Healthcare Navigation, LLC

A Guide to Medicare: Navigating Traps and Gaps

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Slide 2 – Introduction

At Healthcare Navigation, LLC, we have helped many people over a number of years transition onto Medicare. Our Medicare Coverage Transition service is comprehensive as we believe it should be. We understand, however, that not all people want as comprehensive a service or can pay for it. As a result, we have assembled several resource documents to provide support to those handling the transition themselves. After all, we passionately believe that making good healthcare coverage decisions are among the most important decisions Americans can make. Please take note that we sell no insurance products and accept no commissions. We work solely for our clients. Our objective is to help people make the best decisions about their coverage consistent with their priorities, values and budget. We hope you can benefit from our years of expertise.

The Healthcare Navigation web site, www.healthcarenavigation.com, contains an Education tab. In that area, you will find our educational materials relating to *Medicare: Navigating Traps and Gaps*, including the following:

- A PowerPoint slide show
- This Guide to Medicare: Navigating Traps and Gaps – a Word document with text accompanying each PowerPoint slide
- Supplemental Resource Materials

This Guide provides more detailed information than the PowerPoint slides which introduce the basics of Medicare. The Medicare Traps and Gaps supplemental resources section on Healthcare Navigation's web site contains documents, forms and other material that also accompany the PowerPoint and this Guide.

Medicare is more complex and enrollment rules more punitive than people realize, so I can't emphasize enough the importance of performing your own initial research. It is always frustrating when people come to us after they have made poor decisions that can't be undone.

Many other resources are available to help you understand Medicare. A great deal of information is available on medicare.gov. Every year the government publishes *Medicare and You,* a handbook which can be downloaded from medicare.gov under Forms, Help and Resources. The Medicare Rights Center, a national non-profit organization, also includes many useful resources at medicarerights.org. Medicare

Explained, published annually by Wolters Kluwer, is another excellent resource although more appropriate for those already fairly knowledgeable about healthcare coverage issues.

Slide 3 – Medicare History and Evolution

Having some background about the history and evolution of Medicare is helpful because it highlights the fact that Medicare was not enacted as a single piece of legislation. Rather, different parts of Medicare were enacted at different times.

Congress passed legislation creating Medicare Part A and Medicare Part B in 1965 and the program began in 1966. Medicare Parts A and B are referred to as original Medicare.

Because Medicare was created in the 1960's, it was structured like insurance that existed at that time, primarily covering illness and injury and with a benefit design that includes deductibles, copayments and coinsurance. As a result, private policies called Medicare supplements that help cover those out-of-pocket expenses, evolved. Medicare supplements are also known as Medigap plans because they help cover the gaps.

Advantage Plans which started as trial projects became formalized as Medicare Part C in 1997. Advantage Plans aren't typically referred to as Medicare Part C because these plans are offered by private insurers who market to you and the term Advantage Plan is more enticing. Advantage Plans are alternatives to original Medicare. You need to be enrolled in Medicare A and B to elect an Advantage Plan, but you are choosing to leave original Medicare when you enroll in one. Whether or not to stay in original Medicare or to enroll in an Advantage Plan **is a very important decision** which is covered in greater depth in the material on Slide 6, Original Medicare vs. Advantage Plan.

In 2006, Medicare Part D, began. Medicare Part D provides outpatient prescription drug coverage, and, thankfully, begins with the letter D which helps us remember that. Please note that Medicare existed for 40 years before there was coverage for outpatient prescription drugs.

In 2007, Medicare Part B became income-indexed and in 2011, Part D became income-indexed. This means that higher-income people pay more for these benefits. The IRS shares information with Social Security to identify who should pay more and how much more. The charts showing income-indexed premium amounts are included in the supplemental resources section of our web site.

Slide 4 – A Brief Summary of the Parts of Medicare

First, Part A. Part A of Medicare provides coverage for inpatient hospital and skilled nursing facility charges. Part A may also cover home healthcare services if you've recently been an inpatient. It also covers hospice services. If you remain in good health, you may not use your Part A for years because Part

A coverage is almost always associated with inpatient services.

Part B of Medicare covers all physician services and almost all outpatient services like laboratory work, radiology procedures, physical therapy, durable medical equipment and drugs that are administered intravenously.

On this slide we have no space between A and B and private Medicare supplements to show that supplements are only relevant to people who remain on original Medicare, Medicare A and B. No one enrolled in an Advantage Plan should have a private Medicare supplement or Medigap Plan.

As mentioned on the previous slide, a Medicare Advantage Plan or Part C is an alternative to original Medicare. When you enroll in an Advantage Plan the government pays the Advantage Plan an amount similar to what is estimated to be spent on you if you remained in original Medicare.

Most Advantage Plans include drug coverage, Medicare Part D, but unfortunately not all do. In my opinion, given the costs of certain drugs, everyone should have drug coverage. Another aspect of Part D is that although it is a government benefit like Medicare A and B, Congress chose to have it administered through private companies -- so it is more like an Advantage Plan model. In many metropolitan areas you have 20 or more Part D plans to choose from.

Slide 5 – What Medicare doesn't cover

Medicare is fairly good medical coverage if you receive services from Medicare participating providers while on original Medicare or from in-network providers if you choose an Advantage Plan. But this slide shows some of the services Medicare does not cover. It doesn't cover long term custodial services. Those services are provided when it is not safe for you to be alone. Medicare covers you in a skilled nursing facility after a hospital admission when you are recovering from an illness. But Medicare stops covering you in a skilled nursing facility if you aren't actively recovering from an illness or injury.

Medicare doesn't cover routine dental or vision services although sometimes limited services are offered by an Advantage Plan.

Medicare also doesn't cover hearing aids so if you need hearing aids and your existing employer or group plan covers them, you should consider obtaining them before going on Medicare.

