

MEDICARE

Basic Toolkit

Need a doctor that accepts Medicare Assignment?

Not all providers accept Medicare Assignment or new Medicare patients. To find a list of providers by city visit <http://www.pinnaclemedicare.com/bene/medpard/>

No Internet access? Call SHIIP for a list at 1-800-224-6330. →



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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>		

Protect your Medicare number. Do not carry your Medicare Card. For most, the Medicare number is the Social Security Number with a letter on the end and it is easy for those with bad intentions to conduct identity theft or Medicare fraud.

Why so complicated?

Signed into law in 1965, Congress sought medical coverage for aging persons unable to obtain health insurance. In its 46 year history, additions and restrictions to the program leave many Medicare beneficiaries and their caregivers puzzled.

What is Medicare?

Medicare is a federal health insurance program. Medicare beneficiaries must meet one of the following eligibility criteria:

- Age 65 or older
- Social Security Disability beneficiaries who receive benefits (check) for 24 months
- Persons with End-stage Renal Disease (ESRD)
- Persons with Amyotrophic Lateral Sclerosis (ALS) aka Lou Gehrig's disease

When does Medicare coverage begin?

Medicare Automatic Enrollment

Automatic for those receiving

- Social Security benefits check
- Railroad Retirement Board benefits check

Receive a Medicare card in the mail

- 3 months before 65th birthday
- 24th month of drawing disability income
- 1 month of ESRD or Lou Gehrig (ALS) diagnosis

Working with Employer Insurance

Still working or spouse is still working

- If employer has more than 20 employees can keep employer coverage
- Can delay Part B until retirement
- Join during an 8-month period that begins when employer insurance ends (no penalty incurred)
- Medicare coverage begins the month after application

General Enrollment Period

Miss the other enrollment periods? Then enroll from January 1 to March 31. Coverage begins July 1.

Late enrollment penalties of 10% applies.

Initial Enrollment Period

For those turning 65 not yet receiving a Social Security check

If Not Automatically Enrolled Your 7-Month Initial Enrollment Period

If you enroll in Part B	No Delay			Delayed Start			
	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 getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.

If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.



**NO WAITING!
APPLY ONLINE**

Social Security Administration Website

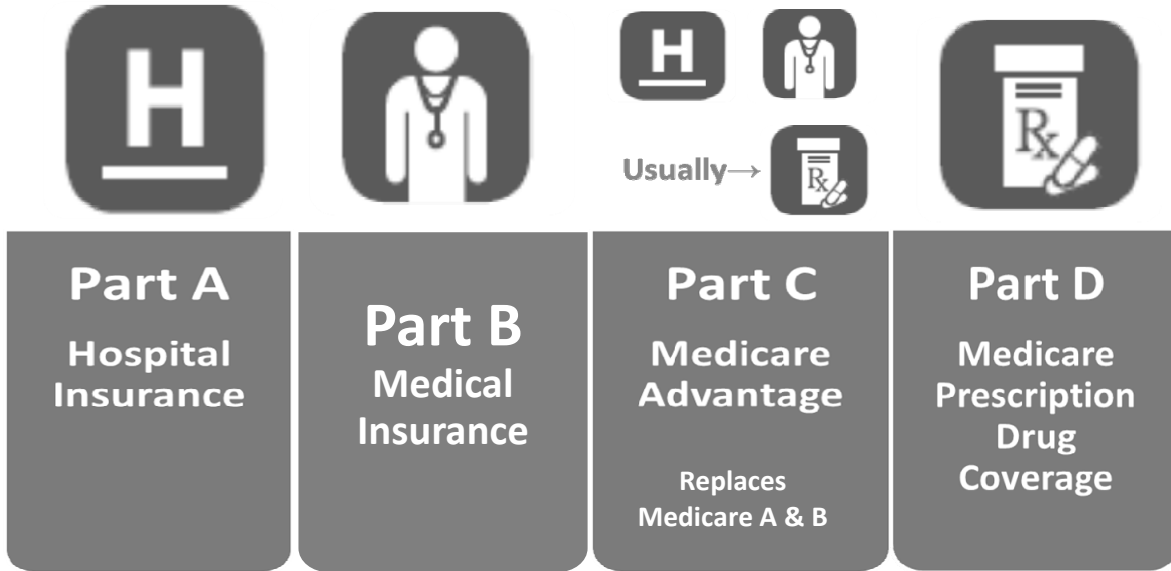
www.ssa.gov

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Retired or Medicare eligible?

