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Education

Medicare - What Clinicians Need to Know

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Medicare- What Clinicians Need to Know

Activity Description

The purpose of this activity is to enable the learner to understand eligibility, coverage options, premiums, and enrollment options for Medicare Parts A, B, C, and D and Medicare supplement insurance plans.

Learning Objectives

At the end of this educational activity, participants should be able to:

- Define and understand eligibility, coverage options, premiums, and enrollment options for Medicare Parts A and B
- Define and understand eligibility, coverage options, premiums, and enrollment options for Medicare Part C, Medicare Part D, and Medicare supplement insurance plan
- List the steps a patient must take when a drug plan denies coverage of a prescribed medication

Objective 1

Original Medicare Parts A and B: Define and understand eligibility, coverage options, premiums and enrollment options.

Background on Medicare

History

- Economic Security Bill of 1935
- Social Security Act of 1965
- Formed to help improve the health and longevity of older Americans
- Made access to health care a universal right
- Funded by payroll taxes

Medicare Today

- 50 million members currently depend on Medicare[1]

[1] November 2012, AARP.org
[2] May 2007, AHA.org

Consumer Knowledge

Not Aware

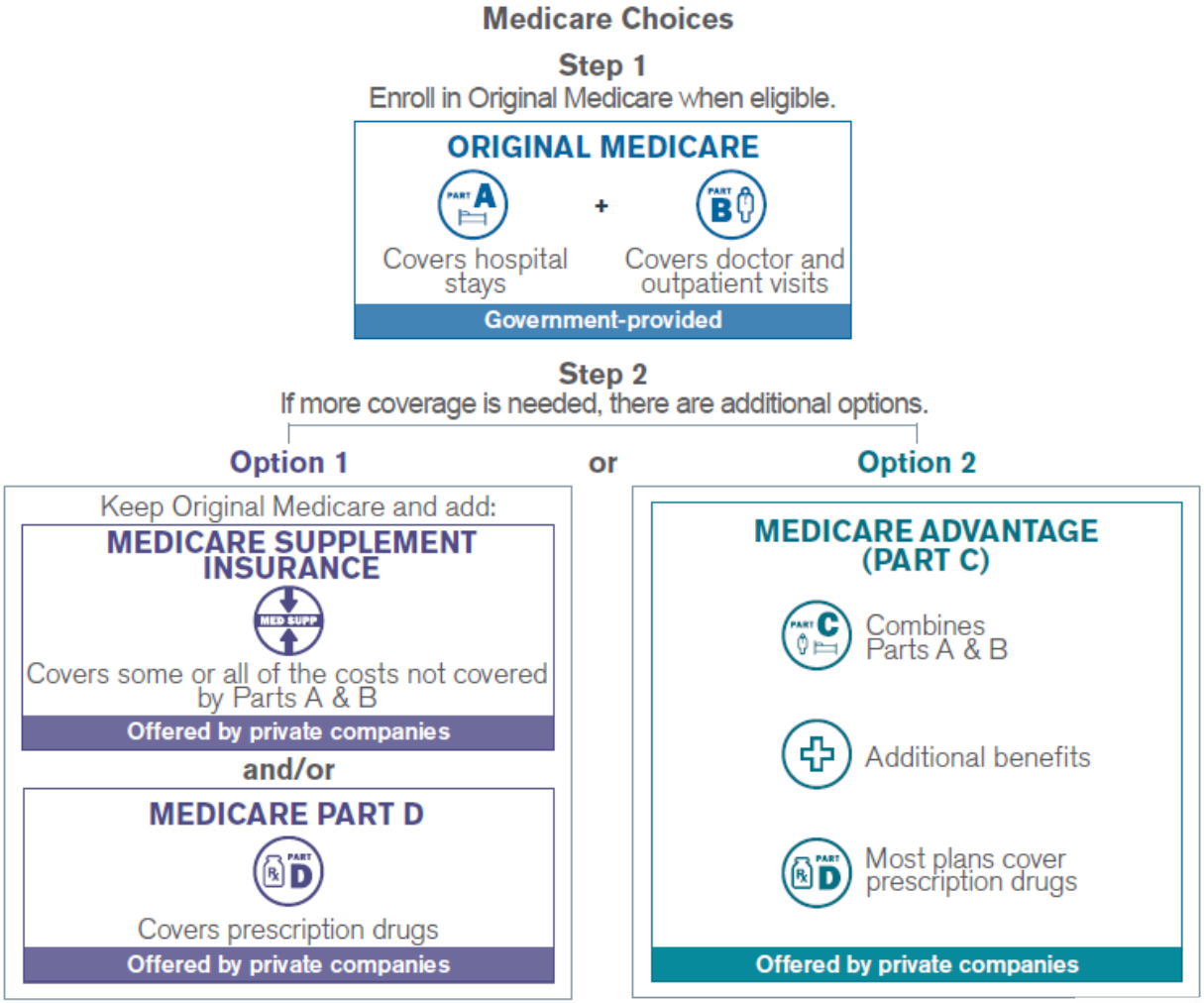
- **Medicare does not** cover every medical or health-related service.
- Medicare and the medical services covered by Medicare are **not free.**
- If a member wants or needs services Medicare does not cover, they will **need to pay** for it themselves.

