"Understanding Medicare" provides an introduction to Medicare, the Federally-facilitated Health Insurance Marketplace, Medicaid, and related resources.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of June 1, 2015. To check for an updated version, visit CMS.gov/outreach-and-education/training/ cmsnationaltrainingprogram/ index.html.

The CMS National Training Program provides this as an informational resource for our partners. It's not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

Session Objectives

- This session should help you
  - Summarize the Medicare program
  - Compare the parts of Medicare and coverage options
  - Describe Medicare-covered services and supplies
  - Recognize Medicare rights and appeals
  - Explain programs for people with limited income and resources

- This session should help you
  - Summarize the Medicare program
  - Compare the parts of Medicare and coverage options
  - Describe Medicare-covered services and supplies
  - Recognize Medicare rights and appeals
  - Explain programs for people with limited income and resources

Lesson 1—Program Basics

- What is Medicare?
- Enrolling in Original Medicare
- Part A and Part B benefits and costs

06/01/2015 Understanding Medicare 3

Lesson 1, “Program Basics,” explains

- What is Medicare?
- Enrolling in Original Medicare
- Part A and Part B benefits and costs

What Is Medicare?

- Health insurance for people
  - 65 and older
  - Under 65 with certain disabilities
    - Amyotrophic Lateral Sclerosis
  - Any age with End-Stage Renal Disease
- Administered by
  - Centers for Medicare & Medicaid Services

NOTE: To get Part A and/or Part B, you must be a U.S. citizen or lawfully present in the United States.

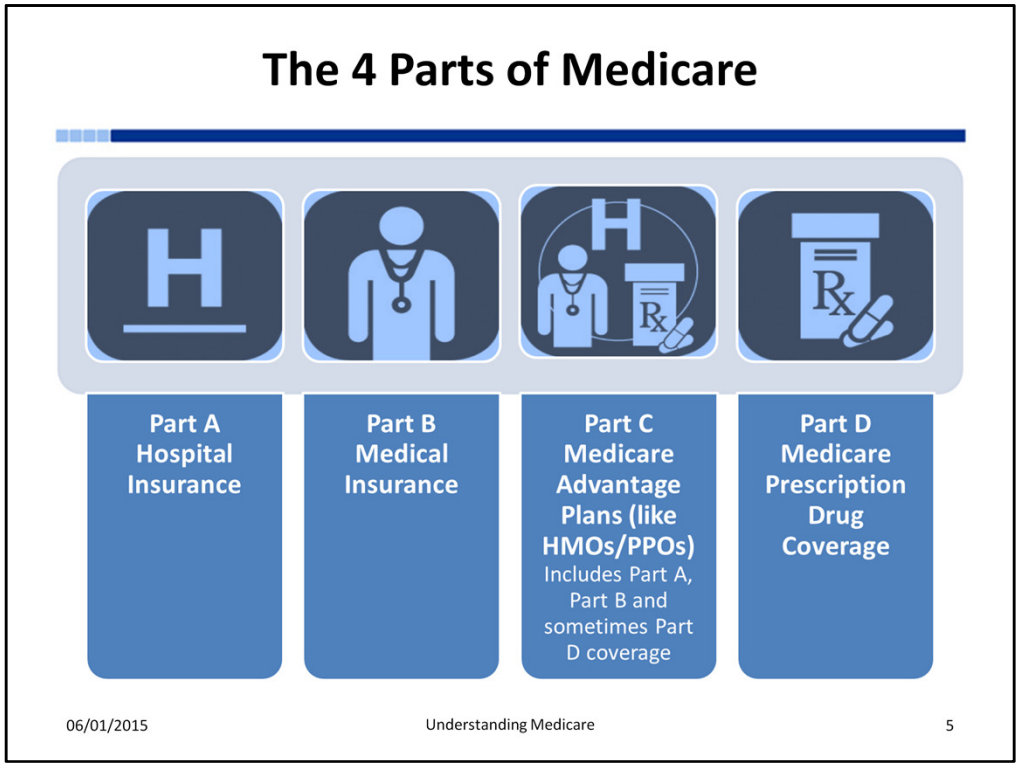
06/01/2015 Understanding Medicare 4

Medicare currently provides health insurance coverage for 54 million U.S. citizens. That's approximately 1 in every 6 Americans.

- Medicare is health insurance for generally 3 groups of people:
  - Those who are 65 and older
  - People under 65 with certain disabilities who've been entitled to Social Security disability benefits for 24 months—includes Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease), without a waiting period
  - People of any age who have End-Stage Renal Disease (ESRD), which is permanent kidney failure that requires a regular course of dialysis or a kidney transplant
- The Centers for Medicare & Medicaid Services administers the Medicare program.

NOTE: To get Part A and/or Part B, you must be a U.S. citizen or lawfully present* in the United States. If you live in Puerto Rico, you must actively enroll in Part B.

*Lawfully present means you are in the United States legally, and includes non–U.S. citizens who have permission to live and/or work in the United States.



Medicare covers many types of services, and you have options for how you get your Medicare coverage. Medicare has 4 parts:

- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.
- **Part B (Medical Insurance)** helps cover medically necessary services like doctor's visits and outpatient care. Part B also covers many preventive services (including screening tests and shots), diagnostic tests, some therapies, and durable medical equipment like wheelchairs and walkers. Together, Part A and Part B are also referred to as "Original Medicare."
- **Part C (Medicare Advantage [MA])** is another way to get your Medicare benefits. It combines Part A and Part B, and sometimes Part D (prescription drug coverage). MA Plans are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services than Original Medicare.
- **Part D (Medicare Prescription Drug Coverage)** helps pay for outpatient prescription drugs. Part D may help lower your prescription drug costs and protect you against higher costs in the future.

Automatic Enrollment—Part A and Part B

- Automatic enrollment for those receiving
  - Social Security benefits
  - Railroad Retirement Board benefits
- Initial Enrollment Period Package
  - Mailed 3 months before
    - 65 or
    - 25th month of disability benefits
  - Includes your Medicare card

06/01/2015 Understanding Medicare 6

If you're already getting Social Security benefits (for example, getting early retirement at least 4 months before you turn 65), you'll be automatically enrolled in Medicare Part A and Part B without an additional application. You'll get your Initial Enrollment Period package, which includes your Medicare card and other information, about 3 months before you turn 65 (coverage begins the first day of the month you turn 65), or 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits).

If you're not getting retirement benefits from Social Security or the Railroad Retirement Board (RRB), you must sign up to get Medicare (see slide 8).

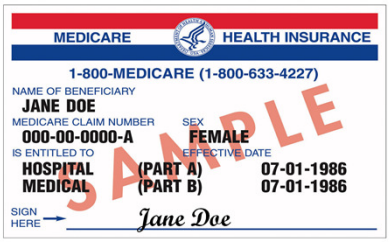
NOTE: If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the first day of the month you turn 65 or after you get disability benefits for 24 months. However, if you want Part B, you'll need to sign up for it. If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Contact your local Social Security office or the RRB for more information.

"Welcome to Medicare," CMS Product No. 11095, is pictured on this slide. It's part of the Initial Enrollment Period package. Visit Medicare.gov/Pubs/pdf/11095.pdf.

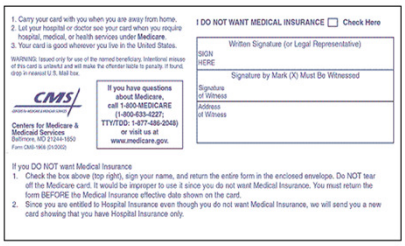
Medicare Card

- Keep it and accept Medicare Part A and Part B
- Return it to refuse Part B
  - Follow instructions on back of card

Front



Back



When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care services. The Medicare card shows the type of Medicare coverage (Part A and/or Part B) you have and the date the coverage started. Your card may look slightly different from this one; it's still valid.

The Medicare card also shows your Medicare claim number. For most people, the claim number has 9 numerals and 1 letter. There also may be a number or another letter after the first letter. The 9 numerals indicate which Social Security record your Medicare is based on. The letter or letters and numbers tell how you're related to the person with that record. For example, if you get Medicare on your own Social Security record, you might have the letter "A," "T," or "M" depending on whether you get both Medicare and Social Security benefits or Medicare only. If you get Medicare on your spouse's record, the letter might be a "B" or "D." For railroad retirees, there are numbers and letters in front of the Social Security number. These letters and numbers have nothing to do with having Medicare Part A or Part B. You should contact Social Security (or the Railroad Retirement Board if you receive railroad retirement benefits) if any information on the card is incorrect.

If you get your Medicare card in your Initial Enrollment Period package and don't want Part B, follow the directions on the back of the card, and return it. We'll describe reasons why you might want to delay taking Part B later in this presentation. If you choose a Medicare health plan, your plan will likely give you a card to use when you get health care services and supplies.

NOTE: Social Security has a new online service that lets you get a replacement Medicare card if your old one needs to be replaced. To create your account and learn more about "my social

security” accounts, visit SSA.gov/myaccount.

When Enrolling Isn't Automatic

- If you're not automatically enrolled
  - You need to enroll with Social Security
    - Visit socialsecurity.gov, or
    - Call 1-800-772-1213, or
    - Visit your local office
  - If retired from the Railroad, enroll with the Railroad Retirement Board (RRB)
    - Call your local RRB office or 1-877-772-5772
- Apply 3 months before you turn 65
  - Don't have to be retired to get Medicare

06/01/2015 Understanding Medicare 8

If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits at least 4 months before you turn 65 (for instance, because you're still working), you'll need to sign up for Part A and Part B (even if you're eligible to get Part A premium free). You should contact Social Security 3 months before you turn 65. If you worked for a railroad, contact the RRB to sign up. You don't have to be retired to get Medicare.

For persons born in 1938 or later, their Social Security benefit may be affected by a provision that raises the age at which full Social Security benefits are payable.

Social Security retirement benefits began gradually increasing from 65 to 67 beginning in 2000 for those retiring at 62. For those who retired or plan to retire at 62, they'll get partial Social Security retirement benefits. The earliest a person can start receiving reduced Social Security retirement benefits remains 62.

For more information or to calculate your age for collecting full Social Security retirement benefits, visit SSA.gov/retirement/ageincrease.htm.

NOTE: Although the age to receive full Social Security retirement benefits is increasing, Medicare benefit eligibility due to age still begins at 65.

When to Enroll in Medicare

- You can first enroll during your Initial Enrollment Period (IEP), which lasts 7 months
  - Begins 3 months before your 65th birthday
  - Includes the month you turn 65
  - Ends 3 months after you turn 65
    - Your start date will be delayed
- Can enroll in premium-free Part A anytime after IEP begins
- Can only enroll in Part B (and premium Part A) during IEP and other limited times
- May have a penalty if you don't enroll during IEP

06/01/2015 Understanding Medicare 9

Your first opportunity to enroll in Medicare is during your Initial Enrollment Period (IEP), which lasts 7 months. Your coverage starts based on when you enroll. If you enroll during the first 3 months of your IEP (the 3 months before the month you turn 65), your coverage will begin the first day of the month you turn 65. If you enroll the month you turn 65, your coverage will begin the first day of the next month. If you enroll in the last 3 months of your IEP (the 3 months after you turn 65), your coverage will begin 2 to 3 months after you turn 65.

If you're eligible for premium-free Part A, you can enroll in Part A once your IEP begins (3 months before you turn 65) and any month afterward. If you're not eligible for premium-free Part A, you can only enroll in Part A during your IEP or during the limited Part B enrollment periods.

For everyone (whether you get premium-free Part A or have to pay a premium for it), you can only enroll in Part B during

- Your IEP
- The annual General Enrollment Period (GEP) January 1–March 31 each year
- In limited situations, a Special Enrollment Period (SEP)

If you don't enroll in Part B (or premium Part A) during your IEP, you may have to pay a penalty. For Part B, it's a lifetime penalty.

General Enrollment Period (GEP)

- For people who didn't sign up for Part B (or premium Part A) during the Initial Enrollment Period
- January 1–March 31 annually
  - Coverage starts July 1
- May have to pay a penalty
  - 10% for twice the number of years you didn't have Part A
  - 10% for each 12 months eligible but not enrolled in Part B
    - As long as you have Part B

06/01/2015 Understanding Medicare 10

If you didn't sign up for Part B (or premium Part A) during your Initial Enrollment Period (IEP), you can enroll during the General Enrollment Period (GEP).

The GEP occurs January 1 through March 31 each year. If you enroll in the GEP, your coverage will begin July 1.

If you aren't eligible for premium-free Part A and 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've had Part A but didn't sign up.

Generally, if you don't take Part B when you're first eligible and more than 12 months have passed since you turned 65, you'll likely have to pay a penalty that is added to your monthly Part B premium. The Part B penalty is 10% for each full 12-month period you could've had Part B but didn't sign up for it. In most cases you'll have to pay this penalty for as long as you have Part B.

Premium Part A and Part B Special Enrollment Period (SEP)

- Most people don't qualify for an SEP
- Must have employer group health plan (EGHP) coverage based on active, current employment of you or your spouse
- Can enroll
  - Anytime still covered by EGHP, or
  - Within 8 months of the loss of coverage or current employment, whichever happens first

NOTE: Retiree and COBRA coverage isn't considered active employment.

06/01/2015 Understanding Medicare 11

There are very few Special Enrollment Periods (SEPs) for Part B and premium Part A allowed by law. Most people don't qualify for an SEP. However, if you're still working, you may be eligible.

The SEP allows you to enroll after your Initial Enrollment Period (IEP) and not wait for the General Enrollment Period (GEP), and you won't have to pay a penalty.

To be eligible, you must have employer group health plan (EGHP) coverage based on active, current employment. If you're 65 or older, you must get this employer-sponsored coverage based on your or your spouse's current employment. If you have Medicare based on disability, you can also have employer-sponsored coverage based on a member's current employment.

You must have this EGHP coverage for all the months you were eligible to enroll in Part B, but didn't. For most people, this means you had EGHP coverage since you turned 65.

If you're eligible, you can enroll using the SEP at any time while you have EGHP coverage based on active, current employment. If you lose either the EGHP coverage **or** the current employment, you have 8 months to enroll. If you don't enroll within the 8 months, you'll have to wait until the next GEP to enroll, you'll have a gap in your coverage, and you may have to pay a penalty.

It's important to note that COBRA, retiree coverage, long-term worker's compensation, or Veterans Affairs coverage isn't considered active, current employment.

You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment.

When Employer or Union Coverage Ends

- When your employment ends
  - You may get a chance to elect Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - You may get a Special Enrollment Period
    - Sign up for Part B without a penalty
- Medigap Open Enrollment Period
  - Starts when you are both 65 and signed up for Part B
  - Once started, it can't be delayed or repeated
  - 6-month period

06/01/2015 Understanding Medicare 12

When your employment ends and you aren't enrolled in Part B, certain things can happen:

- You may get a chance to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, which continues your health coverage through the employer's plan (in most cases for only 18 months), and probably at a higher cost to you.
- You may get a Special Enrollment Period to sign up for Part B without a penalty. This period will run for 8 months and begins the month after your employment ends. This period will run whether or not you elect COBRA. If you elect COBRA, don't wait until your COBRA ends to enroll in Part B. If you enroll in Part B after the 8-month Special Enrollment Period (SEP), you may have to pay a late enrollment penalty and you'll have to wait until the next General Enrollment Period to enroll.

Medicare doesn't pay all health care costs. One way to cover the costs, or "gaps," is to purchase a Medigap (Medicare Supplement Insurance) policy. We'll discuss these in more detail later, but it's important to know that when you sign up for Part B, you have a 6-month Medigap Open Enrollment Period, which gives you a guaranteed right to buy a Medigap policy. Once this period starts, it can't be delayed or repeated.

Medicare Part A—Hospital Insurance Coverage

- Part A–Hospital Insurance helps cover
  - Inpatient hospital care
  - Inpatient skilled nursing facility (SNF) care
  - Blood (inpatient)
  - Home health care
  - Hospice care

06/01/2015 Understanding Medicare 13

Medicare Part A (Hospital Insurance) helps cover medically necessary inpatient services.

- Hospital inpatient care–Semi-private room, meals, general nursing, other hospital services and supplies, as well as care in inpatient rehabilitation facilities and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit).
- Inpatient skilled nursing facility (SNF) care (not custodial or long-term care) under certain conditions.
- Blood—In most cases, if you need blood as an inpatient, you won't have to pay or replace it.
- Home health care—A doctor, or certain health care providers who work with the doctor, must see you face-to-face to certify that you need home health services. You must be homebound, which means that leaving home is a major effort.
- Hospice care—Your doctor must certify that you're expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; as well as services Medicare usually doesn't cover, such as grief counseling.

NOTE: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the United States. Also, in most situations, Medicare doesn't pay for your hospital or medical bills if you're incarcerated.

