

Chapter 5

Medicare Parts A, B, C and D

INTRODUCTION

In this chapter we will discuss the federal Medicare program. Enacted in 1965, the Medicare Program is Title XVIII of the Social Security Act. Medicare is a federal health program that provides both major medical coverage and coverage for medical expenses when an eligible person becomes ill.

This chapter outlines recent changes in the Medicare program and provides an overview of the current options available to eligible beneficiaries.

Paragraph 1 addresses the delivery of Medicare services.

Paragraph 2 addresses the sources of law.

Paragraph 3 is a brief overview of the Medicare program.

Paragraph 4 addresses Medicare eligibility.

Paragraph 5 addresses the four parts of Medicare.

Paragraph 6 addresses what Medicare does not cover.

Paragraph 7 addresses the deductibles, coinsurance and copayments of Medicare.

Paragraph 8 addresses costs with Part A of Original Medicare.

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Paragraph 10 addresses doctors and health care providers that accept assignment.

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Paragraph 13 lists the four ways to enroll in Medicare.

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Paragraph 15 discusses enrollment- when a beneficiary automatically qualifies or must apply for Medicare

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Paragraph 17 addresses ways to supplement Medicare.

Paragraph 19 addresses Part D of Medicare; prescription drug coverage.

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Paragraph 21 addresses Medicare private health plans.

Paragraph 22 addresses concerns with Medicare Advantage plans.

Paragraph 23 addresses types of Medicare plans.

Paragraph 24 addresses when to enroll in a Medicare Advantage plan.

Paragraph 25 discusses common problems with Medicare and tips to avoid them.

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1. Delivery of Medicare services

Medicare is a federal health program for people aged 65 and older and individuals disabled or diagnosed with chronic illness as defined by law. The Medicare program is delivered through the Centers for Medicare and Medicaid Services (CMS.) CMS operates under the supervision of the United States Department of Health and Human Services (HHS.)

2. Sources of law. Changes to the Medicare program were enacted through the following legislation that impacts the Social Security Act:

- Patient Protection and Affordable Care Act (**PPACA**) of 2010
- Medicare Improvements for Patients and Providers Act (**MIPPA**) of 2008

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- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Medicare Modernization Act of 2000
- Balanced Budget Refinement Act of 1999
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Social Security Act of 1965 (Title XIX)

These different laws have been “codified” in the United States Code. The United States Code brings together different enactments on the same subject. Medicare Part A is codified at 42 United States Code Sections 1395c to 1395i-5. Medicare Part B is codified at 42 United States Code Sections 1395j to 1395w-5. Medicare Part C is codified at 42 United States Code Sections 1395w-21 to 1395w-29. Medicare Part D is codified at 42 United States Code Sections 1395w-101 to 1395 w-154.

Medicare Part A may be referred to as hospital insurance. Medicare Part B may be referred to as medical insurance. Medicare Part C may be referred to as Medicare Advantage. Medicare Part D may be referred to as the Medicare Prescription Drug Program or the Medicare Prescription Drug Benefit. The words “United States Code” will often be abbreviated “U.S.C.” or simply “USC” without periods between the letters. The words “Section” or “Sections” will often be replaced by the symbols § or §§.

Although Medicare is under the general administration of CMS, rules resulting from these bills and amendments fall under the jurisdiction of various federal and state agencies and CMS subcontractors. CMS rules pertaining to Medicare are found in 42 Code of Federal Regulations Parts 400 to 1008. The words “Code of Federal Regulations” are sometimes abbreviated “CFR.”

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3. Brief overview of Medicare

Medicare is a federally administered health insurance program for people age 65 or older, have earned entitlement to Social Security disability benefits for 24 months, and most people with end-stage renal disease. Original Medicare has two parts- Part A (hospital insurance) and Part B (voluntary supplemental medical insurance). Enrollment is automatic for people 65 or older who have established eligibility to Social Security or Railroad Retirement Benefits, or are in the 25th month of disability benefits. Because no premium is paid for Medicare Part A for the beneficiaries mentioned above, it should be very rare for anyone to want to “opt out” of Medicare Part A. A monthly premium is charged for Medicare Part B (\$99.90 in 2012). It is typically not beneficial to “opt out” of Part B, unless the person is still covered by an employment based Group health plan (GHP), through their own employer or a spouse. The premium is usually deducted from the monthly Social Security benefit.