Another important issue is that Medicare is intended to cover you while in the United States and not while you are traveling abroad. Some supplements and some Advantage plans have limited foreign travel emergency coverage, but we recommend you arrange for travel coverage if planning a trip outside the United States.

I mentioned earlier that when Medicare began in 1966 most coverage was limited to services related to

illness or injury. So-called "well care" was paid for out-of-pocket at that time. Today many screening exams are covered by Medicare. However, there are some services that if your doctor's office codes as well care rather than related to a diagnosis, Medicare will not pay. Laboratory work done as part of a physical exam after your "Welcome to Medicare" physical is a good example. In sum, there are situations where Medicare will not cover services unless they are related to a diagnosis.

Original Medicare does not have an out-of-pocket maximum like individual or group plan coverage. An out-of-pocket maximum is the total amount you spend on deductibles, copayments and coinsurance for services before the Plan is obligated to pay 100% for in-network claims for the remainder of the benefit year. If you stay on original Medicare and purchase a Medicare supplement, you have more protection and greater predictability of out-of-pocket expenses and if you enroll in an Advantage Plan, the in-network out-of-pocket maximum also provides protection and predictability.

Part D Plans also do not have an out-of-pocket maximum like an individual or group product. The Part D benefit resets every year on January 1st as described later in this material.

Original Medicare also does not have catastrophic hospitalization coverage. This issue is discussed in the material associated with slides 7 and 9.

Slide 6 – Original Medicare vs Advantage Plan

This is an extremely important slide because choosing between Original Medicare or an Advantage Plan is a critical decision. This slide shows the choices most people have when going on to Medicare, on the left, original Medicare, a private Medicare supplement and a Part D plan. Or – on the right, enrolling in an Advantage Plan.

This slide is from the government's *Medicare and You* book and you'll see it says "Decide if you need to add drug coverage" and "decide if you need to add supplemental coverage." In my opinion everyone should have drug coverage and if you choose to remain in original Medicare, everyone should enroll in a supplement. We'll get into this in greater detail later. But now let's address the pros and cons of original Medicare vs. an Advantage Plan.

Original Medicare offers the most freedom of choice of doctors and hospitals with the fewest restrictions and rules. With original Medicare, regardless of where you live you can go to any doctor (unless he or she has opted out which we'll discuss later) and Medicare will cover you. You can also go to any hospital. If you value being able to go to any major medical center in the country regardless of where you live, then you should probably remain in original Medicare. Also, if you buy a supplement that can move with you to any state you might make your permanent residence, then you might never need to change your coverage again except to consider a change in a Part D plan.

Advantage Plans are very popular and growing to the point where it is estimated that over a third of

Americans on Medicare are in an Advantage Plan. One reason they are attractive is that the Advantage Plan premium is typically less than the cost of buying a private Medicare supplement. However, most Advantage Plans have much higher out-of-pocket expense potential than most supplements. The out-of-pocket maximum is the amount you might have to pay out-of-pocket before your insurer pays at 100%.

I used the tool on medicare.gov to review my options as if I were shopping for an Advantage Plan. There were 25 plan choices. The lowest in-network out-of-pocket maximum is $4700. Most ranged from $5000 - $7550. The plans that had out-of-network benefits had out-of-network, out-of-pocket maximums as high as $10,000. In comparing options for yourself, the supplement premium may be more, but you can choose a plan with lower out-of-pocket potential expense. When considering Advantage Plan enrollment, you should do a great deal of homework focusing on in-network doctors and hospitals, the rules of the plan and the out-of-pocket maximum exposure before enrolling.

Also remember that Advantage Plans are managed care products that are associated with a geographic area around your primary home. In-network providers in an Advantage Plan, doctors, hospitals, and other types of providers, have a contract with that Advantage Plan that is based on that geography. All managed care products have a network of providers.

Some love the convenience of paying a small copayment for services with an Advantage Plan if all their doctors are in-network. Advantage Plans can also offer more services not traditionally covered by Medicare like routine dental or vision services or a discount to a local gym. Many in government would like to see more Americans in Advantage Plans, so expect even more enhanced services to be offered in the future.

But - my major concern about Advantage Plans is that in my experience most people who signed on for one signed on without understanding the cons as well as the pros. Some Advantage Plan marketing materials can be misleading. Please take the time to consider your options and study them well.

Another critical point is that through Medicare's Annual Enrollment Period you can choose to go from an Advantage Plan to original Medicare or to a different Advantage Plan, but you cannot always be assured that if you go on an Advantage Plan you will be able to buy a Medicare supplement if you want to return to original Medicare. Whether you can purchase a supplement beyond the six-month period associated with your Part B effective date depends on the state you live in and possibly your health status. Medicare supplement issues will be discussed in greater depth when we get to those slides.

Slide 7 – More on Medicare Part A

To refresh your memory, Part A is largely associated with inpatient facility services, hospital admissions and skilled nursing stays following a Medicare-covered inpatient hospital admission. Of course, one always needs to be meeting Medicare criteria to be an inpatient for Medicare Part A to cover.

For the vast majority of Americans, Part A is premium-free because it is earned by working and paying into Social Security or by being married to someone long enough who paid into Social Security the required time.

Let's talk about how Part A benefits work because the hospital benefit in particular is so different than with other types of coverage. No one on Medicare can be entitled to more than 150 hospital days or 100 skilled nursing days at a time. The reason this isn't more of a problem is because these benefits replenish when you haven't used Part A services for 60 days.

Let's review this. Let's say you are in the hospital for ten days. When you are discharged your Part A hospital benefit has been reduced to 140 days. If you then don't use Part A services for 60 days, your hospital benefit is increased back up to the maximum of 150 days. But can you exhaust 150 hospital days or 100 skilled nursing days? Yes, it is not common but one can. Think of how different this is from an Affordable Care Act compliant plan which is required to have an unlimited hospital benefit.

