

Medicare Basics and Beyond in 2012

The Basics

What is Medicare?

Medicare is a federal health insurance program that began in 1965. States are not involved in the program's administration. In general, the rules governing Medicare's operation are the same nationwide, though payment rates often vary from one region to another.

CMS, SSA, RRB

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers Medicare and Medicaid (known as Medical Assistance in Minnesota). CMS headquarters are in Baltimore, with ten Regional Offices. The Regional Office for Minnesota is located in Chicago, IL. CMS manages Medicare's program operations including claims processing, monitoring the quality of care for patients, handling complaints and reviewing appeals.

The Social Security Administration (SSA) handles Medicare eligibility and enrollment for Social Security recipients. SSA sends enrollment packets and Medicare cards to new Medicare beneficiaries. It also processes applications for Medicare Part D Extra Help (also known as Low Income Subsidy – LIS) program.

The Railroad Retirement Board (RRB) handles Medicare eligibility and enrollment for Railroad Retirees.

Medicare is a national health insurance program for:

- People age 65 or older.
- People under age 65 with certain disabilities.
- People of any age with End-Stage Renal Disease (ESRD) – permanent kidney failure requiring dialysis or a kidney transplant.
- People with Lou Gehrig's disease.
- Medicare is administered by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services located in Baltimore, MD.

Important! Medicare age is not based on Social Security benefits age

Even though the retirement age for full Social Security benefits is increasing until it reaches 67, you will still get Medicare at age 65, even though you may not yet be eligible for Social Security retirement benefits. The age eligibility date for Medicare remains age 65. If you want to enroll in Medicare at age 65 and are not collecting Social Security benefits, you will need to contact Social Security to enroll in Medicare.

The Basics: Medicare Part A

Original Medicare: Medicare Part A

Medicare Part A is hospital insurance.

- Most people do not pay a premium for Part A. They receive it premium-free because they have worked and have more than 40 credits in Social Security-covered employment or they can receive Social Security benefits based on a spouse's earnings.
 - ▶ You can get Medicare Part A at 65 without having to pay premiums if:
 - You already get retirement benefits from Social Security or the Railroad Retirement Board.
 - You are eligible to get Social Security or Railroad benefits but haven't yet filed for them.
 - You or your spouse had Medicare-covered government employment.
 - ▶ If you are under 65, you can get Part A without having to pay premiums if you have:
 - Received Social Security or Railroad Retirement Board disability benefits for 24 months.
 - End-stage renal disease (ESRD) and meet certain requirements.
 - ▶ In 2012, those with fewer than 40 credits, can buy Part A coverage for \$451 per month (with 29 or less credits) or \$248 per month (with 30 to 39 credits).
 - ▶ Who can purchase Medicare Part A?
 - U.S. citizens age 65 and older who do not have enough work quarters.
 - Permanent resident aliens aged 65 and older who have lived in the U.S. for 5 years before applying for Medicare.

Medicare Part A includes:

- Inpatient hospital, including Critical Access hospitals, Inpatient Rehabilitation Facilities, Long Term Care hospitals and Psychiatric hospitals
- Skilled nursing facility
- Home health care
- Hospice care
- Blood

Medicare Part A has deductibles, co-insurance and co-pays.

See "Medicare Savings Programs" in this guide for programs that can help pay for your Medicare premiums, deductibles, co-insurance, and co-pays.

