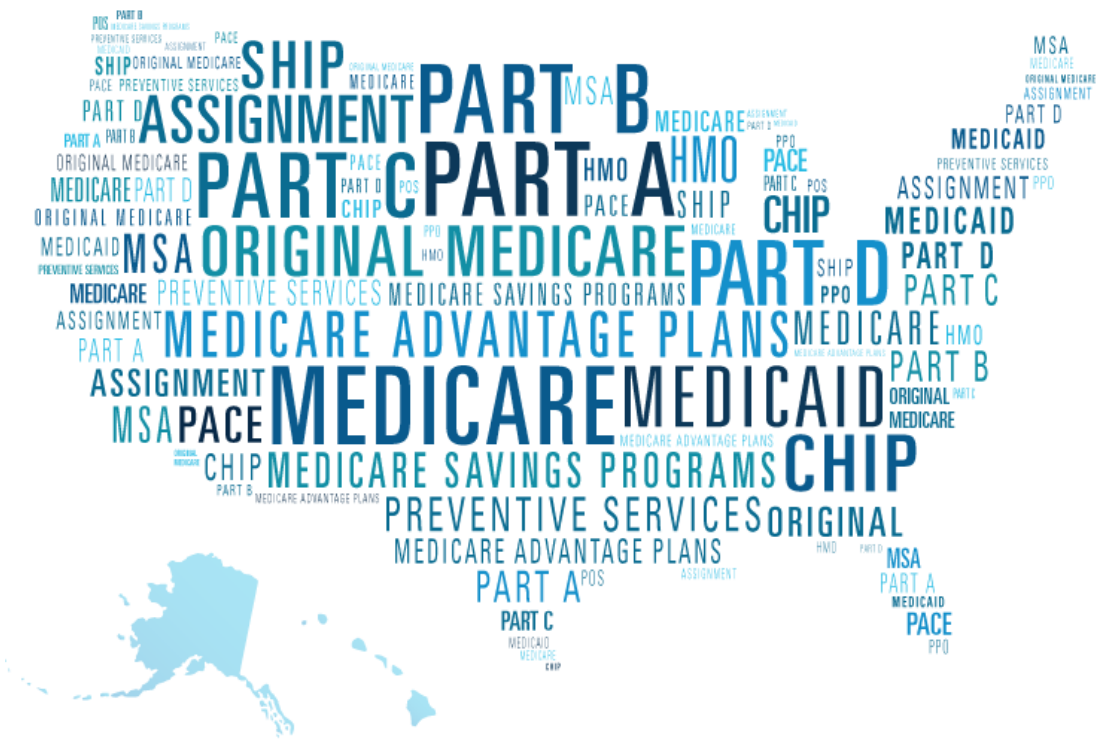
CENTERS FOR MEDICARE & MEDICAID SERVICES

2017 National Training Program



Module 1

Understanding Medicare

Contents

Session Objectives

This session should help you

- Summarize the Medicare program
- Compare the parts of Medicare and coverage options
- Describe Medicare-covered services and supplies
- Recognize Medicare rights and appeals
- Explain programs for people with limited income and resources

Lesson 1—Program Basics

- What is Medicare?
- Enrolling in Original Medicare
- Part A and Part B benefits and costs

What Is Medicare?

- Health insurance for people
  - 65 and older
  - Under 65 with certain disabilities
    - Amyotrophic Lateral Sclerosis known as Lou Gehrig's disease (without waiting period)
  - Any age with End-Stage Renal Disease
- Administered by
  - Centers for Medicare & Medicaid Services

NOTE: To get Medicare Part A and/or Part B, you must be a U.S. citizen or be lawfully present in the U.S.

The 4 Parts of Medicare

Part A
Hospital Insurance

Part B
Medical Insurance

Part C
Medicare Advantage Plans (like HMOs/PPOs)
Includes Part A, Part B and sometimes Part D coverage

Part D
Medicare Prescription Drug Coverage

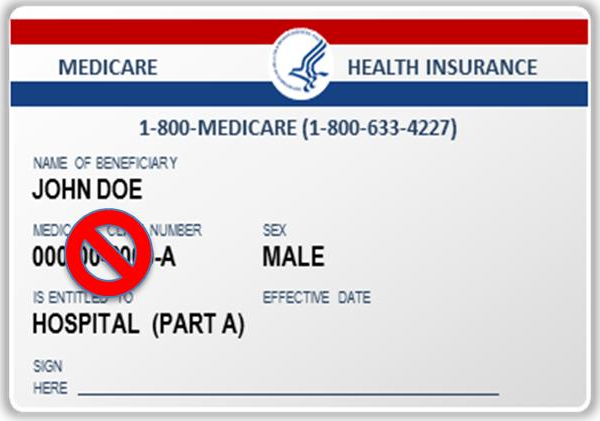
Automatic Enrollment—Part A and Part B

- Automatic enrollment for those receiving
  - Social Security benefits
  - Railroad Retirement Board benefits
- Initial Enrollment Period Package
  - Mailed 3 months before
    - 65 or
    - 25th month of disability benefits
  - Includes your Medicare card

Medicare Card

- Keep it and accept Medicare Part A and Part B
- Return it to refuse Part B
  - Follow instructions on back of card

Front



Back

When Enrolling Isn't Automatic

- If you're not automatically enrolled
  - You need to enroll with Social Security
    - Visit socialsecurity.gov, or
    - Call 1-800-772-1213, or
    - Visit your local office
  - If retired from the Railroad, enroll with the Railroad Retirement Board (RRB)
    - Call your local RRB office or 1-877-772-5772
- Apply 3 months before you turn 65
  - Don't have to be retired to get Medicare

When to Enroll in Medicare

- You can first enroll during your Initial Enrollment Period (IEP), which lasts 7 months

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**	**1** month **after** you turn **65**	**2** months **after** you turn **65**	**3** months **after** you turn **65**
Sign up early to avoid a delay in coverage. To get Part A and/or Part B the month you turn 65, you must sign up during the first 3 months before the month you turn 65.			If you wait until the last 4 months of your Initial Enrollment Period to sign up for Part A and/or Part B, your coverage will be delayed.			

