MEDICARE BASICS

This paper covers the following topics in order:

- Original Medicare
- Medicare Advantage Plan (Part C)
- Medicare Costs
    - Original Medicare
    - Medicare Prescription Drug Plan (Part D)
    - Medicare Advantage Plan
- Medicare Supplement Plan (Medigap)
- Pricing Methods
- Switching Plans
- Financial Assistance

Most seniors enroll in Medicare during what is referred to as the Initial Enrollment Period (IEP). The IEP is a seven-month period that starts three months before your Medicare-eligible date, includes the month of your Medicare-eligible date, and the three months after your Medicare-eligible date.

Basically, there are two options for health insurance coverage under Medicare; 1) Original Medicare with or without a supplement and a prescription drug plan or 2) an Advantage Plan which may or may not include prescription drug coverage.

1. Original Medicare

Original Medicare includes:

- **Part A (Hospital Insurance)**
    - Inpatient care in hospitals
    - Skilled nursing facility care
    - Hospice care
    - Home health care

- **Part B (Medical Insurance)**
    - Services from doctors and other health care providers
    - Outpatient care
    - Home health care
    - Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
    - Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)

For all ***covered costs*** in both Part A and Part B, Medicare will pay 80% of the cost. To help pay out-of-pocket costs under Original Medicare coverage (the 20% Medicare does not pay), Medicare supplemental coverage insurance plans (also known as Medigap Plans discussed below) are available for purchase from private insurance companies.

One of the benefits of the Original Medicare plan is that you can use any medical professional or facility that accepts Medicare, anywhere in the United States!

If you want prescription drug coverage you can purchase a separate insurance plan known as a Prescription Drug Plan (PDP) Part D.

Part D plans (discussed in more detail later) are offered by private insurance companies but these companies must offer coverage that follow rules set by Medicare. Prescription drugs can be very expensive so this is a beneficial coverage to have. But if you have no or few prescriptions at this time and want to wait ….***be aware that the coverage will cost you more if you enroll at a later date!***

2. Medicare Advantage (Part C)

Medicare Advantage Plan (also known as a Part C plan) is an “all in one” alternative to Original Medicare. These plans include Part A, Part B, and usually include prescription drug coverage similar to Part D mentioned above. Often, they include dental, hearing and vision coverage as well. Additionally, the plans ***may*** have lower out-of-pocket costs than Original Medicare. These plans usually have very low premiums including some with zero dollar premiums.

However, these plans typically have several requirements such as:

- Your primary care physician (PCP) and any hospital/medical facility used must be a part of the insurance company’s network of health service providers
- There will normally be co-pays for ***each*** visit to your PCP or medical facility
- You usually will need a referral from your PCP to see a specialist which also must be in the insurer’s network for any use to be a covered expense

If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you'll have special rights under federal law to buy a Medigap policy. You have these rights if you return to Original Medicare within 12 months of joining.

- If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
- The Medigap policy can no longer have prescription drug coverage even if you had it before, but you may be able to join a Medicare drug plan (Part D).
- If you joined a Medicare Advantage Plan when you were first eligible for Medicare, you can choose from any Medigap policy.
- Some states provide additional special rights.

Medicare Costs

Original Medicare

In general, if you paid social security taxes for at least 10 years, you have already paid for Medicare Part A. Most people don't pay a monthly premium for Part A (sometimes called "premium-free Part A"). However, if you paid Medicare taxes for less than 10 years, you will pay more than that and if you don't buy it when you're first eligible, your monthly premium may go up 10%. (You'll have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign up.)

The Medicare Part B premium is deducted from your Social Security benefit or billed to you from the Social Security Administration (SSA) and was $144.60 in 2020 (or higher depending on your income). Most people pay the standard Part B premium amount. But, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount **and** an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium which can increase the monthly premium to as much as $491.60 in 2020.

If you don't sign up for Part B when you're first eligible, you'll have to pay a late enrollment penalty. You'll have to pay this penalty for as long as you have Part B. Your monthly premium for Part B may go up 10% of the standard premium for each full 12-month period that you could have had Part B, but didn't sign up for it. Also, you may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B. Coverage will not start until July 1 of that year.

