# You've got questions about Medicare's 2020 fall enrollment period. We've got answers.

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Medicare's fall open enrollment, which runs from Oct. 15 through Dec. 7, is an opportunity to review your benefits and make changes in time for 2020.

But signing up or reviewing your coverage can seem daunting.

Last year, we asked Philadelphia Inquirer readers what they'd like to know about Medicare, and brought an excellent list of questions to a panel of experts. For 2020, we've updated our primer on Medicare with new details you should know:

## Q: What's the difference between traditional Medicare and Medicare Advantage?

Traditional Medicare is managed by the federal government and offers coverage for hospital services (Part A) and outpatient services, such as primary care doctors, specialists, and routine care (Part B). Medicare Advantage plans are run by private insurance companies approved by the federal government. These managed-care plans must cover all the same benefits as traditional Medicare (though you'll be limited to their provider networks), but may offer extras, such as dental, vision, or hearing services.

## Q: I like my plan and in 2019, it covered the medications I needed—do I need to do anything during the fall enrollment period?

Open enrollment is a time when any current or new Medicare beneficiary can sign up for a plan or switch plans. You can switch from traditional Medicare to Medicare Advantage or vice versa, change your prescription drug plan, or pick a different Medicare Advantage plan. (A supplement plan that begins after age 65 might be more expensive, however, because of underwriting practices.) People with Original Medicare may buy a standalone Part D prescription plan, while Medicare Advantage plans typically include prescription drug coverage.

We heard a lot about prescription drug costs in the news this year, with President Donald Trump's call to require drug companies to include prices in their television ads and several proposals in Congress to address rising prices. But little has actually changed about how drugs are covered under Medicare.

But each plan's drug formulary, the list of covered medications, varies by plan and will change every year, so it is important to make sure the plan you have is still the best fit. Formularies rank medications into tiers, with lower-tier drugs the preferred and least-expensive options. Higher-tier versions of the same medication will cost more. Health plans frequently switch their preferred choices and may even drop medications from the formulary. Even if your drugs are still on the formulary, the plan may have changed how they're covered. They might limit the amount you can order or require prior authorization before filling the prescription—which is not guaranteed to be granted.

## Q: How do I know which plan is right for me?

Which plan you choose depends on your needs and your financial position.

Traditional Medicare is accepted by most doctors, which could be important if you need care while traveling out of state. Similar to many employer-based insurance plans, Medicare Advantage plans have provider networks. If you go to an out-of-network doctor or hospital, the visit may not be covered or may cost more. Medicare Advantage may also include prescription drug coverage, whereas traditional Medicare does not. People who do not have other prescription coverage will need to buy a separate drug plan (Part D).

Use Medicare's online Plan Finder tool or talk to a volunteer counselor to decide which plan best meets your needs.

## Q: If cost is my biggest concern, should I choose Medicare Advantage or traditional Medicare?

There's no clear-cut answer. Your total out-of-pocket expense will depend on how the plan you choose covers the services you use most. Both types of plans have a premium for Part B (doctor's services), $135.50 a month for most people in 2019, and a deductible. Traditional Medicare beneficiaries pay 20% of the Medicare-approved rate for most doctor services after meeting their deductible. Supplemental plans can help cover some of these extra expenses for traditional Medicare members, though people who turn 65 after Jan. 1 will no longer be able to buy supplemental plans with so-called "first-dollar coverage" that covers the Part B deductible, which is $185 in 2019. Medicare Advantage may charge additional premiums for its prescription drug coverage and extra services. Copays, coinsurance, and deductibles will vary for Medicare Advantage plans.

## Q: What's the difference between a premium, a deductible, a copay, and coinsurance?

The annual premium is the number that most often catches people's attention, as this is the price of the policy, paid monthly. A deductible is the amount members must spend out of pocket before the plan begins paying a larger share of your medical expenses. You will still be responsible for part of the bill even after meeting your deductible—this is called coinsurance. Original Medicare has a $185 deductible for Part B and 20% coinsurance after the deductible is met. So you will be billed for the first $185 in medical services, and after that, you will be responsible for 20% of the Medicare rate. For Medicare Advantage, cost-sharing varies from one plan to the next. A copay is a fee your plan may require you to pay when going to a doctor or picking up a prescription. It is important to consider all of these potential sources of out-of-pocket

expenses—not just the premium—when deciding which plan is right for you.

