

Will you pay a higher Medicare Part D premium in 2012?

Filed an individual tax return with income that is:	Filed a joint tax return with income that is:	Part D Income-related Monthly Adjustment Amount
Less than or equal to \$85,000 in 2011	Less than or equal to \$170,000 in 2011	\$0
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$29.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.10
Greater than \$214,000	Greater than \$428,000	\$66.40

Beyond the Basics of Medicare

There are some important things you should know about Medicare that are beyond the basics. Some of these are explained below.

1. Medicare Assignment is when providers agree to accept Medicare's approved amount as payment in full. Medicare pays the provider directly. The provider can only bill you the deductible and co-insurance amounts. Not all Medicare providers accept assignment. In other states, Medicare providers that do not accept assignment are permitted to charge 115% of the Medicare approved charges.

The Minnesota Factor: Since 1996, all Minnesota Medicare providers, with the exception of ambulance and medical equipment suppliers, are not permitted to bill for any charges beyond the Medicare approved amount including deductible and co-insurance, as long as the beneficiary is a Minnesota resident. This is known as the Minnesota Charge Limit and Mandatory Medicare Assignment Law.

2. Advanced Beneficiary Notice

- Physician, supplier and provider must issue Advanced Beneficiary Notice (ABN) before furnishing an item or service if they believe that Medicare may deny payment.
- Providers are not required to give an ABN for services or items explicitly excluded from Medicare coverage. Example: Hearing Aids
- Receiving a properly completed ABN from your provider, means you have been notified that the service or item may not be covered by Medicare and you may have to pay the bill.
- It is a good idea to select the option on the ABN that you want a claim submitted to Medicare. If you do not check this option, the provider is not required to submit a claim.
- ABNs only apply to people in Original Medicare, not Medicare Advantage Plans.

3. Medicare Secondary Payer Rule requires that Medicare not pay until other insurers have paid first. This rule applies if:

- you have Medicare and have other health insurance through an employer group health plan for current employees (not retirees) and spouses;
- you have a Worker's Compensation claim for care provided;
- you have medical care related to an accident that automobile and/or liability insurance covers.

Medicare pays first and the Medicare Secondary Rule **does not** apply to the following:

- a. Medicare supplemental policy coverage
- b. Retiree group insurance
- c. TRICARE for Life
- d. Medical Assistance (Medicaid)
 - ▶ Federal law requires that Medical Assistance be the payer of last resort.

4. Coordination of Benefits (COB) and Medicare Questionnaires

Medicare must make sure that Medicare pays only when it is supposed to pay your claims. The Centers for Medicare & Medicaid (CMS) works with a national Coordination of Benefits contractor to collect and manage information about your other insurance coverage. This information is obtained from your answers to questionnaires you receive from the COB contractor. It is important you respond to the questionnaires. There are two types of COB

questionnaires you may receive:

- i. Initial Enrollment Questionnaire (IEQ)
 - 3 months before you become eligible for Medicare you will receive a four page questionnaire for you to describe any of your other health insurance coverage. The COB needs to find out if you have an employer group health plan that will pay before Medicare.
- ii. Medicare Secondary Claim Development Questionnaire
 - Seeks specific information about an insurance carrier if you indicate you have other benefits through employer coverage, worker's compensation, or under automobile no-fault insurance.

Important!

Answer the questionnaires carefully. Wrong answers can result in delaying Medicare payments for many months.

To correct problems call the COB contractor at 1-800-999-1118 or send a letter to: Medicare Coordination of Benefits; P.O. Box 33847, Detroit, MI 48232. You may also call the Senior LinkAge Line® at 1-800-333-2433 for help.

Medicare Prescription Drug Benefit (Part D): Things to Consider

To get Medicare coverage for your prescription drugs, you must choose and join a Medicare drug plan or a Medicare Advantage plan with Part D drug coverage included. Regardless of how a Medicare drug plan or Medicare Advantage plan decides to offer the coverage, there are some key factors that may vary. Some of these factors might be more important to you than others, depending on your situation and drug needs. These factors are:

Cost

- **Premium**
This is the monthly cost you pay to join a Medicare drug plan. Premiums vary by plan.
- **Deductible**
This is the amount you pay for your prescriptions before your plan starts to share in the costs. Deductibles vary by plans. No plan may have a deductible more than \$320 in 2012. Some plans may not have any deductible.
- **Co-payment/Co-insurance**
This is the amount you pay for your prescriptions after you have paid the deductible.

- ▶ In some plans, you pay the same co-payment (a set amount) or co-insurance (a percentage of the cost) for any prescription.
- ▶ In other plans, there might be different levels or "tiers," with different costs. For example, you might have to pay less for generic drugs than brand names. Or, some brand names might have a lower co-payment than other brand names.
- ▶ Also, in some plans your share of the cost can increase when your prescription drug costs reach a certain limit.

Coverage

• Formulary

A list of drugs that a Medicare drug plan covers is called a formulary.

- ▶ Formularies include generic drugs and brand-name drugs.
- ▶ It is important to make sure that you enroll into a plan that includes your prescriptions on their formulary.
- ▶ The formulary must include at least two drugs in categories and classes of most commonly prescribed drugs to people with Medicare.
- ▶ This makes sure that people with different medical conditions can get the treatment they need.

Restrictions

The plan may have certain coverage rules (including quantity limits, prior authorization and step therapy) on the prescription drug coverage provided.

Quantity Limits: For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time. If the drug has a quantity limit restriction, you should contact the plan for more detail.

Prior Authorization: Prior authorization means that you will need prior approval from an insurance plan before you fill your prescription. If a drug has prior authorization, you will need to work with the plan and your doctor to get an exception. Call your plan or visit their web site to learn more about specific prior authorization requirements. The Senior LinkAge Line® can also assist you with requesting an exception.

Step Therapy: In some cases, plans require you to first try one drug to treat your medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, a plan may require your doctor to prescribe Drug A first. If Drug