

The World of Medicare The A, B, C and D's

Today

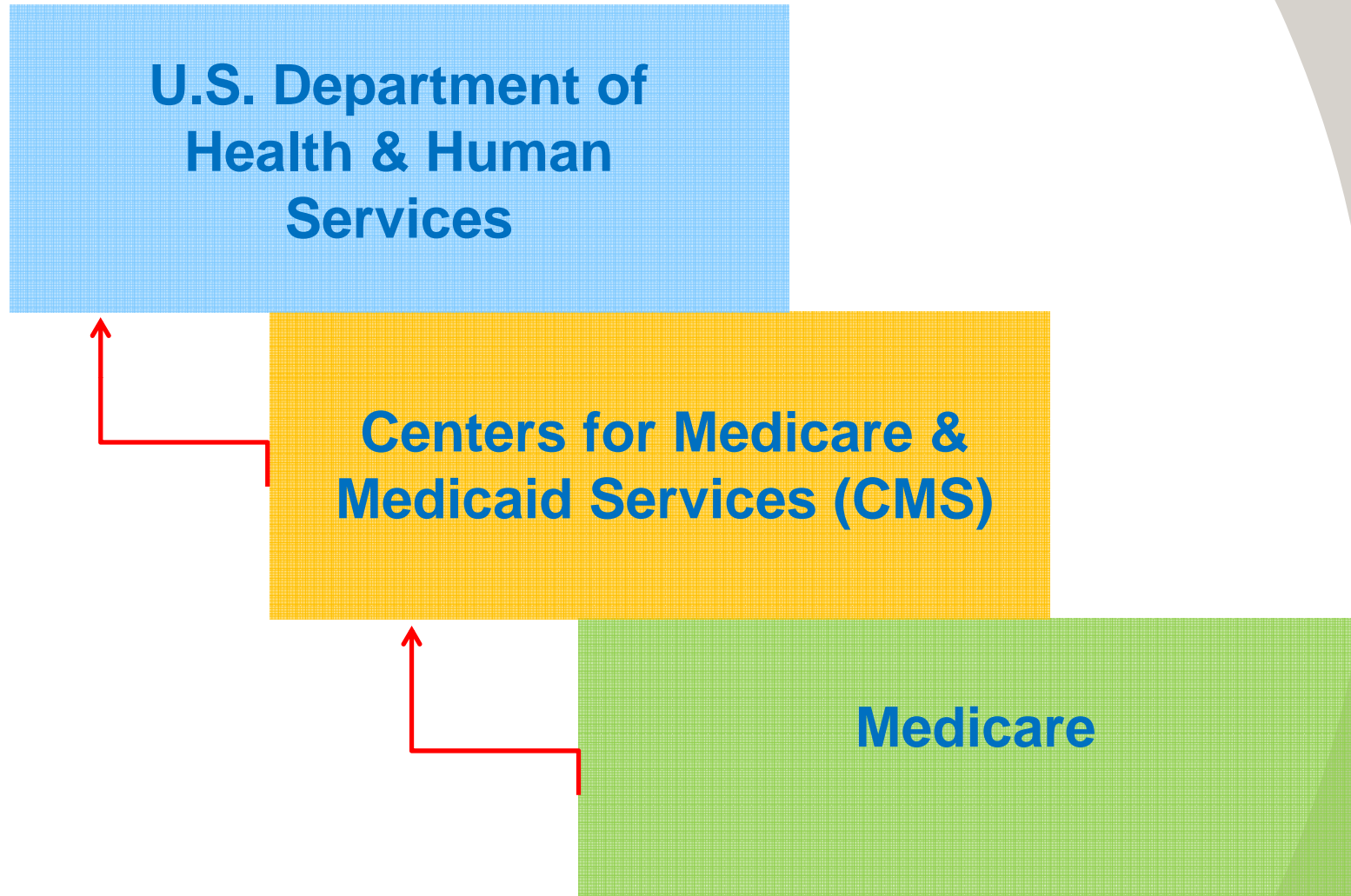
- Original Medicare
 - Part A
 - Part B
- Medicare Advantage Plans
 - Part C
- Prescription Drug Plans
 - Part D
- Medicare Supplement Insurance

