

COSTS AND PRICES

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BACKGROUND ON MA PAYMENT FROM CMS

Medicare pays Medicare Advantage (MA) plans to provide services to beneficiaries enrolled in those plans. Organizations offering MA plans must submit bids to CMS that include the cost of delivering both Part A and Part B benefits, but not Part D benefits, to their enrollees, along with projected profits and administrative costs. CMS reviews the bids and then calculates how much it will pay an MA plan based on the relationship between the plan's bid and the benchmark. The benchmark is a county-based target payment from CMS to MA plans.

Federal law established these county-based benchmarks, and they are updated yearly. Legislation also established a floor rate—a minimum amount that no county benchmarks can fall below. The floor rate is set as an amount greater than Original Medicare's per capita spending in many counties. Later legislation created another floor rate for urban areas to be applied to counties in metropolitan areas with more than 250,000 residents. Also, the benchmark in each county must be above Original Medicare's per capita spending in that county.

If an MA plan submits a bid above the benchmark, then the plan will receive the benchmark amount. In those cases, enrollees must pay an additional premium equal to the difference. If an MA plan submits a bid below the benchmark, then the plan will receive the bid amount. In these cases, MA plans also receive a rebate payment from Medicare. A rebate payment is defined as 75 percent of the difference between the plan's bid and its benchmark. MA plans must return this rebate payment to the plan's enrollees in the form of supplemental benefits, lower cost-sharing, or lower Part B or plan premiums.

This description of payments to MA plans briefly summarizes a complicated set of calculations that CMS uses to compute these values. Often, CMS adjusts payments to the plans to account for those with several counties in their services areas. In addition, CMS adjusts all payments to MA plans based on the characteristics of enrollees. This process is called "risk adjustment," and it includes factors that affect how much it will cost the MA plan to provide health services to its enrollees—demographics and health risk characteristics, including age and prior health conditions. For more details on Medicare Advantage payment methods, see Chapter 8 of the *Medicare Managed Care Manual* (CMS Pub. No. 100-16), available online at <http://www.cms.hhs.gov/manuals/downloads/mc86c08.pdf>.

BASICS OF COSTS AND PRICES

Monthly Premiums

All Medicare beneficiaries have costs associated with their Medicare coverage, whether they are in Original Medicare or Medicare Advantage. The costs of a Medicare Advantage (MA) plan, though, can be different from those in Original Medicare.

Beneficiaries in MA plans must continue to pay the Medicare Part B premium (\$96.40 per month for most beneficiaries, in 2010). See HAP's *Medicare Premiums and Cost-Sharing* fact sheet at <http://www.hapnetwork.org/original-medicare/cost-sharing/2010.html> for more information on Part B premiums in 2010). As mentioned above, MA plans that receive a rebate from CMS can use the rebate dollars to reduce the Medicare Part B premium for enrollees. Therefore, beneficiaries enrolled in some MA plans may have a Part B premium lower than the standard \$96.40 in 2010.

More often, MA plans use the rebate dollars to lower the plan's own premium. This additional premium is sometimes called a Part C premium. It covers the Medicare Part A and Part B benefits as well as any mandatory supplemental benefits. Enrollees pay the plan's Part C premium in addition to the Part B premium. Low monthly Part C plan premiums attract many Medicare beneficiaries to the Medicare Advantage program in the first place. Many MA plans eliminate the Part C premium entirely. SHIP counselors can help their clients make sound MA enrollment decisions by showing them how to balance a plan's low premiums with its other out-of-pocket costs.

Some Medicare Advantage plans may offer optional supplemental benefits to their enrollees. Only those enrollees who choose this optional coverage must pay an extra premium to receive the benefits. Optional benefits packages are similar to "riders" in other kinds of insurance. Medicare Advantage plans cannot use rebate dollars to reduce the actual costs of the optional supplemental premium.

Remember . . .

Optional supplemental benefits include services not covered by Original Medicare (excluding Medicare drug coverage) that are offered as an option to all enrollees in an MA plan. Enrollees are given the opportunity to choose this coverage; if they opt to have these benefits, enrollees must pay for the coverage. The optional supplemental benefits must be offered to all beneficiaries equally upon enrolling in the MA plan and for a uniform time frame afterwards.

