Getting Started with Medicare
Beginning Medicare Training

Medicare Made Clear™

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n4a
n4a is working with UnitedHealthcare to provide educational tools that Aging Network staff and volunteers can utilize to prepare for Medicare Open Enrollment.

A study of Medicare counselors was conducted by n4a and UnitedHealthcare to help identify information gaps in understanding Medicare and to help trainers identify which educational tools and resources are available, training session dynamics and unmet needs. As a result, this training was developed to help assist Medicare counselor staff and volunteers.
Talking Points:

Today, we’re going to talk about the basics of Medicare.

Medicare helps more than 55 million Americans' get health care coverage, but there are some important things an individual should know before signing up. We have tried to simplify the information as much as possible and we hope you’ll walk away with a better understanding of what Medicare is and how it works.

Here are the questions we’ll answer today. First, we’ll go over who is eligible for Medicare.

Next, we’ll talk about all the different Medicare coverage options. Then, I’ll explain the different enrollment periods, so you can understand when an individual can enroll.

Last, we will describe how an individual can save money and where to find more information.

Talking Points:

At the end of this presentation, you'll be able to:
1. Define Medicare eligibility
2. Understand Medicare enrollment
3. Understand the differences between Medicare coverage options; Part A, B, C, D
4. Learn about Medicare supplement insurance plans
Talking Points:

So, let’s talk a little bit about eligibility.
Talking Points:

They are:
A U.S. citizen or legal resident for at least five consecutive years

AND is one of the following:
• Age 65 and older
• Younger than 65 with a qualifying disability
• Any age with a diagnosis of end-stage renal disease or ALS

Some things to know about the “age 65” rule:
Even if an individual is already collecting Social Security they must wait until they’re IEP to enroll, their spouse’s age doesn’t affect it.

Even if an individual is not collecting Social Security yet, they are eligible during their IEP to enroll in Medicare Parts A and B.
Talking Points:

**Medicare enrollment is sometimes automatic.**
An individual will be enrolled automatically in Original Medicare Parts A and B if:
- They are turning 65 and are getting Social Security or Railroad Retirement Board benefits.
- They are under 65 and have received disability benefits for 24 months.
- They have ALS and start getting disability benefits.

**How Automatic Enrollment in Medicare Works**
They will get their Medicare card in the mail three months before their 65th birthday, or before their 25th month of getting disability benefits. They'll get it immediately if they have ALS.

Keeping the card means they accept Original Medicare Part A and Part B coverage. They also agree to pay Part B premiums. (If they live in Puerto Rico, they are not automatically enrolled in Part B. They need to sign up for it if they want it.)

They must notify Medicare if they decide to refuse Part B. They may want to do this if they have other health coverage, through a retirement plan for example. To refuse Part B, they must follow the instructions that come with the card, and send the card back.
Talking Points:

How to Enroll in Medicare

Consumers need to take action to sign up for Medicare if:
- They are turning 65 and are not currently getting Social Security or Railroad Retirement Board benefits.
- They qualify for Medicare because they have End-Stage Renal Disease.
- They live in Puerto Rico and want Part B coverage.
- Or if they don’t receive documentation when they first become eligible for Medicare.

How to sign up:
Go to SocialSecurity.gov to sign up for Medicare online. They can enroll in Medicare Part A, Part B or both. They can also enroll in Medicare by phone or in person at any Social Security office. Call 1-800-772-1213 (TTY 1-800-325-0778) Monday through Friday, 7 a.m. to 7 p.m. local time, to make an appointment.

If they live outside the United States and its territories, they can contact the nearest U.S. Social Security office, U.S. Embassy or consulate, or the Veterans Affairs Regional Office (VARO) in the Philippines.
Talking Points:

Now that you know whether an individual is eligible to sign up, let’s discuss their different coverage options.
Talking Points:

Medicare has four parts that provide coverage for different health-related services: Part A, Part B, Part C and Part D.

There's also something called standardized Medicare supplement insurance plans.

We'll describe each part in more detail to help you understand so you'll be able to assist others with their coverage needs.
Talking Points:

When an individual becomes eligible, they may enroll in Original Medicare.

Original Medicare is provided by the federal government and consists of Parts A and B.

