Open Questions from 10-2-12 Open Enrollment Webinar

Open Questions

1. Why do the Special Needs Plans have a different date to provide the EOC?

   Answer: Only Special Needs Plans (SNPs) for beneficiaries with both Medicare and Medicaid (also called Dual SNPs, or D-SNPs) may choose to send the Annual Notice of Change (ANOC) for member receipt by September 30 and the Evidence of Coverage (EOC) for member receipt by December 31. D-SNPs that choose this option must also send a summary of benefits with the ANOC. D-SNPs that send a combined ANOC/EOC for member receipt by September 30 are not required to send a summary of benefits to current members.

2. If I'm deemed disabled, under 65, Medicare eligible in Massachusetts, can I purchase a Medigap policy?

   Answer: Yes, as long as you don't have End Stage Renal Disease (ESRD). In Massachusetts, people who are under 65 and have Medicare because of ESRD are not eligible to purchase Medigap insurance until they turn 65.

3. Did you say you can change to any higher rated Medicare advantage plan at any time during the year?

   Answer: You can join a 5-Star Medicare Advantage-only plan, a 5-Star Medicare Advantage Plan with prescription drug coverage, or a 5-Star Medicare Prescription Drug Plan at any time during the year, provided you meet the plan's enrollment requirements (e.g., living within the service area, meeting requirements regarding end-stage renal disease, etc). You may use this Special Enrollment Period once per year, from December 8 – November 30.

4. What is the monthly Medicare B premium for 2013?

   Answer: The 2013 Medicare Part B premium has not yet been announced.

5. Are there any restrictions on the Part D plans after you have signed up for the year? Can they modify the formulary to eliminate the drug you are taking?

   Answer: Part D plans may only make specific types of changes to their formularies during the middle of a plan year. All changes must be reviewed and approved by CMS.

   Except when the Food and Drug Administration deems a Part D drug unsafe or a manufacturer removes a Part D drug from the market, a Part D plan may not remove a covered Part D drug from its formulary, or make any change in preferred or tiered cost-sharing status of a covered Part D drug, between the beginning of the Open Enrollment Period and 60 days after the beginning of the plan year.

Both industry best practices and the best interests of Medicare beneficiaries call for limited formulary changes during the contract year. CMS believes that formulary stability is extremely important so that enrollees maintain access to the benefit they chose during enrollment as represented to them by the Part D plan. However, prescription drug therapies are constantly evolving, and new drug availability, medical knowledge, and opportunities for improving safety and quality in prescription drug use at a low cost will inevitably occur over the course of the year. These new developments may require formulary changes during the year in order to provide high-quality, low-cost prescription drug coverage. The following is CMS‟ policy regarding formulary changes:

- Part D plans may expand formularies by adding drugs to their formularies, reducing copayments or coinsurance by placing a drug on a lower cost-sharing tier, or deleting utilization management requirements at any time during the year.

- Formulary Maintenance Changes: After March 1, Part D plans may make maintenance changes to their formulary, such as replacing brand name with new generic drugs or modifying formularies as a result of new information on drug safety or effectiveness.

- Non-maintenance (Other) Formulary Changes: Part D plans may only remove Part D drugs from their formulary, move covered Part D drugs to a less preferred tier status, or add utilization management requirements. For these additional types of formulary changes approved by CMS, Part D sponsors should make such formulary changes only if enrollees currently taking the affected drug are exempt from the formulary change for the remainder of the contract year.

6. Do HMO's cover hospice? As compared to Original Medicare?

   Answer: Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care and some care in qualifying clinical research studies. Original Medicare covers hospice care and some costs for clinical research studies even if you're in a Medicare Advantage Plan.

7. How is one assured that their provider is actually in their plan? Last year I called plan, called providers. Both said yes, orthopedist & internist were part of Humana Advantage Plan. After 1st of year, however, it turned out that neither were. How can this be prevented?

   Answer: A Medicare Advantage Plans (like an HMO or PPO) can make changes to their network of contracted providers at any time during the year. CMS has important safeguards in place to ensure that Medicare beneficiaries are protected from medical care interruptions. For instance, CMS requires plans to maintain continuity of care for impacted enrollees by ensuring continuous access to medically necessary services, without interruption, should a Medicare beneficiary's medical condition require it. Additionally, when an MA Plans makes a change in its provider network, it must provide written notification to beneficiaries who are seen on a regular basis by the provider whose contract is terminating. This notice must be given at least 30 days in advance of the termination date. In this notice, the MA plan must also provide beneficiaries with a list of alternative providers and allow beneficiaries to choose another provider

8. How do MA plans compare to Original Medicare in coverage of drugs covered under part B?

   Answer: Drugs that are covered under Medicare Part B are governed by the Original Medicare regulations and local coverage decisions, even if someone is enrolled in a Medicare Advantage plan. However, cost-sharing may be different for Part B-covered drugs in a Medicare Advantage Plan than under Original Medicare. If an MA enrollee wishes to receive a "not usually self-administered" drug in a physician's office, then the MA Plan must cover the drug and the service of administering the drug. MA Plans may not determine whether it was reasonable and necessary for the patient to choose to have his or her drug administered incident to physician services. MA Plans can continue to make determinations concerning the appropriateness of a drug to treat a patient's condition and the appropriateness of the intravenous or injection form, as opposed to the oral form of the drug.

9. Can an enrollee change plans midyear?

   Answer: You can make midyear changes to your Medicare Advantage and Medicare prescription drug coverage when certain events happen in your life, such as if you move or you lose other insurance coverage. These chances to make changes are called Special Enrollment Periods (SEPs). Rules about when you can make changes and the type of changes you can make are different for each SEP. These chances to make changes are in addition to the regular enrollment periods that happen each year.

10. What is the difference between Medicare Advantage and Medigap?

    Answer: Medicare Advantage and Medigap are two different ways you can get your health care coverage. If you choose to stay in Original Medicare, you have the option to purchase a private Medigap policy to help pay for some of the costs that Original Medicare doesn't cover like copayments, coinsurance, and deductibles. A Medicare Advantage Plan (like an HMO or PPO) is another Medicare health plan choice you have as part of Medicare. You would get all of your Medicare Part A and Part B (and sometimes Part D) coverage from the Medicare Advantage Plan, instead of Original Medicare. If you join a Medicare Advantage Plan, you can't use or be sold a Medigap (Medicare Supplement Insurance) policy.

11. Are Medigap plans available in Utah? I can't find a policy for people under 65.

    Answer: Yes, Medigap plans are available in Utah. According to the Utah Insurance Department, the following companies sell Medigap policies to people under age 65: Bankers Fidelity Life Insurance Company, Sterling Life Insurance Company, and United American Insurance Company. (Source: http://insurance.utah.gov/seniors/medsupco.html)

12. Is there an SEP for members if there plan changes name or merges with another?

    Answer: No, there is not a Special Enrollment Period if a plan changes name or merges with another plan.