FAQ: Highmark Medicare Advantage 2023 PPO Plan for State of Delaware Medicare Retirees

Submitted by Highmark Delaware

FAQ: HIGHMARK MEDICARE ADVANTAGE 2023 PPO PLAN FOR STATE OF DELAWARE MEDICARE RETIREES

Why is the State of Delaware trying to destroy the traditional Medicare program, probably the most important federal program to keep seniors healthy, by privatizing seniors' health insurance? Our Retirees worked for this insurance and deserve better than this plan.

Highmark Comment:
The new State of Delaware Medicare Advantage plan has been designed to mirror the current coverage eligible state retirees have, is exclusively available only to SoD pensioners and dependents and includes the same Medicare Part D prescription plan available today.

Pensioners and dependents who enroll in the SoD Medicare Advantage plan will continue to be enrolled in Medicare and will continue to pay Part B premiums, however the Highmark Blue Cross Blue Shield of Delaware Freedom Blue Medicare Advantage PPO plan assumes responsibility to provide all Medicare Part A and Part B benefits covered by original Medicare. The plan will continue to be an employer sponsored plan administered by Highmark Blue Cross Blue Shield of Delaware, a nonprofit health services organization.

Public comments have been, the Highmark State of Delaware Medicare Advantage PPO plan does not provide "the same levels of benefit coverage and current retiree out of pocket cost share" as original Medicare + the current Medicfill supplemental plan.

Highmark Comment:
The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both In-network and out of network providers both locally and nationally - (i.e., at $0 copay or $0 coinsurance to the member – there is no member share of cost for any Medicare covered service).

The Highmark custom Freedom Blue Medicare Advantage PPO Medical Benefits Chart was made available to all SoD eligible retirees in late September 2022. The Medical Benefits Chart outlined that all Medicare benefits are either $0 copay or 0% member coinsurance. Highmark also sent MA educational and open enrollment mailings to SoD eligible retirees and the SoD sponsored MA educational meetings during August 2022 (20+ meetings) and October 2022 (15+ meetings).

These initiatives were undertaken to help SoD eligible retirees better understand their benefits, including that all Medicare benefits are covered "in full" (i.e., coverage at 100% with no member cost share) for both in network and out of network providers locally and nationally.

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Public comments have been that Highmark's Medicare Advantage contracted provider network is limited (including some comments is does not reach outside of Highmark's 4 state plan footprint

Highmark Comment:
Highmark shares a national Blue Cross Blue Shield national Medical Medicare Advantage provider network that currently has 222,297 contracted "in network" primary care physicians and 534,274 contracted "in network" specialist nationally.

The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both In-network and out of network providers both locally and nationally - (i.e., at $0 copay or $0 coinsurance to the member – there is no member share of cost for any Medicare covered service). Again, the 100% coverage applies regardless if the member seeks care anywhere across of the 50 US states, DC or US territories from a contracted in network or non-contracted out network provider. Lastly, as Highmark has consistently communicated, a "non-contracted" provider that does accept original Medicare has the option to elect not to accept an MA plan (this does not apply in emergency situations) and this is a very limited occurrence nationally.

Highmark's Medicare Advantage Plan and Medical Necessity – Public comments have been the SoD Medicare Advantage plan does not provide the same coverage as original Medicare / Medicfill plans today.

Highmark Comment:
According to the Centers for Medicare and Medicaid Services (CMS), which oversees the Medicare program, Medicare Advantage plans must cover all medically necessary services that Original Medicare covers. Additionally, Highmark uses nationally standardized criteria and national and local "Medicare Coverage Determinations" to review the medical necessity of services.

CMS defines Medical Necessity standards (as opposed to a member's doctor) for both Original Medicare and Medicare Advantage plans. In both original Medicare (and with Medicfill) as well as in a Medicare Advantage plan, if a service provided is determined by CMS to be "not medically necessary" the Medicare beneficiary maybe liable for payment for the service.

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Highmark's Medicare Advantage Plan and Prior Authorization

Highmark Comment:
Highmark's Medicare Advantage PPO plan currently has 24 medical benefit categories require prior authorization, in addition to select Medicare Part B drugs and supplies.

Prior authorization is a process that Highmark uses to determine if a prescribed medical service or supply is 1) covered by the member's plan, and 2), is medically necessary. This process helps to make sure our Medicare Advantage members are receiving the most appropriate medical services or supplies for their condition(s). It also assists the member's doctors by ensuring the member is receiving the service at the right time and place.

If prior authorization is required, the member's doctor contacts Highmark to start the prior authorization process. Our Utilization Management team will then work with the member's doctor to collect the necessary clinical and medical information for review. Highmark's prior authorization review nurses use nationally standardized criteria and national and local "Medicare (CMS) Coverage Determinations" to review the medical necessity of the requested services. If the review nurse is unable to approve the prior authorization request, the case is referred to a Medical Director (who is a physician) for a secondary review and determination. Prior authorization denials can only a made by an MD/Medical Director.

