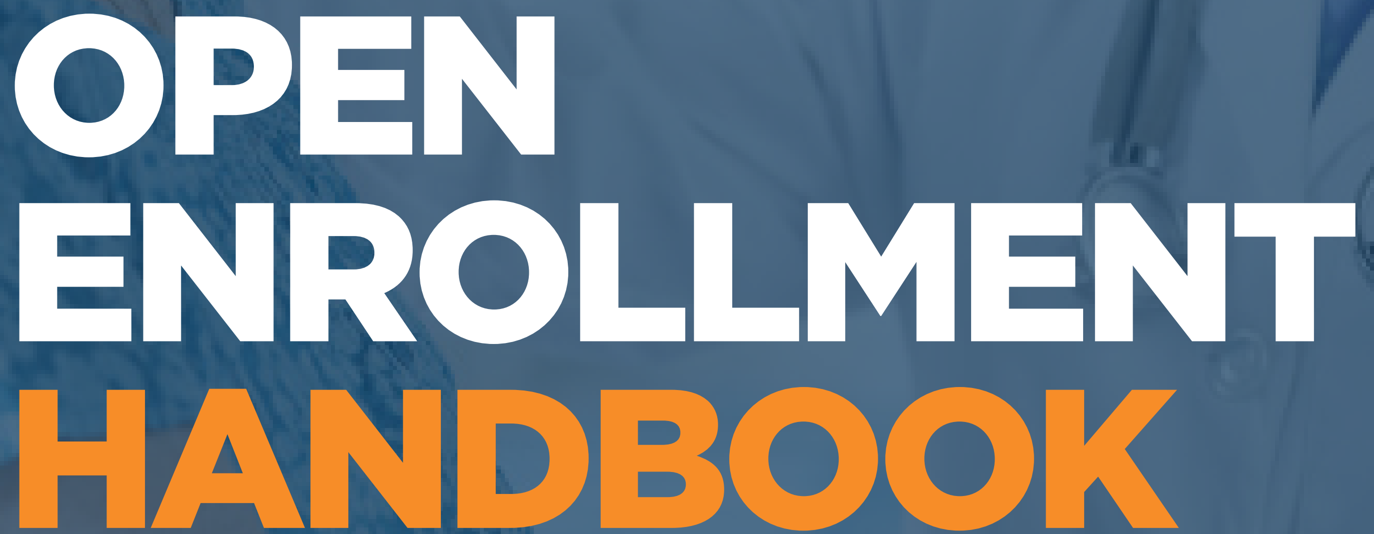
BETTER MEDICARE ALLIANCE

OPEN ENROLLMENT HANDBOOK



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UNDERSTANDING OPEN ENROLLMENT

When Is Open Enrollment?

- Open Enrollment for Medicare takes place each year from **October 15 to December 7.**

What Can I Do During The Open Enrollment Period?

During Open Enrollment, you can:

- Change from traditional Medicare to a Medicare Advantage plan, and vice versa
- Switch from one Medicare Advantage plan to another Medicare Advantage plan.
- Switch from a Medicare Advantage plan that doesn't offer drug coverage to a Medicare Advantage plan that offers drug coverage, and vice versa
- Join a Medicare Prescription Drug plan
- Switch from one Medicare drug plan to another Medicare drug plan
- Drop your Medicare prescription drug coverage completely

What Criteria Must I Meet If I Want To Enroll In A Medicare Advantage Plan?

- If you are eligible for traditional Medicare, you generally are eligible to choose a Medicare Advantage plan.
- To be eligible for a Medicare Advantage plan, you must be enrolled in Medicare Parts A and B, and live in the Medicare Advantage service area.

When Can I Initially Enroll In Medicare Advantage Or A Drug Plan?

- If you are already enrolled in Medicare Part B, you can enroll in Medicare Advantage, a Medicare Advantage Drug plan, or Medicare Part D for the first time between **April 1** and **June 30**.

- To clarify, the April 1 to June 30 enrollment period is for individuals who are enrolling in these plan types for the first time. If you already have one of these plans and would like to make changes, you can do so during Open Enrollment between October 15 and December 7.

What if I Am Already Enrolled In A Plan, And I Do Not Want To Make Changes?

