



MEDICARE 101

Understanding the basics of the Medicare program.



TABLE OF CONTENTS

Understanding the basics of the Medicare program.

- 01.//** The History of Medicare
- 05.//** What is Medicare? Who is Eligible?
- 13.//** Medigap Plans
- 17.//** Medicare Advantage (MA) Plans
- 25.//** Prescription Drug Plans
- 29.//** Interaction with Other Insurance



THE HISTORY OF MEDICARE

Since the beginning of the 20th century, health care issues have continued to escalate in importance for our nation. The Medicare Program has undergone changes since it was signed into Law in 1965. Beneficiaries were first able to sign up during July of 1966.

THE MEDICARE MILESTONE

Medicare History from 1965-2010

This timeline represents a brief overview of the changes and expansion of the Medicare Program throughout the years.

1965

Title XVIII of the Social Security Act established both Medicare and Medicaid. Medicare would provide health care insurance for older individuals. Medicaid would pay for medical assistance for certain individuals and families with limited resources.

1972

Congress expanded the Medicare Program to include certain individuals with disabilities and individuals determined to have End-Stage Renal Disease (ESRD).

2006

The voluntary Medicare Prescription Drug Program began.

2010

The Patient Protection and Affordable Care Act (PPACA or the Affordable Care Act) was signed into law, followed immediately by the enactment of the Health Care and Education Reconciliation Act. With regard to the Medicare program, these new laws will begin to close the Part D coverage gap or “donut hole,” change the way Medicare Advantage Plans are paid, reform payments under Original Medicare, eliminate deductibles, copayments, and other cost-sharing for preventive care, and provide free annual wellness check-ups starting in 2011.

The Affordable Care Act also creates a voluntary long-term care insurance program, which will provide a cash benefit to help seniors and people with disabilities obtain services and supports that will enable them to remain in their homes and communities.

1966

The Medicare Program began on July 1st, establishing health insurance coverage for persons age 65 or older. The program included Medicare Part A and Part B.

1997

With the enactment of the Balanced Budget Act (BBA), Medicare Part C health care options, called Medicare + Choice, were created for people with Medicare.

1977

The Health Care Financing Administration (HCFA) was created to effectively coordinate Medicare and Medicaid – the two largest health care programs in the United States. In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

2000

The SCHIP Benefits Improvement and Protection Act (BIPA) waived the 24-month waiting period before Medicare entitlement for persons with Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease) and who are eligible for Social Security disability benefits.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was signed into law making Medicare a more prevention-focused program and offering prescription drug coverage called Part D.

2008

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was signed into law. MIPPA affected mental health coverage under Medicare, improved coverage of preventive care services under Original Medicare and improved Medicare supplemental coverage.



WHAT IS MEDICARE AND WHO IS ELIGIBLE?



WHAT IS MEDICARE?

Medicare is a federal health insurance program for people age 65 or older, people of all ages with disabilities and people with End-Stage Renal Disease (ESRD) or ALS— Lou Gehrig’s Disease.

Medicare is made up of four parts: Part A (inpatient hospital insurance); Part B (outpatient insurance); Part C (Medicare Advantage Plans); and Part D (Prescription Drug Coverage).

WHO IS ELIGIBLE?

PEOPLE WHO ARE AT LEAST 65 YEARS OF AGE

- ▶ Worked 10 or more years in Medicare-covered employment, and paid (or spouse paid) Social Security for at least 40 quarters.
- ▶ Are citizens or permanent residents of the United States.
- ▶ Have been diagnosed with ESRD or ALS.

PEOPLE WHO ARE NOT YET 65 YEARS OF AGE

- ▶ After 24 months of Social Security Disability income.
- ▶ Have been diagnosed with ESRD or ALS.

IF YOU HAVE QUESTIONS ON ELIGIBILITY, CALL 1-800-MEDICARE.

ORIGINAL MEDICARE PLAN

People with Medicare are called beneficiaries. Beneficiaries can go to any doctor, supplier, hospital, or other facility that accepts Medicare and is accepting new Medicare beneficiaries.