2012 Medicare Part A

Type of Service	Benefit	Medicare Pays	You Pay
<p>Hospitalization (Inpatient)</p> <p>Semi-private room and board, general nursing and other hospital services and supplies, for each <u>benefit period</u>.</p> <p><i>*Please note: these 60 days may be used only once in a person's lifetime. These are known as lifetime reserve days.</i></p> <p><i>*Observation stays in a hospital are not covered by Part A.</i></p>	<p>Day 1 – 60</p> <p>61st - 90th day</p> <p>91st - 150th day*</p> <p>Beyond 150 days</p>	<p>All but \$1,156</p> <p>All but \$289 per day</p> <p>All but \$566 per day</p> <p>Nothing</p>	<p>\$1,156</p> <p>\$289 per day</p> <p>\$566 per day</p> <p>All costs</p>
<p>Skilled Nursing Facility Care</p> <p>Semi-private room and board, skilled nursing and rehabilitation services and other services and supplies, for each <u>benefit period</u>, after a 3-day minimum inpatient hospital stay for a related medical condition. <u>Medicare does not cover long-term custodial care.</u></p> <p><i>*Observation stay in a hospital does not satisfy the 3 day requirement.</i></p>	<p>Days 1 – 20</p> <p>21st - 100th day</p> <p>Beyond 100 days</p>	<p>100% of approved amount</p> <p>All but \$144.50 per day</p> <p>Nothing</p>	<p>Nothing</p> <p>Up to \$144.50 per day</p> <p>All costs</p>
<p>Home Health Care</p> <p>Part-time or intermittent skilled care, therapy, home health aide services and other supplies and services. <u>You must be homebound.</u></p>	<p>Unlimited as long as you meet Medicare's strict requirements for home health care benefits.</p>	<p>100% of approved amount</p> <p>80% of approved amount for durable medical equipment.</p>	<p>Nothing for services</p> <p>20% of approved amount for durable medical equipment.</p>
<p>Hospice Care</p> <p>Pain relief, symptom management and support services for a person with a terminal illness. Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. <u>You can stay up to 5 days each time you get respite care.</u></p>	<p>Your doctor must certify (or recertify) that you are expected to live 6 months or less.</p> <p>A Medicare-approved hospice usually gives hospice care in your home (or other facility like a nursing home).</p>	<p>All but limited costs for outpatient drugs and inpatient respite care.</p> <ul style="list-style-type: none"> \$5 co-payment for prescriptions used to manage pain and symptoms. 5% co-insurance for Medicare approved inpatient respite care. Room and board is not covered. 	<p>Limited cost sharing for outpatient drugs and inpatient respite care.</p> <p>Room and Board</p>
<p>Blood</p> <p>When furnished by a hospital or skilled nursing facility during a covered stay.</p>	<p>Unlimited during a benefit period if medically necessary.</p>	<p>All but first 3 pints per calendar year.</p>	<p>For the first 3 pints.</p>

Medicare Part A Benefit Period:

- A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row.
- If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.
- You must pay the inpatient hospital deductible for each benefit period.
- There is no limit to the number of benefit periods.

The Basics: Medicare Part B

Original Medicare: Medicare Part B

Medicare Part B is medical insurance.

- In 2012, most people will pay a Part B monthly premium of \$99.90. Part B premiums may be higher depending on your income.
- If you are eligible for Part A, you are also eligible for Part B.
- People age 65 and older who are U.S. citizens or permanent resident aliens for 5 years who are not entitled to Part A can enroll in Part B without enrolling in Part A.

Medicare Part B includes:

- Physician services
- Home health care
- Lab tests
- Durable Medical Equipment, prosthetics and supplies
- Prevention and screening services
- Outpatient hospital treatment and surgery
- Ambulance services
- Physical, Speech and Occupational therapies
- Mental health services
- Limited coverage for chiropractic, podiatric and dental surgery
- Limited coverage for drugs and biologicals, including blood (except for the first 3 pints)

Medicare Part B Late Enrollment Penalty: For each 12 month period you delay Medicare Part B enrollment, you will have to pay a 10% Medicare Part B premium penalty unless you have health insurance from you or your spouses' current employment. In most cases, the penalty is permanent.

