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Medicare 101 (2016)
Borchard Foundation Training Series – Part I

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Roadmap of CLE

1. 4 Parts of Medicare & Medicare Eligibility
2. Enrolling in Medicare (Parts A & B, Part D)
3. Medicare Premiums
4. Medicare Choices – Original Medicare vs. Medicare Advantage (Part C)
5. Medicare Services & Costs (Parts A&B, Part D)
6. Reducing Medicare Costs – Medigap, Medicare Savings Programs, EPIC, Medicaid

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Overview: The Four Parts of Medicare

Part A
Hospital
Insurance

Part B
Medical
Insurance

Part C
Medicare
Advantage
Plans , like
HMOs and
PPOs
Includes Part A & B and usually Part D coverage

Part D
Medicare
Prescription
Drug
Coverage

Medicare - **Part A & B** Eligibility

Who gives it?	U.S. Centers for Medicare and Medicaid Services (CMS)
Who gets it?	1. People who are over 65; OR 2. People < 65 with disabilities EITHER: • after receiving Social Security Disability Insurance (SSDI) for 24 months • or immediately for those with ALS (Lou Gehrig) or end-stage renal disease (ESRD)(on dialysis)
Eligibility	• US citizen, or legal alien residing continuously in the US for at least 5 years • Applicant or spouse must be fully insured for Social Security purposes (40 quarters of coverage if age 65+ but less if younger than 65) or • Can pay for Part A ($411/mo). QMB Medicare Savings Program will pay this if age 65+ and eligible for Medicare + income < 100% Federal Poverty Line

Medicare **Part D** Eligibility

Who gives it?	Federal government – Centers for Medicare and Medicaid Services (CMS). Benefit delivered exclusively through private health insurance plans.
Who gets it?	People who already have Medicare Part A or Part B, and who have enrolled in a prescription drug plan.
Eligibility	▸ Entitled to Medicare Part A OR enrolled in Medicare Part B; and ▸ Resides in the service area of a plan.
What do you get?	Health insurance that covers outpatient prescription drugs, subject to deductibles, premiums, co-payments, coverage gap, utilization management, and which drugs are covered.

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ENROLLMENT PERIODS – PARTS A & B

- Automatic Enrollment
- Initial Enrollment Period (IEP)
- General Enrollment Period (GEP) (annual)
- Special Enrollment Periods (SEP)

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Automatic Enrollment – Part A and B

- Automatic for those receiving:
  - Social Security benefits
  - Railroad Retirement Board benefits
  - ALS (Amyotrophic Lateral Sclerosis, also known as Lou Gehrig's disease)
- How will they be notified?
  - Initial Enrollment Period Package will be mailed three months before
    - Age 65
    - 25th month of disability benefits
    - Except:
      - ALS will receive it the month their disability begins

- Others must enroll themselves (ex. if not taking Social Security at age 65)

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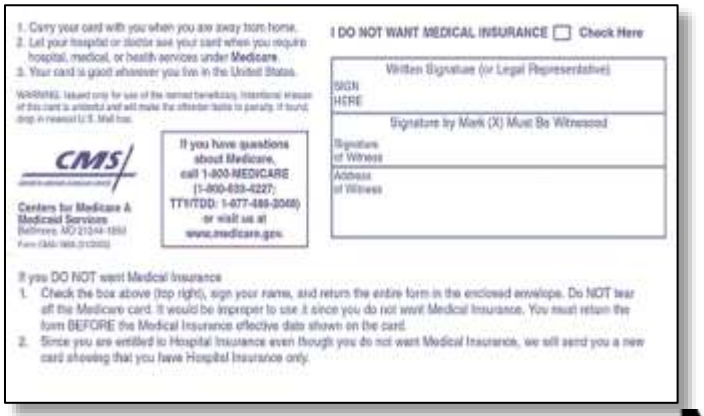
Medicare Card sent to Automatic Enrollees

- Keep it and accept Medicare Parts A and B
- Return it to refuse Part B (if on group health plan through work)
  - Follow instructions on back of card

Front

Back



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When Enrolling in Medicare is Not Automatic

- Some people need to apply for Medicare
  - Those not automatically enrolled (most common example are those individuals not yet receiving SSA retirement benefits)
    - This is true even if you are eligible to get Part A premium-free
  - ESRD (End Stage Renal Disease) - ESRD will start the month after the 4th month of receiving Dialysis
- Enroll through Social Security:
  - Call 1-800-772-1213 (TTY 1-800-325-0778) Monday-Friday 7am-7pm
  - Online at https://www.ssa.gov/medicare/apply.html
  - Visit local SSA office
- Enroll through Railroad Retirement Board for railroad retirees
- Apply 3 months before age 65

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If Not Automatically Enrolled
Your 7-Month Initial Enrollment Period

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

Enrolling in Part B if You Have Employer or Union Coverage

- May affect your Part B enrollment rights
  - You may want to delay enrolling in Part B if
    - You have creditable coverage through an employer or union and
    - You or your spouse, or family member if you are disabled, ***is still working***
      - If you have **retiree** insurance, you must enroll in Part B or will have a Late Enrollment Penalty
    - The size of your employer may determine whether you can decline Part B
- Contact your employer/union benefits administrator before deciding if you should decline Medicare Part B coverage

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Coordination of Benefits

- There are complicated rules about which insurance is PRIMARY – Medicare or employer or retiree insurance of you or your spouse.
- Next slide explains basic rules
- **WARNING** – When the chart shows **MEDICARE** pays first, you and your spouse **MUST enroll in Medicare Part A and Part B, even though you have the work/retiree insurance**. Otherwise you may be liable later to repay what your work/retiree insurance paid.
  - Plus you'll have a late enrollment penalty for Part B when you enroll later.

