Walking Through The Medicare Maze

You are new to Medicare and, for many; it is something you’ve never had to do before: plan your medical future for the rest of your life. The purpose of this booklet is twofold: giving you information on what you need to consider before you make Medicare choices; to explain to you how Medicare works. Let’s get started!

Things to Consider

There are five things you need to consider before you make a decision on what plans you need with Medicare.

**How much money do you have in your pocket?** Medicare is no different than the rest of the world. The more disposable income you have, the more you can buy, but you don’t want to be medically poor although sometimes you have no choice. Medical problems still make up around 60% of all bankruptcies in the United States. In our retirement booklet, we talk about how you can lose 15-25% of your disposable income from the day you retire until the day that you die, so it is important you think about your bills and needs in the coming years.

**Your lifestyle.** What do you plan on doing for the rest of your life. Believe it or not, many people start a small business, others travel, play golf, etc. You get the idea. What do you plan to do for the rest of your life? Many people have two homes, or live with different relatives during the year. As you read through this booklet, you’ll realize how important lifestyle is in your planning.

**Your health.** Consider not only your health, but what about your family’s health? Some people know that will have prostate cancer, breast cancer, diabetes, or heart problems because it runs in their family. If you have kidney disease, be sure and tell your counselor. Don’t take the attitude “I’m well now, so I’ll worry about the correct plan later.” That kind of attitude can come back to bite you in later years, and cost you more money.

**How much do you want to be in charge of your own health?** Do you want to be in charge or do you want to work with an insurance company to plan your medical future? There is no right or wrong answer. Many people prefer to work with a team of doctors to decide treatment, while others want to look at the options and make their own decisions. For example, with one plan available through Medicare you have to work within a network of doctors in your region. Another plan allows you to go anywhere that accepts Medicare in the United States.

**Peace of Mind.** What type of plan you choose will give you peace of mind? This last point is a collection of the previous 4 points. If you buy a plan that is too expensive, or buy a plan that is regional, you might not have peace of mind. Peace of mind comes with looking at all the options and you make a choice that is right for you.
What Is Medicare?

Medicare is health insurance for people 65 and older, disabled under age 65, and at any age for people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). Medicare is divided into four different parts.

**Part A** covers inpatient hospitalization to include critical access hospitals and skilled nursing facilities (SNF), but not custodial or long-term care nursing homes. There is no premium for Part A if you or your spouse has forty (40) tax credits. If you don’t have forty tax credits, you may incur an expense. There are special exceptions for disabilities. If you buy Part A, you’ll pay up to $413 each month. 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 have had Part A, but didn’t sign up.

If you go to the hospital, you are responsible for a deductible ($1316) each benefit period. A SNF as it relates to Part A does not refer to long term care, but to a rehabilitative situation. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins, and you must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods during the year, although inpatient mental health care in a psychiatric hospital is limited to 190 days in your lifetime.

**Part B** covers medical services such as doctors, outpatient care, durable medical equipment (DME), and other services. You pay a premium each month for Part B and it is usually deducted from your Social Security check. In 2018 the amount of the premium is based on your income. Most people will pay $134 a month. Here is a list of your costs for Part B based upon income.

You must pay the Part B deductible each year before the Part B benefit begins. Under Part B, Medicare will pay 80% of the cost and you will pay 20%. This is called cost sharing. If your yearly income in 2015 (for what you pay in 2017) was:

**Part C** causes the greatest concern among new enrollees. You may reenroll in two types of supplements plans: Medigap and Medicare Advantage. Both of these plans have to follow the guidelines of Medicare.

**Medigap:** There are various plans and each is slightly different to meet different needs. It is important that you choose the specific plan that covers your specific needs. Most insurance companies steer clients toward a Plan G. This plan covers most medical expenses that a person will incur. Medigaps are tightly controlled by the government and the rule is if Medicare pays, the Medigap pays. Medigap plans are required to pay with a specified time. The plans are very transparent. You present your insurance care along with your Medicare care when you go to the doctor. The doctor bills Medicare and Medicare sends the balance of the bill to the insurance company to pay its part.
Medicare Advantage: You generally get your entire Medicare covered healthcare through Medicare Advantage Plan (MAP) including prescriptions drugs. There are different types of Medicare Advantage Plans:

- Health Maintenance Organization (HMO’s)
- Preferred Provider Organizations (PPO)
- Private Fee For service Plans
- Special Needs Plans

MAP’s are private insurance companies like Humana, Coventry, Cigna, etc. that offer medical care to millions of Medicare participants. You opt-out of Original Medicare to join these plans, but you can return to Original Medicare. These plans cannot offer less than original Medicare and can offer more services than regular Medicare such as vision, dental, hearing aids, and memberships to Silver Sneakers at various health clubs. Most of these plans do not pay for the full deductible for Part A as a Medigap plan does.