- Can enroll in premium-free Part A anytime after IEP begins
- Can only enroll in Part B (and premium Part A) during IEP and other limited times
- May have a penalty if you don't enroll during IEP

General Enrollment Period (GEP)

- For people who didn't sign up for Part B (or premium Part A) during their Initial Enrollment Period
- January 1–March 31 annually
  - Coverage starts July 1
- May have to pay a penalty
  - 10% for twice the number of years you didn't have Part A
  - 10% for each 12 months eligible, but not enrolled in Part B for as long as you have Part B

Premium Part A and Part B Special Enrollment Period (SEP)

- Most people don't qualify for an SEP
- Must have employer group health plan (EGHP) coverage based on active, current employment of you or your spouse
- Can enroll
  - Anytime still covered by EGHP, or
  - Within 8 months of the loss of coverage or current employment, whichever happens first
    - Retiree and COBRA coverage aren’t considered active employment

When Employer or Union Coverage Ends

- When your employment ends
  - You may get a chance to elect Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - You may get a Special Enrollment Period
    - Sign up for Part B without a penalty
- Medigap Open Enrollment Period
  - A 6-month period that starts when you're both 65 and signed up for Part B
  - Once started, it can’t be delayed or repeated

Original Medicare
Part A—Hospital Insurance Coverage

- Part A– Hospital Insurance helps cover

  - Inpatient hospital care
  - Inpatient skilled nursing facility (SNF) care
  - Blood (inpatient)
  - Certain inpatient non-religious, nonmedical health care in approved religious nonmedical institutions (RNHCIs)
  - Home health care
  - Hospice care

Paying for Medicare Part A

- Most people don’t pay a premium for Part A
  - If you or your spouse paid Federal Insurance Contributions Act (FICA) taxes at least 10 years
- If you paid FICA less than 10 years you can pay a premium to get Part A
- May have a penalty if you don’t enroll when first eligible for premium Part A
  - Your monthly premium may go up 10%
  - You'll have to pay the higher premium for twice the number of years you could’ve had Part A, but didn't sign up

Inpatient Hospital Care

- Semi-private rooms
- Meals
- General nursing care
- Drugs that are part of your inpatient treatment
- Hospital services and supplies

Benefit Periods

- Measures use of inpatient hospital and skilled nursing facility (SNF) services
- Begins the day you first receive inpatient care
  - In hospital or SNF
- Ends when not in hospital/SNF 60 days in a row
- Pay Part A deductible for each benefit period
- No limit to the number of benefit periods you can have

Paying for Inpatient Hospital Stays

For Each Benefit Period in 2017	You Pay
Days 1-60	$1,316 deductible
Days 61-90	$329 per day
Days 91-150	$658 per day (60 lifetime reserve days)
All days after 150	All Costs

Skilled Nursing Facility Covered Services

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, and speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation (limited)
- Dietary counseling

Skilled Nursing Facility (SNF) Care Required Conditions for Coverage

- Require daily skilled services
  - Not just long-term or custodial care
- Hospital inpatient 3 consecutive days or longer
- Admitted to SNF within specific time frame
  - Generally 30 days after leaving hospital
- SNF care must be for a hospital-treated condition
  - Or condition that arose while receiving care in the SNF for hospital-treated condition
- Must be a Medicare-participating SNF

Paying for Skilled Nursing Facility Care

For Each Benefit Period in 2017	You Pay
Days 1-20	$0
Days 21-100	$164.50 per day
All days after 100	All Costs

5 Required Conditions for Home Health Care Coverage

1. Must be homebound
2. Must need skilled care on part-time or intermittent basis
3. Must be under the care of a doctor
   - Receiving services under a plan of care
4. Have face-to-face encounter with doctor
   - Prior to start of care or within 30 days
5. Home health agency must be Medicare-approved

Paying for Home Health Care

- In Original Medicare you pay
  - Nothing for covered home health care services
  - 20% of Medicare-approved amount
    - For durable medical equipment
      - Covered by Part B
- Plan of care reviewed every 60 days
  - Called episode of care

Part A Hospice Care

- Interdisciplinary team for those with a life expectancy of 6 months or less, and their family
- Sign election statement choosing hospice care instead of routine Medicare-covered benefits to treat your terminal illness
- Focus is on comfort and pain relief, not cure
- Doctor must certify each “election period”
  - Two 90-day periods
  - Then unlimited 60-day periods
  - Face-to-face encounter
- Hospice provider must be Medicare-approved

Covered Hospice Services

- Physician and nursing services
- Physical, occupational, and speech therapy
- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care for pain and symptom management
- Respite care in a Medicare-certified facility
  - Up to 5 days each time, no limit to number of times
- Hospice aide and homemaker services
- Social worker services
- Grief, dietary, and other counseling

Paying for Hospice Care

- In Original Medicare you pay
  - Nothing for hospice care
  - Up to $5 per Rx to manage pain and symptoms
    - While at home
  - 5% for inpatient respite care
- Room and board may be covered in certain cases
  - Short-term respite care
  - For pain/symptom management that can't be managed at home
  - If you have Medicaid and live in a nursing facility

Medicare Part B—Medical Insurance Coverage

- Part B—Medical Insurance helps cover

  - Doctors' services
  - Outpatient medical and surgical services, supplies
  - Clinical lab tests
  - Durable medical equipment
  - Diabetic testing supplies
  - Preventive services

What Are Medicare Part B—Covered Services?

Doctors' Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. You pay 20% of the Medicare-approved amount (if the doctor accepts assignment), and the Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures like X-rays, casts, or stitches. You pay the doctor 20% of the Medicare-approved amount for the doctor's services if the doctor accepts assignment. You also pay the hospital a copayment for each service. The Part B deductible applies.

Medicare Part B—Covered Services Continued

Durable Medical Equipment (DME)	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. Medicare has a program called "competitive bidding." If you live in a competitive bidding area, you must use specific suppliers, or Medicare won't pay for the item and you'll likely pay full price. Includes national mail-order program for diabetic self-testing supplies, and includes 9 local programs for infusion pumps, including insulin pumps and pump supplies. Visit Medicare.gov/supplier to find Medicare-approved suppliers in your area. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

More Medicare Part B—Covered Services

Home Health Services	Medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies. You pay nothing for covered services.
Other (including but not limited to)	Medically necessary medical services and supplies, such as clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited outpatient prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services are covered. Costs vary.