Let me share one situation we became involved with after a woman exhausted Part A hospital benefits. The family came to us after she died. The woman had been in and out of the hospital but often readmitted so that she never had 60 days of not using her hospital benefit and exhausted the 150 days. She lived at the hospital for five months beyond using up her benefit and her estate later received an $800,000 bill from the hospital. The hospital was willing to reduce the amount due, but it was still a devastating financial blow. If she had had a Medicare supplement – any Medicare supplement, she would have had an additional 365 days of hospitalization coverage that could have been tapped after Medicare Part A was exhausted.

Americans on Medicare today obtain catastrophic hospitalization coverage beyond 150 days through a Medicare supplement or an Advantage Plan. Catastrophic hospitalization coverage was passed and repealed by Congress in the late 1980's and has never been part of original Medicare since then. Again, it is not common to exhaust your Medicare hospital benefit, but it can happen.

I know this sounds incredibly grim and tedious – and it is. But I share it to emphasize the importance of having catastrophic hospitalization coverage either through a supplement or an Advantage Plan.

Another depressing reality is that in our experience it is more common to see the 100-day Skilled Nursing Facility benefit exhausted than the 150 day hospital benefit. There is nothing like the catastrophic hospital benefit for SNF coverage in a Medicare supplement or an Advantage Plan. Some people who exhaust their 100 days might have long-term care coverage that will help them with such a stay but many people will be private pay. Others will qualify for Medicaid, the program for low income Americans.

Slide 8 – More on Medicare Part B

Let's talk about Medicare Part B, medical services. As stated before, if you remain in relatively good

health after going on to Medicare, you might not use your Medicare Part A benefit for years. However, everyone using services will likely use Medicare Part B services regularly since they cover all physician services and most outpatient services.

There is always a premium for Medicare Part B. If you are low-income, you can get help with the premium but there is always a premium. In 2007, Part B became income-indexed, so higher-income Americans pay much more for their Part B coverage based on the tax returns they filed with the IRS.

One enrolls in both Medicare Part A and Medicare Part B through Social Security. Unlike Part A, however, which is considered a benefit that is earned through years of paying into Social Security, Part B is subsidized through federal taxes so has strict enrollment rules. If these rules aren't followed, the system is designed to be punitive with both a potential gap in coverage and lifetime premium penalties. Insurance is typically designed with rules to penalize people who aren't paying into the system when they are healthy and Medicare is no different. The punitive enrollment rules are meant to encourage everyone to sign up for Part B when they are first eligible and not wait until they are older and sicker. Most of the problems we see with people running afoul of Part B enrollment rules are because more people are working at 65 and older and opting to postpone electing Part B without understanding the rules.

We'll talk about this in greater depth when we get to the slide on enrollment. It is an extremely important issue.

Slide 9 – More on Medicare Private Supplements

Medicare supplements and Medigap plans are synonymous terms. These are not Medicare benefits but private insurance policies that help pay deductibles, copayments and coinsurance associated with Medicare Part A and Medicare Part B. Supplements have nothing to do with Medicare Part D, Medicare's outpatient drug benefit. Supplements existed decades before Part D existed. Several supplements, H, I and J included drug coverage before Part D existed and although some people remain on those supplements, they have not been sold for years.

Referring back to slide 6, most people choose to either stay on original Medicare with a private supplement and Part D Plan or enroll in a Medicare Advantage Plan. There are people who have other options because they have retiree medical or are retired military or are low-income so also on Medicaid.

Like so much of the rest of Medicare, Medicare Private Supplements are complicated. One unfortunate reality is that in the 47 states that use the standard system, they are labeled with letters just like Medicare, which can be very confusing. Years ago, the federal government standardized the benefits so in the 47 states that use that system, so the benefits in a Plan G supplement or a Plan N supplement are the same. Massachusetts, Wisconsin and Minnesota have developed their own benefit designs for coverage secondary to Medicare so if you live in one of those states, you have different options than shown on slide 10. Another variation is that in some states a Medicare Select Supplement option is available. These

supplements have a provider network so you must use in-network providers to maximize coverage after Medicare pays. For additional information, your state insurance department web site is almost always a good resource.

A Medicare A supplement has the least supplemental coverage or benefits and in 2021, a Plan G has the greatest or is the richest plan one can buy if new to Medicare. I'll discuss this more in comments associated with the next slide.

An extremely important point to consider when planning a Medicare transition is that all Medicare supplements are guaranteed issue for the first six months from your Medicare Part B effective date. Guaranteed issue means that if you apply for the product within that window, the insurer must issue you a policy. Because Medicare supplements are private insurance products regulated by state Insurance Departments, states differ on whether you can buy a supplement after that six-month guaranteed issue period.

Most states allow medical underwriting after that six-month guaranteed issue period. That means the insurer requires you to complete a health questionnaire and they can reject your application based on your answers about your health. Other states don't allow medical underwriting but impose a waiting period which is a period of time where you pay monthly premiums, but your coverage doesn't begin until you've completed the waiting period. In New York, for example, supplements are always guaranteed issue but if you apply for one after the six-month period beyond your Part B effective date, the waiting period for all plans is six months. That means you are paying premiums for six months before the Supplement pays for services. Again, these rules are intended to encourage people to buy and keep an insurance product before they are sick and in greater need of the coverage.

As with any insurance product, paying the premium on time is critically important. Late payment can lead to termination. We recommend people set up payment for a supplement through an automatic bank draft so that it is more difficult to miss a payment which can happen – usually due to illness and occasionally due to extensive travel.

