Medicare Minute Teaching Materials – October 2014
Fall Open Enrollment

1. What is Fall Open Enrollment?

Fall Open Enrollment occurs each year from October 15 to December 7. During this time, you can make changes to your health insurance coverage, including adding, dropping, or changing your Medicare coverage. This is the time to review your current health and drug coverage and compare it with other options in your area to make sure you have coverage that is best for you. You can make as many changes as you need to your Medicare coverage during Fall Open Enrollment. Keep in mind that the last change you make will take effect on January 1, 2015. To avoid enrollment problems, it is best to call 800-Medicare when making any changes to your health and/or drug coverage.

Even if you don't plan on changing your coverage during Fall Open Enrollment, you should review your current coverage. Plans may change their coverage and costs each year. Find out whether your plan costs and benefits will change in 2015 and make changes to your coverage accordingly.

2. How will I know if there will be any changes made to my health or drug coverage?

Every fall, you should receive documents explaining how your health and/or drug coverage will change for the coming year. Before switching your current coverage assess your current needs and any upcoming changes. There may be more appropriate health and drug coverage options out there for you. For example, a plan that offers the same coverage you already have may be less expensive, or there may be a plan that covers a drug that your plan doesn't currently offer. Once you know how your current coverage is changing in the coming year, you can make smart choices about whether to stay with your current coverage or switch.

If you have **Original Medicare**, you should receive the *Medicare & You* handbook, which includes a summary of Original Medicare benefits and lists available health and drug plans. Anyone with Medicare should receive the following year's *Medicare & You* handbook in the mail in mid- to late September. You may also download the handbook online at www.medicare.gov. If you do not receive the *Medicare & You* handbook, you can call 800-Medicare and request a copy to be mailed to you.

If you have a **Medicare Advantage plan**, you should, in addition to the *Medicare & You* handbook, receive a notice in the mail called an Annual Notice of Change (ANOC) or Evidence of Coverage (EOC). Plans are required to send these notices to plan members by September 30. The ANOC lists any health and/or drug coverage changes that will take effect through your Medicare Advantage plan in 2015, including any changes made to your plan's formulary (list of

covered drugs). The EOC lists your plan benefits in 2015. If you don't receive both of these notices, call your plan and request them.

If you have Original Medicare and a **Part D plan** (prescription drug plan), your Part D plan must send you an ANOC explaining how your plan's costs and coverage will change in 2015. The plan should also send you a list of drugs it will cover in 2015 (formulary). Since Part D plans are only required to send you a shortened formulary, your drugs may not be listed; if this is the case, you should call your plan to ask if there are any changes to your specific coverage or copay amounts. If your doctor had to make a special request so that your plan would cover a drug you take for the current year (such as a prior authorization or exception request), call your plan to find out how to ensure that your plan continues to cover your drug in the coming year. Your doctor may have to make a new request, and he or she may be able to do so before the end of this year so that your drug will still be covered in 2015. Finally, find out if your plan is adding new coverage restrictions for the medications you take. Coverage restrictions include:

- Prior Authorization: A requirement for you to receive prior approval from the plan before it will cover your drug.
- Step Therapy: A requirement for you to try other drugs that treat your condition before the plan will cover more expensive drugs.
- Quantity Limits: A restriction limiting drug coverage to a specific amount of drugs over a certain period of time.

3. What is a Medigap plan?

A Medigap plan is supplemental coverage designed to fill gaps in Original Medicare. Remember, you can only have a Medigap if you have Original Medicare, not if you have a Medicare Advantage plan. Medigaps help pay your Part A and Part B deductibles and coinsurances. If you don't have any other supplemental coverage, such as retiree insurance, you might want to consider buying a Medigap.

Under federal law, you only have the right to buy a Medigap policy at certain times, though your state may have more generous rules. Keep in mind that you may not be able to buy a Medigap during Fall Open Enrollment, depending on your circumstances and the state you live in. Additionally, federal law only requires that Medigaps be sold to people 65 and older, although some states extend that right to people who are under 65. For specific Medigap rules and protections in your state, contact your State Health Insurance Information and Assistance Program (SHIP) or Department of Insurance. You can find your SHIP's phone number by going online to www.shiptalk.org.