Paying for Medicare Part A

- Most people don't pay a premium for Part A
  - If you paid Federal Insurance Contributions Act (FICA) taxes at least 10 years
- If you paid FICA less than 10 years
  - Can pay a premium to get Part A
- May have a penalty if you don't enroll when first eligible for premium Part A
  - Your monthly premium may go up 10%
  - You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up

06/01/2015 Understanding Medicare 14

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. This is sometimes called premium-free Part A. Federal Insurance Contributions Act (FICA) tax is a United States federal payroll (or employment) tax imposed on both employees and employers to fund Social Security and Medicare.

About 99% of people with Medicare don't pay a Part A premium since they've at least 40 quarters of Medicare-covered employment. Enrollees 65 and over and certain persons with disabilities who have fewer than 40 quarters of coverage pay a monthly premium to receive coverage under Part A.

If you aren't eligible for premium-free Part A, you may be able to buy Part A if you're

- 65 or older, and you have (or are enrolling in) Part B, and meet the citizenship and residency requirements.
- Under 65, disabled, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and disabled, you may continue to get premium-free Part A for up to 8 1/2 years after you return to work.)

In most cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.

Social Security determines if you have to pay a monthly premium for Part A. In 2015, the Part A premium for a person who has worked less than 30 quarters of Medicare covered employment is $407 per month, a decrease of $19 from 2014. Those who have between 30 and 39 quarters of coverage may buy Part A at a reduced monthly premium rate, which is $224 for 2015, a decrease of $10 from 2014.

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10% for every 12 months you didn't have the coverage. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

If you have limited income and resources, your state may help you pay for Part A and/or Part B. Call Social Security at 1-800-772–1213 for more information about the Part A premium. TTY users should call 1-800-325-

0778.

Inpatient Hospital Care

- Semi-private rooms
- Meals
- General nursing care
- Drugs that are part of your inpatient treatment
- Hospital services and supplies

06/01/2015 Understanding Medicare 15

Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor's services you get while you're in a hospital.

Medicare covers certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs). Medicare will only cover the inpatient, non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker. Medicare doesn't cover the religious portion of RNCHI care. Medicare Part A (Hospital Insurance) covers inpatient, non-religious, nonmedical care when certain conditions are met.

NOTE: Staying overnight in a hospital doesn't always mean you're an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You're still an outpatient if you've not been formally admitted as an inpatient, even if you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. You or a family member should always ask if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility. For more information, visit

Medicare.gov/Pubs/pdf/11435.pdf.

Benefit Periods

- Measures use of inpatient hospital and skilled nursing facility (SNF) services
- Begins the day you first receive inpatient care
  - In hospital or SNF
- Ends when not in hospital/SNF 60 days in a row
- Pay Part A deductible for each benefit period
  - $1,260 in 2015
- No limit to the number of benefit periods you can have

06/01/2015 Understanding Medicare 16

A benefit period refers to the way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care or SNF care for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. You must pay the Part A inpatient hospital deductible ($1,260 in 2015) for each benefit period. There is no limit to the number of benefit periods you can have.

Examples:

- You spend 5 days in the hospital. You then enter a SNF for 20 days of rehabilitation. You then return home. Your benefit period will end when you've been out of the SNF for 60 days, or 85 days after you first entered the hospital. If you don't return to the hospital as an inpatient in that time frame, you'll pay another deductible for the next benefit period.
- You've returned home after being an inpatient in the hospital or in a combination of hospital and SNF. After 2 weeks at home you must return to the hospital. You haven't been out of inpatient care for 60 days, so you're still in your first benefit period. You don't have to pay another hospital deductible.

NOTE: To qualify for post-hospital extended care services (i.e. SNF) you must've been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. It's important to note that an overnight stay doesn't guarantee that you're an inpatient. An inpatient hospital stay begins the day you're formally admitted with a doctor's order.

Paying for Inpatient Hospital Stays

For Each Benefit Period in 2015	You Pay
Days 1-60	$1,260 deductible
Days 61-90	$315 per day
Days 91-150	$630 per day (60 lifetime reserve days)
All days after 150	All Costs

06/01/2015 Understanding Medicare 17

For each benefit period in 2015 you pay

- $1,260 deductible and no copayment for days 1–60 each benefit period.
- $315 for days 61–90 each benefit period.
- $630 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime).
  - Original Medicare will pay for a total of 60 extra days (called lifetime reserve days) when you're in the hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don't get any more extra days during your lifetime.
- All costs for each day after the lifetime reserve days.

NOTE: Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Skilled Nursing Facility Covered Services

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, and speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation (limited)
- Dietary counseling

06/01/2015 Understanding Medicare 18

If you qualify, Medicare will cover the following skilled nursing facility (SNF) services:

- Semi-private room (a room you share with one other person)
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy (if needed to meet your health goal)
- Medical social services
- Medications and medical supplies/equipment used in the facility
- Ambulance transportation to the nearest supplier of needed services that aren't available at the SNF when other transportation endangers health
- Dietary counseling

Skilled Nursing Facility (SNF) Care Required Conditions

- Require daily skilled services
  - Not just long-term or custodial care
- Hospital inpatient 3 consecutive days or longer
- Admitted to SNF within specific time frame
  - 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

06/01/2015 Understanding Medicare 19

Part A will pay for skilled nursing facility (SNF) care if you meet the following conditions:

- Your doctor must certify that your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a SNF.
  - This doesn't include custodial or long-term care. Medicare doesn't cover custodial care if it's the only kind of care you need. Custodial care is care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of a colostomy or bladder catheters. Custodial care is often given in a nursing facility. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.
- You were an inpatient in a hospital for 3 consecutive days or longer before you were admitted to a participating SNF. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in 1 or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. It's important to note that an overnight stay doesn't guarantee that you're an inpatient. An inpatient hospital stay begins the day you're formally admitted with a doctor's order.
- You were admitted to the SNF within 30 days after leaving the hospital.
- Your care in the SNF is for a condition that was treated in the hospital or arose while receiving care in the SNF for a hospital-treated condition.
- The facility must be a Medicare-participating SNF.

For more information, visit "Medicare Coverage of Skilled Nursing Facility Care" at

Medicare.gov/Pubs/pdf/10153.pdf.

Paying for Skilled Nursing Facility Care

For Each Benefit Period in 2015	You Pay
Days 1-20	$0
Days 21-100	$157.50 per day
All days after 100	All Costs

06/01/2015 Understanding Medicare 20

Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay. In 2015, under Original Medicare, days 21–100 of SNF care are covered for each benefit period except for coinsurance of up to $157.50 per day. After 100 days, Medicare Part A no longer covers SNF care.

You can qualify for SNF care again every time you have a new benefit period and meet the other criteria.

Five Conditions for Home Health Care

1. Must be homebound
2. Must need skilled care on part-time or intermittent basis
3. Must be under the care of a doctor
   - Receiving services under a plan of care
4. Have face-to-face encounter with doctor
   - Prior to start of care or within 30 days
5. Home health agency must be Medicare-approved

06/01/2015 Understanding Medicare 21

To be eligible for home health care services, you must meet all of these conditions:

1. You must be homebound. An individual shall be considered "confined to the home" (homebound) if the following 2 criteria are met: (1) The patient must either, because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence, OR (2) have a condition such that leaving his or her home is medically contraindicated.

   If the patient meets only 1 of the 2 previous conditions, then the patient must ALSO meet the following two additional requirements; (1) There must exist a normal inability to leave home: AND (2) Leaving home must require a considerable and taxing effort.
2. You must need skilled care on an intermittent basis, or physical therapy, or speech-language pathology, or have a continuing need for occupational therapy.
3. Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
4. Prior to certifying your eligibility for the Medicare home health benefit, the doctor must document that the doctor or a non-physician practitioner has had a face-to-face encounter with you. The encounter must be done up to 90 days prior, or within 30 days after the start of care. The law allows the face-to-face encounter to occur via telehealth in rural areas, in an approved originating site. This means medical or other health services given to a patient using a communications system (like a computer, phone, or television), by a practitioner in a location different than the patient's.
5. The home health agency caring for you must be approved by Medicare.

NOTE: Part B also may pay for home health care under certain conditions. For instance, Part B pays for home health care if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A–covered home health care visits exceed 100. For more information, read "Medicare and Home Health Care," at

Medicare.gov/Publications/Pubs/pdf/10969.pdf. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

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

06/01/2015 Understanding Medicare 22

In Original Medicare, for Part A covered home health care, you pay

- Nothing for covered home health care services provided by a Medicare-approved home health agency.
- If you have Part B, you pay 20% of the Medicare-approved amount for an assigned durable medical equipment claim. If the claim is non-assigned, you're responsible for whatever the durable medical equipment supplier charges over and above the Medicare-approved amount. (We'll discuss assignment later.)

To find a home health agency in your area, visit Medicare.gov and use the Home Health Compare tool, or call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B.

Part A Hospice Care

- Special interdisciplinary team care for the terminally ill and family
  - Life expectancy of 6 months or less
- You must sign an election statement choosing hospice care instead of routine Medicare-covered benefits to treat your terminal illness
- Focus on comfort and pain relief, not cure
- Doctor must certify each "election period"
  - Two 90-day periods
  - Then unlimited 60-day periods
  - Face-to-face encounter
- Hospice provider must be Medicare-approved

06/01/2015 Understanding Medicare 23

Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.

You must sign an election statement choosing hospice care instead of routine Medicare-covered benefits to treat your terminal illness. However, medical services not related to your hospice condition would still be covered by Medicare.

You can get hospice care as long as your doctor certifies that you're terminally ill, and probably have less than 6 months to live if the illness runs its normal course. Care is given in "election periods"—2 90-day periods followed by unlimited 60-day periods. At the start of each benefit period, your doctor must certify that you're terminally ill for you to continue getting hospice care.

Medicare also requires face-to-face visits. The doctor is required to meet with you within 30 days of hospice recertification, starting before the third election period and each subsequent recertification.

The hospice provider must be Medicare-approved.

For more information, read "Medicare Hospice Benefits" at Medicare.gov/Publications/Pubs/pdf/02154.pdf.

Covered Hospice Services

- Physician and nursing services
- Physical, occupational, and speech therapy
- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care for pain and symptom management
- Respite care in a Medicare-certified facility
  - Up to 5 days each time, no limit to times
- Hospice aide and homemaker services
- Social worker services
- Grief, dietary, and other counseling

06/01/2015 Understanding Medicare 24

In addition to the regular Medicare-covered services, such as doctor and nursing care, physical and occupational therapy, and speech language therapy, the hospice benefit also covers

- Medical equipment (such as wheelchairs or walkers).
- Medical supplies (such as bandages and catheters).
- Drugs for symptom control and pain relief.
- Short-term care in the hospital, hospice inpatient facility, or skilled nursing facility when needed for pain and symptom management.
- Inpatient respite care, which is care given to you by another caregiver, so your usual caregiver can rest. You'll be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there's no limit to the number of times you can get respite care. Hospice care is usually given in your home (or a facility you live in). However, Medicare also covers short-term hospital care when needed.
- Hospice aide and homemaker services.
- Social worker services.
- Other covered services as well as services Medicare usually doesn't cover, like spiritual and grief counseling.
- Dietary and other counseling.

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 in certain cases
  - Short-term respite care
  - For pain/symptom management that can't be managed at home
  - If you have Medicaid and live in nursing facility

06/01/2015 Understanding Medicare 25

For hospice care in Original Medicare, you pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while receiving routine or continuous care at home, and 5% of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of $150 per day for inpatient respite care, you'll pay $7.50 per day. The amount you pay for respite care can change each year.

Room and board are only payable by Medicare in certain cases. Room and board are covered during short-term inpatient stays for pain and symptom management, and for respite care. Room and board aren't covered if you receive general hospice services while a resident of a nursing home or a hospice's residential facility. However, if you have Medicaid as well as Medicare, and reside in a nursing facility, room and board are covered by Medicaid.

To find a hospice program, call 1-800-MEDICARE (1-800-633-4227), or your state hospice organization. TTY users should call 1-877-486-2048.

For more information, visit the "Medicare Benefit Policy Manual", Chapter 9, Coverage of Hospice Services under Hospital Insurance at CMS.gov/Regulations-and-Guidance/Guidance/Manuals/ Downloads/bp102c09.pdf.

Medicare Part B—Medical Insurance Coverage

- Part B—Medical Insurance helps cover
  - Doctors' services
  - Outpatient medical and surgical services, supplies
  - Clinical lab tests
  - Durable medical equipment
  - Diabetic testing supplies
  - Preventive services

06/01/2015 Understanding Medicare 26

Medicare Part B (Medical Insurance) helps cover medically necessary outpatient services and supplies.

- Doctors' services—Services that are medically necessary.
- Outpatient medical and surgical services and supplies—For approved procedures like X-rays or stitches.
- Clinical laboratory services—Blood tests, urinalysis, and some screening tests.
- Durable medical equipment like walkers and wheelchairs—You may need to use certain suppliers under the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program. Visit Medicare.gov/supplierdirectory/.
- Diabetic testing supplies—You may need to use specific suppliers for some types of diabetic testing supplies.
- Preventive services—Exams, tests, screening and shots to prevent, find, or manage a medical problem.

What are Medicare Part B-Covered Services?

Doctors' Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. You pay 20% of the Medicare-approved amount (if the doctor accepts assignment) and the Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures like X-rays, casts, 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.

06/01/2015 Understanding Medicare 27

Medicare Part B covers a variety of medically necessary outpatient services and supplies. Certain requirements must be met.

Doctors' Services—Medicare covers medically necessary doctor services (including outpatient and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Outpatient Medical and Surgical Services and Supplies—Medicare covers approved procedures like X-rays, casts, or stitches. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. The Part B deductible applies.

Medicare Part B-Covered Services (continued)

Durable Medical Equipment (DME)	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. Medicare has a program called "competitive bidding." You must use specific suppliers, or Medicare won't pay for the item and you'll likely pay full price. Includes national mail-order program for diabetic self-testing supplies, and includes 9 local programs for infusion pumps, including insulin pumps and pump supplies. Visit Medicare.gov/supplier to find Medicare-approved suppliers in your area. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

06/01/2015 Understanding Medicare 28

Durable Medical Equipment (DME)—Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay.

Medicare has a program called "competitive bidding" to help save you and Medicare money; ensure that you continue to get quality equipment, supplies, and services; and help limit fraud and abuse. In some areas of the country, if you need certain items, you must use specific suppliers, or Medicare won't pay for the item and you'll likely pay full price. This includes mail-order diabetic self-testing supplies, insulin pumps, and pump supplies.

The Centers for Medicare & Medicaid Services (CMS) is required by law to re-compete contracts under the DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program at least once every 3 years. The Round 2 and national mail-order program contract periods expire on June 30, 2016. Round 2 re-compete and the national mail-order re-compete contracts are scheduled to become effective on July 1, 2016, and will expire on December 31, 2018.

The national mail-order re-compete competitive bidding area includes all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

If you need DME or supplies, visit Medicare.gov/supplier to find Medicare-approved suppliers. If your ZIP code is in a competitive bidding area, the items included in the program are marked with an orange star. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information on the competitive bidding program, you can visit: CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/.

More Medicare Part B-Covered Services

Home Health Services	Medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies. You pay nothing for covered services.
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.

06/01/2015 Understanding Medicare 29

Home Health Services—Medicare covers medically-necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, as defined previously. You pay nothing for covered home health services.

Other (including, but not limited to)—Medically necessary clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited prescription drugs, diagnostic X-rays, MRIs, CT scans, EKGs, transplants, and other services are covered. Costs vary.

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B.

Medicare Part B–Covered Preventive Services

- "Welcome to Medicare" preventive visit
- Yearly "Wellness" visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (CVD) Risk Reduction Visit
- Cardiovascular disease screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings
  - Screening fecal occult blood test
  - Screening flexible sigmoidoscopy
  - Screening colonoscopy
  - Screening barium enema
  - Multi-target stool DNA test NEW!
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots (Vaccine)
- Glaucoma tests
- Hepatitis B shots (Vaccine)
- Hepatitis C screening test NEW!
- HIV screening
- Lung Cancer Screening NEW!
- Medical nutrition therapy services
- Obesity screening and counseling
- Pneumococcal shots UPDATE
- Prostate cancer screening
- Sexually-transmitted infections screening and counseling
- Tobacco use cessation counseling

06/01/2015 Understanding Medicare 30

Medicare covers many preventive services to help you stay healthy. Talk to your health care provider about which of these services are right for you. In 2015, Medicare covers

- "Welcome to Medicare" preventive visit
- Yearly "Wellness" visit
- Abdominal aortic aneurysm screening (one time, and referral no longer required at Welcome to Medicare preventive visit)
- Alcohol misuse screening and counseling
- Bone mass measurements
- Breast cancer screening (mammograms)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular disease screening
- Cervical and vaginal cancer screening
- Colorectal cancer screening including a new multi-target stool DNA test
- Depression screening
- Diabetes screening and self-management training
- Flu shots (vaccine)
- Glaucoma tests
- Hepatitis B shot (vaccine)
- Hepatitis C screening test new for people at high risk for HCV
- HIV screening
- Lung cancer screening with Low Dose Computed Tomography once per year (new)
- Medical nutrition therapy
- Obesity screening and counseling
- Pneumococcal shots (vaccine). Effective 9/19/2014, Medicare covers the following:
  - An initial pneumococcal vaccine for all Medicare beneficiaries who've never received the vaccine under Medicare Part B, and
  - A different second pneumococcal vaccine 1 year after the first vaccine was administered (11 full months have passed following the month in which the last pneumococcal vaccine was administered)
- Prostate cancer screening
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling

Paying for Preventive Services

- In Original Medicare you
  - Pay nothing for most preventive services if your provider accepts "assignment"
  - May pay more if provider doesn't accept assignment
  - May have a copayment
    - If doctor performs other services not part of covered preventive benefits, or
    - For certain preventive services

06/01/2015 Understanding Medicare 31

Under Original Medicare you'll pay nothing for most preventive services if you get the services from a doctor or other provider who accepts assignment.

Assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services, and not to bill you for any more than the Medicare deductible and coinsurance. (See slides 44-45 for more information.)

You'll pay nothing for certain preventive services. However, if your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under the preventive benefits, you may have to pay a copayment, and the Part B deductible may apply. Later, we'll discuss which preventive services require a copayment.

Section 4104 of the Affordable Care Act waived deductibles, copayments, or coinsurance effective for date of service or after January 1, 2011, for the following Medicare-covered preventive services:

- The Initial Preventive Physical Examination (IPPE) or ("Welcome to Medicare" preventive visit)
- The yearly "Wellness" visit
- Those preventive services that are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population and are appropriate for the beneficiary (see slide 30).

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 Medicare.gov

06/01/2015 Understanding Medicare 32

Medicare Part A and Part B don't cover everything. If you need certain services that Medicare doesn't cover, you'll have to pay out-of-pocket unless you have other insurance to cover the costs. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.

Items and services that Medicare doesn't cover include, but aren't limited to, long-term care*, routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, and exams for fitting hearing aids.

*Long-term care includes medical and nonmedical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home.

Medicare Part B
Costs for Most People

Yearly Deductible	$147.00
Coinsurance for Part B Services	▪ 20% coinsurance for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for some preventive services ▪ 20% coinsurance for outpatient mental health services, and copayments for hospital outpatient services

06/01/2015 Understanding Medicare 33

In addition to premiums, there are other costs you pay in Original Medicare. This is what you pay in 2015 for Part B covered medically necessary services:

- The annual Part B deductible is $147 in 2015. If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. This means that you must pay the first $147 of your Medicare-approved medical bills in 2015 before Part B starts to pay for your care.
- Coinsurance for Part B services. In general, it's 20% for most covered services for providers accepting assignment.
- Some preventive services have no coinsurance, and the Part B deductible doesn't apply as long as the provider accepts assignment (see slides 44-45).
- You pay 20% for outpatient mental health services (visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions, or outpatient treatment of your condition [like counseling or psychotherapy] for providers accepting assignment).
- If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation.

Monthly Medicare Part B Premium

If Your Yearly Individual Income in 2013 was	If Your Yearly Joint Income in 2013 was	In 2015 You Pay Per Month
$85,000 or less	$170,000 or less	$104.90
$85,000.01–$107,000	$170,000.01–$214,000	$146.90
$107,000.01–$160,000	$214,000.01–$320,000	$209.80
$160,000.01–$214,000	$320,000.01–$428,000	$272.70
Above $214,000	Above $428,000	$335.70

NOTE: Premiums are usually deducted from your Social Security benefit payment.

06/01/2015 Understanding Medicare 34

You pay the Part B premium each month. Most people will pay the standard premium amount, which is $104.90 in 2015. However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you may pay more. Below are the 2015 Part B premiums based on the modified adjusted gross income for an individual. The income ranges for joint returns are double that of individual returns.

- $85,000 or less, the Part B premium is $104.90 per month
- $85,000.01–$107,000, the Part B premium is $146.90 per month
- $107,000.01–$160,000, the Part B premium is $209.80 per month
- $160,000.01–$214,000, the Part B premium is $272.70 per month
- Above $214,000, the Part B premium is $335.70 per month

If you have to pay a higher amount for your Part B premium and you disagree (for example, if your income goes down), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

REMEMBER that this premium may be higher if you didn't choose Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could've had Part B but didn't take it. An exception would be if you can enroll in Part B during a Special Enrollment Period because you or your spouse (or family member if you're disabled) is still employed and you're covered by a group health plan through that employment.

Paying the Part B Premium

- Deducted monthly from
  - Social Security benefit payments
  - Railroad retirement benefit payments
  - Federal retirement benefit payments
- If not deducted
  - Billed every 3 months
  - Medicare Easy Pay to deduct from bank account
- Contact Social Security, the Railroad Retirement Board, or Office of Personnel Management about premiums

06/01/2015 Understanding Medicare 35

The Part B premium is deducted from monthly Social Security, Railroad Retirement, or federal retirement benefit payments.

If you don't get a retirement payment or your payment isn't enough to cover the premium, you'll get a bill from Medicare for your Part B premium. The bill can be paid by credit card, check, or money order.

For information about Medicare Part B premiums, call Social Security, the Railroad Retirement Board, or the Office of Personnel Management for retired federal employees.

If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation.

Part B Late Enrollment Penalty

- See how your insurance works with Medicare
  - Contact your employer/union benefits administrator
- Penalty for not signing up when first eligible
  - 10% more for each full 12-month period
  - May have a penalty as long as you have Part B
- Sign up during a Special Enrollment Period
  - Usually no penalty if you sign up within 8 months of employer coverage ending

If you don't take Part B when you're first eligible, you may have to wait to sign up during the annual General Enrollment Period that runs from January 1 through March 31 of each year. Your coverage will be effective July 1 of that year.

If you don't take Part B when you're first eligible, you'll have to pay a premium penalty of 10% for each full 12-month period you could've had Part B but didn't sign up for it, except in special situations. In most cases, you'll have to pay this penalty for as long as you have Part B.

Having coverage through an employer (including federal or state employment, but not military service) or union while you or your spouse (or family member if you're disabled) is still working can affect your Part B enrollment rights. If you're covered through active employment (yours or your spouses), you have a Special Enrollment Period (SEP). This means you can join Part B anytime that you or your spouse (or family member if you're disabled) is working, and covered by a group health plan through the employer or union based on that work, or during the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first. Usually, you don't pay a late enrollment penalty if you sign up during a SEP. This SEP doesn't apply to people with End-Stage Renal Disease.

You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment.

Part B Late Enrollment Penalty Example

Mary delayed signing up for Part B 2 full years after she was eligible. She'll pay a 10% penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium ($104.90 in 2015). For 2015, her premium will be calculated as follows:

$104.90 (2015 Part B standard premium)
+ $ 20.98 (20 % of $104.90 [2 X 10%])
$125.88 (Round up)
$125.90 (Mary's Part B monthly premium for 2015)

This is an example of how you might calculate a late enrollment penalty for Part B.

Mary delayed signing up for Part B 2 full years after she was eligible. She'll pay a 10% penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium ($104.90 in 2015). For 2015, her premium will be as follows:

$104.90 (2015 Part B standard premium)
+ $ 20.98 (20% of $104.90 [2 X 10%])
$125.88 (Round up)
$125.90 (Mary's Part B monthly premium for 2015)

When You Must Have Part B

- If you want to buy a Medigap policy
- If you want to join a Medicare Advantage Plan
- You're eligible for TFL or CHAMPVA
- Your employer coverage requires you have it (less than 20 employees)
  - Talk to your employer's or union benefits administrator
- Veterans Affairs (VA) benefits are separate from Medicare
  - You pay a penalty if you sign up late or if you don't sign up during your Initial Enrollment Period

06/01/2015 Understanding Medicare 38

You must have Part B if

- You want to buy a Medigap (Medicare Supplement Insurance) policy
- You want to join a Medicare Advantage Plan
- You're eligible for TRICARE for Life (TFL)* or Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- Your employer coverage requires you or your spouse/family member to have it—less than 20 employees (talk to your employer's or union benefits administrator)

Veterans Affairs (VA) benefits are separate from Medicare. With VA benefits, you may choose to not enroll in Part B, but you pay a penalty if you don't sign up for Part B during your Initial Enrollment Period (visit VA.gov). If you have VA coverage, you won't be eligible to enroll in Part B using the Special Enrollment Period (SEP).

*TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain former spouses. You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to get TFL benefits. However, if you're an active-duty service member, or the spouse or dependent child of an active-duty service member, you don't have to enroll in Part B to keep your TRICARE coverage. When the active-duty service member retires, you must enroll in Part B to keep your TFL coverage. You can get Part B during a Special Enrollment Period if you have Medicare because you're 65 or older, or you're disabled. For more information, visit Tricare.mil/mybenefit.

You must have Part A and Part B to keep your CHAMPVA coverage.

NOTE: See also Medicare.gov/Pubs/pdf/02179.pdf for more information on "Who Pays First."

Check Your Knowledge—Question 1

The Part B premium most people with Medicare will pay in 2015 is $104.90.

a. True

b. False

06/01/2015 Understanding Medicare 39

Check Your Knowledge—Question 1

a. True

b. False

Answer: 1. True

The standard Medicare Part B monthly premium is $104.90 in 2015. Most beneficiaries will pay the standard premium.

Check Your Knowledge—Question 2

Medicare uses a "benefit period" to measure your use of which of the following services?

a. Inpatient hospital

b. Inpatient skilled nursing facility

c. Home health episodes

d. All of the above

e. a and b

06/01/2015 Understanding Medicare 40

Check Your Knowledge—Question 2

Medicare uses a "benefit period" to measure your use of which of the following services?

a. Inpatient hospital

b. Inpatient skilled nursing facility

c. Home health episodes

d. All of the above

e. a and b

ANSWER: e. a and b (Inpatient hospital and inpatient skilled nursing facility)

A benefit period refers to the way that Original Medicare measures your use of inpatient hospital and skilled nursing facility (SNF) services with a $1,260 deductible and no coinsurance for days 1–60 of each benefit period.

Hospice care is given in benefit periods. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. The use of the term "benefit period" in hospice isn't included in this measure, as the hospice benefit is a standalone benefit for the terminally ill where the inpatient deductible doesn't apply.

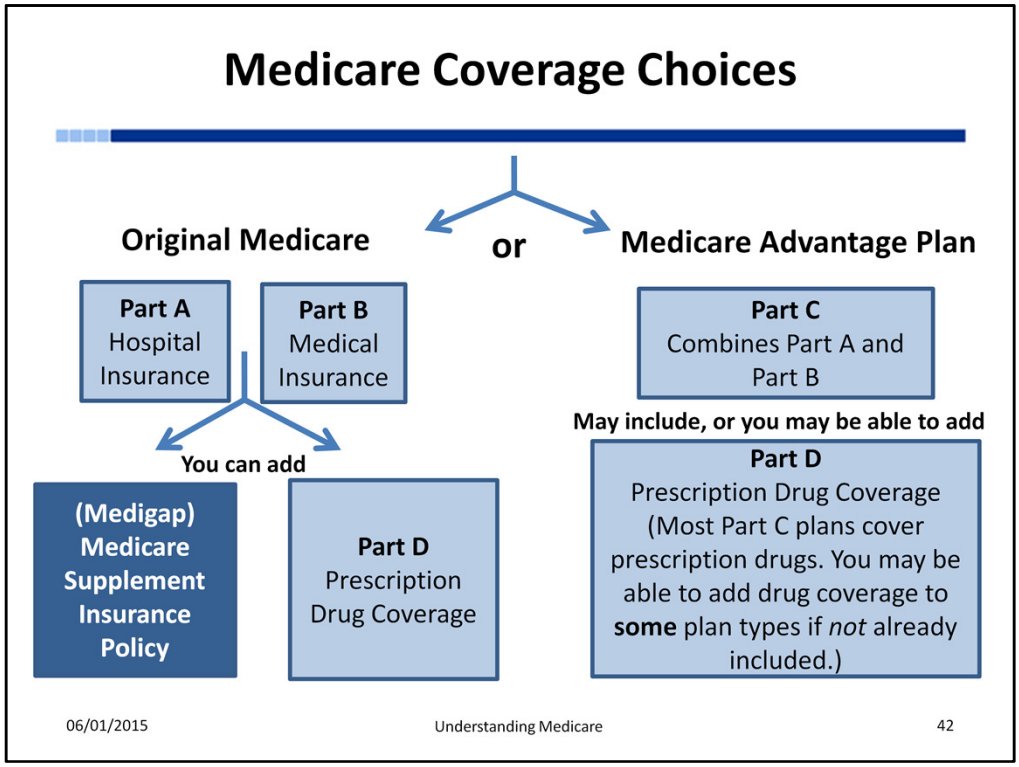
Lesson 2—Medicare Coverage Choices

- Your Medicare Coverage Choices
- Original Medicare (Part A and Part B)
  - Assignment
  - Private Contracts
- Medigap (Medicare Supplement Insurance) Policies
- Medicare Prescription Drug Coverage (Part D)
- Medicare Advantage Plans (Part C)
- Other Medicare Health Plans

06/01/2015 Understanding Medicare 41

Lesson 2, "Your Medicare Coverage Choices," explains

- Your Medicare Coverage Choices
- Original Medicare (Part A and Part B)
  - Assignment
  - Private contracts
- Medigap (Medicare Supplement Insurance) Policies
- Medicare Prescription Drug Coverage (Part D)
- Medicare Advantage Plans (Part C)
- Other Medicare Health Plans



There are 2 main ways to get your Medicare coverage: Original Medicare, or Medicare Advantage (MA) Plans. You can decide which way to get your coverage:

1. Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). You can choose to buy a Medigap policy (you must have Part A and Part B) to help cover some costs not covered by Original Medicare. You can also choose to buy a Medicare prescription drug coverage (Part D) from a Medicare Prescription Drug Plan (PDP) (you can have Part A only, Part B only, or both).

2. MA Plans (Part C), like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), cover Part A and Part B services and supplies. They also may include Medicare prescription drug coverage (MA-PD). If adding Part D to MA Plans—you can add to Private Fee-for-Service and Medicare Medical Savings Account (MSA) Plans; you can't add to an HMO or PPO plan without drug coverage*.

   Medigap (Medicare Supplement Insurance) policies don't work with these plans. If you join an MA Plan, you can't use a Medigap policy to pay for out-of-pocket costs you have in the MA Plan.

*Visit Medicare.gov/Pubs/pdf/11135.pdf to access the publication "How Medicare Prescription Drug Coverage Works With a Medicare Advantage Plan or Medicare Cost Plan."

Original Medicare

- Health care option run by the federal government
- Provides your Part A and/or Part B coverage
- See any doctor or hospital that accepts Medicare
- You pay
  - Part B premium (Part A is usually premium free)
  - Deductibles, coinsurance, or copayments
- Get Medicare Summary Notice
- Can join a Part D plan to add drug coverage

06/01/2015 Understanding Medicare 43

Original Medicare is one of the coverage choices in the Medicare program. You'll be in Original Medicare unless you choose to join a Medicare Advantage Plan or other Medicare health plan. Original Medicare is a fee-for-service program that is managed by the federal government. With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.

If you have Medicare Part A, you get all medically necessary Part A–covered services. If you have Medicare Part B, you get all medically necessary Part B–covered services. As we mentioned earlier, Part A is premium-free for most people. For Medicare Part B you pay a monthly premium. The standard Medicare Part B monthly premium is $104.90 in 2015.

In Original Medicare, you also pay deductibles, coinsurance, or copayments. After you receive health care services, you'll get a notice in the mail, called a "Medicare Summary Notice" (MSN), that lists the services you received, what was charged, what Medicare paid, and how much you may be billed. If you disagree with the information on the MSN or with any bill you receive, you can file an appeal. There's information on the MSN about how to ask for an appeal.

If you're in Original Medicare, you can also join a Medicare Prescription Drug Plan (Part D) to add drug coverage.

Assignment

- Doctor, provider, supplier ***accepts assignment***
  - Signed an agreement with Medicare
    - Or is required by law
  - Accept the Medicare-approved amount
    - As full payment for covered services
    - Only charge Medicare deductible/coinsurance amount
- Most accept assignment
  - They submit your claim to Medicare directly

06/01/2015 Understanding Medicare 44

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. Participating providers have signed an agreement to accept assignment for all Medicare-covered services.

Here's what happens if your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less
- They agree to charge you only the Medicare deductible and coinsurance amount, and usually wait for Medicare to pay its share before asking you to pay your share
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim

In some cases, doctors, providers, and suppliers must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.