Let's break down what each part covers.
Talking Points:

Part A is sometimes called “hospital insurance” because it covers most inpatient services, including:
- Inpatient hospital care
- Inpatient mental health care
- Skilled nursing services
- Hospice care
- And some blood transfusions
- Medicare Part A covers home health care under certain conditions.
Talking Points:

Part A Costs:
- Most people don’t pay a monthly premium
- Someone only pays their deductible for a hospital stay of less than 60 days
- No out-of-pocket maximum

Enrollment:
- Can’t be turned down because of medical history or a pre-existing condition

Coverage:
- Stays of more than 60 days require a daily co-payment
- Multiple stays may mean multiple deductibles
- Any qualified hospital in the U.S. that accepts new Medicare patients
- Hospital care outside the U.S. isn’t usually covered
Talking Points:

Part B covers doctor and outpatient visits. This includes:
• Physician services
• Outpatient hospital services
• Ambulance
• Outpatient mental health
• Laboratory services
• Durable medical equipment (wheelchairs, oxygen, etc.)
• Outpatient physical, occupational and speech-language therapy
• Some preventive care
Talking Points:

**True or False:** Medicare Part A covers costs when you're hospitalized, and Part B covers doctor visits and tests.

**The correct answer is true. Here's why:** Medicare Part A covers you when you need to go to the hospital. It also covers things like skilled nursing care after you've been hospitalized and other types of skilled care, including hospice care. Part B helps pay for doctor visits, laboratory tests and some diagnostic screenings.
Talking Points:

Costs:
- There is no maximum out-of-pocket
- For co-insurance, in general, someone pays 20% of the Medicare-approved cost
- Part B has a monthly premium that is determined by income. Most people have it deducted from their Social Security check
- If someone waits to join until after the initial enrollment period, he or she may have to pay a higher premium

Enrollment:
- Medical history or pre-existing condition doesn’t matter

Coverage:
- Generally, care outside of the U.S. is not covered
- Can receive care from any participating physician who accepts new Medicare patients
- Some preventive health care is provided
Talking Points:

Medicare Parts A and B don’t cover all of someone’s health care costs. Individuals are still responsible for any deductibles, co-insurance, premiums, excess charges and prescription drug coverage. Additional benefits, such as hearing and dental coverage, may not be covered under Original Medicare.
Talking Points:

**True or False:** Original Medicare (Parts A and B) is premium free.

The correct answer is false. Here's why: In most cases, an individual won't pay a Medicare Part A premium. However, there is a Medicare Part B premium based on their income. The Medicare Part B premium is deducted from their Social Security check, if they receive one.
Talking Points:

Now let's talk about Part C, which is also known as a Medicare Advantage plan.
Talking Points:

Medicare Advantage (Part C) plans are single plans offered by private insurance companies that combine coverage for Original Medicare (Parts A and B) and sometimes prescription drug coverage (Part D).

Part C covers:
Part A: Covers equivalent Medicare Part A approved services, except hospice care:
• Hospital stays, skilled nursing and home health

Part B: Covers equivalent Medicare Part B approved services:
• Doctor’s visits, outpatient care, screenings, shots and lab tests

Part D: Prescription drug coverage is included in many Part C plans, but not all of them

+ Additional benefits
• May include routine vision care, hearing, wellness services and nurse phone line support
Talking Points:

To be eligible for Part C, someone must:
• Be enrolled in Medicare Parts A and B
• Live in the plan service area
• Not have end-stage renal disease (ESRD)

Eligibility for enrollment is not affected by someone’s health or financial status.

There are special rules for end-stage renal disease (ESRD). People with ESRD may be able to join a Medicare Special Needs Plan (SNP) if one is available in their area.
**Talking Points:**

**Costs:**
- Plan terms, premiums, covered services, co-pays, deductibles and other out-of-pocket limits can change from year to year
- An individual must continue to pay Part B monthly premium

**Coverage:**
- Convenience of one plan
- Many plans include prescription drug coverage
- Must receive coverage in a service area — unless it’s an emergency (for some plans)
- Required to see in-network doctors and hospitals (for some plans)
- Many plans offer additional benefits not covered by Medicare
Talking Points:

There are different types of Part C plans:

**Coordinated care plans**
- Health Maintenance Organization (HMO) plans
- Preferred Provider Organization (PPO) plans
- Special Needs Plans (SNP)
- Health Maintenance Organization Point of Service (HMO-POS) plans

Here is an overview of the most common types of Part C plans:

**What’s an HMO?**
- Health Maintenance Organization
- Plan with a network of physicians, hospitals and other health care professionals
- Generally, someone must get routine care from an approved network of doctors and hospitals
- Many plans include prescription drug coverage and additional benefits

**What is a PPO?**
- Preferred Provider Organization
- Hospital costs, doctor and outpatient care in one plan
- Many plans include prescription drug coverage and additional benefits
- Generally, someone may get care from doctors and hospitals in and out of network

**What is an SNP?**
- Special Needs Plan
- Designed for people with special or complex health care needs
  - Residents of nursing homes
  - People eligible for both Medicare and Medicaid
  - People with certain chronic diseases such as diabetes or heart disease
Talking Points:

Other plans include:

**Other plans**

- Private Fee-For-Service (PFFS) plans
- Medical Savings Account (MSA) plans
- There are also two other types of non-coordinated care plans.