Costs for Health Care Services

Beneficiaries in Original Medicare have a Part A inpatient hospital deductible (\$1,100 per benefit period in 2010) and an annual deductible for Part B (\$155 in 2010). After these deductibles are met, beneficiaries will owe coinsurance charges for most covered services they receive. The 20 percent coinsurance charge is familiar to many beneficiaries who receive services under Medicare Part B.

Note: Coinsurance is a percent of the total cost of a service charged to the beneficiary. Copayments are a fixed amount charged to the beneficiary for a service.

Federal law gives Medicare Advantage (MA) plans flexibility to create cost-sharing structures that differ from Original Medicare's. MA plans may use percentage coinsurance charges, fixed copayment charges, or a combination of the two, depending on the service. Because the plans also set the cost-sharing amounts, they can create incentives for plan members to use certain types of care by, for example, not charging for preventive screening tests. Keep in mind that plans can change their cost-sharing structures and payment amounts yearly. Note that CMS requires plans to notify plan members of these changes through an "Annual Notice of Change," or ANOC.

While beneficiaries in Original Medicare may purchase a Medigap policy to pay for some of the out-of-pocket costs – or gaps – in Original Medicare, the law prohibits Medigap policies from coordinating with MA plans. At this time, there are no Medicare-approved policies, like a Medigap, to cover the out-of-pocket costs for Medicare Advantage enrollees. Therefore, enrollees in some MA plans must be prepared to pay out-of-pocket for annual deductibles, copayments, and coinsurance amounts without limit. Other MA plans, however, make total out-of-pocket spending more predictable by using annual spending caps. The caps limit plan members' financial exposure to set dollar amounts. Note that the law requires Regional PPOs to use spending caps in their cost-sharing structures. After a person reaches a spending cap, the MA plan covers the full cost of care for the rest of the year.

Using Medicare Options Compare to Assess Plan Costs and Features

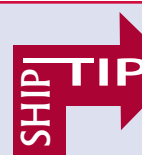
The *Medicare Options Compare* online plan comparison tool (<http://www.medicare.gov>) provides useful information on all MA plans' cost-sharing charges and spending caps. Counselors can use the tool to help clients view a side-by-side summary of the benefits and costs for up to three MA plans at a time. The summary shows annual "estimated out-of-pocket costs" for each plan. By using drop-down boxes, you can adjust the estimate to reflect a person's health status (excellent, very good, good, fair, and poor) and age range. The tool also gives estimated monthly cost-sharing for three health conditions: diabetes, congestive heart failure, and heart attack. Note that these out-of-pocket spending data have limitations. The projections use average spending data from the Original Medicare program that is five years old. Counselors should use the information for general comparison purposes only.

Fortunately, counselors can access more detailed cost and benefit information about each MA plan on the *Medicare Options Compare* Web site. After selecting a plan to compare, click on the “View Details” button. The Web tool then shows a “Review Plan Details” page that outlines a plan’s covered benefits, including its mandatory and optional benefits, along with any associated deductibles, copayments, and coinsurance charges. It would be difficult to accurately assess an MA plan’s value to a particular client, or for a client to make an informed decision about an MA plan, without taking some time to evaluate this detailed information.

The “Review Plan Details” page in *Medicare Options Compare* also has a link (click “View Plan Ratings”) to view a table reporting on the quality and performance of an MA plan, such as “Members Choosing to Leave the Health Plan.” Click on “View Star Details” and the data shows, for example, the percentage of members who left in the previous plan year (for the 2010 plan year, the data reflects the percentage of members who left the plan in 2009). CMS draws this information from the complaints Medicare received about health plans from the Medicare Complaint Tracking Module (CTM), information from a third party Independent Review Entity (IRE), information from Medicare’s enrollment system, and findings from CMS’s audits. SHIP counselors can review any of these 33 different plan star rating topics with their clients and encourage them to take the data into consideration when selecting a plan.

In a 2004 report on MA plans’ benefit design and cost sharing, the Medicare Payment Advisory Commission (MedPAC) observed that “more tools that reflect out-of-pocket costs under various scenarios and their likelihood” would help some Medicare beneficiaries better understand the implications of their coverage and benefit options. (See MedPAC, *Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans* (Dec. 2004), available online at http://www.medpac.gov/publications/congressional_reports/Dec04_CostSharing.pdf.) After counselors learn about a client’s personal situation and health care concerns, they can use the detailed cost-sharing information on *Medicare Options Compare* to tailor scenarios or out-of-pocket spending examples to meet a client’s unique information needs.

