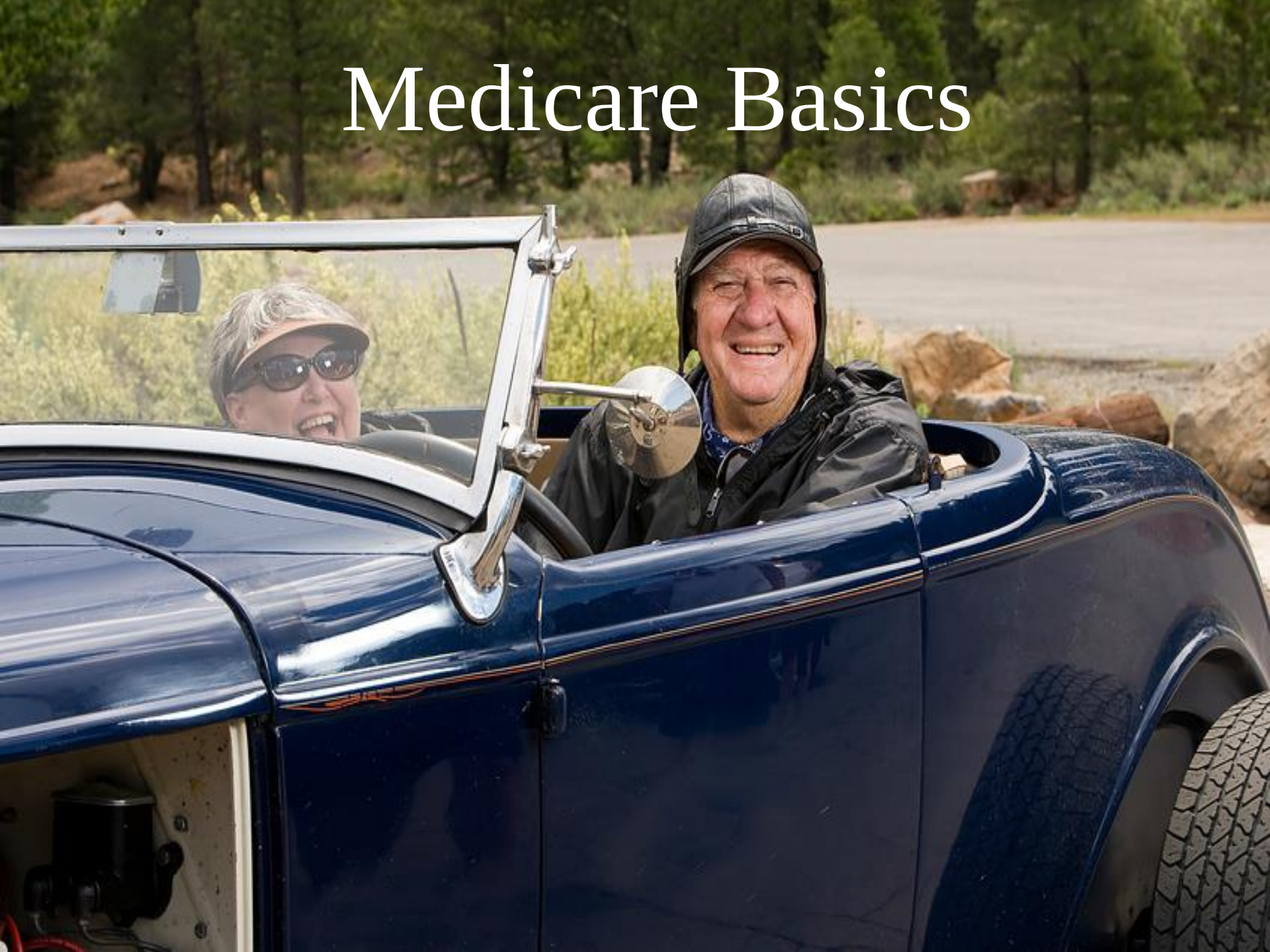
Medicare Basics



What are the Four Parts of Medicare?