Medicare Parts A & B pay primary or before retiree insurance. Be sure to join Medicare A & B.

Four Parts of Medicare



What do the various parts pay?

PART A

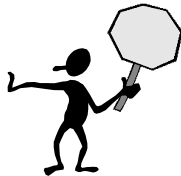


- Inpatient hospital stay
- Hospice care
- Skilled nursing care inpatient stay for rehabilitation

PART B



- Doctor visits
- Outpatient surgery
- Outpatient tests
- Home health care
- Wheelchair
- Diabetic test strips, lancets
- Mammogram, PSA Test



Medicare does not pay for dental, hearing, vision, or long term care such as custodial, 24-hour nursing home care

PART C Medicare Advantage

- Replaces Medicare A & B
 - Buy from a private insurance
 - Possible vision, dental or hearing coverage
 - May pay premium in addition to Part B
 - May require a network of providers
- See page 6 for more information

PART D



- Prescription drugs
- Private insurance approved by Medicare
- Costs vary plan to plan
- Compare plans annually

See page 7 for more information

Medicare Fraud, Waste & Abuse

Fraud is giving false information on purpose.

Waste & Abuse is when health care providers or suppliers don't follow good medical practices, which results in medical care that doesn't help patients.

Examples

- Billing for medical care or equipment never received
- Unauthorized use of Medicare card

HOW BAD IS IT?



Check your **Medicare Summary Notice** quarterly to detect and report potential fraud and abuse. Sign up for www.mymedicare.gov to check claims regularly. The **Arkansas Senior Medicare Patrol (SMP)** can help with suspected Medicare fraud, **1-866-726-2916**.



Medicare Premiums

Avoid 10% Penalties

PART A = Sign up when eligible even if still working

PART B = Sign up if no other medical coverage or retired

Medicare Part A Premium

Part A requires no additional premium because it's paid through payroll taxes called FICA or Medicare tax. For those working at least 10 years, or whose spouse worked and paid, there is no monthly premium for Part A. There is a 10% penalty for late enrollment so join Part A when eligible.

For those not able to get Medicare Part A for free, because they lack the 10 years of paying FICA, the monthly premium is \$451.00 and can be prorated based on work.

Medicare Part B Premium

If Yearly Income is		Monthly Premium Payment
File Individual Tax Return	File Joint Tax Return	
\$85,000 or below	\$170,000 or below	\$99.90 per month
\$85,001-\$107,000	\$170,001-\$214,000	\$139.90 per month
\$107,001-\$160,000	\$214,001-\$320,000	\$199.80 per month
\$160,001-\$214,000	\$320,001-\$428,000	\$259.70 per month
Above \$214,001	Above \$428,001	\$361.70 per month

2012 Medicare Deductibles & Copayments

Part A Hospital insurance covered services

Services	Benefits	Medicare pays	You pay
Hospitalization Semiprivate room, general nursing, misc. services	First 60 days	All but \$1,156	\$1,156
	61st to 90th day	All but \$289 per day	\$289 per day
	91st to 150th day	All but \$578 per day	\$578 per day
	Beyond 150 days	Nothing	All charges
Skilled Nursing Facility Care	First 20 days	100% of approved	Nothing if approved
	21st to 100th day	All but \$144.50 per day	\$144.50 per day
	Beyond 100 days	Nothing	All costs
Home Health Care Medically necessary skilled care or therapy	Part-time care as long as you meet guidelines	100% of approved	Nothing if approved
Hospice Care For the terminally ill	As long as doctor certifies need	All but limited costs for drugs & respite care	Limited costs for drugs & respite care
Blood	Blood	All but first 3 pints	First 3 pints

Part B Medical insurance covered services

Services	Benefits	Medicare pays	You pay
Medical Expense Physician services & medical supplies	Medical services in and out of the hospital	80% of approved amount (after \$140 deductible)	20% of approved amount (after \$140 deductible)
Clinical Laboratory	Diagnostic tests	100% of approved	Nothing if approved
Home Health Care Requires a prescription	Part-time care for medically necessary skilled care or therapy	100% of approved	Nothing if approved
Outpatient Hospital Treatment	Unlimited if medically necessary	80% of approved	20% of approved amount (after \$140 deductible)
Durable Medical Equipment Requires a prescription for equipment	Prescribed by doctor for use in home	80% of approved amount (after \$140 deductible)	20% of approved amount (after \$140 deductible)
Blood	Blood	All but first 3 pints	First 3 pints