Beneficiaries are responsible for the deductible and coinsurance for most services. The deductible is the amount a beneficiary must pay before Medicare begins to pay for services and supplies covered under the program. Coinsurance is the share of the cost for services that the beneficiary is responsible for after the deductible is met (normally a 20/80 percentage).

To help pay for some of the health care costs that the Original Medicare Plan doesn't cover, beneficiaries may choose to purchase Medicare supplemental health insurance (Medigap policy). They may also choose to enroll in a Medicare Prescription Drug Plan (Medicare Part D) to receive prescription drug benefits.

WHAT MEDICARE PART A AND PART B DON'T COVER

- ▶ Acupuncture
- ▶ Chiropractic services (except to correct a subluxation using manipulation of the spine)
- ▶ Cosmetic surgery
- ▶ Custodial care
- ▶ Dental care and dentures
- ▶ Eye care (routine exam), eye refractions, and most eyeglasses
- ▶ Routine foot care
- ▶ Health care while travelling outside the U.S.
- ▶ Hearing aids and exams for the purpose of fitting a hearing aid
- ▶ Hearing tests that haven't been ordered by a doctor
- ▶ Long-term care
- ▶ Orthopedic shoes (with few exceptions)
- ▶ Prescription drugs (most outpatient drugs aren't covered)
- ▶ Syringes or insulin, unless the insulin is used with an insulin pump

THE FOUR PARTS OF MEDICARE

PART A

(Inpatient Hospital Insurance)

Eligible individuals are automatically enrolled in Part A with no premium. Others apply to the program when they are eligible or pay a monthly premium if they have worked less than 40 quarters (or 10 years) in their lifetime.

COVERS

- Helps cover inpatient care in hospitals (includes critical access hospitals, inpatient rehabilitation facilities and long-term care hospitals)
- Helps cover skilled nursing facilities (not custodial or long-term care), hospice and home health care services.

DOES NOT COVER

- Physician services in the hospital, personal care items, private rooms (unless medically necessary), phone, television, and custodial care, such as assistance with eating, bathing and getting dressed.

LIMITATIONS

- There are some limitations on the number of hospital days covered for unusually long hospital stays. Days 1-90 are covered with days 90-150 covered only once in a lifetime. Providers must be accepted by Medicare and accepting new patients.

PART B

(Outpatient/Physician Insurance)

To obtain Part B an eligible individual must enroll at their Social Security office during a specific period and pay a premium that is determined by their annual income. If an individual does not enroll during that period he/she must pay a penalty when he/she does enroll.

COVERS

- Part B is voluntary and is designed to supplement Part A coverage.
- Helps cover doctor services, outpatient care and durable medical equipment (DME).
- Helps cover some preventive services to help maintain a person's health, now including an annual physical.

DOES NOT COVER

- Routine vision, alternative healthcare, routine hearing screening exams, routine chiropractic care, prescription drugs, first three pints of blood.

LIMITATIONS

- Part B only covers care for eyes, teeth or hearing when medically necessary. No coverage for custodial care, such as assistance with eating, bathing and getting dressed. No coverage outside the United States.

PART C

(Medicare Advantage Plans)

A way to get Medicare benefits through private companies approved by and under contract with Medicare.

COVERS

- Includes Part A, Part B and usually additional benefits Medicare doesn't cover (such as fitness benefits, chiropractic care, or vision and hearing benefits).
- Optional prescription drug coverage.
- Benefits that go beyond Original Medicare such as out-of-pocket maximums.

DOES NOT COVER

- Hospice Care (still provided by Original Medicare).
- It's important to review each plan carefully to see what they do and do not cover.

LIMITATIONS

- Coverage options vary by plan and plan type. It's important to review options carefully.

PART D

(Prescription Drug Coverage)

Voluntary plans that help cover prescription drug costs. Plans are available through private companies that contract with Medicare to provide coverage. Each plan can vary in cost and drugs covered. If an individual does not enroll during a specific period he/she must pay a penalty when he/she does enroll.