The Medicare Advantage prior authorization timeframe for confirming a decision is tightly regulated by CMS. For urgent/expedited prior authorization requests for medical services, a determination must be made within 72 hours. Decisions regarding standard/non-urgent requests for medical services or supplies must be made within 14 days. The vast majority of Highmark's request for Medicare Advantage prior authorizations are approved by Highmark with a 92% approval rate (as of mid-2022). If a prior authorization request is denied (again only by a MD/Medical Director), the member or the member's doctor, or the member's representative have the right to appeal the decision. Additionally, all Medicare Advantage plans must follow CMS guidelines regarding MA appeal rights, process and review and response timelines.

The prior authorization process not only helps ensure the member is getting the right care at the right time in the right place, but it also helps curb healthcare costs by limiting duplicative services. The prior authorization process also ensures ongoing or recurrent services are effective in improving or maintaining health.

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Retirees have no out of pocket maximum under Medicare/Medicfill and we do under the Highmark Medicare Advantage PPO plan for 2023.

Highmark Comment:
An out-of-pocket maximum in our Medicare Advantage plan for SoD retirees is included for the protection of members. Currently, the Medicfill coverage does not include any out-of-pocket maximum, so covered benefits under the Medicfill plan that have a member share of cost do not have any cap or limit to the member's share of costs.

The SoD custom Medicare Advantage plan added an out-of-pocket limit to provide a cap or "limit" to the retiree share of cost for the foreign travel professional services to maximum of $1,000/year. This is one of the many enhancements offered under the SoD custom Medicare Advantage plan.

The Highmark Medicare Advantage plan has been said to have co-payment, co-insurance, deductibles, and cost-share that are do not exist under original Medicare and the Medicfill supplemental plan today.

Highmark Comment:
While the current Medicfill plan does include some coinsurance, Highmark's SoD custom Medicare Advantage plan covers all Medicare benefits in full with $0 copay or $0 coinsurance to the member. A few examples include:

Inpatient hospital care
Highmark Comment:
With the SoD custom Medicare Advantage plan, all Medicare benefits including Inpatient rehabilitation is covered in full with $0 copay or $0 coinsurance to the member – there is no member share of cost for any Medicare covered service.

Additionally, under the Highmark SoD custom Medicare Advantage plan, there is no limit on the number of covered inpatient hospital days (upon Medical necessity defined by Medicare).

Under original Medicare + the Medicfill plan, inpatient hospital days coverage is limited to up to 365 days (upon Medical necessity defined by Medicare), and after day 365 the member would be responsible for all costs.

Skilled Nursing Facility care (SNF)

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Highmark Comment:
Both the original Medicare + the Medicfill plan and the Highmark SoD custom Medicare Advantage plan provide up to 100 days of SNF coverage per Medicare benefit period and this benefit is covered in full (i.e., no member cost share).

Emergency and Urgent care

Highmark Comment:
With the SoD custom Medicare Advantage plan, all Medicare benefits including Emergency care are covered in full at $0 copay or $0 coinsurance to the member – there is no member share of cost for any Medicare covered service.

Public comments have stated the difference between the current coverage under Medicare + Medicfill and the coverage under custom Highmark Medicare Advantage is limited to "in network" services only. Out of network coverage more limited than in-network and have additional costs share.

Highmark Comment:
The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both In-network and out of network providers both locally and nationally - (i.e., at $0 copay or $0 coinsurance to the member – there is no member share of cost for any Medicare covered service) across all 50 states, DC and in all US territories.

Public comments have been that Medicare Advantage plans are all from For profit insurance companies and that are only interested in profits.

Highmark Comment:
Medicare Advantage is a federally designed program, governed at the federal level and sustains extensive and frequently updated rules and guidance for all aspects of the program. CMS regularly reviews and audits Medicare Advantage plans adherence to these rules and regulations to ensure Medicare beneficiaries are receiving proper benefits and care, as well as ensuring these federal funds are used properly. Highmark's health plans are not for profit and take our responsibilities to each Medicare Advantage member, our plan sponsors and CMS very seriously.