In addition to reviewing the premium for a Medicare supplement because premiums even for a standard plan vary, it is important to purchase a Medicare supplement that is portable. An insurance product is portable if you can move to another state and keep that coverage. With a portable product you simply inform the insurer of your new address and they let you know your new premium. Many products are portable but not all are. Again, the states are different. Some states have fewer than fifteen insurers approved to sell supplements in that state. Others have dozens. In addition to the importance of portability, it is advisable to consider insurers which are major companies that have provided supplements to customers for many years.

And don't be seduced by television commercials. Go to objective sources for information. You can often see fairly accurate insurance company comparisons on your state insurance department web site because those departments approved the rates.

Slide 10 – Comparing Medigap Plans

Let's review the system that most states (all but Massachusetts, Wisconsin and Minnesota) use for Medicare supplements. Over the years as we discussed before, changes have been made to these standard offerings. An important change in 2020 is that Plan F which was the richest plan since 2010, can no longer be sold. If you were enrolled in Medicare Part A prior to January 1, 2020, you are able to purchase a Plan F supplement. People who have Plan F can keep it but as of January 1, 2020 no plan issued to someone new to Medicare can cover the Medicare Part B deductible which in 2021 is $203. This means that you have to spend $203 out-of-pocket medical services covered by Medicare Part B before a supplement pays.

People who stay on Plan F will continue to have coverage for the Medicare Part B deductible. The thinking behind Congress acting to stop Plan F from being sold is that people should not be able to have 100% coverage after Medicare Part B pays because that could lead people to over-utilize services. That seems rather silly because most deductibles people have before going on Medicare are much higher. Suffice it to say that the only difference between a Plan F, that used to be available, and a Plan G, that is now the richest plan, is the Medicare Part B deductible. The Medicare Part B deductible tends to go up every year but remember that Medicare started in 1966 so the increases over time have been modest.

In general, a plan with fewer benefits should cost less but be careful because that's not always the case for different reasons. For example, federal law does not require that supplements be sold to people under age 65 who are on Medicare, but some states require that certain plans be offered. People can have Medicare under age 65 for different reasons but all reasons are associated with illness or disability. In Connecticut, for example, my home state, you can see a chart on the Insurance Department web site of all the companies that offer Medicare supplements and the premiums they charge. You can view this chart in the Supplemental Resources material associated with this presentation. One can actually pay more for a Plan A supplement which has the least benefit than another insurer's Plan G supplement which is the richest. Of course, Connecticut requires that Plan A be available to those on Medicare who are under 65 and those higher rates reflect the higher utilization of medical services in that population.

My bias is that even without the options that can no longer exist, (Plans C, E, F, H, I and J), there are still too many options. Here are some thoughts to keep in mind. To make your homework on this subject manageable, concentrate on Plan G, the richest benefit, Plan N, the second richest benefit, or high deductible G which provides a much lower premium than regular Plan G but pays at 100% like Plan G after a $2370 deductible is met in 2021. The deductible tends to increase modestly each year.

Plan G, the richest plan available in 2021, covers all the coinsurance after Medicare pays and the charges associated with doctors who don't accept assignment after the deductible of $203. Plan G is the logical choice for those who frequently use medical services or those who can afford it and just want the convenience of not dealing with small medical bills after Medicare pays.

Plan N, the second richest plan available, has a different benefit design. A person on Plan N pays a

copayment for a visit to a doctor who accepts assignment. If the doctor doesn't accept assignment which is a different way of relating to Medicare, then the person on Plan N is responsible for the total excess amount of coinsurance. On the chart, you can see there is no benefit under Plan N for "Part B excess charges" which refers to doctors who do not accept assignment which we'll discuss in further detail later. A person who chooses Plan N is motivated to use doctors who accept Medicare assignment, which is fairly analogous to being in-network in the non-Medicare world.

In 2021, there is also a high deductible Plan G which covers 100% of the coinsurance and excess charges after a deductible of $2370. Some people may find this option attractive because they don't use medical services frequently enough to justify the more extensive coverage of a full Plan G. The high deductible Plan G was new in 2020 and replaces the high deductible Plan F. Like the regular Plan F, those who already have it can keep the high deductible Plan F but it is no longer available for sale as of January 1, 2020.

If you are considering Plans A or B, be sure to note that there is no benefit for skilled nursing facility coinsurance. After the first 20 days in a nursing home, you are responsible for a copay, which in 2021 is $185.50 a day. I have known a number of people who had buyer's remorse about their Plan A or B supplement after receiving a large bill from a skilled nursing facility.

Please note that ALL supplements include an extra 365 days of hospitalization coverage after Medicare benefits are exhausted and that Plans D, G, M and N include limited foreign travel emergency coverage. It's important coverage because Medicare rarely covers you outside the United States but it's really not enough coverage. It's a $50,000 lifetime maximum amount that could potentially be exhausted with a single hospital admission even outside the United States where hospital costs tend to be lower. Consider obtaining travel coverage for medical issues and evacuation when you travel outside the United States.

In summary, selecting a supplement is an important decision. Do your homework so that you can make the best decision consistent with your priorities and approach the decision as though you'll have this coverage for the rest of your life. Don't overpay and make sure your plan can move with you.

Slide 11 – More on Advantage Plans

Now let's move on to More about Advantage Plans. Remember, Advantage Plans are sold by private companies, so you are opting out of original Medicare when you enroll in one. Although you have to be enrolled in both Medicare Part A and Part B to be in an Advantage Plan, you don't use your Medicare card once you're in an Advantage Plan. You put the Medicare card away and use the card the Advantage plan forwards to you.

Advantage Plans aren't portable. They are always tied to your area of geographic residence. If you move out of that area and are no longer eligible for the Advantage Plan you were in, you have a Special Enrollment period to sign up for another Advantage Plan or register anew with the plan you were in if it

serves your new home location. If you move to another area you can also return to original Medicare and a free-standing Part D prescription drug plan. Again, whether you can get a supplement if you return to original Medicare depends on the rules in that state, as we discussed before.

