a *standard* Part D plan with a premium at or below the benchmark amount do not have to pay a Part D premium.
- If someone enrolls in a standard plan with a premium above the benchmark, they would have to pay the portion of the premium that exceeds the benchmark.
- If someone with full-LIS enrolls in an *enhanced* plan, they must pay the portion of the plan premium attributed to the enhanced benefit, even if the total plan premium is below the benchmark amount.

- 2017 WV Benchmark $39.45

Part D Prescription Assistance

People With Medicare and…	Basis for Qualifying	Data Source	Enrollment
Full Medicaid benefits	Automatically qualify	State Medicaid agency	Automatic enrollment in Part D drug plan (unless already in a drug plan) ▪ Letter on YELLOW paper ▪ Coverage starts first month eligible for Medicare and Medicaid ▪ Continuous Special Enrollment Period (SEP) ▪ Randomly assigned to plans below benchmark
Medicare Savings Program	Automatically qualify	State Medicaid agency	Facilitated enrollment in Part D drug plan ▪ Letter on GREEN paper ▪ Coverage starts 2 months after CMS receives notice of your eligibility ▪ Continuous SEP ▪ Randomly assigned to plans below benchmark
Supplemental Security Income benefits	Automatically qualify	Social Security (SSA)	
Limited income and resources	Must apply and qualify	SSA (most) or state Medicaid agency	

What are Medicare Savings Programs?

- Help from Medicaid paying Medicare costs
  - Pay Medicare premiums
  - May pay Medicare deductibles and coinsurance
- Often higher income and resources
- Income amounts change each year
- Some states offer their own programs

2017 Medicare Savings Program Income/Resource Limits

Medicare Savings Program	Individual Monthly Income Limit*	Married Couple Monthly Income Limit*	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$1,025	$1,373	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,226	$1,644	Part B premiums only
Qualifying Individual (QI)	$1,377	$1,847	Part B premiums only

Assets* - $7,390 individual $11,090 couple; doesn't count home or first vehicle

* Income and asset limits may vary depending on state

Medicare's Limited Income Newly Eligible Transition (NET) Program

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare's Limited Income NET Program
  - Has an open formulary
  - Doesn't require prior authorization
  - Has no network pharmacy restrictions
  - Includes standard safety and abuse edits

Contact Us!

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