Medicare Group	Work Status	# of Employees	Who Pays First
65 or Older	Retired (self or spouse)	N/A	**Medicare**
	Currently working (self or spouse)	20+	Group Health Plan
		Less than 20	**Medicare**
Under 65 and Disabled	Family member currently working	100+	Group Health Plan
		Less than 100	**Medicare**
End-Stage Renal Disease	Currently working (self or spouse)	N/A	Group Health Plan for first 30 months and Medicare thereafter

General Enrollment Period (GEP)

- January 1 through March 31 each year
- Coverage effective July 1st (up to 6-month delay!)
- Part B Premium penalty
  - 10% for each 12-months eligible but not enrolled
  - Must pay penalty in addition to the Part B premium as long as you have Part B
  - Penalty eliminated if low income & enroll in a Medicare Savings Program (MSP)(discussed later)

Special Enrollment Periods for A/B (SEP)

If you did not enroll in Medicare during your IEP or GEP, you may qualify for a very limited Special Enrollment Period, which would allow you to enroll.

1. Individuals who are age 65 or over, or eligible for Medicare based on disability, can enroll (or re-enroll) in Part B, during any month (including a partial month) in which they are:
   - Enrolled in a group health plan (GHP) or a large group health plan (LGHP)
   - based on **current employment status** or that of a spouse. SSA POMS HI 00805.275; HI 00805.270 * (not for retirees)
2. OR after stop working, you have 8 consecutive months following the last month of coverage through a GHP or LGHP to enroll in Medicare Part B. See next slide for more.

* http://policy.ssa.gov/poms.nsf/lnx/0600805270 , https://secure.ssa.gov/poms.nsf/lnx/0600805275

SEP: Employer or Union Coverage Ends

- When your employment ends
  - You have a Special Enrollment Period (SEP) to sign up for Medicare Part B without a penalty – 8 months after month Group Health Plan coverage ends.
  - You may also get a chance to elect COBRA – see http://www.wnylc.com/health/entry/145/
- ***COBRA and Medicare***
  - Medicare does NOT consider COBRA to be creditable coverage, which would ordinarily allow you to delay enrollment in Medicare Part B. This is because it is not based on your own or a spouse's ACTIVE employment.
  - **If you elect COBRA**, ***you must still enroll in Medicare Part B*** within the 8 month Special Enrollment Period (SEP).
  - If you do not enroll in Part B during the SEP, you will pay a Part B penalty when you do enroll AND may be liable for costs paid by COBRA.
  - Remember you may not enroll in Part B at anytime. You'll have to wait until the next General Enrollment period. This means your Part B coverage will not be effective until July 1st of that year or the following, which may cause a gap in your health insurance coverage.

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Enrollment in Medicare if You Have TRICARE Coverage

- Medicare Part A and TRICARE For Life
  - If retired you must have Part B to keep TRICARE
- Active-duty member, spouse or dependent child
  - You don’t have to have Part B to keep TRICARE
- You get a Part B Special Enrollment Period
  - If you have Medicare because you are age 65 or
  - Because you are disabled

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PART D ENROLLMENT PERIODS

For complete reference on Part D, with legal citations, see NYLAG Training Outline on Part D
http://www.wnylc.com/health/download/6/

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Initial Enrollment Period for Part D

Initial Enrollment Period (IEP) is the same as Medicare Part A/B – 7 months surrounding the month turn 65. But some differences -

- **If you want coverage in month turn AGE 65** – you must enroll in one of the 3 months before that month.
    - NO automatic enrollment when you turn 65, even if receive Social Security (UNLESS you are on Medicaid/ MSP
- **If enroll in month you turn 65 or in 3 following months -**
    - Part D coverage effective the month following the enrollment. This is better than Part B, which is 2-3 months after enrollment.
- **Late Enrollment Penalty** You pay a higher premium for Part D for the rest of your life if you delay enrolling after first eligible. The penalty is 1% for every month you delayed enrollment.
    - Exceptions include: Creditable Coverage or Extra Help

Automatic Enrollment due to Extra Help status

People with "Extra Help," a/k/a the "Low Income Subsidy" have these special enrollment benefits:

1. **Automatic Enrollment into Part D** if not already in a plan-
   - **Medicaid** (SSI/dual eligibles) – random auto-assignment to a "benchmark" drug plan, which means premium-free for Medicaid
   - **Medicare Savings Program** – same

   WARNING: Assigned plan may not be best. Check *Planfinder* on www.medicare.gov for utilization controls, drug not on formulary
2. **WAIVER of Late Enrollment Penalty** – no increased premium for late enrollment.