Medicare Supplement Insurance (Medigap)

- Secondary health insurance policy to pay the “gaps” in Medicare (see page 4)
- Need Medicare A & B
- Sold by private insurance companies
- Pay monthly premium
- Comparison guide containing a list of all companies approved to sell insurance in Arkansas called **Bridging the Gap** available from SHIIP or www.arkansas.insurance
- Only pays after original or traditional Medicare A & B (not needed with Medicare Advantage aka Part C)
- Federal & state laws require the plans be standard
- Lettered Plans: A, B, C, D, F, G, K, L, M, N

Apply anytime. Unlike Medicare Drug and Advantage Plans, there is no specific time of year to purchase a Medicare Supplement Policy.

JOIN

**age 65
or older**

Medigap for Medicare recipients age 65 or older

The Medigap Open Enrollment Period is a six month period when an insurance company must issue a policy regardless of medical history, health status, or prior claims. Medigap Open Enrollment Period begins the first day of Medicare Part B enrollment at age 65 or older. Getting Part B starts the Medigap Open Enrollment Period.

**under
age 65**

Medigap for Medicare recipients under age 65

Federal law does not require people under the age of 65 with Medicare Part B be granted a Medigap Open Enrollment Period. Younger Medicare beneficiaries are subject to medical underwriting and may be denied a policy based on medical history. There is no assurance that those under age 65 be issued a Medigap Policy.

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NOTE

Retiree benefits may pay after Medicare, like Medigap does. Some retiree plans do not pay after Medicare or have high deductibles, to they and are less desirable than Medigap. Some retiree plans are Medicare Advantage and replace Medicare. Be sure to check with Human Resources before enrolling in a Medigap Plan, to learn the impact on retiree benefits. Other benefits may be affected like life, dental, hearing or vision insurance.

Medicare Advantage (MA) Part C

What is it?

- Called Medicare Health Plans or Medicare Replacement Plans
- Sold by private insurance companies with Medicare approval
- Replaces Original Medicare A & B (no need for Medigap)
- May offer additional benefits such as vision, dental, hearing or transportation– be sure to get specific coverage details in writing
- Most plans require use of certain doctors and hospitals (providers) or you may pay all or more of the cost
- May have special rules to follow such as prior authorization

What is the cost?

- Still pay Medicare Part B premium of \$99.90 in 2012
- Usually pay copayments (set amount) for medical services per visit vs. original Medicare 20% coinsurance.
- May pay an additional premium to MA company can range from \$0 to \$165 monthly

What does it pay?

- Coverage is not standard and varies from plan to plan
- Federal law requires MA cover the same benefits as Original Medicare but the costs such as deductibles and copays vary
- Some plans include drug coverage (Part D)
- Some plans may include vision, home meal delivery after surgery, gym membership, hearing, or dental coverage

What is the advantage?

Beneficiaries may receive **additional benefits**. Many of the dental and hearing benefits are preventive, which means they pay for teeth cleaning or hearing exams but not for dentures or hearing aids. Ask questions about what the policy will pay and get a list of benefits in writing.

Cost sharing may be better for some. For instance, Original Medicare hospital coverage requires a deductible of \$1,156 in 2012. An MA Plan might change the cost sharing so the patient pays \$200 per day for the first five days. If the patient stays two days, they owe \$400 vs. the Original Medicare deductible of \$1,156. If the patient stays five hospital days, they owe \$1,000 vs. Original Medicare \$1,156.

More considerations for MA Plans

1. Are prescription drugs covered?
2. Does the plan cover current prescriptions ? And, is the cost higher or lower than the current plan?
3. What are the costs (copayments, deductibles or coinsurance) compared with current coverage?
4. Which doctors, hospitals and pharmacies accept the insurance plan? Be sure to call before making changes because some providers do not accept all MA Plans.

