

The Medicare Counselor

March 2017 Quarterly Issue

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Medicare Resources

- Medicare Interactive
www.medicareinteractive.org
- Medicare Rights Center:
www.medicarerights.org
- Medicare:
www.medicare.gov

Hot Topic from the Helpline

I recently signed up for Part D and received notification that I have a late enrollment penalty, increasing my monthly premium significantly. I am worried about paying this premium in addition to the copayments for my medications. Is there any way to get rid of the late enrollment penalty?

-Helpline caller

Medicare’s prescription drug benefit (Part D) is the part of Medicare that provides outpatient drug coverage. Part D is provided only through private insurance companies that have contracts with the federal government—it is never provided directly by the government (unlike Original Medicare).

If a Medicare-eligible individual went without Part D or creditable drug coverage for more than 63 days, they may face a Part D late enrollment penalty (LEP). The purpose of the LEP is to encourage Medicare beneficiaries to maintain adequate drug coverage. The penalty is 1% of the national base beneficiary premium (\$35.63 in 2017) for every month the individual did not have Part D or certain other types of drug coverage while eligible for Part D. This amount is added to their monthly Part D premium.

Most people have to pay the LEP as long as they are enrolled in the Medicare prescription drug benefit. There are some exceptions:

- The penalty is permanently erased for

- beneficiaries who receive Extra Help
- The LEP ends when a beneficiary under 65 with Medicare turns 65
- State pharmaceutical assistance programs (SPAPs) may pay the penalty

If a person feels that they were wrongly assessed a LEP, they have the right to file an appeal with MAXIMUS. MAXIMUS is the company contracted by Medicare to handle these appeals. Beneficiaries can appeal the penalty (if they were continuously covered) or its amount (if they think it was calculated incorrectly). They should complete the appeal form they received from their plan, attach any evidence, and mail everything to the address indicated by the plan.

The appeal deadline is 60 days from the date the beneficiary received the letter informing them about the penalty. If they miss this deadline, they can write a letter explaining why they had good cause, or a good reason—like serious illness—that prevented them from appealing on time. Beneficiaries should attach this letter to their appeal. Once the appeal is submitted, they can expect a determination from MAXIMUS within 90 days. In the meantime, a person should pay the LEP to the plan along with the premium. If the appeal is successful, the plan is required to pay back LEP payments made while the appeal was pending.

Medicare Summary Notice

The Medicare Summary Notice (MSN) is a summary of health care services and items a beneficiary has received during the previous three months. The MSN is not a bill. The contractor that processes claims for Medicare will send the MSN, so it may have the name and address of a private company on it.

MSNs are usually mailed four times a year and contain information about submitted charges, the amount that Medicare paid, and the amount the beneficiary is responsible for. Some beneficiaries may receive additional MSNs if they receive reimbursement for a bill they paid.

Beneficiaries who have not received health care services during a particular quarter will not receive an MSN. If someone did receive services but not their MSN, they could call them to call 1-800-MEDICARE or access their MSN online at www.mymedicare.gov. Beneficiaries can also access their MSN online or request a paper copy if they lose or misplace the original document.

In addition to the health care services received, the MSN lists:

- The amount providers billed Medicare for those services
- The amount Medicare paid providers for each service
- The amount the beneficiary may need to pay directly to providers (indicated in the “You May Be Billed” field)
- Any non-covered charges. This field shows the portion of charges for services that are denied or excluded (never covered) by Medicare. A \$0.00 in this field means that there were no denied or excluded services.

In many instances, Medicare forwards the MSN to the beneficiary’s secondary insurance, which may help with some or all of the remaining costs.

Beneficiaries should try and save their MSNs. They might need them in the future to prove that payment was made if a provider’s billing department makes a mistake or if they claimed a medical deduction on their taxes.

Dear Emily

Dear Emily,

I'm helping a person who is actively working and planning to enroll in Medicare this year. My client is interested in joining a Medicare Advantage Plan and I want to be sure I can help them enroll without issues. I've heard about the ICEP, but can you explain how it works?