Part A
Hospital
Insurance

Part B
Medical
Insurance

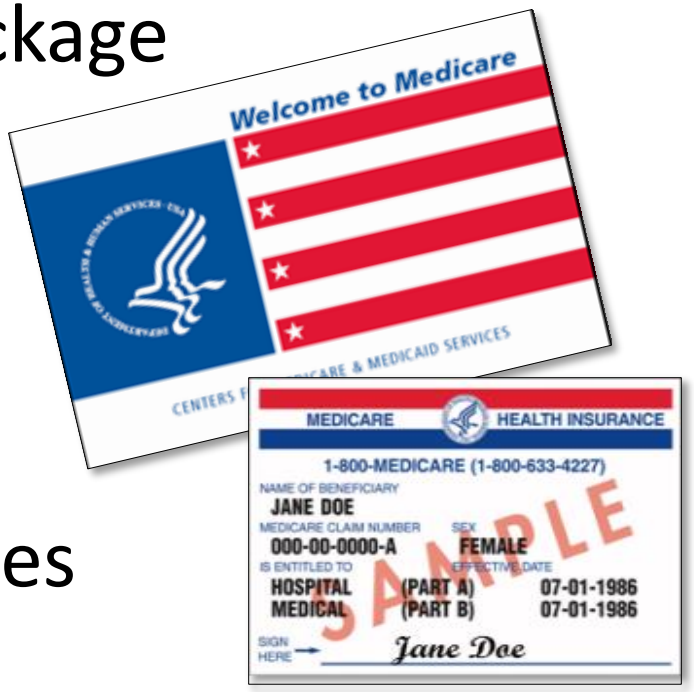
Part C
Medicare
Advantage
Plans , like
HMOs and
PPOs

Includes Part A & B and usually Part D coverage

Part D
Medicare
Prescription
Drug
Coverage

Automatic Enrollment – Part A and B

- Automatic for those receiving
  - Social Security benefits
  - Railroad Retirement Board benefits
- Initial Enrollment Period Package
  - Mailed 3 months before
    - Age 65
    - 25th month of disability benefits
- Others must enroll themselves



When Enrolling in Medicare is Not Automatic

- Some people need to sign up
  - Those not automatically enrolled
  - Even if you are eligible to get Part A premium-free
- Enroll through Social Security
  - Railroad Retirement Board for railroad retirees
- Apply 3 months before age 65
  - Don’t have to be retired

If Not Automatically Enrolled
Your 7-Month Initial Enrollment Period

	No Delay			Delayed Start			
If you enroll in Part B	**3 months before the month you turn 65**	**2 months before the month you turn 65**	**1 month before the month you turn 65**	***The month you turn 65***	**1 month after you turn 65**	**2 months after you turn 65**	**3 months after you turn 65**
Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.				If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.			

General Enrollment Period (GEP)

- January 1 through March 31 each year
- Coverage effective July 1
- Premium penalty
  - 10% for each 12-months eligible but not enrolled
  - Must pay as long as you have Part B
    - Limited exceptions

Enrolling in Part B if You Have Employer or Union Coverage

- You may want to delay enrolling in Part B if you or your spouse is actively employed and you carry active insurance coverage through your current employer.

When Employer or Union Coverage Ends

- When your employment ends
  - You may get a chance to elect COBRA. However, COBRA is not an “active employer” insurance coverage, so you must take out Part B to avoid any penalty for late enrollment
  - When employment ends, you will get a Special Enrollment Period
    - Make sure to sign up for Part B prior to retirement to avoid a penalty

Enrollment in Medicare if You Have TRICARE Coverage

- When you retire, you must enroll in Part B to keep your TriCare coverage

- If you are an Active-duty member, you do not have to enroll in Part B to keep TriCare

Medicare Part A Covered Services

Inpatient Hospital Stays	Semi-private room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in psychiatric hospital (lifetime 190-day limit). Generally covers all drugs provided during an inpatient stay received as part of your treatment.
Skilled Nursing Facility Care	Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.
Home Health Care Services	Can include part-time or intermittent skilled care, and physical therapy, speech-language pathology, a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies.
Hospice Care	For terminally ill and includes drugs, medical care, and support services from a Medicare-approved hospice.
Blood	In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.

