★ ★ TIP SHEET ★ ★

Information Partners Can Use on:

# Refunds of Premiums and Copayments

**Medicare Prescription Drug Coverage** **Revised September 2011**

This tip sheet explains how people with Medicare can get paid back for Medicare drug plan copayment and/or premium amounts they may have overpaid.

## How to get reimbursed for incorrect copayment amounts

**What should people with Medicare do if they paid out-of-pocket for drug costs because they needed to fill a prescription before they got their plan membership card or confirmation letter?**

A Medicare drug plan will reimburse people with Medicare who pay for prescriptions that should be covered by their plan. To get reimbursed, the person should take the following steps:

1) Save the original receipt from the drug purchase. If the person no longer has the original receipt, he or she can contact the pharmacy and ask for a replacement receipt or other proof of purchase.
2) Call the plan's customer service phone number on the membership card, read the plan's printed materials, or look on the plan's member Web site to find out about the reimbursement process.
3) Get a copy of the plan's claim submission or reimbursement form, if needed.
4) Fill out the form and submit it to the plan with the original or replacement receipt.

**What if someone who qualifies for the low-income subsidy (LIS), but doesn't have proof, is charged an incorrect deductible or copayment amount?**

To avoid paying incorrect amounts, people who qualify for LIS should provide the pharmacy or their plan with one of the following documents as proof they qualify:

- A copy of their yellow, green, or purple automatic enrollment letter from Medicare
- Their "Notice of Award" from Social Security
- Their Medicaid card (if they have one) or any document that shows they have Medicaid
- A bill from an institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month
- A print out from their state's Medicaid system showing that they lived in the institution for at least a month
- Effective January 1, 2012, a document from their state that shows they have Medicaid and get home and community-based services

**What if someone who qualifies for the low-income subsidy (LIS), but doesn't have proof, is charged an incorrect deductible or copayment amount? (continued)**

If proof isn't available, a person who qualifies for LIS should contact their State Medical Assistance (Medicaid) office or Social Security to get at least one of the documents mentioned here. The person can call 1-800-MEDICARE (1-800-633-4227) to get the phone number for their Medicaid office. TTY users should call 1-877-486-2048.

People who qualify for LIS after they enrolled in a Medicare drug plan may be due refunds from their plan for premiums and copayments paid during months they qualified for LIS retroactively. If people paid premiums or copayments in excess of LIS amounts during a period of retroactive LIS coverage, they should contact their Medicare drug plan to find out how to submit a claim for reimbursement. They should save the original receipt from the purchase in case they need to submit it with the claim. Their drug plan should give them a refund within 45 days.

**Note:** When Medicare records show that a person's Medicaid or Supplemental Security Income (SSI) eligibility is retroactive to past months, their LIS and automatic Medicare drug coverage (if they aren't already enrolled in a Medicare drug plan) is retroactive for the same period. People with retroactive coverage can get reimbursed for covered Part D prescriptions they paid for during any past months they were entitled to retroactive coverage. For more information about retroactive coverage, visit www.cms.gov/partnerships/downloads/11401-P.pdf to view the tip sheet "The Limited Income NET Program for People With Retroactive Medicaid & SSI Eligibility."

## How to get reimbursed for incorrect premium amounts

**What should people do if a higher premium amount is deducted from their Social Security or Railroad Retirement Board (RRB) benefit?**

If there is a premium overpayment, such as when a person changes to a lower premium plan and the premium change doesn't immediately go into effect, Social Security or RRB will automatically refund the premium overpayment. The person will get a refund check separate from his or her regular monthly Social Security or RRB benefit. It may take 2–3 months to get a refund. After 3 months, people should contact 1-800-MEDICARE.

**What happens if a person is in a Medicare Advantage Plan that lowers the Medicare Part B premium, but the person is charged the full premium amount?**

Some Medicare Advantage Plans pay some or all of their members' Part B premium as part of the plan's benefits. It may take up to 2 months for a member to see an increase in his or her Social Security check equal to the amount of the reduction in the Part B premium. If a member didn't see an increase, the incorrect withholding amount will be repaid to the member all at once.

**What happens if a person is in a Medicare Advantage Plan that lowers the Medicare Part B premium, but the person is charged the full premium amount? (continued)**

Depending on the payment method a member selected, one of the following will occur:

- They will have their regularly scheduled Social Security benefit payment increased.
- They will get a refund check from the plan or Social Security.

The member should call his or her plan if the amount that was incorrectly withheld isn't refunded.

**What happens if a person who qualified for the low-income subsidy (LIS) is charged a premium?**

People who qualified for the full LIS should generally pay no monthly prescription drug premium. However, if they select a plan that doesn't have a $0 premium for people qualifying for the full LIS, they will have to pay a small premium amount. Also, if they join a Medicare drug plan with supplemental benefits, they will pay the plan's supplemental premium. People who qualified for the partial subsidy may pay no premium or a reduced premium for a basic plan, depending on income.

Drug plan sponsors have been instructed not to bill a new member until Medicare tells the plan what the member's premium should be. However, in some cases, plans might mistakenly send bills for full plan premiums to certain members who qualify for LIS or to members who qualify retroactively for LIS. If a person with LIS receives a bill in error, they should call their plan.

Plans have the option to not disenroll members for failure to pay their premium bill if the person might qualify for the full or partial LIS amount. People who get a notice that says they will be disenrolled for non-payment of premiums should call their plan.

If the Medicare drug plan billed a member who should have a reduced or $0 premium and the member paid the premium, the Medicare drug plan will refund the amount overpaid. The member can call the customer service phone number on the membership card, read the plan's printed materials, or look on the plan's member Web site to find out about the reimbursement process.

## Questions about premium witholding

**Why would someone have two premiums deducted in one month?**

People who enroll in a Medicare drug plan at the end of the month may be billed multiple premium payments in a later month. Depending on which payment method was selected, one of the following will occur:

- They will get a bill for 2 months of premiums. Plans generally send bills at either the beginning or the end of the month. It varies by plan.

**Why would someone have two premiums deducted in one month? (continued)**

- They will have 2 months of premiums withdrawn from the selected account. This could show as two separate withdrawal amounts, or one withdrawal at double the amount, depending on the plan. These withdrawals generally happen at either the beginning or the end of the month.
- Depending on when the withholding request gets processed by the withholding agency (Social Security or RRB), they may have 2 months of premiums withheld from their monthly Social Security or RRB benefit payment. If requests to have premiums withheld beginning January 1, 2012 are received after December 7, 2011, they will be converted to direct bill for the January premium. Plans should then resubmit a person's election for premium withholding prospectively.

**What happens if people choose the premium withholding, but they also have a secondary insurer that pays part of the drug plan premium?**

People who get a premium benefit from a secondary insurer (a plan other than their Medicare drug plan), such as an employer health plan or a State Pharmacy Assistance Program (SPAP), will have the entire monthly premium withheld if they choose the Social Security premium withholding option. The Medicare drug plan will give the member a refund for the amount the employer health plan or SPAP pays the plan. For example, if a member with a $20 drug plan premium has a SPAP premium benefit of $10 per month and the member chooses premium withholding, Social Security will withhold the full $20. The Medicare drug plan will refund the member $10.

Plans shouldn't convert a member with secondary coverage from premium withholding to direct billing, unless the member requests it, but they may encourage members to choose this method of billing. If a member chooses direct billing, he or she will get a bill from the plan for the correct premium amount. Generally, the SPAP or employer will pay its share directly to the plan.