



Getting Medicare right

The Medicare Counselor

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In this issue...

In these three pages you will find a frequently asked question from our consumer helpline, information on Enhanced Part D plans, and a Medigap pop quiz.

Hot Topic from the Helpline

I have Original Medicare and recently received a Medicare Summary Notice in the mail. What is a Medicare Summary Notice and how do I go about understanding it?

-Helpline Caller

If you have Original Medicare, the traditional Medicare program directly administered by the federal government, Medicare will typically mail you a Medicare Summary Notice every three months (i.e. four times a year). A Medicare Summary Notice (MSN) is a summary of health care services and items you recently received from doctors, hospitals or other health care providers. MSNs list the following:

- The health care service you received;
- Medicare’s decision on whether the service you received is covered;
- The amount your provider charged Medicare for the health care service you received;
- The amount Medicare paid your provider for that service; and
- The amount you may directly owe to your provider.

Beginning in January 2013, the Centers for Medicare and Medicaid Services (CMS) redesigned the look of MSNs to make Medicare information clearer and easier for Medicare beneficiaries and caregivers to understand. The revised MSN includes simpler language and defines terms mentioned on the MSN in an effort to render the notice more easily and widely understood amongst beneficiaries and caregivers. Several new features of the revised MSN include:

- An update on your Medicare deductible status;
- A list of health care providers you saw;

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Medicare Resources

- **Medicare Interactive:**
<http://www.medicareinteractive.org/>
- **Medicare Rights Center:**
<http://www.medicarerights.org/>
- **Medicare:**
<http://www.medicare.gov>
- **Health Care Reform and Medicare:**
<http://www.medicarerights.org/issues-actions/health-reform-and-medicare.php>

- Whether Medicare approved your claims;
- Information on how to read the MSN notice;
- Information on how to report fraud; and
- Information on Medicare preventive services.

Remember, the MSN is not a bill, even though it may look like one. Instead, it gives you information on the charges made by your provider and the payments made by Medicare. Whenever you receive a health care service, your provider submits a bill to Medicare for the service you received. Medicare then pays the provider a set amount for that service, called the approved amount. After Medicare pays the approved amount to your provider, you may be responsible for a portion of the total health care service cost. The amount you are responsible for is generally called the coinsurance or copayment.

If you owe a coinsurance or copayment, you will generally receive a bill from the doctor or health care provider that provided you with the health care service or item. If you agree with the charges listed on your MSN, you can submit payment to the doctor, hospital or health care provider that provided you with the service. If you already paid your provider, make sure you paid the right amount for that service. This is the amount listed under the “Maximum You May Be Billed” column on your MSN. If you have any questions on the amount you owe to your doctor or health care provider, contact them, directly.

If Medicare refuses to pay for a health care service you received, you can ask Medicare to reconsider this decision by filing an appeal. You will know whether Medicare denied coverage of a service you received, if you see a “No” under the “Service Approved” column on your MSN. If you have Original Medicare and you need help understanding your MSN, you can call 800-MEDICARE for assistance. You can also download a sample of the revised MSN from www.medicare.gov.

If you have a Medicare Advantage plan, you will not receive an MSN. Instead, you will generally receive the plan’s version of the MSN, called an Explanation of Benefits (EOB). Like the MSN, the EOB is not a bill and just gives you information on the charges and payments related to the health care service you received. Your Medicare Advantage plan will typically mail you an EOB, after you receive a health care service. Some plans give you the option of accessing your EOB online, using secure account information. If you are interested in accessing your EOB online, either go to your plan’s website or call your plan using the number on the back of your insurance card to learn how to set up your account online. Keep in mind that Medicare prescription drug

plans (Part D) may also send EOBs that summarize prescription drug costs to plan members.

Remember, each Medicare Advantage plan is different. If you have any questions about how to read your EOB, contact your plan, directly. You can do so by calling the number on the back of your Medicare Advantage card.

Understanding Enhanced Medicare Part D Plans

Many Medicare beneficiaries find that enhanced Prescription Drug Plans (PDPs) help them fill the gaps in the Medicare drug benefit. Enhanced drug plans may charge higher monthly premiums than basic plans, but typically offer a wider range of benefits. A basic plan is limited in the benefits it can offer, but also limited in how much it can charge. It may be difficult to tell if a plan is an enhanced or basic because plans are not mandated to indicate special or extra features in their plan name.