You may sign up for a MAP during your initial enrollment period or during the annual enrollment from October 15 to December 7. You also may disenroll from your MAP ever year from January 1 through February 14 and return to Original Medicare.

Things To Consider

Choosing a supplemental plan is a difficult decision for many people. There are many things for you to consider.

Consider your lifestyle: If you spend at least three months per year outside of a MAP’s service area and have a serious medical problem, a MAP may not be the type of insurance coverage that is best for you. Let’s say you live with a daughter during these three months and you have a serious ailment. Under the MAP, you will probably have to go to the emergency room or urgent care every time because most MAPs are regional (some MAPs are now allowing you to go to a doctor and you pay the out of network price, but the doctor has to accept you.)

Your health: If you have end-stage renal disease, you are ineligible to join a MAP, but if you aren’t at stage 4 and first joining Medicare, a MAP has to accept you. If you go on dialysis later, you will meet the out of pocket expense maximum every year. Most MAP’s provide care for all other conditions. On the other hand, if you have a health problem and want a second opinion from a specialty clinic such as MD Anderson or Mayo, the MAP may not approve payment since it is out of the region.

If you move: Moving to another area of the country allows you 60 days to re-enroll in another MAP or a Medigap.

Co-Pays: The MAP’s have copays and some Medigaps have copays.

Hospital stay: You will most likely be out more money with a MAP than a Medigap plan. MAPs generally do not cover 100% of the Part A deductible and you may be responsible for copays.

Routine Services under Part B: You may pay 20% of the cost under a MAP although the amount paid may be lower than under regular Medicare. The copays will be different under differ plan, depending on the contract between the MAP and the providers.
Disposable income: How much can you pay for a supplemental plan? Medigap plans can cost approximately $150-175 a month or more depending on which plan you choose. This monthly cost will rise as you age. The cost of a MAP may be much less per month, but you have copays each time you use medical providers and services.

Part D Prescription Drugs

The Part D benefit under Medicare is run by private insurance companies and regulated by Medicare. Since its inception in 2006, Part D has been one of the most confusing and controversial benefits of Medicare.

The prescription drug program is designed to provide lower drug costs for beneficiaries through competition. You may switch to a new drug program every year, which means you have to check with various drug plans to see if your prescriptions are included in the plan’s formulary and compare the costs. You may get lower costs by using mail order, but not always. So, you pay a monthly premium for a drug plan and the cost of your drugs. There may be a deductible with your plan that you must pay before you benefit from the lower costs. Here is an important fact to remember when picking a plan. You want to look at the total costs for the year instead of the monthly costs.

Choosing a Drug Plan. Here are some things to consider when choosing a plan:
- Make a list of your prescriptions to include all the information such as any letters that may be at the end of the prescription, the strength, and the dosage.
- Make sure the drug plan covers your prescriptions.
- See if the plan requires step therapy for your drugs.
- Is there a quantity limit for your drugs such as a 30 day supply?
- Look at the total out of pocket expense for your drugs under each plan.

How Do You Enroll In Medicare?

If you took Social Security (SSA) before you reached the age 65, you will be automatically enrolled in Medicare. You will receive your card two to three months before your 65th birthday. If you did not sign up for SSA early, you are now able to enroll online at http://www.ssa.gov. If you don’t want to enroll online, you should go to the local SSA office two to three months before your birthday to apply. You can call for an appointment at 1-800-772-1213. You have a 7-month window (3 months before and after your birthday month) in which you can join Medicare without any restrictions. If you don’t receive your card, you should call Social Security at the above number.

Opt-Out Part B? When you enroll in Medicare, you will be automatically enrolled in Part B. You will have the choice to decline Part B. If you don’t sign up for Part B when you are first eligible, the penalty* for Part B may go up 10% for each full 12-month period that you didn’t sign up for it.
Still working: If you are still working and have medical insurance from your company, you might want to consider postponing Part B at the time you sign-up if your company provides you with health insurance. If you decide not to take Part B at this time because you have other insurance, you will not be penalized later when you want to enroll in Part B. Once you retire, it is important that your company provides you with a letter of continuing coverage. Medicare will require this letter so you won’t be penalized.

Problems can arise when the company’s prescription drug plan is not considered as good as or better than Medicare. Most company plans do not separate medical and prescription coverage. This can mean a penalty when you finally join a Medicare Prescription Drug Plan.

