

## Changes to Medicare due to COVID-19 public health emergency

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The Centers for Medicare and Medicaid Services or CMS has responded to the COVID-19 pandemic by making several temporary changes to the health care coverage provided to the nearly 60 million Americans covered by Medicare.

Recent legislation and the declaration of a public health emergency has given CMS the authority to make changes in Medicare coverage.

During this podcast, keep in mind that Medicare not only covers individuals age 65 and older but also younger adults with long term disabilities. Those covered by Medicare, young and old are more vulnerable to becoming seriously ill if infected by coronavirus that causes COVID-19.

COVID- 19 is an infectious respiratory disease. There is no vaccine or cure currently.

The diagnosis of the disease is made through testing. Treatment varies depending on the illness severity.

### Current Medicare Coverage

Before we begin discussing how CMS has changed Medicare coverage rules, let's review current Medicare coverage. That will give us a basis to better understand how the diagnosis of COVID-19 will be covered by Medicare.

First, there are two ways a beneficiary may be covered under Medicare. The first is through **traditional Medicare**.

Traditional Medicare includes:

**Part A** covers hospital stays and stays in a skilled nursing facility after a stay in a hospital. In 2020 a beneficiary pays the first \$1,408 of a hospital stay during a benefit period. This co-payment applies to the first 60 days of the hospital stay. If the stay goes beyond 60 days, co-payments apply. Part A covers the stay in a skilled nursing facility after a stay in a hospital. Days 1 through 20 are covered 100%; days 21 through 100 include a \$176 per day deductible.

**Part B** pays 80% of the approved cost of doctor bills, outpatient services, durable medical equipment and some prescription drugs (those administered in the doctor's office). The beneficiary pays 20% of the cost. For COVID-19 related outpatient services covered by Part B, the beneficiary must pay a \$198 annual deductible in 2020 and the 20% coinsurance that applies to seeing the doctor and ambulance services.

81 percent of beneficiaries in traditional Medicare have some form of supplemental coverage. Supplemental coverage includes Medigap plans provided by private insurance, retiree health

benefits and, for beneficiaries who meet the income and asset tests, Medicaid. Unfortunately, over 6 million beneficiaries do not have supplemental coverage. This means they must pay the annual deductible, co-insurance and co-payments out of pocket. Keep in mind also, that Medicare does not have an annual out-of-pocket limit.

**Part D** covers prescription medications. These medications are typically self-administered. Plans are offered through private insurance companies. Each plan includes an annual deductible (\$435 in 2020), co-payments and co-insurance. The deductibles, co-pays and co-insurance are not paid by any supplemental coverage.

The second type of coverage is through a **Medicare Advantage** plan. These plans are offered through private insurance companies. In addition to providing health care coverage, most plans include a prescription drug plan. While Medicare Advantage plans must offer similar benefits as traditional Medicare, cost-sharing varies among plans. Most Medicare Advantage plans are either a Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO). Beneficiaries going outside network providers in a PPO may pay more than seeing a network provider. HMO beneficiaries must go to network providers for the plan to pay for the care. Exceptions are provided for emergency care.

***So, now that you know the basic structure of care provided under traditional Medicare and Medicare Advantage plans, let's review the changes made by CMS due to the pandemic. Our first focus will be on current testing for COVID-19 and treatment. We will then consider the expansion of telemedicine services paid for by Medicare. We will discuss what will happen if a vaccine is developed and approved, changes to Part D (prescription drug) coverage, use of out-of-network providers by Medicare Advantage beneficiaries and waiver of the 3 day hospital stay rule in order for Medicare to cover a subsequent stay in a skilled nursing facility.***

***Many of the changes described (such as telemedicine coverage) are temporary and will presumably end once the public health emergency is declared ended.***

### **Changes due to COVID-19**

**Testing** for COVID-19 ordered after February 4, 2020 is covered under traditional Medicare Part B when ordered by a physician or other health care provider. Beneficiaries are not required to pay the Part B deductible or any related co-insurance. Clinical diagnostic laboratory tests are covered under traditional Medicare with no out-of-pocket costs. ***Costs normally paid by the beneficiary for services related to the COVID-19 testing are eliminated.*** "Testing-related services" include the costs of a visit to a physician or outpatient facility. Medicare Advantage plans may not charge for COVID-19 tests and testing related services. Nor may plans use prior authorization or other utilization requirements for testing.

**Treatment** - As I discussed earlier in the podcast, Medicare Part A covers stays at a hospital, skilled nursing facilities, home health care, hospice care. Part B covers doctor visits, outpatient services, emergency room visits, ambulance transportation, durable medical equipment. Part B also covers certain prescription drugs (usually those administered by a health care professional).