Not Accepting Assignment

- Providers and suppliers that don't accept assignment
  - May charge you more
    - The limiting charge is 15% more
    - May have to pay entire charge at time of service
- Providers sometimes must accept assignment
  - Medicare Part B–covered prescription drugs
  - Ambulance suppliers

06/01/2015 Understanding Medicare 45

"Non-participating" providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services.

Here's what happens if your doctor, provider, or supplier doesn't accept assignment:

- You might have to pay the entire charge at the time of service. Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. In some cases, you might have to submit your own claim to Medicare using form CMS-1490S to get paid back. Visit Medicare.gov/forms-help-and-resources/forms/medicare-forms.html for the form and instructions.
- They can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge" or "excess charge." The provider can only charge you up to 15% over the amount that non-participating providers are paid. Non-participating providers are paid 95% of the fee schedule amount. The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.

To find out if your doctors, suppliers, and other health care providers accept assignment or participate in Medicare, visit Medicare.gov/physician or Medicare.gov/supplier.

If you get your Medicare Part B–covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, they're supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Private Contracts

- Agreement between you and your doctor
  - Doctor doesn't furnish services through Medicare
  - Original Medicare and Medigap won't pay
  - Other Medicare plans won't pay
  - You'll pay full amount for the services you get
  - No claim should be submitted
  - Can't be asked to sign in an emergency
  - The doctor can't bill Medicare for 2 years for any services provided to anyone with Medicare

06/01/2015 Understanding Medicare 46

A private contract is an agreement between you and a doctor who has decided not to furnish services through the Medicare program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medigap (Medicare Supplement Insurance) policies won't pay for the services you get from the doctor with whom you have a private contract. You can't be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor

- No Medicare payment will be made for the services you get from the doctor.
- Your Medigap policy, if you have one, won't pay anything for the service.
- You'll have to pay whatever this doctor or provider charges you. (The Medicare limiting charge won't apply.)
- Other Medicare plans won't pay for the services.
- No claim should be submitted, and Medicare won't pay if one is submitted.
- Many other insurance plans won't pay for the service either.
- The doctor can't bill Medicare for 2 years for any services provided to anyone with Medicare.

Medicare Supplement Insurance

- Medigap policies
  - Are private health insurance
  - Supplement Original Medicare
    - You must have both Medicare Part A and Part B to get a Medigap policy
  - Help pay some health care costs that Original Medicare doesn't cover (coverage "gaps")
    - Medicare will pay its share of the Medicare-approved amounts for covered health care costs
      - Then your Medigap policy pays its share
    - A Medigap policy covers one person

06/01/2015 Understanding Medicare 47

A Medicare Supplement Insurance policy (often called Medigap) is private health insurance that's designed to supplement Original Medicare.

This means it helps pay some of the health care costs that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). These are "gaps" in Medicare coverage. If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then your Medigap policy pays its share.

- You must have both Medicare Part A and Part B to get a Medigap policy.
- You pay the private insurance company a monthly premium for your Medigap policy in addition to your monthly Part B premium.

Medigap policies cover only one person. If you and your spouse both want Medigap coverage, you'll need to have separate Medigap policies.

NOTE: Module 3, "Medigap (Medicare Supplement Insurance)" describes this topic in more detail at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

Medigap Plans

- Standardized plans identified by a letter
  - Plans A, B, C, D, F, G, K, L, M, and N are currently sold
  - Companies don't have to sell all plans
  - Plans E, H, I, and J exist but are no longer sold
  - Plans with the same letter must offer the same basic benefits
    - Only the policy cost will vary between companies
- Waiver states (Massachusetts, Minnesota, and Wisconsin) standardize in a different way

06/01/2015 Understanding Medicare 48

In most states, Medigap insurance companies can only sell you a standardized Medigap policy identified by letters A, B, C, D, F, G, K, L, M, and N. Plans D and G with an effective date on or after June 1, 2010, have different benefits than Plans D and G bought before June 1, 2010. Plans E, H, I, and J are no longer sold, but, if you already have one, you can generally keep it. Plan F has a high-deductible option.

Each standardized Medigap plan must offer the same basic benefits, no matter which insurance company sells it. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from. Cost is usually the only difference between Medigap policies with the same letter sold by different insurance companies. You're encouraged to shop carefully for a Medigap policy.

Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap plan, they must also offer either Medigap Plan C or Plan F. Not all types of Medigap policies may be available in your state. If you need more information, call your State Insurance Department or State Health Insurance Assistance Program. You can find their contact information on Medicare.gov under helpful contacts.

Some people may still have a Medigap policy they purchased before the plans were standardized. If they do, they can keep these plans. If they drop them, they may not be able to get them back.

Medigap policies are standardized in a different way in Massachusetts, Minnesota, and Wisconsin. These are called waiver states.

NOTE: See "Medigap (Medicare Supplement Insurance) Policies," Module 3 for more information at CMS.gov/Outreach-and-Education/ Training/ CMSNationalTrainingProgram/Training-Library.html.

Medigap Policies

- You pay a monthly premium
- Costs vary by plan, company, your age, and location
- Follow federal/state laws that protect you
- Medigap Open Enrollment Period
  - Starts when you are both 65 and signed up for Part B
  - Once started, it can't be delayed or repeated
- Doesn't work with Medicare Advantage
- No networks except with a Medicare SELECT policy

06/01/2015 Understanding Medicare 49

You pay a monthly premium for a Medigap policy to the insurance company that sells it. With a Medigap policy, costs can vary by plan, company, your age, and location.

Must follow federal and state laws that protect people with Medicare.

Your Medigap Open Enrollment Period (OEP) starts when you are both 65 and signed up for Part B. Once it has started, it can't be delayed or repeated. During your Medigap OEP, an insurance company can't

- Use medical underwriting*
- Refuse to sell you any Medigap policy it offers
- Charge you more for a Medigap policy than they charge someone with no health problems
- Make you wait for coverage to start (except in certain pre-existing circumstances)

You can buy a Medigap policy any time a company will sell you one.

Medigap policies don't work with Medicare Advantage Plans.

Medigap policies pay for Medicare-covered services provided by any doctor, hospital, or provider that accepts Medicare.

- The exception is Medicare SELECT policies that require you use specific hospitals, and in some cases, specific doctors to get full benefits.

* Medical underwriting is a process insurance companies use to decide, based on your medical history, whether to accept your application for insurance, whether to add a waiting period for pre-existing conditions, and how much to charge you.

Delayed Medigap Open Enrollment Period (OEP)

- If you delay enrolling in Medicare Part B
  - Because you or your spouse is still working, **and**
  - You have group health coverage
- Medigap OEP is delayed
  - Until you're 65 **and** enrolled in Part B
  - No late enrollment penalty
- Notify Social Security to delay Part B

06/01/2015 Understanding Medicare 50

If you have group health coverage through an employer or union, because either you or your spouse is currently actively working, you may want to wait to enroll in Medicare Part B. This is because benefits based on current employment often provide coverage similar to Part B, you would be paying for Part B before you need it, and your Medigap Open Enrollment Period (OEP) might expire before a Medigap policy would be useful.

When the employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty, which means your Medigap OEP will start when you're ready to take advantage of it. If you enroll in Part B while you still have current employer coverage, your Medigap OEP will start, and unless you buy a Medigap policy before you need it, you'll miss your OEP entirely. If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare.

If you aren't going to enroll in Part B due to current employment, it's important that you notify Social Security that you want to delay Part B.

NOTE: Remember, if you took Part B while you had employer coverage, you don't get another Medigap OEP when your employer coverage ends. You must have both Medicare Part A and Medicare Part B to purchase a Medigap policy.

Pre-Existing Conditions and Medigap

- Health problem you had before the new insurance policy starts
  - Treated or diagnosed 6 months before coverage start date
- Pre-Existing Condition Waiting Period
  - Insurance companies can refuse to cover out-of-pocket costs for excluded condition for up to 6 months ("look-back period")
    - Without 6 months of prior creditable coverage and no break in coverage more than 63 days

The Affordable Care Act doesn't impact the pre-existing condition waiting period for Medigap coverage.

06/01/2015 Understanding Medicare 51

The insurance company may be able to make you wait for coverage related to a pre-existing condition (i.e., a health problem you have before the date a new insurance policy starts) for up to 6 months. This is called a "pre-existing condition waiting period." After 6 months, the Medigap policy will cover the pre-existing condition.

Coverage for a pre-existing condition can only be excluded in a Medigap policy if the condition was treated or diagnosed within 6 months before the date the coverage starts under the Medigap policy. This is called the "look-back period." Original Medicare will still cover the condition, even if the Medigap policy won't cover your out-of-pocket costs, but you're responsible for the Medicare coinsurance or copayment.

If you buy a Medigap policy during your Medigap Open Enrollment Period and you're replacing certain kinds of health coverage that count as "creditable coverage" (generally any other health coverage you recently had before applying for a Medigap policy), it's possible to avoid or shorten this waiting period. If you had at least 6 months of continuous prior creditable coverage (with no break in coverage for more than 63 days), the Medigap insurance company can't make you wait before it covers your pre-existing conditions. You can learn more about creditable coverage by reviewing the Code of Federal Regulations, 45 CFR 146.113 at ecfr.gov/cgi-bin/ECFR?page=browse.

If you buy a Medigap policy when you have a guaranteed issue right, the insurance company can't use a pre-existing condition waiting period. See Lesson 3 for additional discussion on "Guaranteed Issue Rights."

Medigap for People With a Disability or End-Stage Renal Disease (ESRD)

- People with a disability or ESRD may not be able to buy a policy until they turn 65
  - Some states require insurers to sell Medigap policies to people with a disability or ESRD
- Companies may voluntarily sell Medigap policies
  - May cost more than policies sold to people over 65
  - Can use medical underwriting
- Get a Medigap Open Enrollment Period at 65

06/01/2015 Understanding Medicare 52

If you're under 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD), you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law doesn't require insurance companies to sell Medigap policies to people under 65. However, the following states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65:

- California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, and Wisconsin

However, Medigap isn't available to people with ESRD under 65 in California, Massachusetts, or Vermont. In Delaware, Medigap is only available to people under 65 with ESRD.

Even if your state isn't on the list above, some insurance companies may voluntarily sell Medigap policies to people under 65, although they'll probably cost you more than Medigap policies sold to people over 65, and they can use medical underwriting. Check with your State Insurance Department (see Appendix B for a list of phone numbers) about what rights you might have under state law.

Remember, if you're already enrolled in Medicare Part B, you'll get a Medigap Open Enrollment Period (OEP) when you turn 65. You'll probably have a wider choice of Medigap policies and be able to get a lower premium at that time. During your Medigap OEP, insurance companies can't refuse to sell you any Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65.

Because Medicare (Part A and/or Part B) is creditable coverage, if you had Medicare for more than 6

months before you turned 65, you may not have a pre-existing condition waiting period.

Right to Suspend Medigap for People With Medicaid

- If you have both Medicare and Medicaid
  - You generally can't buy a Medigap policy
- You can suspend your Medigap policy
  - Within 90 days of getting Medicaid
    - For up to 2 years
- You can start it up again
  - No new medical underwriting or waiting periods

06/01/2015 Understanding Medicare 53

If you have both Medicare and Medicaid, most of your health care costs are covered. Medicaid is a joint federal and state program, and coverage varies from state to state. People with Medicaid may get coverage for things that aren't covered by Medicare, like some nursing home care and home health care.

If you already have Medicaid, an insurance company can't legally sell you a Medigap policy unless one of the following is true:

- Medicaid pays your Medigap premium
- Medicaid only pays all or part of your Medicare Part B premium

Remember, the insurance company may use medical underwriting, which could affect acceptance, cost, and the date of coverage.

There are a few things you should know if you have a Medigap policy and then become eligible for Medicaid:

- You can put your Medigap policy on hold (suspend it) within 90 days of getting Medicaid.
- You can suspend your Medigap policy for up to 2 years. However, you may choose to keep your Medigap policy active so you can see doctors who don't accept Medicaid, or if you no longer meet Medicaid spend-down requirements.
- At the end of the suspension, you can restart the Medigap policy without new medical underwriting or waiting periods for pre-existing conditions.

NOTE: If you suspend a Medigap policy you bought before January 2006, and it included prescription drug coverage, you can get the same Medigap policy back, but without the prescription drug coverage.

Check Your Knowledge—Question 3

Medigap policies work with which of the following?

a. Original Medicare
b. Medicare Advantage Plans
c. Medicaid

06/01/2015 Understanding Medicare 54

Check Your Knowledge—Question 3

Medigap policies work with which of the following?

a. Original Medicare
b. Medicare Advantage Plans
c. Medicaid

Answer: a. Original Medicare

A Medigap policy is private health insurance that supplements Original Medicare. If you have Original Medicare and a Medigap policy, Medicare will pay for its share of the Medicare-approved amounts for all covered health care costs. Then your Medigap policy pays its share. A Medigap policy isn't part of Medicare.

Medicare Advantage Plans are a type of Medicare health plan offered by private insurance companies that contract with Medicare to provide you with all your Part A and Part B benefits.

If you already have Medicaid, an insurance company can't by law sell you a Medigap policy unless

- Medicaid pays your Medigap premium, or
- Medicaid only pays all or part of your Medicare Part B premium.

If you become eligible for Medicaid and you already have a Medigap policy you can suspend your Medigap policy for up to 2 years, as long as notify your Medigap insurer in writing within 90 days of getting Medicaid.

Medicare Prescription Drug Coverage (Part D)

- What Is Part D?
- Medicare Prescription Drug Plans
- Medicare Drug Plan Costs
- Standard Structure
- Improved Coverage in the Coverage Gap
- Eligibility Requirements
- When to Join and Switch Plans
- Part D–covered Drugs
  - Drugs Not Covered
- How Plans Manage Access To Covered Drugs
- Requirements for Prescribers NEW!

06/01/2015 Understanding Medicare 55

"Medicare Prescription Drug Coverage" explains the following:

- What Is Part D (Medicare Prescription Drug Coverage)?
- Medicare Prescription Drug Plans
- Medicare Drug Plan Costs
- Standard Structure
- Improved Coverage in the Coverage Gap
- Eligibility Requirements
- When to Join and Switch Plans
- Part D–covered Drugs
  - Drugs Not Covered
- How Plans Manage Access to Covered Drugs
- Requirements for Prescribers

What Is Part D (Medicare Prescription Drug Coverage)?

- Medicare drug plans
  - Approved by Medicare
  - Run by private companies
  - Available to everyone with Medicare
- You must join a plan to get coverage
- There are 2 ways to get coverage
  1. Medicare Prescription Drug Plans
  2. Medicare Health Plans with prescription drug coverage

06/01/2015 Understanding Medicare 56

Medicare prescription drug coverage (Part D) adds to your Medicare health care coverage. It helps you pay for medically necessary brand-name and generic prescription drugs. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare. All people with Medicare are eligible to enroll in a Medicare drug plan. To get coverage, you must join a plan (enrollment isn't automatic for most people).

There are 2 main ways to get Medicare prescription drug coverage:

1. Join a Medicare Prescription Drug Plan (PDP). These plans add coverage to Original Medicare, and may be **added** to some other types of Medicare health plans (but not Medicare Advantage [MA] Plans).
2. Join an MA Plan with prescription drug coverage (MA-PD) (like a Health Maintenance Organization or a Preferred Provider Organization) or another Medicare health plan that **includes** Medicare prescription drug coverage. **You'll get all your Medicare coverage (Part A and Part B), including prescription drug coverage (Part D) through these plans.**

The term "Medicare drug plan" is used throughout this presentation to mean both PDPs and MA-PDs or other Medicare plans with prescription drug coverage.

NOTE: Some Medigap (Medicare Supplement Insurance) policies offered prescription drug coverage before January 1, 2006. This isn't Medicare prescription drug coverage.

Medicare Prescription Drug Plans

- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
  - Different tier and/or copayment levels
  - Deductible
  - Coverage for drugs not typically covered by Part D
- Benefits and costs may change each year

06/01/2015 Understanding Medicare 57

Medicare drug plans may be different from each other in terms of which prescription drugs they cover, how much you have to pay, and which pharmacies you can use. All Medicare drug plans must give at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Plans may offer more coverage and additional drugs, generally for a higher monthly premium.

Most plans continue to offer different benefit structures, including tiers, copayments, and/or deductibles. Enhanced plans may offer additional benefits, like coverage in the coverage gap or coverage for drugs that Medicare Part D doesn't traditionally cover.

Plan benefits and costs may change each year, so it's important to look at and compare your plan options annually.

Medicare Prescription Drug Plan Costs

- Costs vary by plan
- In 2015, most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - 45% for covered brand-name drugs in the coverage gap
  - 65% for covered generic drugs in the coverage gap
  - Very little after spending $4,700 out of pocket

06/01/2015 Understanding Medicare 58

Your costs for prescription drug coverage will depend on the plan you choose and some other factors, like which drugs you use, which Medicare drug plan you join, whether you go to a pharmacy in your plan's network, and whether you get Extra Help paying for your drug costs.