- If you are already enrolled in a Medicare Advantage plan or a Medicare Part D prescription and you do NOT want to make changes to your coverage for 2017, you do not need to do anything during Open Enrollment.
- However, it is important to make sure your plan will still be available in 2017.
- If your plan is being discontinued and is not eligible for renewal, you will receive a non-renewal notice from your insurance carrier prior to Open Enrollment.
- It is also important to be mindful that your benefits and premium could be changing for 2017. Please research your options to verify that your current plan is still the best available option for you.

How Do I Change My Medicare Advantage Coverage After The Open Enrollment Period?

- If you are enrolled in a Medicare Advantage plan, you can leave your plan and return to original Medicare between **January 1 and February 14** each year. This known as disenrollment.
- You cannot switch to another Medicare Advantage plan during this time unless you have a circumstance that affords you a Special Enrollment Period.
- After you leave your plan, you will have until February 14 to enroll in a Part D plan that will begin the first day of the following month that you enroll.

When Can I Enroll In Traditional Medicare?

- If you did NOT sign up for Medicare Parts A and B when you were first eligible, you can do so each year from **January 1 to March 31**, with coverage effective July 1.
- However, you may be subject to a late enrollment penalty.

The chart below summarizes the enrollment options, enrollment periods, and coverage start dates:

Enrollment Option	Start	End	Coverage Start
Traditional Medicare Part A/Part B Enrollment	January 1	March 31	July 1
Initial Medicare Advantage, and/or Medicare Prescription Drug Plan (if enrolled in Part B)	April 1	June 30	*see note
Initial Part D (if enrolled in Part B)	April 1	June 30	*see note
Medicare Advantage/Part D Annual Open Enrollment	October 15	December 7	January 1
Medicare Advantage Disenrollment Period	January 1	February 14	*see note

[*Note: Your coverage will begin the first day of the month after you ask to join a plan. If you join during one of the 3 months before you turn 65, your coverage will begin the first day of the month you turn 65]

https://www.medicareresources.org/faqs/when-is-the-next-medicare-open-enrollment-period/

UNDERSTANDING THE DIFFERENCE BETWEEN TRADITIONAL MEDICARE AND MEDICARE ADVANTAGE

What Is Medicare Advantage?

- Medicare Advantage, sometimes referred to as Medicare Part C, is the option within Medicare that allows beneficiaries to enroll in a healthcare plan offered through private companies.
- If you join a Medicare Advantage Plan, you still have Medicare. You will receive your Medicare Part A and Medicare Part B coverage from the Medicare Advantage Plan, instead of through traditional Medicare.
- Under traditional Medicare, the government pays for your Medicare benefits when you are eligible to receive them.
- Under Medicare Advantage Plans, Medicare pays private companies a set amount per person per month to cover your benefits.

What Is The Difference Between Medicare Advantage And Traditional Medicare?

- Traditional Medicare includes Part A (hospital) and Part B (medical) coverage, if you enroll in both.
- Most people pay a monthly, income-based premium for Medicare Part B.
- Traditional Medicare does not cover visual, hearing, and dental benefits, and there is no limit on yearly amounts of out-of-pocket care costs.
- Under Traditional Medicare, you can go to any doctor or hospital in the United States that accepts Medicare.
- If you want Medicare drug coverage (Part D), you must purchase a separate Prescription Drug Plan (PDP) from a private insurance company.
- If you have traditional Medicare, you may also choose to purchase a

supplemental insurance policy to cover out-of-pocket physician costs called Medigap.

- Under Medicare Advantage, you still pay Part B premiums.
- However, over 97% of Medicare Advantage plans offer at least a vision, hearing, or dental benefit, and half of Medicare Advantage plans offer all three benefits.
- Medicare Advantage Plans does have yearly limits on your out-of-pocket health care costs. Once you reach your maximum out-of-pocket spending, you pay nothing.
- Under Medicare Advantage, the providers you can visit depend on the type of plan you select.
- This is referred to as the “provider network” and plans offer information on which providers are in their plan.
- If you want a plan that includes Medicare drug coverage (Part D), you can sign up for a Medicare Advantage Prescription Drug Plan (MA-PD) which includes both health and drug coverage.
- To learn more about traditional Medicare and Medicare Advantage, please visit medicare.gov.

UNDERSTANDING MEDICARE PART B PREMIUMS

What Does The Medicare Part B Premium Cover?