Consumer Literacy Levels

- **One out of five** American adults reads at the **fifth grade level** or below and the average American reads at the eighth-to-ninth grade level.[1]
- More than **66 percent of American adults** age 60 and over have inadequate or marginal literacy rates. But most health care information is written at the **tenth grade level** or higher.[1]

[1] 3 Doak CC, Doak LG, Root JH. The literacy problem. In: Teaching Patients With Low Literacy Skills. 2nd ed. Philadelphia: J.B. Lippincott Co. 1996: 1-9.

Medicare Choices



Get answers.
Medicare made clear.

Eligibility for Original Medicare

To be eligible for Medicare, the member must be:

- 65 or older or under 65 and qualify on the basis of disability or other special situation.

AND

- A U.S. citizen or legal resident who has lived in the U.S. for at least five consecutive years.

OR

- Any age requiring dialysis via end-stage renal disease program.

Some things to know about the age 65 rule:

- Even if someone is already collecting Social Security, he or she must wait until age 65.
- A spouse's age doesn't count.

When can a Member Join?

Medicare Part A	Any time after an individual is 64 years and 9 months old or otherwise becomes eligible for Medicare. Enrollment will be automatic if they are already receiving Social Security benefits; otherwise, they'll have to enroll at their local Social Security office.	Generally, there are no penalties for signing up late. The individual may pay a penalty on their premium for signing up late if they are one of the people who pay a monthly premium for Part A because neither them nor their spouse contributed enough to Social Security.
Medicare Part B	Seven-month window Generally, **for most,** they can first enroll three months before their 65th birthday month, during their birthday month, and up to three months after their birthday month.	Their eligibility month  Initial enrollment period If an individual enrolls after the initial enrollment period, premiums will be higher unless they qualify for an exception. Contact Medicare to learn more about these exceptions.

Medicare Part A: Overview

Coverage

- Inpatient hospital care
- Inpatient care in a skilled nursing facility
  - After a three-day minimum medically necessary hospitalization
- Hospice care services
- Home health services
- Inpatient mental health care
- Some blood transfusions during inpatient care

Patients should be aware:

- Long hospitalizations can be expensive.
- Multiple stays may mean multiple deductibles.
- Members may go to any hospital in the US that accepts qualified patients.

Medicare Part A

Providers

- Any qualified provider who has been accepted by Medicare and is accepting new patients.

Refusal or Delay of Coverage

- As long as eligibility is met, Part A coverage cannot be refused.

Renewal

- Renews automatically each year.

Late Enrollment Penalty

- If a member is not eligible for premium-free Part A and they do not buy it when they are first eligible, the premium could go up 10 percent.

Medicare Part A: Costs

Premium

- No premium as long as contributions are made to Social Security for at least 10 years.

Deductibles

- **2013 deductible:** $1,184 for a hospital stay of less than 60 days.
- Part A pays a share of the costs after the deductible is met within the benefit period.
- The benefit period begins when admitted and ends when out of the hospital for 60 days.

Coverage limits

- **Hospital days:** Part A limits the number of days it will pay over 90 days. Granted a lifetime reserve of 60 days to cover hospital days that last beyond 90 days.
- **Skilled nursing days**:100 days per benefit period. The member must have 60 days of wellness before another 100 days are granted.
- **Home health care and hospice visits:** Unlimited as long as eligibility is met.

Copay

Hospital	Day 0-60	None
	Day 61-90	2013 - $296
	Day 91-150	2013 - $592
SNF	Day 1-20	None
	Day 21-100	2013 - $148

Medicare Part A: Hospice

- Hospice is a benefit for members with a terminal illness and life expectancy of six months or less.
- Part A covers hospice care delivered by a Medicare-certified hospice program.
- Members can continue to receive hospice care as long as a hospice physician continues to recertify that they are terminally ill. Recertification needs to occur every six months.
- Most hospice care is delivered in the member's home (or nursing home if the individual resides there).
- Small coinsurance amount for prescription drugs used in respite care.

