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Medicare 2017

A. **Medicare**. What is Medicare? Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (kidney failure requiring dialysis or kidney transplant). Title XVIII of the Social Security Act is administered by the Centers for Medicare and Medicaid Services. Title XVIII appears in the United States Code as §§1395-1395ccc, subchapter XVIII, chapter 7, Title 42. Regulations of the Secretary of Health and Human Services relating to Title XVIII are contained in chapter IV, Title 42, and in subtitle A, Title 45, Code of Federal Regulations. When researching you will want to utilize **www.medicare.gov** and **www.ssa.gov.**

1. **Part A**. Premium is $0 if individual or spouse has 40 or more quarters of Medicare covered employment. If individual does not have required quarters premiums are up to $413/month. Enroll at least 3 months prior to turning 65 years of age.

   a. **Hospital Benefits**. Deductible: $1,316 deductible for each benefit period. Days 1-60: $0 coinsurance. Days 61-90: $329 coinsurance per day of each benefit period. Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)hospital admission days 1-60. Coverage includes acute care hospitals, inpatient rehabilitation facilities, long-term care hospitals, and inpatient mental health care. The individual must be admitted as an inpatient for Part A to pay for care. A benefit period ends when you haven't received any inpatient hospital (or skilled care in a SNF) for 60 days in a row.
   b. **Home Health Care Benefits**. Home-bound individual pays nothing for covered home health services. (Individual must pay 20% of the Medicare approved co-pay for Durable Medical Equipment). Doctor must see individual face-to-face to certify individual requires home health services

such as skilled nursing services, physical therapy, speech therapy, and occupational therapy.

c. **Hospice Benefits**. Individual pays nothing for hospice care, co-pay of up to $5 per prescription for outpatient prescription drugs for pain and symptom management, and 5% of the Medicare approved amount for inpatient respite.
d. **Skilled nursing/Rehabilitation Benefits**. Individual is eligible for these benefits after a 3-day minimum medically-necessary inpatient hospital stay for a related illness or injury. The individual pays nothing for the first 20 days each benefit period, individual will pay a co-insurance of $164.50/day for days 21-100. After that, the individual will pay all costs for each day after day 100 in a benefit period.
e. **Mental Health Inpatient Stay**. No limit of benefit periods when you get mental health care in a general hospital. You can have multiple benefit periods when you get care in a psychiatric hospital. Lifetime limit of 190 days. Deductible: $1,316 for each benefit period. Days 1-60, $0 coinsurance per day of each benefit period. Days 61-90, $329 coinsurance per day of each benefit period. Days 91 and beyond: $658 coinsurance for each lifetime reserve day after day 90 for each benefit period. Beyond lifetime reserve days: all costs. Twenty percent (20%) of the Medicare-approved amount for mental health services you get from doctors and other providers while you are a hospital inpatient.
f. **Late enrollment Penalty**. If you don't buy when first eligible you will have to pay a higher premium.

2. **Part B.** Premium is $134.00 if the premium is withdrawn from the individual's Social Security check and income is $85,000 or less. For those with income greater than $85,000 the premium is $187.50/month plus income adjusted amount up to $428.60. There is an annual deductible of $183 and a co-pay of 20% of the Medicare-approved amount of service if the medical provider accepts assignment. There is no annual limit to what the individual may pay out of pocket.

    a. **Physician services**. After meeting the deductible Part B pays 80% of doctors' services, outpatient care (often described as "observation status"), durable medical equipment, and other medical services.
    b. **Preventative Services**. Abdominal Aortic Aneurysm Screening. Ambulance Services (medically necessary between hospital and skilled nursing facility). Advance Care Planning. Alcohol misuse screening and counseling. Ambulatory Surgical Centers Services. Blood. Bone Mass Measurement test (individual pays nothing). Breast Cancer Screening (mammogram- individual pays nothing). Cardiac Rehabilitation. Cardiovascular Screenings. Cervical and Vaginal Cancer Screening (individual pays nothing). Chemotherapy. Chiropractic services to help correct subluxation. Chronic Care Management Services. Clinical Research Studies. Colorectal Cancer Screenings (individual pays nothing). Continuous Positive Airway Pressure (CPAP) therapy. Defibrillator.