COVERS

- Part D is voluntary and is designed to supplement Part A and B coverage.
- All drugs mandated by Medicare.

DOES NOT COVER

- Drugs not on the Medicare formulary.
- Certain drugs that are covered under Part B.

LIMITATIONS

- Coverage options vary by plan and plan type. It's important to review options carefully.



MEDIGAP PLANS

MEDICARE SUPPLEMENTAL

Health Insurance

Medigap is Medicare supplemental health insurance sold by private insurance companies that helps pay some of the health care costs that the Original Medicare Plan doesn't cover. Beneficiaries must have Medicare Parts A and B in order to purchase a Medigap policy. If a beneficiary is enrolled in the Original Medicare Plan and has a Medigap policy, then Medicare and Medigap will each pay its share of covered health care costs. Medigap helps beneficiaries pay for their out-of-pocket costs, as well as other services not covered by Medicare.

How Medigap Works

Medigap only works with the Original Medicare Plan. Medigap policies **will not** work with Medicare Advantage (MA) Plans or other Medicare plans. Beneficiaries pay a monthly premium for Medigap insurance, and continue to pay their Part B Premium.

There are 12 standardized Medigap plans. Each plan has a different set of benefits and private insurance companies offer the plans of their choice.

Each type of Medigap policy offers the same basic benefits, no matter which insurance company sells it. Usually, the only difference between Medigap policies of the same type sold by different companies is the cost. Medigap policies must follow Federal and State law.

Some Medigap policies sold before 2006 included outpatient prescription drug benefits. Beneficiaries who still have this coverage and choose not to sign up for a Medicare Prescription Drug Plan may keep this policy that includes outpatient prescription drug coverage.

Medigap policies currently sold do not include prescription drug coverage. Individuals may enroll in a stand alone Medicare Prescription Drug Plan (Part D) for this coverage.

NOTE:

Beneficiaries who have other types of supplemental insurance, such as TRICARE for Life or through an employer or union, might not need to purchase a Medigap policy.

WHAT MEDIGAP PLANS COVER

The federal government has 10 different Medigap plans, named with letters from "A" to "N". (These letters have no relationship to the Medicare Part A,B,C, and D designations.) The different types vary in which gaps in coverage they fill. All policies with the same letter offer the same benefits. This chart shows standard benefits for each plan type.

BENEFITS COVERED	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Part A hospital coinsurance and 365 extra hospital days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part A deductibles		100%	100%	100%	100%	100%	50%*	75%*	50%*	100%
Part B coinsurance or copays	100%	100%	100%	100%	100%	100%	50%*	75%*	100%	100% except certain copays**
Part B annual deductible			100%		100%					
Part B excess charges					100%	100%				
Cost of blood transfusion (first 3 pints)	100%	100%	100%	100%	100%	100%	50%*	75%*	100%	100%
Cost of foreign travel emergency (up to the plan limits)			80%	80%	80%	80%			80%	80%
Hospice care coinsurance cost	100%	100%	100%	100%	100%	100%	50%*	75%*		
Preventive care coinsurance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%*	75%*	100%	100%
Yearly out-of-pocket limit (2010)	No limit	No limit	No limit	No limit	No limit	No limit	\$4,620	\$2,310	No limit	No limit

Note: Plan E, H, I and J are no longer offered to new enrollees.

*100% after you reach your yearly out of pocket limit

**\$20 copay for doctor visit and \$50 copay for ER visit.



MEDICARE ADVANTAGE (MA) PLANS

MEDICARE *Advantage (MA) Plans*

- ▶ Medicare Part A | Medicare Part B



ADDITIONAL *Benefits*

- ▶ Lower or no cost sharing
 - ▶ More preventive care
- ▶ Coverage of health care services not covered under Original Medicare



PRESCRIPTION *Drug Coverage*

- ▶ MA Plans usually have optional prescription drug coverage.