Deductibles:

Medicare Part A has a deductible that applies to each benefit period rather than a calendar year deductible like Part B or private insurance plans and is $1,484 in 2021. The Part A benefit period begins the day you are admitted to a hospital or to a skilled nursing facility (SNF) as an inpatient and ends the day you have been out of the hospital or SNF for 60 days in a row. So, if you are readmitted as an inpatient on day 61, a new benefit period begins and you must pay the deductible again. Just another reason for Medicare supplemental insurance plans that pay the deductible!

Medicare Part B coverage has a deductible which is $203 in 2021. Each year the Medicare premiums, deductibles, and copayment rates are adjusted according to the Social Security Act.

Medicare Prescription Drug Plan (Part D)

Most people only pay a Part D premium dictated by the insurer. However, you may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Medicare drug coverage or other Creditable prescription drug coverage. You'll generally have to pay the penalty for as long as you have Medicare drug coverage.

As with the Part B premium, if you have a higher income, you might pay more for your Medicare drug coverage (sometimes called "Part D-IRMAA"). You'll also have to pay this extra amount if you're in a Medicare Advantage Plan that includes drug coverage. To lower costs, many plans offering prescription drug coverage place drugs into different "tiers" on their formularies. Each plan can divide its tiers in different ways. Each tier costs a different amount. Generally, a drug in a lower tier will cost you less than a drug in a higher tier.

Here's an example of a Medicare drug plan's tiers (your plan's tiers may be different):

- Tier 1—lowest copayment: most generic prescription drugs
- Tier 2—medium copayment: preferred, brand-name prescription drugs
- Tier 3—higher copayment: non-preferred, brand-name prescription drugs
- Specialty tier—highest copayment: very high cost prescription drugs

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs.

Not everyone will enter the coverage gap. The coverage gap begins once you and your plan have spent $4,020 on covered drugs in 2020 ($4,130 in 2021). People with Medicare who get Extra Help paying Part D costs won't enter the coverage gap.

Once you reach the coverage gap, you'll pay no more than 25% of the cost for your plan's covered brand-name prescription drugs. Some plans may offer you even lower price in the coverage gap. Although you'll pay no more than 25% of the price for the brand-name drug, almost the full price of the drug will count as out of pocket cost to get you out of the coverage gap. What you pay and what the manufacturer pays (95% of the cost of the drug) will count toward your out-out-pocket spending. Medicare will pay 75% of the price for generic drugs during the coverage gap. You'll pay the remaining 25% of the price. The coverage for generic drugs works differently from the discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap.

Once you've spent $6,350 out-of-pocket in 2020 ($6,550 in 2021), you're out of the coverage gap. Once you get out of the coverage gap (Medicare prescription drug coverage), you automatically get "catastrophic coverage." It assures you only pay a small coinsurance or copayment amount for covered drugs for the rest of the year.

Deductibles:

Deductibles vary between Medicare (Part D) drug plans. No Medicare drug plan may have a deductible more than $435 in 2020 ($445 in 2021). Some Medicare drug plans don't have a deductible but their premiums may be higher.

Medicare Advantage (Part C) Plan

These are the plans advertised by flyers that fill up your mailbox and TV in the fall and are pushed by such health experts as Joe Namath and Mike Ditka. There must be a reason!

A Medicare Advantage Plan takes the place of Original Medicare coverage (provides the same coverage except an insurance company is providing it rather than the government) and may add prescription drug coverage plus other services such as dental, vision, silver sneakers, etc. If a "one company supplies all" coverage with a single insurance card is desirable, an Advantage Plan may be the right choice. These plans range from zero premium to fairly expensive depending on the insurance company and the wide range of coverage selected. They also require participation in their network of hospitals, doctors, clinics and pharmacies. Coverage outside the network is limited to emergencies and requires transport back to a network facility within