**What is a PFFS?**

- Private Fee-For-Service
- Offered by private insurance companies
- Many plans may offer prescription drug coverage

**For PFFS plans it is important to keep in mind:**

- Doctors and hospitals must accept the payment terms and conditions of the private insurance company
- Payment comes from the Private Fee-For-Service plan, not Medicare
- Important for someone to make sure his or her doctor or hospital will accept payment from the specific plan each time before receiving services
Talking Points:

**True or False:** Medicare Advantage (Part C) and Part D prescription drug plans are optional — an individual needs to buy them.

The correct answer is false. Here's why: Medicare Advantage (Part C) and Part D prescription drug plans are optional — an individual needs to buy them.
Talking Points:

Now let's discuss Part D prescription drug plans.
Talking Points:

Part D plans help an individual with the cost of prescription drugs. An individual can only receive Part D coverage through a private insurance company. We suggest that an individual shops around and finds a Part D plan that covers the medications he or she is currently taking.

Note that an individual must also continue to pay their Medicare Part B premium with a prescription drug plan.
Talking Points:

**True or False:** Original Medicare (Parts A and B) automatically includes prescription drug coverage (Medicare Part D).

The correct answer is false. Here’s why: To receive prescription drug coverage, an individual needs to purchase a separate Medicare Part D plan. Part D can be paired with Original Medicare (Parts A and B) or with Medicare supplement insurance plans. In contrast, most Medicare Advantage (Part C) plans come with prescription drug coverage already built into the plan.
Talking Points:

Things to keep in mind:
How much does it cost? An individual will want to look at the premiums, co-payments and co-insurance associated with the medications he or she takes, whether there’s any additional coverage as part of that Part D plan, and he or she will also want to look at current medications to ensure they are on the list of covered drugs for that Part D plan.

Unless an individual qualifies for an exception, there will be a penalty if he or she doesn’t enroll before the initial enrollment deadline.
Talking Points:

- Many drug plans have a tiered formulary. That means the plan divides drugs into groups called "tiers." Generally, the lower the tier, the lower the co-pay.
- Plans build their formularies by selecting drugs from these groups (see: left side of graphic)
- Many plans use tiered formularies to group covered drugs according to cost (see: right side of graphic)
- Medicare provides guidelines about the types of drugs that need to be covered, but not the specific drugs
- Each plan has its own formulary, so be sure to review each plan’s drug list since an insurance company may have multiple formularies for different plans
- Medicare has excluded some types of drugs, but some plans may include them as part of an enhanced formulary
- Medications not on a plan’s formulary may not be covered or may cost more

Note: Not all plans have 5 tiers.
Talking Points:

Let's talk about drug coverage stages and how they work.

If a plan has a deductible, people pay the total cost of drugs until they reach the deductible amount set by their plan. Some plans may have a deductible for only specific drug tiers. If a plan has this type of deductible, people pay the total cost of their drugs on those tiers until they reach the deductible. Then they move to the initial coverage stage. If they don't have a deductible, their coverage begins in the initial coverage stage.

Once the initial drug coverage stage begins, he or she pays a flat fee (co-pay) or a percentage of the drug’s total cost (co-insurance) for each prescription that is filled. The plan pays the rest until the total drug costs reach $3,310 in 2016.

If the total drug costs go beyond $3,310, the individual reaches what’s called the “drug coverage gap stage. This is also referred to as the “donut hole.” During this stage in 2016, the individual pays 45% of the total cost for brand-name drugs and 58% of the total cost for generic drugs. The dollar amounts in that coverage gap can change from year to year. If the individual’s total out-of-pocket costs in 2016 reach $4,850, then he or she moves to the catastrophic drug coverage stage.

In this stage, the individual pays only a co-pay or co-insurance amount for each filled prescription. The plan and Medicare pay the rest until the end of the calendar year.
Talking Points:

Enrico, age 66, has several chronic conditions. Without coverage he spends more than $950 a month on drugs. He has Original Medicare (Medicare Part A and Part B), plus a stand-alone Medicare Part D drug plan with a $384 annual premium. Because his drug costs are high, he reaches Stage 3 – catastrophic coverage.