Hospice Coverage

- Medications, medical supplies and durable medical equipment.
- Inpatient stay if medically necessary for symptom management that cannot be delivered in the home.
- Respite care in an approved facility.

Medicare Part B: Overview

Coverage

- Medicare Part B helps cover medically-necessary and certain preventive services including:
  - Doctors' services.
  - Outpatient care.
  - Home health services.
  - Durable medical equipment.

Examples:

- Welcome to Medicare preventive visit and yearly wellness visit.
- Bone mass measurement.
- Chemotherapy.
- Colorectal cancer screenings.
- Diabetes supplies.
- Annual flu vaccine.

Medicare Part B

Providers

- Any qualified provider who has been accepted by Medicare and accepts new patients.

Refusal or Delay of Coverage

- As long as member is eligible for Medicare, coverage cannot be refused based on preexisting illness or medical history.

Renewal

- Renews automatically each year.

Late Enrollment Penalty

- If the member does not enroll when first eligible, they likely will have to pay a late enrollment penalty (unless they meet certain requirements).
- Penalty is a 10 percent increase on the premium for each full 12-month period that the member could have had Part B.
- Penalty is for the entire time the member had Part B.

Medicare Part B: Costs

Premium	• Can be taken out of the individual's Social Security benefits. • 2013 cost is between $104.90 to $335.70 per month based on annual income. • Penalty for those who do not enroll in Part B during their initial enrollment period.
Deductibles	• Coverage begins after member meets an annual deductible. • 2013 deductible is $147.
Coverage limits	• Limits on how much Medicare will pay for services like therapy (occupational, physical, etc.). • Screenings for preventive care may only be covered at specific intervals. • Except in a few situations, medical care that is provided outside of the U.S. is not paid for by Medicare Part B.
Copay/ Coinsurance	• Copays for outpatient hospital services. • After deductible is met, Part B usually will pay 80 percent and the beneficiary pays the remaining 20 percent. • No limits on out-of-pocket expenses.

Medicare Assignment & Medicare-approved Amount

Medicare Assignment

- When a health care provider agrees to take the Medicare-approved amount as full payment.

Medicare-approved Amount

- Amount Medicare Part B will pay for a procedure or service.
  - The Medicare-approved amount may be different from how much a health care provider would charge a non-Medicare member for the same service ("usual and customary amount").
  - Usual and customary amount: Amount paid for a health care service or procedure that has been established by insurance companies and is consistent with charges from similar providers for identical or similar services within a given locality.

Medicare contractual options for providers

- "PAR" providers- sign a participating or PAR agreement and agree to accept Medicare-approved amounts as full payment for their services
  - These providers must "accept assignment" on all Medicare claims
  - This includes the 80% that Medicare pays plus the 20% patient copayment
  - However, Medicare PAR agreements do not mandate providers to accept every Medicare patient who seeks care from them

PAR Provider Billing Example	
Procedure X (total Medicare-approved amount)	$100
Medicare pays the provider 80% of approved amount	$80
Patient (or Medicare supplement) pays the provider 20 percent	$20

Medicare contractual options for providers- continued

- "non-PAR" providers- are allowed to make assignment decisions on a case-by-case basis
  - Medicare reduces payments to non-PAR providers by five percent (95 percent of the Medicare-approved amount)
  - Medicare allows non-PAR providers to pass the cost onto the member by charging up to an additional 15 percent of the reduced Medicare-approved amount for unassigned claims

Medicare contractual options for providers- continued

non-PAR provider billing examples		
Non-PAR assigned claim	Procedure X (total Medicare-approved amount)	$100
	Reduced Medicare-approved amount	$100 x 95 percent= $95
	Medicare pays 80% of the approved amount (directly to the provider)	$76
	Patient (or Medicare supplement provider) pays 20%	$19
Non-PAR unassigned claim	Procedure X (total Medicare-approved amount)	$100
	Reduced Medicare-approved amount	$100 x 95 percent= $95
	Reduced Medicare approved amount + 15 percent of approved amount (provider allowed to charge)	$95 x 15 percent = $109.25
	Medicare pays 80% of the approved amount (directly to the patient)	$76
	Patient (or Medicare supplement provider) pays 20%	$19
	Balance of provider charge paid by patient	$109.25- $76- $19= $14.25

Objective 2

Medicare Parts C and D and Medicare Supplement Plans: Define and understand eligibility, coverage options, premiums and enrollment options.