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Part D Enrollment Periods after Initial IEP

- **Annual Coordinated Election Period (ACEP)(Open Enrollment)**
  - **October 15 – December 7 of every year.** You can enroll in Part D for the first time or change your existing drug plan or Medicare Advantage plan**.**
  - Your Part D or MAPD coverage will be **effective January 1st** of the following year.
  - Some individuals who already have Part D coverage may be automatically reassigned by CMS, if their old Part D plan terminates or is no longer a "benchmark" plan that is free or those with Extra Help
- **Medicare Advantage Disenrollment Period**
  - **January 1 – February 14 every year**, during which members of Medicare Advantage plans can disenroll and return to Original Medicare + a PDP
  - Cannot enroll in Medicare Advantage, switch MA plans, or switch PDPs during this time

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Special Enrollment Periods (SEP) for Part D

Dozens of different exceptions; most important are:

1. Perpetual SEP for people with Extra Help and **Medicaid**
2. **EPIC** SEP – EPIC members may change plans once/year
3. SEP to enroll in a **Five-Star plan** (PDP or Medicare Advantage) anytime
4. Involuntary **loss of creditable coverage**: two months after loss of coverage (ie Group Health Plan from work)
5. **Plan moves or terminates, or member moves**
6. Member moves into or out of a **nursing home**
7. Member enrolled based upon **misleading or incorrect information** provided by plan employees, agents, or brokers

MEDICARE PREMIUMS

Part A & Part B

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Medicare Part A Premium

- Most people receive Part A premium free --
  - If you paid FICA taxes at least 10 years (40 quarters)
- Must pay a premium to get Part A** --
  - If you paid FICA taxes for less than 10 years

Paid FICA Taxes for	Part A Premium
40 Quarters or More	FREE
Between 30-39 Quarters	$226/month
Less than 30 Quarters	$411/month

** Medicaid or “QMB” Medicare Savings Program may pay Premium if Low Income

Monthly Part B Premium

If your Yearly Income in 2014 was			You Pay
File Individual Tax Return		File Joint Tax Return	
$85,000 or less		$170,000 or less	$121.80 ($104.90 for those "held harmless"*)
IRMAA Income-Related Monthly Adjust-ment Amount	$85,001–$107,000	$170,001–$214,000	$170.50
	$107,001–$160,000	$214,001–$320,000	$243.60
	$160,001–$214,000	$320,001–$428,000	$316.70
	above $214,000	above $428,000	$389.80

*Those who had Medicare in Nov-Dec 2015 without an "IRMAA" premium are held harmless from 2016 increase (grandfathered in) if premium was deducted from Social Security check

Paying the Part B Premium

Elect automatic monthly deduction from:

- Social Security payments
- Railroad retirement payments
- Federal retirement payments

- If not automatic deduction:
  - Billed every 3 months
  - Medicare Easy Pay to deduct from bank account (http://tinyurl.com/jj3eef9)
- Contact SSA, RRB or OPM about premium payment options

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Part B Late Enrollment Penalty

- Sign up during a Special Enrollment Period
  - Usually no penalty
- Penalty for not signing up when first eligible
  - 10% more for each full 12-month period
  - May have penalty as long as you have Part B
    - EXAMPLE: Mary delayed signing up for Part B two full years after she was eligible. She will pay a 10% penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium ($121.80 in 2016):

2016 Part B Standard Premium	$121.80
Penalty: 2 years x 10% = 20% 20% of $121.80 = $24.36	+ $24.36
Mary's 2016 Monthly Premium	**$146.16**

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MEDICARE CHOICES

ORIGINAL MEDICARE

OR

MEDICARE ADVANTAGE

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What is 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 – providers bill Medicare on "fee for service" basis
- You pay:
  - Part B premium (Part A free for most people)
  - Deductibles, coinsurance or copayments
- You may supplement with:
  - Enroll in a separate **Part D plan** to add drug coverage
  - May buy private **Medigap** supplemental policy to pay deductibles, coinsurance

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Original Medicare – How many cards?

Original Medicare + Part D + Medigap (optional)

Medigap
Plan F
John Doe
Member ID: 123456ABC

NOTE: Extra Help - Part D subsidy is automatic if has Medicaid.

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What is Medicare Advantage (MA)?

- Part A & B services authorized & delivered by a private health insurance plan, under contract with Medicare
- Also called Medicare **Part C**
- Medicare pays plan a monthly "capitation" rate for each member's care. Plan contracts with providers, which bill plan, not Medicare, for payment.
- About 30% of Medicare beneficiaries are in these plans – costs may be less, no Medigap policy needed. But tradeoff – must use provider networks.

How Medicare Advantage Plans Work

- Still in Medicare with all rights and protections, though different appeal system.
- Still get all Medicare-covered services, except some may require prior approval by plan
  - Some plans may provide additional benefits (i.e. dental, eyeglasses, gym membership, transportation)
- Plan may include prescription drug coverage (so don't enroll in a separate Part D plan)
- Benefits and cost-sharing may be different than Original Medicare, provided CMS has approved them as "actuarially equivalent"

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Medicare Advantage Eligibility Requirements

- You must live in the plan's service area
- You must have Medicare Part A **and** Part B
- You must not have ESRD when you enroll
  - Some exceptions
- You must provide necessary information
- You must follow plan's rules re staying in network, getting prior approval
- You can only belong to one plan at a time

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Medicare Advantage Plan Costs

- Must still pay the **Medicare Part B premium**
  - Some people may be eligible for state assistance with their Part B premium
- You *may* also be charged a monthly health **premium** – depends on type of plan. See next slide.
- You pay deductibles/coinsurance/copayments
  - Different from Original Medicare
  - Varies from plan to plan
- **NO MEDIGAP policy** needed, since they don't pay coinsurance/costs for MA plans. Saves that cost, but tradeoff with network limits and could have high copayments in MA too.