If the beneficiary is admitted to a skilled nursing facility after a hospital stay, Medicare does provide coverage for up to 100 days (days 1 through 20 are covered by Medicare at 100%; days 21 through 100 Medicare covers the cost of the stay less a \$176 per day co-payment).

Medicare Advantage plans must cover all Part A and Part B services for treatment related to COVID-19 as does traditional Medicare. The Medicare Advantage plan may not cover the \$176 per day co-payment for days 21 through 100.

Beyond the 100 days of coverage, Medicare does not cover long-term services and supports (LTSS) for an extended stay in a nursing home.

Here are some differences.

If a Medicare patient is required to be quarantined in the hospital even if they no longer require acute care, they will not be required to pay an additional deductible for the cost of the quarantine.

Recall that for those Medicare beneficiaries that have Medicare supplemental coverage, the annual deductible, co-insurance and co-payments may be paid by the supplemental coverage. **But which of these costs is paid for by the supplemental plan depends on the plan. Some supplemental plans pay the daily co-pay for a stay at a skilled nursing facility (Medigap Plan G) while others do not (Medigap Plan A).**

In addition, traditional Medicare does not have an annual out-of-pocket limit for Part A and Part B services. For traditional Medicare beneficiaries without supplement coverage, they run the risk of high medical expenses.

For Medicare Advantage beneficiaries, cost-sharing requirements vary across plans. Medicare Advantage plans are required to have an annual out-of-pocket maximum which offers some protection of high medical expenses. Medicare Advantage plans may waive or reduce cost sharing for COVID-19 related treatments but this is not required. A few companies have announced plans to reduce cost sharing. CMS has also announced that Medicare Advantage plans may waive prior authorization requirements for COVID-19 services.

***If you or your clients participate in a Medicare Advantage plan check with the plan regarding COVID-19 related changes to both testing and treatment.***

**Vaccine** – Under recent legislation, Medicare Part B is required to cover a COVID-19 vaccine if it becomes available. Cost sharing, the Part B annual deductible and the 20% co-insurance, will not apply.

**Telemedicine** – Effective for services beginning on March 6, 2020 telemedicine services are now available to beneficiaries in any geographic area. This is most important to beneficiaries in traditional Medicare. Medicare Advantage plans are already able to offer telemedicine services to beneficiaries. The Kaiser Family Foundation describes these services as allowing “beneficiaries in any geographic area to receive telemedicine services; allows beneficiaries to remain in their homes for telemedicine visits reimbursed by Medicare; allows telemedicine visits to be delivered via smartphone with real-time audio/video interactive capabilities in lieu of other equipment; and removes the requirement that providers of telemedicine services have treated the beneficiary receiving these services in the last three years.” Note that telemedicine services are NOT limited to COVID-19 related services, and can include regular office visits, mental health counseling and preventive health services.

Telemedicine also includes “virtual check ins” (aka, “brief communication technology-based services”) with the client’s doctors and certain other practitioners. Virtual check-ins allow the client to talk to his or her doctor or certain other practitioners, like nurse practitioners or

physician assistants, using a device like a phone, integrated audio/video system, or captured video image without going to the doctor's office. The Medicare beneficiary pays 20% of the Medicare approved amount.

**Extended medication supplies** – Recent legislation requires Medicare Part D (prescription drug) plans to provide up to a 90-day supply of covered drugs to beneficiaries who request it. This will help ensure an ongoing supply of prescription medications. Part D sponsors are also required to cover drug purchases at out-of-network pharmacies if the beneficiary cannot be reasonably expected to use a network pharmacy. Part D may also relax any restrictions they may have regarding the delivery method (e.g., home delivery, mail delivery).

**Other changes include:**

- ✓ As mentioned early in this podcast, Medicare Advantage plans are often network plans in the form of a PPO or an HMO. During the declaration of a public health emergency, Medicare Advantage plans must cover services at out-of-network health care facilities. Beneficiaries who receive out of network care, may not be charged any more than they would be charged if they went to an in-network provider.
- ✓ Prior to the pandemic, Medicare paid for a stay in a skilled nursing facility only if it was preceded by a 3 day stay in a hospital. This requirement has been waived for those beneficiaries transferred to the skilled nursing facility as a result of a disaster or emergency. If a beneficiary has recently stayed in a facility for more than 100 days, he or she may extend their covered stay.

Other rules apply. For details go to [www.medicare.gov](http://www.medicare.gov) . Click on What Medicare Covers. From the drop-down menu click on Is my test, item or service covered? You can input virtual check-ins, E-visits, Telemedicine, COVID-19, skilled nursing care for additional information.

To find more financial planning resources related to the impact of COVID-19, visit [aicpa.org/pfp/covid19](http://aicpa.org/pfp/covid19). For all other AICPA PFP Section resources, visit [aicpa.org/PFP](http://aicpa.org/PFP).