- Medicare Part B generally covers two types of services:
    1. Medically necessary services which include services or supplies necessary to diagnose or treat your medical condition.
    2. Preventive services which include services to prevent illnesses (i.e. the flu or pneumonia), or to detect illnesses at an early stage.
- Examples of services covered by Medicare Part B include: lab tests, surgeries, doctor visits, and supplies such as wheelchairs and walkers.

How Is The Medicare Part B Premium Paid?

- Most people pay a monthly, income-based premium for Medicare Part B.
- If you receive Social Security, Railroad Retirement Board, or Office of Personnel Management benefits, your Part B premium will be automatically deducted from your benefit payment.
- If you do not receive these benefit payments, you will receive a monthly bill called a "Notice of Medicare Premium Payment Due".
- Once you begin collecting retirement benefits from Social Security, your Part B premiums will automatically shift to Social Security deduction.
- You must pay your Part B premium every month for as long as you have Part B (even if you don't use it).
- If you are dually enrolled in Medicare and Medicaid, Medicaid covers the Medicare Part B premium.

- Under Medicare Advantage, you are still responsible for paying the Part B premium.
- Your Medicare Advantage plan must cover at least the same Part B services and supplies covered under traditional Medicare.

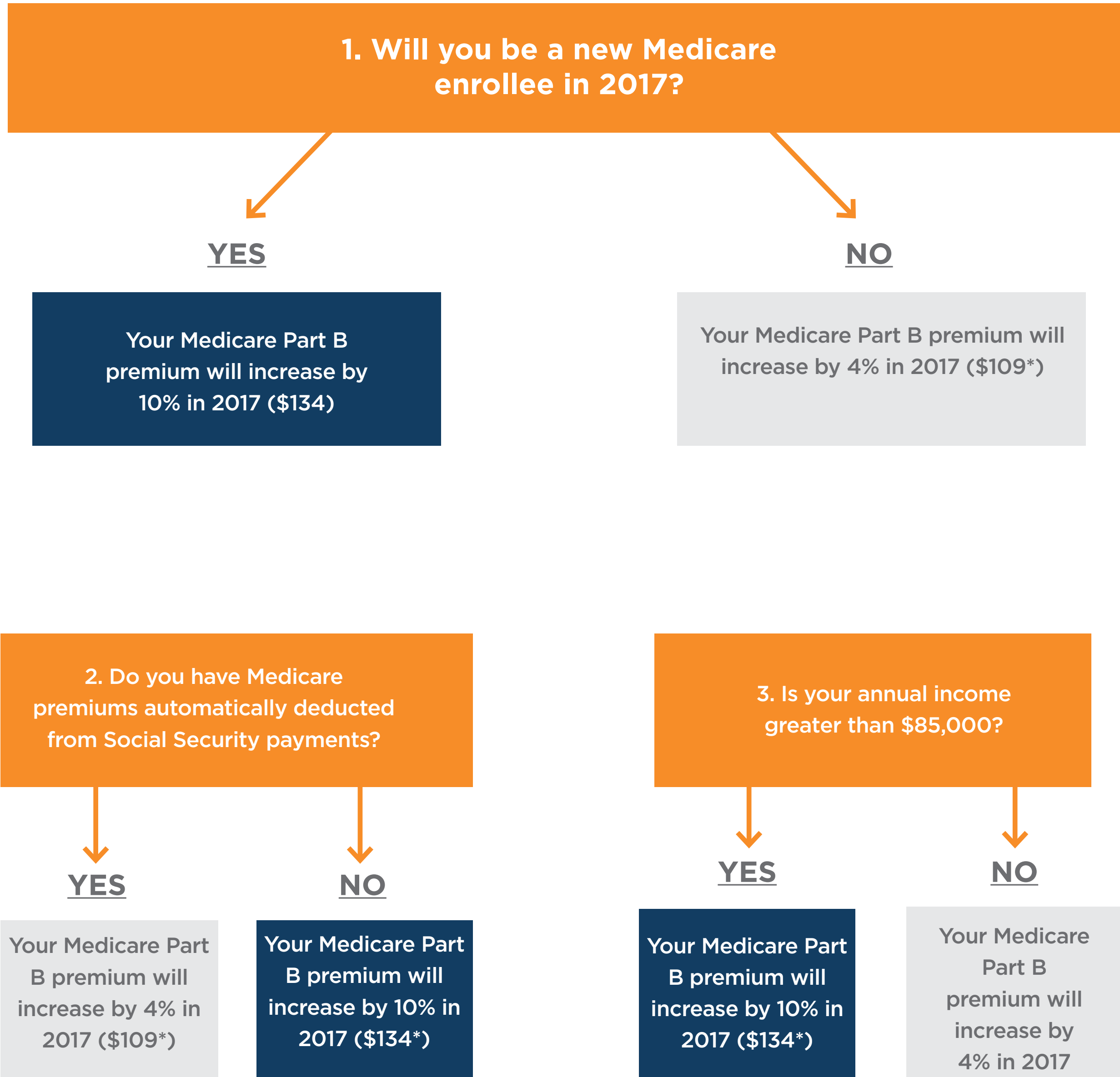
What Is The Current Part B Premium?