4. What are the main differences between Original Medicare and Medicare Advantage plans?

There are two different ways to receive your Medicare health benefits:

- **Original Medicare** is the traditional fee-for-service Medicare coverage you get through the federal government. Original Medicare consists of Parts A (hospital insurance) and Part B (medical insurance). Most people who have Original Medicare need to sign up for a stand-alone Part D plan. Listed below are some important things to know about Original Medicare:
    - Lets you see any doctor in the country who accepts Medicare

    - Doesn't require you to get a referral before seeing other doctors or specialists
    - Pays 80% of the cost of most medical services and you must pay the remaining 20% coinsurance
        - If you purchase a Medigap supplemental plan, it will help with some or all of your remaining costs after Medicare pays, depending on the specific plan
    - Doesn't cover certain services such as routine vision, dental, and hearing care
- **Medicare Advantage plans** offer Medicare benefits and are sold by private insurance companies. Most Medicare Advantage plans include health and drug coverage. These plans must offer at least the same benefits as Original Medicare, but each plan has different costs and restrictions. Listed below are some important things to know about Medicare Advantage plans:
    - You typically pay the least if you go to a health care provider that is in the plan's network
    - May require you to get a referral from your primary care doctor before seeing other doctors or specialists
    - Coinsurance/copay amounts vary, depending on the plan
    - Rules and coverage restrictions vary, depending on the plan
    - May cover health care services that Original Medicare does not cover, such as limited dental or vision coverage
    - Must have a maximum limit on out-of-pocket costs (after you spend a certain amount, your care will be free or very low-cost)

Keep in mind that you cannot have both Original Medicare and a Medicare Advantage plan. Additionally, you cannot have a Medigap if you have a Medicare Advantage plan.

5. What are some things I should consider when making changes to my health and drug coverage?

After you've carefully reviewed your current health and drug coverage and any upcoming changes, think about your health care needs. Ask yourself a few questions:

- What are my current health and drug costs?
- How often do I see my doctors and/or specialists?
- What types of insurances do my doctors accept?
- What health care services do I need?
- What are the prescription drugs I take?
- Do I travel often?
- Which pharmacies do I regularly go to for my medications?

Use these questions to help you decide the type of coverage that will best suit your health care needs. Remember, you may receive your Medicare coverage through Original Medicare or a Medicare Advantage plan.

6. What are some things I should consider when choosing a Medicare Advantage plan?

Ask yourself the following questions before choosing a Medicare Advantage plan:

- How much are the premium, deductible, and copay amounts?

- What is the annual maximum out-of-pocket cost for the plan? This amount may be high, but can help protect you if you have expensive health care costs.
- What service area does the plan cover?
- Are my doctors in the plan's network?
- What are the rules I have to follow to access health care services and drugs?
- Does the plan cover additional health care benefits?
- How will this plan affect any additional coverage I may have?
- What is the plan's star rating? (See question 8)

Remember, when choosing a Medicare Advantage plan, you are also choosing the drug component of the plan. You should also ask yourself the questions listed in question 7 when considering the drug portion of the plan's coverage.

7. What are some things I should consider when choosing a prescription drug plan?

Ask yourself the following questions before choosing a Part D drug plan:

- Does the plan cover all the medications I'm taking?
- Does the plan have restrictions on my drugs (i.e. prior authorization, step therapy, or quantity limits—see question 2)?
- How much will I pay at the pharmacy (copay/coinsurance) for each drug I take?
- How much will I pay for monthly premiums and the annual deductible?
- Is my pharmacy in the plan's preferred network? You pay the least if you used preferred network pharmacies.
- Can I fill my prescriptions by mail order?
- Will the Medicare drug plan work with the drug coverage I get through my retiree plan?
- What is this plan's star rating? (See question 8)

You may also find it helpful to use Medicare's Plan Finder tool, which can give you a comprehensive list of Medicare Advantage and Part D plans, the drugs they cover, and their costs. You can access Plan Finder by calling 800-Medicare or going online at www.medicare.gov.

8. What are star ratings?

Star ratings are quality ratings that provide a measure of a plan's performance. Medicare scores Medicare Advantage and Part D plans in several categories, including quality of care and customer service. Ratings range from 1 to 5 stars, with five being the highest and one being the lowest score. Medicare assigns plans an overall star rating to summarize the plan's performance as a whole. Plans also receive separate star ratings in each individual category reviewed. The overall star rating score provides a way to compare performance among several plans. To learn more about differences among plans, look at plans' ratings in each category.