Medicare Part B–Covered Preventive Services

- "Welcome to Medicare" preventive visit
- Yearly “Wellness” visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (CVD) Risk Reduction Visit
- Cardiovascular disease screenings
- Cervical and vaginal cancer screening
  - Human Papillomavirus (HPV) Testing
- Colorectal cancer screenings
  - Screening fecal occult blood test
  - Screening flexible sigmoidoscopy
  - Screening colonoscopy
  - Screening barium enema
  - Multi-target stool DNA test

- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots (Vaccine)
- Glaucoma tests
- Hepatitis B shots (Vaccine)
- Hepatitis C screening test
- HIV screening
- Lung Cancer Screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Pneumococcal shots
- Prostate cancer screening
- Sexually-transmitted infections screening and counseling
- Tobacco use cessation counseling

Paying for Preventive Services

- In Original Medicare you
  - Pay nothing for most preventive services if your provider accepts “assignment”
  - May pay more if provider doesn’t accept assignment
  - May have a copayment
    - If doctor performs other services that aren’t part of covered preventive benefits, or
    - For certain preventive services

NOT Covered By Part A and Part B

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting hearing aids
- Other – check Medicare.gov

Medicare Part B Costs for Most People

Yearly Deductible	$183.00
Coinsurance for Part B Services	▪ 20% coinsurance for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for some preventive services ▪ 20% coinsurance for outpatient mental health services, and copayments for hospital outpatient services

What You Pay—Part B Premiums

- 2017 Premiums
  - Standard premium—$134 (or higher depending on your income)
  - Average premium—$109 (if receiving Social Security benefits)
    - Part B premium increased more than the cost-of-living increase for 2017 Social Security benefits
    - Social Security will tell you the exact amount

Monthly Part B Standard Premium—Income-Related Medicare Adjustment Amount for 2017

Chart is based on your yearly income *in 2015* (for what you pay in 2017)

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	In 2017 You Pay
$85,000 or less	$170,000 or less	$85,000 or less	$134.00
$85,000.01–$107,000	$170,000.01–$214,000	Not applicable	$187.50
$107,000.01–$160,000	$214,000.01–$320,000	Not applicable	$267.90
$160,000.01–$214,000	$320,000.01–$428,000	Above $85,00 and up to $129,000	$348.30
Above $214,000	Above $428,000	Above $129,000	$428.60

NOTE: You may pay more if you have a Part B late enrollment penalty.

Paying the Part B Premium

- Deducted monthly from
  - Social Security benefit payments
  - Railroad retirement benefit payments
  - Federal retirement benefit payments
- If not deducted
  - Billed every 3 months
  - Medicare Easy Pay to deduct from bank account
- Contact Social Security, the Railroad Retirement Board, or the Office of Personnel Management about premiums

Part B Late Enrollment Penalty

- See how your insurance works with Medicare
  - Contact your employer/union benefits administrator
- Penalty for not signing up when first eligible
  - 10% more for each full 12-month period
  - May have a penalty as long as you have Part B
- Sign up during a Special Enrollment Period
- Usually no penalty if you sign up within 8 months of employer coverage ending

Part B Late Enrollment Penalty Example

Mary's Initial Enrollment Period ended September 30, 2009. She waited to sign up for Part B until the General Enrollment Period in March 2012.

- Total time Mary delayed Part B: 30 months
- Mary's Late Enrollment Penalty: 20% (30 months includes 2 full 12-month periods)
- The penalty is added to the Part B monthly premium
- Mary will have the penalty for as long as she has Part B

When You Must Have Part B

- If you want to buy a Medigap policy
- If you want to join a Medicare Advantage Plan
- You're eligible for TRICARE for Life (TFL) or CHAMPVA
- Your employer coverage requires you have it when you become eligible for Medicare (less than 20 employees)
  - Talk to your employer’s or union benefits administrator
- Veterans Affairs (VA) benefits are separate from Medicare
  - You pay a penalty if you sign up late or if you don’t sign up during your Medicare Initial Enrollment Period

Check Your Knowledge—Question 1

In 2017, most people will pay $109.00 for their Part B premium.

