# Responses to Misconceptions regarding the Aetna Medicare Advantage PPO Plan – June 9, 2023

1. **Aetna Medicare Advantage is not a Medicare plan.**

This is not correct. The Aetna Medicare Advantage PPO plan is offered under a contract with the Centers for Medicare and Medicaid Services (CMS). CMS is also the federal agency that administers the Original Medicare program. Medicare Advantage plans are offered under Medicare Part C and Medicare prescription drug plans are offered under Medicare Part D, so these plans are offered as part of the Medicare program. The Aetna Medicare Advantage PPO plan is required to cover, at a minimum, the same benefits covered under Original Medicare. Insurance companies offering Medicare Advantage plans are required to comply with their CMS contract and applicable federal laws, rules and regulations, which provide numerous protections to Medicare beneficiaries enrolled in Medicare Advantage plans. Medicare Advantage plans are also overseen by CMS and other federal agencies with jurisdiction.

The Medicare Part C law is found in 42 U.S. Code §§ 1395w-21–1395w-28 and the regulations are located at 42 C.F.R. Part 422. The Medicare Part D law is found in 42 U.S Code §§ 1395w-101–1395w-154 and the regulations are located at 42 C.F.R. Part 423.

2. **Aetna sells Part D plans in the Individual Market for as little as $6/month. Aetna is ripping off the City Retirees with it $103 rate for 2023 and $135 for 2024.**

This is simply False. Individual Market Part D plans generally offer less benefits and smaller formularies as compared to employer group Part D plans, like the City's Part D Rider plan offered to retirees. The City of NY Part D Rider plan offers a robust plan design and an "Open formulary." This means that all FDA approved drugs (which includes all Part D drugs) are available to City retirees. The formulary for the City's Part D Rider plan includes about 460,000 drugs. Retirees need to consider these benefit and formulary differences between the City's Part D Rider and Individual Market Part D plans. (However, please note that CMS does not allow Medicare beneficiaries to enroll in an Individual Market Part D plans when they are enrolled in a group Medicare Advantage plan). Additionally, the current 2023 prices for Individual Market Part D plans do not reflect the potential impact of the Inflation Reduction Act (IRA) that goes into effect for 2024. Individual Market Part D pricing for 2024 has not been released yet by any carrier. Pricing comparisons (now more than ever) need to be based on the same year due to recent legislation and the impact of its timing.

3. **St. Francis Hospital on Long Island does not accept the Aetna Medicare Advantage PPO plan.**

This is False. In fact, Aetna and St. Francis Hospital have a multi-year network contract in place for the Aetna Medicare Advantage PPO plan. So, St. Francis Hospital is in the Aetna Medicare Advantage PPO plan network and accepts the plan.

4. **Memorial Sloan Kettering (MSK) and Hospital for Special Surgery (HSS) are not in Aetna's Medicare Advantage network, so they will not accept the plan.**

Again, this is not true. Both MSK and HSS have signed network contracts with Aetna specifically for the Medicare Advantage PPO plan offered to the City of NY retirees. These contracts were signed months ago. So, MSK and HSS are in the Aetna Medicare Advantage PPO plan network and accept the plan offered to City of NY retirees.

5. **NYU Langone is not in Aetna's network and does not accept Aetna's Medicare Advantage Plan.**

Once again, this is not true. NYU Langone has been a longtime partner of Aetna's and is in the Aetna Medicare Advantage network. They look forward to treating City of NY retirees enrolled in Aetna's Medicare Advantage PPO plan.

6. **Stony Brook does not accept the Aetna Medicare Advantage PPO plan.**

This is incorrect. While Stony Brook is currently out of network, Stony Brook has treated Aetna Medicare Advantage patients and has accepted the Aetna Medicare Advantage PPO plan. In fact, Aetna has paid numerous Medicare Advantage plan claims submitted by Stony Brook in 2022 on behalf of Aetna Medicare Advantage members living in the NYC area. Aetna continues to pay Medicare Advantage claims from Stony Brook in 2023. Aetna and Stony Brook are in the very final stages of completing and signing a Network contract specifically for City of NY retirees enrolled in our Aetna Medicare Advantage PPO plan.

7. **Aetna is misleading people when it says that it covers 88% of the doctors. Why doesn't it state what % of doctors nationally accept their plan? When we get a lot older, we'll need more doctors.**

The claim that Aetna is misleading people is incorrect.

After Aetna was selected by the City to administer the Medicare Advantage plan, in early January 2023 Aetna received a file a with the most recent provider utilization data for Senior Care members. This file includes all providers that treated Senior Care members in 2023.