Medicare Part C: Overview

- Offered through private insurance companies.
- Part C plans are also referred to as Medicare Advantage (MA) plans.
  - Some MA plans are coordinated or managed care plans.
- Generally offer hospital coverage (Part A), medical coverage/doctor visits (Part B) and drug coverage (Part D) in one plan.
- All MA plans must be approved by the Centers for Medicare & Medicaid Services and are required to offer at minimum what original Medicare offers.

Coordinated Care and Accountable Care Organizations

Coordinated or Managed Care Plans

- Care may be managed and coordinated through a primary care physician (PCP).
- Care is called “coordinated” because in most plans, the member must receive care from providers within the plan’s provider network.
- Aims to integrate and avoid fragmentation of care.
- Aims to deliver the right care at the right time, especially to those with chronic illnesses.
- May offer additional services and coverage, such as nurse help lines.

Medicare supports Accountable Care Organizations (ACO)

ACO: a health care provider organization that agrees to receive a flat fee from Medicare and be responsible for the overall cost, quality and care of an assigned group of Medicare members.

Types of Coordinated or Managed Care Plans

- **Health Maintenance Organization (HMO)**
  - Member may be required to choose a PCP and may need a referral to see a specialist.
  - Generally no coverage for care received outside the plan's network unless for emergency care or out-of-area dialysis.

- **Point of Service (POS)**
  - Type of HMO plan that allows for some out-of-network coverage for certain types of providers.
  - Referrals for specialists not required in some plans.
  - May pay more for services received outside the network.

- **Preferred Provider Organization (PPO)**
  - Coverage for services outside the network, but may cost more than in-network.
  - Generally, referrals for specialists not required.

Types of Coordinated or Managed Care Plans

- **Special Needs Plans (SNP)**
  - Designed for those who have more complex care needs.
  - 3 types of SNP plans approved by CMS:
    - Institutional: for people living in nursing homes.
    - Dual: for people eligible for both Medicare and Medicaid.
    - Chronic: for those with certain chronic illnesses.
  - Members may join a SNP plan any time as long as they are eligible.
  - Some SNP plans provide a care manager or nurse practitioner who serves as a care advocate to help assist with complex health needs and help manage costs.
  - A Care Advocate also educates and coaches the member.

Other plans: Types of MA plans

- **Private Fee-For-Service Plans (PFFS)**
  - Members may go to any doctor or hospital, as long as the provider is willing to accept the payment terms and conditions of the health plan.
  - Provider can decide at each episode of care.
  - Plan determines what it will pay for services and how much the member is responsible for.

- **Medical Savings Account Plans (MSA)**
  - Combines coverage for Parts A and B with a savings account that can be used for covered expenses.
  - Higher deductible, but once deductible is met the plan pays 100 percent of covered services.

Part D Coverage:

Some PFFS and MSA plans do not have prescription drug (Part D) coverage included, so the member may need to purchase a stand-alone Part D plan.

Medicare Part C

Providers

- For some plans, members may have to choose specific doctors/hospitals within network.
- For some plans, members may be able to access care from any Medicare-eligible provider, as long as the provider accepts the payment terms and conditions of the plan.
- Required to cover nationwide emergency care, urgent care and renal dialysis.

Renewal

- Coverage renews automatically. The member must continue to pay their plan and Part B premiums and the plan must still be available in the service area.

Refusal or Delay of Coverage

- As long as a member is eligible for Medicare and the plan accepts new members, coverage cannot be refused.

Eligibility

- To be eligible for Part C, a member:
  - Must be eligible for Part A and enrolled in Part B.
  - Must live in the plan's service area.
  - Cannot have ESRD.
- Some SNPs have additional eligibility requirements.

Medicare Part C: Costs

Premium	• Member pays their Parts A and B premiums (if applicable). • MA plan may charge an additional premium.
Deductibles	• Vary by plan.
Coverage limits/ Maximum out-of-pocket limits	• Vary by plan. • MA plans generally limit the out-of-pocket expenses a member has to pay each year.
Copay/ Coinsurance	• Vary by plan.

Medicare Part C:
Cost-Sharing and Out-of-Pocket Limits

- Cost-sharing varies depending on the plan.
- Cost-sharing may different from original Medicare.
- Cost-sharing will likely be set up as deductibles, copays and coinsurance and be applied to all services covered by the plan (Parts A, B and D services).

Original Medicare vs. Medicare Part C:

- In Original Medicare, there is no maximum out-of-pocket spending for members.