a. True

b. False

Check Your Knowledge—Question 2

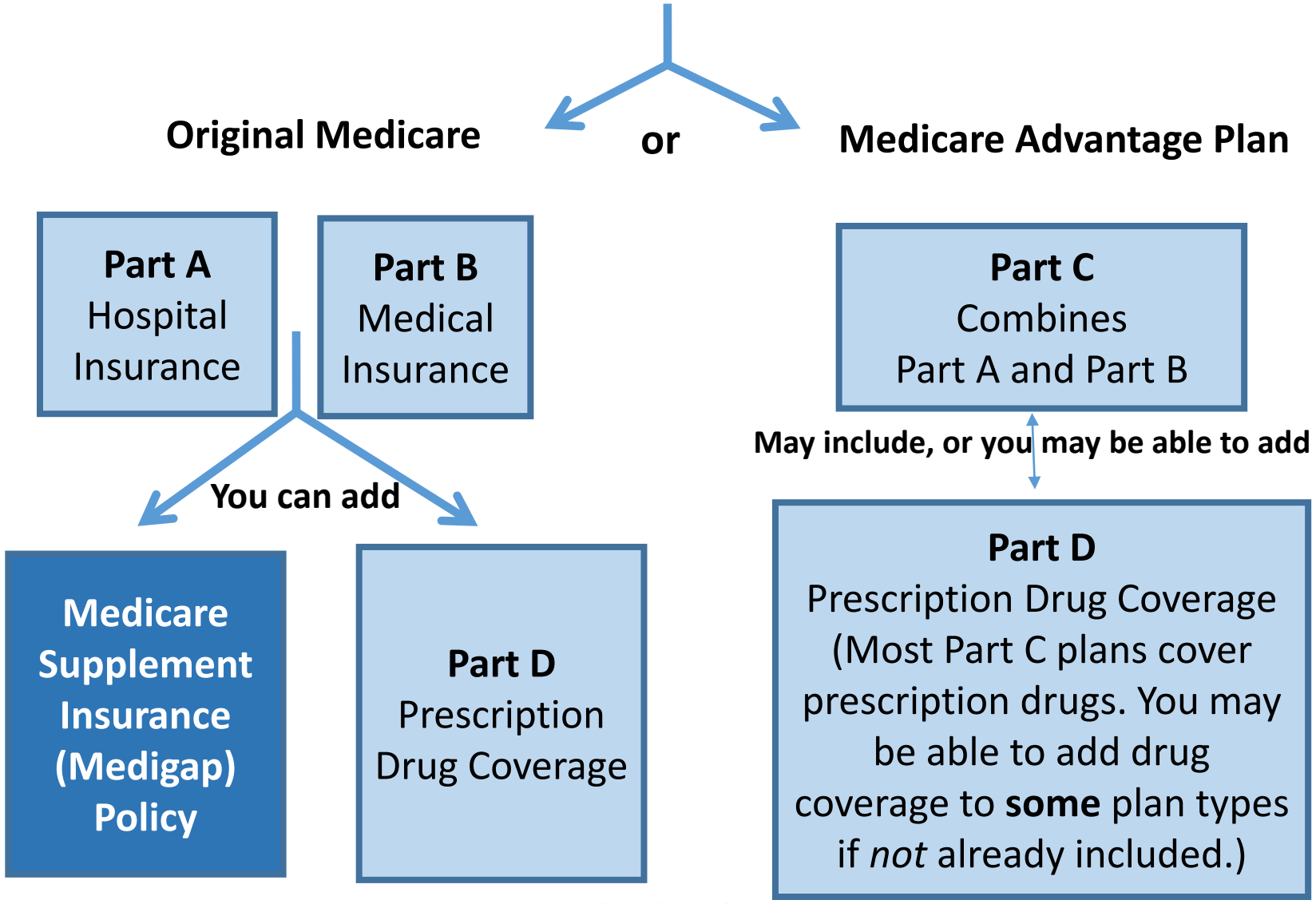
What are the elements of a "Benefit Period"?

a. Measures the use of some Part A services
b. The Part A deductible applies for each
c. Ends when not in a hospital/SNF for 60 days in a row
d. All of the above

Lesson 2—Medicare Coverage Choices

- Your Medicare Coverage Choices
- Original Medicare (Part A and Part B)
  - Assignment
  - Private Contracts
- Medicare Supplement Insurance (Medigap) Policies
- Medicare Prescription Drug Coverage (Part D)
- Medicare Advantage Plans (Part C)
- Other Medicare Health Plans

Your Medicare Coverage Choices



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
- You pay
  - Part B premium (Part A is usually premium free)
  - Deductibles, coinsurance, or copayments
- Get Medicare Summary Notice
- Can join a Part D plan to add drug coverage

Assignment

- Doctor, provider, supplier accepts assignment
  - Signed an agreement with Medicare
    - Or is required to by law
  - Accepts the Medicare-approved amount
    - As full payment for covered services
    - Only charges Medicare deductible/coinsurance amount
- Most accept assignment
  - They submit your claim to Medicare directly

Don’t Accept/Must Accept Assignment

- Providers and suppliers that **don’t** accept assignment
  - May charge you more
    - The limiting charge is 15% more
    - May have to pay entire charge at time of service
- Providers sometimes **must** accept assignment
  - Medicare Part B–covered prescription drugs
  - Ambulance suppliers

Private Contracts

- Agreement between you and your doctor
  - Doctor doesn't furnish services through Medicare
  - Original Medicare and Medigap won't pay
  - Other Medicare plans won't pay
  - You'll pay full amount for the services you get
  - No claim should be submitted
  - Can't be asked to sign in an emergency
  - The doctor can't bill Medicare for 2 years for any services provided to anyone with Medicare

Medicare Supplement Insurance (Medigap) Policies

- Medigap policies are private health insurance that
  - Supplement Original Medicare
    - You must have both Medicare Part A and Part B to get a Medigap policy
    - You pay a monthly premium to the insurer and also pay the Part B monthly premium
  - Help pay some health care costs that Original Medicare doesn't cover (coverage "gaps")
    - Medicare will pay its share of the Medicare-approved amounts for covered health care costs
      - Then your Medigap policy pays its share
    - A Medigap policy covers one person

Medigap Plans

- Standardized plans identified by a letter
  - Plans A, B, C, D, F, G, K, L, M, and N are currently sold
  - Companies don't have to sell all plans
  - Plans E, H, I, and J exist but are no longer sold
  - Plans with the same letter must offer the same basic benefits
    - Only the policy cost will vary between companies
- Waiver states (Massachusetts, Minnesota, and Wisconsin) standardize in a different way

Medigap Policies

- You pay a monthly premium
- Costs vary by plan, company, your age, and location
- Follow federal/state laws that protect you
- Medigap Open Enrollment Period
  - Starts when you're both 65 and signed up for Part B
  - Once started, it can’t be delayed or repeated
  - States may have longer period (check with your state)
- Doesn’t work with Medicare Advantage
- No networks except with a Medicare SELECT policy

Delayed Medigap Open Enrollment Period (OEP)

- If you delay enrolling in Medicare Part B
  - Because you or your spouse is still working, and
  - You have group health coverage
- Medigap OEP is delayed
  - Until you're 65 **and** enrolled in Part B
  - No late enrollment penalty
- Notify Social Security to delay Part B

Pre-existing Conditions and Medigap

- Health problem you had before the new insurance policy starts
  - Treated or diagnosed 6 months before coverage start date
- Pre-existing Condition Waiting Period
  - Insurance companies can refuse to cover out-of-pocket costs for excluded condition for up to 6 months ("look-back period")
    - Without 6 months of prior creditable coverage and no break in coverage more than 63 days

The Affordable Care Act doesn't impact the pre-existing condition waiting period for Medigap coverage.

