A SUMMARY OF MEDICARE PARTS A, B, C, & D

PROVIDED BY:
RETIRED INDIANA PUBLIC
EMPLOYEES ASSOCIATION – RIPEA

AUTHOR:
JAMES BENGE, RIPEA
INSURANCE CONSULTANT

M E D I C A R E

A Summary of Parts A, B, C, & D

Medicare was signed into law by President Lyndon B. Johnson in 1965 and became law on January 1, 1966. It provided a national health plan for senior citizens over the age of 65 and under age 65 with certain disabilities. It was called Medicare. Original Medicare had two distinct parts:

Part A: Hospital Expense

Part B: Physician Expense

I MEDICARE: PART A

A Coverage: Part A Covers:

1 Inpatient Hospital Care
2 Skilled Nursing Care
3 Home Health Care
4 Hospice Care

B Cost:

1) Many people get Medicare Part A without a premium, if they worked and paid Medicare taxes for 40 quarters (10 Years).
2) Medicare A has other costs, as well. The program contains deductibles, copayments, and coinsurance, just like employer sponsored health plans. A person's overall cost will depend on the types of services' and length of time treatment is received.

C Medicare Care A Coverage

1) Coverage Details

a	2018 Deductible	$1,340
b	1st 60 days of each hospital stay period:	No Cost
c	61st to 90th day of each hospital period:	$335 / Day
d	91st day and beyond	$670 / Day

2) Each covered person is allowed 60 reserve hospital days, after these reserve days are used, the patient pays full price.

3) Skilled Nursing Facility Care:

a	1st day to 20th day	No Cost
b	21st day through the 100th day	$167.50 / day
c	No coverage after the 100th day	

D Enrollment:

1) ELIGIBILITY: If you have paid FICA (Social Security and Medicare) taxes for 10 years (40 quarters) you will be eligible for Medicare Parts A and B, beginning on the first day of the month during which you will turn age 65.

2) AUTOMATIC: If you are already drawing Social Security benefits when you are first eligible for Medicare, your enrollment will be automatic.

3) SELF-ENROLL: If you are not enrolled Social Security when first eligible for Medicare, you will need to self-enroll in Medicare. Since Medicare is effective on the first day of the month in which you turn age 65, you need to enroll for Medicare 3 months in advance of you 65th birthday. Below is the current contact information:
   - a On-line: Go to ssa.gov
   - b Call: Social Security - 1-800-772-1213
     TTY Users – 1-800-325-0778
   - c In Person: Visit a Social Security Office

4) There are additional circumstance that will require manual enrollment in Medicare:
   - a If you have not worked long enough to get Medicare without premium.
   - b If you have not paid Medicare taxes through your employer
   - c If you have end-stage renal disease before age 65, you may apply for Social Security disability regardless of age.

5) Late Enrollment Penalty:
   - a If you are eligible for premium free Medicare Part A, you may enroll in Medicare any-time after initial eligibility, without a penalty.
   - b If you are <u>not eligible</u> for premium-free Part A, and you do not enroll in Medicare Part A during the initial 7month enrollment period (3 months before your birthday month, your birthday month, and 3 months after your birthday month) you will need to wait until the next "Open Enrollment Period" which is January 1st to March 31st. Your Medicare effective date will be the following July 1st.

II MEDICARE: PART B

A Coverage: Part B Covers:

1 Outpatient services received at a hospital, doctor's office, clinic, or other health facility.

2 Preventive services to prevent or detect blindness at an early stage.

3 Included Services:
- a Doctor visits
- b Laboratory tests
- c Diagnostic tests
- d Emergency ambulance service
- e Mental health services
- f Durable medical equipment
- g Preventive services: Pap smears, flu shots, etc.
- h Rehabilitative services: physical therapy, speech therapy, etc.

B Part B Cost:

1 You will generally pay a monthly premium of $134.00 and an annual deductible: of $183.00.

2 If any of the following applies, you will generally pay $130.00 as Part B premiums
- a Enrolled in Part B for the first time in 2015 or earlier.
- b You're receiving Social Security or Railroad Retirement Board benefits.

3 You may have to pay a higher premium if:
- a Your annual income is above a specified level.
- b If you did not enroll in Medicare Part B when you were first eligible – in some cases you pay a late enrollment penalty instead of a higher premium.
- c For individual services and supplies, your Medicare Part B cost may vary. Some preventive services are covered at 100% if the provider accepts Medicare assignment.
- d After the deductible is met, you generally pay 20% of the Medicare approved amount or a copay.

III WHAT IS NOT COVERED BY MEDICARE?