Example: You turned age 65 in 2002 but delayed enrolling in Medicare Part B until 2008. You did not have any employer group health insurance from 2002-2008. You decided to enroll in Medicare Part B during the General Enrollment Period (January 1 – March 31, 2008). Your Medicare Part B became effective on July 1, 2008. Your monthly Part B premium was 60% higher for as long as you have Medicare (6 years x 10%). Since the monthly Medicare Part B premium for most people was \$96.40 in 2008, your monthly premium with the penalty would be \$154.24 ($\$96.40 \times 0.6 + \96.40).

Medicare Part B has premiums, deductibles, co-insurance and co-pays.

See “Medicare Savings Programs” in this guide for programs that can help pay for your Medicare premiums, deductibles, co-insurance, and co-pays.

Will you pay a higher Medicare Part B monthly premium in 2012?

Income Threshold	Part B Individual Monthly Premium
Less than or equal to \$85,000 (\$170,000 couples) and <u>did have</u> Social Security withhold Medicare Part B premium in 2010	\$99.90
Less than or equal to \$85,000 (\$170,000 couples) and <u>did not have</u> Social Security withhold Medicare Part B premium in 2010	\$99.90
Greater than \$85,000 and less than or equal to \$107,000 (\$170,000 to \$214,000 couples)	\$139.90
Greater than \$107,000 and less than or equal to \$160,000 (\$214,000 to \$320,000 couples)	\$199.80
Greater than \$160,000 and less than or equal to \$214,000 (\$320,000 to \$428,000 couples)	\$259.70
Greater than \$214,000 (\$428,000 couples)	\$319.70

2012 Medicare Part B

Type of Service	Benefit	Medicare Pays	You Pay
Medical Services Physician's services, inpatient and outpatient medical and surgical services and supplies, therapy, diagnostic tests, durable medical equipment and other services.	Unlimited if medically necessary.	80% of approved amount after you pay the \$140 annual deductible.*	20% co-insurance after you pay the \$140 annual deductible.*
Mental Health Care Help with depression, anxiety or substance abuse usually outside a hospital. <i>Please note: beginning in 2010, Medicare coverage for outpatient mental health services increased and will be equal to the 80% coverage for other medical services in 3 years.</i>	Visits and treatment with a doctor, psychiatrist, clinical psychologist or clinical social worker, and lab tests.	80% for doctor visits to diagnose condition or monitor prescriptions. 60% for outpatient counseling or psychotherapy. The % will decrease over the next 3 years.	20% co-insurance after you pay the \$140 annual deductible.* 40% co-insurance after you pay the \$140 annual deductible.*
Part B Prescription Drugs	Limited number of drugs such as injections in a doctor's office; certain oral cancer drugs; some drugs used with a nebulizer or infusion pump; and certain drugs you get in an outpatient hospital department.	80% of approved amount.	20% co-insurance after you pay the \$140 annual deductible.*
Physical, Occupational and Speech Therapy Evaluation and treatment for injuries, diseases and illnesses that change your ability to function and/or to help you return to usual activities. Physician must certify your need to receive the services.	Physical and speech therapy dollar amount cap: \$1,870. Occupational therapy cap: \$1,870. The exception request process to continue services beyond the \$1,870 cap continues in 2012.	80% of approved amount.	20% co-insurance after you pay the \$140 annual deductible.*
Clinical Lab Services Blood tests, urinalysis, some screening tests and more.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
Outpatient Hospital Treatment Services for the diagnosis or treatment of an illness or injury. This includes Observation stays in the hospital.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital costs.	Varies by services, after you pay the \$140 annual deductible.*
Diagnostic Tests X-rays, MRIs, CT scans, EKGs and other diagnostic tests.	Unlimited if medically necessary. If you receive the test at a hospital as outpatient, your cost sharing may be more than 20%.	80% of approved amount.	20% co-insurance after you pay the \$140 annual deductible.

***IMPORTANT:** Once you have had \$140 of expense for covered services, the Part B deductible does not apply to any other covered services you receive for the rest of the year.

