Medicare enrollees can switch coverage now: Here's what's new and what to consider

October 19 2023, by Julie Appleby, KFF Health News

Credit: Pixabay/CC0 Public Domain

Consumers know it's fall when stores start offering Halloween candy and flu shots—and airwaves and mailboxes are filled with advertisements for Medicare options.

It's annual open enrollment time again for the 65 million Americans covered by Medicare, the federal health program for older people and some people with disabilities.

From Oct. 15 to Dec. 7, enrollees in either the traditional program or Medicare Advantage plans, which are offered by private insurers, can change their coverage. (First-time enrollees generally sign up within a few months of their 65th birthday, whether that's during open enrollment season or not.)

There are a few new features for 2024, including a lower out-of-pocket cost limit for some patients taking expensive drugs.

No matter what, experts say, it's a good idea for beneficiaries to examine their current coverage because health and drug plans may have made changes—including to the pharmacies or medical providers in their networks and how much prescriptions cost.

"The advice is to check, check, and double-check," said Bonnie Burns, a consultant with California Health Advocates, a nonprofit Medicare advocacy program.

But as anyone in the program or who helps friends or relatives with coverage decisions knows, it is complicated.

Here are a few things to keep in mind.

Know the basics: Medicare vs. Medicare Advantage

People in traditional Medicare can see any participating doctor or hospital (and most do participate), while those in Medicare Advantage must select from a specified list of providers—a network—unique to that plan. Some Advantage plans offer a broader network than others.

Always check to see if your preferred doctors, hospitals and pharmacies are covered.

Because traditional Medicare doesn't cover prescriptions, its members should also consider signing up for Part D, the optional drug benefit, which includes a separate premium.

Conversely, most Medicare Advantage plans include drug coverage, but make sure before enrolling because some don't. These private plans are advertised heavily, often touting that they offer "extras" unavailable in traditional Medicare, such as dental or vision coverage. Read the fine print to see what limits, if any, are placed on such benefits.

Those 65 and older joining traditional Medicare for the first time can buy a supplemental, or "Medigap," policy, which covers many out-of-pocket costs, such as deductibles and copays, which can be substantial. Generally, beneficiaries have a six-month window after they enroll in Medicare Part B to purchase a Medigap policy.

So, switching from Medicare Advantage back to traditional Medicare during open enrollment can raise issues for those who want to buy a supplemental Medigap policy. That's because, with some exceptions, private insurers offering Medigap plans can reject applicants with health conditions, or raise premiums or limit coverage of preexisting conditions.

Some states offer beneficiaries more guarantees that they can switch Medigap plans without answering health questions, although rules vary.

Making all of this more confusing, there is a second open enrollment period each year, but it's only for those in Medicare Advantage plans. They can change plans, or switch back to traditional Medicare, from Jan. 1 to March 31.

Drug coverage has changed—for the better

Beneficiaries who signed up for a Part D drug plan or get drug coverage through their Medicare Advantage plan know there are a lot of copays and deductibles. But in 2024, for those who require a lot of high-priced medications, some of these expenses will disappear.

President Joe Biden's Inflation Reduction Act places a new annual limit on Medicare beneficiaries' out-of-pocket costs for drugs.

"That policy is going to help people who have very expensive medications for conditions like cancer, rheumatoid arthritis, and hepatitis," said Tricia Neuman, senior vice president and head of the KFF Medicare policy program.

The cap will greatly help beneficiaries who fall into Medicare's "catastrophic" coverage tier—an estimated 1.5 million Americans in 2019, according to KFF.

Here's how it works: The cap is triggered after patients and their drug plans spend about $8,000 combined on drugs. KFF estimates that, for many patients, that means about $3,300 in out-of-pocket spending.

Some people could hit the cap in a single month, given the high prices of many drugs for serious conditions. After reaching the cap, beneficiaries don't have to pay anything out-of-pocket for their medicines that year, potentially saving them thousands of dollars annually.

It's important to note that this new cap won't apply to drugs that are infused into patients, generally at doctor's offices, such as many chemotherapies for cancer. Those medicines are covered by Medicare Part B, which pays for doctor visits and other outpatient services.

Medicare next year is also expanding eligibility for some low-income beneficiaries to qualify for low- or zero-premium drug coverage that comes with no deductibles and lower copayments, according to the Medicare Rights Center.

Insurers offering Part D and Advantage plans might have also made other changes to drug coverage, Burns said.

Beneficiaries should check their plan's "formulary," a list of covered drugs, and how much they must pay for the medications. Be sure to note whether prescriptions require a copayment, which is a flat dollar amount, or coinsurance, which is a percentage of the drug cost. Generally, copayments mean lower out-of-pocket costs than coinsurance, Burns said.

Help is available

In many parts of the country, consumers have a choice of more than 40 Medicare Advantage plans. That can be overwhelming.

Medicare's online plan finder provides details on the Advantage and Part D drug plans available by ZIP code. It allows users to drill down into details about benefits and costs and each plan's network of health providers.

Insurers are supposed to keep their provider directories up to date. But experts say enrollees should check directly with doctors and hospitals they prefer to confirm they participate in any given Advantage plan. People concerned about drug costs should "check whether their pharmacy is a 'preferred' pharmacy and if it's in network" under their Advantage or Part D plan, Neuman said.

"There can be a significant difference in out-of-pocket spending

between one pharmacy and another, even in the same plan," she said.

To get the fullest picture of estimated drug costs, Medicare beneficiaries should look up their prescriptions, the dosages, and their pharmacies, said Emily Whicheloe, director of education at the Medicare Rights Center.

"For people with specific drug needs, it's also a good idea to contact the plan and say, "Hey, are you still covering this drug next year?" If not, change to a plan that is," she said.

Additional help with enrollment can be had for free through the State Health Insurance Assistance Program, which operates in all states.

Beneficiaries can also ask questions via a toll-free hotline run by Medicare: 1-800-633-4227, or 1-800-MEDICARE.

Insurance brokers can also help, but with a caveat. "Working with a broker can be nice for that personalized touch, but know they might not represent all the plans in their state," said Whicheloe.

Whatever you do, avoid telemarketers, Burns said. In addition to TV and mail advertisements, telephone calls hawking private plans bombard many Medicare beneficiaries.