a defined period. Copayments at the time of access to medical care such as making a $300/day copayment for each day in the hospital for the first 5-7 days and paying 20% of all diagnostic and lab tests, etc. are not uncommon. Coverage of the individual's medicine is also a factor to consider since the prescription drug plan is a part of the Advantage Plan. These are the only plans with zero or near zero premiums but of course they come with service/network restrictions and copays or co-insurance for just about everything. A word of caution with this type of plan. Since they operate with a network of doctors and hospitals, it is possible that a doctor or hospital may drop out of the network. If that happens, the individual will either have to change to a different doctor or hospital or change to a policy with a different insurance company that includes the desired doctor or hospital. Some retirees feel that the Advantage plans are a gamble for older folks. An extended stay in a hospital wipes out the premium savings of an Advantage plan over a Medigap plan. If the individual is covered by an Advantage plan and develops a chronic illness later in life and wants to switch back to Original Medicare with a Medigap plan, the Medigap plan may be difficult, very expensive or impossible to purchase. In addition, if the individual's drug needs change to a prescription not covered by the Advantage Plan, the individual will need to change Advantage Plans (doctor, hospital & drug) to obtain coverage for the new prescription drug.

Out-of-pocket costs in a Medicare Advantage Plan (Part C) depend on:

- Whether the plan charges a monthly premium. Many Medicare Advantage Plans have a $0 premium. If you enroll in a plan that does charge a premium, you pay this in addition to the Part B premium.
- Whether the plan pays any of your monthly Medicare Part B (Medical Insurance) premium. (some plans pay all or part of your Part B premium)
- Whether the plan has a yearly Deductible or any additional deductibles.
- How much you pay for each visit or service (Copayment or Coinsurance). For example, the plan may charge a copayment, like $20 or 20% every time you see a doctor.
- The type of health care services you need and how often you get them.
- Whether you go to a doctor or Supplier who accepts Assignment if:
    - You're in a PPO, a Pay For Services, or a Medical Services Account plan.
    - You go Out-of-Network.
- Whether you follow the plan's rules, like using Network providers.
- Whether you need extra Benefits and if the plan charges for it.
- The plan's yearly limit on your out-of-pocket costs for all medical services.
- Whether you have Medicaid or get help from your state.

Medicare Advantage Plans available by area are listed in the back of the Medicare & You white book or on the Medicare website, https://www.medicare.gov/find-a-plan/questions/home.aspx insert the appropriate zip code to do a GENERAL SEARCH, select (don't know) each time available, then NO DRUGS and SKIP DRUGS and finally MEDICARE PLANS WITH DRUG COVERAGE to quickly view possible Advantage Plans. A customized search can be performed later to view prices specific to the individual's health situation. CMS also rates these plans in terms of stars showing the quality of the plan. These ratings are posted for each plan in both the Medicare book and website. Consumer Reports is a good resource for health insurance selection advice.

Deductibles:

Many Part C plans have co-pays and deductibles that don't necessarily adjust with the Social Security Act so their out-of-pocket costs have had different fluctuations over the last few years than those associated with Original Medicare.

Medicare Supplement (Medigap) Plan

Medigap plans are basically bookkeeping operations. Unlike Medicare Advantage Plans, Medigap plans don't make any decisions about what to cover and they don't have networks of doctors or hospitals. Medigap plans pick up a specified share of the medical bills that Medicare covers but doesn't pay, such as deductibles, co-pays or the 20% of allowable expenses. If Medicare approves the claim and the individual still owes a part of the bill, the Medigap plan will pay, no questions asked. Medigap plans are available in standardized benefits packages labeled A thru N which vary according to coverage. The more expenses the plan covers, the higher the premium. You make the choice based on your medical needs, risk tolerance, and budget. The benefits are standardized by the government which means that it does not matter what insurer you choose, the coverage will be the same.

Although the plans are standard, the monthly premiums are not. Different health insurance companies may charge different rates for the exact same plan. That means you can save money by shopping around.

If choosing Original Medicare and a Medigap plan rather than an Advantage plan, it's wise to enroll during your six-month Initial Enrollment Period (IEP) for Medigap plans. The IEP starts with the first month you are 65 or older and enrolled in Medicare Part B. If you sign up for a plan during this time, you can't be turned away. That is, all policies are "guarantee issue" during this period and cannot be withheld or the premium

“adjusted” based on your health condition or history. If you wait or change plans later, your coverage may be medically underwritten. This means you could face higher premiums or be turned down altogether because of health conditions. The IEP is a once in a life-time event and the insurance plan selection made at this time should be considered carefully.