A Part A

1 Part A - generally covers:
- Semi-private hospital room
- Hospital meals
- General nursing
- Medically Necessary
  - * Prescriptions, Supplies, and Equipment
- Skilled nursing facility care
- Hospice care
- Home health care (for a specified length of time)

2 Part A generally does NOT cover:

- Custodial care in Nursing Homes
- Private Duty Nursing
- Care outside the United States
- Hospital stays for cosmetic surgery
- Hospital stays not medically necessary
- Outpatient prescription drugs

B Part B

1 Generally Covers:

- Doctor visits (office & hospital)
- Outpatient medical care
- Laboratory tests
- Emergency ambulance services
- Preventive exams and screenings
- Mental Health services
- Durable medical equipment
- Rehabilitative services- including therapy: physical, occupational, speech

2 Generally NOT Covered:

- Prescription drugs (except in limited circumstances)
- Routine Foot care & Podiatry services
- Routine beauty care and aids
- Routine eye exams and prescription eye wear
- Routine dental care including exams, fillings, extractions, and dentures
- Fitness and wellness programs

III MEDICALRE: PART D

A Background:

The Part D drug plan was signed into law by George W Bush and was effective January 1, 2006. It was specifically designed to be an add-on to Medicare Parts A & B. The legislation put forth a specific benefit plan to create the minimum level of coverage. Drug companies were encouraged to offer several plans, but all plans offered must, as a minimum, equal or exceed the base plan outlined in the legislation. Insurance carriers and drug companies were encouraged to design their own plan offerings which would allow competition to help restrain costs.

B Formularies:

Each Medicare drug plan has its own list of covered drugs (drug formulary). Many Part D drug plans categorize drugs into different “tiers” on their formularies. Drugs are assigned to tiers based on cost, with the lower cost drugs (generics) being assigned to tier 1, and brand name drugs being assigned to tier 2, or 3, with the more expensive drugs being

assigned to tier 3. Therefore, tier 1 will have the lowest copays, while higher numbered tiers will have increasingly higher copays relative to the cost of the drug, as illustrated below.

Tier 1	Lower cost generic drugs: Lowest cost drugs =	lowest copays
Tier 2	Higher cost generics & Lower cost brand name drugs =	higher copays than tier 1
Tier 3	Higher cost brand name drugs=	higher copays than tier 2
Tier 4	Lower cost specialty drugs (higher cost than brand drugs)=	higher copays than tier 3
Tier 5	Higher cost specialty drugs (higher cost than tier 4 drugs)=	highest copay

NOTE: A) Some drug plans have as many as 6 drug tiers.

B) Some formularies cover only the generics when they are available, while others may require prior approval to cover a brand name drug.

C Changes to Formularies:

1 Drug formularies change almost every year. If the change involves a drug you are currently taking, your Part D Carrier must either:

a Provide to you written notification of the changes at least 60 days prior to the date the changes become effective, or

b When you request a refill, your insurance provider must provide written notification of the changes and a 60-day supply of the drug under the rules of the prior plan

D Special Rules:

1 Prior Authorization – You or your drug prescriber must contact the drug plan before filling certain prescriptions. The prescriber may need to provide information certifying that the drug is "medically necessary" before the prescription can be approved.

2 Quantity Limits – In some cases there are limits on how much of a medication can be issued with a prescription. Amounts above this level must be approved and will require information from the prescriber.

3 Step Therapy – A patient is required to try or have tried one or more alternative but similar drugs before the drug plan will approve the prescription. In some cases a letter from your physician certifying that you have already tried the required drugs will suffice to get the requested drug approved.

4 Part D Vaccine Coverage – Except for vaccines covered under Medicare Part B, Medicare drug plans' formularies must include all commercially available medically necessary vaccines to prevent illness.

E Drug Plan Design:

1 Deductible is defined as the amount you must pay each year before your Part D Drug plan benefits begin. Deductibles vary between drug plans, although currently, no Medicare Drug plan can have a deductible higher than $405 (2018). Many drug plans require a deductible only for tier 3 drugs and above. Of course, the maximum drug plan deductible changes slightly each year.

F Copayments and Coinsurance:

1 The amount you pay for each of your prescriptions after you have met the deductible is either a copay or coinsurance. A copay would be a set dollar amount, and a coinsurance would require you to pay a percentage of the regular cost. For a "generic" drug you may pay a $8 copay; however, for a more expensive drug you may pay a percentage of the wholesale cost of the drug and that would be a coinsurance.

G How and when do you enroll in Part D drug coverage?