Thanks,
Alex

The Initial Coverage Election Period (ICEP) is the period when people who are new to Medicare have the opportunity to enroll in a Medicare Advantage (MA) Plan if they choose to do so. MA Plans (sometimes known as "Part C" of Medicare) are private plans that contract with the federal government to provide Medicare benefits. To understand the ICEP, it is helpful to first understand the Initial Enrollment Period (IEP).

People who are new to Medicare get an IEP to enroll in Medicare. Their IEP is a seven-month window beginning three months before the month of entitlement to Medicare (if the person is eligible for Medicare due to age, then this is their 65th birthday month) and ending three months after the month of entitlement to Medicare. The timing of the ICEP is similar to that of the IEP. It's the first chance to enroll in an MA Plan for people who are new to Medicare. If they choose to enroll in an MA Plan, it generally takes effect the first of the month following the enrollment decision. However, it cannot take effect before the person has both Medicare Parts A & B.

For example, if your client turned 65 on March 15, 2017, their IEP & ICEP began December 1 (3 months before their 65th birthday) and ends July 31 (3 months after their 65th birthday month). If your client is interested in joining an MA Plan and enrolled in Parts A & B effective March 1, they can have their MA plan begin March 1 if they enroll in an MA Plan during the three months leading up to their 65th birthday. If they enroll in an MA

Plan between March 1 and July 31, it will begin the first of the month following their enrollment decision.

The ICEP works similarly for people who did not enroll in Medicare Part B during their IEP because they were enrolled in an employer plan and currently working. Once they retire or lose employer health coverage, they get an 8-month Special Enrollment Period (SEP) to enroll in Part B. Unlike during a person's IEP, the ICEP for someone using the Part B SEP ends the last day of the month before the person enrolls in both Parts A and B. In other words, they wouldn't be able to enroll in a MA plan once their Medicare Part B is effective. The following example illustrates one such scenario.