Most people will pay a monthly premium for Medicare prescription drug coverage. You'll also pay a share of your prescription costs, including a deductible (if applicable), copayments, and/or coinsurance.

Contact your drug plan (not Social Security) if you want your premium deducted from your monthly Social Security payment. Your first deduction will usually take 3 months to start, and 3 months of premiums will likely be deducted at once.

After that, only one premium will be deducted each month. You may also see a delay in premiums being withheld if you switch plans. If you want to stop premium deductions and get billed directly, contact your drug plan.

When you are in the coverage gap, you pay 45% for covered brand-name drugs, and 65% for covered generic drugs.

With every plan, once you've paid $4,700 out of pocket for drug costs in 2015 (including payments from other sources, like the discount paid for by the drug company in the coverage gap) you leave the coverage gap and pay 5% (or a small copayment) for each drug for the rest of the year.

Part D Eligibility Requirements

- You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan
- You must have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
- You must have Medicare Part A and Part B or only Part B to join a Medicare cost plan with Part D coverage
- You must live in the plan's service area
  - You can't be incarcerated
  - You can't be unlawfully present in the United States
  - You can't live outside the United States
- You must join a plan to get drug coverage

Effective 1/1/2016

06/01/2015 Understanding Medicare 59

To join a Medicare Prescription Drug Plan, you must have Medicare Part A and/or Part B. To join a Medicare Advantage Plan with prescription drug coverage, you must have both Medicare Part A and Part B. To join a Medicare cost plan with prescription drug coverage, you must have Medicare Part A and Part B, or have Medicare Part B only.

Each plan has its own service area, which you must live in to enroll. People in the United States territories, including Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa can enroll. If you live outside the United States and its territories, or incarcerated, you're not eligible to enroll in a plan, and therefore, can't get Part D coverage. Effective January 1, 2016, you must be lawfully present in the United States to be eligible to enroll in a plan.

Medicare drug coverage isn't automatic. Most people must join a Medicare drug plan to get coverage. So while all people with Medicare can have this coverage, you need to take action to get it. If you qualify for Extra Help to pay for your prescription drugs, Medicare will enroll you in a Medicare drug plan unless you decline coverage or join a plan yourself. You can only be a member of one Medicare drug plan at a time.

Part D Initial Enrollment Period (IEP)

- When you first become eligible to get Medicare
  - 7-month IEP for Part D

If You Join	Coverage Begins
During the 3 months before you turn 65	Date eligible for Medicare
During the month you turn 65	First day of the following month
During the 3 months after you turn 65	First day of the month after month you apply

06/01/2015 Understanding Medicare 60

When you first become eligible to get Medicare, you have a 7-month Initial Enrollment Period (IEP) for Part D:

- You can apply as early as 3 months before your month of Medicare eligibility. Coverage will start on the date you become eligible for Medicare.
- If you apply during your month of eligibility, then your Medicare drug coverage begins the first day of the following month.
- You can apply during the 3 months after your month of eligibility, with coverage beginning the first day of the month after the month you apply.

Some groups of people who become eligible to get Medicare will be enrolled in a Medicare drug plan by CMS unless they join a plan on their own. We'll discuss these groups in Lesson 4.

NOTE: If you get Social Security or Railroad Retirement benefits when you turn 65, you'll be enrolled automatically in Medicare Part A and Part B. However, you'll still need to choose and enroll in a Part D plan during your IEP if you'd like to have Medicare drug coverage. If you enroll later, you may pay a penalty.

When You Can Join or Switch Plans

- Medicare's Open Enrollment Period is October 15–December 7 each year, coverage starts January 1
- You can leave a Medicare Advantage Plan and switch to Original Medicare from January 1–February 14 each year
  - You have until February 14 to also join a Part D plan
- If you don't have Medicare Part A coverage, and enroll in Part B during the General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan from April 1–June 30 each year

06/01/2015 Understanding Medicare 61

- Medicare's Open Enrollment Period runs from October 15–December 7 each year with changes going into effect on January 1
- 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, you have until February 14 to also join a Medicare drug plan to add drug coverage. Coverage starts the first day of the month after the plan gets the enrollment form.
- April 1–June 30 (limited)
  - If you don't have Medicare Part A coverage, and enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan from April 1–June 30. Your coverage begins July 1.

Special Enrollment Period (SEP)

- Life events that allow an SEP include
  - You permanently move out of your plan's service area
  - You lose other creditable prescription coverage
  - You weren't properly told that your other coverage wasn't creditable, or your other coverage was reduced and is no longer creditable
  - You enter, live at, 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
  - You join or switch to a plan that has a 5-star rating
  - Other exceptional circumstances

06/01/2015 Understanding Medicare 62

You can make changes to your Medicare prescription drug coverage when certain events happen in your life. These chances to make changes are called Special Enrollment Periods (SEPs). Each SEP has different rules about when you can make changes and the type of changes you can make. These chances to make changes are in addition to the regular enrollment periods that happen each year. The SEPs listed below are examples. The list doesn't include every situation:

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage
- If you weren't properly told that your other coverage wasn't creditable, or that the other coverage was reduced so that it's no longer creditable
- If you enter, live at, or leave a long-term care facility like a nursing home
- If you qualify for Extra Help, you have a continuous SEP, and can change your Medicare drug plan at any time
- If you belong to a State Pharmaceutical Assistance Program
- If you join or switch to a plan that has a 5-star rating (see next slide)
- Other exceptional circumstances, like if you no longer qualify for Extra Help

NOTE: It's important to remember that the SEPs for Part B and Part D have different time frames for when you need to sign up for coverage. You may be eligible for a Medicare Part B SEP if you're over 65 and you (or your spouse) are still working and have health insurance through active employment. Your Part B SEP lasts for 8 months and begins the month after your employment ends. However, your Part D SEP lasts for only 2 full months after the month your coverage ends.

SEP options will display for you if you enroll through the Medicare Plan Finder on Medicare.gov. By checking any of the listed SEPs, you're certifying that, to the best of your knowledge, you're eligible for an enrollment period. If at a later time it's determined that this information was incorrect, you may be disenrolled from the plan.

5-Star Special Enrollment Period (SEP)

- Use the Medicare Plan Finder tool at Medicare.gov to see quality and performance ratings
- Star ratings are given once a year, assigned in October of the past year
- Use 5-star SEP to switch to any 5-star plan one time
  - December 8–November 30 of following year
  - Coverage starts first day of month after enrolled
  - Be careful not to switch from a Medicare Advantage (MA) Plan with drug coverage to an MA Plan with **no** Part D coverage

Plans are assigned their star rating once per year, in October. However, the plan won't actually get this rating until the following January 1. To find star rating information, visit the Medicare Plan Finder at Medicare.gov/find-a-plan. Look for the Overall Plan Rating to identify 5-star plans that you can change to during this Special Enrollment Period (SEP). The "Medicare & You" handbook doesn't have the full, updated ratings for this SEP.

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 stars. A 5-star rating is considered excellent.

At any time during the year, you can use the 5-star SEP to enroll in a 5-star Medicare Advantage (MA)–only plan, a 5-star MA plan with prescription drug coverage (MA-PD), a 5-star Medicare Prescription Drug Plan (PDP), or a 5-star Cost Plan, as long as you meet the plan's enrollment requirements (for example, living within the service area). If you're currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

CMS also created a coordinating SEP for prescription drug plans. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a PDP, if that combination is allowed under CMS rules. You may use the 5-star SEP to change plans one time between December 8 and November 30 of the following year. Once you enroll in a 5-star plan, your SEP ends for that year and you're allowed to make changes only during other appropriate enrollment periods. Your enrollment will start the first day of the month following the month in which the plan gets your enrollment request.

For more information, please see the "5-Star Enrollment Period Job Aid" at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2014-5-Star-Plan-Ratings-Overview-Job-Aid.pdf.

NOTE: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that has no drug coverage. You'll have to wait until the next applicable enrollment period to get drug coverage and may have to pay a penalty.

Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Exceptions if you have
    - Creditable coverage
    - Extra Help
- Pay penalty for as long as you have coverage
  - 1% of base beneficiary premium ($33.13 in 2015)
    - For each full month eligible and not enrolled
  - Amount changes every year

06/01/2015 Understanding Medicare 64

If you choose not to join a Medicare drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you enroll later. If you have creditable coverage when you first become eligible for Medicare, you can generally keep that coverage and won't have to pay a penalty if you choose to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends. Also, you won't have to pay a higher premium if you get Extra Help paying for your prescription drugs.

The late enrollment penalty is calculated by multiplying the 1% penalty rate times the national base beneficiary premium ($33.13 in 2015) times the number of full, uncovered months you were eligible to join a Medicare drug plan but didn't and went without other creditable prescription drug coverage. The penalty calculation isn't based on the premium of the plan in which you are enrolled. The final amount is rounded to the nearest $.10 and added to your monthly premium. The national base beneficiary premium may go up each year, so the penalty amount may also go up each year. You may have to pay this penalty for as long as you have a Medicare drug plan.

After you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. You may have to pay this penalty for as long as you have a Medicare drug plan. If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You'll need to fill out a reconsideration request form (that your plan will send you), and you'll have the chance to provide proof that supports your case.

Income-Related Monthly Adjustment Amount (IRMAA)

Your Yearly Income in 2013 Filing an Individual Tax Return	Your Yearly Income in 2013 Filing a Joint Tax Return	In 2015 You Pay Monthly
$85,000 or less	$170,000 or less	Your Plan Premium (YPP)
Above $85,000 Up to $107,000	Above $170,000 Up to $214,000	YPP + $12.30*
Above $107,000 Up to $160,000	Above $214,000 Up to $320,000	YPP + $31.80*
Above $160,000 Up to $214,000	Above $320,000 Up to $428,000	YPP + $51.30*
Above $214,000	Above $428,000	YPP + $70.80*

IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.

06/01/2015 Understanding Medicare 65

You pay only your plan premium if your yearly income in 2013 was $85,000 or less for an individual, or $170,000 or less for a couple.

If you reported a modified adjusted gross income of more than $85,000 (individuals and married individuals filing separately) or $170,000 (married individuals filing jointly) on your Internal Revenue Service (IRS) tax return 2 years ago (the most recent tax return information provided to Social Security by the IRS), you'll have to pay an extra amount for your Medicare prescription drug coverage, called the income-related monthly adjustment amount (IRMAA). You pay this extra amount in addition to your monthly Medicare drug plan premium.

If your income has gone down due to any of the following situations, and the change makes a difference in the income level Social Security considers, contact them to explain you have new information and may need a new decision about your IRMAA:

- You married, divorced, or became widowed
- You or your spouse stopped working or reduced your work hours
- You or your spouse lost income-producing property due to a disaster or other event beyond your control
- You or your spouse experienced a scheduled cessation, termination, or reorganization of an employer's pension plan
- You or your spouse received a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization

Standard Structure in 2015

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1, 2015. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first $320 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $2,960.	Once Ms. Smith and her plan have spent $2,960 for covered drugs, she's in the coverage gap. In 2015, she pays 45% of the plan's cost for her covered brand-name prescription drugs and 65% of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent $4,700 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

06/01/2015 Understanding Medicare 66

Here's an example showing what you'd pay each year in a standard Medicare drug plan. Very few plans actually follow this design. Your drug plan costs will vary.

- **Monthly premium**—Most drug plans charge a monthly fee that differs from plan to plan. You pay this in addition to the Part B premium (if you have Part B). If you belong to a Medicare Advantage plan (like a Health Maintenance Organization or a Preferred Provider Organization) that includes drug coverage, the monthly plan premium may include an amount for prescription drug coverage.
- **Yearly deductible (you pay up to $320 in 2015)**—This is the amount you pay each year for your prescriptions before your plan begins to pay. No Medicare drug plan may have a deductible more than $320 in 2015. Some drug plans don't have a deductible.
- **Copayments or coinsurance (you pay approximately 25%)**—These are the amounts you pay for your covered prescriptions after you pay the deductible (if the plan has one). You pay your share and the drug plan pays its share for covered drugs.
- **Coverage gap**—The coverage gap begins after you and your drug plan have spent a certain amount of money for covered drugs ($2,960 in 2015). In 2015, once you enter the coverage gap, you pay 45% of the plan's cost for your covered brand-name drugs and 65% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Certain costs count toward getting out of the coverage gap, including your yearly deductible, coinsurance, and copayments, the discount you get on covered brand-name drugs in the gap, and what you pay in the gap. However, the drug plan premium, what you pay for drugs that aren't covered, and the discount for covered generic drugs in the coverage gap don't count toward getting you out of the coverage gap.
- **Catastrophic coverage (you pay 5%)**—Once you reach your out-of-pocket limit ($4,700 in 2015), you leave the coverage gap, and automatically get catastrophic coverage, where you only pay a small coinsurance or copayment for covered drugs for the rest of the year.

Improved Coverage in the Coverage Gap

Year	What You Pay for Covered Brand-Name Drugs in the Coverage Gap	What You Pay for Covered Generic Drugs in the Coverage Gap
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

06/01/2015 Understanding Medicare 67

Once you reach the coverage gap in 2015, you'll pay 45% of the plan's cost for covered brand-name prescription drugs. You get these savings if you buy your prescriptions at a pharmacy or order them through the mail. The discount will come off of the price that your plan has set with the pharmacy for that specific drug. In 2015, 95% of the price—what you pay plus the 50% manufacturer discount payment—will count as out-of-pocket costs, which will help you get out of the coverage gap. What the drug plan pays toward the drug cost (5% of the price) and what the drug plan pays toward the dispensing fee (55% of the fee) aren't counted toward your out-of-pocket spending.

In 2015, Medicare will pay 35% of the price for generic drugs during the coverage gap. You'll pay the remaining 65% of the price. What you pay for generic drugs during the coverage gap will decrease each year until it reaches 25% in 2020. 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.

Visit Medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html for examples of what you pay for generic or brand-name drugs.

If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the price of the drug. The discount for brand-name drugs will apply to the remaining amount that you owe.

NOTE: Visit CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11522-P.pdf to download the publication, “Information Pharmacists Can Use on Closing the Coverage Gap” (CMS 11522-P), and CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11495-P.pdf to download the publication “Information Partners Can Use on Closing the Coverage Gap” (CMS 11495-P).

Part D–Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the U.S. Food and Drug Administration
  - Used and sold in United States
  - Used for medically accepted indications
- Includes drugs, biological products, and insulin
  - And supplies associated with injection of insulin
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan

06/01/2015 Understanding Medicare 68

Medicare drug plans cover generic and brand-name drugs. To be covered by Medicare, a drug must be available only by prescription, approved by the U.S. Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication.

Medicare covers prescription drugs, insulin, and biological products (e.g., antibodies, proteins, cells, etc.). Medicare also covers medical supplies associated with the injection of insulin, like syringes, needles, alcohol swabs, and gauze.

To make sure people with different medical conditions can get the prescriptions they need, drug lists (formulary) for each plan must include a range of drugs in each prescribed category. All Medicare drug plans generally must cover at least 2 drugs per drug category, but the plans may choose which specific drugs they cover. Coverage and rules vary by plan, which can affect what you pay.

Even if a plan's prescription drug list doesn't include your specific drug, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes none of the drugs on your plan's drug list will work for your condition, you may ask for an exception.

Required Coverage

- All drugs in 6 protected categories
  1. Cancer medications
  2. HIV/AIDS treatments
  3. Antidepressants
  4. Antipsychotic medications
  5. Anticonvulsive treatments
  6. Immunosuppressants
- All commercially available vaccines
  - Except those covered under Part B (e.g., flu shot)

06/01/2015 Understanding Medicare 69

Medicare drug plans must cover all drugs in 6 protected categories to treat certain conditions:

1. Cancer medications
2. HIV/AIDS treatments
3. Antidepressants
4. Antipsychotic medications
5. Anticonvulsive treatments for epilepsy and other conditions
6. Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles shot (but not vaccines covered under Part B, like the flu and pneumococcal shots). You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

Requirement for Prescribers

NEW!

- Enforcement date January 1, 2016
- Prescribers of Part D drugs must
  - Be enrolled in an approved status, or
  - Have a valid opt-out affidavit on file for their prescriptions to be covered under Part D

06/01/2015 Understanding Medicare 70

CMS is using prescription drug event data to guide efforts to combat fraud and abuse and sharing the results of data analysis with Part D plan sponsors, law enforcement agencies, and pharmacy and physician licensing boards, as appropriate. A key fraud and abuse provision in the CY 2015 policy and technical changes to the Medicare Advantage (MA) and prescription drug program final rule requires prescribers of Part D drugs to enroll in Medicare. CMS finalized CMS-4159-F "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" on May 23, 2014. This rule requires doctors and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file with an A/B Medicare Administrative Contractor (MAC) for their prescriptions to be covered under Part D. The final regulation stated that the effective date for this requirement would be June 1, 2015, but CMS delayed enforcement of the requirements in 42 CFR 423.120(c)(6) until December 1, 2015. CMS published an interim final rule with comment (IFC) that changed the enforcement date to January 1, 2016. CMS-6107-IFC allows people with Medicare benefits to continue receiving medications prescribed by individuals permitted to prescribe by state law but who are prevented from enrolling in or opting out of Medicare by statutory provisions that govern the types of individuals who can enroll. View the IFC at federalregister.gov/articles/2015/05/06/2015-10545/medicare-programs-changes-to-the-requirements-for-part-d-prescribers.