Medicare

Federal health insurance program for people

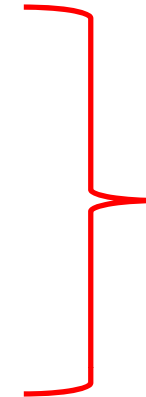
- Age 65 and older
- Under age 65 with certain disabilities
- Any age with End Stage Renal Disease
 - Permanent kidney failure requiring dialysis or a kidney transplant

Medicare Governing Bodies



Medicare: Part A, B, C and D

- Part A
 - Hospital Benefits
- Part B
 - Doctor and Medical Services
- Part C
 - Medicare Advantage Plans
- Part D
 - Prescription Drug Plans



**Original
Medicare**

Getting Medicare – Two Options

Option 1 – Original Medicare

Part A
Hospital coverage

Part B
Outpatient &
physician coverage

Part D
Prescription drug
coverage

*Can purchase a Medicare
Supplement plan to fill in Part A and
B gaps in coverage*

Option 2 – Medicare Advantage Plans

Medicare Part C
(HMO, PPO, PFFS)
Combines both A & B

Medicare Part D
Prescription Drug Coverage

Original Medicare Parts A and B

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY JANE DOE			
MEDICARE CLAIM NUMBER 000-00-0000-A		SEX FEMALE	
IS ENTITLED TO HOSPITAL MEDICAL		EFFECTIVE DATE (PART A) 07-01-1986 (PART B) 07-01-1986	
SIGN HERE → <u>Jane Doe</u>			

Original Medicare Plan – Part A+B

- Single payer system managed by federal government
- See any doctor or supplier that is contracted with Medicare, or any hospital or other facility
- Beneficiary pays deductible before Medicare pays, then Medicare pays its share
- Beneficiary pays co-insurance or co-pay for covered services and supplies
- Supplemental insurance may pay deductibles, co-insurance or other costs not covered by Original Medicare plan

Original Medicare – Enrollment Periods

- Initial enrollment 7 months long
 - 3 months prior to birth month
 - Birth month
 - 3 months following birth month
- General enrollment period
 - For people not enrolling during initial enrollment period
 - January 1 – March 31 for coverage beginning in July
- Special enrollment period
 - Beneficiary may enroll if certain conditions apply, such as loss of group health coverage

Original Medicare – Part A

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY JANE DOE			
MEDICARE CLAIM NUMBER 000-00-0000-A		SEX FEMALE	
IS ENTITLED TO HOSPITAL (PART A)		EFFECTIVE DATE 07-01-1986	
MEDICAL (PART B)		07-01-1986	
SIGN HERE → <u>Jane Doe</u>			

Medicare Part A – Hospital Benefits

- Covers inpatient care
 - Hospitals
 - Skilled nursing facilities (excluding custodial or long term care)
- Covers hospice care
- Covers some home health care

Medicare Part A - Premiums

- In most cases, individuals qualify for Part A without having to pay a monthly premium because the person or spouse paid Medicare taxes while working 40 quarters in their lifetime
- In other cases, individuals may be able to buy Part A if neither spouse paid Medicare taxes
 - Premium is \$461 per month for 0 to 29 paid quarters
 - Premium is \$254 per month for 30-39 paid quarters

Medicare Part A – Defining Benefit Period

- Benefit period is how Medicare measures the use of Part A benefits
- Under Part A, Medicare allows a certain number of inpatient hospital and Skilled Nursing Facility days per benefit period
- No limit to the number of benefit periods a Medicare recipient may have

Medicare Part A – Benefit Period

- Benefit period begins the day beneficiary enters hospital or skilled nursing facility
- Benefit period ends when beneficiary hasn't received inpatient hospital or skilled nursing facility care for 60 days in a row for the same illness (per cause)
- If beneficiary enters hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins
- Beneficiary must pay inpatient hospital deductible for each benefit period