2012 Medicare Part B

Type of Service	Benefit	Medicare Pays	You Pay
Blood		Unlimited if medically necessary.	First 3 pints of blood plus 20% co-insurance of approved amount for additional pints (after you pay the \$140 deductible*).
Home Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare's strict requirements including being homebound.	100% of approved amount.	Nothing for most services; 20% co-insurance for durable medical equipment after you pay the \$140 annual deductible.*
Chiropractic Services Medically necessary manual adjustments to the spine (manipulation for subluxation of the spine).	Unlimited as long as you meet Medicare's strict requirements for coverage. X-rays or physical therapy provided by chiropractors are not covered.	80% of approved amount.	20% of approved amount after you pay the \$140 annual deductible.*
Durable Medical Equipment, Prosthetics, Orthotics and Supplies Items such as oxygen equipment and supplies, wheelchairs, walkers, hospital beds.	Limitations may apply.	80% of approved amount.	20% of approved amount after you pay the \$140 annual deductible.*
Transplants and Immunosuppressive drugs Immunosuppressive drugs covered if Medicare paid for the transplant. Must be entitled to Part A at the time of the transplant and you must be entitled to Part B at the time you get the immunosuppressive drugs. Some drugs may be covered by your Part D plan.	Including physician services for heart, lung, kidney, pancreas, intestine, liver, bone marrow and cornea transplants under certain conditions. Must be provided in a Medicare certified facility.	80% of approved amount.	20% co-insurance after you pay the \$140 annual deductible.*
Diabetes supplies Blood sugar testing monitors, test strips, lancets. Insulin covered if used with an insulin pump.	Unlimited if medically necessary. Note: Insulin and syringes may be covered under Medicare Part D.	80% of Medicare-approved amount.	20% co-insurance after you pay the \$140 annual deductible.*

***IMPORTANT:** Once you have had \$140 of expense for covered services, the Part B deductible does not apply to any other covered services you receive for the rest of the year.

The Basics: Medicare Part C and Other Medicare Plans

Medicare Part C also known as Medicare Advantage

1. Is a series of private health insurance options that must cover the same services and benefits available through Original Medicare.
2. People who enroll in a Part C (Medicare Advantage) plan receive all of their Medicare Part A, B and sometimes Part D benefits through the plan.
3. In most cases, the Part C (Medicare Advantage) plan is the only payer for most if not all of your Medicare benefits.
4. There are a variety of Medicare Advantage plan options including:

A. Health Maintenance Organizations (Local HMOs)

- a. You must use the plan's network of providers, except in an emergency or urgently needed care, to get coverage, or you may have to pay the charges in full on your own.
- b. Local HMO plans may require referrals to see a specialist, but some Local HMO Medicare Advantage plans include a point-of-service self-referral option, which gives you some flexibility with going to out-of-network providers.
 1. Point-of-Service (POS) plans have an option that allows visits to out-of-network providers at an additional cost. If the POS plan offers Medicare Part D coverage, enrollees must get it from the POS plan. If you enroll in a stand alone plan, you will be dis-enrolled from the Local HMO Medicare Advantage plan.
- c. Whether or not the Local HMO Medicare Advantage plan includes Part D coverage, you CANNOT ENROLL IN A SEPARATE STAND ALONE PART D PLAN or you will be dis-enrolled from your Local HMO Medicare Advantage plan.
- d. Every company offering Local HMO Medicare Advantage plans in Minnesota must offer at least one plan option that includes standard Medicare Part D coverage. If you enroll in a Local HMO Medicare Advantage plan and want Part D coverage included, you will want to enroll in a Local HMO Medicare Advantage plan option that includes Part D coverage.
- e. If Part D is not included in the plan option you choose, you will not have Medicare Part D drug coverage.

1. This may work fine for you if you have Medicare Part D creditable coverage (refer to Part D information) such as Veterans Administration prescription drug coverage, employer group health, union or retiree plan coverage for prescription drugs that provides coverage that is at least as good as the standard Medicare Part D coverage.
2. If you do not have creditable prescription drug coverage and decide to enroll in Medicare Part D at a later date, you will most likely be required to pay a premium penalty. Refer to Medicare Part D for additional information.