Advantage Plans are structured similar to other managed care products like HMOs and PPOs, so you need to know the provider network. If you enroll in an HMO product and receive services from a provider who isn't in the Advantage Plan network, you're not covered. And if you are enrolled in an HMO product it is likely you will only be covered outside your local geographic area for urgent and emergent services. If you are enrolled in a PPO product with out-of-network benefits and you receive services from an out-of-network hospital, your out-of-pocket exposure can be high so know how that benefit works and your out-of-pocket maximum. Like other managed care products, Advantage Plans are more likely to have rules like prior authorization so there is more potential for dealing with administrative hassles with Advantage Plans.

Of course, on the plus side Advantage Plans have more flexibility to offer additional benefits.

As mentioned previously, my concern about Advantage Plans results from people who've bought them as a result of a strong sales pitch rather than after studying and understanding their options. But if you enroll in an Advantage Plan where all your doctors and preferred hospitals are in the network, you have the funds to meet the out-of-pocket maximum should you need to and you don't plan to relocate, an Advantage Plan can be a good, stable option for you.

Slide 12 – More on Part D

Part D which covers outpatient prescription drugs, is the newest part of Medicare. Part D began in 2006 after years of debate about whether the country could afford a drug benefit for those on Medicare. Part D is a government benefit, but it is managed entirely by private companies competing with one another. There is a premium paid to that company and for those who pay an income-indexed premium, an income-indexed premium paid to the government.

Part D has strict enrollment rules with premium penalties and a gap in coverage if you don't follow them. We have seen many people conclude that if they are not on any prescription medications or only taking inexpensive generics that they do not need to sign up for a Part D plan. I strongly disagree with that conclusion. You never know what you might be prescribed, and many drugs are very expensive. The risk of not remaining enrolled in a drug plan is substantial because you may have to wait until the following annual enrollment period, which is now every October 15 to December 7, to enroll in a plan for the following January 1. That is also a time of year when one can choose to change from one plan to another.

Part D benefits are administered on an annual calendar basis which begins on January 1 for everyone on Part D (or the first of the month of the year you first enroll in Medicare) and are designed to give everyone good drug coverage after they meet their annual deductible while in what is called the Initial Coverage

Limit. The Initial Coverage Limit is the total cost for drugs a covered individual has paid that year for drugs AND the amount that person's Plan has paid. The criticism of Part D is because if one exceeds the Initial Coverage Limit, coverage may not be as good – essentially a discounted amount – if and until one reaches the Out-of-Pocket Threshold. Those who reach the Out-of-Pocket Threshold see their out-of-pocket expense plummet for the remainder of the calendar year and then the whole process resets on January 1.

The benefit was designed this way to encourage everyone to sign up for a Part A Plan but also to protect those with the highest drug costs.

The 2021 Initial Coverage Limit is $4130. If the total cost (your share and your plan's share) of your drugs exceeds this threshold, your coverage may not be as comprehensive. You'll pay discounted amounts through the rest of the calendar year unless you reach the out-of-pocket threshold of $6550. If you spend $6550 out-of-pocket, then your copays are lower for the rest of the calendar year.

If you are taking all generic prescription drugs and the copayments seem modest, then it is probably unnecessary to do an annual Part D review because changing coverage can be disruptive. However, if you're uncertain about whether your copayments are reasonable and/or you are taking brand name drugs, it is advisable to do an annual Part D to verify that there is not a better plan for you. The most important factor in doing a Part D drug review which uses a tool on the medicare.gov web site is to determine that your drugs or are on the Plan's formulary, the list of covered drugs. Also, most people do not want a plan which includes step therapy. Step therapy gives your drug plan the option of requiring you to try a cheaper drug than your doctor prescribed and proving the cheaper drug isn't effective for you.

Slide 13 – Enrollment Periods

Most people transition on to the various parts of Medicare all at once and most people do this at age 65, when they are first eligible for Medicare. The people who go on Medicare before age 65 have serious illness and/or disability. Others enroll after age 65 because they have active group coverage through their employment or a spouse's active employment. Many people with active group coverage enroll in Medicare Part A at 65 because it is premium-free and allows them to obtain a Medicare number but defer enrolling in Medicare Part B and other products until retirement. Still others choose to have group coverage and Medicare Parts A and B.

For this discussion, we will concentrate on the major enrollment periods that allow you to enroll in Medicare and the annual enrollment period, that period from October 15 to December 7, for those ALREADY on Medicare who might want to change their Part D Plan, Advantage Plan or to switch between Medicare Advantage and original Medicare.

Medicare's Initial Enrollment Period begins three months before the month of your birthday. If you want your Medicare in place as soon as you are eligible, you should start your enrollment process early now that Medicare numbers are not Social Security numbers but randomly generated numbers. You need that

Medicare number to complete other enrollments. If you enroll in Medicare Part B during the last four months of your Initial Enrollment Period, your Part B effective date is not the first date you are eligible for Medicare. In fact, it gets pushed out further the longer you delay.

If you are already receiving Social Security benefits before you become eligible for Medicare, then you will automatically be enrolled in original Medicare and sent your Medicare card showing Medicare Parts A and B effective dates the first day you are eligible. In situations where you might have active group coverage through employment or more typically through a spouse, you might consider opting out of Part B.

Most people are eligible for Medicare the first of the month they turn 65. If your birthday is the first of the month, you are eligible for Medicare on the first of the month of the month prior to your birthday.

The vast majority of people should plan to go on Medicare at 65 during their Initial Enrollment Period.