Medicare Part D: Overview

- Offered through private insurance companies.
- Part D/the prescription drug benefit was put into effect in 2006.
- Part D plans are administered by private insurance companies and are available as:
  - Stand-alone prescription drug plans OR
  - Part of a Medicare Advantage plan.
- Part D plans cover both generic and brand name medications.

CMS has set a minimum level of coverage for all plans.

Medicare Part D

Pharmacies

- Each Part D plan determines what pharmacies are in the network.
- Some plans cover pharmacies across the U.S. and others provide coverage within a given area.
- Some plans offer mail order pharmacy services.

Refusal or Delay of Coverage

- Anyone entitled to Part A and/or enrolled in Part B cannot be denied enrollment based on prior health conditions .
- Members may only join one plan at a time and at certain times of the year based on their situation.

Renewal

- Coverage renews automatically. Members must continue to pay plan and Part B premiums and the plan must still be available in the service area.
- Members may change coverage every year during the annual enrollment period.

Eligibility

- Anyone entitled to Part A and/or enrolled in Part B.
- Must live within a PDP's service area.
- Member may join as soon as they are eligible for Medicare or during the annual enrollment period (unless eligible for an exception).

Medicare Part D: Costs

Premium	• Member pays their Part A (if applicable) and Part B premiums. • Part D plans may charge an additional premium. • Penalty may be added if a member does not enroll in a Part D plan as soon as they are eligible for Medicare (unless they meet eligibility for an exception). • People with low income may be eligible to receive Part D at a reduced or zero premium.
Deductibles	• Vary by plan.

Formularies	• All formularies must include:
	  • At least two drugs from every drug class and category.
	  • All drugs in the following classes: anti HIV/AIDS drugs, anticonvulsants, antidepressants, anti-neoplastics, antipsychotics and immunosupressants.
	  • A procedure to handle appeals and exceptions if a non-formulary drug is required.

Copay/ Coinsurance	• Vary by plan.

Understanding Drug Payment Stages

Part D coverage gap

Annual Deductible

Not all plans have a deductible. An individual pays their deductible before inital coverage begins.

Initial Coverage Stage

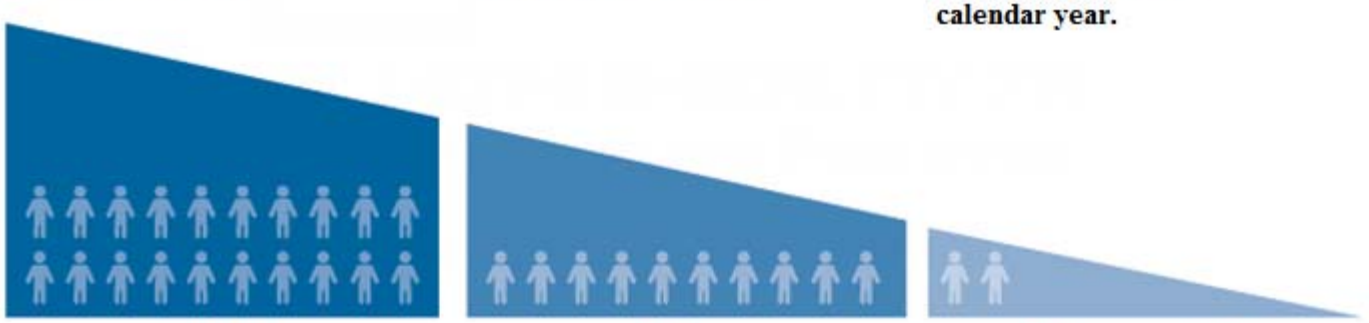
During this stage the individual pays a flat fee (copay) or a percentage of a drug's total cost (coinsurance) for each prescription. **The plan pays the rest until the total drug costs (paid by the individual and the plan) reach $2,970.**

Coverage Gap Stage

During this stage an individual pays 47.5% of the total cost for brand name drugs and 79% of the total cost for generic drugs. **Once the out-of-pocket costs reach $4,750, the individual moves to catastrophic coverage.**

Catastrophic Coverage Stage

In this stage an individual pays only a small copay or coinsurance amount for each filled prescription. **The plan and Medicare pay the rest until the end of the calendar year.**



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Common Medicare Part D Questions

What vaccines does Medicare cover?

- **Flu:** Part B covers a shot once per flu season in the fall and winter.
- **Shingles:** Not covered under Parts A or B. Generally covered under Part D.
- **Pneumonia:** Part B covers a shot once.
- **Hepatitis B:** Covered by Part B.
- **Diphtheria, tetanus and whooping cough**: Covered by Part B.

What drugs are covered under Part B versus Part D?