B. Preferred Provider Organizations (PPO)

- a. With the Preferred Provider Organization Medicare Advantage plan, you can see any doctor or provider that accepts Medicare.
- b. You don't need a referral to see a specialist but you may pay more if you go outside the network.
- c. Whether or not the PPO Medicare Advantage plan includes Part D coverage, you CANNOT ENROLL IN A SEPARATE STAND ALONE PART D PLAN or you will be dis-enrolled from your PPO Medicare Advantage plan.
- d. Every company offering PPO Medicare Advantage plans in Minnesota, must offer at least one plan option that includes standard Medicare Part D coverage. If you enroll in a PPO Medicare Advantage plan and want Part D coverage included, you would want to enroll in a PPO Medicare Advantage plan option that includes Part D coverage.

C. Private-Fee-for-Service plans (PFFS)

- a. Since 2011, there have been three types of contractors required for PFFS plans. These include direct contractors, deemed contractors and non-contracting contractors.
- b. Direct contractors contract with a PFFS plan to deliver services to the PFFS plan's members. Deemed contractors are providers who agree to the PFFS plan terms and conditions of payment before providing services to a PFFS plan member. Non-contracting contractors are usually providers furnishing emergency services to PFFS plan members.
- c. You may have out-of-pocket costs for co-pays and deductibles and the provider is allowed to bill you for these costs.
- d. Be sure to understand the plan's cost-sharing terms

before enrolling.

- e. The PFFS Medicare Advantage plan available in Minnesota includes Part D drug coverage but if it did not, you could enroll in a separate stand alone Medicare Part D plan.

D. Special Needs Plans (SNP)

- a. There are several different types of Medicare Advantage Special Needs Plans (SNP) available in Minnesota:

1. Medicare Advantage Special Needs Plans for Chronic Conditions.

- a. In 2012, Medica offers 3 SNP plans for people with specific chronic conditions, including diabetes, cardiovascular disease, heart failure, chronic lung disorders and dementia.
 - i. These Medicare Advantage Special Needs Plans for Chronic Conditions have unique benefit designs to manage the specific chronic conditions.
 - ii. All Medicare Part A, Part B and Part D coverage is provided through one specific plan.
 - iii. If you have a chronic condition listed above that may qualify you for enrollment into one of these plans, please call Medica directly at 952-992-2030 or 1-800-266-2157 for additional information.
 - iv. These plans have a monthly premium and other out-of-pocket costs.

2. Medicare Advantage Special Needs Plans for people age 65 and older with Medicare and Medical Assistance (Medicaid) – MSHO

- a. Also known as Minnesota Senior Health Options (MSHO) these plans provide both Medicare and Medical Assistance coverage for people who are enrolled and eligible for both Medicare and Medical Assistance (Medicaid).
- b. To qualify for MSHO:
 - i. you must be age 65 or older;
 - ii. enrolled in both Medicare Part A and B; and
 - iii. enrolled in Medical Assistance (Medicaid) through your county human services agency.
- c. Coverage includes Medicare Part A, B and D as well as Medical Assistance coverage for home and community based services, Elderly Waiver, transportation and nursing home care.
- d. Each plan provides a Care Coordinator to

help you get the services you need as well as coordinating your benefits.

- e. There are 8 MSHO plans available in 2012 (refer to MSHO plan grids in the appendix).
- f. MSHO plans are available in all 87 counties of Minnesota.

3. Medicare Advantage Special Needs Plans for people under age 65 with Medicare and Medical Assistance (Medicaid) - SNBC

- a. Also known as Medicare Advantage Special Needs BasicCare (SNBC) plans that provide both Medicare and Medical Assistance coverage for people who are enrolled and eligible for both Medicare and Medical Assistance (Medicaid).