Submitted Draft Report by Mr. Wayne Emsley, RHBAS Member

Draft Report to the Governor and Legislature:

The RHBAS, formed as a part of SB29, met in public session seven times, March 6, 16, 22 and 27, April 3, 17, and 26. By majority votes of the members, it makes the following findings and recommendations:

Task 1*: Conduct public meetings and receive public comment about current and future State retiree healthcare benefits, including the previously proposed Medicare Advantage Plan for State retirees, while taking into consideration the previous work of the State Employee Benefits Committee and the Retirement Benefit Study Committee.*

The subcommittee heard public comment at each meeting and devoted two meetings (March 22 and April 17) fully for public input. A 30-minute overview from a retiree perspective, was provided by Mary Graham, wife of a University of Delaware retiree. Public comments generally expressed a dissatisfaction with the preauthorization process required with Medicare Advantage, as well as in-network v. out-of-network issues. Commenters noted that major healthcare institutions such as Mayo Clinic, Johns Hopkins and Sloan-Kettering do not participate in Medicare Advantage. They expressed a desire to continue with the existing Special Medicfill plan.
The subcommittee reviewed the FY 2024 Group Health Insurance Plan cost projections and proposed premium increases to offset the forecast health fund deficit. In addition, the subcommittee reviewed the three considerations made by the Retiree Benefits Study Committee:

- Increase state funding for the OPEB Trust Fund
- Address Medicare-eligible and Pre-Medicare Costs
- Review Eligibility Changes for Future Retirees

In addition, the subcommittee studied prior OPEB funding and the 1% carveout initiated in FY2023 ($48 million) and proposed FY2024 ($51 million)

Task 2*: In the course of its work, consider how reporting and analyses regarding Medicare Advantage Plans nationwide relate to the terms of the previously proposed Medicare Advantage Plan for State retirees.*

The subcommittee reviewed the Medicare Plan options by state. Findings included:

- Five states offer different plans for state v. school retirees.
- 19 states (38%) offer choice between Medicare Supplement and Medicare Advantage plans to some or all Medicare Eligible retirees
- 39 states (78%) offer Medicare Supplement only, or Medicare Supplement as a choice.
- 16 states (32%) provide Medicare Advantage only.
- 5 states (10%) provide a Health Reimbursement Account to purchase Medicare Supplement and/or Medicare Advantage.

Had Delaware instituted the Medicare Advantage plan as proposed it would have been the 17th state (out of 50) to do so.

Task 3: *Study, review, and evaluate the fiscal and other implications of the extension of the existing Medicare Supplement plan to January 1, 2024.*

The subcommittee found that nearly all the premium cost for Medicare retirees is borne by the state. According to the Pension Office approximately $6.7 million in premiums are paid annually by retirees to the state (in addition to the monthly premium paid to Medicare), with the remaining $151 million paid by the state. However, the premiums paid have exceeded the claims and administrative costs consistently since 2016, with an accumulated excess of $107.9 million.

Clair DeMatteis, Secretary of the Department of Human Services, announced the administration's intent to continue the Special Medicfill plan for Medicare Retirees until June 30, 2024.

Task 4: *evaluate options for continuing to provide strong State retiree healthcare benefits in a fiscally sustainable way, including options to maintain their current coverage similar to residents in other states that offer a choice to buy into a Medicare Supplement plan.*

The subcommittee has begun considering the feasibility of maintaining retirees' current coverage by converting to an existing "off the shelf" Medicare Medigap Plan, perhaps plans F or G. This option, coupled with a Heath Reimbursement Agreement (Account) may provide retiree healthcare benefits in a way that is fiscally sustainable for the state and may provide retirees with choice to buy into a Medicare Supplement plan.

Task 5: *By May 1, 2023, issue findings and recommendations to the Governor and the General Assembly*

Recommendations:
The OPEB shortfall and long-term health care liability has developed over a 20-year period. The RBHAS task was made less burdensome because of the work done by the Retirement Benefits Study Committee, but it was too large a task to be reasonably completed in the six-week period allotted. With this in mind, the RBHAS recommends:

1. the Special Medicfill plan be extended until December 31, 2024.
2. the RBHAS subcommittee's authority be extended to September 30, 2023
3. the RBHAS be required to submit a final report to the Governor and Legislature by September 30, 2023, and that this report include:
    - a retiree health plan that is fiscally sustainable
    - addresses the OPEB liability
    - leads to a forecasted funding consistent with the existing Pension Fund
    - includes grandfathering for designated retirees
    - provides options for retirees to maintain their current coverage
4. a "Medicare Advantage only" plan for retirees will not be considered.

Document Submitted by Ms. Diana Noonan, Medicare Retiree

HIGHMARK DELAWARE FREEDOM BLUE PPO SPONSORED BY the State of Delaware

MEDICAL BENEFITS CHART

The following is a comparison of coverages as shown in the Highmark Medical Benefits Chart under Medicare Advantage compared to the coverage that we currently posse under traditional Medicare with Medicfill. The items in quotes are quotes from The Medical Benefits Chart..

"The Medical Benefit Chart on the following pages lists the services Freedom Blue covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met." "Your Medicare covered services must be provided according to the coverage guidelines established for Medicare."