- The standard Part B premium for 2016 is $121.80 (or higher depending on your income).
- For approximately 7 million individuals, the Part B premium was expected to be 52% higher in 2016.
- However, Congress passed a budget deal in November 2015 that led to 16% increase instead of a 52% increase. The 16% increase resulted in the $121.80 Part B premium for 2016.
- In 2016, 70% of Medicare beneficiaries continued to pay the same $104.90 they paid in 2015.

What Are The Proposed Changes To Part B Premiums In 2017?

- In November 2016, the Centers for Medicare and Medicaid Services announced a 10% increase in Part B premiums for approximately 30% of Medicare beneficiaries, and a 4% increase for approximately 70% of Medicare beneficiaries.
- The chart below provides an illustration on whether you should expect the 10% or 4% increase in the Part B premium for 2017.
- Similar increases in Part B premiums have been proposed in the past, and Congress has intervened to lessen the impact of these changes.
- It is important to advocate for stability in Medicare by contacting your members of Congress, signing petitions, and encouraging other seniors to speak out against more changes.
- There are three groups of people who would be affected by the premium increase (see flow chart on the next page).

Will the Medicare Part B Premium Increases Affect Me?



UNDERSTANDING THE DIFFERENCES BETWEEN MEDICARE ADVANTAGE AND MEDIGAP

What Is Medicare Advantage?

- If you are enrolled in traditional Medicare, you may choose to purchase a supplemental insurance policy to cover out-of-pocket physician costs called Medigap.
- Medigap provides supplemental coverage that pays for all or most of Medicare Parts A & B out-of-pocket costs including copayments, coinsurance, and deductibles.
- Under Medigap, beneficiaries must be at least 65 years old, and may enroll in Medigap in the first six months after they sign up for Medicare Part B.
- After that period, people in most states can be turned down by Medigap, or charged extra for pre-existing conditions.
- You are not permitted to enroll in both a Medicare Advantage plan and a Medigap plan simultaneously.
- Medigap plans are not necessary if you chose a Medicare Advantage plan because Medicare Advantage plans typically cover the services covered by Medigap.
- Medigap does not cover Part D (drug) coverage.
- Almost 90% of Medicare Advantage plans include drug coverage.
- Medicare Advantage plans have yearly limits on your out-of-pocket health care costs. Once you reach your maximum out-of-pocket spending, you pay nothing.
- Medigap plans do not have a limit on out-of-pocket health care costs.
- Medicare Advantage plans and Medigap plans are both provided through private insurance companies.

- Click here to learn more about the Medigap program
- Click here to learn more about the Medicare Advantage program
- Click here to learn more about traditional Medicare

The following chart highlights the key differences between Medicare Advantage, Medigap, and traditional Medicare.

Traditional Medicare	Medigap	Medicare Advantage
• Consists of Medicare Part A (hospital) and Medicare Part B (medical coverage) • Part D (drug coverage) must be purchased separately • Most people pay a monthly, income-based premium for Medicare Part B • Does not cover vision, hearing, or dental benefits • Does not have an annual limit on out-of-pocket spending	• Optional coverage for traditional Medicare beneficiaries • Pay additional premium to cover services not covered under traditional Medicare such as copays, coinsurance, and deductibles • Medigap plans are provided by private companies • There are 10 different types of Medigap plans that vary by design • Does not have an annual limit on out-of-pocket spending	• Covers traditional Medicare Parts A (hospital) and B (medical) benefits. • Almost 90% of Medicare Advantage plans also include Part D (prescription drug) coverage. • Over 97% of Medicare Advantage plans offer at least a vision, hearing, or dental benefit. • Approximately 50% of Medicare Advantage plans offer all three benefits. • There is an annual cap limit on out-of-pocket spending. This limit changes each year. • Medicare Advantage is provided through private insurance companies. • The government sets quality standards, known as star ratings, for Medicare Advantage plans. • Under Medicare Advantage, you are still required to pay Part B premiums. • Some Medicare Advantage plans do not have an additional premium, whereas other Medicare Advantage plans require an additional premium. • These premiums may differ in cost due to zip code and plan type.