*Please note: SNBC plans **do not** require Medicare enrollment to be eligible, but you must be enrolled in Medical Assistance (Medicaid). If you are enrolled in Medicare, you must be enrolled in both Part A and Part B.*

- b. To qualify for SNBC:
 - i. you must be age 18-64;
 - ii. must be certified disabled; and
 - iii. enrolled in Medical Assistance (Medicaid) through your county human services agency.
- c. SNBC plan coverage includes most Medical Assistance (Medicaid) services and Medicare Part A, B and D if applicable.
- d. Your home and community based waiver services, personal care attendants (PCA) and private duty nurses are paid for by Medical Assistance (Medicaid) fee-for-service and not the SNBC plan.
- e. There are 3 SNBC plans available in 2012 (refer to SNBC plan grids within this publication).

E. Medicare Savings Accounts (not available in MN in 2012)

Other Medicare Health Plans

F. Medicare Cost Plans

- a. These are plans that provide Medicare A, B and often Part D coverage and have some important differences when compared to other Medicare Advantage plan options:
 1. Cost Plans have networks of providers to use in order to receive the maximum amount of coverage with the lowest out-of-pocket cost.
 2. Cost Plan enrollees may obtain Medicare-covered services outside of the Cost Plan network. Providers will be paid by Original

Medicare for the services and you will be responsible for Medicare deductibles and co-insurance.

3. Cost Plan enrollment periods are not bound to Medicare Advantage enrollment periods so enrollment is possible if the plan is open to new enrollees. You can also dis-enroll from the plan at any time and return to Original Medicare.
4. Cost Plans are allowed to include Medicare Part D coverage, but they are not required to offer it. When a Cost Plan offers Part D, the Part D coverage is much like Local HMO Medicare Advantage Plan Part D coverage.
5. Cost Plan enrollees in plans that do not offer Part D coverage are allowed to enroll in a separate stand alone Medicare Part D plan.

Medicare Part D: Medicare Prescription Drug Coverage

6. An optional private insurance plan that covers part of outpatient prescription drugs costs.
7. There are 2 ways you can get Medicare Part D coverage:
 - a. **Stand Alone Medicare Prescription Drug Plan**
 - i. Also known as PDPs
 - ii. These are plans that only provide Medicare Part D coverage. They add the prescription drug benefit to your Original Medicare, some Medicare Cost Plans, and some Private-Fee-For-Service Plans.
 - b. **Medicare Advantage Plans or Other Medicare Health Plans**
 - i. Also known as MA-PDs
 - ii. These plans provide your Medicare Part A, Part B and Part D coverage – all through one plan.
8. Anyone who is covered by Medicare Part A and/or Medicare Part B is eligible for Medicare Part D.
9. Generally you will pay a monthly premium for the Part D coverage. You may also have additional out-of-pocket costs including deductibles, co-insurance or co-pays.
10. Extra Help, also known as LIS or Low Income Subsidy program, is available for beneficiaries with limited income and assets. See “Extra Help” in this guide.

Medicare Part D Late Enrollment Penalty: If you do not enroll in Medicare Part D plan when you are first eligible for Medicare Part A and/or Part B, and you do not have other creditable prescription drug coverage (refer to glossary), you may have to pay a Medicare Part D monthly premium penalty when you do enroll. The penalty also applies if you have a break in your Medicare Part D coverage or other creditable coverage for at least 63 days in a row.

- The Part D premium penalty is 1% of the current national base beneficiary premium (\$36.02 in 2012) for each full, uncovered month that you were eligible to enroll in a Part D plan but did not.
- The amount of the Part D monthly premium penalty you pay will change in January of each year (most likely will increase). This is because the national base beneficiary premium changes every year and it is the amount used to recalculate the Part D premium penalty for the new calendar year.