The people who have active group coverage can delay their enrollment in Medicare and are entitled to what is called a Special Enrollment Period. They might enroll in Medicare Part A during their Initial Enrollment Period and then enroll in Part B when they retire using a Special Enrollment Period.
Two very important things to remember are, first, for whatever reason you cannot enroll in Part B using a Special Enrollment Period while still in your seven-month Initial Enrollment Period so advance planning is required for people for whom that matters. Second, according to IRS rules neither the enrolled nor an employer should be contributing to a health savings account-type plan while on Part A for those on a high deductible plan coupled with a health savings account. If you have a health savings account and want to continue contributing to it, then you should defer going on to Medicare Part A while you still have the active group coverage. Of course, most people at the latest go on Social Security at age 70 and when you are on Social Security, you are on Part A. As a result, contributions to a health savings account should stop six months before electing Social Security benefits at 70 even if you continue with active group coverage because Social Security will make your Part A effective date retroactive by six months.

Everyone – let me repeat – everyone going on to Medicare should use their Initial Enrollment Period, A Special Enrollment Period or both to go on Medicare. Someone who gets beyond their Initial Enrollment Period and is entitled to a Special Enrollment Period due to active group coverage remains in a Special Enrollment Period as long as they or their spouse have active group coverage and can enroll in Part B at any time. The Special Enrollment Period begins to end when active employment or active coverage ends – whichever comes first at which point there is an eight-month opportunity to enroll in Part B without penalty. I don't even like mentioning the eight-month window because almost everyone should plan to have active group coverage end on the last day of a given month and have all their Medicare coverage begin the next day. We have seen so many well-intended severance packages for executives and others actually make the transition to Medicare more difficult for the person who is supposed to benefit because the employer assumes COBRA can be extended to a retiree at the company's expense without complicating Medicare enrollment rules. That is typically not the case for those 65 and older.

Anyway, the General Enrollment Period is shown on red in this slide to denote DANGER – do not go there.

The General Enrollment Period is the first quarter of every year for a Part B effective date the following July 1. This is the method to get on Medicare Part B that is punitive and almost always accompanied by lifetime premium penalties and a gap in coverage. The Part B penalty is 10% of the Part B base premium for every full 12-month period that one could have been on Medicare Part B and wasn't, typically back to turning 66. The penalty is assessed for life or in more gentle terms as in the government's *Medicare and You* book – as long as you are on Medicare.

Just a reminder that Part A enrollment isn't ordinarily punitive like Part B. There are strict rules for those who don't qualify for premium-free Part A but that's a pretty small group who didn't either work and pay into Social Security long enough or weren't married long enough to someone who did. Lifetime premium penalties are more commonly associated with Medicare Parts B and D.

The General Enrollment Period was designed to be punitive to make those who delayed their Medicare Part B enrollment pay more. Remember rules of insurance are designed to encourage people to be paying for coverage before they need it, so the General Enrollment Period is designed to punish those who waited to sign up for Medicare Part B until they were sick. The most common problem we see with this relates to people who work beyond age 65 and elect COBRA. COBRA is rarely, I repeat – rarely a good option for someone age 65 or over. Those who elect it often miss their Special Enrollment window and then have to use the General Enrollment Period to get on Medicare
Part B.

The Annual Enrollment Period is for those already on Medicare. It is primarily used to change Part D plans, Advantage Plans or to switch between original Medicare and an Advantage Plan. The Annual Enrollment Period, every year from October 15 to December 7, is particularly confusing to those retiring on December 31 and planning a transition to Medicare. They can actually use the Annual Enrollment Period if they are already on Medicare Part A to enroll in a drug plan, but they also have an enrollment opportunity associated with their retirement. Everyone should understand the Annual Enrollment Period because there is always a great deal of marketing by plans during this period – some of it misleading – and the scamsters are also out in force often with terribly misleading information. You have to be well-informed to interpret the "pitches" you will receive every year during this period.

Slide 14 – Enrolling in Medicare

Let me summarize the information on this slide before getting into the detail. It is important to know the entities through which you file applications and the various means to do so.

First, you enroll in Medicare Parts A and B through Social Security unless you are one of those people who worked or was married to someone who worked for the railroad in which case you enroll in Medicare A and B through the Railroad Retirement Board. So – let me repeat again – you don't enroll in Medicare A and B through Medicare. The vast majority of people enroll in Medicare A and B through Social Security.

As soon as Social Security has processed your Medicare Part A or Part B enrollment, you will be able to create an on-line mymedicare.gov account. This is a very useful tool so do that and become familiar with the site.

You enroll in a Medicare supplement directly or through a broker with the private insurer you choose and make payment directly to them.

Medicare Part D is a government benefit but administered through private companies. You enroll in a Medicare Part D drug plan directly with the plan you choose or through Medicare.

Advantage Plans are managed by private companies. You enroll with the company you choose directly or through Medicare.

Now let's discuss the ways to enroll. You can call Social Security to make a telephone or in-person appointment with them or go to your local office to enroll in Medicare Part A, although you risk a long wait with a walk-in option. You can also use an on-line process if you are applying for benefits on your own work record. You do this at ssa.gov but you must now have a user name and password for a My Social Security account to use the on-line process.

If you are enrolling in Medicare Part B during your Initial Enrollment Period which is around your 65th birthday, you also have all the options noted above in interacting with Social Security (or the Railroad Retirement Board).

If you have gone beyond your Initial Enrollment Period because you had active group coverage, then there is a paper process to enroll in Medicare Part B. This is to demonstrate to the government that you had active group coverage. One needs to submit two types of forms to Social Security to enroll during this Special Enrollment. One is a CMS-40B which the individual completes. We recommend entering under Comments at the bottom "Please make my Part B effective (and the actual date which is always the first of a month)" so there is no confusion about the effective date you're requesting.