You can see on the chart the cost benefit to Enrico for having a Part D drug plan. In this example, without a Part D plan he would have paid over $11,000 on his prescription drugs. By joining a prescription drug plan he is able to save $5,930.
Talking Points:

Now let’s talk about standardized Medicare supplement insurance plans.
Talking Points:

- Medicare supplement insurance plans are also referred to as a “Medigap” policy
- They are offered by private insurance companies to help cover some of what Medicare Parts A and B don’t pay, meaning they cover co-insurance, co-payments and deductibles not covered by Original Medicare
- Plans (not to be confused with “Parts”) are named A, B, C, D, F, G, K, L, M, N, and a high-deductible plan, F
- Benefits vary by plan
- Generally, the more comprehensive the coverage, the higher your premium will be

Note: Plans are different in Massachusetts, Minnesota, and Wisconsin.
Talking Points:

• Generally, an individual must be enrolled in Medicare Parts A and B at the time his or her Medicare supplement insurance coverage will begin
• Must be a resident of the state in which he or she is applying for coverage
• Must be age 65 or older (or under age 65 with certain disabilities or end-stage renal disease (ESRD) in some states)
**Talking Points:**

**True or False:** Medicare supplement insurance (Medigap) plans vary by state.

The correct answer is **false. Here's why:** Medicare supplement insurance plans are issued through private insurance companies. However, Medicare supplement insurance plans and benefits are standardized by federal law. Every insurer's Medicare supplement insurance Plan A, for example, is identical to every other insurer's Plan A. Massachusetts, Minnesota and Wisconsin (known as the “waiver” states) are exceptions. These states each have their own standardized plans.
Talking Points:

Costs:
• Helps with some of the out-of-pocket costs not paid by Medicare
• Premiums vary based on the plan and insurance carrier. In some states and plans, premiums rise as an individual’s age increases.

Enrollment:
• Everyone is guaranteed the right to buy a Medicare supplement insurance plan during the Open Enrollment Period
• Enrollment after the Open Enrollment Period can be denied based on health
• This period begins the first day of the month that someone is enrolled in Medicare Part B
• There are other situations when acceptance may be guaranteed. In some other states, open enrollment is on-going.
Talking Points:

Coverage:
- No network restrictions and no referrals required
- Coverage may go with someone during a move or travel anywhere in the U.S.
- With some plans, someone has a foreign travel benefit for emergency medical services
- Coverage is guaranteed to continue as long as someone pays his or her premium on time and has not made material misrepresentation on the application for insurance
Talking Points:

So now that we’ve gone over all of the details of the plan, let’s look at how it all works together.

When a person becomes eligible, they can enroll in Original Medicare (Parts A and B). If more coverage beyond Original Medicare is needed there are two options:
1. They can add a Medicare supplement insurance plan and/or a Medicare Part D prescription drug plan.

Or

2. They can choose to enroll in a Medicare Advantage (Part C) plan that combines Parts A and B coverage, has additional benefits and often includes prescription drug coverage.
Talking Points:

**True or False:** Medicare supplement insurance (Medigap) plans help pay for some of the things Original Medicare (Parts A and B) does not cover, such as out-of-pocket costs, like deductibles and co-pays.

The correct answer is true. Here's why: Original Medicare helps pay for hospitalization, skilled nursing and outpatient care, but it doesn’t pay for everything. Medicare supplement insurance plans can help fill in some of the gaps. They're offered by private insurance companies. Be sure to check what's available in your area.
Talking Points:

Now let’s talk about when an individual can enroll. We’ll go through each of the Medicare parts separately.
Talking Points:

When can an individual first enroll in Part A?
The three months before an individual’s 65th birthday, the month of, and the three months after, or when an individual otherwise becomes eligible for Medicare. Enrollment will be automatic if an individual is already receiving Social Security benefits.

If an individual is on disability, he or she also becomes eligible after the 24th month of receiving Social Security Disability. Someone’s IEP is the three months before and the three months after they 25th month of Disability.

What if an individual doesn’t enroll during this time?
Generally, there are no penalties for signing up after the initial enrollment period for Part A. An individual may pay a penalty on his or her premium for signing up after the initial enrollment period if he or she is one of the people who pays a monthly premium for Part A because of insufficient contributions to Social Security.