> These two statements would encourage the Retiree to believe that all coverages under Medicare Advantage are equal to the coverages we currently receive under traditional Medicare and Medicfill This is a misleading statement and not true. Not all services covered under Medicare are i covered under Medicare Advantage.

The services listed in the Medical Benefits Chart (MBC) that are not covered equally under traditional Medicare, with our current Medicfill plan, and Medicare Advantage are addressed below. This is not a complete list.

The MBC states that out-of-pocket costs for each service are stated, but the items below clearly state differences in coverage. Also, the contractual costs are not defined, or identified in the MBC.

> The language for cost, cost sharing, $1000 out of pocket, and coinsurance is vague and ambiguous. All services are subject to the review for *"medically necessary."* In the MBC, there are 41 pages of services that must have prior authorization and are subject to cost sharing. It is important to note that all cost sharing must be paid at the time of service, in other words, prior to the procedure or service. An example of this would be when a retiree needs surgery, the provider would, in many cases need to obtain prior authorization, and the retiree would then be notified of the cost sharing amount that would have to be paid prior to the procedure. This means that the retiree would only be able to obtain the procedure, if they could afford the cost sharing. The cost sharing could be a small amount that would be difficult for a fixed income retiree to handle.
>
> *"Medically necessary" are services, supplies or drugs that are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice."*
>
> Cost sharing is not specifically defined in any of the Highmark literature.

Throughout the State and Highmark printed documents, terms are vaguely used and not definitively explained. The Statement that there is $1,000 out of pocket maximum would make the retiree believe that the most they would be accountable for in a year is $1000. In fact, services that require cost sharing are excluded from the $1000 out-of-pocket limit, and the charges that would be applied to the $1000 are not identified in the MBC.

In a March 27th presentation at the SEBC subcommittee meeting, the $1000 was stated in the footnotes as *"Applicable to any medical costs incurred by members during travel outside of the U.S. but would otherwise be defined by Medicare as covered services."* (Page 20 of the slide presentation *on March 27)* The MBC itself states that this item would not be covered by Medicare Advantage but would be covered by Medicare.

> *However, Page 96 of Chapter 10 'Definitions of Important words" Of the " 2023 Evidence of Coverage for Freedom Blue PPO"* section of the Highmark and State of Delaware Contract states:
>
> > Combined Maximum Out-of-Pocket Amount – *"This is the most you will pay in a year for all Part A and Part B services from both network(preferred) providers and out of network (non-preferred) providers See Chapter 4 Sect 1. Information about your combined maximum out-of-pocket amount."*
> >
> > Chapter 4 Section 1.2 Page 36 "*What is the most you will pay for Medicare Part A and Part B covered medical services? Can be found in the Medical Benefits Chart appendix." "The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount (The amounts you pay for services from out-of-n network providers do not count toward in-network maximum or out-of-pocket amount)." "In addition, amounts you pay for some services do not count toward your in-network services from network providers, "*

I believe it is easy to see that the terminology used throughout the Highmark literature is confusing to the retiree. What exactly is covered under the $1000 maximum remains a mystery.

The MBC also does not precisely define *"Medically necessary."* A service could be given to a retiree and then Highmark might decide that it was not medically necessary and deny coverage. Retirees face an unsure financial liability under Medicare Advantage; Medicare Advantage poses a threat to our very health and economic security.

> I have not had one item denied as medically unnecessary in the over ten years that I have had traditional Medicare and Medicfill, nor have I paid coinsurance, or had to obtain a prior authorization. There are many items covered by Medicare, that would need prior authorization under MA, and if the retiree or doctor did not know all the 41 pages. necessary of prior authorizations, before the service, coverage would be denied. Medicare Advantage does not have copays for most preventive services, that is true, however, if the preventive service becomes diagnostic during the procedure, it changes from a preventive service without copay to a diagnostic service that requires coinsurance, and/or one that could be denied, coverage. An example would be that a colonoscopy which would be covered as preventative but if surgery or polyp removal became necessary, only the part of the procedure that was preventative would be covered. The additional removal of the polyps would be subject to cost sharing, or denial when it became diagnostic, and the cost sharing would be required at the time of service.

The term *"meet accepted standards of medical practice"* could also be deceptively interpreted and the retiree could then be stuck with an expensive medical bill.

> *"Some of the services listed in the Medical Benefits Chart are covered as in-network services only or if your doctor or other network provider gets approval in advance (sometimes called "prior authorization")."*
>
> There are over 2000 medical procedures and services listed in the 41 pages of the Contract, along with many prescription drugs, that require prior authorization under Medicare Advantage. These items and medications are currently covered under traditional Medicare and Medicfill and would not be subject to prior authorization. Of course, the worry that seniors have is that these items could be denied, though ordered by our doctor and considered medically necessary in the eyes of our doctor. In the case that a procedure or test is denied, or that the retiree could not afford the coinsurance, there will be a pensioner whose very life might be in jeopardy.

"Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the Medical Benefits Chart."

> The State retiree population varies from those just 60 or 65 to retirees in their 90's. Some live in nursing homes, some have difficulties with their eyesight, and some do not have access to a computer. Marking items in the booklet with asterisks, check marks, which are supposed to apply to the Out-of-Pocket maximum, and a picture of an apple, which is supposed to be next to the preventive services listed in the MBC can, and will, be confusing to many seniors. This verbiage in entire MBC is vague, with ambiguous wording and confusing symbols, or in the case of cost sharing, preauthorizations, coinsurance and copays extremely deceptive.

"You never need approval in advance for out-of-network services from out-of-network providers."

> What the MBC does not state, is that if a service is out-of-network, it is subject to an unspecified cost sharing that must be paid at the time of service. Also, the service could be denied coverage as not medically necessary, or for a lack of preapproval.

"For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from."

"If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plans reimbursement rate (as determined in the contract between the provider and the plan).'

> The coinsurance percentage has not been identified in any of the literature that I have seen, nor have Retirees been made aware of the intricacies of cost sharing, or a *"percentage multiplied by the plan reimbursement rate?"*
>
> How can Retirees decide on Medicare Advantage, when we do not have the complete information, and the information that we do have is vague, and filled with inconsistences.

"If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers."

Again, we have not been notified of the particulars of coinsurance for out of network providers and are unaware of what it means in terms of dollars.

How can the SEBC Subcommittee make a recommendation without full knowledge of what you are recommending. It does not seem you that you can without an understanding of the total risk that the Pensioners will face?

MNC Pages A1-5

The following MBC pages describe benefits. I will only address most of those that are not covered, or if the coverage is inconsistent with traditional Medicare and Medicfill.

"Abdominal aortic aneurysms"

Coverage only applies to a diagnostic screening once a year. "Diagnostic cost sharing may apply."

This coverage would be an issue for people who have an abdominal Aortic aneurysm and may require more than one scan a year. My own husband falls in this case.

Traditional Medicare and Medicfill cover the costs.

"Acupuncture for chronic low back pain"'

Visits are limited to 12 visits per 90 days in total.

Services are covered only, if not associated with surgery or pregnancy.

An additional 8 sessions are possible, if preapproved, for a total of 20 per year.

"Treatment must be discontinued if the patient is not improving or is regressing."

Many pregnant women might require this service and not be covered under MA.

\ Medicare and Medicfill cover Acupuncture.

"Ambulance services* "(Require Prior Authorization)"

Medicare Advantage only covers Emergency Ambulance Service if it is **PREAPPROVED,** or if any other form of transportation would endanger the retiree's life. If preapproval is not obtained, the service may be denied as not *"medically necessary."*

There is a question if Medicare Advantage will cover the Paramedic that provides the care in the Ambulance. Paramedics could be an out-of-pocket charge to the retiree but would be covered by traditional Medicare and Medicfill. Also, MA could decide that the transport was not medically necessary, and coverage could be denied.

Nonemergency transport is only covered if the Retiree's condition would be endangered with another form of transportation. Highmark will not cover ambulance services it they determine that another means of transpiration would have been safe for the patient.

Traditional Medicare and Medifill would cover this service fully.

MA will only authorize payment of transport to the nearest facility that they deem appropriate.

There is an * next to Ambulance Services which indicates that prior authorization is needed. The service could be denied if deemed not medically necessary, or if prior authorization was not obtained.

Advanced life support services delivered by paramedics in Delaware would not be covered. These services seem only to have coverage if the paramedics work out the fire station that houses the ambulance.

Non-emergency ambulance services require a Physician Certification Statement.

Traditional Medicare and Medicfill cover Ambulance and Paramedic services.

MBC Pages A6-8

"Bone Mass Measurement"

THE MBC states that there is no coinsurance or copayment or deductible but does not address coverage for treatment,

Traditional Medicare pays for Bone Mass Measurement and treatment.

"Breast cancer screening"

MA allows for one screening mammogram every calendar year for women aged 40 and older and that includes a 3D mammogram.

"A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost sharing."

If a lump or suspicious image is found, then the test goes from preventative to diagnostic, there is a cost sharing despite the MBC indication that there is no cost sharing for this procedure. This wording is suspicious and confusing for a retiree. At the time of service

and/or procedure, the retiree is expected to pay the cost sharing charge; a charge they did not expect and most likely are unprepared to pay.

“Cardiovascular disease testing”

Blood tests for cardiovascular disease is allowed once every five years and are covered if the disease associated with the need for the blood tests is covered.

Again, vague wording and unpredictable costs.