The CMS-L564 form needs to be completed by every employer who provided coverage to you since turning 65. The good news is that you can download these forms from the internet. However, Social Security wants original signatures on the original forms. You make copies and give them the originals.

We recommend personally delivering these forms to your local Social Security office about four weeks before your requested effective date. We have never had forms misplaced that were personally delivered but have had forms lost that were overnight mailed – even with tracking and a signature. This sometimes requires starting the process anew which is definitely worth avoiding.

The General Enrollment Period is largely to be avoided as discussed previously. One can enroll using all the methods described above, telephone, telephone appointment, in person at Social Security or on-line.

Medicare Supplement

You can enroll in a Medicare supplement in various ways described above – on-line, over the phone yourself, through a broker, etc. If the insurer has local walk-in offices, you could use that method too.
Advantage Plan

Enroll in an Advantage Plan over the phone with 1 800 Medicare, on-line through medicare.gov, through the insurer's web site, or through a broker. If you are receiving Social Security, you can choose to have any Advantage Plan premium withheld from your Social Security payment and Social Security will pay the Advantage Plan. Unlike your Part B payment, which is always withheld from your Social Security payment, having the Advantage Plan premium withheld is optional.

Medicare Part D

Enroll in a Part D prescription drug plan over the phone with 1 800 Medicare, on-line through medicare.gov, through the insurer's web site, or through a broker. Some pharmacies are willing to help with Part D reviews and enrollment but keep in mind that many who do are affiliated with a Plan.
If you are receiving Social Security, you can choose to have any prescription drug plan premium withheld from your Social Security payment and Social Security will pay the Plan. Unlike your Part B payment, which is always withheld from your Social Security payment, having the prescription drug plan premium withheld by Social Security is optional.

An important part of any enrollment is, of course, keeping good records, following up if you don't receive timely confirmation of enrollment and, ultimately, a card.

Slide 15 – Income-Indexing Medicare Parts B and D

For the first 40 some years of Medicare, everyone on Part B paid the same premium. Then in 2007, Part B premiums became income-indexed. A few years later, Medicare Part D premiums became income-indexed. For the Americans that this affects, Medicare is more complicated because the IRS reports income information to Social Security. Income-indexed premiums for current year Medicare Parts B and D are based on the tax return filed two years prior.

Social Security refers to this payment as IRMAA, the income-related monthly adjustment amount. It is based on Modified Adjusted Gross Income, the sum of adjusted gross income from line 37 of IRS form 1040 and tax-exempt interest income from line 8b of IRS form 1040. In 2021 the IRMAA brackets will affect those with income that exceed $88,000 for an individual or $176,000 for a couple filing jointly. There are five brackets of income-indexing. The top bracket is for those whose income exceeds $500,000 for an individual or $750,000 for a couple filing jointly. To see the specifics for this year, go to the Supplemental Resources document on the web site associated with this presentation.

Most people will pay $148.50/month, the base premium, for their Medicare Part B in 2021 but at the highest level of income, individuals will pay $504.90/month for Part B and $77.10 in income-indexed D premiums. What is somewhat confusing is that sometimes Social Security correspondence will break out the base Part B premium from the income-indexed Part B premium while information available from other sources combines the two parts. Part D is always two components and listed that way because there is a premium that is paid to the prescription drug plan and an income-indexed amount which goes to the government.

When you're applying for Medicare Part B and you receive the initial confirming letter from Social Security, it's common for the first letter to not address income-indexing but such a letter should follow. Review this correspondence carefully and make sure it is correct.

Let's discuss how income-indexed amounts are paid.

If you are receiving Social Security, the entire Part B amount and the income-indexed Part D amount are withheld from your Social Security payment. You have no choice about this. As discussed previously, if you're receiving Social Security you can choose to have Social Security directly pay the prescription drug plan premium or an Advantage plan premium to the plan. Many choose having Plan D premiums paid by Social Security for the convenience but it is advisable to monitor the situation.

If you are not yet receiving Social Security, you will receive a bill from Medicare for your Part B base premium, income-indexed Part B premium and Part D income-indexed premium. If you're not yet receiving Social Security, then you must pay any Advantage Plan or prescription drug plan premium directly to the plan you choose.

Life Changing Event

Anyone experiencing a life-changing event, like divorce or retirement (as defined by Social Security), which might significantly alter their income should become familiar with form SSA-44. In those instances, within a certain timeframe, one can ask Social Security by filing form SSA-44 to base income-indexed premiums on current projected income rather than income from two years prior. This can possibly reduce income-indexed premiums in the case of retirement, divorce, or death of a spouse.

Slide 16 – Doctors and Hospitals

Let's now talk about doctors, hospitals and Original Medicare. We've already discussed that Medicare Advantage Plans have a network of doctors and hospitals so if you are in an Advantage Plan take the time to become familiar with your network.

Original Medicare does not have a network but there are different categories of how doctors relate to Medicare with terminology that is different from other types of coverage. There are two categories of

doctors that file Medicare claims for patients, doctors who accept assignment and doctors who do not accept assignment. But this doesn't refer to a network. Assignment refers to where Medicare sends the payment.

Accepts Assignment is the category most similar to being in-network. The doctor's office doesn't collect payment from you up front. After services are rendered, the office submits a claim to Medicare and receives payment directly from Medicare. The amount doctors who accept assignment can charge for services is regulated by Medicare. You can look up which doctors accept assignment on the provider tool on medicare.gov. You can also ask the doctor's office if the doctor accepts assignment or is in some other category.

Doctors who don't accept assignment are allowed to ask for payment at the time of service. Like the doctors who accept assignment, the office also submits claims to Medicare, but payment is made to the patient. Also, the doctor can charge a slightly higher fee schedule than doctors who accept assignment. Payment amounts are also regulated by Medicare.