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Types of Medicare Advantage Plans

- Many plans usually have **no premium --**
  - Health Maintenance Organization (HMO) –no or low premium, **but must stay "in network**"
  - Special Needs Plan (SNP)-cater to "dual eligibles" or nursing home residents, HIV-AIDS, etc.
- Plans usually with a **premium, may go out of network**
  - Preferred Provider Organization (PPO) Private Fee-for-Service (PFFS)
  - HMO Point-of-Service Plan (HMOPOS)
- Medicare Medical Savings Account (MSA)
- Not all types of plans are available in all areas

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Private Contracts (Opting Out of Medicare)

- Doctor opts out of Medicare
- Agreement between you and your doctor
  - Doctor doesn't furnish services through Medicare
  - Original Medicare and Medigap will not pay
  - Other Medicare plans will not pay
  - You will pay full amount for the services you get
  - No claim should be submitted
  - You cannot be asked to sign this agreement in an emergency

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	Who Provides Coverage	How DO Beneficiaries use it	Premium
PART A	Federal Government	Medicare Card	Free for most
PART B	Federal Government	Medicare Card	$104.90 if pre-2016 $121.80 if 2016+ More if high income
PART C (Medicare Advantage)	Private Insurance Plan (HMO, PPO, PFFS, MSA)	Medicare Advantage Card from Insurance Company	Usually free, some additional fee for some plans
Part D	Private Insurance - Prescription Drug Plan or Medicare Advantage w/Part D	Prescription Drug Plan Card or Medicare Advantage Card	Additional Premium for all plans unless you receive Extra Help
MEDIGAP	Private Insurance Policy	Medigap Card + Medicare Card	Additional premium for all plans

MEDICARE SERVICES, DEDUCTIBLES & COSTS

WARNING: Services in USA only, with rare exceptions in border areas.

Must buy MEDIGAP with foreign coverage to supplement if travel.

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Part A & B Services and Costs

- The following slides describe services covered by Part A and B, which are the same in Original Medicare & Medicare Advantage.
- The costs of these services are shown for Original Medicare.
- Medicare Advantage plans may use the same deductibles, copayments and coinsurance OR have variations.
- In Original Medicare, many beneficiaries buy a Medigap policy to pay the beneficiary charges – deductibles and coinsurance.

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Medicare Part A Covered Services

Inpatient Hospital Stays	• Semi-private room, meals, general nursing, lab tests, radiology, supplies, & medications. • Includes care in critical access hospitals and inpatient rehabilitation facilities. • Inpatient care in psychiatric hospital (lifetime 190-day limit).
Skilled Nursing Facility up to 100 days	Semi-private room, meals, skilled nursing and rehabilitation services (physical, occupational, speech therapy, medications, and other services and supplies.
Home Health Care Services – only if "homebound" and have skilled need	• Skilled need met by "Visiting nurse" on part-time or intermittent basis and/or physical, speech, & occupational therapy, • Limited home health aide services • Medical social services • Durable Medical Equipment and medical supplies.
Hospice Care	Palliative care - < 6 months to live. Includes drugs, medical care, grief counseling, PT/OT, support services from a Medicare-approved hospice.
Blood	In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.

Paying for Inpatient Hospital Stays

For each benefit period in 2016	You Pay
Days 1-60	$1,288 deductible
Days 61-90	$322 per day
Days 91-150	$644 per day (60 lifetime reserve days)
All days after 150	All Costs

Medicare Advantage plans usually charge same Part A deductible as Original Medicare.

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More on Part A Hospital Deductible & Benefit Periods

- Must pay Part A deductible for each "benefit period"
  - $1,288 in 2016 for inpatient hospital stay
- Benefit Period begins the 1st day of inpatient care
  - In hospital or skilled nursing facility (SNF)
- Ends when not in hospital or Skilled Nursing Facility for 60 days in a row
- No limit to number of benefit periods
- EXAMPLE: Betty was rehospitalized after being at home for 3 months, after a prior rehab stay. She is charged another $1,288 deductible as it's a new BENEFIT PERIOD.

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Part A - Skilled Nursing Facility ("Rehab")

Must meet all conditions:

1. Require daily **skilled** services (**5 days/week**)
   - Not just long-term or custodial care
2. Must have had a **3-day inpatient hospital stay, not counting day of discharge,** within 30 days prior to being admitted to SNF (beware of "observation status")(see next slides)
   - 2013 amendment – "…the admitting physician expects the patient to require hospital care that crosses **two midnights."** 42 CFR § 412.3(d).
3. SNF care must be for a **hospital-treated condition**
   - Or condition that arose while receiving care in the SNF for hospital-treated condition
4. MUST be a Medicare-participating SNF

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Skilled Nursing Facility - Rehab Care

If you meet the conditions on previous slide, Medicare covers SNF rehab with following copayments.