- Part B covers a limited number of outpatient drugs under specific conditions.
- Examples:
  - Infused drugs.
  - Antigens.
  - Osteoporosis drugs.
  - Erythropoisis-stimulating agents.
  - Blood clotting factors.
  - Injectable drugs.
  - Oral ESRD.
  - Immunosuppressive drugs.
  - Oral anti-cancer and anti-nausea drugs.
  - Self-administered drugs in outpatient settings.

How is the coverage gap changing?

- Patient Protection and Affordable Care Act (PPACA) is gradually reducing the coverage gap.
- More than one million seniors and people with disabilities saved $687 million on prescription drugs in the donut hole (Source: CMS).
- In 2013, members are expected to pay 47.5 percent for brand name drugs and 79 percent for generic drugs while in the coverage gap.
- It is expected that discounts will increase each year until the coverage gap closes (projected for 2020).

What if a drug isn't covered?

Change to Another Drug	Transition Supply	Step Therapy	Prior Authorization	Exception
• Member should talk to their doctor and/or pharmacist to see if another drug on the formulary will work.	• Member may be able to request a temporary supply of the drug. • Under certain circumstances if, for instance, the plan can offer a temporary supply if the drug is no longer on the formulary or when it is restricted in some way.	• Requirement to try one or more alternative drugs before the plan covers a medication. • If one of the alternatives doesn't work, member may request an exception.	• Approval from the health plan before the specific drug will be covered. • Member must call the health plan to obtain prior authorization and provide a statement from the doctor to support request.	• Member and doctor can ask the plan for an exception. • Plan could cover drug not on a formulary or a drug without restrictions.

High Risk Medications in the Elderly

- Beers criteria
  - The American Geriatrics Society (AGS) released the **AGS Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (2012)**.
  - Identifies medications that may be inappropriate for people over age 65
    - Limited effectiveness in this population.
    - Availability of alternative treatments.

Three Categories

- Potentially inappropriate medications for the elderly.
- Potentially inappropriate drug use in older adults due to drug-disease or drug-syndrome interactions.
- Potentially inappropriate medications are to be used with caution with older adults.

High Risk Medications in the Elderly

- If a medication is on the list, it does not mean the medication is unsafe for adults 65 or older.
- It does mean these drugs are potentially or possibly inappropriate for older people.
- Use as a reference, but don't make decisions on these lists alone.
- Criteria does not apply to all clinical situations and in certain circumstances these medications may be the best choice for a patient.
- All patients respond differently to medications so patients and doctors should discuss the best course of action.

Overview of Medicare Supplemental Plans

- Sold by private insurance companies
- Help to cover out-of-pocket costs not covered by original Medicare (e.g. deductibles, coinsurance, etc.)
- Also called Medigap or Med Supp plans
- Must follow federal and state laws designed to protect the consumer and need to be identified as Medicare Supplement Insurance
- Can only be sold as standardized plans labeled as Plans A-N (in most states)*

*Massachusetts (MA), Minnesota (MN) and Wisconsin (WI) plans are standardized differently.

Medicare Supplement Insurance Plans are Standardized

- Plan L sold by Company A will be identical to Plan L sold by Company B, but premiums, copays, etc. could be different

Overview of Medicare Supplement Insurance Plans

10 Standard Medicare Supplement Plans

Benefits Covered	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Part A hospital coinsurance and 365 extra hospital days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part A deductibles		100%	100%	100%	100%	100%	**50%***	**75%***	50%	100%
Part B coinsurance or copays	100%	100%	100%	100%	100%	100%	**50%***	**75%***	100%	100% **except** certain copays**
Part B annual deductible			100%		100%					
Part B excess charges					100%	100%				

* Plans in MA, MN, and WI differ from the plans shown.

Overview of Medicare Supplement Insurance Plans

10 Standard Medicare Supplement Plans

Benefits Covered	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Cost of blood transfusion (first three pints)	100%	100%	100%	100%	100%	100%	**50%***	**75%***	100%	100%
Cost of foreign travel emergency (up to the plan limits)			80%	80%	80%	80%			80%	80%
Hospice care coinsurance cost	100%	100%	100%	100%	100%	100%	**50%***	**75%***	100%	100%
Preventive care coinsurance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	**50%***	**75%***	100%	100%
Yearly out-of-pocket limit (2013)	No limit	No limit	No limit	No limit	No limit	No limit	**$4,800**	**$2,400**	No limit	No limit

Note: Plans E, H, I and J are no longer offered to new enrollees.
*100% after you reach your yearly out-of-pocket limit.
**$20 copay for doctor visit and $50 copay for ER visit.