To assess the likely occurrence of various health care scenarios, some clients may find it helpful to review information about the incidence of health conditions that may lead to sizable out-of-pocket costs for treatment and follow-up care. The American Cancer Society publishes annual “Cancer Facts and Figures” that include statistics on the lifetime probability, by gender, of developing certain types of cancer. The Cancer Society reports, for example,



Does your client have, for example, a history of cancer in her family? A scenario based on the likely cost of a series of outpatient chemotherapy treatments might be helpful. Make sure she understands how a plan’s 20 percent coinsurance charge on Part B drugs operates. It could result in thousands of dollars in out-of-pocket costs that are her financial responsibility. Factor in a plan’s annual cap on out-of-pocket spending if one exists, and ask your client how the out-of-pocket costs would affect her ability to access the needed care.

that the lifetime probability of developing colorectal cancer is one in 18 for men and one in 19 for women. Similarly, the American Heart Association offers a statistical fact sheet on “Older Americans and Cardiovascular Diseases” with data on the risk of heart attack, stroke, and other health conditions, available online at <http://www.americanheart.org/downloadable/heart/1237142337168OLD.pdf>.

Billing for Services

Medicare Advantage billing is a process very similar to other commercial health insurance products. When an MA plan enrollee receives a covered service, the health care provider collects the copayment, if applicable, from the enrollee. Then the provider submits the claim to the plan. If the MA plan agrees to cover the service, the plan sends the provider a payment. If the MA plan declines to cover the service, the plan notifies the provider. It issues a written *Notice of Denial of Payment* (see Appendix A) to explain the reasons for its denial. In such cases, the provider may bill the enrollee for the full cost of the service. An enrollee who disagrees with a plan’s coverage denial (i.e., a plan’s “organization determination”) may initiate the appeals process.

Medicare Advantage plans may have restrictions on certain health services. For example, they may require enrollees to receive prior authorization for some services. If the physician requests prior approval for such a service and the MA plan denies the request, the plan issues a written *Notice of Denial of Medical Coverage* (see Appendix B) to explain its decision. When this happens, enrollees have a few options. First, they can start the appeals process. Second, they may file a grievance with the MA plan. Third, the physician may provide more information to meet the plan’s coverage requirements.



For more information about coverage denials, see Grievances and Appeals on page 75.

The prior authorization process is quite different from the way that beneficiaries in Original Medicare receive covered services. In Original Medicare, the beneficiary receives a service from a Medicare provider. At that point, Medicare decides whether the service is covered. If the service is not covered, the beneficiary may pay the bill or appeal the denial if he believes Medicare should have covered the service. In Medicare Advantage, an enrollee may have to request coverage for a service before receiving it. If the plan denies coverage the enrollee may pay out-of-pocket for the service or start an appeal. The key difference between these two delivery mechanisms is that under Original Medicare a beneficiary may have to appeal to receive payment for a service received. Under Medicare Advantage a beneficiary may have to appeal to receive the service itself.

In Original Medicare, beneficiaries receive a *Medicare Summary Notice (MSN)* every three months if Medicare has paid a claim on their behalf. The MSN outlines all of the services a beneficiary received, how much Medicare paid for the service, and the amount providers