Medicare Part A – Hospital Stays

- Covers semi-private room, meals, general nursing and other hospital services and supplies
- Includes inpatient care provided in critical access hospitals and mental healthcare facilities
- Excludes private duty nursing, television, telephone and private room (unless medically necessary)
- Inpatient mental healthcare in a psychiatric hospital is limited to 190 days in a lifetime

Key phrase: medically necessary

Medicare Part A – Skilled Nursing Facility

- After 3-day minimum, coverage for up to 100 days in a benefit period
 - Semi-private room and meals
 - Skilled nursing and rehabilitative services
 - Medications
- Excludes
 - Long-term or custodial care
 - Personal care supplies
 - Private duty nursing

Medicare Part A – Hospice Care

- For beneficiary with terminal illness and less than six months to live. Coverage includes:
 - Drugs for symptom control and pain relief
 - Medical and support services from Medicare-approved hospice
 - Other services not otherwise covered by Medicare, such as grief counseling
- Generally care is provided in-home, but may include a nursing or assisted living facility if beneficiary's place of residence
- Covers some short-term hospital and inpatient respite care so usual caregiver can rest

Medicare Part A – Home Health Care

Limited to **reasonable and necessary** part-time or intermittent care ordered by a physician

- Skilled nursing care and home health aide services
- Physical, occupational and speech therapy
- Medical social services
- Durable medical equipment for use at home, including
 - Wheelchair
 - Hospital bed
 - Oxygen
 - Walker
- Medical supplies for use at home

Medicare Part A - Blood

Pints of blood received by beneficiary at a hospital or skilled nursing facility during a covered stay

Medicare Part A – 2010 Deductibles & Coinsurances

Benefit	Beneficiary pays:
Hospital Stay	<ul style="list-style-type: none"> • First 60 days – beneficiary pays \$1,100 • Days 61-90 – beneficiary pays \$275 per day • Lifetime reserve days – 91-150 days <ul style="list-style-type: none"> - one time use – beneficiary pays \$550 per day - after these days are used, the next benefit period has a 90-day maximum, after 90 days beneficiary pays all costs
Blood	<ul style="list-style-type: none"> • All inpatient costs for the first 3 pints of blood • 20% of Medicare-approved amount for additional pints
Home Healthcare	<ul style="list-style-type: none"> • \$0 for home healthcare services • 20% of Medicare-approved amount for DME
Hospice Care	<ul style="list-style-type: none"> • Copay up to \$5 for outpatient prescription drugs • 5% of Medicare-approved amount for inpatient respite care
Skilled Nursing Facility	<ul style="list-style-type: none"> • \$0 for first 20 days of each benefit period • \$137.50 per day for next 21-100 days of each benefit period • All costs for each day after 100 days of each benefit period

Original Medicare – Part B

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY JANE DOE			
MEDICARE CLAIM NUMBER	SEX		
000-00-0000-A	FEMALE		
IS ENTITLED TO	EFFECTIVE DATE		
HOSPITAL (PART A)	07-01-1986		
MEDICAL (PART B)	07-01-1986		
SIGN HERE →	<i>Jane Doe</i>		

Medicare Part B – Outpatient/Physician Svcs

- Optional coverage
- Helps cover medical services deemed medically necessary, such as
 - Doctor's services
 - Outpatient hospital care
 - Other medical services not covered by Part A
- Covers some preventive services
- Updates as of January 1, 2010
 - Mental health costs

Medicare Part B – 2010 Premiums

Beneficiaries filing 2009 individual tax return with income	Beneficiaries filing 2009 joint tax return with income	2010 Monthly Part B premium
Less than or equal to \$82,000	Less than or equal to \$164,000	\$96.40 or \$110.50 (applies only to new age-ins effective 2010)
Greater than to \$82,000 and less than or equal to \$102,000	Greater than \$164,00 and less than or equal to \$204,000	\$154.70
Greater than \$102,000 and less than or equal to \$153,000	Greater than \$204,000 and less than or equal to \$306,000	\$221.00
Greater than \$153,000 and less than or equal to \$205,000	Greater than \$306,000 and less than or equal to \$410,000	\$287.30
Greater than \$205,000	Greater than \$410,000	\$353.60