This service would be covered by Medicare and Medicfill.

“Cervical and vaginal cancer screening.”

The MBC does not explain that should the preventative test turn diagnostic, there would be cost sharing.

Medicare and Medifill would cover this procedure.

“Correctol cancer screening”

If a biopsy is taken during the colonoscopy, or there is a removal of a polyp or growth, it becomes a diagnostic procedure and there is cost sharing for the portion that is not strictly preventative. A cost sharing that the retiree did not anticipate but will be expected to pay at the time of service.

MBC Pages A9-12

“Diabetes Screening”

Blood test screening is covered only if the patient meets a list of risk factors, or other requirements, such as family history. Based on test results, patient may be eligible for up to two diabetes screening every 12 months. Currently diabetes blood screening can happen every 6 months and even 3 months if medically necessary under traditional Medicare.

Diabetes screening is covered under Medicare and Medicfill.

**“Diabetes self-management training, services and supplies*

The booklet does not address medications. It also does not address services covered under Medicare for dietary care, exercise, or out-of-network coverage. There is a question about what diabetes supplies are covered. **MBC states the Retiree should call Member Services for details.**

These services are covered under Medicare and Medicfill.

Booklet Pages 10 – 16

“Durable medical equipment (DME) and related supplies”

“(For a definition of “durable medical equipment,” see Chapter 12 and Chapter3, Section 7 of the Evidence of Coverage.)” I believe they are referring to the contract, which a retiree would not possess, but I cannot be sure because they do not specify.

The MBC states that DME is 0% coinsurance for Medicare covered items but then it says cost sharing for Medicare Oxygen equipment is covered but the oxygen contents are subject to coinsurance for 36 months. The language is confusing, and it is uncertain what exactly is covered. Prior authorization is required for certain items, but it does not state what those items are.

I called Medicare to verify coverage, and they cover all DME at 80% and Medicfill picks up the 20%.

“Emergency care”

While the MBC states In and out-of-network emergency care has $0 copay, it also states*: “If you are admitted to the hospital with 3 days for the same condition, you pay $0 for the emergency room visit. The emergency room copayment applies if you are in the hospital for observation or rapid treatment and these are not considered hospital admissions.”* The language is very vague, but all emergency treatment is subject to the plan’s definition of medically necessary and is in danger of denied coverage.

Unless you are admitted as an inpatient, you will have to pay cost sharing amounts for overnight stays and until the MA coverage takes effect after the third day.

Our current plan, under traditional Medicare and Medicfill covers outpatient stays in the hospital from the first day with zero copay or coinsurance.

Traditional Medicare does not limit a retiree’s ability to be seen at an urgent care facility, and there is no charge with Medicare and Medicfill coverage for urgent care visits. If a retiree goes to an urgent care facilely on a weekend, MA can deny the coverage as not meeting the *“Medically necessary”* language in the policy. The retiree could then be responsible to pay the entire charge for the visit.

MA defines urgent care as being covered only in the case that the retiree cannot seek treatment from network providers, and it would be subject to cost sharing. They also can deny the visit making the retiree go through the appeal process. This entire section is subjective and relies on MA making fair and accurate decisions about the retiree’s health.

All Urgent care visits and service are paid under traditional Medicare and Medicfill.

“Home health agency care*

MBC states that there is 0% coinsurance per visit, but there is an asterisk in the heading indicating that prior authorization is needed.

Currently, under Medicare and Medicfill there is no charge for these services, nor is a prior authorization necessary.

“Home infusion therapy*

“Prior authorization is required for certain Part B drugs.”

I understand that there is some concern for this item, but I am unaware of exactly what it is.

I called Medicare to verify the coverage and they cover home Infusion therapy at 80% and Medifill covers the additional 20%.

“Hospice Care”

Retirees would be subject to cost sharing: “You will be billed Original Medicare cost sharing.” Our Medicfill plan would cover *the “cost sharing”* under traditional Medicare. The language is complicated and vague. However, the patient must continue to pay premiums to traditional Medicare and there will be different levels of payment and cost sharing depending on services and who provides the services.

Traditional Medicare and Medicfill will cover these services with no cost sharing. I know this, because I recently went through this with my mother, and there was no cost sharing involved.

I have to say, when reading this section, I was very troubled. Image a person who has just weeks or months to live, trying to decipher the language and intent of this section.]

Booklet Pages 16 – 26

“Immunizations”

MA does not pay for the same variety of immunizations as traditional Medicare. MA only pays for Pneumonia, flu, Hepatitis B and Covid. I recently had to have a tetanus shot, and the doctor remarked that it was a good thing that I did not have MA because they would not have covered tetanus vaccines.

Medicare and Medicfill cover immunizations.