1 Medicare drug coverage is available to anyone age 65 or older who is enrolled in Part A and Part B of Medicare. You may contact the individual drug plans directly or you can shop drug plans on Medicare.gov. This website is easy to use and provides the information that you need to determine which drug plan is the best fit for you.

H Late enrollment penalty:

1 You may be penalized If you fail to enroll in a drug plan when you are first eligible and you do not:

a) have other creditable drug coverage, or
b) qualify for "Extra Help" (financially) to afford the cost of needed drugs.

2 The "Late Enrollment" penalty is a 1% surcharge per month for each month you were eligible for Part D coverage, but were not covered, added to you monthly premium for the rest of your life. Although this does appear to be a harsh penalty, please remember it is assessed against a relatively low-cost coverage. For example, if you were to be without drug coverage for 15 months after you were first eligible, that would be a 15% penalty against a low cost monthly premium of maybe $35.63. Your penalty cost would be 15% added to the $35.63 normal monthly premium, which would increase your monthly Part D premium by $5,34 to $40.97. Since the penalty is percentage assessment, the dollar value of the penalty will increase each year, as the premiums increase.

I IRMAA (Income Related Monthly Adjustment Amount):

1 Part D enrollees with income levels above $85,000 (individually), or $170,000 (married filing jointly), will be assessed larger costs for Medicare Part B (medical coverage) and Part D (drug coverage). This is called the Income Related Monthly

Adjustment Amount and is assessed according to the income chart included at the back of this presentation.

J Prescription Drug Coverage varies by "Coverage Phase":

1 The coverage offered by your Prescription Drug plan will vary according to the "coverage phase". Prescription Drug coverage is paid in 4 phases:

a Deductible Phase
b Initial Coverage Phase
c Coverage Gap
d Catastrophic Coverage Phase

2 **Deductible Phase**: For most stand-alone Medicare Prescription Drug Plans and Medicare Advantage Prescription Drug Plans you will pay 100% of the cost for medications until you have met the annual deductible (usually a lesser amount, but not more than $405). After the deductible, the prescription drug coverage moves ahead to the initial coverage phase.

3 **Initial Coverage Phase**: After meeting the deductible, your drug plan begins actual coverage. You will be assessed a copay or coinsurance based on the drug and the cost factor determined by the drug tier to which it is assigned. For most drugs, you will be assessed a small to moderate copay for the drug. Coverage for some drugs is determined on percentage of the cost basis. However, once you and your plan, including the deductible have spent $3750 (during a calendar year) for covered drugs, you have reached the Initial coverage limit and will then move into the "Coverage Gap" phase.

4 **Coverage Gap Phase:** Many people do not spend enough on prescriptions annually to make it to the Coverage Gap, however, when you do, you enter this phase which is better known as the "DONUT HOLE". In this phase the enrollee typically pays 100% of the cost of prescription drugs, however, the Federal Government has negotiated with drug companies to reduce the cost of drugs when purchased in the "Coverage Gap". Now, while in the Coverage Gap, the average person will pay about 35% of the actual cost of a brand name drug and about 44% of the cost of generic drugs. The costs of the drugs in the "donut hole" are expected to continue to drop to approximately 25% of the actual cost by the year 2020. Once your out of pocket expense for drugs is $5,000, you qualify for the "Catastrophic Phase". If your drug plan requires that you purchase all of your drugs at a particular drug company, be certain that you continue to honor that requirement because drugs purchased at other pharmaceutical companies will not count toward various phases described above.

5 **Catastrophic Coverage Phase:** Again, not everyone will reach this phase; it begins when your out of pocket costs reach $5,000 in 2018. During the

catastrophic phase, you'll only pay a small coinsurance or copayment for covered prescription drugs for the remainder of the year

6 **Cost Sharing:** Each coverage phase is specifically designed to cost-share with the insured on the following basis:

Phase	Insured Pays	2018.
Deductible	100% up to	Deductible Maximum
Initial Coverage	25%	to $3,750 out of pocket
Coverage Gap	35% - 44%	to $5,000 out of pocket
Catastrophic Gap	Higher of 5% of the drug cost or a small copay	Remaining Costs

IV MEDICARE ADVANTAGE PLANS:

A Medicare Alternative:

1 We have already presented: Medicare Part A, Part B, and Part D; but now it is time to discuss the least known alternative to Medicare – Medicare Advantage Plans. These plans are sometimes referred to as Part C since they were initially called "Choice Plans". These plans were designed to provide original Medicare in a different format. Original Medicare did not include prescription drug coverage. However, Medicare Advantage plans include all three coverage plans: Part A (hospitalization), Part B (Physician coverage) and Part D (prescription drug coverage).