Medigap for People With a Disability or End-Stage Renal Disease (ESRD)

- People with a disability or ESRD may not be able to buy a policy until they turn 65
  - Some states require insurers to sell Medigap policies to people with a disability or ESRD
- Companies may voluntarily sell Medigap policies
  - May cost more than policies sold to people over 65
  - Can use medical underwriting
- Get a Medigap Open Enrollment Period at 65

Check Your Knowledge—Question 3

Which of the following is NOT a possible Medicare coverage choice?

a. Part A only
b. Part B only
c. Original Medicare and a Medicare Advantage Plan
d. Original Medicare and a Medicare Prescription Drug Plan

Medicare Prescription Drug Coverage (Part D)

- What's Medicare Prescription Drug Coverage (Part D)?
- Medicare Prescription Drug Plans
- Medicare Drug Plan Costs
- Standard Structure
- Improved Coverage in the Coverage Gap
- Eligibility Requirements
- When to Join and Switch Plans
- Part D-covered Drugs
  - Drugs Not Covered
- How Plans Manage Access To Covered Drugs
- Requirements for Prescribers

What's Medicare Prescription Drug Coverage (Part D)?

- Medicare drug plans
  - Approved by Medicare
  - Run by private companies
  - Available to everyone with Medicare
- You must join a plan to get coverage
- There are 2 ways to get Medicare drug coverage
  - Medicare Prescription Drug Plans
  - Medicare health plans with prescription drug coverage

Medicare Part D Drug Coverage

- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
  - Different tier and/or copayment levels
  - Deductible
  - Coverage for drugs not typically covered by Part D
- Benefits and costs may change each year

Medicare Part D Costs

- Most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - Costs in the coverage gap
- Costs vary by
  - Plan
  - Late enrollment penalty
  - Extra Help

Part D Standard Benefit

Ms. Smith joins a Medicare Prescription Drug Plan. Her coverage begins on January 1. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first $400 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $3,700.	Once Ms. Smith and her plan have spent $3,700 for covered drugs, she's in the coverage gap. In 2017, she pays 40% of the plan's cost for her covered brand-name prescription drugs and 51% of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent $4,950 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

Part D Eligibility Requirements

- You must
  - Have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan
  - Have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
  - Have Medicare Part A and Part B or only Part B to join a Medicare Cost Plan with Part D coverage
  - Live in the plan's service area
  - Not be incarcerated
  - Not be unlawfully present in the U.S.
  - Not live outside the U.S.
- You must join a plan to get drug coverage

Part D Initial Enrollment Period (IEP)

- When you first become eligible to get Medicare
  - 7-month IEP for Part D

If You Join	Coverage Begins
During the 3 months before you turn 65	Date eligible for Medicare
During the month you turn 65	First day of the following month
During the 3 months after you turn 65	First day of the month after month you apply

When You Can Join or Switch Plans

- Medicare's annual Open Enrollment for Medicare Advantage and Medicare Prescription Drug Plans is October 15–December 7, coverage starts January 1
- You can leave a Medicare Advantage Plan and switch to Original Medicare from January 1–February 14 each year
  - You have until February 14 to also join a Part D plan
- If you don't have Medicare Part A coverage, and enroll in Part B during the General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan from April 1–June 30 each year

Special Enrollment Period (SEP)

- Life events that allow an SEP include if you
  - Permanently move out of your plan's service area
  - Lose other creditable prescription coverage
  - Weren't properly told that your other coverage wasn't creditable, or your other coverage was reduced and is no longer creditable
  - Enter, live at, or leave a long-term care facility
  - Have a continuous SEP if you qualify for Extra Help
  - Belong to a State Pharmaceutical Assistance Program
  - Join or switch to a plan that has a 5-star rating
  - Have other exceptional circumstances

5-Star Special Enrollment Period (SEP)

- Use the Medicare Plan Finder tool at Medicare.gov to see quality and performance ratings
- Star ratings are given once a year, assigned in October of the past year
- Use 5-star SEP to switch to any 5-star plan 1 time each year
  - From December 8–November 30
  - Coverage starts first day of month after enrolled
  - Be careful not to switch from a Medicare Advantage (MA) Plan with drug coverage to an MA Plan with no Part D coverage

Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Exceptions if you have
    - Creditable coverage
    - Extra Help
- Pay penalty for as long as you have coverage
  - 1% of base beneficiary premium
    - For each full month eligible and not enrolled
  - Amount changes every year, visit Medicare.gov for current figures

Income-Related Monthly Adjustment Amount (IRMAA)

Your Yearly Income in 2016 Filing an Individual Tax Return	Your Yearly Income in 2016 Filing a Joint Tax Return	In 2017 You Pay Monthly
$85,000 or less	$170,000 or less	Your Plan Premium (YPP)
Above $85,000 Up to $107,000	Above $170,000 Up to $214,000	YPP + $13.30*
Above $107,000 Up to $160,000	Above $214,000 Up to $320,000	YPP + $34.20*
Above $160,000 Up to $214,000	Above $320,000 Up to $428,000	YPP + $55.20*
Above $214,000	Above $428,000	YPP + $76.20*

***IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.**

Part D-Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the U.S. Food and Drug Administration
  - Used and sold in United States
  - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
  - And supplies associated with injection of insulin
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan

Required Coverage

- All drugs in 6 protected categories
  1. Cancer medications
  2. HIV/AIDS treatments
  3. Antidepressants
  4. Antipsychotic medications
  5. Anticonvulsive treatments
  6. Immunosuppressants
- All commercially available vaccines
  - Except those covered under Part B (e.g., flu shot)

Requirement for Prescribers

NEW!

- Enforcement date February 1, 2017
- Prescribers of Part D drugs must
  - Be enrolled in an approved status, or
  - Have a valid opt-out affidavit on file for their prescriptions to be covered under Part D
    - Includes dentists, doctors, residents, psychiatrists, nurse practitioners, and physician assistants

Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs

How Plans Manage Access to Drugs

Prior Authorization	Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered
Step Therapy	▪ 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

Formulary

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

Check Your Knowledge—Question 4

Effective February 1, 2017, will a dentist be able to prescribe Part D covered drugs?

a. Yes, if he or she opts out of Medicare

b. Yes, if he or she is enrolled in an approved status

c. Both of the above

d. None of the above

Medicare Advantage (MA) Plans (Part C)

- What's an MA Plan?
- How MA plans work
- MA Plan costs
- Who can join
- When to join and switch plans
- Other Medicare health plans

What's a Medicare Advantage Plan?