Depression Screening. Diabetes Screenings (individual pays nothing). Diabetes Self-Management Training and Diabetes Supplies. Durable Medical Equipment. EKG Screening. Emergency department services. Eyeglasses. Flu Shots (individual pays nothing). Foot exams. Glaucoma Tests. Hearing and Balance exams. Hepatitis B Shots (individual pays nothing). Hepatitis C Screening. HIV screening (individual pays nothing). Home Health Services – when there has not been a hospital admission. Kidney Dialysis Services and Supplies. Kidney disease education services. Laboratory services. Lung Cancer Screening. Medical Nutrition Therapy Services. Mental Health care (outpatient). Obesity Screening and Counseling. Occupational Therapy. Outpatient Hospital Services. Physical Therapy. Outpatient hospital care. Pneumococcal Shot. Prescription drugs (limited). Prostate Cancer Screenings. Prosthetic/Orthotic Items. Pulmonary Rehabilitation. Rural Health Clinic (RHC) Services. Second Surgical Opinions. Sexually Transmitted infections screening and counseling. Speech-language pathology services. Surgical Dressing Services (wound care). Tobacco Use Cessation Counseling. Telehealth. Tests (other than lab tests). Transitional Care Management Services. Transplants and Immunosuppressive Drugs. Tobacco-use cessation counseling. Travel coverage (limited). Urgent Care. Welcome to Medicare preventative visit (individual pays nothing). Yearly "Wellness" visit (individual pays nothing).

c. **Services not covered**. Long-term care. Routine Dental and Eye care. Dentures. Cosmetic surgery. Acupuncture. Hearing aids and exams for fitting them. Concierge care.

3. **Part C**. Medicare Advantage Plans are offered by private companies approved by Medicare. Premium for Part C is in addition to the Part B premium, and established by the private insurance company. If an individual joins a Medicare Advantage Plan it will provide the Part A and Part B coverage (except for Hospice care), not original Medicare. Medicare Advantage Plans must cover all of the services that original Medicare covers except hospice care. They may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Part D coverage (prescription drug coverage). Keep your original Medicare card, you will need it if you ever switch back to regular Medicare.

    a. **Health Maintenance Organization (HMO) Plans**. Typically can only go to doctors, other health care providers, or hospitals on the plan's list except in an emergency. Services often require a referral from a primary care doctor. You must follow the plan rules. Drug coverage included in most plans, check with plan for coverage and formulary.
    b. **Preferred Provider Organization (PPO)**. In a PPO the individual may pay less if they use health care providers and hospitals that belong to the plan network. You can use out-of-network providers, usually for a higher cost. Drug coverage included in most plans, check with plan for coverage and formulary.

c. **Private Fee-for Service Plan (PFFS).** Similar to regular Medicare, individual may generally see any health care provider; the plan determines your co-pays and deductibles. Sometimes includes drug coverage, otherwise you can purchase a Part D plan.
d. **Special Needs Plan (SNP).** SNP's provide focused and specialized healthcare for specific groups of people, such as those who are dual eligible (eligible for Medicare and Medicaid), who live in a nursing home, or have certain chronic conditions. All SNP's must provide drug coverage.
e. **Medical Savings Account Plans (MSA).** This is a plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible) and the individual may use the money to pay for health care services throughout the year.
f. **Join, Switch, or Drop a Medicare Advantage Plan.** Individuals may join 3 months before turning 65 through 3 months after turning 65. If the individual is eligible due to disability, they may join 3 months before their 25th month of disability, and up to 3 months after. This year between October 15 – December 7, individuals can join, switch, or drop a plan, any change is effective January 1. Generally, the individual must stay enrolled in the plan selected unless they move out of the plan's service area; lose other creditable coverage; or live in an institution (like a nursing home).
g. **Changes after December 7.** Individual may leave a Medicare Advantage plan between January 1 – February 14 and switch to Original Medicare.
h. **5-Star Special Enrollment Period.** December 8 – November 30 an individual may switch to a 5-star Medicare Advantage Plan at any time during the year. The overall plan star ratings are available at **www.medicare.gov/find-a-plan**. Can only join if plan available in individual's area. Individual may only switch one time each year.
i. **Read the information you get from your Plan.** Evidence of Coverage (EOC) gives you details about what the plan covers, how much you pay, and more. The Annual Notice of Change (ANOC) includes any changes in coverage, costs, provider networks, service area, and more that will be effective in January. You must follow the plan rules. Providers can join or leave the network any time. Medicare Advantage Plans can't charge more than regular for certain services, i.e. chemotherapy, dialysis, and skilled nursing facility care. MAP's have a yearly limit on your out of pocket costs for medical services, once you reach this limit, you will pay nothing for covered services.