In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. If you buy a Medicare SELECT policy, you have the right to change your mind within 12 months and switch to a standard Medigap policy. When switching policies, never cancel the old policy until the new policy is in force. You have 30 days to decide if you want to keep the new Medigap policy. This is called your "free look period." The 30-day free look period starts when you get your new Medigap policy. You'll need to pay both premiums during the free look month.

Guaranteed Issue

In every state an individual has a guaranteed right to buy a Medigap policy for a six month period starting the first day of the month they turn 65 and are enrolled in Part B. During this six month Initial Enrollment Period (IEP), the insurance company is not allowed to deny coverage or charge more due to a pre-existing condition. This is called "guaranteed issue." (Medicare.gov)   After the IEP, guaranteed issue only applies to Medigap plans in specific situations:

1. Your Medicare Advantage plan shuts down **or** you move out of its service area.
2. Your company sponsored retiree health insurance plan terminates.
3. You joined Medicare Advantage at age 65 but decide to switch back to original Medicare within a year.
4. Your Medigap plan shuts down.

The minimum rules for when a Medigap policy must be sold are explained on the medicare.gov website. But some states have chosen to go beyond these minimums by requiring insurers to sell Medigap plans to applicants at any time for example. The SHIP and the state insurance department can provide information on each state's rules.

FYI: **ALL Medicare Advantage plans are guaranteed issue**.

Medigap Changes & Options After DEC 2019

If you first became eligible for Medicare on or after January 1, 2020, you can no longer purchase a Medigap Plan C or F. Plans C and F were among the most popular Medigap Plans since they were the only ones that covered the deductible of Medicare

Part B. After 2019 there is no Medigap Plan available to anyone aging-in to Medicare that will cover the Plan B deductible. But, you can purchase a Plan G which has all the benefits of Plan F without the Part B deductible coverage.

Alternatives to Plan C and Plan F:

One alternative to Plan C is Plan N. Plan N is considered a cost-sharing plan. You have to pay a co-pay of up to $20 for doctor visits and up to $50 in the emergency room. One good thing about Plan N is that if you go to urgent care vs to your primary care physician or to an emergency room, there is no co-pay.

Another alternative to Plan C is Plan D. Plan D offers the same protection as Plan C, with the exception of covering the Part B deductible. If you don't want the co-pays that come with Plan N, then Plan D is the way to go. Neither Plan D nor Plan N cover excess charges. If you want coverage for excess charges, you would want to go with Plan G.

An alternative to the old Plan F is Plan G. Aside from the Part B deductible, Plan G is the exact same plan as Plan F. This plan covers virtually all your medical and hospitalization costs, including excess charges. Plan G was already a popular plan because it offered great coverage with a lower premium than Plan F. The Plan G premium has been so much lower than Plan F that is has been the most economical plan on an annual cost basis of the two plans and if your annual out-of-pocket costs were less than the deductible, it was even more economical than Plan F.

Plan G is a good bet if you want the fullest possible coverage. Once you meet the annual Part B deductible, you shouldn't have any further expenses for services covered by Medicare.

Plan N is a good choice if you're looking to save money on premiums, don't mind copays and aren't concerned about excess charges. Excess charges aren't allowed in some states, and even where they're permitted, not all providers charge them. In fact, only 3% of providers charge excess charges.

Plan D and Plan G are Guaranteed Issue plans starting 2020 for those who become eligible for Medicare on or after January 1, 2020. If you're Medicare-eligible **prior to 2020**, Plan D and Plan G are not guaranteed issue plans unless the insurer chooses to offer them with that feature, but you will still be eligible for a guaranteed issue with Plan C and Plan F.

New High Deductible Plan G

Even though Medigap Plan F High Deductible was not a no out-of-pocket cost plan as was Plan F, it was discontinued anyway since it was a plan that fell under Plan F. The good news is, there's a new high-deductible plan, High Deductible Plan G.

Starting in 2020, anyone with Original Medicare can sign up for High-Deductible Plan G, regardless if they're considered "Medicare-eligible" before or after 2020. This policy would be a good fit for individuals who want comprehensive coverage but find the standard Plan G is out of their budget. This would also work well for those currently experiencing a rate increase on High-Deductible Plan F and are looking for a way to benefit from quality coverage at a lower premium.