Example: You did not have creditable prescription drug coverage. Your initial enrollment period for Medicare Part D ended on May 15, 2006. You waited to join a Medicare Part D plan until December 2008 and your Part D coverage became effective on January 1, 2009. Since you were not enrolled in a Medicare Part D for 7 months in 2006 (June through December), all 12 months in 2007, and all 12 months in 2008, you will have to pay a 31% (1% for each full, uncovered month that you were eligible to enroll in a Medicare drug plan but didn't) penalty. Since the national base beneficiary premium for 2009 was \$30.36, you will be charged \$9.40 (\$9.41 rounded to the nearest \$.10) each month in addition to your plan monthly premium. This amount will change each year when the national base beneficiary premium changes.

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

A doesn't work for you, then the plan will cover Drug B. If a drug has step therapy restrictions, you will need to work with the plan and your doctor to request an exception. The Senior LinkAge Line® can also assist you with requesting an exception.

Coverage Gap (Donut hole): If you have high drug costs, you may consider which plans offer additional coverage to help you pay for Part D drug costs during the coverage gap/donut hole (\$3,725 in 2012). During the donut hole, you pay 100% of your drug costs, but the prices are now discounted (50% for brand name and 14% for generics in 2012).

Total Out of Pocket Costs: If you reach the point where you have spent \$4,700 in 2012 out-of-pocket for drug costs during the year, the plan will pay most of your remaining drug costs, except for a co-pay or 5% co-insurance, whichever is higher.

Convenience

- Drug plans must contract with pharmacies in your area. Check with the plan to make sure your pharmacy or a pharmacy in the plan is convenient to you. Also, most plans offer a mail-order program that will allow you to have drugs sent directly to your home.
- You should consider all of your options in determining what is the most cost-effective and convenient way to have your prescriptions filled.

Savings

- **Extra Help:** Look into Medicare Part D Extra Help, also known as Low Income Subsidy (LIS) for help paying your Part D plan costs. Your monthly income can be as much as \$1,362 (single) or \$1,839 (couple) and maximum assets are \$12,640 (single) or \$25,260 (couple). You can enroll on line at <https://secure.ssa.gov/apps6z/i1020/main.html> or call the Senior LinkAge Line® at 1-800-333-2433 for assistance.
- **Medical Assistance and Medicare Savings Programs:** If you are on Medical Assistance or a Medicare Savings Program (Qualified Medicare Beneficiary, Service Limited Medicare Beneficiary or Qualified Individual), Medicare Part D will cover your prescriptions and will enroll you in a benchmark (lower cost) Part D plan automatically if you are not already enrolled in plan. If you are not pleased with the plan, you can change plans monthly.

Other Considerations

- Don't forget that if you're married, each person must sign up for a Medicare Plan D plan individually.
- If you are still working at age 65 and have an employer plan or you have a retiree health plan, find out if the company's plan's drug coverage is "creditable." If it is, you can delay getting Part D with no penalty. If it isn't ask if you can get Part D without losing your current health care plan. *Note:* Veterans or TRICARE drug coverage is creditable.

Peace of mind now and in the future

- Even if you don't take a lot of prescription drugs now, you still should consider joining a drug plan. As we age, most people need prescription drugs to stay healthy.
- For most people, joining now means you will pay a lower monthly premium in the future since you may have to pay a penalty if you choose to join later. You will have to pay this penalty as long as you have a Medicare drug plan.

The Senior LinkAge Line® (1-800-333-2433) provides statewide comprehensive options counseling and is available to help those without Internet access review their Medicare options. People with Internet access are encouraged to research their options by using the Medicare Plan Finder tool at www.medicare.gov.

- To help make sure you get the assistance you need, please have the following with you before you call 1-800-333-2433 or go onto the Medicare Plan Finder Tool:
 - ▶ Your Medicare card.
 - ▶ The list of all of the prescriptions you take regularly, including the name, dosage amount and how often you take the dosage.
 - ▶ Name and address of your current pharmacy.
 - ▶ It is also a good idea to have an estimate of your monthly income and assets available in case you want to apply for the Extra Help (LIS).