* Plans in MA, MN, and WI differ from the plans shown.

Medicare Supplement Insurance Plans

Providers

- Any qualified provider who participates in Medicare and accepts new patients.

Refusal or Delay of Coverage

- After a member's initial open enrollment period, coverage can be refused, or a higher premium can be charged based on health status or an insurer can delay coverage due to a current illness.

Renewal

- Automatic as long as the premium is paid and the member has not made any untrue statements on the application.
- Policy can be dropped at any time.
- A member can apply for a new policy, but if it is not during their open enrollment they could be refused coverage or charged a higher premium.
- Must continue to pay Part B monthly premium (unless covered by the plan).

Eligibility

- Apply to purchase a policy at any time after turning 65 and enroll in Part B.
- The initial open enrollment period for a policy is the six month period after a member's 65th birthday and enrollment in Medicare Part B.
- During open enrollment, CMS ensures members have the right to buy any policy and the insurer cannot base the premium on their health status.

Medicare Supplement Insurance Plans

Premium	• Varies by plan and insurer. • Generally, the more coverage, the higher the premium.
Deductibles	• Plans C and F cover the Part B deductible. • Plan F also offers a high-deductible plan in some states. If this option is chosen, the member must pay for Medicare-covered costs (coinsurance, copayments and deductibles) up to the deductible amount of $2,110 in 2013 before the plan pays anything.
Coverage Limits	• No policy covers SNF days beyond the 100 days covered by traditional Medicare. Some policies cover emergency care that is provided outside of the U.S. for travel emergencies. • Other coverage limits may apply.
Copay/ Coinsurance	• Plan N pays 100 percent of the Part B coinsurance except for a copayment of up to $20 for some office visits and up to $50 for emergency room visits that don't result in an inpatient admission. • Plans K and L have coinsurances that members pay until they reach their annual out-of-pocket limit.

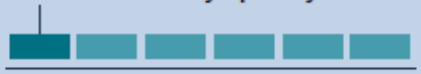
When can a member join?

Medicare Part C (Medicare Advantage)	Seven-month window Generally, **for most,** they can first enroll three months before their 65th birthday month, during their birthday month, and up to three months after their birthday month.	Their eligibility month  Initial enrollment period If an individual misses the enrollment window, they must wait to join a plan between October 15 and December 7, unless they qualify for an exception. exception.

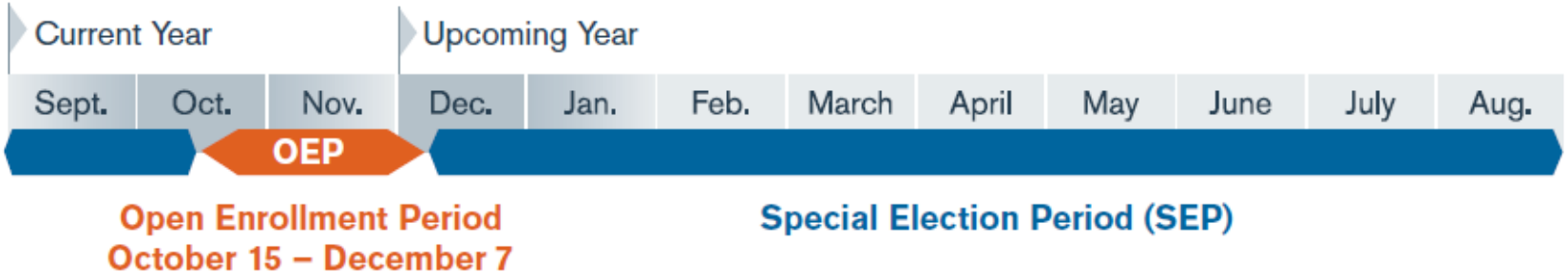
When can a member join?

Medicare Part D	Seven-month window	Their eligibility month
	Generally, **for most**, they can first enroll three months before their 65th birthday month, during their birthday month, and up to three months after their birthday month.	 Initial enrollment period If an individual misses the enrollment window, they must wait to join a plan between October 15 and December 7, unless they qualify for an exception. If they enroll later, premiums could be higher.

When can a member join?

Medicare supplement (Medigap) insurance	Six-month window for guaranteed right When an individual turns 65 AND enrolls in Medicare Part B, they have the guarunteed right to buy a Medigap policy for six months. They cannot be refused if they sign up during the open enrollment period.	Month they qualify  Open enrollment period If an individual misses the enrollment window, they can apply later at any time. But they may be charged a higher rate or be rejected if they have a health history that makes them appear to be at a higher risk.