Pricing Methods for Insurance

The type of pricing method chosen will impact future costs. A policy that looks inexpensive when first purchased at age 65 could end up being the most expensive at age 80. Insurance companies set premiums in three ways but not all pricing methods are available in all states.

- Community-rated (also called no-age rated). The same premium is charged to everyone regardless of age. Medigap experts say these plans are the least expensive over time, though not when first purchased.
- Issue-age rated. The premium is based on age when the policy is first purchased and doesn't increase with age but will adjust for cost of operations including claims experience.
- Attained-age rated. The premium starts low but goes up based on age. Over time this type of pricing may be the most expensive and is by far the most common.

Even Issue-age and Community-rated plans which do not increase premiums with age may still go up in price to adjust for inflation in health care costs and cost of claims experience of the insurance pool. Other factors that can affect the overall cost paid include insurance plans with a high-deductible, or discounts, and whether the insurer uses medical underwriting (medical screening) to set the premium. Private insurance companies set their own prices, so it is important to ask how an insurance company prices its policies. When choosing an insurance plan, consider which type of pricing best fits what the individual can afford, both now and into the future while providing the required coverage. The insurance advisors at Via Benefits and SHIP can help with this.

When to switch a plan

- **Medicare Open Enrollment Period (MOE)**. From October 15 – December 7 each year, you can join, switch, or drop a plan. During this period you can buy any policy the company sells for the same price as people with good health.

Your coverage will begin on January 1 (as long as the plan gets your request by December 7). Medicare.gov when to buy

- **Medicare Advantage Open Enrollment Period**. From January 1 – March 31 each year, if you're enrolled in a Medicare Advantage Plan, you can switch to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time.

- **Outside Open Enrollment.** You can apply for Medigap coverage outside the open enrollment period but there's no guarantee that an insurance company will sell you a Medigap policy if you don't meet their medical underwriting requirements.

What if I can't afford any of this?

Eligible beneficiaries who have limited income may qualify for a government program that helps pay for medical costs. Medicare Extra Help

In addition, Medicare beneficiaries receiving the low-income subsidy (LIS) get assistance in paying for their Part D monthly premium, annual deductible, coinsurance, and copayments. Also, individuals enrolled in the Extra Help program do not have a gap in prescription drug coverage, also known as the coverage gap or the Medicare "donut hole." The amount of subsidy depends on the individual's income compared to the Federal Poverty Level and resource limitations set by the Social Security Act.

Medicare Extra Help eligibility

You may qualify for the LIS available under Medicare Part D if:

- Your annual income and assets are below the eligibility thresholds. The Medicare Extra Help program eligibility limits may change from year to year. For the most up-to-date levels, visit Medicare.gov.
- Your annual income is higher than the eligibility limit, but you support other family members who also live in the same household; or you live in Hawaii or Alaska.

Assets that count toward eligibility include:

- Cash and bank accounts, including checking, savings, and certificates of deposit
- Real estate outside of your primary residence
- Stocks and bonds, including U.S. savings bonds
- Mutual funds and IRAs

When calculating eligibility for the low-income subsidy, Medicare does not count resources such as your home (or primary residence); insurance policies; or a car. Many people qualify for Medicare Extra Help savings and do not know it. The best way to find out if you qualify is to go ahead and apply.

How to apply for Medicare Extra Help

To apply for the Medicare low-income subsidy, simply fill out an "Application for Extra Help with Medicare Prescription Drug Plan Costs" (SSA-1020) form with Social Security. You can apply and submit this form by:

- Applying online at www.socialsecurity.gov/extrahelp.
- Calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) and requesting an application be mailed to you or applying over the phone. Social Security representatives are available by phone Monday through Friday, from 7AM to 7PM.
- Applying in person at your local Social Security office.

After you submit your application, Social Security will review it and send you a notification in the mail if you are eligible. If you qualify for Extra Help and are not yet enrolled in a Medicare Part D Prescription Drug Plan, you can enroll in a plan at that time.

Use the link below to download the official Medicare manual "Medicare and You":

https://www.medicare.gov/medicare-and-you