Paying for Inpatient Hospital Stays

For each benefit period in 2017	You Pay
Days 1-60	$1,316 deductible
Days 61-90	$329 per day
Days 91-150	$658 per day (60 lifetime reserve days)
All days after 150	All Costs

Skilled Nursing Facility Care

- Must meet all conditions
  - Require daily skilled services
    - Not just long-term or custodial care
  - Hospital inpatient 3 consecutive days or longer
  - Admitted to SNF within specific timeframe
    - Generally 30 days after leaving hospital
  - SNF care must be for a hospital-treated condition
    - Or condition that arose while receiving care in the SNF for hospital-treated condition
  - MUST be a Medicare-participating SNF

Paying for Skilled Nursing Facility Care

For each benefit period in 2017	You Pay
Days 1-20	$0
Days 21-100	$164.50 per day
All days after 100	All Costs

Benefit Periods

- Measures the number of days of inpatient care (hospital or skilled nursing facility).
- Begins the day you first receive inpatient care.
- Benefit period ends when you have been out of the hospital or skilled nursing facility for 60 days in a row.
- You pay the Part A deductible for each benefit period, which is $1,316.00 for 2017.
- No limit to number of benefit periods

Five Conditions for Home Health Care

1. Must be homebound
2. Must need skilled care on intermittent basis
3. Must be under care of a doctor
   - Receiving services under a plan of care
4. Have face-to-face encounter with doctor
   - Prior to start of care
5. Home health agency must be Medicare-approved

Paying for Home Health Care

- Fully covered by Medicare
- Plan of care reviewed every 60 days
  - Called episode of care
- In Original Medicare you pay
  - Nothing for covered home health care services
  - 20% of Medicare-approved amount
    - For durable medical equipment (covered by Part B)

Hospice Care

- Special care for the terminally ill and family
  - Expected to live 6 months or less
- Focus on comfort and pain relief, not cure
- Doctor must certify each “benefit period”
  - Two 90-day periods
  - Then unlimited 60-day periods
  - Face-to-face encounter
- Hospice provider must be Medicare-approved

Paying for Hospice Care

- In Original Medicare you pay
  - Nothing for hospice care
  - Up to $5 per Rx to manage pain and symptoms
    - While at home
  - 5% for inpatient respite care
- Room and board may be covered
  - Short term respite care or for pain/symptom management
  - If you have Medicaid and live in nursing facility

Blood (Inpatient)

- If hospital gets blood free from blood bank
  - You won't have to pay for it or replace it
- If hospital has to buy blood for you
  - You pay for first 3 units per a calendar year, or
  - You or someone else donates to replace blood

Medicare Part B Coverage

Doctor's Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. **Except for certain preventive services, you pay 20% of the Medicare-approved amount (if the doctor accepts assignment) and the Part B deductible ($183) applies.**
Outpatient Medical and Surgical Services and Supplies	For approved procedures (like X-rays, a cast, or stitches). You pay the doctor 20% of the Medicare-approved amount for the doctor's services if the doctor accepts assignment. You also pay the hospital a copayment for each service. The Part B deductible applies.