If an individual enrolls in Part B after the initial enrollment period, premiums will be higher by 10% for each full 12-month period, unless he or she qualifies for an exception. Contact Medicare to learn more about these exceptions.
Talking Points:

**True or False:** You can enroll in Medicare without penalty anytime after you turn 65.

**The correct answer is false. Here’s why:** For most people, you’re eligible to first enroll in Medicare during your Initial Enrollment Period (IEP), three months before your 65th birthday month*, during your birthday month, and three months after your birthday month. If you miss your IEP, there are still opportunities to enroll, but you may pay higher premiums or have fewer plan choices unless you qualify for an exception.

*If your birthday is on the first day of the month, your Part B coverage will start the first day of the prior month. If this is true for you, use the month before you turn 65 as your birthday month.
Talking Points:

Susan waited to sign up for Part B three full years after she was eligible. She’ll pay a 10% penalty for each full 12-month period she waited. The penalty is added to the Part B monthly premium, which is $121.80 in 2016.

### Example
Enrolling after the Initial Enrollment Period

<table>
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<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>2016 standard Part B premium</td>
<td>$121.80</td>
</tr>
<tr>
<td>3 years x 10% = 30% of $121.80</td>
<td>$36.54</td>
</tr>
<tr>
<td>Susan’s Part B monthly premium for 2016</td>
<td>$158.34</td>
</tr>
</tbody>
</table>
Talking Points:

**When can an individual first enroll in Parts C or D?**
There is a seven-month window. Generally, for most, an individual can first enroll three months before his or her 65th birthday month, during the birthday month and up to three months after.

**What if an individual is late?**
If an individual misses the enrollment window, he or she must wait to join a plan until the Open Enrollment Period (between October 15 and December 7), unless he or she qualifies for an exception, such as a special enrollment period.
Talking Points:

- An individual can enroll in Parts A and B, but they may choose to delay enrollment in Part B since there is a monthly premium cost
- Recommend they contact their benefit administrator to find out the options and how their coverage works with Medicare
- When an individual retires, they become eligible for a Special Enrollment Period (SEP) and can sign up for Part B without penalty — this Part B SEP lasts 8 months from the day of retirement or when the employer health insurance ends, whichever comes first.
- If an individual enrolls in Part B after the 8-month SEP, they may have to pay a late enrollment penalty and they’ll have to wait until the next General Enrollment Period (GEP) to enroll.
Talking Points:

**When can an individual first enroll in a Medicare supplement insurance plan?**

The Medicare Supplement Insurance Open Enrollment Period begins the first day of the month that an individual turns 65 and is enrolled in Medicare Part B. In most states, this period lasts for six months. Some states allow ongoing open enrollment and some states require that coverage be offered to people who are under the age of 65 and eligible for Medicare due to a disability or end-stage renal disease. There are other situations where a person may be eligible for guaranteed acceptance.

An individual can drop a policy and apply for another whenever they like, but they could be charged a higher premium or refused entirely.

**What if an individual is late?**

If an individual misses the window, they can apply later at any time, but they may be charged a higher rate or be rejected if they have a health history that makes them appear to be at a higher risk.
Talking Points:

Now let’s talk about ways to save money.
Talking Points:

Some things an individual should think about as they compare their options are:

Health status
- Has their health changed?

Finance
- Has their financial situation changed?

Location
- Have they moved? *(Could qualify for SEP)*
- Will they be away from their hometown for a significant period of time in the next year?
- How frequently do they travel and where?

Coverage needs
- Are their doctors and hospital in-network?
- Are their prescriptions covered?
- Could they benefit from coverage for things like a gym membership, routine dental care, hearing aids, etc.? 

The individual should review their situation and find the right insurance option based on their situation.
Talking Points:

Earlier we went over the Part D coverage gap. If an individual and their plan spends more than $3,310 in prescription drug costs, they will enter the "donut hole." Once they are in the donut hole, they will pay most of the costs of their prescription drugs. If they reach this stage, they may be able to save money by talking with their doctor to see if the medication they take has a generic or lower tiered drug option.

- It's important for an individual to utilize the preventive services that may be included in their coverage to save money in the long term.
- An individual should be sure to stay in their plan’s network of doctors and pharmacies to help them save money.
- There may be additional benefits available through an individual’s plan, such as wellness programs.
- When it comes to prescription drug savings, consumers should remember to use pharmacies that are in their plan’s network. Some Part D plans have what’s called a preferred pharmacy network where consumers can access drugs for even lower costs.
- Consumers might also have an option to use a mail-order pharmacy, which can save money.
- Sometimes the price of the same medications one receives at the brick-and-mortar pharmacies is less when delivered by mail.
Thank you for your time.

This was a lot of information to go over and if you have any questions or want to learn more, go to Medicare.gov.