MEDICARE ADVANTAGE PLANS

Individuals can also receive their Part A and Part B Medicare benefits by joining a Medicare Advantage (MA) Plan, also referred to as Medicare Part C.

MA Plans provide Part A and Part B Medicare coverage, except hospice. All Medicare-covered services a MA Plan beneficiary receives while in hospice care are paid by the Original Medicare Plan.

In addition to Part A and Part B Medicare coverage, MA Plans often offer extra benefits such as vision, hearing, dental, and/or health and wellness programs and many include prescription drug coverage.

Many MA Plans will include Medicare prescription drug coverage at no extra charge.

In order to join a Medicare Advantage Plan, beneficiaries must:

- ▶ Be entitled to Part A and enrolled in Part B (note: beneficiaries must continue to pay their Part B premium)
- ▶ Permanently reside in the service area of the MA Plan; and
- ▶ Elect to enroll in a MA Plan during AEP or, if they qualify for a Special Enrollment Period.

Individuals who are age 64 may enroll in a MA plan three months before their month of birth, during their month of birth or three months following their month of birth. Individuals of any age who have been determined to have End-Stage Renal Disease (ESRD) are generally excluded from enrolling in MA Plans. However, individuals who develop ESRD after MA Plan enrollment may remain enrolled.

MA Plans generally have provider networks. Beneficiaries may have to see doctors in the plan's provider network or go to certain hospitals to get services. If members use providers who aren't in the network, they may have to pay the entire cost of the service.

If a beneficiary switches from the Original Medicare Plan to a Medicare Advantage Plan and also has a Medigap policy, they will not be able to use the Medigap policy to cover deductibles, copayments, or coinsurance while enrolled in the MA Plan. Also, when a beneficiary with a Medigap policy enrolls in a MA Plan, they are not automatically disenrolled from the Medigap policy. They must contact the Medigap carrier to request disenrollment. There is no benefit to having a MA plan and a Medigap plan.

TYPES OF MEDICARE ADVANTAGE PLAN

HMO, PPO, SNP, MSA

HEALTH MAINTENANCE ORGANIZATION
(HMO)

An **HMO Plan** is a type of MA Plan in which beneficiaries can generally only go to doctors, specialists, or hospitals that are part of the plan's network, except in an emergency.

MEDICAL SAVINGS ACCOUNT
(MSA)

A **Medical Savings Account (MSA) Plan** combines a high deductible health plan with a Medical Savings Account that beneficiaries can use to manage their health care costs. Once the deductible is met, the plan covers 100% of Part A and Part B costs. There are no premiums for MSAs. Beneficiaries must still pay a Part B premium. Prescription drugs are not covered in an MSA Plan, although enrollment in a prescription drug plan is permitted.

PREFERRED PROVIDER ORGANIZATION
(PPO)

A **PPO Plan** is a type of MA Plan that has a network of providers, but beneficiaries can also use out-of-network providers for covered services, usually for a higher cost.

SPECIAL NEEDS PLAN
(SNP)

A **Special Needs Plan (SNP)** is a type of MA Plan in which membership is limited to certain groups (or subsets) of Medicare beneficiaries, such as those in certain institutions (like a nursing home), those eligible for both Medicare and Medicaid, or those with certain chronic or disabling conditions.

HOW MEDICARE ADVANTAGE PLANS WORK

The System

- ▶ **Most Medicare Advantage Plans offer prescription drug coverage.**
- ▶ Beneficiaries may choose not to enroll in a MA drug plan, however penalties apply for late enrollment.
- ▶ **Cost, extra benefits, and rules vary by plan.**
- ▶ Some out-of-pocket costs may be higher in one plan than another. However the Centers for Medicare and Medicaid Services (CMS) sets minimum coverage limits that all plans must meet.
- ▶ Enrollees may have to pay an extra monthly premium in addition to the monthly Part B premium. **NOTE:** Enrollees will still be responsible for the Part B premium.
- ▶ When a beneficiary joins a Medicare Advantage Plan, they will not need, and cannot buy, a Medigap policy. If the beneficiary already has a Medigap policy, he/she can keep it, but Medigap will not pay for any plan costs, such as copayments.
- ▶ **Beneficiaries are only able to join or leave a Medicare Advantage Plan at certain times, such as the Annual Enrollment Period.**
- ▶ Beneficiaries must have Part A and Part B to join and permanently reside in the Plan's service area.
- ▶ Beneficiaries can join a Medicare Advantage Plan even if they have pre-existing conditions, except for End-Stage Renal Disease (ESRD). Medicare beneficiaries with ESRD usually cannot join a Medicare Advantage Plan.