Assignment

- Doctor, provider, supplier ***accepts assignment***
  - Signed an agreement with Medicare
  - Accept the Medicare-approved amount
    - As full payment for covered services
    - Only charge Medicare deductible/coinsurance amount
- ***Don't accept assignment***
  - May charge you more
    - The limiting charge is 15% more
    - May have to pay entire charge at time of service

Medicare Part B Coverage

Home Health Care Services	Medically necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, occupational therapy, part-time or intermittent home health aide services, medical social services, and medical supplies. Durable medical equipment and an osteoporosis drug are also covered under Part B. **You pay nothing for covered services**.
Durable Medical Equipment	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

DMEPOS Competitive Bidding Program

- Medicare's Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program changes the amount Medicare pays for certain DMEPOS items.
- Under this program, suppliers submit bids to provide certain medical equipment and supplies to people with Medicare living in, or visiting, competitive bidding areas.
- Medicare uses these bids to set the amount it pays for each item.
- Qualified, accredited suppliers with winning bids are chosen as Medicare contract suppliers.

DMEPOS Competitive Bidding Program

- This program:
  - Helps you and Medicare save money.
  - Ensures that you continue to get quality products from accredited suppliers.
  - Helps limit fraud and abuse in the Medicare Program.

Medicare Part B Coverage

DMEPOS Round 2 July 1, 2013	Austin-Round Rock-San Marcos Beaumont-Port Arthur El Paso Houston-Sugarland-Baytown McAllen-Edinburg-Mission San Antonio-New Braunfels
DMEPOS Round 2 Categories	Oxygen, oxygen equipment, and supplies Wheelchairs, scooters, and related accessories Enteral nutrients, equipment, and supplies CPAP devices, RADS and related supplies Hospital beds and related accessories Walkers and related accessories Support surfaces (mattresses and overlays) Negative Pressure Wound Therapy pumps

Medicare Part B Coverage

DMEPOS Round 2 July 1, 2013	National Mail-Order Program for diabetic testing supplies. Includes all part of the United States.
Other (including but not limited to)	Medically necessary medical services and supplies, such as clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, ***mental health care***, limited outpatient prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services are covered. Costs vary.

Part B Covered Preventive Services

- "Welcome to Medicare" visit
- Annual "Wellness" visit
- Abdominal aortic aneurysm screening*
- Alcohol misuse screening and counseling
- Behavioral therapy for cardiovascular disease
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- Hepatitis C screening test
- HIV screening
- Lung cancer screening
- Mammograms (screening)
- Medical nutrition therapy services
- Obesity screening and counseling
- Pap test/pelvic exam/clinical breast exam
- Pneumococcal pneumonia shot
- Prostate cancer screening
- Sexually transmitted infection screening (STIs) and high-intensity behavioral counseling to prevent STIs
- Smoking cessation

*When referred during Welcome to Medicare physical exam

NOT Covered by Part A and Part B

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting hearing aids
- Other – check on www.medicare.gov

Paying for Medicare Part A

- Most people receive Part A premium free
  - If you paid FICA taxes at least 10 years
- If you paid FICA less than 10 years
  - Can pay a premium to get Part A
    - $227 a month for a person who has worked 30-39 quarters or 7.5 to 10 years
    - $413 for a person who has worked less than 30 quarters or 7.5 years
  - May have penalty if not bought when first eligible

Part A Late Enrollment Penalty

If you don't buy Medicare Part A when you are first eligible:

- Your monthly premium may go up 10% when you enroll. You will have to pay the higher premium for twice the number of years that you could have had Part A but did not sign up
- This penalty won't apply to you if you are eligible for a Special Enrollment due to being covered by a group health plan through the employer or union
- Or during the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first

Monthly Part B Premium

If your Yearly Income in 2015 was		You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or less	$170,000 or less	$134.00
$85,001–$107,000	$170,001–$214,000	$187.50
$107,001–$160,000	$214,001–$320,000	$267.90
$160,001–$214,000	$320,001–$428,000	$348.30
above $214,000	above $428,000	$428.60

Paying the Part B Premium

- Deducted monthly from
  - Social Security payments
  - Railroad retirement payments
  - Federal retirement payments
- If not deducted
  - Billed every 3 months
  - Medicare “Easy Pay” to deduct from bank account
- Contact SSA (Social Security Administration), RRB (Railroad Retirement Board) or OPM (Office of Personnel Management) about premiums