4. Medicare eligibility, people are eligible for Medicare if:

They are age 65 or older and eligible for Social Security or Railroad Retirement benefits;

They are age 65 or older, are a current U.S. resident and are either a U.S. citizen or a permanent resident who has lived in the U.S. for five years in a row before applying for Medicare;

They have received Social Security Disability Insurance (SSDI) for at least 24 months;

They qualify for disability insurance due to being diagnosed with ALS (Lou Gehrig’s disease);

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They have been diagnosed with end-stage renal disease and they, their spouse or parent have paid Medicare taxes for a sufficient amount of time.

Note: It is not necessary for people 65 years old or older to have a work history to get Medicare. However, people who have worked less than 10 years in the United States have to meet residency and citizenship requirements and may have to pay more for Medicare. Legal residents 65 and older that do not have 10 or more years of work history may be able to qualify for Medicaid and Medicare Savings Programs.

People younger than 65 with a disability must meet certain work history requirements to get Medicare.

In order to qualify for Part D an individual must have either Medicare Part A or Part B.

5. The 4 parts of Medicare

Medicare is 4 parts, there are 3 benefits, Part C is an option.

Part A hospital insurance covers most medically necessary hospital, skilled nursing facility, some home health and hospice care.

Inpatient hospital care for up to 90 days each benefit period;

A benefit period starts the first day the beneficiary enters the hospital or skilled nursing facility;

The benefit period ends when the beneficiary has not gotten hospital care or skilled care in a skilled nursing facility for 60 days in a row;

Part A also pays for 60 more days, called lifetime reserve days, in a general hospital. These days can only be used once. They are not renewable.

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Part A pays for more lifetime reserve days when someone gets inpatient care in a psychiatric hospital. It covers up to 190 lifetime reserve days in a Medicare-certified psychiatric hospital. These days aren't renewable and can only be used once.

However, people aren't allowed to use all their lifetime reserve days at one time. Part A only covers 150 days of inpatient psychiatric hospital care in a benefit period.

Skilled nursing facility care for up to 100 days each benefit period for beneficiaries that qualify for skilled nursing care.

Home health care for those who are homebound and need skilled care after a hospital stay. Part A of Medicare covers up to 100 days for those who qualify after being hospitalized. Part B covers home health care for people who haven't been hospitalized and for those who go beyond the 100-day Part A limit.

Hospice care is covered for the terminally ill if a provider certifies that life expectancy is 6 months or less.

Part B medical insurance covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health services, and home health and ambulance services.

Doctors' services;

Outpatient physical, speech and occupational therapy;

Outpatient mental health services;

Durable medical equipment, such as wheelchairs, walkers and oxygen tanks;

Some home health services for those who are homebound and need skilled care;

X-rays and lab tests;

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Many preventive care services, such as annual wellness visits, diabetes screenings and flu shots;

The first three pints of blood needed each year;

Some prescription drugs that people get at their doctor's office that aren't usually self-administered.

Part C part of Medicare rules that allows private insurance companies to provide Medicare benefits. These Medicare private health plans, such as HMOs and PPOs, are known as Medicare Advantage plans (MA).

Part C is not a separate benefit. Part C gives the option of joining a Medicare private health plan.

Medicare private health plans include the health benefits of Parts A and B. Some Medicare private health plans also include Part D (MAPD) drug coverage.

There are different coverage rules and costs with a Medicare private health plan than with Original Medicare.

Part D covers prescription drugs. Part D is provided only through private insurance companies that have contracts with the government, it is never offered directly by the government.

This coverage is optional for most people. Whether it is a good idea to sign up depends on current drug coverage and needs.

People must choose a Part D plan that works with their Medicare health benefits. With Original Medicare, choose a Part D plan. This is a plan that only covers prescription drugs.

Question: Which of the following are considered part of Medicare?

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- A. _____ Medicare Part A.
- B. _____ Medicare Part B.
- C. _____ Medicare Preventive services.
- D. _____ Medicare Part D.
- E. _____ All of the above.

6. What Medicare does not cover

Medicare doesn't cover all health services. Health services that Medicare doesn't cover include, but are not limited to:

- Routine dental care
- Routine foot care
- Hearing care, including hearing aids
- Extended long-term care
- Personal care and custodial care except for people who need skilled care and qualify for skilled nursing facility or home health benefits
- Routine vision care
- Most care received outside the United States
- Most non-emergency transportation
- Trial treatments unless offered under approved demonstration programs.