Cost Comparison Chart: 2010

| | Original Medicare, Part A and Part B | Medicare and Medigap | MA Plan #1 | MA Plan #2 |
|---|---|--|---------------|---------------|
| Monthly Premium | Part A: Usually \$0 Part B: \$96.40, for most beneficiaries* | Part A: Usually \$0 Part B: \$96.40 for most beneficiaries Medigap: At age 65, from \$27 to \$228 per month, depending on the type of policy | | |
| Part A Inpatient Hospital Care (Deductible + Coinsurance) | Days 1-60: Up to \$1100 deductible per benefit period Days 61-90: \$275 per day Days 91-150: \$550 per lifetime reserve day | Part A deductible and coinsurance covered by most Medigap policies | | |
| Part B Deductible | Part B: \$155 | Part B deductible covered by some Medigap policies | | |
| Skilled Nursing Facility Care | Days 1-20: \$0 per day Days 21-100: \$137.50 per day | Coinsurance covered by most Medigap policies | | |
| Part B Outpatient Care (e.g., doctor visits, emergency care, outpatient rehabilitation) | 20% coinsurance | Coinsurance covered by most Medigap policies | | |
| Mental Health Services | 45% coinsurance | Coinsurance covered by most Medigap policies | | |
| Durable Medical Equipment | 20% coinsurance | Coinsurance covered by most Medigap policies | | |
| Physical Exams | 20% coinsurance, for one Welcome to Medicare physical in first 12 months of Part B coverage | Coinsurance covered by most Medigap policies | | |
| Prescription Drugs | Part B drugs: 20% coinsurance Part D drugs: Must buy a separate Part D plan for coverage. | Part B drugs: Coinsurance covered by most Medigap policies Part D drugs: Not covered by most Medigap policies | | |
| Supplemental Services: | | | | |
| Dental Services | Most dental services not covered | Not covered by Medigap policies | | |
| Hearing Services | 20% coinsurance for diagnostic hearing exams | | | |
| Vision Services | 20% coinsurance for limited covered services | | | |
| Emergencies Outside U.S. | Generally not covered, with limited exceptions | Covered by some Medigap policies | | |
| Other Extra Benefits | | | | |

See HAP's Medicare Premiums and Cost-Sharing fact sheet at <http://www.hapnetwork.org/original-medicare/cost-sharing/2010.html> for more information on Part B premiums in 2010.

may bill the beneficiary for each service. Medicare Advantage does not have an official, standard, system like the MSN for providing notice to enrollees about services they received. CMS instead expects plans to “give the beneficiary prompt notice of acceptance or denial of claims in a format specified by CMS.” Most plans send an Explanation of Benefits (EOB) after they have paid for a service. For denials, they issue a form captioned *Notice of Denial of Payment* (see Appendix A).

LOW-INCOME ASSISTANCE

Some Medicare beneficiaries with limited income receive benefits from the state Medicaid program to pay some of the out-of-pocket costs associated with Medicare coverage. There are several levels of assistance, including full Medicaid benefits and the different categories of Medicare Savings Programs (MSPs).

Medicare beneficiaries who qualify for full Medicaid benefits are known as full dual-eligible beneficiaries (or “full duals”). Because full duals have few, if any, out-of-pocket expenses associated with their Medicare and Medicaid coverage, most of them have coverage through Original Medicare. However, some full dual beneficiaries may choose to enroll in an MA plan.

Some Medicare beneficiaries may qualify for the Medicare Savings Program called “Qualified Medicare Beneficiary,” or QMB. Similar to the full dual-eligible beneficiaries, those with QMB have lower out-of-pocket costs associated with their Medicare coverage, and most of them have coverage through Original Medicare. However, some QMBs may choose to enroll in a Medicare Advantage plan.

Both full duals and QMBs receive assistance from Medicaid to pay for certain costs associated with Medicare Advantage plans. These costs include:

- Medicare premiums
- Deductibles
- Coinsurance and copayments (except for Part D copayments)

Enrollment of full duals and QMBs into some Medicare Advantage (MA) plans can be problematic. Not all MA plans have a contract in place with the state Medicaid office. Without such a contract, payment to providers for services received by enrollees may not occur as it should. When these beneficiaries receive covered services



In some states, Special Needs Plans (SNPs) for duals have been very successful in enrolling dual-eligible beneficiaries. Not all SNPs for duals arrange with the state Medicaid office for payment. These SNPs also do not have to ensure that all providers in their networks serve both Medicare and Medicaid populations. Because of the limited restrictions placed on these plans, it is important for beneficiaries to understand the benefits and limitations of a SNP for duals before enrolling in one.

from a provider, the provider bills the MA plan for the services. If the plan does not have a contract with Medicaid, the claim is not always submitted by the provider to Medicaid for payment. The provider then may end up billing the beneficiary for the copayment charges that, for other Medicare beneficiaries, would be associated with the service. Many times beneficiaries pay out-of-pocket for these charges, not realizing that they are protected by law from being charged these cost-sharing amounts and that Medicaid should cover these costs. For more information on QMBs and Medicare cost-sharing, see HAP's *Getting Started: What SHIPs Need to Know*, available online at <http://www.hapnetwork.org/troubleshooting-medicare/qmb/getting-started-tool.html>.