Part B Late Enrollment Penalty Example

Mary delayed signing up for Part B two full years after she was eligible. She will pay a 10% penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium ($134.00 in 2017). So for 2017, her premium will be as follows:

$134.00 (2017 Part B standard premium)
\+ $26.80 (20% [of $134.00] (2 X 10%)

$160.80 (Mary's Part B monthly premium for 2017)

Your Medicare Coverage Choices

- Original Medicare (Part A and Part B)
  - Medicare Supplement Insurance Policies (Medigap)
- Medicare Advantage Plans (Part C)
- Medicare Prescription Drug Coverage (Part D)

Medicare Supplement Insurance Policies

- Medicare Supplement Insurance (Medigap)
  - Private health insurance for individuals
  - Sold by private insurance companies
  - Supplement Original Medicare coverage
  - Follow federal/state laws that protect you
- Medigap Open Enrollment Period
  - Starts when you are both 65 and sign up for Part B and lasts for six months
  - Underage 65 beneficiaries have another OE at age 65

Medigap Policies

- Costs vary by plan, company, and location
- Medigap policies are sold with standardized "***basic***" benefits
- Plans are identified in most states by letters
- No networks except with a Medicare SELECT policy
- You pay a monthly premium in addition to the Medicare Part B premium

Medigap Basic Benefits	Medigap Plans									
	A	B	C	D	F*	G	K**	L**	M	N
Part A Coinsurance up to an addition 365 days	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Care Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)			80%	80%	80%	80%			80%	80%

*Plan F has a high-deductible plan
*** Plan N pays 100% Part B coinsurance with copay up to $20 for some office visits and $50 for emergency room visits not resulting in an inpatient admission

Out-of-Pocket Limit**	
$4,960	$2,480

Medicare Advantage (MA) Plans

- Health plan options approved by Medicare
- Also called Medicare Part C
- Run by private insurance companies
- Part B claims are processed and paid by the insurance company
- Medicare then reimburses the insurance company for the member's services
- Part A hospitalization claims are sent directly to Medicare for processing

How Medicare Advantage Plans Work

- Still in Medicare with all rights and protections
- Still get regular Medicare-covered services
  - Some plans may provide additional benefits
- Plan may include prescription drug coverage
- May include extra benefits like vision or dental
- Benefits and cost-sharing differ between plans and also change each year
- Normally have to use network doctors and hospitals

Types of Medicare Advantage Plans

- Medicare Advantage Plans include
  - Health Maintenance Organization (HMO)
  - Preferred Provider Organization (PPO)
  - Private Fee-for-Service (PFFS)
  - Special Needs Plan (SNP)
  - HMO Point-of-Service Plan (HMOPOS)
- Not all types of plans are available in all areas

Medicare Advantage Plan Costs

- Must still pay Part B premium
  - Some plans may pay all or part for you
  - Some people may be eligible for state assistance
- You may also pay monthly premium to plan
- You pay deductibles/coinsurance/copayments
  - Different from Original Medicare
  - Varies from plan to plan

Medicare Advantage Eligibility Requirements

- You must live in plan's service area
- You must have Medicare Part A **and** Part B
- You must not have ESRD (End Stage Renal Disease) when you enroll
- You must provide necessary information
- You must follow plan's rules
- You can only belong to one plan at a time

Medicare Prescription Drug Coverage

- Also called Medicare Part D
- Prescription drug plans approved by Medicare
- Run by private insurance companies
- Available to everyone with Medicare
- Must be enrolled in a plan to get coverage
- Two sources of coverage
  - Medicare Prescription Drug Plans (PDPs)
  - Medicare Advantage Plans with Rx coverage (MA-PDPs)