## Q: How do I choose supplemental coverage?

Supplemental coverage is for people with traditional Medicare; it cannot be used to cover out-of-pocket expenses associated with Medicare Advantage plans. Supplemental coverage is known as Medigap plans because they cover "gaps" in traditional Medicare plans, such as health expenses while traveling abroad, excess medication charges, or copays. They are sold by private insurance companies and are categorized by a letter system; plans with the same letter offer the same coverage. Choose the one that fills the gaps you are most concerned about. And be aware that prices can vary widely between companies, even for the same coverage, according to the Centers for Medicare and Medicaid.

## Q: Does Medicare restrict which doctors I can see? Can I change doctors?

Most doctors accept traditional Medicare, but always ask before making an appointment. Medicare Advantage has in-network doctors, so call your doctor's office to see which plans they accept and double-check with your plan. You can switch doctors at any time, but to avoid unexpected bills, make sure your new doctor is covered by your plan.

## Q: How do I figure out which prescription plan will be the lowest cost to me?

Look beyond the premium. Check that your medications are included in the plan's formulary—the list of medications covered, which will vary by plan, can change annually, so it is wise to check every year. Formularies rank drugs into tiers, with lower-tier medications the preferred and least-

expensive options. Higher-tier versions of the same medication will cost more and may be available only after you've tried a lower-tier option. Also look at cost-sharing—how much you will pay vs. how much the plan will pay—and whether you will be required to fill prescriptions at certain preferred pharmacies. Medicare's Plan Finder allows you to search based on the medications you want covered.

## Q: Where can I go for help?

First, don't be surprised if you need advice. The options can get complicated and scams abound during enrollment season. Pennsylvania and New Jersey both provide free counseling. These programs do not offer legal advice, endorse plans, or sell insurance, which makes them an impartial resource. Pennsylvania's APPRISE program has a phone helpline and locations across the state, where people can go for one-on-one assistance. Learn more online at aging.pa.gov or call 1-800-783-7067. New Jersey's State Health Insurance Assistance Program similarly staffs offices with volunteer counselors in addition to its helpline. Find locations online at state.nj.us/humanservices or call 1-800-792-8820.

Nonprofit organizations such as CARIE also provide assistance. Independent brokers—those who are not bound to sell just one insurer's products—can also be a good source for help.

## Q: How do I find a reputable independent broker? How do I know their fees aren't adding to my premium cost?

Independent brokers must be licensed by the state and could lose their licenses if they don't follow strict rules about selling private Medicare plans (Medigap, drug, and Advantage plans). Brokers typically get an

initial payment in the first year of the policy they sell and half that fee in the following years the individual remains in the plan. These fees are paid by the insurer, not the consumer, and must be reported to federal regulators and are available online.

## Q: Are there any programs to help people pay for Medicare?

Yes, people who meet income and asset qualifications may be eligible for one of several financial assistance programs. The Qualified Medicare Beneficiary program offers the highest level of assistance, helping pay for Part A and B premiums, deductibles, coinsurance, and copays for individuals with a monthly income of no more than $1,061 and assets of no more than $7,730 in 2019. Income and assets requirements may vary by state and are higher for couples. The Specified Low-Income Medicare Beneficiary program is available to people who earn too much to be eligible for the QMB program and helps pay Part B premiums. The Qualifying Individual program, which helps cover Part B premiums, has an even higher income threshold and is available on a first-come, first-served basis.

People younger than 65 with a disability who are currently working may be eligible for the Qualified Disabled and Working Individuals program, which helps cover Part A premiums. Medicare beneficiaries in New Jersey may also be eligible for a state-run assistance program that helps pay for prescription drugs for seniors and people with disabilities.

The National Council on Aging has developed a website, called BenefitsCheckup, to help people find benefit programs and determine their eligibility.

## Q: I've seen advertisements for zero-dollar-premium

## Medicare Advantage plans. Are they really free?

Everyone pays a monthly premium for Part B, regardless of whether you have Original Medicare or Medicare Advantage. The premium in 2019 is $135.50 a month for most people. Medicare Advantage plans often include extra services, such as prescription drugs, vision, or dental—for an extra charge. When a plan advertises a "zero dollar premium," it is referring to these additional plan-specific benefits—you will still pay the Part B premium. It's important to keep in mind that premiums are only one source of out-of-pocket costs. Plans with low premiums may have high deductibles, copays, and coinsurance. You should also consider how much your medications will cost under the plan and whether the doctors you see will be in-network, as these factors will also affect how much you spend on health care in a year. Medicare's online plan finder, medicare.gov/find-a-plan" target="_blank">www.medicare.gov/find-a-plan, can help you compare options.