For each benefit period in 2016	You Pay
Days 1-20	$0
Days 21-100	$161 per day
All days after 100	All Costs

Coverage for SNF rehab care may end before 100 days if no longer necessary to maintain an individual's condition or slow deterioration. *Jimmo v. Sibelius* class action settlement struck down requirement to show "**medical improvement**." Cannot deny services because individual "plateaued." Settlement incorporated in MBP Manual, Ch 8 §30.2.2; 42 CFR § 403.33(c)(5). CMS transmittal at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf. See http://www.medicareadvocacy.org/medicare-info/improvement-standard/

Observation Status – Barrier to SNF/ Rehab Coverage

- Hospitals often keep patients in "observation status" in the ER without admitting them. Unless admitted as inpatients for 3 days before discharge, Medicare won't pay for SNF rehab care.
- Lawsuits have not yet been successful, but some chipping away.

1. **NOTICE LAWS–**
   - NYS is one of 5 states requiring hospitals to inform patients when they are in Observation status within 24 hours , and the consequences of not being admitted as inpatients. NY Pub. Health L. § 2805-w
   - The federal *Notice of Observation, Treatment and Implication for Care Eligibility Act,* signed into law August 2015, requires hospitals, by August 2016, to tell Medicare beneficiaries of their outpatient status within 36 hours, or, if sooner, upon discharge. 42 U.S.C. 1395cc(a)(1)

More on Observation Status

2. **TWO-Midnight Rule loosened** –

   Effective January 1, 2016, CMS will allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if medical record supports the admitting physician's determination that the patient requires inpatient hospital care despite an expected length of stay that is **less than 2 midnights**.

   42 C.F.R. § 412.3 (d) (as amended August 2015)

- See advocacy tools on Observation Status at http://www.medicareadvocacy.org/medicare-info/observation-status/ and info on lawsuits

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Medicare Home Health Services

Description	Your Cost
Home health aide, visiting nurse, PT/OT	$0
Durable Medical Equipment (covered by Part B)	20% approved charge

Medicare will cover home health care services if:

1. Must be homebound
2. Must need skilled care on intermittent basis ("visiting nurse," PT, OT)
3. Services must be prescribed in a plan of care established and reviewed by a physician every 60 days
4. Have face-to-face encounter with doctor prior to start of care
5. Certified Home health Agency ("CHHA") must be Medicare-approved

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More Medicare Part A Services/Costs

Service	Description	Cost
Hospice Care Palliative care < 6 months to live. Includes drugs, medical care, grief counseling, PT/OT, support services from a Medicare-approved hospice.	Hospice care – home or inpatient	$0
	Pain medications at home	Up to $5 per Rx
	Inpatient respite care (5 day limit)	5% approved charge
Blood	If the hospital gets blood free from blood bank	$0
	If hospital has to buy blood	You pay for first 3 units per calendar year; or You or someone else donates to replace blood

Medicare Part B Coverage

After you pay annual deductible ($166 – 2016) – You generally pay **20% of Medicare approved charge** for these services. **May be more if provider does not "accept assignment." See below.**	
Doctors' Services	Physician's offices, hospital outpatient care, and some doctor services provided while a hospital inpatient such as surgeon, anesthesiologist), or covered preventive services. EXCEPTION: Certain preventive services have NO coinsurance.
Outpatient Medical/ Surgical Services & Supplies	X-rays, CT scan, MRI, EKG outpatient surgery, dialysis COST: 20% of the Medicare-approved amount If test performed in hospital outpatient clinic, also charged a copayment for each service.

Medicare Part B Coverage

Durable Medical Equipment	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. 20% coinsurance.
Therapy – PT/OT/SLP	Pay 20% of approved amount. Subject to therapy cap limits (2016) - $1,960 for physical therapy (PT) and speech-language pathology (SLP) services combined; $1,960 for occupational therapy (OT) services. Exceptions allowed if medically necessary.
Lab tests	NO COINSURANCE.

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Does Provider Accept "Assignment"?

- Most providers "accept assignment."
  - Provider signs an agreement with Medicare – they are called "**participating providers**"
  - Accepts the Medicare-approved amount as full payment for covered services – Medicare pays 80% of approved charge
  - You pay 20% of approved charge (coinsurance)
  - They submit your claim to Medicare directly
  - You receive Medicare Summary Notice (MSN) stating amount of 20% coinsurance.
  - **Some providers must accept** assignment - Medicare Part B-covered prescription drugs, Ambulance suppliers

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If provider does not accept assignment

- Providers and Suppliers that don't accept assignment are called "non-participating" providers.
- They may charge you more than the 20% but it is limited by federal and state law.
- The **federal** limiting charge is **15%** above the approved rate. 42 USC § 1395w-4(g)(2)(B)-(C) (you pay 20% + 15% of the approved rate = 35% of approved rate)
- **NYS** has a lower maximum charge – **5%** over the approved rate. NY Pub. Health Law §19
- May have to pay entire charge at time of service, then be reimbursed by Medicare.