Often, enhanced Part D plans do not charge a plan deductible. A deductible is the amount a person must pay for health care expenses before their health insurance begins to pay. Enhanced plans may compensate for not having deductibles by shifting cost sharing to plan copayments and monthly premiums. This means enhanced plans may offer a lower deductible in conjunction with higher cost sharing.

Enhanced PDPs may charge enrollees higher cost-sharing amounts for their prescriptions than basic plans. This means plans will likely charge more than the standard 25 percent coinsurance. These higher coinsurances and copayments are usually charged on non-preferred brand name and other higher-tiered drugs.

Enhanced plans may protect people from falling into the coverage gap or doughnut hole. The doughnut hole is a gap in Part D coverage. It begins when total drug costs—including what you and your plan have paid for drugs since the start of the year—reaches \$2,970. During this coverage gap, drug costs increase. People in enhanced plans may not experience these doughnut hole cost increases. Enhanced plan doughnut hole coverage usually only extends to generic drugs. A plan offering doughnut hole coverage tends to have higher premiums. Enhanced plans are allowed to offer some doughnut hole coverage (though they are not required to). However, basic plans are never allowed to offer doughnut hole coverage.

In addition, enhanced plans may have a broader list of covered drugs (formulary). Some of these plans may also cover drugs that are excluded from

Medicare drug coverage by law. Benefits vary widely by plan, so not all enhanced plans will offer formularies that are more extensive. Keep in mind that all Part D plans are required to meet minimum formulary requirements and must cover effectively all types of certain drugs, such as anti-cancer medications and immunosuppressant drugs.

Enhanced plans typically charge premiums higher than the state benchmark, but not always. A state benchmark is the amount of money that Full Extra Help will pay towards the monthly premium of a Part D plan that offers basic benefits. Different states have different benchmark amounts. According to the [Kaiser Family Foundation](#) “In 2010, average unweighted monthly premiums are 50 percent higher for enhanced PDPs than basic PDPs ...and more than half (52 percent) of all enhanced plans have monthly premiums in excess of \$50, compared to only nine percent of basic plans.”

Enhanced Part D plans may come up in the cases of Extra Help beneficiaries. This is because Extra Help will pay up to the state benchmark amount for basic Part D plans only. In the case of enhanced PDPs, Extra Help will only pay for the basic coverage portion of the plan, meaning the beneficiary may be responsible for more than half of the monthly plan premium.

Because enhanced plans are more expensive and not totally covered by Extra Help, almost all beneficiaries enrolled in Extra Help have basic plans. No one with Extra Help will ever be automatically enrolled into an enhanced PDP, even if the plan does fall below the state benchmark.

Oftentimes, people with Extra Help who are members of enhanced PDPs are confused about why they are paying a large portion of a Part D monthly premium, even if the plan is close to, or even below the state benchmark. The reason for this is Extra Help will only pay for the basic portion of the plan, leaving the remaining enhanced features to be paid by the beneficiary. If a beneficiary is having a hard time paying for an enhanced plan, they have a couple of options. 1) If applicable, they can enroll into the State Pharmaceutical Assistance Program (SPAP), which, in many cases, will pay for the Enhanced version of a PDP. 2) They can use their Extra Help once-monthly Special Enrollment Period (SEP) to enroll into a new basic plan that falls below the state benchmark.

Medigap Pop Quiz

Answers upside down at the bottom of the page.

1. What is a guaranteed issue right?
 - A. A consumer protection that gives you the right to buy Medigap supplemental insurance, without health underwriting and without a waiting period, after you lose certain kinds of health coverage.
 - B. A guaranteed right that allows you to see any doctor within the plan's network.
 - C. A guaranteed right that allows you to see any doctor, as long as the provider accepts Medicare.
 - D. A consumer protection that gives you the right to appeal a denial for a health care service you received.
2. True or False? Mr. J has is planning on moving to another state. If Mr. J moves, he can take his Medigap policy with him and use it in his new state of residence.
3. Mrs. P has decided to buy Medigap Plan C to help cover some of her costs. She has found two companies in her area that offer this plan. One costs \$150 a month and the other costs \$185 a month. If she is mainly concerned about costs, should she buy the cheaper one?
 - A. Yes, the cheaper one offers the same benefits as the more expensive one.
 - B. No, the cheaper one does not offer as many benefits.
 - C. Maybe. Both plans might have different benefits that may affect her health care.
 - D. Maybe. The difference in cost is generally a fair indicator that the plan offers different benefits.

3 A
2 True
1 A