Medicare private plans (Medicare Advantage) may include certain benefits that Original Medicare does not pay for, such as vision, dental or hearing.

Keep in mind that even if Medicare covers a service, Medicare does not usually pay 100 percent of the cost. Without supplemental insurance, people generally have premiums, deductibles and coinsurances.

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Question: What is not covered by Medicare?

- A. _____ Over the counter drugs.
- B. _____ Routine dental care.
- C. _____ Non-emergency transportation.
- D. _____ Hearing aids.
- E. _____ All of the above.

7. Deductibles, coinsurance and copayments in Medicare

There are deductibles and coinsurance amounts that beneficiaries must pay themselves or need supplemental insurance to cover. Out of pocket costs will occur in Part A, Part B and Part D. Each year the amounts of deductibles and copayments typically change, with the changes taking place on January 1st of the next year.

Those that enroll in Medicare Advantage health plans should compare the benefits in the plan versus Original Medicare to get a clear picture of how they are different.

8. Out of Pocket costs with Medicare Part A

The cost of Part A under Original Medicare depends on work history and which Part A services are used.

There is no premium for Part A when a person qualifies for SSDI. There is also no premium for people who are 65 years or older and they or their spouse have worked at least 10 years in the United States.

People who have worked fewer than 10 years in the United States must pay a premium for Part A. In 2012, people 65 years old or older who have worked only 7.5 to 10 years in the United States must pay \$248 a month for Part A. Those who have worked less than 7.5 years in the United States must pay \$451 a month for Part A.

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People with Medicare that need inpatient hospital care must pay a \$1,156 deductible (in 2012) each benefit period. Part A only covers hospital care after the deductible is met.

A benefit period starts the first day in the hospital or skilled nursing facility. It ends when no skilled care has been received from the hospital or skilled nursing facility for 60 days in a row.

After paying the Part A deductible, the beneficiary pays nothing for inpatient hospital care for the first 60 days in the hospital. For days 61 to 90, there is a daily \$289 copayment in 2012.

For hospital stays longer than 90 days, people have 60 lifetime reserve days. There is a daily \$578 copayment per lifetime reserve day in 2012. Lifetime reserve days can only be used once. They are not renewable.

There is no deductible or a coinsurance for skilled nursing facility care until after the 20th day in the facility. Then, there is a \$144.50 daily copayment for days 21 to 100 per benefit period.

The beneficiary pays the full cost of skilled nursing facility care after day 100 in a benefit period.

Question: How many years of work history are needed to qualify for Medicare benefits?

- A. _____ 0 years, just need to be a legal citizen of United States.
- B. _____ 5 years.
- C. _____ 7.5 years.

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D. _____ 10 years.

9. Out of Pocket costs with Medicare Part B

In addition to the Part B premium (\$99.90 in 2012) there is a \$140 deductible for Part B services in 2012 that must be paid before Medicare covers any outpatient care. This is a 22\$ **decrease** from 2011.

There is a coinsurance for most services Part B covers. In general, if a provider accepts assignment, Medicare pays 80 percent of the Medicare-approved amount. The Medicare-approved amount is the fee that Medicare sets as the amount a provider who accepts assignment should be paid for a particular service. The Medicare-approved amount includes what Medicare pays and what the beneficiary pays (deductibles, copays and coinsurances).

Patients must pay a higher coinsurance for outpatient mental health care. In 2012, there is a 40 percent coinsurance for outpatient mental health care that Medicare covers. If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital. This amount will vary depending on the service provided but will be between 20% and 40% of the Medicare-approved amount.

Preventive services have been added to Original Medicare due to federal health reform. The list of services is on page 3 in your 2012 *Medicare & You* booklet.

10. Doctors and health care providers that accept assignment

In order to keep health care costs as low as possible, people with Medicare should use doctors and other providers who take assignment.

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Doctors who take assignment accept Medicare's approved-amount as payment in full. Medicare pays the doctor 80 percent of its approved charge for most services, and the patient must pay the remaining 20 percent coinsurance

For doctors who do not take assignment, the government limits how much they can charge. Doctors who do not take assignment generally can't charge more than 15 percent above Medicare's official amount for providers who do not accept assignment. People can look at their Medicare Summary Notice (MSN) to find out how much they need to pay when they see a provider who doesn't take assignment. The MSN is a statement people get every three months that lists services they received and how much Medicare paid.