Aetna analyzed the provider utilization data for Senior Care members and determined that 88% of providers currently treating Senior Care members are in-network for the Aetna Medicare Advantage PPO plan, and an additional 8.3% of these providers submitted and accepted claim payment for Aetna Medicare Advantage PPO plan members. In total, this means that 96.3% of the providers who treated Senior Care members are either contracted with Aetna or are non-contracted but agreed to treat Aetna Medicare Advantage PPO plan members in the past. The providers who do not have a contract with Aetna but have treated their members were paid at 100% of the Medicare allowable rate, which is the same rate that providers are paid when they see Senior Care members.

8. **The contract says Aetna can reinstate the prior authorizations it turned off after the first two years of the contract.**

This claim is not true. Some prior authorizations for services such as radiology (MRI, CAT Scan, PET Scan etc.) were removed for the first term of the contract (5 years and 4 months). Another set of prior authorizations were removed for a payment of $15 per member per month by the City to Aetna and this removal was not tied to a specific timeframe in the contract. Aetna cannot reinstate prior authorizations during the applicable contract timeframes without approval from the City and the MLC.

As part of the contract management process, Aetna, the City and the MLC will review prior authorizations every 2 years after the start date of contract. This review will be focused on the performance of the prior authorization process. For example, we will evaluate any new procedures, treatments, therapies and drugs that were added to plan coverage since the last review to check if they need prior authorization. Aetna, the City and the MLC must agree on whether any new procedures, treatments, therapies or drugs need prior authorization.

9. **Some have urged retirees to call their doctors and ask them if they accept the "City of New York Advantage plan" and then to report back what the response is from the doctor's office. Should I be concerned if my doctor's office has said they will not accept that plan?**

This is misleading. The doctor's offices will likely say that they don't accept the "City of New York Advantage plan" because there is no health plan with that name. The name of the plan is the "Aetna Medicare Advantage PPO plan". While the Aetna Medicare Advantage PPO plan is a unique, customized plan built specifically for the City of New York, the plan is built on the "Aetna Medicare Advantage PPO plan" network, so that is the plan name the doctor's offices are familiar with.

Here are some steps you can take to confirm if your doctor accepts the Aetna Medicare Advantage PPPO plan:

- Look your doctor up on Aetna's dedicated CONY (cony.aetnamedicare.com) website to see if he/she is in Aetna's network.
- If you don't see your doctor listed as being in network on the Aetna website, call Aetna and give them your doctor's name/number and they will reach out to him/her on your behalf to see if they will accept the plan. Aetna will follow up with you to let you know the results.
- Call your doctor's office and ask if he/she accepts the "Aetna Medicare Advantage PPO Plan".

10. **Aetna's Star Rating has dropped to 3.5 Stars.**

Like many large insurance companies who sell Medicare Advantage products, Aetna has many different contracts with the Centers for Medicare and Medicaid Services (CMS). One of Aetna's contracts did fall to a 3.5 Star Rating for 2023. However, the Aetna Medicare Advantage plan offered to the City of New York's retirees will be placed on a contract with a 4.5 Star Rating for 2023. As a reminder, CMS' Star Rating System ranges from 1 to 5 Stars, with 5 Stars being the highest Rating.

11. **Medicare Advantage plans have over 100 Prior Authorizations in place.**

Aetna can't comment on all Medicare Advantage plans, but they can focus on the unique, customized Medicare Advantage plan that was built just for the City of New York. The Aetna Medicare Advantage PPO plan being offered to City of New York retirees the overwhelming majority of prior authorizations have been turned off. There are six categories of items/services that will still require prior authorization.

Here is a link to a document on the City's website that provides more information regarding prior authorizations with the Aetna Medicare Advantage PPO plan:
[https://www.nyc.gov/assets/olr/downloads/pdf/health/aetna-ma-docs/22-cny-0025-prior-authorization-brochure-single-pages.pdf](https://www.nyc.gov/assets/olr/downloads/pdf/health/aetna-ma-docs/22-cny-0025-prior-authorization-brochure-single-pages.pdf)

12. **Medicare Advantage plans limit access to care and treatments.**

Pursuant to 42 C.F.R. Section 422.101, Medicare Advantage plans must follow coverage guidelines set by CMS for Medicare-covered services.

13. **We have no options other than Medicare Advantage. If we try to get a Medigap plan, we will be denied coverage due to pre-existing conditions.**

This is not the case. Under federal law, if you are eligible for a Medigap plan on a guaranteed issue basis and you are over 65 insurance companies cannot impose an exclusion of benefits based on pre-existing conditions.

Guaranteed Issue means that you are guaranteed to be issued a Medigap policy regardless of any health conditions you may have.