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Part B Covered Preventive Services

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

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NOT Covered by Part A and Part B

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

Factors to Choose Medicare Advantage vs Original Medicare

- About 30% of Medicare beneficiaries are in Medicare Advantage ("MA"). Costs can sometimes be less but there are tradeoffs.
- In both MA and Original Medicare, beneficiary must pay monthly **Part B premium**.
- Most Medicare Advantage plans charge a flat copayment for different services, such as $50/specialist visit, rather than 20% Medicare approved charge. If surgery bill has $5,000 approved charge, MA copay is $50, while Original Medicare coinsurance is 20% =$1,000 (and more if MD not take assignment)
- RISKS – if MA member needs inpatient hospital or SNF rehab care, MA plans generally charge similar Part A hospital, SNF deductibles and coinsurance. Since no Medigap to pay those costs, they can be steep. But – save $ on Medigap.

MEDICARE PART D SERVICES

See more on Part D with legal citations at

http://www.wnylc.com/health/download/6/

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Access to Covered Drugs

- Plans must cover at least 2 drugs in each Therapeutic Category (e.g., Cardiovascular Agents), and in each Pharmacologic Class (e.g., MAO Inhibitors, Reuptake Inhibitors) a
- Includes Prescription & Generic drugs approved by FDA, biological products, insulin, and supplies associated with injection or inhalation
- Coverage and rules vary by plan
- Plans can manage access to drug coverage by limiting formularies and requiring approvals. See more below.

Formularies: Required Coverage in 6 Special Classes

- Plans must cover "all or substantially all" prescription brand-name and generic drugs in 6 categories
  - Cancer medications
  - HIV/AIDS treatments
  - Antidepressants
  - Antipsychotic medications
  - Anticonvulsive treatments
  - Immunosuppressants
- All commercially-available vaccines
  - Except those covered under Part B (e.g., flu shot)

Drugs Excluded By Law Under Part D

- Anorexia, weight loss or weight gain drugs
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- 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
- Since 2013 – these drugs are no longer excluded - Barbiturates and benzodiazepines

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Formulary & Tiers of Drugs/Copayments

- 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	Highest copayment	Non-preferred, brand-name
Specialty	Highest copayment or coinsurance	Unique, very high-cost

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Rules Plans Use to Manage Access to Drugs

Prior Authorization	▪ Doctor must contact plan for prior approval • Before prescription will be covered • Must show medical necessity for drug ▪ Process for requests may vary by plan
Step Therapy	▪ Type of prior authorization ▪ You 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

Costs of Part D

- Premium
- Deductible
- Co-payments
- Coverage gap (aka “donut hole”)
- Catastrophic coverage

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Medicare Part D - Coverage Period

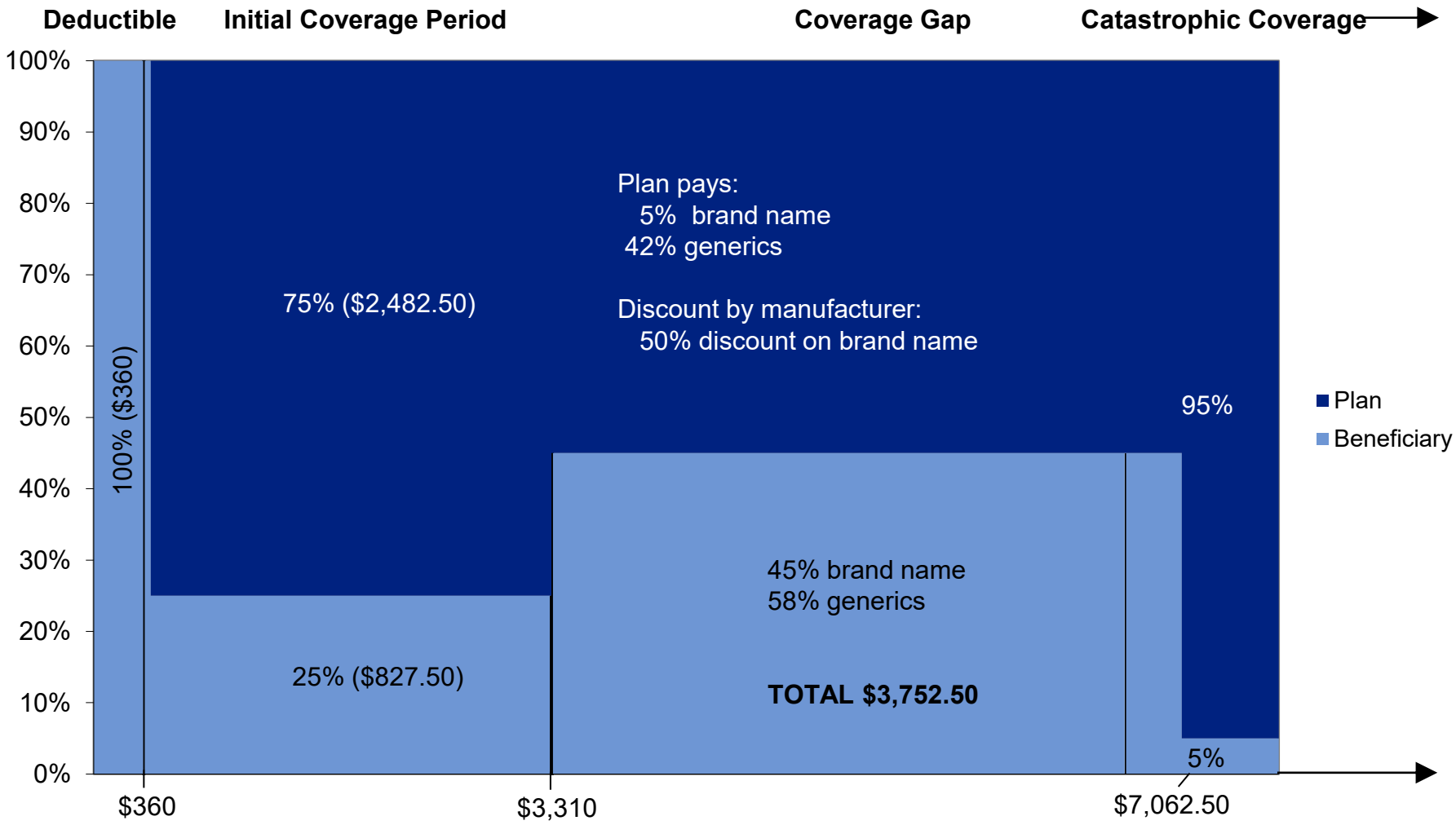
Deductible
- Can range from $0 to $360
- Not all plans have a deductible