## Q: How do I sign up for Silver Sneakers?

Silver Sneakers is a fitness program offered by some Medicare Advantage plans that gives members access to free gym memberships, fitness classes, and health education resources. It is not part of Original Medicare. Plans that don't offer Silver Sneakers may have a similar fitness program—ask your plan administrator. While the program can be a valuable benefit, also consider whether the plan will meet your health care needs, how it covers the medications you take, and whether you can continue seeing the same doctors. And, as with any fitness membership, make sure that the facility fits your physical needs, schedule, and location so you will use it enough to make it worthwhile.

Q: What happens if I don't sign up during my 'new to Medicare' period?

What if I plan on working past 65 and want to keep my employer-sponsored health plan?

People become age-eligible for Medicare at 65 and have a seven-month period to sign up—their birth month plus three months before and after. Sign up early if you want coverage to start when you turn 65. Missing this enrollment period could lead to penalties that remain with you for the duration of your Medicare coverage. The penalty for signing up late to Plan B is 10% of the premium for every 12 months you were not enrolled. Part D prescription coverage has a penalty of 1% of the premium for every month missed. If you miss your "new to Medicare" enrollment period, you will most likely have to wait until the annual open enrollment, which could leave you temporarily uninsured.

People who have health insurance through an employer with more than 20 people on its health plan and are actively working can keep their plan and delay signing up for Part B until they retire without penalty. If you have coverage through a company with fewer than 20 people, you'll have to move to Medicare when you become eligible. If you're in any doubt, talk to your human resources department. If you keep your employer-sponsored health plan beyond age 65, when you do decide to retire, your employer will need to fill out a form verifying you have had continuous coverage.

## Q: How do I decide if I should stick with my employer-sponsored health plan or transition to Medicare?

If you have the option of one or the other, you'll need to crunch the numbers, as it's an individual decision. Consider the premium, deductible, and other cost-sharing expenses of each plan, how prescriptions will be covered by each, and how the doctor networks compare. If you are covered under a spouse's plan, look at how the

employer handles dependent coverage. Often companies pay for a large share of the employee's health insurance, but require employees to pay the full cost or at least a larger share of the cost of insuring spouses and children. In this case, it may be more cost-effective for an over-65 spouse to move to Medicare.

Q: I have Medicare, but my wife has an employer-sponsored health plan with a health savings account. Can we use the HSA to pay for my out-of-pocket medical expenses?

Yes—with limits. An employee's HSA can be used to pay eligible medical bills for a spouse who is covered by Medicare. Eligible medical expenses include copays for prescriptions and services applied to your plan's deductible, as well as Part A and Part B premiums. An HSA cannot be used to pay for supplemental policy premiums. Once you sign up for Medicare, however, you will no longer be allowed to contribute pre-tax funds to an HSA.

## Q: I have an individual health plan through the Affordable Care Act marketplace. What do I need to know about transitioning to Medicare?

People with ACA marketplace health plans almost always transition to Medicare when they turn 65. You may be able to keep your individual health plan, but you won't be eligible for a tax subsidy after age 65 and could face penalties if you don't sign up right away, so most people find it is better to switch to Medicare than hold on to their ACA plan. The cost and coverage could be very different from what you're used to in an individual plan. The premium for Medicare Part B is $135.50 in 2019, which may be a lot less than what many people in their 60s pay for individual coverage. But people who have been receiving an income-based tax subsidy to offset the cost of a marketplace health plan may

find that their Medicare costs are greater, though Medicare also offers income-based financial assistance. Consider meeting with an enrollment adviser to talk about plan options or visit the National Council on Aging's BenefitCheckup website to find out if you're eligible for financial assistance.

## Q: How do Medicare entitlements, such as those for individuals with a disability or end-stage renal disease, coordinate benefits for individuals who also have private health insurance?

People who are under 65 may qualify for Medicare on top of their private health insurance because of a disability or select medical condition. The private health plan is considered primary insurance and billed first. Providers can bill Medicare second to cover any remaining costs. Give both insurance cards when you go to an appointment.