- Health plan options
  - Approved by Medicare
  - Run by private companies
- Part of the Medicare program
- Sometimes called Part C
- Available across the country
- Provide Medicare-covered benefits
  - May cover extra benefits

How Medicare Advantage Plans Work

- Receive services through the plan
  - All Part A- and Part B-covered services
  - Some plans may provide additional benefits
- Most plans include prescription drug coverage
- You may have to use network doctors/hospitals
- May differ from Original Medicare in
  - Benefits
  - Cost sharing

How Medicare Advantage (MA) Plans Work (Continued)

- You're still in the Medicare program
  - Medicare pays the plan every month for your care
- You still have Medicare rights and protections
- If the plan leaves Medicare you can
  - Join another MA Plan, or
  - Return to Original Medicare

Medicare Advantage Costs

- You still pay the Part B premium
  - A few plans may pay all or part for you
- State assistance for some people with limited income and resources
- You may pay plan an additional monthly premium
- You pay deductibles, coinsurance, and copayments
  - Different from Original Medicare
  - Varies from plan to plan
  - May be higher if out of network

Who Can Join a Medicare Advantage Plan?

- Eligibility requirements—you must
  - Be enrolled in Medicare Part A (Hospital Insurance)
  - Be enrolled in Medicare Part B (Medical Insurance)
  - Live in the plan's service area
  - Be a United States (U.S.) citizen or lawfully present in the U.S.
  - Not be incarcerated
- To join you must also
  - Provide necessary information to the plan
  - Follow the plan's rules
  - Can only belong to one plan at a time

When You Can Join or Switch Medicare Advantage (MA) Plans

Initial Enrollment Period (Technically the Initial Coverage Enrollment Period)	▪ 7-month period begins 3 months before the month you turn 65 ▪ Includes the month you turn 65 ▪ Ends 3 months after the month you turn 65 **Important:** If you delay Part B enrollment (for example, due to active employer group coverage), your time to enroll in an MA Plan may be more restricted. For more information, visit CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf.

- You can only join 1 MA Plan at a time, and enrollment is generally for a calendar year.

When You Can Join or Switch Medicare Advantage Plans*

Fall Open Enrollment	▪ October 15—December 7 ▪ Coverage begins January 1
Medicare due to a Disability	▪ 7-month period begins 3 months before the 25th month of disability. ▪ Ends 3 months after the 25th month of disability.

* Plans must be allowing new members to join

When You Can Join or Switch Plans

Special Enrollment Periods (SEP)

- Move out of your plan's service area
- You have Medicaid
- Plan leaves Medicare program or reduces its service area
- Leaving or losing employer or union coverage
- You enter, live at, or leave a long-term care facility
- You have a continuous SEP if you qualify for Extra Help
- Losing your Extra Help status
- You join or switch to a plan that has a 5-star rating
- Retroactive notice of Medicare entitlement
- Other exceptional circumstances

When You Can Join or Switch Medicare Advantage (MA) Plans

5-Star Special Enrollment Period (SEP)

- Can enroll in 5-star MA Plan, Prescription Drug Plan (PDP), Medicare Advantage Plan with prescription drug coverage (MA-PD), or Cost Plan
- Enroll once yearly from December 8–November 30
- New plan starts first day of month after enrolled
- Star ratings given once per year
  - Ratings assigned in October and effective January 1
  - Use Medicare Plan Finder to see star ratings
    - Look at Overall Plan Rating to find eligible plans

When You Can Leave Medicare Advantage (MA) Plans

January 1 – February 14

- You can leave an MA Plan
- Switch to Original Medicare
  - Coverage begins first day of month after switch
  - May join Part D Plan
    - Drug coverage begins first day of month after plan gets enrollment
- May not join another MA Plan during this period
- May be able to buy a Medicare Supplement Insurance (Medigap) policy

Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan
- Private Fee-for-Service
- Medicare Medical Savings Account

Other Medicare Plans

- Some types of Medicare health plans that provide health care coverage aren't part of Medicare Advantage
  - But are still part of Medicare
  - Some provide Part A and/or Part B coverage
  - Some provide Medicare prescription drug coverage
  - Examples include
    - Medicare Cost Plans
    - Innovation Projects and Pilot Programs
    - Medicare Program of All-inclusive Care for the Elderly (PACE) Plans

Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more
- Visit Medicare.gov/find-a-plan/

Check Your Knowledge—Question 5

Most people enrolled in a Medicare Advantage Plan will continue to pay a monthly Medicare Part B premium.

a. True

b. False

Lesson 3—Rights and the Appeals Process

- Patient rights
- Appeals process
  - Part A and Part B (Original Medicare)
    - Medigap Rights
  - Part C (Medicare Advantage)
  - Part D (Medicare Prescription Drug Coverage)

Medicare Guaranteed Rights

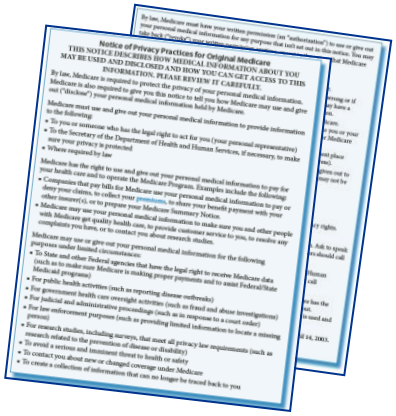
- Specific rights in
  - Original Medicare
  - Medicare Advantage and other Medicare health plans
  - Medicare Prescription Drug Plans
  - In general, these rights protect
    - You when you get health care
    - You against unethical practices
    - Your ability to get medically necessary services
    - Your privacy

Your Medicare Rights

- You have the right to be
  - Treated with dignity and respect
  - Protected from discrimination
    - Race, color, or national origin
    - Disability
    - Age
    - Religion
    - Sex
  - If you think you haven't been treated fairly, visit HHS.gov/ocr
    - Call the Office for Civil Rights at 1-800-368-1019
    - TTY users should call 1-800-537-7697

"Notice of Privacy Practices for Original Medicare"

- Tells you how Medicare
  - Must protect the privacy of your personal health information
  - Uses and discloses your personal medical information
- Describes your rights and how you can exercise them
- Published annually in the "Medicare & You" handbook
- For more information
  - Visit Medicare.gov
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048


Notice of Privacy Practices for Original Medicare

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who's the Medicare Beneficiary Ombudsman?