Medicare Part B – Eligibility

- Individuals entitled to Part A benefits can purchase Part B
- Voluntary program requiring payment of monthly premium
- Premium typically taken out of beneficiary's monthly Social Security or Railroad Retirement check

Medicare Part B – Deductibles & Coinsurance

Benefit	Beneficiary pays:
Deductible	The first \$155 annually for Part B-covered services or items
Blood	<ul style="list-style-type: none"> • All outpatient costs for the first 3 pints of blood • 20% of Medicare-approved amount for additional pints
Clinical Lab Services	<ul style="list-style-type: none"> • \$0 for Medicare-approved services
Home Health Services	<ul style="list-style-type: none"> • \$0 for Medicare-approved services • 20% of Medicare-approved amount for DME
Medical and Other Services	<ul style="list-style-type: none"> • 20% of the Medicare-approved amount • Most doctor services and preventive services, outpatient therapy
Mental Health Services	<ul style="list-style-type: none"> • 50% for outpatient mental health care
Other Covered Services	<ul style="list-style-type: none"> • Co-payment and coinsurance amounts
Outpatient Hospital Services	<ul style="list-style-type: none"> • Co-payment or coinsurance amount that varies by service <p>Note: cost share cannot be more than the amount of the inpatient hospital deductible (\$1,100)</p>

Medicare and Medicaid

- State program for individuals with limited income
 - Program pays Part B premiums
 - May also pay Part A and Part B deductibles and coinsurance
- Also known as
 - Medicare Savings Program
 - Dual Eligibles
 - Medi/Medi (Medicare/Medicaid)

End Stage Renal Disease (ESRD) Entitlement

- Stage of kidney impairment that appears irreversible and permanent
 - Requires regular course of dialysis or kidney transplant to maintain life
- Medicare covers individuals who have not reached age 65 suffering from ESRD

Disability Eligibility

Social Security & Railroad Retirement beneficiaries entitled to Medicare Coverage

- Disabled workers
- Disabled widows/widowers between age 50-65
- Persons age 18 and over receiving Social Security Benefits because they were disabled before reaching age 22
- Coverage begins 24-months after individual is deemed permanently disabled
- No waiting period for individuals with amyotrophic lateral sclerosis (ALS)
- Month to month entitlement for permanent disability ends last day of the month before birth month in which individual turns age 65

Medicare – Part C

Medicare Part C - Eligibility

Beneficiary requirements

- Must have Medicare Parts A and B
- Must continue to pay premium for Part B
- Must live in the service area where plan is offered
- Cannot have ESRD when joining the plan

Medicare Part C – Coverage Types

“MA” Medicare Advantage Plans

- Medical health plan that **does not** include prescription drug coverage
- If enrolled in a Medicare Advantage plan, enrollee must select a Part D plan offered by the same carrier

“MAPD” Medicare Advantage Prescription Drug Plans

- Integrated medical and prescription drug plan
- Plans and coverage vary by carrier

Medicare Part C – “MA” Plan Types

HMO	Health Maintenance Organization
PPO	Preferred Provider Organizations
POS	Point of Service
PFFS	Private Fee for Service
SNP	Specialized Needs Plan
MSA	Medicare Medical Savings Account

Medicare Part C – MA Enrollment Periods

OEP	Open Enrollment Period (applies only to Traditional Medicare and MA)
AEP	Annual Election Period 11/15 – 12/31
OEP (new)	Begins month individual starts Medicare Part A & B; ends last day of the 3rd month following Medicare entitlement or Dec. 31, whichever comes first
OEPI	Original election period for institutional enrollees – have two months post-discharge to switch to new Medicare Advantage plan
SEP	Special Election Period