Enrollment Periods



- **General enrollment:** January 1 - March 31 if the member did not sign up for Part A or Part B when they were first eligible.

Medicare Supplement Insurance Open Enrollment Period (OEP)

- Begins the first day of the month the member turns 65 and is enrolled in Medicare Part B and lasts for six months. Some states allow ongoing open enrollment and/or require coverage be offered to people under age 65 and eligible for Medicare because of disability.
- Members may drop a policy and apply for another at any time, but could be denied or charged a higher premium.

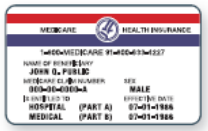
How does a beneficiary get started?

How does a beneficiary get started?

- Study options
  - Visit Medicare.gov
  - Local SHIP office
- Understand needs
- Compare coverage in the area
- Review each plan
  - Costs: Including annual deductible, copays and coinsurance.
  - Formulary (drug list).
  - Plan network.

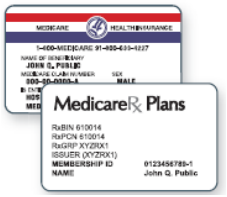
How to Determine Medicare Coverage

Original Medicare (Parts A & B)



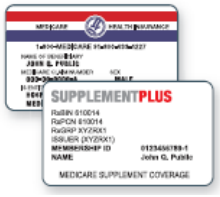
If a member only uses their Medicare card issued by the federal government.

Original Medicare + Part D Plan



If a member has a Medicare card plus a separate drug plan card. A discount card for drugs does not mean they have a Part D plan.

Original Medicare + Medicare Supplement



If a member uses their Medicare card and a second card that pays expenses Medicare doesn't cover.

Original Medicare + Medicare Supplement + Part D Plan

If a member has three cards that include a Part D plan and Medicare supplement card that covers expenses Medicare doesn't cover.

How to Determine Medicare Coverage (cont.)

Medicare Advantage (Part C) Medical Only + Part D Plan

If a member only uses a health plan card instead of their Medicare card from the federal government for medical and drug coverage.

Medicare Advantage (Part C) Medical Only + Part D Plan

If a member uses a health plan card for their medical coverage and a second health plan card for their drug coverage expenses.

Assistance for People with Lower Incomes

- Less than 50 percent of those who quality for assistance sign up.[1]
- Medicare members who are eligible should be encouraged to apply.

Programs include:

Medicaid.
Medicare Savings Programs.
PACE (Programs of All-inclusive Care for the Elderly).
Prescription Drug Assistance Programs.

- Eligibility is based on income and assets.
- Income eligibility is determined at the state level.

For individuals, help may start when income is around $16,755.[2]

For couples, help may start when combined income is around $22,695.[1]

1 March 2012, PolitiFact.com
2 Medicare.gov

Resources

- **Administration on Aging:** For help finding local, state and community-based organizations that serve older adults and their caregivers.
  - 1- 800-677-1116, TTY 711, 8 a.m. to 8 p.m. EST, Monday through Friday,
  - Eldercare.gov
- **Hospice:** For information about hospice care programs, call your state's hospice care organization.
  - For the number in your state, call the Medicare Helpline at 1-800-MEDICARE (1-800-633-4227), TTY 877-486-2048, 24 hours a day, 7 days a week.
- **Medicare Helpline:** For questions about Medicare and detailed information about plans in your area
  - 1-800-MEDICARE (1-800-633-4227), TTY 877-486-2048, 24 hours a day, 7 days a week
  - Medicare.gov
- **Medicare & You:** The official Medicare handbook
  - Medicare.gov
- **Social Security Administration:** For questions about eligibility, enrollment and arranging for the cost of Medicare, and for answers about Social Security retirement and disability benefits
  - 1-800-772-1213, TTY -800-325-0778, 7 a.m. to 7 p.m. local time, Monday through Friday.
- **Medicare Made Clear:** Understand Medicare health plan coverage, benefits and health insurance plans with easy to use materials, videos and tools
  - MedicareMadeClear.com

Resources

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- CMS (2012). Glossary-R (Religious Nonmedical Care Institution). Retrieved November 26, 2012 from http://www.medicare.gov/glossary/r.html
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- National Academy of Social Insurance (n.d.). What is the history of Medicare? Retrieved November 26, 2012 from http://www.nasi.org/learn/medicare/history
- UnitedHealthcare (2013). Medicare Made Clear™.

Questions & Answers

Thank You.

Please direct questions regarding the activity to OptumHealth Education at moreinfo@optumhealtheducation.com