MedicareUpdate
The latest news and information for Medicare participants
member insurance solutions
Protecting tomorrows. Today.
Fall 2021 | Issue 10

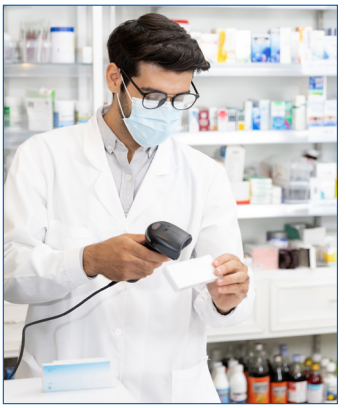
Medicare's Annual Election Period Kicks Off Oct. 15

The Medicare Annual Election Period (AEP), when you can change your Medicare Advantage Plan or stand-alone Part D prescription plan, will open on Oct. 15 and run through Dec. 7. If a plan change is made, the new plan will take effect on Jan. 1, 2022.

If you would like Member Insurance Solutions to review your medications in relation to selecting a 2022 Part D pharmacy benefit plan please visit mdaprograms.com/wp-content/uploads/Prescription-Medication-List.pdf, complete the form and email it to rseely@mdaifg.com or fax it to 517-484-5460 as soon as possible.

If you would like to schedule a phone or Zoom meeting with Rick Seely, please contact Lisa Sillman at lsillman@mdaifg.com or call her at 800-878-6765 ext 450.

Aetna Silver Script Part D Prescription Plans



If you are currently covered by a Silver Script Part D prescription drug plan, please keep in mind that Silver Script re-branded their plans to the name "Aetna Silver Script" in 2021. This is important because any correspondence that you receive relating to your plan will be from Aetna, so please do not automatically discard mailings from Aetna.

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Additionally, keep in mind that if you have been enrolled in a Silver Script plan for several years using electronic funds transfer or credit card payment methods and your credit card expires or your bank account is closed, you will need to reset your payment options with Aetna, not Silver Script.

Medicare Part D Cost-Sharing Amounts for 2022

The Medicare Part D cost sharing amounts that an individual must pay or reach in 2022 in order to move from one level to the next have been announced:

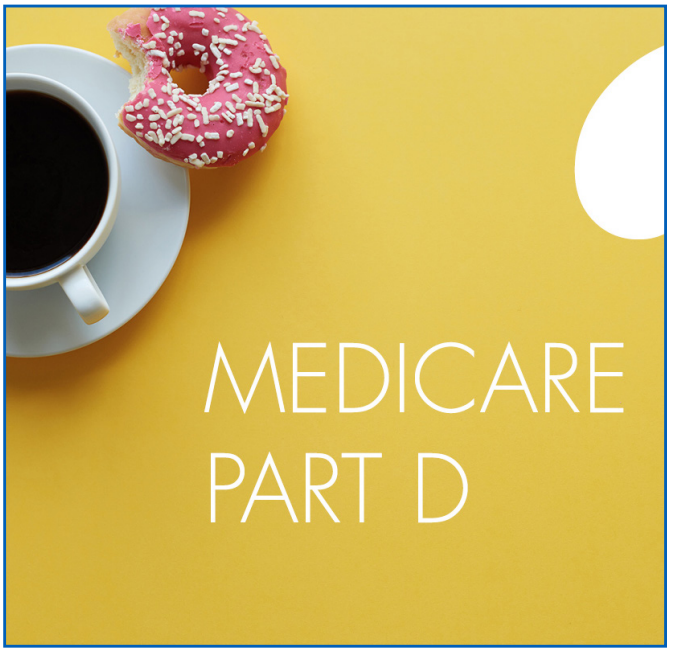
- The Part D plan annual deductible maximum is $480.
- The Initial Coverage Stage limit is $4,430.
- The out-of-pocket threshold to exit the Donut Hole—$7,050 (True Out of Pocket costs or TrOOP).

MedicareUpdate

How to Predict If You Will Enter the Part D Donut Hole in 2022

The Initial Coverage Stage limit of $4,430 is the entry point for the Donut Hole in 2022. Therefore:

Month you will enter the Donut Hole:	If your 2022 monthly retail drug costs are over
January	$4,430
February	$2,215
March	$1,477
April	$1,108
May	$886
June	$738
July	$633
August	$554
September	$492
October	$443
November	$403
December	$369



How does Retail Drug Cost Compare to Your Actual Out-of-Pocket Drug Cost?

Retail drug costs are not what a member spends out-of-pocket for prescriptions. Instead, retail cost is what they spend, plus what their Medicare Part D plan pays (or others pay on the member's behalf). Let's say Dr. Smith takes a medication that has a negotiated retail price of $443. It happens to be a Tier 3 medication on his Part D plan's formulary and the Tier 3 copay is $42 for a 30-day refill. Dr. Smith will pay $42 out of pocket, his drug plan will pay $401, and $443 will be applied toward his Initial Coverage Stage limit.

Typically, a Medicare plan's monthly Explanation of Benefits (EOB) letter does not state "Retail Drug Cost," but instead, the EOB will show two different columns with: "Plan Paid" and "You Paid." Add these two columns and the sum is the member's Medicare drug plan's negotiated retail drug cost, $443, in Dr. Smith's case.