Medicare Drug Plans

- Must offer at least standard level of coverage
- Can be flexible in benefit design
- May offer different or enhanced benefits
- Benefits and costs may change each year

Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Penalty is an additional 1% of base beneficiary premium for each month eligible but not enrolled
  - Penalty continues for as long as you are enrolled
  - National base beneficiary premium
    - $35.63 for 2017
    - This amount can change each year

Creditable Drug Coverage

- Current or prior prescription drug coverage
- Creditable if it meets or exceeds Medicare's minimum standards
- With creditable coverage
  - May not have to pay a late enrollment penalty
- Plans inform yearly about whether creditable
  - For example, employer group health plans (EGHPs), retiree plans, VA, TRICARE and FEHB

Medicare Drug Plan Out-of-Pocket Cost

- Costs vary by plan
- In 2017, most people will pay
  - A monthly premium
  - A yearly deductible
  - Copayments or coinsurance
  - 40% on brand name drugs while in gap
  - 51% on generic drugs while in gap
  - Very little after spending $4,950 out-of-pocket

Part D Eligibility Requirements

- To be eligible to join a Prescription Drug Plan
  - You must have Medicare Part A **or** Part B
- To be eligible to join a Medicare Advantage plan with drug coverage
  - You must have Part A **and** Part B
- You must live in plan's service area
  - You cannot be incarcerated
  - You cannot live outside the United States
- You **must** be enrolled in a plan to get drug coverage

When You Can Join

- When you become newly entitled to Medicare
  - 7-month Initial Enrollment Period (IEP) for Part D

If You Join	Coverage Begins
3 months before your month of eligibility	Date eligible for Medicare
Month of eligibility	First of the following month
3 months after your month of eligibility	First of the month after month you apply

When You Can Join or Switch Plans

Medicare's Open Enrollment Period ("Open Enrollment")	October 15 – December 7 each year Changes are effective January 1
Medicare Advantage Disenrollment Period (MADP)	Between January 1–February 14, if you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch to Original Medicare during this period, you will have until February 14 to also join a Medicare drug plan to add drug coverage. Coverage begins the first of the month after the plan gets the enrollment form.

When You Can Join or Switch Plans

Special Enrollment Periods (SEP)	▪ You permanently move out of your plan's service area ▪ You lose other creditable prescription coverage ▪ You weren't adequately informed your other coverage was not creditable or was reduced and is no longer creditable ▪ You enter, live in, or leave a long-term care facility ▪ You have a continuous SEP if you qualify for Extra Help ▪ You belong to a State Pharmaceutical Assistance Program (SPAP) ▪ Or in other exceptional circumstances

5-Star Special Enrollment Period (SEP)

- Can enroll in 5-Star Medicare Advantage (MA), Prescription Drug Plan (PDP), or MA-PD
- Enroll at any point during the year
  - Can only be done once per year
- New plan starts first of month after enrolled
- Plan ratings granted on calendar basis
  - Ratings assigned in October of the preceding year
  - Use Medicare Plan Finder to view plan ratings
    - Look at Overall Plan Rating to identify eligible plans

Open Enrollment (continued)

- Beneficiaries who were satisfied with their plan in 2017 still need to review their options for 2018. This is important because Part D plans can change their formularies (list of covered drugs), tiers, utilization management tools, exceptions and appeals processes, and other aspects of their Part D plans. Medicare Advantage plans can change their entire benefit package and provider network

Things to Remember

- The Annual Coordinated Election Period for Medicare Advantage and Medicare Part D drug coverage begins October 15 and goes through December 7, 2017. During this period, ALL people with Medicare can make changes to their health and prescription drug plans for the next year. October 15th is the first day you can change your Medicare coverage for next year.

Open Enrollment (continued)

- Beneficiaries who take no action will remain in their current plan, with some exceptions for individuals who receive Extra Help or who are in plans that are terminating their Medicare contract.