Note that enrollment functions for doctors and other prescribers are handled by Part B MACs. To prepare the prescribers and Part D sponsors for the January 1, 2016, enforcement date, CMS is making available an enrollment file that identifies doctors and eligible professionals who are enrolled in Medicare in an approved or opt-out status. The first iteration of the enrollment file is now available at data.CMS.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx. For more information, visit CMS.gov /Outreach-and-Education/Medicare-Learning-Network-

MLN/MLNMattersArticles/downloads/SE1434.pdf.

Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs

06/01/2015 Understanding Medicare 71

By law, Medicare doesn't cover the following drugs:

- Drugs for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose [i.e., morbid obesity]).
- Erectile dysfunction drugs when used to treat sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which use the U.S. Food and Drug Administration approved the drugs. For example, a Medicare drug plan may cover an erectile dysfunction drug when used to treat an enlarged prostate (also known as benign prostatic hyperplasia, or BPH).
- Fertility drugs.
- Drugs for cosmetic or lifestyle purposes (e.g., hair growth).
- Drugs for symptomatic relief of coughs and colds.
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations).
- Non-prescription drugs.

Plans may choose to cover excluded drugs at their own cost or share the cost with you.

Visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf (42 CFR 423.100) for more information on excluded drugs.

How Plans Manage Access to Drugs

Prior Authorization	▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered
Step Therapy	▪ Must first try similar, less expensive drug ▪ Doctor may request an exception if • Similar, less expensive drug didn't work, or • Step therapy drug is medically necessary
Quantity Limits	▪ Plan may limit drug quantities over a period of time for safety and/or cost ▪ Doctor may request an exception if additional amount is medically necessary

06/01/2015 Understanding Medicare 72

Medicare drug plans manage access to covered drugs in several ways. These are known as "Coverage Rules." These include prior authorization, step therapy, and quantity limits.

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, your doctor or other prescriber must first show the plan you have a medically necessary need for that particular drug. Plans also do this to be sure you're using these drugs correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

Step therapy is a type of coverage rule. In most cases, you must first try a certain less expensive drug on the plan's drug list that has been proven effective for most people with your condition before you can move up a step to a more expensive drug. For instance, some plans may require you first try a generic drug (if available), then a less expensive brand-name drug on their drug list before you can get a similar, more expensive brand-name drug covered.

However, if you've already tried a similar, less expensive drug that didn't work, or if the doctor believes that because of your medical condition it's medically necessary to take a step-therapy drug (the drug the doctor originally prescribed), with your doctor's help, you can contact the plan to request an exception. If the request is approved, the plan will cover the originally prescribed step-therapy drug.

For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time. If your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate, you or your prescriber can contact the plan to ask for an exception. If the plan approves your request, the quantity limit won't apply to your prescription.

For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf (see Section 30.2.2).

Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

Tier Structure Example

Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand name
3	High copayment	Non-preferred, brand name
4 or Specialty	Highest copayment or coinsurance	Unique, very high cost

06/01/2015 Understanding Medicare 73

Each Medicare drug plan has a formulary, which is a list of prescription drugs that it covers. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.

Here's an example of how a plan might form its tiers:

- **Tier 1–Generic drugs** (the least expensive)—Tier 1 drugs are generic drugs and are the same as their brand-name counterparts in safety, strength, quality, the way they work, how they're taken, and the way they should be used. They use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug. They're less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration (FDA). Today, almost half of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.
- **Tier 2–Preferred brand-name drugs**—Tier 2 drugs cost more than Tier 1 drugs.
- **Tier 3–Non-preferred brand-name drug**—Tier 3 drugs cost more than Tier 2 drugs.
- **Tier 4–(or Specialty Tier)**—These drugs are unique and have a high cost.

NOTE: In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can request an exception and

ask your plan for a lower copayment.

Check Your Knowledge—Question 4

The Part D late enrollment penalty lasts for

a. 12 months

b. 2 years

c. As long as you have coverage

d. 36 months

06/01/2015 Understanding Medicare 74

Check Your Knowledge—Question 4

The part D late enrollment penalty lasts for

a. 12 months

b. 2 years

c. As long as you have coverage

d. 36 months

ANSWER: c. As long as you have coverage

If you choose not to join a Medicare drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you enroll later. If you have creditable coverage when you first become eligible for Medicare, you can generally keep that coverage and won't have to pay a penalty if you choose to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends. Also, you won't have to pay a higher premium if you get Extra Help paying for your prescription drugs.

After you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. You may have to pay this penalty for as long as you have a Medicare drug plan. If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You'll need to fill out a reconsideration request form (that your plan will send you), and you'll have the chance to provide proof that supports your case.

Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more
- Visit Medicare.gov/find-a-plan/ questions/ home.aspx

06/01/2015 Understanding Medicare 75

Visit Medicare.gov/find-a-plan/questions/home.aspx and use the Medicare Plan Finder:

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on quality ratings, benefits covered, costs, and more

You should compare Medicare drug plans based on what's most important to your situation and your drug needs. You may want to ask yourself the following questions:

- Which plan(s) covers the prescriptions I take?
- Which plan(s) gives me the best overall price on all of my prescriptions?
- What's the monthly premium, yearly deductible, and the coinsurance or copayment(s)?
- Which plan(s) allows me to use the pharmacy I want or get prescriptions through the mail?
- Which plan(s) gives me coverage in multiple states, if I need it?
- What star ratings did the plan(s) get?
- Can my coverage start when I want it to?
- Is it likely that I'll need protection against unexpected drug costs in the future?

Visit CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1239988.html.

Practice website to be used with approved training scenarios: training.medicare.gov/find-a-plan/questions/home.aspx.

Medicare Advantage (MA) Plans (Part C)

- What they are
- How the plans work
- MA Plan costs
- Who can join
- When to join and switch plans
- Other Medicare health plans

06/01/2015 Understanding Medicare 76

"Medicare Advantage (MA) Plans," explains the following:

- What they are
- How the plans work
- MA Plan costs
- Who can join
- When to join and switch plans
- Other Medicare health plans

NOTE: In this presentation, when we use the term "Medicare Advantage Plans," we mean those with and without prescription drug coverage. (We won't include Original Medicare or stand-alone Medicare Prescription Drug Plans.) Module 11, "Medicare Advantage Plans" describes this topic in more detail at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

What is a Medicare Advantage Plan?

- Health plan options
  - Approved by Medicare
  - Run by private companies
- Part of the Medicare program
- Sometimes called Part C
- Available across the country
- Provide Medicare-covered benefits
  - May cover extra benefits

06/01/2015 Understanding Medicare 77

Medicare Advantage (MA) Plans are health plan options that are approved by Medicare and run by private companies.

They're part of the Medicare program and are sometimes called Part C.

MA Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays these private plans for their members' expected health care.

MA Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Original Medicare doesn't cover, such as vision or dental services or allowances. The plan may have special rules that its members need to follow.

How Medicare Advantage Plans Work

- Receive services through the plan
  - All Part A– and Part B–covered services
  - Some plans may provide additional benefits
- Most plans include prescription drug coverage
- You may have to use network doctors/hospitals
- May differ from Original Medicare
  - Benefits
  - Cost-sharing

06/01/2015 Understanding Medicare 78

In Medicare Advantage (MA) Plans, you receive all Medicare-covered Part A (Hospital Insurance) and Part B (Medical Insurance) services through that plan. Some MA Plans provide additional benefits.

Many plans also include Medicare prescription drug coverage. This is Medicare Part D coverage.

In some plans, like Medicare Health Maintenance Organizations (HMOs), you may only be able to see certain doctors or go to certain hospitals. You save the most money out of pocket when you obtain services through the plan's network.

Benefits and cost-sharing in an MA Plan may differ from Original Medicare.

How Medicare Advantage (MA) Plans Work (Continued)

- You're still in the Medicare program
  - Medicare pays the plan every month for your care
- You still have Medicare rights and protections
- If the plan leaves Medicare you can
  - Join another MA Plan, or
  - Return to Original Medicare

06/01/2015 Understanding Medicare 79

It's important to note that when you join a Medicare Advantage (MA) Plan or other Medicare health plan you are still in the Medicare program. Medicare pays these private health plans for your care every month whether you use services or not.

You still have Medicare rights and protections.

You'll have the opportunity to join another MA Plan or return to Original Medicare, if the plan decides to stop participating in Medicare.

Medicare Advantage Costs

- You still pay the Part B premium
  - A few plans may pay all or part for you
  - State assistance for some
- You may pay plan an additional monthly premium
- You pay deductibles, coinsurance, and copayments
  - Different from Original Medicare
  - Vary from plan to plan
  - May be higher if out of network

06/01/2015 Understanding Medicare 80

If you join a Medicare Advantage (MA) Plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2015 is $104.90 for most people.

- A few plans may pay all or part of the Part B premium for you.
- Some people may be eligible for state assistance.

When you join an MA Plan there are other costs you may have to pay, such as

- An additional monthly premium to the plan
- Deductibles, coinsurance, and copayments
  - These costs may
    - Be different from Original Medicare
    - Vary from plan to plan
    - Be higher if you go out of network

Who Can Join a Medicare Advantage Plan?

- Eligibility requirements
  - Enrolled in Medicare Part A (Hospital Insurance)
  - Enrolled in Medicare Part B (Medical Insurance)
  - Live in the plan's service area
- To join you must also
  - Provide necessary information to the plan
  - Follow the plan's rules
- Can only belong to one plan at a time

06/01/2015 Understanding Medicare 81

Medicare Advantage (MA) Plans are available to most people with Medicare. To be eligible to join a MA Plan you must be enrolled in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). You must also live in the plan's geographic service area.

To join an MA Plan, you must also agree to

- Provide the necessary information to the plan, such as your Medicare number, address, date of birth, and other important information
- Follow the plan's rules

You can only belong to one MA Plan at a time

To find out which MA Plans are available in your area, visit Medicare.gov and click "Find Health and Drug Plans," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

When You Can Join or Switch Medicare Advantage Plans

Initial Enrollment Period	▪ 7-month period begins 3 months before the month you turn 65 ▪ Includes the month you turn 65 ▪ Ends 3 months after the month you turn 65
Medicare Open Enrollment Period "Open Enrollment"	▪ October 15–December 7 ▪ Coverage begins January 1
Medicare due to a Disability	▪ 7-month period begins 3 months before the 25th month of disability. ▪ Ends 3 months after the 25th month of disability.

▪ Plans must be allowing new members to join

06/01/2015 Understanding Medicare 82

You can join a Medicare Advantage (MA) Plan during the following times:

- the When you first become eligible for Medicare, i.e., during your Initial Enrollment Period, which begins 3 months immediately before your first entitlement to both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance)
- During Medicare Open Enrollment Period (OEP)

You can switch to another MA Plan or to Original Medicare during the OEP, also known as the Annual Enrollment Period. This period runs from October 15 through December 7 each year, with coverage starting January 1.

If you get Medicare due to a disability, you can join during the 7-month period that begins 3 months before your twenty fifth month of disability and ends 3 months after your twenty fifty month of disability.

You can only join one MA Plan at a time, and enrollment in a plan is generally for a calendar year.

Plans must be allowing new members to join. Plans may be prohibited from accepting new members if there is a Centers for Medicare & Medicaid Services (CMS)—approved capacity limit or a CMS-issued enrollment sanction in effect.

When You Can Join or Switch Plans

Special Enrollment Periods (SEP)	▪ Move out of your plan's service area ▪ Plan leaves Medicare program or reduces its service area ▪ Leaving or losing employer or union coverage ▪ You enter, live at, or leave a long-term care facility ▪ You have a continuous SEP if you qualify for Extra Help ▪ Losing your Extra Help status ▪ You join or switch to a plan that has a 5-star rating ▪ Retroactive notice of Medicare entitlement ▪ Other exceptional circumstances

06/01/2015 Understanding Medicare 83

You may be able to join or switch plans if any of these special circumstances that grant a Special Enrollment Period (SEP) apply to you:

- Move out of your plan's service area
- Are enrolled in a plan that decides to leave the Medicare program or reduce its service area at the end of the year
- Leave or are losing employer or union coverage
- Enter, live at, or are leaving a long-term care facility
- Qualify for Extra Help (you have a continuous SEP, meaning you can enroll in or switch your plan at any time)
- Lose your Extra Help status
- Join or switch to a plan that has a 5-star rating
- Receive notice of retroactive Medicare entitlement
- Other exceptional circumstances

NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in a Medicare Advantage Plan, or Original Medicare and a Medigap policy. More information about conditions that allow an exception can be found in Chapter 2 of the "Medicare Managed Care Manual," Section 30.4 at CMS.gov/medicare/health-plans/healthplansgeninfo/downloads/mc86c02.pdf.

When You Can Join or Switch Medicare Advantage Plans

5-Star Special Enrollment Period (SEP)

- Can enroll in 5-star Medicare Advantage (MA), Prescription Drug Plan (PDP), Medicare Advantage Plan with prescription drug coverage (MA-PD), or Cost Plan
- Enroll once yearly from December 8–November 30
- New plan starts first day of month after enrolled
- Star ratings given once per year
  - Ratings assigned in October and effective January 1
  - Use Medicare Plan Finder to see star ratings
    - Look at Overall Plan Rating to find eligible plans

06/01/2015 Understanding Medicare 84

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 stars. A 5-star rating is considered excellent.

You can use the 5-star Special Enrollment Period (SEP) to enroll in a 5-star Medicare Advantage (MA)—only Plan, a 5-star MA Plan with prescription drug coverage (MA-PD), a 5-star Medicare Prescription Drug Plan (PDP), or a 5-star Cost Plan, as long as you meet the plan's enrollment requirements (for example, living within the service area). If you're currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

The Centers for Medicare & Medicaid Services (CMS) also created a coordinating SEP for prescription drug plans. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a prescription drug plan, if that combination is allowed under CMS rules.

You may use the 5-star SEP to change plans one time each year between December 8–November 30. Once you enroll in a 5-star plan, your SEP ends for that year and you're allowed to make changes only during other appropriate enrollment periods. Your enrollment will start the first day of the month following the month in which the plan gets your enrollment request.

Plans get their star ratings in October each year. Although CMS assigns the plan star ratings in October, plans won't actually have the rating effective until January 1. To find star rating information, visit the Medicare Plan Finder at Medicare.gov/find-a-plan. Look for the Overall Plan Rating to identify 5-star plans that you can change to during this SEP. The "Medicare & You" handbook doesn't have the full, updated ratings for this SEP.

NOTE: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that doesn't. You'll have to wait until the next applicable enrollment period to get coverage and may have to pay a penalty.

When You Can Leave Medicare Advantage Plans

January 1 – February 14

- You can leave a Medicare Advantage (MA) Plan
- Switch to Original Medicare
  - Coverage begins first day of month after switch
  - May join Part D Plan
    - Drug coverage begins first day of month after plan gets enrollment
- May not join another MA Plan during this period
- May be able to buy a Medigap (Medicare Supplement Insurance) policy

06/01/2015 Understanding Medicare 85

If you belong to a Medicare Advantage (MA) Plan or Medicare Advantage with Prescription Drug (MA-PD) Plan, you can switch to Original Medicare from January 1 through February 14. If you go back to Original Medicare during this time, plan coverage will take effect on the first day of the calendar month following the date on which the election or change was made.

To disenroll from an MA Plan and return to Original Medicare during this period, you can

- Make a request directly to the MA organization.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you make this change, you may also join a Medicare Prescription Drug Plan to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

If you leave an MA Plan you may, or may not, be able to buy a Medigap (Medicare Supplement Insurance) policy. It will depend on your individual circumstances. Certain federal rights may apply. States may provide additional protections. You can buy a Medigap policy any time a plan will sell you one. See slide 15 for more information.

You may not join another MA Plan during this period. It's important to remember that anytime you enroll in a new MA, MA-PD, or Prescription Drug Plan, it will automatically disenroll you from your previous plan. This includes MA-only Health Maintenance Organization and Preferred Provider Organization plans. However, there are limited exceptions for members of MA-only Private Fee-for-Service, Cost and Medicare Medical Savings Account Plans. Once enrolled, coverage begins the first of the month after the plan gets the enrollment form.

Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan
- Private Fee-for-Service
- Medicare Medical Savings Account

06/01/2015 Understanding Medicare 86

Medicare Advantage Plans include

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan
- Private Fee-for-Service
- Medicare Medical Savings Account

Other Medicare Plans

- Other types of Medicare health plans that provide health care coverage aren't part of Medicare Advantage
  - But are still part of Medicare
  - Some provide Part A and/or Part B coverage
  - Some provide Medicare prescription drug coverage
- Examples include Medicare Cost Plans, Innovation Projects and Pilot Programs, and Medicare Program of All-inclusive Care for the Elderly (PACE) Plans

06/01/2015 Understanding Medicare 87

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage (MA) Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Medicare prescription drug coverage (Part D). These plans have some of the same rules as MA Plans. Some of these rules are explained briefly on the next few slides. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details. Examples include Medicare Cost Plans, Innovation Projects and Pilot Programs, and Medicare Program of All-inclusive Care for the Elderly (PACE) plans.

NOTE: Additional details are provided in Module 11, "Medicare Advantage Plans" at CMS.gov/Outreach-and-Education/Training/ CMSNationalTrainingProgram/Training-Library-Items/ CMS1241850.html.

Check Your Knowledge—Question 5

Most people are no longer required to pay a monthly Medicare Part B premium while enrolled in a Medicare Advantage Plan.

a. True

b. False

06/01/2015 Understanding Medicare 88

Check Your Knowledge—Question 5

Most people are no longer required to pay a monthly Medicare Part B premium while enrolled in a Medicare Advantage (MA) Plan.

a. True

b. False

ANSWER: b. False
If you join a Medicare Advantage (MA) Plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2015 is $104.90 for most people.

- A few plans may pay all or part of the Part B premium for you.
- Some people may be eligible for state assistance.

Lesson 3—Rights and the Appeals Process

- Patient rights
- Appeals process
  - Part A and Part B (Original Medicare)
    - Medigap Rights
  - Part C (Medicare Advantage)
  - Part D (Medicare Prescription Drug Coverage)

06/01/2015 Understanding Medicare 89

Lesson 3, "Rights and the Appeals Process," provides an overview of your Medicare rights and the process for appealing certain decisions.

- Patient rights
- Appeals process
  - Part A and Part B (Original Medicare)
  - Medigap rights
  - Part C (Medicare Advantage)
  - Part D (Medicare Prescription Drug Coverage)

NOTE: Module 2, "Rights and Protections" describes this topic in more detail at CMS.gov/Outreach-and-Education/Training/ CMSNationalTrainingProgram/Training-Library.html.

Medicare Guaranteed Rights

- Specific rights in
  1. Original Medicare
  2. Medicare Advantage and other Medicare health plans
  3. Medicare Prescription Drug Plans
- In general, these rights
  - Protect you when you get health care
  - Protect you against unethical practices
  - Make sure you get medically necessary services
  - Protect your privacy

06/01/2015 Understanding Medicare 90

"Medicare Rights" explains that no matter how you get your Medicare, you have certain guaranteed rights and protections. We'll provide information on additional rights that are specific to how you choose to get your Medicare coverage.

1. Original Medicare
2. Medicare Advantage and other Medicare health plans
3. Medicare Prescription Drug Coverage

Your Medicare rights and protections are designed to

- Protect you when you get health care
- Protect you against unethical practices
- Make sure you get the medically necessary health care services that the law says you can get
- Protect your privacy

Your Medicare Rights

You have the right to

- Be treated with dignity and respect
- Be protected from discrimination
  - Race, color, or national origin
  - Sex
  - Age
  - Disability
- If you think you haven't been treated fairly, visit HHS.gov/ocr
  - Call the Office for Civil Rights at 1-800-368-1019
  - TTY users should call 1-800-537-7697

06/01/2015 Understanding Medicare 91

If you have Medicare, you have the right to be

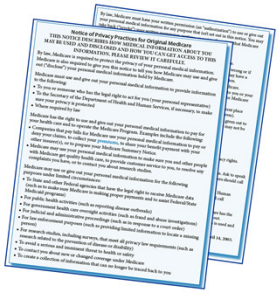
- Treated with dignity and respect at all times
- Protected from discrimination
  - Discrimination is against the law. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your
    - Race, color, or national origin
    - Sex
    - Age
    - Disability

These protections are generally limited to complaints of discrimination filed against providers of health care and social services who get federal financial assistance.

If you think you haven't been treated fairly for any of these reasons, call the U.S. Department of Health and Human Services, Office for Civil Rights, at 1-800-368-1019. TTY users should call 1-800-537-7697. For more information, visit HHS.gov/ocr.

“Notice of Privacy Practices for Original Medicare”

- Tells you how Medicare
  - Must protect the privacy of your personal health information
  - Uses and discloses your personal medical information
- Describes your rights and how you can exercise them
- Published annually in the “Medicare & You” handbook
- For more information
  - Visit Medicare.gov
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048



06/01/2015 Understanding Medicare 92

Medicare is required to protect your personal medical information. The “Notice of Privacy Practices for Original Medicare” describes how Medicare uses and gives out your personal health information and tells you your individual rights. If you’re enrolled in a Medicare Advantage Plan or other Medicare health plan, or in a Medicare Prescription Drug Plan, your plan materials describe your privacy rights.

The “Notice of Privacy Practices” is published annually in the “Medicare & You” handbook at Medicare.gov/medicare-and-you.

To learn more about the “Notice of Privacy Practices” for Original Medicare, visit Medicare.gov/forms-help-and-resources/privacy-practices/privacy.html.

For more information, go to Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Who's the Medicare Beneficiary Ombudsman?

- An ombudsman is a person who reviews complaints and helps resolve them
- The Medicare Beneficiary Ombudsman help make sure information is available about
  - Medicare coverage
  - Making good health care decisions
  - Medicare rights and protections
  - Getting issues resolved
- The Ombudsman reviews the concerns raised by people with Medicare
- The Ombudsman reports yearly to Congress

06/01/2015 Understanding Medicare 93

An ombudsman is a person who reviews complaints and helps resolve them.

The Medicare Beneficiary Ombudsman helps make sure information is available about

- Medicare coverage
- Making good health care decisions
- Medicare rights and protections
- Getting issues resolved

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE and through your State Health Insurance Assistance Program (SHIP).

Visit Medicare.gov for information on inquiries and complaints, activities of the Ombudsman, and what people with Medicare need to know.

The Ombudsman reports yearly to Congress.

Medicare Rights—Claims and Appeals

You have the right to

- Have a claim for payment filed with Medicare
- Get decisions about
  - Health care payment
  - Coverage of services
  - Prescription drug coverage
- Get an appeal (review) of the decisions above

06/01/2015 Understanding Medicare 94

If you have Medicare, you have the right to the following:

- Have a claim for payment filed with Medicare and get a decision about health care payment, coverage of services, or prescription drugs, even when your doctor says that Medicare won't pay for a certain item or service.
  - When a claim is filed, you get a notice from Medicare letting you know what will and won't be covered. This might be different from what your doctor says. If you disagree with Medicare's decision on your claim, you have the right to appeal.
- Appeal if you disagree with a decision about your health care payment, coverage of services, or prescription drug coverage.
  - For more information about appeals, visit Medicare.gov/appeals.
  - For help with filing an appeal, call the State Health Insurance Assistance Program (SHIP) in your state. To get the most up-to-date SHIP phone numbers, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.

Medicare Grievance Rights

You have the right to

- File complaints (also called grievances) about
  - Services you got
  - Other concerns or problems getting health care and quality of care
    - In Original Medicare, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
    - In Medicare Advantage or other Medicare health plan, call your plan, the BFCC-QIO, or both
    - If you have End-Stage Renal Disease (ESRD), call the ESRD network in your state

06/01/2015 Understanding Medicare 95

If you have Medicare, you have the right to the following:

- To file complaints (also called grievances) about services you got, other concerns or problems you have in getting health care, and the quality of the health care you received.
- If you're concerned about the quality of care you're getting
  - In Original Medicare, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your region to file a complaint. Visit Medicare.gov/contacts to get your BFCC-QIO's phone number, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - In a Medicare Advantage or other Medicare health plan, call the BFCC-QIO, your plan, or both.
  - If you have End-Stage Renal Disease (ESRD) and have a complaint about your care, call the ESRD network in your state. To get the phone number, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

NOTE: The next slide displays a map of the BFCC-QIOs by region.

Medigap Rights in Original Medicare

- Buy a private Medigap (Medicare Supplement Insurance) policy
  - Guaranteed issue rights in your Medigap Open Enrollment Period ensure insurance companies
    - Can't deny you Medigap coverage
    - Can't place conditions on coverage
    - Must cover pre-existing conditions
    - Can't charge more because of past or present health problems
  - Some states give additional rights

06/01/2015 Understanding Medicare 96

A Medigap (Medicare Supplement Insurance) policy is a health insurance policy sold by private insurance companies to fill the gaps in Original Medicare coverage, like coinsurance amounts.

Your rights when you're enrolled in Original Medicare include the following:

- In some situations, you have the right to buy a Medigap policy.
  - Medigap policies must follow federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."
  - Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a standardized Medigap policy. These policies are identified by the letters A, B, C, D, F, G, K, L, M, and N. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
- You have the right to buy a Medigap policy during your Medigap Open Enrollment Period, a 6-month period that automatically starts the month you're 65 and enrolled in Medicare Part B, and once it's over, you can't get it again.
- When you have guaranteed issue rights, the Medigap policy
  - Can't deny you Medigap coverage or place conditions on your policy
  - Must cover you for pre-existing conditions
  - Can't charge you more for a policy because of past or present health problems
- Some states offer additional rights to purchase Medigap policies.

NOTE: Module 3, "Medigap (Medicare Supplement Insurance)," describes these situations at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

Coverage and Appeal Rights in Medicare Health Plans

You have the right to

- Know how your doctors are paid
- Get a coverage decision or coverage information
- A fair, efficient, and timely appeals process
  - Five levels of appeal
  - Decision letter sent explaining further appeal rights
  - Automatic review of Part C plan reconsideration
    - By Independent Review Entity (IRE)
- File a grievance about concerns or problems

06/01/2015 Understanding Medicare 97

If you're in a Medicare health plan, you have the right to

- Know how your doctors are paid. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- Find out from your plan, before you get a service or supply, if it'll be covered. You can call your plan to get information about the plan's coverage rules.
- A fair, efficient, and timely appeals process to resolve differences with your plan. You have the right to ask your plan to provide or pay for an item or service you think should be covered, provided, or continued.
  - The appeals process consists of 5 levels.
  - If coverage is denied at any appeal level, you'll get a letter explaining the decision and instructions on how to proceed to the next appeal level.
  - If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C (Medicare Advantage) Independent Review Entity.
- File a grievance about other concerns or problems with your plan, check your plan's membership materials, or call your plan to find out how to file a grievance.

See "Medicare Rights & Protections" (CMS Product No. 11534) for more details at Medicare.gov/publications/pubs/pdf/11534.pdf.

Requesting Part D Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, you must make your appeal requests in writing
  - Plans must accept verbal expedited (fast) requests
  - Limited timeframe to file an appeal request (within 60 days or later with good cause)
- An appeal can be requested by
  - You or your appointed representative
  - Your doctor or other prescriber
- There are 5 levels of appeals

06/01/2015 Understanding Medicare 98

If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully and call your plan if you have questions. Most appeals must be requested within 60 days of the coverage determination or denial of an exception. However, this timeframe may be extended for good cause (a circumstance that kept the party from making the request on time or whether any actions by the plan may have misled the party). For more information on good cause, see Chapter 18 of the Prescription Drug Benefit Manual "Part D Enrollee Grievances, Coverage Determinations, and Appeals," Section 70.3—"Good Cause Extension" at CMS.gov/medicare/appeals-and-grievances/ medprescriptdrugapplgriev/index.html.

In general, you must make your appeal requests in writing. However, plans must accept verbal expedited (fast) redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials, or contact your plan to see if you can make verbal standard redetermination requests.

You or your appointed representative (see Appendix F) may ask for any level of appeal. Your doctor or other prescriber can only ask for a redetermination or Independent Review Entity reconsideration (level 1 or 2 appeal) on your behalf without being your appointed representative.

Check Your Knowledge—Question 6

An appeal is related to

a. The quality of the services you received
b. A coverage and/or payment decision
c. A payment decision
d. The health care you received

Check Your Knowledge—Question 6

An appeal is related to

a. The quality of the services you received

b. A coverage and/or payment decision

c. A payment decision

d. The health care you received

ANSWER: b. A coverage and/or payment decision

An appeal is the action you should take if you disagree with a coverage or payment decision (for example, if you think Medicare should have paid but didn't, or didn't pay enough; a Medicare health plan denied a needed service; or a Medicare drug plan didn't cover a prescription drug).

Lesson 4—Programs for People With Limited Income and Resources

- Differences between Medicare and Medicaid
- Medicaid
- Children's Health Insurance Program (CHIP)
- Medicare Savings Programs
- Extra Help
- Help available for people in the United States territories

06/01/2015 Understanding Medicare 100

Lesson 4, "Programs for People With Limited Income and Resources," explains differences between Medicare and Medicaid and provides an overview of the following:

- Extra Help
- Medicaid and the Children's Health Insurance Program (CHIP)
- Medicare Savings Programs
- Help available for people who live in the U.S. territories

What Is Medicaid?

- Federal-state health insurance program
  - For people with limited income/resources
  - Covers most health care costs
    - If you have both Medicare and Medicaid
- Eligibility determined by state
- Application processes and benefits vary
- State office names vary
  - Apply if you MIGHT qualify
- Children's Health Insurance Program (CHIP)
  - Covers uninsured children up to age 19 and may cover pregnant women when
    - Family income too high for Medicaid

06/01/2015 Understanding Medicare 101

Medicaid is a program that helps pay medical costs for some people with limited income and resources. Medicaid is jointly funded by the federal and state governments and is administered by each state. It can cover pregnant women and children; aged, blind, and disabled people; and some other groups, depending on the state.

If you're eligible for both Medicare and Medicaid, most of your health care costs are covered; we sometimes refer to these people as "dually eligible." People with both Medicare and Medicaid get drug coverage from Medicare, not Medicaid. People with Medicaid may get coverage for services that aren't fully covered by Medicare, such as nursing home care and home health care.

Medicaid eligibility is determined by each state, and Medicaid application processes and benefits vary from state to state. You should contact your State Medical Assistance Office to see if you qualify.

You should apply if you think you MIGHT qualify. For more information or to apply, you can call

- 1-800-MEDICARE (TTY users should call 1-877-486-2048)
- Your State Health Insurance Assistance Program
- Or visit your State Medical Assistance (Medicaid) Office

NOTE: Module 12, "Medicaid," describes this topic in more detail at CMS.gov/Outreach-and-Education/Training/ CMSNationalTrainingProgram/Training-Library.html.

To also see "Federal Policy Guidance," visit Medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

Medicare Savings Programs

- Help from Medicaid paying Medicare costs
  - For people with limited income and resources
- Often higher income and resources than full Medicaid
- Programs include
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-income Medicare Beneficiary (SLMB)
  - Qualifying Individual (QI)
  - Qualified Disabled & Working Individuals (QDWI)

06/01/2015 Understanding Medicare 102

States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than full Medicaid. These programs are collectively called Medicare Savings Programs, and include the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.

Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the federal poverty level.

Medicare beneficiaries who are interested in qualifying for financial "extra help" with the Medicare Part D Prescription Drug plans should visit SocialSecurity.gov/i1020.
Many states figure your income and resources differently, so you may qualify in your state even if your income or resources are higher than the amounts listed above. If you have income from working, you may qualify for benefits even if your income is higher than the limits above. Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs.

Contact your State Health Insurance Assistance Program (SHIP) to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting Medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

NOTE: For annual updates, visit Social Security Administration Program Operations Manual System (POMS) at https://secure.ssa.gov/apps10/poms.nsf/Home?readform. For more information, visit "Getting Help with your Medicare Costs" at Medicare.gov/Pubs/pdf/10126.pdf.

What Is Extra Help?

- Program to help people pay for Medicare prescription drug costs (Part D)
  - Also called the low-income subsidy
- If you have lowest income and resources
  - Pay no premiums or deductible, and small or no copayments
- If you have slightly higher income and resources
  - Pay reduced deductible and a little more out of pocket
- No coverage gap or late enrollment penalty if you qualify for Extra Help

06/01/2015 Understanding Medicare 103

The Federal Poverty Level (FPL) guidelines updated annually in late January (ASPE.hhs.gov/poverty/15poverty.cfm) determine the income level requirements for people applying for the Medicare Part D Low-Income Subsidy (LIS) program, also known as the "Extra Help" program. If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs.

If you have the lowest income and resources, you'll pay no premiums or deductible, and have small or no copayments. If you have slightly higher income and resources, you'll have a reduced deductible and pay a little more out-of-pocket.