4. **Part D.** Prescription Drug Coverage, offered through stand alone insurance plans or as part of Medicare Advantage Plans. Monthly/annual premium determined by insurance company and individual's contract. If the individual does not have creditable prescription drug coverage and does not join a Medicare D plan when first eligible, the individual may have to pay a late enrollment penalty.

a. **Creditable prescription drug coverage.** Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.
b. **Join, Switch, or Drop Part D.** Individuals may join 3 months before turning 65 through 3 months after turning 65. If the individual is eligible due to disability, they may join 3 months before their 25th month of disability, and up to 3 months after. This year between October 15 – December 7, individuals can join, switch, or drop a plan, any change is effective January 1. Generally, the individual must stay enrolled in the plan selected unless they move out of the plan's service area; lose other creditable coverage; or live in an institution (like a nursing home).
c. **Late enrollment penalty.** Calculated by multiplying 1% of the "national base beneficiary premium" ($35.63 in 2017) times the number of full, uncovered months individual was eligible but didn't join a Medicare drug plan and went without creditable coverage.
d. **Covered Drugs.** Each Part D plan has its own formulary – a list of covered drugs. Many Medicare Drug plans place drugs in different tiers in their formularies. The individual will need to contact their Part D plan to evaluate its current formulary. The plan must notify the member of any formulary changes.
e. **Medication Therapy Management (MTM).** Individual in a Part D plan may participate in a MTM program to make sure their medications are working. The program includes a free discussion and review of all medications by a pharmacist or other health professional and a written summary of the discussion to get the most benefit from the medications.
f. **Prior authorization.** Individual and/or prescriber must contact the drug plan before filling certain prescriptions.
g. **Quantity Limits.** Plan may limit how much medication received at one time.
h. **Step therapy.** Plan may require you to try a similar, lower cost drug before the plan will cover the prescribed drug.
i. **Donut Hole.** Most Part D plans have a coverage gap, placing a temporary limit on what the plan will pay for drugs. The coverage gap begins after the individual has spent a certain amount for covered drugs. Once the individual enters the coverage gap, they pay 40% of the plan's cost for covered brand name drugs and pay 51% of the plan's cost for covered generic drugs until they reach the end of the coverage gap.
j. **Catastrophic Coverage.** Once the individual is out of the coverage gap, they are immediately eligible for "catastrophic coverage." This coverage ensures the individual only has to pay a small coinsurance or copayment for covered drugs the rest of the year.
k. **Extra Help Program.** This is a Medicare program to help individuals with limited income and resources to pay Medicare prescription drug costs. Income limit and asset limits apply, for a single person the income limit is $17,655 and asset limit is $13,640 (2016). For married individuals, the income limit is $23,895 and asset limit is $27,250 (2016). The

program will help pay the Part D premium, deductibles, coinsurance and copayments; there is no coverage gap, and no late enrollment penalty. Make sure you pay no more than the LIS drug coverage cost limit. In 2017, costs are no more than $3.30 for each generic /$8.425 for each brand-name covered drug.

l. **5-Star Special Enrollment Period.** During December 8 – November 30, an individual may switch to a 5-star Medicare Drug plan once any time during the year. The overall plan star ratings are available individual's area. Individual may only switch one time each year.

5. **Medicare Supplement Insurance Policies (Medigap).** A policy sold by private insurance companies that helps pay health care costs that Original Medicare Part A and Part B do not cover, like copayments, coinsurance, and deductibles. All policies must follow federal and state law. Medicare Supplemental Plans are identified as A, B, C, D, F*, G, K, L, M, N.
    a. **You can't use and can't be sold a Medicare Supplemental Insurance policy while you are in a Medicare Advantage Plan**. In most cases if you drop your Medigap Policy to join a Medicare Advantage Plan, you won't be able to get it back.
    b. **If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you will have special rights to buy a Medigap policy if you return to Original Medicare within 12 months of joining.**
    c. **You must have Part A and Part B to purchase Medigap coverage.** You pay a monthly premium for the policy.
    d. **Best time to buy a Medigap policy is during your Medigap open enrollment period.** This 6 month period begins on the first of the month you are 65 or older and enrolled in Part B. If you delay enrolling in Part B because you have group health coverage based on your current employment, your Medigap Open Enrollment Period won't start until you sign up for Part B.