“Inpatient hospital care”

Payment for inpatient care starts the day after a retiree is admitted and ends the day before they are discharged. This leaves the retiree libel for full payment of those two days.

Traditional Medicare and Medicfill pay for these two days.

“Private Duty Nursing in an acute hospital setting is covered. You pay, 20% coinsurance up to a 240-hour maximum within a 12-month period. MA pays 100% after the maximum hours are met. The cost sharing for Private Duty Nursing is not applied to your Out-of-Pocket Maximum.”

Organ Transplants - There is a list of covered transplants in the brochure; cost sharing applies. Patients must call Member Services for more information. I did not see drugs mentioned. There is a limit to the number of days a patient may say inpatient, but the MBC does not identify the number and if it is longer than the allowed days and the Retiree is unaware of this limit, they may be responsible for a huge hospital bill.

The Medicare booklet says that there is coverage in a Medicare approved facility for surgery, additional services and immunosuppressant drugs.

“Medicare Part B Prescription Drugs”

There is confusion about what injectables are covered under the MA plan. Part of the MBC suggests that injectables must be self-administered. It states that there is a 0% copayment for certain drugs, yet there is an asterisk in this category suggesting that preauthorization is necessary.

The MBC refers retires to HighmakStepBTargets.com for clarification. The retiree is at the mercy of the plan’s interpretation of what drugs are medically necessary and/or covered, as well as what charges will be applied.

These Drugs are covered under our current Plan.

The whole issue of Step Drugs is disturbing, but I am not addressing this issue at this time.

“Outpatient diagnostic tests and therapeutic services and supplies

The MBC says there is no coinsurance for lab services. However, the * in the heading, clearly indicates that preauthorization is necessary. The language again is vague and misleading to the retiree who has no idea what will or won’t be covered for outpatient diagnostic tests. Even the Medicare yearly blood tests require a preauthorization.

These tests and services are fully covered by traditional Medicare and Medicfill.

“Outpatient hospital observation”

“Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services.”

A retiree would not be considered an inpatient until the third day; therefore, these charges would be open to cost sharing, or a determination of not medically necessary, and could be denied coverage.

These charges are fully covered under Medicare and Medicfill.

“Self-administered drugs covered under Part D that are administered in an outpatient setting cannot be billed under the medical coverage and must be submitted through your Medicare Part D Coverage.” The language is vague as to what medical coverage would be paid, such as the Doctor or facility?

These charges would be paid under traditional Medicare and Medicfill.

“Outpatient hospital services*

Outpatient hospital services require prior authorization.

*“Unless the provider h*as written an order to admit you as an inpatient to the hospital, you are an and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered and outpatient.”

These services are covered by traditional Medicare and Medicfill.

‘Outpatient mental health care,” ”Outpatient rehabilitation services,” and ”Outpatient substance abuse services” all contain an asterisk in their heading signaling the need for prior authorization.

Since these services are Outpatient, it would follow that there would be a coinsurance, or cost sharing, however, the MBC states $0 copay and it is unclear if there is a coinsurance.

These services are fully covered under traditional Medicare and Medicfill.

“Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*”

All outpatient services are subject to cost sharing, though the Chart states that there is 0% coinsurance for these services.

These services are covered under traditional Medicare and Medicfill.

MBC Pages 27-38

"Physician/Practitioner services, including doctor's office visits."

"Services that are available via telehealth are listed in the description of this benefit. The cost sharing for an in-person telehealth visit will be the same for the type of service."

There are explicit categories of telehealth visits that would be covered; it is a long list. The Chart states $0 copay for primary care in-person and telehealth visits but then it limits when visits are an option as well as states that coinsurance is applied for telehealth visits. The language is vague and confusing.

Cost sharing for virtual visits: "all physician visits are covered under traditional Medicare and Medicfill."

This statement is contradictory to the next section.

"Telehealth – Remote access."

Telehealth visits for PCP or specialists' coverage is only available if the call is for medications reconciliation post-discharge, nutritional counseling, and pharmacy clinic counseling (chronic disease and medication management.

This information is in direct contradiction of the previous section. The two sections are vague though they have $0 copay, it appears that they have coinsurance, if covered at all.

Traditional Medicare and Medicfill cover all Telehealth calls.

"Urgently needed services"

Services needed on a weekend or while the Retiree is out of network, or unable to obtain care by a network provider, are covered with cost sharing and subject to *"medically necessary"* review. Any service not deemed *"medically necessary"* by Highmark would be denied coverage.

Traditional Medicare and Medicfill would cover these costs.

"Vision care"

Eye screening are covered once a year, if there is a diagnosis requiring care such as diabetes or glaucoma. There is no copay, but the Chart does not address coinsurance or cost sharing.

Traditional Medicare and Medicfill will cover yearly vision check-ups and medically needed rechecks.