2 Just as with the separate Part D drug plans that are purchased with original Medicare, most Medicare Advantage Plan carriers make changes to their coverage designs and drug formularies almost every year. Therefore, it is also prudent to annually (during Open Enrollment - October 15th to December 7th) check the coverage, pricing and formularies available for the up-coming year to be certain your current Advantage Plan drug formulary is still the best alternative for you. This small annual exercise can save you headaches and sometimes large amounts of money during the coming year.

3 Original Medicare covered enrollees at medical providers that accepted Medicare reimbursements (generally much lower than the provider's normal fees). Although the number of medical providers that take Medicare assignment is growing

smaller, most medical providers still accept Medicare assignment; consequently, Medicare enrollees are not limited to a specific network of providers. However, most Medicare Advantage Plans have some type of defined network, such as Health Maintenance Organizations, HMO Point of Service Plans, Preferred Provider Networks, Private Fee-For-Service Plans, and Special Needs Plans. Consequently, Advantage Plan participants must be aware of their plan's provider network and diligently work within their assigned provider network; using non-network providers without authorization can be very costly.

4 Medicare Advantage Plans are funded primarily by Medicare and premiums, copays paid by the policyholders. Funding is provided to the various carriers based on a set formula that determines payment schedules to carriers based on the average amount of claims dollars paid to a Medicare recipient in that geographical area, plus an additional amount for risk. The carrier (subject to Medicare approval) determines the coverage and drug formulary that can be economically provided by this funding. The extra risk amount is provided to participating carriers that agree to accept the risk of funding all costs and claims overages; therefore, they are totally accountable for the risk. Carriers appreciate this financial arrangement as it allows them to make profits from their expertise in claims management; the Feds like it because they are not at risk for claims losses.

5 Since participating insurance carriers receive Federal funding as outlined above, many of them can design benefit plans with deductibles, coinsurance and copays that results in lower claims costs; thereby allowing some Advantage Plans to be offered at no premium cost to the insured. These "zero cost" programs are very popular and can be very beneficial, especially to beneficiaries with limited income.

6 The coverage offered by Medicare Advantage Plans varies by plan, but can be very comprehensive. Of course, they must cover all of the medical and hospital services included in Original Medicare. Coverage includes emergency services, urgent care, hospitalization, surgery, physician office visits, diagnostic tests, and more. Some plans also include additional coverages like dental services, hearing benefits, wellness programs and even memberships to health and exercise facilities. Also, many plans include prescription drug coverage (as previously mentioned)

7 Below are the general qualifications required to participate in a Medicare Advantage Plan:

a Must be enrolled in Medicare Part A and Part B
b You must live in a Medicare Advantage Plan service area.
c You cannot have end-stage renal disease.
d Exceptions to the above are determined by the individual carrier; therefore, it may be worthwhile to contact local carriers for more specific information.

8 Although a large majority of Medicare enrollees take Original Medicare and add a Medicare Supplement and a Part D drug plan, the numbers of folks enrolling in Medicare Advantage plans is increasing every year. Both Original Medicare (with a supplement and drug plan) and Medicare Advantage Plans can offer very comprehensive coverage and still be reasonably priced. It is important for people to have affordable and yet comprehensive choices. If you have not considered a Medicare Advantage Plan, it may be worthwhile to check them out.

9 There are certain time frames when you can enroll in Medicare Advantage Plans.

a Initial Coverage Election Period – A 7 month period beginning three months before and 3 months after the month of your 65th birthday.

b If you didn't sign up for Original Medicare during the Initial Enrollment Period (still covered by an employer or union) your Initial Coverage Election Period is the three-month period before your Medicare Part B start date, which would coincide with the date you ceased your employer or union coverage.

c The Annual Election Period runs from October 15th to December 7th each year. You can switch from Original Medicare to a Medicare Advantage Plan at that time and make other changes as well. If you're already enrolled in a Medicare Advantage Plan and want to switch to a different Advantage plan, this period is a good time to make the change. The effective date of your new plan would be the following January 1st.

d. You may be able to change Medicare Advantage Plans during the Special Election Periods (SEPs). This election period is available for certain situations; for example: losing your current coverage, moving to a new address, qualifying for other coverage, changes in your current health plan that negatively impact your coverage. If you want to switch back to Original Medicare (Part A and Part B), you can also do so during this period or during the Medicare Advantage Disenrollment Period which runs from January 1 to February 14 each year.