Some doctors officially opt out of Medicare and do not have to follow Medicare rules that limit how much they can charge.

People who see doctors who have opted out of Medicare must pay the entire bill unless it's an emergency. Medicare will not pay for any of those services. Doctors must tell patients if they have opted out of Medicare before providing services. Patients will be asked to sign a contract saying they understand they are responsible for the full cost of the services.

For instance, say a doctor takes assignment and charges \$150 for an office visit. If Medicare only approves \$100 for the visit, then Medicare pays 80 percent or \$80 and the patient pays the 20 percent coinsurance, or \$20. A doctor who takes assignment cannot ask for the remaining balance of \$50.

A doctor who does not take assignment can charge the patient more than a doctor who does take assignment can charge. (They can charge up to 115% of Medicare's approved amount for providers who don't accept assignment.)

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Last, if the doctor charges \$150 for an office visit and opts out of Medicare, Medicare will not pay for the services. The patient must pay the entire \$150.

Question: How much more (as a percentage) can doctors charge; if they do not accept assignment?

- A. _____ 0%.
- B. _____ 5%.
- C. _____ 10%.
- D. _____ 15%.

11. Enrolling in Medicare

Whether people should enroll in Medicare depends on their situation.

Most people do not have to pay a premium for Part A. Part A coverage is free for people who qualify for Medicare because of a disability. It's also free for people 65 or older who qualify for Social Security or Railroad Retirement benefits and they or their spouse worked in the United States for at least 10 years. So, for most people, it is a good idea to enroll in Medicare Part A.

Whether it is a good idea to take Part B depends on the kind of health insurance the beneficiary has upon becoming eligible for Medicare. **In some cases, there is a premium penalty for delaying Part B enrollment and a risk of losing other health insurance coverage, such as coverage from a former employer.**

The Part B premium penalty is a monthly charge tacked onto the Part B premium. It is 10 percent of the annual standard premium for every 12 months someone delayed enrollment. In most cases, the penalty never goes away and increases when the Part B premium increases.

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People who have insurance through a current job (either their own or their spouse's), may be able to delay enrolling in Part B without facing a premium penalty.

Additionally, people who qualify for Medicare because of a disability may have insurance from a family member's current job that will enable them to delay Part B enrollment without facing a penalty.

The ability to delay Part B enrollment without penalty applies only to people who have insurance from a current employer, not insurance from a past employer, such as retiree insurance, unless it is long-term disability coverage that allows participation in the employer's benefit plan for current employees. The beneficiary should find out whether the employer insurance is primary or secondary for people who also have Medicare. Primary insurance pays first for covered health services. Then, secondary insurance pays some or all the unpaid portion of covered health expenses.

If current employer coverage is primary, the beneficiary can delay enrolling in Medicare Part B. People can enroll in Medicare at any time, without penalty, while they have current employer coverage and up to eight months after losing that coverage. It may be unnecessary to get Medicare Part B with employer coverage, unless the beneficiary is unhappy with that coverage.

If Medicare is primary, it is important to enroll in Medicare when first eligible. People who wait to enroll and lose employer coverage may have no health coverage at all until Medicare takes effect.

12. How to know if employer coverage is primary

Employer insurance is primary in the following situations:

The beneficiary is 65 or older and has health coverage through a current job (theirs or their spouse's) with an employer that has 20 or more employees; **or**

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The beneficiary is under 65 and has a disability or is diagnosed with ALS (Lou Gehrig's Disease) and has health coverage through a current job (theirs or their spouse's) with an employer that has 100 or more employees.

Note that employer insurance is also primary with long-term disability coverage from a **former** employer that allows the beneficiary to continue to participate in the benefit plan for current employees, and the employer has 100 or more employees.

For people who are not in one of the situations described above, and do not have End-Stage Renal Disease (ESRD), Medicare is primary. They should enroll in Medicare when they first become eligible.

For people with ESRD, employer coverage from a current job is primary for the first two and a half years, or 30 months, after they are first eligible for Medicare Part A. Medicare usually becomes primary after that 30-month coordination period even if they have not applied for Medicare.

13. The four ways to enroll in Medicare

There are several ways to enroll in Medicare, and each has different rules and different time frames. Sometimes there are penalties for late enrollment, so it is important to know how to enroll to avoid these penalties. The four ways to enroll are:

Automatic enrollment

People are **automatically enrolled** in Medicare parts A and B if one of the following is true:

They signed up for Social Security or railroad retirement benefits before they turned 65;

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They are disabled and have been receiving Social Security Disability Insurance (SSDI) or railroad disability annuity checks for total disability for at least 24 months;

They have been diagnosed with ALS (Lou Gehrig's disease.)