And if Dr. Smith continues to take this medication every 30 days, he will enter the Part D Donut Hole in October.

What is a Medicare Advantage Plan?

One frequently asked question is "What are Medicare Advantage Plans that I see advertised on television or hear friends mention?" Medicare Advantage plans are known as Medicare Part C. Nationally, about 40% of Medicare Beneficiaries are enrolled in Medicare Advantage plans. In Michigan, because of large employer group Medicare plans, the percentage of beneficiaries covered by Medicare Advantage plans is about 50%.

A Medicare beneficiary must be enrolled in Medicare Part A and Part B to be eligible to enroll in a Medicare Advantage plan. The beneficiary must also continue to pay the government their Medicare premiums for Part B and Part D (if applicable). Medicare Advantage plans are required to cover all Medicare Part A and B benefits but are sold by private insurance companies. The plans cannot discriminate against individuals who are ill or have pre-existing conditions, therefore, there are no health questions on a Medicare Advantage application. *(continued on following page...)*

MedicareUpdate

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Most plans offer coverage through a single insurance plan and go further than Original Medicare (A & B) and cover things that it does not. In most instances, a Medicare Advantage plan provides some basic coverage for dental, vision, hearing, health club membership, and Part D prescription coverage. Some may offer transportation and meal plan benefits.

The greatest appeal of Medicare Advantage plans is their lower premiums, compared to Medicare Supplement plans. In fact, there are some $0 monthly premium Medicare Advantage plans available in Michigan. While there are many benefits to Medicare Advantage plans there are also some negatives that beneficiaries need to be aware of before they make the commitment to apply for a plan.

Medicare Advantage plans typically have limited provider networks compared to using Original Medicare where people are covered for services from any doctor, hospital or other provider in the country that accepts Medicare. An individual covered by a Medicare Advantage plan is usually restricted to getting care from providers in the plan's network, which is normally an HMO or PPO network. Over the last few years there has been some movement by Medicare Advantage insurers to expand geographic coverage options or offer expanded coverage for "snowbirds."

Medicare Advantage plans can charge less and offer more benefits because they save money on expenses through their business agreements with providers and they are managed care plans. Most plans usually require pre-authorization from the plan before approving coverage and can require less-expensive treatment alternatives.

While the monthly premiums tend to be lower, the member will pay out of pocket for the plan's annual deductibles, copays, and coinsurance until they reach the annual Maximum Out of Pocket (MOOP) amount. There is generally one MOOP amount for in-network expenses and a higher MOOP amount for out-of-network expenses. These out-of-pocket costs vary with each plan.

In 2021, the weighted average Maximum Out-of-Pocket amount is $5,091 for in-network services and $9,208 for in-network and out-of-network services combined.

The decision whether to apply for a Medicare Advantage plan or to use Original Medicare with a Medicare Supplement Plan should be carefully considered and based on the individual circumstances of each Medicare beneficiary. While a Medicare Advantage plan can be changed every year or a beneficiary can move from Original Medicare to a Medicare Advantage plan during Medicare's AEP each fall, it may not be so straight forward for a beneficiary to move from a Medicare Advantage plan to a Medicare Supplement plan due to the health questions and underwriting review that are part of a Medicare Supplement application.

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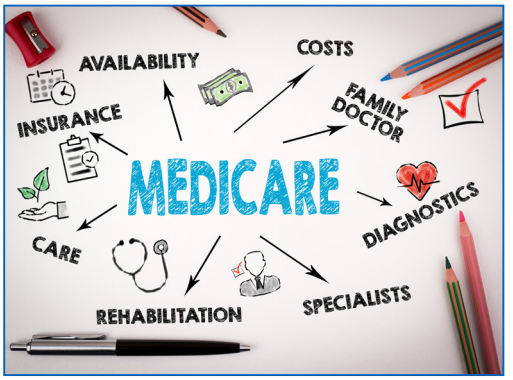
House Passes $3.5 Trillion Social Spending Bill

The $3.5 Trillion Social Spending bill passed by the House in August contains provisions to expand benefits under Original Medicare. This bill is a budget resolution bill which means in the Senate it only needs a simple majority to be passed into law. Within this bill is a proposal to add dental, vision, and hearing coverage to Original Medicare.

America's Health Insurance Plans (AHIP) has reported that adding these benefits could result in additional annual costs to Medicare of up to $1,056 per person who is covered by Original Medicare if the benchmark for Medicare Advantage is not adjusted. The benchmark is a base rate against which a health service provider submits a Medicare Advantage plan bid to the Centers for Medicare and Medicaid Services (CMS) proposing the benefits for and payments to the plan for the benefit year. The benchmark is based on what the equivalent costs would be for the Medicare program if the person were enrolled in Original Medicare.

Some potential impacts of adding dental, vision, hearing coverage to Original Medicare, if the benchmark for Medicare Advantage plans is not adjusted could be:



- Reduction of current Medicare Advantage plans benefits.
- Reduction in the number of or elimination of Medicare Advantage plans that offer $0 premium plans.

By the same token, the gap in spending between Medicare Advantage and Original Medicare has come under increased scrutiny as the Kaiser Family Foundation discovered that CMS paid out $7 billion more to Medicare Advantage plans in 2019 than to Original Medicare. That is a trend that will need to be reviewed as well.

At this point, we will just have to see how the Senate acts on this bill.

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