MEDICARE PRESCRIPTION DRUG PLANS

People with limited income and resources may qualify for help paying their Medicare prescription drug coverage costs.

This is referred to as the **Low Income Subsidy (LIS)**. Individuals with the lowest incomes will pay no Part D premiums or deductibles and have small or no copayments for their medications. Those with slightly higher incomes will have no premium or have a reduced premium, have a reduced deductible, and pay a little more out of pocket.

MEDICARE PRESCRIPTION DRUG PLANS, OR MEDICARE PART D PLANS.

Medicare Prescription Drug Plans provide prescription drug coverage to beneficiaries who elect to enroll in a prescription drug plan.

Anyone who has Part A and/or Part B and lives in a plan's service area is eligible to join the plan.

People with Medicare (who do not already have prescription drug coverage through an employer or union, TRICARE for Life, COBRA, or other means) can obtain prescription drug coverage by either:

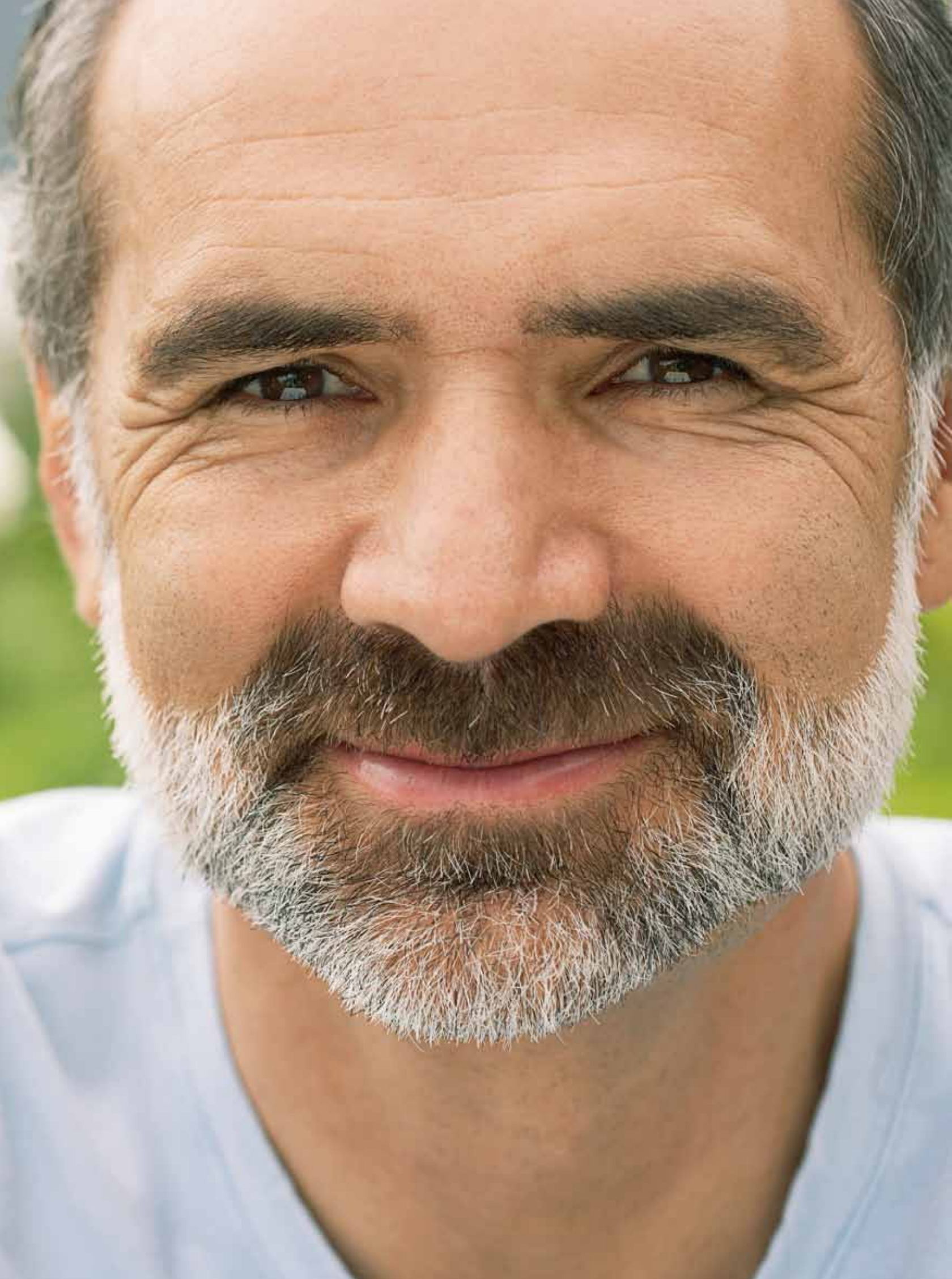
- ▶ Joining a (stand alone) Part D Prescription Drug Plan; or
- ▶ Joining an MA plan that includes Part D prescription drug coverage. Costs can be different for each plan, but all Medicare drug plans must provide at least the standard level of coverage set by Medicare.