People who fall into one of those categories do not have to do anything—they will get a letter telling them they have been automatically enrolled into Medicare and will get a Medicare card for parts A and B in the mail.

Remember it is usually best to keep Medicare Part B unless the beneficiary or their spouse works for a company with at least 20 employees and has health insurance through that company. People who have Medicare because of a disability should keep Part B unless they, their spouse or other family member works for a company with at least 100 employees and has health insurance through that company.

Initial Enrollment

People who are not automatically enrolled when first eligible for Medicare and want to enroll in Parts A and B must actively enroll during their Initial Enrollment Period.

The Initial Enrollment Period is the seven-month period that starts three months before the month the beneficiary becomes eligible for Medicare and continues for three months after.

The date Medicare coverage starts depends on the enrollment date. People should enroll one to three months before their first month of eligibility to get coverage as soon as they are eligible.

Special Enrollment Period for Part B

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There is a Special Enrollment Period to enroll in Part B for people who delay signing up for Part B because they have health insurance from a current employer or their spouse's current employer. This is often referred to as an SEP.

An SEP allows a person with Medicare to enroll in Part B without penalty, at any time while they are still working or for up to eight months after they retire or lose their current employment status.

COBRA and retiree insurance coverage are not considered current employment or coverage and do not give a person an SEP (Special Enrollment Period).

Without this SEP, a person must wait until the General Enrollment Period (GEP) to enroll.

The General Enrollment Period is January 1 through March 31 of every year. If a person enrolls during the GEP, their Medicare coverage begins July 1st of the year they enroll.

General Enrollment (annual)

People who do not enroll in Medicare or refused Medicare when they originally became eligible for it can sign up during the **General Enrollment Period**.

The General Enrollment Period is January 1 through March 31 each year. Coverage starts July 1 the year they sign up.

Keep in mind that without a Special Enrollment Period to sign up for Part B, people must pay a 10-percent Part B premium penalty for each 12-month period they delay enrolling.

Question: What are the four enrollment options for Medicare?

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- A. _____ General, Annual, Special and Initial.
- B. _____ General, Retroactive, Special and Initial.
- C. _____ General, Annual, Special and On-going.
- D. _____ General, Annual, Inclusionary and Initial

14. How to enroll in Medicare

People who do not get Social Security or Railroad Retirement benefits must take action to enroll in Medicare. They should contact their local Social Security office, or, if they are railroad employees or retirees, their local Railroad Retirement Board field office by going in person, writing a letter or calling.

People should keep proof of when they tried to enroll in Medicare to protect them from incurring a Part B premium penalty if the application is lost. If enrolling by mail, they should use certified mail or return receipt requested. If enrolling in person or on the phone, they should take down the name of the person who helped them and ask for a written receipt.

People getting Social Security benefits, railroad retirement benefits, Social Security Disability Insurance or railroad disability annuities when they become eligible for Medicare do not need to do anything. They will get a Medicare card in the mail.

15. Enrollment- when a beneficiary automatically qualifies or must apply for Medicare

There are people who will turn 65 and will not automatically qualify for Medicare Part A. These are people that have not accumulated the 40 credits of Social Security coverage needed for automatic Medicare entitlement. They may choose to

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enroll in Medicare Part A during specified enrollment periods. The first three calendar months of each year are always one of these periods. The other is the “initial enrollment period” which is the three calendar months before the month in which the person turns 65, the birth month and the three calendar months after the person turns 65. The people that choose to purchase Part A are enrolled in “Premium Medicare”, meaning they will pay a premium for their coverage. For Part A in 2012, the monthly premium is \$451. The amount will be different if they have accumulated 30 or more of the 40 credits needed to get Part A. If the person chooses to enroll in Part B, they will pay the usual amount for that (\$99.90 in 2012.) More detailed information about Social Security credits can be found by visiting their website @ www.ssa.gov.

16. Medicare coverage options

People can start with Original Medicare when they first enroll in Medicare. Original Medicare does not pay in full for health care, so it is best to have a supplemental plan, such as retiree insurance or a Medigap plan, to help pay for care. Original Medicare pays directly for the care and supplemental insurance covers the out-of-pocket costs.