Extra Help or Low Income Subsidy

- If you have limited income and resources, you may qualify for “Extra Help” to pay your prescription drug costs
- Extra Help or Low Income Subsidy is a federal program paid for by the Social Security Administration
- The extra help program helps individuals by providing “extra help” with their monthly premiums, annual deductibles and copays for prescriptions

Extra Help (continued)

- Extra help also allows individuals to enroll in a Part D prescription drug plan anytime during the year and not just at open enrollment. It also allows an individual to switch their Part D plan at any time throughout the year
- Extra help allows the individual to avoid any penalty that would have been incurred due to late enrollment into a Part D plan
- Once approved, the benefit is in effect for one year and individuals are reevaluated annually

Extra Help (continued)

- Qualifications are based on limited income and resources
- Income includes wages, Social Security, retirement income, veteran's benefits, alimony, pensions or annuities, worker's compensation or any other income
- Resources include all bank accounts, stocks, bonds, mutual funds, IRAs, other investments, cash at home or anywhere else and real estate other than your home and the land on which it resides

Extra Help (continued)

- Income limits for 2017 are:
  - Individual $1528.00
  - Couple $ 2050.00

- Resource limits for 2017 are:
  - Individual $13,820.00
  - Couple $27,600.00

Medicare Savings Program

- The Medicare Savings Programs (MSP) are another benefit available which assists Medicare beneficiaries who have low income and resources
- These are state funded Medicaid programs that help individuals pay for their Medicare expenses
- Some individuals may be eligible for additional benefits depending on which MSP program they are entitled to
- These benefits could include paying for the Medicare Part A and Part B deductibles and copayments

Medicare Savings Programs (continued)

- There are four programs, which are:
  - QMB – Qualified Medicare Beneficiary
  - SLMB – Specified Low-Income Medicare Beneficiary
  - QI 1 – Qualified Individual
  - QDWI – Qualified Disabled Working Individual
- Individuals qualify for these programs based on their income and resources. The income limits are based on a percentage of the federal poverty level

Medicare Savings Programs (continued)

- To qualify for one of these programs
  - The monthly income limit is:
    - Individual $1,377.00
    - Couple $1,847.00
  - The resource limit is:
    - Individual $7,390.00
    - Couple $11,090.00

Medicare Savings Program (continued)

- Resources include money, stocks, bank accounts, etc
- Resources that are excluded are one vehicle, the individual's home and the property that it sits on, burial plots and up to $1500.00 per person in burial expenses
- Applications can be completed online or by submitting a paper application to the Health and Human Services Commission and a determination is made within 45 days

Need Assistance?

- The Area Agency on Aging of Central Texas has Benefit Counselors available to assist you with determining whether you may qualify for one of these programs
- The Benefit Counselors can also assist you with submitting an application for benefits
- We are also available to assist with reviewing Part D plans, Medicare Advantage plans and supplemental policies

Need Assistance?

- Contact the Area Agency on Aging of Central Texas at

254-770-2330 local

1-800-447-7169 toll free

Additional Information

Resources

Centers for Medicare & Medicaid Services (CMS)
1-800-MEDICARE
(1-800-633-4227)
(TTY 1-877-486-2048)
w ww.CMS.gov

Plan Finder:
www.medicare.gov

Social Security
1-800-772-1213
TTY 1-800-325-0778
http://www.socialsecurity.gov/

Railroad Retirement Board
1-877-772-5772
http://www.rrb.gov/

State Health Insurance Assistance Programs (SHIPs)*

*Telephone number for Texas HICAP is 1-800-252-9240

Affordable Care Act

www.healthcare.gov/law/full/index.html

www.tdi.texas.gov

Publications

Medicare & You Handbook
CMS Product No. 10050

Your Medicare Benefits
CMS Product No. 10116

Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare
CMS Product No. 02110

Medicare Supplement Handbook and Rate Guide
TDI Product No. CB014

Medicare Advantage Plans
TDI Product No. CB036

Any Questions?

Thank you