Plan ratings change from one year to the next. Medicare reviews plan performances each year and releases new star ratings each October. Keep in mind that a plan's star rating is only one factor to review when you compare plans in your area. Even though a plan has a high star rating, it may not be right for you. Look at the plan's coverage and costs before considering the star rating. For example, choose a Medicare Advantage or Part D plan based upon whether the plan covers the health care services and drugs you need, works with the pharmacies you use, and fits

your budget rather than its star rating alone. Remember, it's important that you first assess your own health care needs before making any decisions. Also keep in mind that the star ratings listed in the *Medicare & You* handbook solely represent a plan's customer satisfaction quality rating. For the most up-to-date comprehensive star ratings, you may call 800-Medicare or use the online Plan Finder tool at www.medicare.gov.

9. Aside from Fall Open Enrollment, are there any other times during the year in which I can make changes to my health and drug coverage?

You may make changes during the Medicare Advantage Disenrollment Period (MADP) and Special Enrollment Periods (SEPs).

- The **Medicare Advantage Disenrollment Period (MADP)** spans from January 1 through February 14 of each year. During this time, you may switch from a Medicare Advantage plan to Original Medicare and a stand-alone Part D plan. Changes you make during this time will become effective the first of the following month. Remember, you can only make a change during this time if you have a Medicare Advantage plan and want to switch back to Original Medicare.
- **Special Enrollment Periods (SEPs)** are special times outside of Fall Open Enrollment that you can switch your Medicare coverage, if you meet certain conditions. Examples include permanently moving, retiring, or receiving certain Medicare cost assistance programs like Extra Help. With an SEP, your new coverage will usually start the first of the month after you make a change. For more information on whether you qualify for an SEP, you may contact your State Health Insurance Information and Assistance Program (SHIP) or 800-Medicare.

Remember, when switching your Medicare coverage you should look at your current coverage, assess your own health care needs, and ask yourself questions before making any changes.

10. Where can I go for help in comparing my plan options?

If you need help comparing your plan options, you can call your local State Health Insurance Assistance Program (SHIP). Depending on your state, the SHIP may even provide in-person visits to help you decide which plan best fits your needs. You can find your SHIP's phone number by going online to www.shiptalk.org. Additionally, you can call 800-Medicare. It is a 24-hour helpline and the counselors are able to help you compare plans. Finally, you can visit www.medicare.gov and click on "find health and drug plans." This takes you to the Plan Finder tool, and once you input your information, you will be able to compare a list of plans available in your area.

Before using any of these options, you should compile a list of health care professionals you see, drugs you take, and pharmacies where you get your drugs. This will allow you to compare your options. Additionally, when you decide on a plan, you should call 800-Medicare or use www.medicare.gov to enroll in that plan. It is helpful for Medicare to have the official enrollment record in case any issues arise.

11. How do the Marketplaces, or Insurance Exchanges, affect my Medicare?

The Marketplaces, or Insurance Exchanges, will not affect your Medicare. The Marketplaces do not change your Medicare benefits or how you access them. If you have Medicare, you should **not** use the Marketplaces to get health and drug coverage.

Individual Marketplaces provide a way for people who lack health insurance to get coverage. Individual Marketplace policies are not meant for people who qualify for Medicare. If you enroll in an Individual Marketplace plan—called a Qualified Health Plan (QHP)—before you qualify for Medicare, make sure to enroll in a Medicare plan when you first qualify to avoid gaps in coverage or penalties.

The Small Business Health Options Program (SHOP) allows small businesses to help their employees get health insurance. If you have a SHOP plan through a current employer, it works with Medicare in the same way as any other current employer insurance.

It is important to remember that plans through the Marketplace and Medicare are not the same thing, even though the Marketplace enrollment period overlaps with Medicare's Fall Open Enrollment. You should use the Fall Open Enrollment Period to review and make changes to your Medicare health and drug coverage. You should not use the Marketplace enrollment period.

Note: The advisability of Individual Marketplace plans may be different for people who qualify for Medicare based on having ESRD only (are under 65 but not otherwise disabled), or for those who would need to pay a premium for Medicare Part A. Individual Marketplace plans **may** provide a more cost-effective option for these groups. Individuals in these circumstances should contact the Medicare Rights Center (800-333-4114) for more information.