Initial Coverage
- Co-Payment and Plan pays its share for each drug
- Up to the combined amount (+ deductible) of $3,310

Coverage Gap (Donut Hole)
- Once the combines amount of $3,310 is reached
- Patient pays 45% of Brand Name and 58% of Generic of plan's cost

Catastrophic Coverage
- Once patient reaches $4,850 in out-of-pocket costs for their medication for the year
- Will only have to pay co-insurance or co-payment for covered drug

Basic Benefit (2016)



REDUCING MEDICARE COSTS

- Medigap – Private Insurance Supplements
- Medicare Savings Program
- EPIC
- Medicaid

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Filling the Financial Gaps in Medicare Coverage

- **Medigap** - private insurance policy, monthly premium
- **Medicaid** (** Non-MAGI / unless parent/caretaker)
  - May pay for the A/B Deductibles
  - May pay for the 20% Coinsurance for Part B services
  - May pay the Part D premium up to $39.73/month and reduce medication copayments to $7.40 per medication or less
- **Medicare Savings Program** (income limits apply)
  - Will pay the Medicare Part B premium of $104.90/$121.80
  - May pay for Part A/B deductible and coinsurance
  - Will pay the Part D premium up to $39.73/month and reduce medication copayments to $7.40 per medication or less
- **Extra Help** (Low-Income Subsidy or LIS)
  - Will pay for Part D premium up to $39.73/month and reduce medication copayments to $7.40 per medication or less
- **Elderly Pharmaceutical Insurance Program** (EPIC)
  - May pay the Part D premium up to $39.73/month
  - May reduce your medication copayments to $20 or less

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Medigap Policies

- Medigap (Medicare Supplement Insurance) policies
  - Private health insurance for individuals
  - Sold by private insurance companies
  - Supplement Original Medicare coverage
  - Follow Federal/state laws that protect you
- Medigap Open Enrollment Period
  - Starts when you are both 65 and sign up for Part B
  - Once started cannot be delayed or repeated
  - In NYS there is always open enrollment. Other states may limit to part of each year.

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Medigap

- Costs vary by plan, company, and location
- Medigap insurance companies may only sell a "standardized" Medigap policy
    - Identified in most states by letters
- Does not work with Medicare Advantage
- You pay a monthly premium

Compare costs of Medigap plans sold in NYS on NYS Dept. of Financial Services website – updated frequently
http://www.dfs.ny.gov/consumer/caremain.htm#tables

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

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

Out-of-Pocket Limit**	
$4,960 for Plan K	**$2,480 for Plan L**

Medicare Savings Program

- There are three different types of Medicare Savings Programs:
    1. Qualified Medicare Beneficiary (QMB)
    2. Specified Low-Income Medicare Beneficiary (SLIMB)
    3. Qualified-Individual (QI-1)
- They each pay the Medicare Part B premium, but some have additional benefits or restrictions.

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Medicare Savings Program (MSP)

Monthly Income Limit - 2016			
		Single	Couple
QMB	100% FPL	$990	$1335
SLIMB	120% FPL	$1188	$1602
QI- 1	135% FPL	$1337	$1803

- In New York State, there is **no asset test** for MSPs.
- Income budgeting guidelines are the same as Medicaid for Disabled/Aged/Blind (DAB). Deduct from gross income:
  - $20 unearned income,
  - Medigap & health insurance premiums other than Part B,
  - Over half of gross earned income
- People in MSP automatically receive "Extra Help" - the federal subsidy for Medicare Part D

MSP: Qualified Medicare Beneficiary (QMB)

QMB Benefit Pays:

- The monthly Medicare Part B premium ($104.90 for 2015 / $121.80 for 2016)
- The monthly Medicare Part A premium (up to $411 for 2016) for people who do not qualify for premium-free Part A
- Co-insurance and co-payments for Medicare-covered services
- Deductibles for Medicare-covered medical services