Under federal law, you have two ways to get access to a Guaranteed Issue Medigap plan in the Individual Market. Both ways will require you to waive City health benefits. Here are the two ways:

First, while Senior Care is not a Medigap plan, it operates as such as it supplements original Medicare. (Some States may not recognize the Senior Care plan as a Medigap plan under their Guarantee Issue rules.) For City of NY retirees, Aetna has agreed to broadly interpret the City's termination of the Senior Care plan effective 9/1/23 as triggering Guaranteed Issue rights. City of New York retirees can begin shopping for or even purchase a Medigap Plan in the Individual market now if they have a Senior Care plan termination letter, which they will need to show insurance companies to get a Medigap plan on a guaranteed issue basis. Retirees will want to apply for coverage no later than 63 days from the termination date of the Senior Care plan to get the coverage on a guaranteed issue basis. Aetna will offer access to Guaranteed Issue Medigap plans in the States where we offer Medigap plans. As a retiree, if you decide to choose this path, we urge you to discuss your options with an independent licensed health insurance agent. The agent's services do not cost you anything. They are paid by the insurance company whose plan you decide to purchase. An independent health insurance agent will represent many different insurance companies and can guide you to the right options for you to choose from based upon your needs.

The second way to obtain Guaranteed Issue Individual Market Medigap plans is through the use of the

Federal "Trial Right". This is for retirees who have never been in any type of Medicare Advantage plan. For those retirees who meet this requirement, they can go into the Aetna Medicare Advantage PPO Plan and try it for up to 12 months. If during the 12-month trial period the retiree decides that they don't like the Medicare Advantage plan, they can choose to leave the plan and purchase a Guaranteed Issue Medigap plan. This is a federal rule, so this is available in all 50 States. It is important to note that if the retiree chooses to exercise their right to purchase a Medigap policy, they will be waiving City of New York coverage of their healthcare and they will be responsible for paying the Medicare Part B and IRMAA premiums.

**14. Prior authorization is not required with any items or services under Original Medicare.**

This is not true. CMS runs a variety of programs under Original Medicare that support efforts to safeguard Medicare beneficiaries' access to medically necessary items and services while reducing improper Medicare billing and payments, which are described on CMS' website. CMS explains on its website that: "Through prior authorization and pre-claim review initiatives, CMS helps ensure compliance with Medicare rules."

Since September 2012, CMS has subjected selected items and services to prior authorization (PA) and pre-claim reviews—a process similar to prior authorization where the review takes place after services have begun and prior to final reimbursement—through several fixed-length demonstrations and a permanent program for certain DMEPOS items.

The following initiatives are currently in place:

- Certain Hospital Outpatient Department (OPD) Services
  - Mandatory PA for blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation started on June 17, 2020, for dates of service on or after July 1, 2020. Two additional hospital OPD services (cervical fusion with disc removal and implanted spinal neurostimulators) requiring prior authorization started on June 17, 2020, for dates of service on or after July 1, 2021. Facet joint interventions will require prior authorization for dates of service on or after July 1, 2023. A complete list of the many procedure codes for OPD services requiring prior authorization can be found on CMS' website. *See* Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services Frequently Asked Questions (FAQs) available here: opd-frequently-asked-questions.pdf (cms.gov).
- Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)
  - PA is voluntary. However, if an ambulance supplier elects to bypass prior authorization, applicable RSNAT claims will be subject to a prepayment medical review. Claims for the first three (3) round trips are permitted to be billed without prior authorization and without being subject to prepayment medical review.
- Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items
  - Mandatory PA for certain DMEPOS. CMS maintains a Master List of DMEPOS Items that may be subject to one or both of the following prior to delivery:
    - a face-to-face encounter and written order
    - prior authorization requirements
- Review Choice Demonstrations for Home Health Services and Inpatient Rehabilitation Services
  - CMS selects IRFs and HHAs that bill to certain Medicare Administrative Contractor (MAC) jurisdictions and offers them the option of selecting between several review choices such

as pre-claim review, post-payment review, and spot check review to validate whether the IRF/HHA is demonstrating compliance with Medicare rules through their pre-claim review affirmation rate or post-payment review approval rate.

15. **Retirees will be forced to pay for their own medical care out of pocket if they choose to see an out-of-network medical provider who refuses to bill Aetna despite agreeing to see patients enrolled in the Aetna MA plan.**

This is an extremely unlikely scenario. In the event that an out-of-network provider agrees to treat an Aetna MA plan member but refuses to bill Aetna for the service, the member has the *option* to obtain services from that provider, pay for the services out of pocket, and submit the claim for reimbursement to Aetna. If the provider is eligible to receive Medicare payment and the service is covered under the Aetna MA plan and Medicare, Aetna will issue reimbursement in the amount of Aetna's share of the cost for the services. In 2022, Aetna received 1,165,313 claim reimbursement requests from group MA PPO ESA plan members for items/services provided by an out-of-network provider. Aetna paid approximately 99.42% of these member out-of-network reimbursement requests.

Additionally, Aetna explicitly encourages members to ask out-of-network providers to bill Aetna first to avoid this scenario, and Aetna customer service is available to assist members with all claim scenarios. To further help avoid this scenario, if a member chooses to obtain services from an out-of-network provider that will not bill Aetna, the out-of-network provider or member may call Aetna Member Services to confirm that the services they will receive are covered and medically necessary.