Medicare Part C - Open Enrollment Period Limits

If coverage is:	Can use OEP to get:	Cannot use OEP to get:
Medicare Advantage with prescription drug coverage (MA-PD)	A different MA-PD, or Original Medicare + PDP, or Fee-for-Service + PDP	MA-only, or Original Medicare only (cannot drop drug coverage)
Medicare Advantage with no prescription drug coverage (MA only)	A different MA-only, or Original Medicare only	MA-PD, or Original Medicare + PDP (cannot add drug coverage)
MA-only PFFS +PDP	MA-PD, or Different MA only PFFS & same PDP, or Original Medicare & same PDP	MA-only, or Original Medicare only (cannot drop drug coverage)
Original Medicare + Prescription Drug Plan (PDP)	MA-PD, or MA-PFFS + same PDP	MA-only, or Different PDP to use with Original Medicare
Original Medicare only	MA-only	MA-PD, or Original Medicare + PDP (cannot add drug coverage)
MSA	N/A	MA OEP does not apply to enroll or disenroll from an MSA plan

Medicare – Part D

Medicare Part D – Prescription Drug Coverage

To be eligible for Part D, beneficiary must be enrolled in Part A **and** Part B.

Part D:

- Adds drug coverage to Original Medicare
- Adds drug coverage to Medicare Advantage plans, except MSA
 - If enrolled in a Medicare Advantage plan, enrollee must select a Part D plan offered by the same carrier

Medicare Part D – Late Enrollment Penalty

- After initial Medicare enrollment period ends, any break of 63 days or longer in “creditable coverage” from another source will result in a higher Medicare Part D premium of 1% per month once enrolled
- The 1% is based on the National Medicare average premium
 - Average premium will vary by year
 - Penalty assessed for as long as the beneficiary has Part D entitlement

Medicare Supplement Insurance

Medicare Supplement Insurance

- Medicare Supplement policy is health insurance sold by private companies to fill in the “gaps” in Original Medicare
- Beneficiary must have Part A and Part B
- All Medicare Supplement policies are “standardized” plans
- Each plan has a different set of basic and extra benefits

Medicare Supplement - MIPPA

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Goal

- Apply changes to Medicare Supplement plans in order to “modernize” plans
- Avert a 10.6% cut in physician payments scheduled for July 1, 2008 with positive updates through end of 2009
- Apply benefit changes to Traditional Medicare - \$4.5 billion increase over 5 years
- Apply wide variety of changes to Medicare Advantage Program - \$13.8 billion decrease over 5 years

Passed by House July 24, 2008

Medicare Supplement – 2010 Changes

Summary of Changes

BENEFITS

Eliminates plans E, H, I and J as duplicative due to the shift of prescription drug coverage to Medicare Part D

Adds hospice benefit as basic benefit for all plans

Removes preventive and at-home recovery coverage

Two new plan choices to provide options for higher cost-sharing with a lower premium

ADMINISTRATION

Carriers who want to offer more than Plan A must also offer Plan C or Plan F

Carriers are required to freeze existing standardized plans and launch a new pool

Plans can choose to apply medical underwriting for members of existing standardized plans who want to change to the new 6/2010 plans

Medicare Supplement – Standardized Plans

- Insurance companies don't always offer all plan options, but must make Plan A available
- Basic Benefits
 - Hospitalization
 - Part A coinsurance
 - Coverage for 365 days after Medicare benefits end
 - Medicare Expenses
 - Part B coinsurance (generally 20% of Medicare-approved expenses) or copays for hospital outpatient services
 - Blood
 - First 3 pints of blood each year

Medicare Supplement – Plans M and N

Newest plans

Plan M

- Basic benefits, including 100% Part B coinsurance
- Skilled Nursing Facility Coinsurance
- 50% Part A Deductible
- Foreign Travel Emergency

Plan N

- 100% coverage on all Part A (inpatient services)
- Member pays Part B deductible (\$155 in 2010), then
 - \$20 copay per office visit
 - \$50 per emergency room visit (waived if admitted)
- Foreign Travel Emergency

Medicare Supplement – SELECT Plans

- Sold in only some states (not in Alaska)
- One of the standardized Plans A through L
- To receive full benefits (except in emergency), must:
 - Use specific hospitals
 - Use specific doctors in some cases

Medicare Supplement – Enrollment Period

- Enrollment period lasts six months
 - Starts on 1st day of the month Medicare Beneficiary is both
 - Age 65 or older
 - Enrolled in Medicare Part B
 - During this period, insurance carrier cannot use medical underwriting
- Once 6-month open enrollment period starts, it can't be changed
- During this open enrollment period, insurance carriers cannot:
 - Deny any policy it sells*
 - Charge more for the policy

*pre-existing condition can be applied if the enrollee did not have 6 months of “creditable coverage” prior to the start date

Medicare Supplement – Guaranteed Issue Rights

Medicare beneficiaries have guaranteed issues rights if they have other healthcare coverage that is changing in some way or they are losing their coverage.