People can instead choose to get their Medicare benefits through a Medicare private health plan, also known as a Medicare Advantage plan (MA.) Medicare Advantage plans are usually HMOs, PPOs or PFFS plans. Medicare private health plans have a contract with the government to provide Medicare Part A and B benefits to their members. They often also include Part D coverage. If a beneficiary chooses to join a MA plan when they first become eligible for Medicare, the beneficiary may choose to leave the MA plan at any time during the first year and return to Original Medicare without penalty.

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Note that people who want Medicare prescription drug coverage, Part D, must make sure that the Part D coverage works with their other health coverage.

People in Original Medicare should sign up for a stand-alone Medicare private drug plan (often referred to as a PDP). A PDP only covers prescription drugs.

People in a Medicare private health plan must usually get drug coverage as part of the health plan benefits package (often referred to as a MA-PD).

Those with a Private Fee-for-Service plan (PFFS) without drug coverage or a Medicare Medical Savings Account plan (MSA) can join a stand-alone Medicare private drug plan.

People with insurance from a current or former job should find out whether signing up for Part D will affect the benefits they get from their employer. Some employer plans don't let their members have Part D. People and their family members (dependents) could lose their employer-based insurance coverage if this is the case.

Question: What are common types of Medicare Advantage plans?

- A. _____ PPO, HMO, and SLMB.
- B. _____ PPO, HMO, and PFFS.
- C. _____ PPO, HMO, and MSP.
- D. _____ PPO, HMO and QE2.

17. Ways to supplement Medicare coverage

For a full review of ways to supplement Original Medicare please see Chapter 6 of this manual.

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It is a good idea to have supplemental coverage with Original Medicare to help pay for Medicare out-of-pocket costs, like deductibles and coinsurances. It may also fill other gaps, such as coverage while traveling or routine hearing or vision care.

There are different types of health coverage that can supplement Original Medicare, including:

- Employer insurance through a current job or union
- Retiree coverage through a former employer or union
- Medigap insurance from insurance companies such as Blue Cross Blue Shield or Mutual of Omaha, or from sponsoring organizations such as AARP. These policies were created to pay Medicare out-of-pocket costs.
- Medicaid or other state assistance programs, such as a Medicare Savings Programs, for people who have low incomes.

18. Part D of Medicare- Prescription drug coverage.

People who are in Original Medicare and want the Medicare drug benefit (Part D) should enroll in a stand-alone private drug plan that only covers drugs. This is also known as a PDP. Original Medicare still covers all of other medical services, such as doctor visits and hospital stays.

Before signing up for Part D, people who have employer-based insurance coverage should check with their employer to find out whether signing up for Part D will affect their benefits.

Each Part D plan has different costs, a different list of covered drugs (formulary), and its own pharmacy network. It is vital that people pick a plan that covers the drugs they

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need and works at the pharmacies they use. To enroll, people can call the plan itself, call 800-MEDICARE, or go to Medicare's web site, Medicare.gov.

People with low incomes may qualify for Extra Help, a federal program that helps pay some or most of the costs of Medicare prescription drug coverage. How much people pay for drugs with a Medicare drug plan depends on which drugs they need and how the plan structures its benefits.

Every Medicare drug plan charges a monthly premium that varies from plan to plan. The average national premium in 2012 is \$31.08, but premiums can range from less than \$15 a month to more than \$100 a month. The \$31.08 amount is important to know as benefits counselors because it is the "national base beneficiary premium."

There are usually four coverage phases under a Medicare drug plan. The beneficiary must pay the monthly premium through all four periods.

First, there is an annual deductible to meet before the plan pays anything. In 2011, it could not be more than \$310. Some plans do not charge a deductible before they start paying for drugs. Other plans may pay for some drugs (like generics) during the deductible phase.

The initial coverage period starts after a person pays the deductible. During this time, the beneficiary pays some and the plan pays some, but only for drugs on the plan's formulary and from pharmacies in the plan's network. Some plans charge a flat copay for drugs (like \$15); others charge a coinsurance (like 25 percent of the cost of each drug). Most plans arrange drugs by tiers; beneficiaries pay less for drugs in lower cost tiers.