Medicare Drug Coverage (Part D)

COSTS



COVERAGE

There are three main costs to consider:

1. **Monthly premium** = dollar amount paid per month to have prescription insurance
2. **Deductible** = dollar amount paid each year before the plan starts to pay, maximum in 2012 is \$320. Not all plans have a deductible.
3. **Copayment or coinsurance** = share of the out-of-pocket cost per medication. This amount will be different for each plan and for each medication.
 - **coinsurance** is usually listed as a percentage of the cost of the medications, 10%, 15%, 20%, etc.
 - **copayments** are specific dollar amounts paid per prescription. (If a plan has a deductible, the copayment amount will be higher until the deductible is met.)

Each plan covers a different list of drugs known as a **formulary**. Formularies vary from plan to plan and affect the cost.

Plans may have **special rules** about how they provide coverage for different drugs on their formulary. These special rules are known as **restrictions** and may include the following:

1. **Quantity Limits** = limit to the number of pills or amount of liquid measure a patient may obtain within a specific period of time.
2. **Prior Authorization** = the insurance plan will require the patient's physician to complete a form detailing why the patient needs the prescribed medication. The insurance plan reviews the form and approves or denies the request.
3. **Step Therapy** = the insurance plan may require the patient to take a substitute/ lower cost medication for up to 90 days. The patient's physician must document on the plan's form the reasons the substitute medication is not effective.

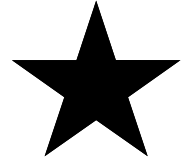
Really need Part D?

Some people have "creditable coverage" or something at least as good as Medicare Part D and do not need Part D such as veterans or those with retiree coverage. Others choose whether or not to enroll. Many don't take medications and delay enrollment. Remember, there is a permanent penalty for late enrollment. The penalty in 2012 is \$0.32 per month for each month of delayed enrollment.



Shop and compare plans every year.

Drug costs (premiums, deductibles and formularies) change every year.
Use the Medicare Plan finder at www.medicare.gov or
call SHIP for help 1-800-224-6330.



Medicare Coverage Gap (Doughnut Hole)

1. Monthly Premium – Mrs. Smith pays a monthly premium throughout the year for Part D.

2. Yearly deductible	3. Copayment or coinsurance	4. Coverage gap	5. Catastrophic Coverage
Mrs. Smith pays the first \$320 of her drug costs before her plan starts to pay its share.	Mrs. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches \$2,930.	Once Mrs. Smith and her plan spend \$2,930 for covered drugs, she enters the coverage gap. In 2012, she receives a discount. She pays 50% for brand name drugs and 87% for generics. If her brand name drug cost \$300 she pays \$150 at the pharmacy. She receives credit for paying the full \$300 toward the required \$4,700 out-of-pocket cost to exit the coverage gap.	Once Mrs. Smith spends \$4,700 out-of-pocket for the year, her coverage gap ends. Now she pays a small copayment for each drug until the end of the year.

Medicare Preventive Services

People with Medicare Part B pay no deductible (\$140 annual) or coinsurance (20%) for the following services;

- Welcome to Medicare Physical Exam
- Annual Wellness Visit
- Abdominal Aortic Aneurysm Screening
- Bone Density Test
- Cardiovascular Disease Screening
- Colorectal Cancer Screening
- Diabetes Screening
- Pap Test/Pelvic Exam/Clinical Breast Exam
- Prostate Cancer Screening (PSA Blood Test)
- Mammogram
- Flu, H1N1, Hepatitis B & Pneumococcal Pneumonia Shots

NEW ANNUAL WELLNESS VISIT

Medicare Part B (and Medicare Advantage) will pay the full cost for one Wellness Visit every 12 months.

- Patient pays no
 - Part B deductible
 - Part B coinsurance
 - Part C copayment

Physician should exam head, neck, heart, lungs, abdomen and extremities. Digital rectal examinations in men and pelvic exams in women may be needed.

- Visit includes the following measures:
 - height
 - weight
 - blood pressure
 - cognitive function

CAUTION: If a test results in a diagnosis (doctor “finds something”), then it is considered diagnostic and the patient will owe a 20% coinsurance and the deductible will apply.