- Employer-based coverage ends
- Medicare Advantage plan withdraws
- Beneficiary moves out of the plan's service area
- Enrolled in a Medicare Advantage Plan when first eligible and within first year of joining, wants to switch to the Original Medicare Plan
- Beneficiary dropped a Medicare Supplement policy to join a Medicare Advantage Plan for the first time; beneficiary has been in the plan for less than a year and wants to switch back.
- Medicare Supplement insurance company goes bankrupt

Medicare Supplement – Guaranteed Issue

Guaranteed Issue Rights Situations	Medicare Supplement Plan Choices
Beneficiary Medicare Advantage plan or PACE program coverage ends due to the plan leaving the Medicare program, or stops care in beneficiary area	A, B, C, F, K, L
Beneficiary employer group health plan coverage ends. Note: Washington state requires it to be Retiree group health coverage	A, B, C, F, K, L
Beneficiary's employer group health plan, MA MCO, PACE, Medigap, or Medicare SELECT health coverage ends because beneficiary moves out of the plan's service area	A, B, C, F, K, L

Medicare Supplement – Guaranteed Issue

Guaranteed Issue Rights Situations	Medicare Supplement Plan Choices
Beneficiary joins a MA plan or PACE program when first enrolled for Medicare and wants to leave within the first year of joining	All plans
Beneficiary terminates a Medigap policy to enroll in a MA plan, Medicare Select, or PACE program for the first time and now wants to terminate the policy after no more than 12 months of enrollment	Original plan. If not available, then A, B, C, or F
Beneficiary's Medigap insurance company goes bankrupt and they lose coverage, or beneficiary's Medigap policy coverage ends through no fault of beneficiary	A, B, C, F, K, L

Medicare Supplement – Guaranteed Issue

Guaranteed Issue Rights Situations	Medicare Supplement Plan Choices
Beneficiary leaves plan because MA plan, MCO, PACE, Medicare Select, or Medigap insurance company has committed fraud. For example, the marketing materials were misleading, or quality standards were not met.	A, B, C, F, K, L
Beneficiary's Medicare Select insurer has had its certification terminated, the insurer has discontinued providing the plan in beneficiary's area, or has substantially violated a material provision of the organization's contract in relation to the individual.	All plans

Medicare Supplement – Disabilities & ESRD

Medicare beneficiaries under the age of 65 and eligible for benefits due to **DISABILITY** or **END STAGE RENAL DISEASE**

- Federal government doesn't require insurance companies to sell Medicare Supplement policies to beneficiaries under age 65
- Some states (not Alaska) do require insurance companies to sell Medicare Supplement policies to Medicare beneficiaries under age 65
- Once a Medicare beneficiary "ages in to" Medicare, they receive a new open enrollment period

Medicare Supplement – Unintended Consequences

Enrollees on “frozen” Medicare Supplement Plans I or J that include drugs, as of June 1, 2010:

- Can continue to keep their coverage as issued, or
- Purchase a Part D prescription drug plan, in which
 - they will be required to apply for a new Medicare Supplement plan, which may be subject to medical underwriting
 - Part D penalties apply

Drug coverage provided with these plans generally does not provide as comprehensive coverage as a Part D plan and these are considered by CMS to be non-creditable

Medicare Coverage References

The content of this presentation has been provided to you with the use of the following reference resources:

- “Your Medicare Benefits”
 - CMS Publication
- “Medicare and You”
 - CMS Publication
- “2009 Choosing a Medicare Supplement Policy”
 - CMS Publication
- MIPPA Regulations