Document
Submitted by
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Retired State Senator

RECENT NEWS COVERAGE OF MEDICARE ADVANTAGE PLANS

Compiled by Karen Peterson

"A Third of Docs Blame Prior Authorizations for Serious Harm to Patients"
(MedPage Today – March 13, 2023)

"The Wrong choice of Medicare Advantage Plan could kill you"
(Justcare usa, 9/9/20)

"Highmark fined for violations, including wrongly denying claims or paying them too slowly"
(Post Gazette, 2/10/23)

"Opinion: Medicare Advantage? More like Medicare Disadvantage"
(Washington Post, 11/30/22)

"HHS Report: Medicare Advantage Plans Deny Some Needed Care --
13 percent of MA-denied services likely covered under original Medicare"
(AARP, 4/28/22)

"City of Hope Study Finds Medicare Advantage May Put Complex Cancer Surgery Patients at a Disadvantage"
(City of Hope, 11/21/22)

"Diabetes Patients on Medicare Advantage Plans More Likely to Have Worse Health, Study Finds"
(Univ. of Pittsburgh Med. Ctr., 7/7/22)

"Providers say Medicare Advantage hinders new methadone benefit"
(Roll Call, 1/4/23)

"Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care"
(Office of Inspector General, HHS, 4/27/22)

"Privatization Scam Threatens to Replace Traditional Medicare Altogether by 2030 – Medicare Advantage serves private health insurers and investors at the expense of the public interest"
(Truthout, 1/11/23)

"'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions – By next year, half of Medicare beneficiaries will have a private Medicare Advantage plan. Most large insurers in the program have been accused in court of fraud."
(New York Times, 10/8/22)

"Nursing Home Surprise: Advantage Plans May Shorten Stays to Less Time Than Medicare Covers"
(Kaiser Health News, 10/4/22)

"Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need"
(STAT News, 3/13/23)

"The Medicare Advantage scam and beyond"
(Justcare usa, 9/29/20)

"Should Doctors Warn Patients About the Downsides of Medicare Advantage Plans?"
(MedPage Today, 12/8/22)

" The Inability to Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight"
(Office of Inspector General, HHS, Feb. 2023)

"How big insurance is profiting massively from Medicare privatization"
(Raw Story, 2/28/23)

"Medicare Advantage Plans Take Top Spot in Shkreli Awards – Lown president calls the list 'a tragic comedy of grift and profiteering'"
(MedPage Today, 1/10/23)

"Replace the failure of Medicare Advantage with 'Medicare Part F'"
(STAT News, 11/15/22)

"Time to End the Medicare Advantage Scam"
(Hartmann Report, 9/8/21)

“Pitfalls of Medicare Advantage Plans”
(Investopedia, 6/27/22)

“Medicare is being privatized right before our eyes”
(Vox, 3/17/23)

“Barriers to Care for Medicare Advantage Enrollees Highlighted even as Insurance Industry Continues Effort to Retain their Overpayments”
(Medicare Advocacy, 3/16/23)

“Insurance requirements for prior authorization may prompt ‘devastating’ delays”
(CNN Health, 3/10/23)

“Seniors are getting ripped off”
(The Guardian, 2/1/23)

“Biden administration proposes crackdown on scam Medicare ads”
(Associated Press, 12/15/22)

“Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare’s Solvency and Affordability Challenges”
(Kaiser Family Foundation, 8/17/21)

“Considering a Medicare Advantage Plan? Be Wary of Promises”
(Kiplinger, 10/18/22)

“States jump into fight over prior authorization requirements”
(Axios, 1/27/23)

“Feds expect to collect $4.7B in insurance fraud penalties”
(Associated Press, 1/31/23)

“Medicare Advantage Enrollees Discover Dirty Little Secret – Getting out is a lot harder than getting in”
(MedPage Today, 1/9/20)

“Medicare Delays a Full Crackdown on Private Health Plans”
(delayed for three years – could result in higher premiums or reduced benefits)
(New York Times, 3/31/23)

“Highmark CEO sees 11% pay boost to $8.64 million”
(Pittsburgh Post Gazette, 11/12/22)

“How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them.”
(ProPublica, 3/25/23)

“Medicare Advantage Plans Losing Their Edge for Patient Outcomes”
(MedPage Today, 12/6/22)

“Toll from prior authorization exceeds alleged benefits, say physicians”
(American Medical Association Press Release, 3/13/23)

“Skilled Nursing Operators Protest ‘Insane Amount’ of Administration Needed as Medicare Advantage Expands”
(Skilled Nursing News, 2/24/23)

“Dr. Marvin Malek: State workers – and the rest of us – should resist Medicare ‘Advantage’”
(vtdigger, 3/31/23)

“It’s Time to End the Medicare Advantage Scam”
(The Nation, 12/9/22)