Automatically qualifies you for **Extra Help** for Part D costs

One can have both QMB & Medicaid

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QMB – Balance Billing

- Balance billing is the practice in which Medicare providers bill a beneficiary for Medicare cost sharing. Medicare cost sharing can include deductibles, coinsurance, and copayments.
- Providers are not allowed to charge QMBs for Medicare cost-sharing ("no balance billing") under any circumstances

  Social Security Act §1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A)
- This rule applies to Original Medicare and Medicare Advantage
- QMBs cannot waive their right not to be balance billed.
- If Provider accepts Medicaid, Medicaid *may* pay all or part of coinsurance. (2015 law bans payment in Original Medicare if Medicaid rate lower than Medicare rate). SSL §367-a, subd. 1 (d). But if does not accept Medicaid, or Medicaid doesn't pay, provider *can't balance bill*.
- See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf and http://www.wnylc.com/health/entry/94/
- http://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/balance-billing/

MSP : SLIMB & QI-1

- **Specified Low-Income Medicare Beneficiary (SLIMB)**
  - Pays the monthly Medicare Part B premium ($104.90 for 2015 / $121.80 for 2016)
  - Automatically gives Extra Help for Part D costs
  - You can have both SLIMB and Medicaid
- **QI-1 (Qualified Individual)**
  - Pays the monthly Medicare Part B premium ($104.90 for 2015/$121.80 for 2016)
  - Automatically gives Extra Help for Part D costs
  - You cannot have both QI-1 and Medicaid

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Medicare Part D – Extra Help

- Extra Help, also known as the Low-Income Subsidy (LIS) Program, is a federal program that helps people with low incomes pay for most or all of the costs of Medicare prescription drug coverage (Part D).
- Extra Helps pays for:
  - All or part of the monthly Part D **premium** up to $39.73;
  - All or part of the **yearly Part D deductible**;
  - Most of the **coinsurance or copays** for Part D plan-covered drugs. Copayment for each covered drug is $7.40 or less
  - People with Extra Help will not have a coverage gap or "**donut hole**".
- Most individuals are automatically deemed eligible for Extra Help by having Medicaid or the Medicare Savings Program.

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Extra Help through SSA

- Individuals who have not been automatically deemed eligible can apply for Extra Help through the Social Security Administration. Since eligibility is stricter than NYS Medicare Savings Program, few New Yorkers apply with the SSA. Like MSP, income limit is 135% Federal Poverty Line, but there is a low asset limit, while MSP in NYS has no asset limit.

Income	Assets	Extra Help Coverage
Single: $1,356 Couple: $1822	Single: $8,780 Couple: $13,930	**Full Extra Help :** $0 premium and deductible $2.95 generic copay $7.40 brand-name copay No copay after $4,850 in out of pocket drug costs
Below Single: $1,505 Couple: $2022	Single: $13,640 Couple: $27,250	**Partial Extra Help** Premium depends on your income $74 deductible or the plan's standard deductible, whichever is cheaper 15% coinsurance or the plan copay, whichever is less After $4,850 in out of pocket drug costs, you pay $2.95/generic & $7.40/brand-name or 5% of the cost, whichever is greater

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Elderly Pharmaceutical Insurance Coverage (EPIC)

- Eligibility
  - NYS Resident
  - 65 years of age
  - annual income: < 75,000 single or < $100,000 if married. NO ASSET LIMIT
  - be enrolled or eligible to be enrolled in a Medicare Part D plan (no exceptions), and
  - not be receiving full Medicaid (must have a spend-down)
- Fee EPIC
  - Income eligibility threshold: $20,000 yearly/singles, $26,000/couples.
  - Members are charged an annual fee on a sliding scale basis. Fee ranges from $8 to 300 and is waived for full "Extra Help" recipients.
- Deductible
  - Income eligibility threshold: $20,001-$75,000 yearly (single); $26,001-$100,000 yearly (couples).
  - No fee charged, but no EPIC coverage until member's out of pocket Part D drug costs meet deductible, which ranges from $530 to $3,215 based on the household income.

EPIC – How it Works with Part D

Deductible -- If your Part D plan has a deductible, EPIC does not cover drugs during the deductible. Nor will your costs in the Part D deductible count toward the EPIC deductible. But once you meet the Part D deductible, EPIC will subsidize the copayments.

Premium Subsidy -- EPIC pays the Part D premium for members with annual income < $23,000 (single) and $29,000 (married)

- For members with higher income, EPIC will give a credit against the EPIC deductible for the cost of Part D premium

Co-payments – EPIC "wraps around" Part D to subsidize copayments – see next slide.

EPIC covers excluded drugs such as prescription vitamins and cough and cold preparations, if on EPIC formulary

EPIC Subsidy for Part D Copayments

If Part D co-pay is...	EPIC member pays	EPIC pays
Up to $15	$3	$12
$15 – $35	$7	$8-$28
$35 – $55	$15	$20-$30
Over $55	$20	$35 and up

EPIC Statute: N.Y. Elder Law § 240 et seq.;

Website: http://www.health.ny.gov/health_care/epic/

Additional Resources

- Center for Medicare Advocacy http://medicareadvocacy.org
- Medicare Rights Center, http://medicareinteractive.org
- Medicare Website, https://www.medicare.gov/
- http://Nyhealthaccess.org

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