People on Cobra: When you enter your Initial Enrollment Period for Medicare, you may have to refrain from taking Part B because your spouse is not yet 65 and is also covered under your Cobra policy. You should sign up for Part B three months before your Cobra coverage runs out. If you don’t enroll in Part B during the 8 months, you may have to pay a penalty, or enrollment in Part B may be delayed. You should talk to your Human Resources contact or call the Shepherd’s Center nearest you to insure you are making the right decision.

Self-Employed—Many people who are self-employed have purchased their own insurance because they do not qualify for a group plan. If you are still working and have an individual plan that you have purchased, enrolling in Medicare may produce significant savings.

Retired—Most people who are retired take Part B. If not, you will be subject to the penalty if you didn’t have a letter of continuation of medical coverage under another plan. Some people do opt-out of Medicare but you must be able to pay for any incurred medical expenses. The exception is if you are covered under a government or a private health plan that is as good as or better than Medicare.

Disabled—If you are disabled (under or over 65) and you are covered by your own insurance policy or your spouse’s, you can delay Part B. It also depends upon your disability. If you believe like many who have disabilities, plan for the worst, expect the best, it might be wise to take Part B at the time you are first eligible (Usually, a disabled person become eligible for Medicare after receiving Social Security Disability Income for 24 months.) Medicare can act as a safety net if you, or a spouse, are laid off, a death, or a loss of insurance. There are programs that may help with the cost of Part B premiums for persons with limited income. If you enroll in Part B the month you become 65, or during the last 3 months of your Initial Enrollment Period, your Part B start date will not be delayed. If you did not enroll in Part B during your Initial Enrollment Period and did not opt out of Part B, you may enroll in Part B from January 1-March 31 each year, and coverage will begin on July 1. It is important that you talk with a Medicare Counselor if you have any questions about how or when to sign up for Part B.

Helpful Information

Ambulance—If you call for an ambulance to take you to the hospital, remember that Medicare might not pay for it if it doesn’t lead to a hospital stay. This isn’t an iron-clad rule, but Medicare takes the position that if you walk out of the hospital four hours later you most likely you condition did not need an ambulance,. You could have been driven by car.
Emergency Room-if the doctor says that he want to watch you overnight, ask if you are being admitted to the hospital or you are under observation. If you are under observation for 24 hours, the bill may not be paid by Medicare.

Advanced Beneficiary Notice (ABN)-If your provider believes or know that Medicare won’t pay for a service, you will be give a ABN that states that you will most likely be responsible for payment, not Medicare. When you get this notice, it is wise to call your doctor to make sure the request is correct. You could be out a great sum of money.

Appeals-When a person receives a Medicare Summary Notice (MSN) and finds out that a payment for a service has been denied, they believe they have to pay for that service. Many times Medicare needs additional information, an item was miscoded, or it was a duplicate service. You can appeal to Medicare.

Extra Help-If you meet certain income and resource limits, you may qualify for Extra Help from Medicare to pay the costs of Medicare prescription drug coverage. In 2017, costs are no more than $3.30 for each generic/$8.25 for each brand-name covered drug. Other people pay only a portion of their Medicare drug plan premiums and deductibles based on their income level. In 2017, you may qualify if you have up to $18,090 in yearly income ($24,360 for a married couple) and up to $13,820 in resources ($27,600 for a married couple). If you don’t qualify for Extra Help, your state may have programs that can help pay your prescription drug costs. Contact your Medicaid office or your State Health Insurance Assistance Program (SHIP) for more information. Remember, you can reapply for Extra Help at any time if your income and resources change.

Countable resources include:
- Money in a checking or savings account
- Stocks
- Bonds

Countable resources don’t include:
- Your home
- One car
- Burial plot
- Up to $1,500 for burial expenses if you have put that money aside
- Furniture
- Other household and personal items

Glossary

Benefit Period-A “benefit period” begins the day you go to a hospital or skilled nursing facility (SNF). The benefit period ends when you haven’t received any hospital care (or skilled care in a SNF) 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. There is no limit to the number of benefit periods.

Deductible-The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or other insurance begins to pay. For example, in Original Medicare, you pay a
new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

**Inpatient Care**—Health care that you get when you are admitted to a hospital or skilled nursing facility. Medicare Advantage Plan—A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plans, and are not paid for under Original Medicare.

**Medigap**—Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan.

Original Medicare—A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

**Penalty**—An amount added to your monthly premium for Medicare Part B, or for a Medicare Prescription Drug Plan, if you don’t join when you’re first able to. You pay this higher amount as long as you have Medicare. There are some exceptions.

**Premium**—The periodic payment to Medicare, to an insurance company, or a health care plan for health care or prescription drug coverage.

**Skilled Nursing Care**—A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse). Skilled Nursing Facility—A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health