- An ombudsman is a person who reviews complaints and helps resolve them
- The Medicare Beneficiary Ombudsman helps make sure information is available about
  - Medicare coverage
  - Making good health care decisions
  - Medicare rights and protections
  - Getting issues resolved
- The Ombudsman reviews the concerns raised by people with Medicare
- The Ombudsman reports yearly to the Secretary of Health & Human Services, Congress, and other organizations about what works and doesn't work well to improve the quality of the services and care you get through Medicare

Medicare Rights—Claims and Appeals

- You have the right to
  - Have a claim for payment filed with Medicare
  - Get decisions about
    - Health care payment
    - Coverage of services
    - Prescription drug coverage
  - Get an appeal (review) of the decisions above

Medicare Grievance Rights

You have the right to file complaints (also called grievances) about

- Services you got
- Other concerns or problems getting health care and quality of care
  - In Original Medicare, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
  - In Medicare Advantage or other Medicare health plan, call your plan, the BFCC-QIO, or both
  - If you have End-Stage Renal Disease (ESRD), call the ESRD network in your state

Medigap Rights in Original Medicare

- Buy a private Medicare Supplement Insurance (Medigap) policy
  - Guaranteed issue rights in your Medigap Open Enrollment Period ensure insurance companies
    - Can't deny you Medigap coverage
    - Can't place conditions on coverage
    - Must cover pre-existing conditions
    - Can't charge more because of past or present health problems
  - Some states give additional rights

Coverage and Appeal Rights in Medicare Health Plans

You have the right to

- Know how your doctors are paid
- Get a coverage decision or coverage information
- A fair, efficient, and timely appeals process
  - Five levels of appeal
  - Decision letter sent explaining further appeal rights
  - Automatic review of Part C plan reconsideration
    - By Independent Review Entity (IRE)
- File a grievance about concerns or problems

Requesting Part D Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, you must make your appeal requests in writing
  - Plans must accept verbal expedited (fast) requests
  - Limited timeframe to file an appeal request (within 60 days or later with good cause)
- An appeal can be requested by
  - You or your appointed representative
  - Your doctor or other prescriber
- There are 5 levels of appeals

Check Your Knowledge—Question 6

In a Medicare Health Plan, the right to a coverage decision lets you find out if a service or supply will be covered after you receive it.

a. True

b. False

Lesson 4—Programs for People With Limited Income and Resources

- What is Medicaid and the Children's Health Insurance Program (CHIP)?
- Medicare Savings Programs
- What is Extra Help?
- Programs in the United States territories

What Is Medicaid and the Children's Health Insurance Program (CHIP)?

- Medicaid is a federal-state health insurance program
  - For people with limited income and resources
  - Covers most health care costs if you have both Medicare and Medicaid (dual eligible)
  - Eligibility is determined by the state
    - Application processes and benefits vary
    - State office names vary
    - Apply if you MIGHT qualify
- Children's Health Insurance Program (CHIP) is administered by states, according to federal requirements
  - Covers uninsured children up to 19
  - May cover pregnant women when family income's too high for Medicaid

Medicare Savings Programs

- Help from Medicaid paying Medicare costs
  - For people with limited income and resources
  - Often higher income and resources than full Medicaid
- Programs include
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-income Medicare Beneficiary (SLMB)
  - Qualifying Individual (QI)
  - Qualified Disabled & Working Individuals (QDWI)

What Is Extra Help?

- Program to help people pay for Medicare prescription drug costs (Part D)
  - Also called the low-income subsidy
- If you have lowest income and resources
  - Pay no premiums or deductible, and small or no copayments
- If you have slightly higher income and resources
  - Pay reduced deductible and a little more out of pocket
- No coverage gap or late enrollment penalty if you qualify for Extra Help

Qualifying for Extra Help

- You automatically qualify for Extra Help if you get
  - Full Medicaid coverage
  - Supplemental Security Income (SSI)
  - Help from Medicaid paying your Medicare premiums
- All others must apply
  - Online at socialsecurity.gov
  - Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)
    - Ask for "Application for Help with Medicare Prescription Drug Plan Costs" (SSA-1020)
  - Contact your state Medicaid agency

Steps to Take

- If you think you might qualify for any of these programs
  - Review the income and asset guidelines
  - Collect your personal documents
- To get more information call your
  - State Medical Assistance (Medicaid) Office
  - Local State Health Insurance Assistance Program (SHIP)
  - Local Area Agency on Aging
- Complete application with your State Medical Assistance (Medicaid) Office

Programs in U.S. Territories

- Help people pay their Medicare costs
- U.S. territories
  - Puerto Rico
  - Virgin Islands
  - Guam
  - Northern Mariana Islands
  - American Samoa
- Programs vary
  - Contact your local Medical Assistance office

Check Your Knowledge—Question 7

If you think you might qualify for a program that may help pay some of your costs you should

a. Check the income and asset guidelines

b. Collect your personal documents

c. Complete an application with your state Medical Assistance Office

d. All of the above

Lesson 5—Medicare and the Health Insurance Marketplace

- Marketplace and People with Medicare
- Marketplace and Becoming Eligible for Medicare
- Enrollment Considerations

Marketplace and People With Medicare

- Medicare isn't part of the Marketplace
- If you have Medicare you don't need to do anything related to the Marketplace
  - Your benefits don't change because of the Marketplace
  - No one can sell you a Marketplace plan
    - Even if you have only Medicare Part A and/or Part B
    - Except an employer through the Small Business Health Options Program (SHOP) if you're an active worker or dependent of an active worker
      - The SHOP employer coverage may pay first
      - No late enrollment penalty if you delay Medicare
        - Doesn't include COBRA coverage
      - The Marketplace doesn't offer Medigap or Part D plans