Most plans have a coverage gap, also called the doughnut hole, where what someone pays for drugs suddenly increases. It begins each year once the beneficiary and the

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plan spend a certain amount. In 2011, this amount is \$2,840 in total drug costs in most plans. Realize that total drug costs are what the beneficiary pays plus what the plan pays. Once the beneficiary enters the coverage gap, they will pay 50 percent of the cost of most brand-name drugs and 93 percent (84% in 2012) of the cost of generic drugs. The doughnut hole is being phased out so that by 2020, people in Part D plans will pay no more than 25 percent of the cost of their drugs throughout the year. Some plans provide additional coverage during the coverage gap so people may pay even less for drugs in the gap.

After the beneficiary spends \$4,550 out of pocket, they leave the coverage gap. This \$4,550 limit is the out-of-pocket maximum in 2011. This out-of-pocket cost does not include the Part D premium that the beneficiary continues to pay. Once they leave the coverage gap, their drug costs go down significantly. This last period is called catastrophic coverage. The beneficiary pays either a 5 percent coinsurance or \$2.50 for generics and \$6.30 for brand-name drugs, whichever is greater.

If the beneficiary buys drugs that are not on the plan's formulary, those costs do not count toward the out-of-pocket maximum. Payments made by other types of insurance also do not count toward the out-of-pocket maximum, but can help the person pay less up front. Payments made by beneficiaries, by other people on their behalf, by state prescription drug assistance programs, by ADAP programs, by the Indian Health Services and by most charities count towards the out-of-pocket maximum. The 50 percent discount that people get on their brand-name drugs during the coverage gap counts toward the out-of-pocket maximum. However, the 7 percent (14% in 2012) discount on generic drugs in the coverage gap does not count.

Remember that people with limited incomes can get Extra Help, the federal program that pays most of the costs of a Medicare private drug plan.

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Question: What is the national base beneficiary premium in 2012?

- A. _____ \$31.80.
- B. _____ \$30.81.
- C. _____ \$30.18.
- D. _____ \$31.08.

19. Part D enrollment.

The Medicare drug benefit (Part D) is optional. Whether a person should sign up depends on the quality of current drug coverage and their drug needs. People who have other drug coverage (like an employee or retiree plan) that is at least as good as the basic plan outlined in Medicare law, called **creditable coverage**, find it is usually beneficial to keep it. People can take Part D later without penalty as long as they have not been without creditable coverage for more than 63 days.

People can find out if their drug coverage is creditable from the company that provides their benefits. The company should send members a written notice about each year saying whether their coverage is creditable. People can also contact the company directly if they have questions.

People without creditable coverage may have to pay a premium penalty if they wait to enroll. The penalty means the person must pay a higher monthly premium to get Medicare drug coverage. The premium penalty is 1 percent of the national average drug plan premium for every month the person did not have Medicare drug coverage but could have. (\$31.08 in 2012)

People who get Extra Help do not have to pay a Part D premium penalty, even if they delayed enrolling in a Medicare private drug plan. People also do not have a premium

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penalty if they can show they got inadequate information about whether their drug coverage was creditable.

People can enroll in Part D at the following times:

- During their **Initial Enrollment Period**.
- During the **Fall Open Enrollment Period**, which is October 15 through December 7 each year
- During a **Special Enrollment Period** for people who qualify. Special Enrollment Periods let people enroll in or change Medicare drug plans outside of normal enrollment periods because of special circumstances. For example, people who have Extra Help can change Part D plans once a month.

20. Medicare private health plans.

Most people with Medicare get health coverage from Original Medicare. However, people can choose to get their benefits from a Medicare private health plan, like an HMO or PPO. These are also called Medicare Advantage plans.

People still have Medicare if they join a Medicare private health plan. The private plan must provide all Part A and Part B services. Some plans provide extra benefits that Original Medicare does not cover, such as routine vision or dental care.

People who join a Medicare Medical Savings Account (MSA) or a Private Fee-For Service (PFFS) without drug coverage can join a separate stand-alone drug plan. Part D coverage from a Medicare private health plan works the same way as it does in a stand-alone private drug plan (PDP).

Question: True or False? A beneficiary may join a MA plan and a stand-alone Part D prescription drug plan?

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_____ True.

_____ False.

21. Addressing concerns about Medicare Advantage health plans.

Before joining a Medicare private health plan, it is important to understand the plan's costs, rules and restrictions. Medicare private health plans can cost less than Original Medicare for someone who does not need a lot of care. But people in Medicare private plans have less ability to decide when they get care, what care they get and which doctors they use.