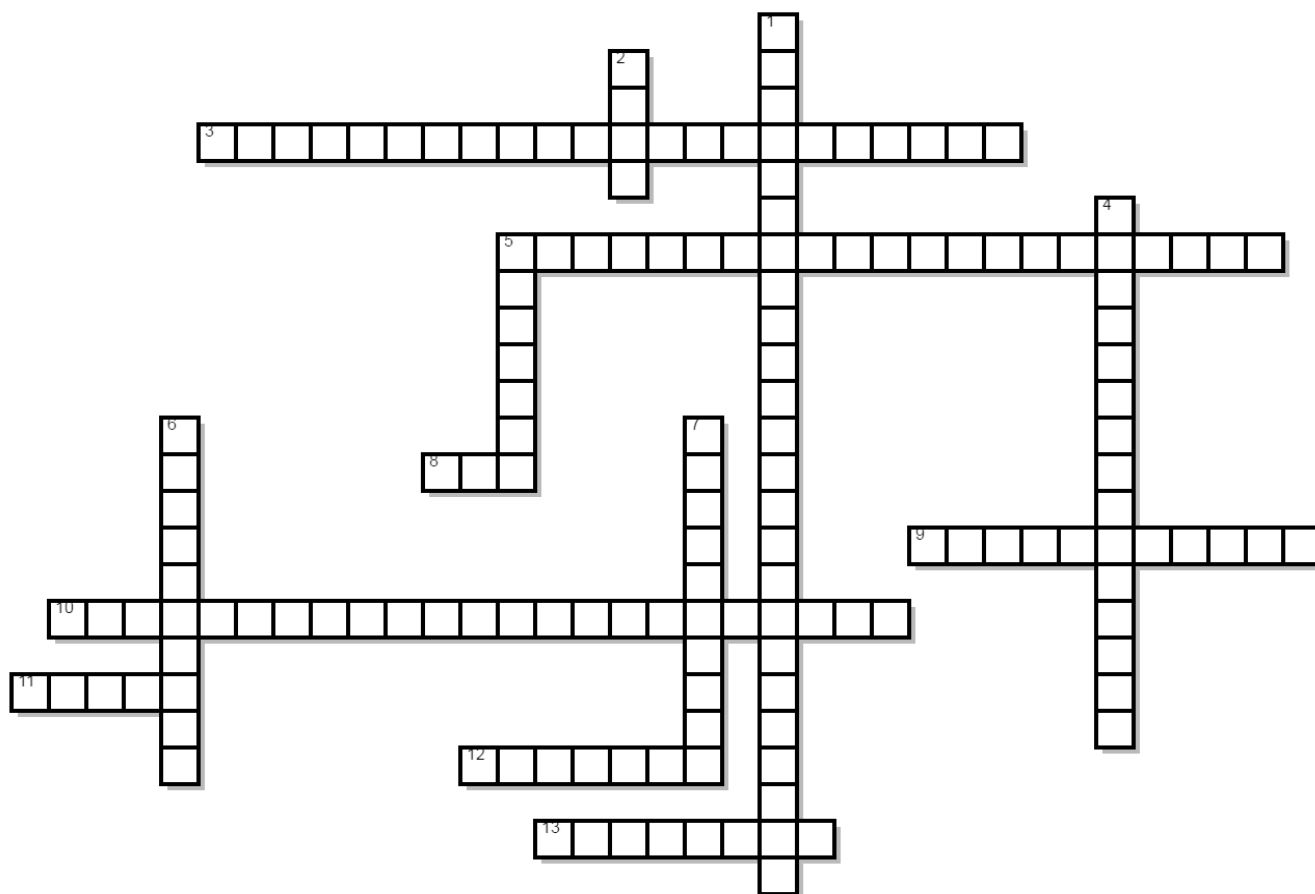
Mr. Williams turned 65 on April 1, 2015. He delayed enrollment into Part B because he planned to keep working for another year and had insurance through his employer. He planned his retirement for the end of April 2016 and used the Part B SEP to enroll in Part B effective May 1, 2016. Mr. William's ICEP to enroll in an MA Plan began February 1, 2016 (3 months before he enrolled in Part B) and ended April 30, 2016 (the last day of the month before he has both Parts A and B).

Beneficiaries who missed their IEP and do not have an SEP must enroll during the General Enrollment Period (GEP). This means their Medicare Parts A and/or B are effective July 1 of the year they use the GEP to enroll. For these individuals, the ICEP is April 1 through June 30.

Thanks again for your question. If you have additional questions, feel free to reach out to the HIICAP helpline (hiicap@medicarerights.org / 800-480-2060).

Best,
Emily

Medicare Crossword Puzzle



ACROSS

- 3 Facility where beneficiaries can receive skilled post-hospital care
- 5 Medicare private health plan
- 8 Also known as Lou Gehrig's Disease
- 9 Beneficiaries need 40 of these to qualify for premium-free Part A
- 10 Seven months to enroll in Medicare for the first time
- 11 Part of Medicare that handles outpatient care
- 12 Supplemental insurance for Original Medicare
- 13 Drugs that cost less than their brand-name counterparts

DOWN

- 1 Also known as a waiver of liability
- 2 SPAP for New York State
- 4 In Original Medicare appeals, the second level where your appeal is reviewed by a Qualified Independent Contractor (QIC)
- 5 Company contracted my Medicare to handle LEP appeals
- 6 The amount you must pay for health care before your insurance begins to pay
- 7 Limit on the amount of physical therapy, occupational therapy, and speech therapy Medicare covers for the year

(1) Advance Beneficiary Notice; (2) EPLC; (3) Skilled nursing facility; (4) Reconsideration; (5) Medicare Advantage Plan; (6) Deductible; (7) Therapy Cap; (8) ALS; (9) Work credits; (10) Initial Enrollment Period; (11) Part B; (12) Medigap; (13) Generics