Marketplace and Becoming Eligible for Medicare

- You can keep a Marketplace plan after your Medicare coverage begins
  - You may cancel the plan when Medicare coverage starts
    - Once your Part A coverage starts you won't be able to get lower costs for your Marketplace plan
- Sign up for Medicare during your Initial Enrollment Period
  - Or, if you enroll later, you may have to pay a late enrollment penalty for as long as you have Medicare

If You Have a Marketplace Plan First and Then Get Medicare Coverage

- You lose eligibility for any premium tax credits and/or reduced cost sharing for your Marketplace plan
- If you drop your Marketplace plan, you must contact the plan at least 14 days before you want to end that coverage. Time it to avoid a gap in coverage.
  - Depending on your income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments
  - You may also be able to buy a Medicare Supplement Insurance (Medigap) Policy or join a Medicare Advantage Plan (like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO))

Choosing Marketplace Instead of Medicare

- The Individual Marketplace isn't employer-sponsored coverage
- You can’t choose Marketplace coverage instead of Medicare unless
  - You pay or you’d have to pay a Part A premium
    - You can drop Part A and Part B and may be eligible to get a Marketplace plan
  - You have a medical condition that qualifies you for Medicare (like ESRD) but haven’t applied for Medicare
  - You’re not yet collecting Social Security retirement or disability benefits and not yet eligible for Medicare based on age (or you’re in the waiting period)
    - Medicare enrollment will be automatic once eligible and getting a Social Security Cash benefit

Medicare for People With Disabilities and the Marketplace

- You may qualify for Medicare based on a disability
  - You must be entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
    - On the 25th month, you're automatically enrolled in Medicare Part A and Part B
- If you're getting SSDI, you can get a Marketplace plan to cover you during your 24-month waiting period
  - You may qualify for premium tax credits and reduced cost-sharing until your Medicare coverage starts

Marketplace/Medicare Enrollment Considerations

- If you don't enroll in Medicare when you're first eligible (Initial Enrollment Period)
  - A late enrollment penalty may apply (lifetime penalty for as long as your have Part B)
  - You generally can't enroll until the Medicare General Enrollment Period (January 1 to March 31) and coverage won't start until July 1
- If your Marketplace plan isn't through your employer and you must pay a premium for Part A, you would need to drop Part A and Part B to be eligible to get a Marketplace plan
  - However, if you're also receiving Social Security benefits, you would have to drop your Social Security if you drop Medicare

Check Your Knowledge—Question 8

You can enroll in the Individual Marketplace instead of Part B and get Part B later using a Special Enrollment Period.

a. True

b. False

Introduction to Medicare Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)

- 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048
- Medicare.gov
- CMS.gov
- Medicaid.gov/

Social Security

- 1-800-772-1213; TTY users should call 1-800-325-0778
- SocialSecurity.gov/

Railroad Retirement Board

- 1-877-772-5772; TTY users should call 1-312-751-4700
- RRB.gov/

Affordable Care Act

- HealthCare.gov
- HealthCare.gov/law/full/index.html

Medicare Plan Finder

- Medicare.gov/find-a-plan

State Health Insurance Assistance Programs and State Insurance Departments

- shiptacenter.org/

U.S. Department of Health and Human Services, Office for Civil Rights

- HHS.gov
- HHS.gov/ocr/office/index.html
- 1-800-368-1019; TTY users should call 1-800-537-7697

Additional Resources

- Benefits.gov
- InsureKidsNow.gov

Introduction to Medicare Resource Guide (continued)

Medicare Products

1. **"Medicare & You Handbook"**
   CMS Product No. 10050
2. **"Your Medicare Benefits"**
   CMS Product No. 10116
3. **"Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"**
   CMS Product No. 02110

To access these products

- View and order single copies at Medicare.gov/publications
- Order multiple copies (partners only) at productordering.cms.hhs.gov.

You must register your organization.

Acronyms

- BPH Benign Prostatic Hyperplasia
- BFCC-QIO Beneficiary and Family Centered Care Quality Improvement Organization
- CHAMPVA Civilian Health and Medical Program of the Department of Veterans Affairs
- CHIP Children's Health Insurance Program
- CMS Centers for Medicare & Medicaid Services
- COBRA Consolidated Omnibus Budget Reconciliation Act
- DME Durable Medical Equipment
- EGHP Employer Group Health Plan
- ESRD End-Stage Renal Disease
- FDA Food and Drug Administration
- FICA Federal Insurance Contributions Act
- FPL Federal Poverty Level
- GEP General Enrollment Period
- HMO Health Maintenance Organization
- HMOPOS HMO Point-of-Service
- IEP Initial Enrollment Period
- IRMAA Income-Related Monthly Adjustment Amount
- IRS Internal Revenue Service
- LIS Low-Income Subsidy
- MA Medicare Advantage
- MA-PD Medicare Advantage Prescription Drug
- MRI Magnetic Resonance Imaging
- MSA Medical Savings Account
- MSN Medicare Summary Notice
- NTP National Training Program

Acronyms (continued)

- NPI National Provider Identifier
- OEP Open Enrollment Period
- PACE Programs of All-inclusive Care for the Elderly
- PDP Prescription Drug Plan
- PFFS Private Fee-for-Service
- PPO Preferred Provider Organization
- QDWI Qualified Disabled & Working Individuals
- QI Qualifying Individual
- QMB Qualified Medicare Beneficiary
- QHP Qualified Health Plans
- RNHCI Religious Nonmedical Health Care Institution
- RRB Railroad Retirement Board
- SEP Special Enrollment Period
- SHIP State Health Insurance Assistance Program
- SHOP Small Business Health Options Program
- SLMB Specified Low-income Medicare Beneficiary
- SNF Skilled Nursing Facility
- SNP Special Needs Plan
- SPAP State Pharmaceutical Assistance Program
- SSA Social Security Administration
- SSDI Social Security Disability Insurance
- SSI Supplemental Security Income
- TFL TRICARE for Life
- TTY Teletypewriter

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