If you qualify for Extra Help, you won't have a coverage gap or late enrollment penalty. You'll also have a continuous special enrollment period and can switch plans at any time, with the new plan going into effect the first day of the next month.

It's easy and free to apply for "Extra Help." You or a family member, trusted counselor, or caregiver can apply online at socialsecurity.gov/i1020 or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

NOTE: Residents of U.S. territories aren't eligible for Extra Help. Each of the territories helps its own residents with Medicare drug costs. This help is generally for residents who qualify for and are enrolled in Medicaid. This assistance isn't the same as Extra Help.

See Guide to Consumer Mailings (Social Security LIS and MSP Outreach Notice), which are issued in mid-May and late November CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/2014Mailings.pdf.

Qualifying for Extra Help

- You automatically qualify for Extra Help if you get
  - Full Medicaid coverage
  - Supplemental Security Income (SSI)
  - Help from Medicaid paying your Medicare premiums
- All others must apply
  - Online at socialsecurity.gov
  - Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)
    - Ask for "Application for Help with Medicare Prescription Drug Plan Costs" (SSA-1020)
  - Contact your state Medicaid agency

06/01/2015 Understanding Medicare 104

You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get full Medicaid coverage, Supplemental Security Income (SSI) benefits, or help from Medicaid paying your Medicare Part B premiums (Medicare Savings Program). Medicare will provide "Extra Help" that may cover 85% to 100% of prescription costs, and may also pay a part or all of your Medicare Part D premiums.

If you don't meet one of the above conditions, you may still qualify for Extra Help, but you'll need to apply for it. If you think you qualify but aren't sure, you should still apply. You can apply for Extra Help at any time, and if you're denied, you can reapply if your circumstances change. Eligibility for Extra Help may be determined by either Social Security or your state Medicaid agency.

You may qualify for extra help in 2015, if your yearly income is below $17,505 for a single person (or $23,595 for a married couple living together or even more if you have dependent children or grandchildren living with you), AND if your assets are below $13,440 for a single person (or $26,860 if you are married). These amounts may change each year. The poverty guidelines may be used as soon as they're published in the *Federal Register* each year — usually in late January. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents living with you). You can apply for Extra Help by completing a paper application you can get by calling Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also apply online at http://www.ssa.gov/medicare/prescriptionhelp/cms.html; you may also apply through your state Medicaid agency, or by working with a local organization, such as your State Health Insurance Assistance Programs.

Steps to Take

- If you think you might qualify for any of these programs
  1. Review the income and asset guidelines
  2. Collect your personal documents
  3. Get more information
     - Call your state Medical Assistance office
     - Call your local State Health Insurance Assistance Program
     - Call your local Area Agency on Aging
  4. Complete application with state Medical Assistance office

06/01/2015 Understanding Medicare 105

Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses.

1. Review the income and resource (or asset) guidelines for your area.
2. If you think you may qualify, collect the personal documents the agency requires for the application process. You will need
   - Your Medicare card
   - Proof of identity
   - Proof of residence
   - Proof of any income, including pension checks, Social Security payments, etc.
   - Recent bank statements
   - Property deeds
   - Insurance policies
   - Financial statements for bonds or stocks
   - Proof of funeral or burial policies
3. You can get more information by contacting your state Medical Assistance office, your local State Health Insurance Assistance Program, or your local Area Agency on Aging.
4. Complete an application with your state Medical Assistance office.

Programs in U.S. Territories

- Help people pay their Medicare costs
- U.S. territories
  - Puerto Rico
  - Virgin Islands
  - Guam
  - Northern Mariana Islands
  - American Samoa
- Programs vary
  - Contact Medical Assistance office

06/01/2015 Understanding Medicare 106

There are also programs available to help people with limited income and resources who live in the U.S. territories—Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa—pay their Medicare costs. Programs vary in these areas. Contact the Medical Assistance office in the territory for more information.

NOTE: If none of these territories are in your area, you may wish to hide this slide.

Check Your Knowledge—Question 7

Medicare Savings Programs frequently have higher income and resource limits than Medicaid.

a. True

b. False

06/01/2015 Understanding Medicare 107

Check Your Knowledge—Question 7

Medicare Savings Programs frequently have higher income and resource limits than Medicaid.

a. True

b. False

ANSWER: a. True

Medicare Savings Programs help pay out-of-pocket costs for people who have limited income and resources and frequently have higher income and resource limits than Medicaid.

Lesson 5—Medicare and the Health Insurance Marketplace

- Marketplace and People with Medicare
- Marketplace and Becoming Eligible for Medicare
- Enrollment Considerations

06/01/2015 Understanding Medicare 108

Lesson 5, “Medicare and the Health Insurance Marketplace,” provides information for people aging into Medicare or who qualify for Medicare based on a disability.

Marketplace and People With Medicare

- Medicare isn't part of the Marketplace
- If you have Medicare you don't need to do anything related to the Marketplace
  - Your benefits don't change because of the Marketplace
  - No one can sell you a Marketplace plan
    - Even if you have only Medicare Part A and/or Part B
    - Except an employer through the Small Business Health Options Program (SHOP) if you're an active worker or dependent of an active worker
      - The SHOP employer coverage may pay first
      - No late enrollment penalty if you delay Medicare
        - Doesn't include COBRA coverage
- The Marketplace doesn't offer Medigap or Part D plans

06/01/2015 Understanding Medicare 109

Medicare isn't a part of the Health Insurance Marketplace. Medicare Part A provides minimum essential coverage. If you have Medicare, you don't have to do anything related to the Marketplace. The Marketplace doesn't change your Medicare plan choices or your benefits. Medicare plans and Medigap (Medicare Supplement Insurance) policies aren't available in the Marketplace. It's against the law for someone who knows that you have Medicare to sell or issue you a Marketplace policy. This is true even if you have only Medicare Part A or only Part B. The exception is coverage from your employer through the Small Business Health Options Program. If you receive your coverage this way

- The Small Business Health Options Program (SHOP) employer coverage may pay first
- You could delay Medicare enrollment without a penalty
  - This doesn't include COBRA coverage

The Marketplace doesn't offer Medigap (Medicare Supplement Insurance) policies or Medicare Part D plans.

Marketplace and Becoming Eligible for Medicare

- You can keep a Marketplace plan after your Medicare coverage begins
  - You may cancel the plan when Medicare coverage starts, or
  - Once your Part A coverage starts **you *won't* be able to get lower costs for your Marketplace plan**
- Sign up for Medicare during your Initial Enrollment Period
  - Or, if you enroll later, you may have to pay a late enrollment penalty for as long as you have Medicare
  - The Individual Marketplace isn't employer-sponsored coverage
    - You won't be able to enroll in Part B later using the Special Enrollment Period

06/01/2015 Understanding Medicare 110

You can keep a Marketplace plan to cover you after you're eligible for Medicare. You can then cancel the Marketplace plan once your Medicare coverage starts.

Once you're eligible for Medicare, you'll have an Initial Enrollment Period (IEP) to sign up. For most people, their 7-month Medicare IEP starts 3 months before their 65th birthday and ends 3 months after their 65th birthday.

In most cases it's to your advantage to sign up when you're first eligible because

- Once your Medicare starts, you won't be able to get lower costs for a Marketplace plan based on your income.
- If you enroll in Medicare after your IEP, you may have to pay a late enrollment penalty for as long as you have Medicare.

If you have individual Marketplace coverage and only enroll in Part A during your IEP, you won't be able to enroll in Part B later using the Special Enrollment Period. The Individual Marketplace isn't employer-sponsored coverage.

Once your Part A coverage starts, any premium tax credits and reduced cost-sharing you may've qualified for through the Marketplace will stop. That's because Part A is considered minimum essential coverage, not Part B.

NOTE: You may have Medicare and Marketplace coverage concurrently, only if you had your Marketplace coverage before you had Medicare. It's against the law for someone who knows you have Medicare to sell you a Marketplace plan. There is no coordination of benefits (COB) between a Qualified Health Plan(QHP) and Medicare. You need to be aware of this if you decide to remain in a QHP after enrolling into Part A. It isn't a secondary insurance. Also, drug coverage in QHP may not be creditable and a penalty may result if you sign up for Part D later.

If You Have a Marketplace Plan First and Then Get Medicare Coverage

- You lose eligibility for any premium tax credits and/or reduced cost sharing for your Marketplace plan
- If you choose to drop your Marketplace plan, wait until you're covered by Medicare to avoid a gap in coverage
  - Depending on your income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments
  - You may also be able to buy a Medigap (Medicare Supplement Insurance) policy or join a Medicare Advantage Plan (like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO))

06/01/2015 Understanding Medicare 111

You can get a Marketplace plan to cover you before your Medicare begins. You can then cancel the Marketplace plan once your Medicare coverage starts. However, it's important that you time the end of your Marketplace plan so that it doesn't end before your Medicare coverage begins, or you could have a gap in coverage.

Once you're eligible for Medicare, you'll have an Initial Enrollment Period to sign up. In most cases it's to your advantage to sign up when you're first eligible because once you're getting Medicare, you won't be able to get lower costs for a Marketplace plan based on your income like premium tax credits and reduced cost-sharing (except if you only have Part B).

If you have limited income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments.

Choosing Marketplace Instead of Medicare

- The Individual Marketplace isn't employer-sponsored coverage
- You can't choose Marketplace coverage instead of Medicare unless
  1. You pay or you'd have to pay a Part A premium
     - You can drop Part A and Part B and may be eligible to get a Marketplace plan
  2. You have a medical condition that qualifies you for Medicare (like ESRD) but haven't applied for Medicare
  3. You're not yet collecting Social Security retirement or disability benefits before you're eligible for Medicare

06/01/2015 Understanding Medicare 112

It's against the law for someone who knows you have Medicare to sell you a Marketplace plan policy. You can choose Marketplace coverage instead of Medicare if you

- Would have to pay a premium for Part A, you can drop your Part A and Part B coverage and get a Marketplace plan instead.
- Only have Part B and would have to pay a premium for Part A, you can drop Part B and get a Marketplace plan instead.
- Have a medical condition that qualifies you for Medicare, like End-Stage Renal Disease (ESRD), but haven't applied for Medicare coverage
- Aren't yet collecting Social Security retirement or disability benefits before you're eligible for Medicare

Before choosing a Marketplace plan over Medicare, there are 2 important points to consider:

1. If you enroll in Medicare after your Initial Enrollment Period (IEP) ends, you may have to pay a late enrollment penalty (LEP) for as long as you have Medicare.
2. Generally you can enroll in Medicare only during the Medicare General Enrollment Period (from January 1 to March 31). Your coverage won't begin until July of that year.

If you don't have or dropped Medicare Part A because you have to pay a premium, and instead enroll in a Marketplace plan, you'd be eligible for the premium tax credit and cost-sharing reductions, assuming that you meet the eligibility requirements for those programs.

REMEMBER: If you choose to enroll in Medicare later and keep your Qualified Health Plan (QHP) coverage, generally there's no coordination of benefits between a Marketplace plan and Medicare. You need to be aware of this, if you decide to remain in a QHP after enrolling into Medicare. Marketplace plans aren't secondary insurance. In fact, the QHP isn't required to pay any costs toward your coverage if you have Medicare.

Medicare for People With Disabilities and the Marketplace

- You may qualify for Medicare based on a disability
  - You must be entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
    - On the 25th month, you're automatically enrolled in Medicare Part A and Part B
- If you're getting SSDI, you can get a Marketplace plan to cover you during your 24-month waiting period
  - You may qualify for premium tax credits and reduced cost-sharing until your Medicare coverage starts

06/01/2015 Understanding Medicare 113

If you're entitled to Social Security Disability Insurance (SSDI), you may qualify for Medicare. However, there is a 24-month waiting period before Medicare coverage can start. During this waiting period, you can apply for coverage in the Marketplace. You can find out if you'll qualify for Medicaid or for premium tax credits that lower your monthly Marketplace plan premium, and cost-sharing reductions that lower your out-of-pocket costs.

If you apply for lower costs in the Marketplace, you'll need to estimate your income for 2015. If you're getting Social Security disability benefits and want to find out if you qualify for lower costs on Marketplace coverage, you'll need to provide information about your Social Security payments, including disability payments.

Your Medicare coverage is effective on the twenty fifth month of receiving SSDI. Your Medicare card will be mailed to you about 3 months before your twenty fifth month of disability benefits. If you don't want Part B, follow the instructions that are included with the card. However, once you're eligible for Medicare, you won't be able to get lower costs for a Marketplace plan based on your income.

Once your Part A coverage starts, any premium tax credits and reduced cost-sharing you may've qualified for through the Marketplace will stop. That's because Part A is considered minimum essential coverage, not Part B.

Also, remember, the QHP isn't required to pay any costs towards your coverage once you have Medicare.

Marketplace/Medicare Enrollment Considerations

- If you don't enroll in Medicare when you're first eligible (Initial Enrollment Period)
  - A late enrollment penalty may apply (lifetime)
  - You generally can't enroll until the Medicare General Enrollment Period (January 1 to March 31) and coverage won't start until July 1
- If your Marketplace plan isn't through your employer
  - And you must pay a premium for Part A, you would need to drop Part A and Part B to be eligible to get a Marketplace plan
  - However, if you're also receiving Social Security benefits, you would have to drop your Social Security if you drop Medicare

June 2015 Understanding Medicare 114

There are a few situations where you can choose a Marketplace private health plan instead of Medicare.

1. If you're paying a premium for Part A. In this case you can drop your Part A and Part B coverage and get a Marketplace plan instead. In the rare instance that you only have Part B, you also could drop it and get coverage in the Marketplace. If you're eligible for Medicare but haven't enrolled in it, this could be because
   - You'd have to pay a premium
   - You have a medical condition that qualifies you for Medicare, like End-Stage Renal Disease (ESRD), but haven't applied for Medicare coverage
   - You're not collecting Social Security retirement or disability benefits before you're eligible for Medicare
2. If you're getting Social Security retirement or disability benefits before you're eligible for Medicare, you'll automatically be enrolled in Medicare once you're eligible. Before choosing a Marketplace plan over Medicare, there are two important points to consider:
   - If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up (Note: If you're already receiving Social Security benefits prior to becoming eligible then you'll be automatically enrolled in Part A; no penalty would be applicable here). If you don't enroll in Part B when first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. You may owe a Part D late enrollment penalty if, at any time after your Initial Enrollment Period (IEP) is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage. Marketplace plans aren't required to provide creditable coverage. You may have to pay this penalty as long as you have Part D coverage.
   - Generally, if you miss your IEP, you can enroll in Medicare **only** during the Medicare General Enrollment Period (from January 1 to March 31 each year). Your coverage won't start until July. This may cause a gap in your coverage.

Employer coverage offered through the Small Business Health Options Program (SHOP) is treated like any other employer

coverage. Medicare Secondary Payer rules apply. “Medicare & the Health Insurance Marketplace,”

For more information, view the publication CMS Product No. 11694 at Medicare.gov/Pubs/pdf/11694.pdf.

Check Your Knowledge—Question 8

You can enroll in the Individual Marketplace instead of Part B and get Part B later using a Special Enrollment Period if you don't have coverage from current, active employment.

a. True

b. False

06/01/2015 Understanding Medicare 115

Check Your Knowledge—Question 8

You can enroll in the Individual Marketplace instead of Part B and get Part B later using a Special Enrollment Period (SEP).

a. True

b. False

Answer: a. False

If you delay enrolling in Part B and don't have employer-sponsored coverage based on current, active employment of you or your spouse, you aren't eligible to enroll using the SEP. The Individual Marketplace isn't employer-sponsored coverage.

Introduction to Medicare Resource Guide

Resources	Additional Resources	Medicare Products
Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) Medicare.gov CMS.gov Medicaid.gov **Social Security** 1-800-772-1213 1-800-325-0778 for TTY users SocialSecurity.gov/ **Railroad Retirement Board** 1-877-772-5772 1-312-751-4700 for TTY users RRB.gov/ Benefits.gov InsureKidsNow.gov	State Health Insurance Assistance Programs* *For phone numbers, call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users Medicare.gov/Contacts/ HealthCare.gov **Affordable Care Act** HealthCare.gov/law/full/index.html U.S. Department of Health and Human Services, Office for Civil Rights HHS.gov HHS.gov/ocr/office/index.html 1-800-368-1019 1-800-537-7697 for TTY users	**"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 **To access these products:** View and order single copies at Medicare.gov/publications Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.

CMS National Training Program (NTP)

To view all available NTP training materials, or to subscribe to our email list, visit

CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html

For questions about training products email

training@cms.hhs.gov

This training module is provided by the CMS National Training Program (NTP).

To view all available CMS NTP materials, including additional training modules, job aids, educational activities, and webinar and workshop schedules, or to subscribe to our email list, visit CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram. For questions about these training products, email training@cms.hhs.gov.