B. What's Important in 2017?

1. **Preventative Services.** Under original Medicare you pay nothing for most covered preventative services from a doctor who accepts assignment. However, some preventative services may require a deductible or coinsurance, or both. These costs may apply if you get a preventive service in the same visit as non-preventive service. **Assignment** means that your doctor, provider, or supplier agrees to accept the Medicare – approved amount as full payment for covered services.
    a. **Advance Care Planning.** Planning for care you would want to get if you become unable to speak for yourself is now covered as part of the Yearly "Wellness" visit. You can talk about an advance directive with your health care professional, and they can help you fill out the forms,

if you want. **If not part of your Yearly "Wellness" visit, the Part B deductible and coinsurance apply.

b. **Bone Density Scan, 1x 24 months.** You pay nothing if doctor accepts assignment.
c. **Breast Cancer Annual, Screening.** You pay nothing if doctor accepts assignment.
d. **Chronic Care Management.** If you have 2 or more chronic conditions that are expected to last at least a year, Medicare may pay a health care provider to help manage those conditions. This includes a comprehensive care plan that lists your problems and goals, other health care providers, medications, community services you have and need, and other information about your health. It also explains your care and how it will be coordinated. There is a monthly fee, and the Part B deductible and coinsurance apply.
e. **Multi-target stool DNA test**. Covered once every 3 years, you pay nothing is doctor accepts assignment.
f. **Screening Fecal Occult Blood Test.** Covered every 12 months, you pay nothing if doctor accepts consignment.
g. **Screening flexible sigmoidoscopy.** Covered once every 4 years. You pay nothing if doctor accepts assignment.
h. **Screening colonoscopy.** Covered every 10 years, you pay nothing if doctor accepts assignment. If polyp or other tissue found and removed, you may have to pay the 20% co-pay.
i. **Screening barium enema.** Covered every 4 years, you pay 20% for the doctor services.
j. **Continuous Positive Airway Pressure (CPAP) therapy.** You pay 20% of Medicare approved rental, after 13 months you own it.
k. **Depression Annual Screening.** You pay nothing if doctor accepts assignment.
l. **Diabetes Screening, 2x annually**. You pay nothing if doctor accepts assignment.
m. **EKG or ECG screening**. Included in your one-time "Welcome to Medicare" preventative visit.
n. **Flu Shots**. You pay nothing if doctor accepts assignment.
o. **Lung Cancer Screening**. Medicare covers a lung cancer screening with Low Dose Computed Tomography (LDCT). You pay nothing if doctor accepts assignment.
p. **Obesity Screening and Counseling**. If you have body mass index (BMI) of 30 or more, face-to-face individual counseling is covered and you pay nothing if your doctor accepts assignment.
q. **Pneumococcal Shot**. You pay nothing if doctor accepts assignment.
r. **Prostate Cancer Screenings**. Medicare covers a PSA test and a digital rectal exam once every 12 months. You pay nothing for the PSA, and a co-pay for the digital rectal exam.

s. **Urgent Care**. Medicare covers urgent needed care to treat a sudden illness or injury that isn't a medical emergency. Co-pays and deductibles apply.

t. **Welcome to Medicare preventative visit**. During the first 12 months that you have Part B you are eligible for this visit and you pay nothing if your doctor accepts assignment. This visit includes a review of your medical and social history related to your health, and education and counseling about preventative services, including screenings, shots and referrals for other care. You pay nothing if your doctor accepts assignment, if you receive additional services during same visit you may have to pay co-pay and deductible.

u. **Yearly Wellness Visit**. After your first year of Medicare eligibility you can get an annual "Wellness" visit to develop or update a personalized plan to prevent disease or disability based on your current health and risk factors. You will need to complete a Questionnaire, called a "Health Risk Assessment," as part of this visit. You must let doctor know you are scheduling your yearly "wellness visit." You pay nothing if doctor accepts assignment. If additional services provided may need to pay co-pay and deductibles.

2. **Sign up for Electronic Medicare Summary Notices**. This is the electronic version of your Medicare Summary notice that lists all services billed and what Medicare paid. You will get an email every month with a secure link to your MSN, instead of waiting three months for a copy in the mail.