Before joining a Medicare private plan, people should make sure their doctors are in the plan's network and that they are accepting new patients from the plan. Many plans only cover services from doctors, hospitals and pharmacies in their network.

Private health plans must cover all health services that Original Medicare covers but can put other restrictions on care, such as requiring a referral from a primary doctor to see a specialist. They can also require the doctor to ask the plan's permission before providing certain services or drugs.

A private health plan may not be the best option for people who need a lot of specialized care.

Keep in mind that doctors and hospitals may leave the plan at any time, but members can only leave a Medicare private health plan at certain times of the year. Plans may also close, forcing members to find a new plan.

Question: True or False? A Private health plan must cover all of the benefits that Original Medicare would provide?

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_____ True.

_____ False.

22. Types of Medicare plans.

Medicare private health plans are usually managed care plans. The most common types of Medicare Advantage plans are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-For-Service (PFFS) plans.

There are others, like Provider Sponsored Organizations (PSOs), and Medicare Medical Savings Accounts (MSAs), but they are not available in many parts of the country.

Special Needs Plans (SNPs) are Medicare private health plans that serve certain populations, such as people with low incomes or specific chronic conditions.

No matter which type of Medicare private health plan a person decides to join, it is important to know the specific plan's network rules, restrictions and costs. Even plans of the same type can vary greatly.

23. When to enroll in a Medicare Advantage plan.

People can only enroll in Medicare private health plans at certain times:

- During their **Initial Enrollment Period (IEP)**. This is the seven-month window surrounding the month people become eligible for Medicare. It starts three months before the month they become eligible for Medicare and ends three months after the month they become eligible. The eligibility month is either the month they turn 65 if they qualify for Medicare because of their age,

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or the month they get their 25th SSDI check if they qualify because of a disability.

- Remember that a person must have both Parts A and B to enroll in a Medicare private health plan.
- During the **Fall Open Enrollment Period**, which is October 15th through December 7th, each year.
- Some people with special circumstances can get a **Special Enrollment Period** to enroll in or change Medicare private health plans outside of normal enrollment periods. For example, people who have Extra Help or enter a nursing home get a Special Enrollment Period.

24. How to enroll in a Medicare health or drug plan.

People who enroll in both Part A and Part B can choose to enroll in a Medicare Advantage plan instead of Original Medicare. People thinking about doing this should do their homework first. They should make sure there is a Medicare private health plan available in their area that meets their health care needs and that they can afford. As a Benefits Counselor, you will be asked to help people make these decisions.

For people with Medicaid, Original Medicare may give the most benefits and choice at the lowest cost. Medicaid beneficiaries thinking about joining a Medicare private health plan should find out how it works with Medicaid.

People who decide to join a Medicare private health plan can call 800-MEDICARE to enroll when they find one that meets their needs.

Generally, the new coverage starts the first day of the month after the month of enrollment. However, coverage starts January 1 for people who enroll during the Fall Open Enrollment Period, which runs October 15 through December 7 each year.

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Once coverage starts, people should use the card from the Medicare private plan when they go to the doctor or hospital. Do not use the red, white, and blue Original Medicare card.

The same enrollment process applies for people who want to sign up for Medicare drug coverage from a stand-alone private drug plan. They should think about their options and do their homework before picking a plan. Then, they can call 800-MEDICARE to sign up.

Question: True or False? A beneficiary can join a Medicare Advantage health plan at any time?

_____ True.

_____ False.

25. Common problems with Medicare and tips to avoid them.

To avoid penalties, people should sign up for Medicare Part B as soon as they are eligible, unless they have health coverage from a big company where either they or their spouse still work.

People who do not have drug coverage that is as good as Part D should consider enrolling in Part D when they first qualify to avoid having to pay a premium penalty for drug coverage in the future.

To save money in Original Medicare, people should make sure their doctors and other health service providers take assignment.

26. Appeals and denials of coverage.

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People have a right to all of the benefits Original Medicare covers no matter which Medicare plan they are in. **People can appeal to Medicare** if they think they are not getting the health care or coverage they should get from Medicare, their doctor, a hospital or a Medicare private health or drug plan.

As a Benefits Counselor you would be certified to handle certain appeals on behalf of clients when you complete Benefits Counselor II training, and pass the test given with at least 70 percent correct.

The Texas Legal Services Center is also a resource and is capable of handling advanced appeals and other matters as attorneys on behalf of clients. There is a dedicated phone number for benefits counselors to call Texas Legal Services for information and support.