Each Medicare Prescription Drug Plan has a formulary. Even if a drug is on the plan's formulary, there may be special rules for filling the prescription such as limiting the quantity of a drug a plan covers over a certain period of time for safety and cost reasons.

Prior authorization from the plan may be required before a prescription will be covered to ensure drugs are used correctly and only when medically necessary. Drugs may also have different cost-sharing levels, sometimes called tiers.

Beneficiaries who don't enroll in a Medicare Prescription Drug Plan when they are first eligible may have to pay

a **late enrollment penalty** to enroll in a plan later if they don't maintain creditable coverage. Most people who wait until after the end of their Initial Enrollment Period (IEP) to join a plan will have their premiums go up 1% for every month they waited to enroll. These individuals will usually have to pay this penalty as long as they have Medicare prescription drug coverage.



INTERACTION WITH OTHER INSURANCE

*Employer or Union, Federal Employee, Indian,
Medicaid & TriCare*

EMPLOYER *or Union Health Coverage*

Health coverage based the individual's, or individuals' spouse's or other family member's current or former employment.

If beneficiaries have prescription drug coverage based on employment, the employer or union will notify the beneficiary annually to let them know if this coverage is creditable.

FEDERAL *Employee Health Benefits Program (FEHBP)*

For current and retired Federal employees and their eligible dependents.

If the beneficiary joins a Medicare drug plan then they can keep their FEHBP plan.

INDIAN *Health Services*

For American Indian/Alaska Natives. Medicaid and Medicare services are provided through Indian Health Services (IHS).

MEDICAID

Medicare beneficiaries who have limited incomes and resources may also receive help from the Medicaid Program. People who qualify for both Medicare and Medicaid are called dual eligibles.

TRICARE *Military Health Benefits*

For active-duty service members, retirees and their eligible dependents.

Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits.

FOR MORE INFORMATION ON HOW THESE PROGRAMS AND OTHER INSURANCE INTERACTS WITH MEDICARE, CONTACT YOUR INSURANCE COMPANY OR CALL 1-800-MEDICARE.

We're here to help.



Soundpath
HEALTH

1-866-362-2427
TDD 1-866-264-4141

You can also visit us on
the web at www.soundpathhealth.com