It is more difficult to rely on the provider tool on the medicare.gov web site to identify doctors who don't accept assignment. You can call the doctor's office or view what information might be available on a provider web site to determine a doctor's status.

With both accepting assignment and not accepting assignment categories, if you have a Medicare supplement, the supplement typically receives claim information after Medicare pays. This is a great convenience for patients and payment works the same way as the Medicare payment works. If the doctor accepts assignment, payment is made to the doctor. If the doctor does not accept assignment, the payment goes directly to the patient.

Doctors who opt out of Medicare have no relationship with Medicare. They can't submit claims to Medicare and be paid for services. Doctors who opt out of Medicare are supposed to provide patients with what is called a private agreement which is a document that summarizes the situation – the doctor can't submit claims to Medicare, the patient shouldn't submit claims to Medicare, and the patient understands the doctor is expecting full payment from the patient. Medicare does not regulate fees of doctors who opt out of Medicare.

Doctors who opt out of Medicare tend to be prominent physicians in affluent areas of the country who've built a loyal following of patients who are willing to pay them directly for services. These doctors are often primary care physicians, behavioral health practitioners, dermatologists, or gynecologists. The Hospital for Special Surgery in Manhattan has a number of affiliated surgeons who have opted out of Medicare. Medicare will cover the medically necessary services like the hospital stay but the patient pays for the surgery. Doctors who opt out are typically very compliant with the rules of informing their patients of their status. Some doctors who are not in-network with any non-Medicare insurers actually do have a relationship with Medicare so, again, it's always advisable to know the status of your doctor. The good news is that approximately 96% of physicians have a relationship with and submit claims to

Medicare.

When doctors are employed by a physician group or hospital organization, they tend to all have the same status and either accept assignment or do not accept assignment.
Hospitals

If you remain in original Medicare, you will find that all hospitals participate with and submit claims to Medicare on your behalf. Medicare reimbursement is so important to hospitals that if they lose the ability to submit claims to Medicare due to some type of sanction, it often means the hospital's future is in jeopardy. Only those on Advantage Plans and Medicare Select Supplements need to determine which hospitals are in their network.

Slide 17 – Advantage Plan Doctors and Hospitals

We have already covered most of the information on this slide, but I want to reiterate that when you enroll in an Advantage Plan, the burden is on you to understand the network of doctors, hospitals and other providers. This is not true in original Medicare. With original Medicare the burden is on providers to inform you if they are not Medicare-participating providers.

When an individual has an Advantage Plan with out-of-network benefits there are situations where the doctor's office might not cooperate in submitting claims. We recommend asking if the office will submit claims for you when you schedule an appointment.

Again, it is always important to understand who is in your Advantage Plan network and to understand your financial exposure if you choose to go to providers who are not in the network.

Slide 18 – Retiree Medical Benefits

Retiree benefits are those that a former employer provides and typically subsidizes. Retiree benefits have changed quite dramatically over the last ten or so years because employers have moved to limit their financial exposure and responsibility for retirees, especially those 65 and over. If you are still among the fortunate who are eligible for retiree benefits prior to age 65, you need to plan to be on Medicare Parts A and B as soon as you are eligible.

Many employers have outsourced retiree benefit administration to organizations called private exchanges which are run by large employee benefit organizations. These organizations typically offer a subset of options for Advantage Plans, Medicare Supplements and Part D plans and the employers contribute to a fund to help pay the cost. That amount varies widely and sometimes there is no employer contribution, or it is very modest.

Other companies have moved their retirees to Advantage Plans or actively encourage Advantage Plan enrollment.

In sum, former employers have a more detached relationship with retirees than they used to. More of the responsibility is on you to understand how much you are benefiting from the former employer's program.

Slide 19 – Medicare Coordination of Benefit Issues

Coordination of Benefits refers to who pays first if there is more than one source of coverage. With Medicare and active group coverage it is clear that if an employer has 20 or more employees the group pays first. A large employer should not discriminate against the employee who is 65 or older and should offer those employees the same group coverage as those under 65.

The much more confusing issue is working for a small employer of under 20 employees. Medicare materials suggest one must be enrolled in Medicare Parts A and B in this situation, but this actually varies by state and sometimes even by insurer. Anyone working for a small employer should determine in advance of the Initial Enrollment Period if they are required to be on Medicare Parts A and B. If you can't get a reliable answer from your employer or plan, call your state's Insurance department and ask to speak to a health and life examiner.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a landmark federal law, passed in 1985, that provides for continuing group health insurance coverage for some employees and their families after a job loss or other qualifying event. COBRA provides for the temporary extension of group benefits but Medicare and COBRA are typically not a good mix so please beware. If you are on COBRA before age 65, you should plan to transition onto Medicare when eligible due to Medicare Part B enrollment rules and penalties.

The same is true if you are over 65 and your employer offers you some type of severance arrangement that involves COBRA. Be careful because you don't want to miss your Medicare Part B enrollment window.

The Coordination of Benefit rules also have to be considered when considering COBRA. COBRA is supposed to be secondary to Medicare Parts A and B if you are Medicare-eligible so you should actually be on both A and B **BEFORE** electing COBRA. If you are not on Part B at 65 or later and elect COBRA, you have no primary medical coverage because your insurer should be looking for Medicare Part B to pay before it pays.
Please be very, very careful and understand all the implications if you are on COBRA and turn 65 or are 65 or older and are offered COBRA.

Conclusion – Supplemental Resources page

I hope this information has been helpful and that you better understand Medicare and the decisions you must make. The clients whom we help retain us to help with research, but we still spend hours devoted to helping them become Medicare savvy. After all, most people who go on to Medicare will be on it the rest of their lives so making the right decisions and managing the enrollments properly is critically important.