UNDERSTANDING COST SHARING IN MEDICARE ADVANTAGE

What Is Cost Sharing?

Individuals who have health insurance, including traditional Medicare, Medicare Advantage, or other types of coverage, generally pay for their healthcare two ways:

1. Premiums
   - A premium is a fixed amount paid in advance for an insurance policy. The standard monthly premium for Medicare Part B in 2016 is $121.60. **To learn more about Part B premiums, please view our "Understanding Part B Premiums" fact sheet.*
2. Cost sharing
   - Cost sharing refers to the out-of-pocket payments that beneficiaries are required to make when they receive health care.
   - Cost sharing occurs when a portion of beneficiaries' health care costs are not covered by health insurance.
   - The term "cost sharing" generally includes **deductibles**, **coinsurance**, and **copayments**. Cost sharing does not include premiums, amounts billed for non-network providers, or the **cost** of non-covered services.

What Is A Deductible?

- A deductible is the amount of money that a beneficiary must pay before an insurance company will begin to pay. The Part B deductible for 2016 is $166.

What Is Coinsurance?

- Coinsurance is the percentage of a covered health care service beneficiaries pay after they have paid their deductible.
- Under traditional Medicare, after the deductible is met, you typically pay 20% of Medicare approved services or goods.

What Is A Copayment?

- A copayment is payment made by a beneficiary in addition to that made by an insurer.
- For example, a doctor's visit may require a co-payment of $20 by the beneficiary with the remaining cost of the doctor's visit covered by the insurance provider.

What Is The Out-Of-Pocket Limit?

- Medicare requires Medicare Advantage plans to have a mandatory out-of-pocket limit on all Part A and B services. This limit is imposed on an annual basis.
- In 2016, the out-of-pocket limit for Medicare Advantage plans is $6,700, but plans may choose to have a lower limit (i.e. some Medicare Advantage plans have an out-of-pocket limit of $3,400).
- Once a beneficiary reaches their out-of-pocket limit, his or her Medicare Advantage plan pays for all the covered services for the remainder of the year.

How Is Cost Sharing Structured Under Medicare Advantage?

- Medicare Advantage plans may require beneficiaries to pay copayments or coinsurance when they receive medical care.
- Each Medicare Advantage plan determines how much these charges will be.
- These out-of-pocket payments are likely to differ from the out-of-pocket charges under traditional Medicare.
- In some instances, Medicare Advantage out-of-pocket copayment costs may be less than the comparable costs in traditional Medicare.
- Services covered under traditional Medicare at zero cost-sharing must also be covered under Medicare Advantage at zero cost sharing.

In general, cost-sharing requirements in Medicare Advantage plans are lower than those in traditional Medicare.

Example Of Cost Sharing Under Medicare Advantage:

***Disclaimer: The following is ONLY an example. Please do not expect this example to be applicable to your Medicare Advantage plan type.**

Robert, a Medicare Advantage beneficiary, needs to have a medical procedure that costs a total of $12,000.

Under his particular Medicare Advantage plan, he has the following deductible, coinsurance, and out-of-pocket maximum:

- Deductible: $750
- Coinsurance: 30%
- Out-of-pocket limit: $6,700

First, Robert would need to pay all of his deductible, which is **$750**.

Then, Robert would have to pay his coinsurance which is 30% of the remaining cost after paying his deductible.

- $12,000-$750 = $11,250
- $11,250 x 30% = **$3,375 coinsurance**

Therefore, Robert's total out-of-pocket cost for his $12,000 medical procedure would be $4125 (his $750 deductible plus his $3,375 coinsurance).

When Robert's total out-of-pocket spending reaches $6,700, his Medicare Advantage plan will pay for all of his covered services for the remainder of the year.