Two programs help with Medicare costs

1

Medicare Savings Programs pay the costs of Medicare

	Full Medicaid Services	Part B Late Enrollment Penalty	Part B Premium	Part B Coinsurance	Part A & B Deductible	Part A Copayments
AR Seniors	Yes	Yes	Yes	Yes	Yes	Yes
QMB		Yes	Yes	Yes	Yes	Yes
SLMB & QI-1		Yes	Yes			

2

Extra Help pays the costs of Part D

	Part D Late Enrollment Penalty	Part D Monthly Premium	Part D Deductible	Part D Copayment
Full Benefit A	Yes	Yes	Yes	Patient pays up to \$3.30
Full Benefit B	Yes	Yes	Yes	Patient pays up to \$6.30
Partial Benefit	Yes	Portion of the Part D Premium	Portion of Part D Deductible	Patient pays 15% of cost

- No in-person interview required. Can provide information over the phone to SHIP.
- No estate recovery – neither federal nor state government will take assets upon death
- Not Medicaid – Programs only help with Medicare costs

Qualification levels

	Individual	Couple
Gross monthly income	\$1,361.25	\$1,838.75
Assets	\$12,640	\$25,260
Primary residence and vehicle do not count as assets.		

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Call SHIP for application help 1-800-224-6330

Medicare Internet Resources



Email Medicare Man questions
insurance.shiip@arkansas.gov
or call 1-800-224-6330

www.medicare.gov

- Compare drug plans (Part D)
- Compare Medicare advantage plans (Part C)
- Compare hospitals
- Compare nursing homes
- Compare home health agencies
- Search “coverage database” and learn what Medicare pays for specific items, services, and tests like second opinions, hospital beds, diabetic supplies, etc.
- Order a replacement Medicare card

www.mymedicare.gov

- Create an account
- Secure site to manage personal Medicare information
 - * Review eligibility, entitlement and plan information
 - * Track preventive services
 - * Keep a prescription drug list
 - * Complete Authorization Form
- Review Claims

Medicare Rights & Protections

Advanced Beneficiary Notice of Noncoverage (ABN)

Medicare requires providers to notify patients in writing if the provider thinks Medicare is not likely to pay for an item or service. The purpose is protection from unexpected bills. The notice lists the cost of the item or service. The patient must decide whether to proceed or refuse, indicate their choice, and sign the form.

Notice of Medicare Provider of Noncoverage

Home health, skilled nursing, hospice, and comprehensive outpatient rehab providers must provide this notice at least two days before services end. If you disagree, request an immediate review by AFMC.

Admission Denial

If the hospital will not admit a Medicare beneficiary and you disagree, put it in writing and call AFMC for an immediate review.

Quality of Care

Submit in writing or by phone quality of care concerns to AFMC.

Appeal Rights

Appeal a denied item or service if you think Medicare should pay but didn't or if you think Medicare didn't pay the right amount. Follow the directions on the Medicare Summary Notice to appeal.

Important Message from Medicare

Receive this form at hospital admission and discharge which explains the right to an immediate appeal if you disagree with your discharge. Call AFMC to request a review.



www.afmc.org

The **Arkansas Foundation for Medical Care (AFMC)** is the Medicare Quality Improvement Organization in Arkansas. To request an immediate review or submit quality of care concerns, call the AFMC hotline available 7 days per week **1-888-354-9100**.

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Our job is to help people save money and make informed decisions about Medicare.

SHIIP needs volunteers

Volunteer opportunities include:

1. **Office Assistant**– Provides administrative support including data entry, answering phone, scheduling appointments and other clerical duties.
2. **Medicare Counselor**– Helps Medicare recipients with Medicare questions and applications for money saving programs like Extra Help and Medicare Savings Plans.
3. **Outreach Assistant**– Make 5 minute scripted presentations called “Medicare Minutes” to groups of Medicare beneficiaries and their caregivers. Handout materials at health fairs and booths.
4. **Special Projects** like taking photographs an events, writing newsletter articles, and more...

SHIIP provides training and support for all volunteer roles. Call or email to learn more 1-800-224-6330 or insurance.shiip@arkansas.gov

Advanced Directive

Get one today!

An Advanced Directive is written instruction provided by individuals to define actions to be taken for their health in the event that they are not able to make decisions due to illness or incapacity, or to appoint a person to make such decisions for them. Several free forms are available online. Consider filing an Advanced Directive with family and doctors in case of emergency as these decisions are difficult.



Arkansas Insurance
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Toll Free: 1-800-224-6330

www.insurance.arkansas.gov



LOCAL HELP FOR PEOPLE WITH MEDICARE

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