Understanding Your Patients’ Medicare Options

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Medicare Rights Center

What is the Medicare Rights Center?

- The Medicare Rights Center is a national, not-for-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through:
  - counseling and advocacy;
  - educational programs; and
  - public policy initiatives.
Section 1: Introduction

What We Will Cover Today

- What role pharmacists can play in helping educate patients about their Medicare options.
- What your patients’ Medicare health plan options are.
- What questions your patients should ask when choosing a plan.
- How your patients can enroll in a plan.
A Pharmacist’s Role

- Patients trust their pharmacist and look to them for health care advice, information
- Pharmacists are accessible and many participate in community outreach events
- Pharmacists are in ideal position to educate Medicare patients about their Medicare plan options
  - Be careful not to steer
  - Simply act as a resource

Section 2:
Medicare Options
Parts of Medicare

- Original Medicare has two parts:
  - **Part A**
    Covers inpatient care (hospital, skilled nursing facility care, home health care, hospice)
  - **Part B**
    Covers outpatient care (medical visits, DME, a few prescription drugs)
- **Part D** – Prescription drug benefit
- What happened to **Part C**?
  - Part C is not a separate benefit. It lets patients get Medicare benefits through a private health plan.

Medicare Options

- There are different ways patients can get Medicare medical benefits.
  - Original Medicare (Part A and B)
  - Original Medicare with supplemental insurance (Medigap, Retiree Plan)
  - Medicare Private Health Plan (also known as Medicare Advantage Plan – HMO, PPO)
- When it comes to prescription drug benefits, patients can choose from:
  - Stand-alone drug plan (PDP)
  - Medicare Private Health Plan that includes drug coverage (MA-PD)
Section 3: Original Medicare

Original Medicare (Parts A and/or B)

- The majority of Medicare patients have Original Medicare.
- Red, white and blue card
- Name for traditional Medicare
- Pay-per-visit system ("fee-for-service")
  - Patient usually pays a 20% "coinsurance" for services.
- Covers care from most doctors and hospitals in the country
- Limits on doctors’ fees that the patient pays
Part A Costs (Inpatient Care)

- **Premium**
  - Free for those with 10 yrs. work
- **Hospital deductible**
  - $1,068 in 2009 for each benefit period
- **Hospital coinsurance**
  - $267 a day for days 61-90, each benefit period
  - $534 for days 91-150 (these are 60 non-renewable lifetime reserve days)
- **Skilled nursing facility coinsurance**
  - $133.50 a day for days 21-100 for each benefit period

Part B Costs (Outpatient Care)

- **Annual deductible**: $135 in 2009
- **Monthly premium**: $96.40 in 2009
  - Higher if you have high income
- **Coinsurance**:
  - Medicare generally pays 80% of Medicare-approved amount for doctors’ services; patient pays 20% coinsurance.
- **Covers some pharmacy items**
  - Diabetes supplies
  - Durable Medical Equipment
  - Vaccines
  - Some prescription drugs
Original Medicare Concerns

- Does not cover all patient costs.
  - Many routine services such as an annual physical, dental care, foot care, ear care or eye care are not covered.
  - Does not cover most long-term care.
  - 20% coinsurance for Part B services and Part A hospital deductible can add up.
  - Does not offer drug coverage.

Ways to Supplement Original Medicare

- Through a current or former job or union (employer or retiree insurance).
- By buying a “Medigap” policy from an insurance company.
- From the state through Medicaid or a Medicare Savings Program.
Medigap Policies

- These are supplemental insurance policies sold by private insurance companies to fill “gaps” in Original Medicare coverage.
- Patient pays a monthly premium for the Medigap in addition to their Part B premium.
- There are 12 standardized Medigap plans, labeled A through L. Patients can choose a plan based on what services they want covered.
- Medigap pays after Medicare and only covers services approved by Medicare.

Part D (Prescription Drugs)

- To add drug coverage, patients can choose to enroll in a stand-alone prescription drug plan (PDP)
- Plans vary widely in their costs and benefits.
  - Premium
  - Co-pays
  - Deductible
  - Formulary
  - Use of mail order
Common Part D Terms

- True Out-of-Pocket (TrOOP)
  - Refers to costs your patient pays for covered drugs.
  - Includes the deductible, co-payments/coinsurance and drug costs; does not include monthly plan premiums.
  - Used to determine when patients reach their deductible and exit the catastrophic coverage phase.

- Donut Hole/Coverage Gap
  - Temporary period during which time the patient is responsible for 100% of their drug costs.
  - By the standard model (2009), this typically starts when the patient reaches $2,700 in total drug costs (both what the patient and the plan pays) and lasts until TrOOP reaches $4,350.

Common Part D Terms (continued)

- Dual-Eligible
  - A person who qualifies for Medicare and full Medicaid benefits.

- Low-Income Subsidy (LIS)/Extra Help
  - Refers to federal program that helps Medicare beneficiaries pay for the out-of-pocket costs of a Medicare drug plan (monthly premium, deductible, coinsurances and co-payments).
  - Administered by the Social Security Administration.
  - Includes full-benefit dual eligibles, SSI recipients with Medicare, Medicare Savings Programs participants and others with limited income and assets who apply through SSA.
Common Part D Terms (continued)

- Late Enrollment Penalty (LEP)
  - Fee added to a patient’s premium for Medicare beneficiaries who choose not to enroll in Part D when they are first eligible.
  - Equal to 1% of the national average premium for each month that the patient went without creditable drug coverage.

Section 4:
Medicare Private Health Plans (Medicare Advantage)
Medicare Private Health Plans

- Patients choose to get their benefits from an insurance company that contracts with Medicare.
- Private health plans replace Original Medicare.
- Must provide all Part A and Part B services.
  - Usually have different rules, costs and restrictions for covering those services.
- May offer extra services (vision, dental, etc.).
- Usually include drug coverage (MA-PD).

Patient Costs—Private Health Plans

- Patient must continue to pay Part B premium.
- Plan may charge additional monthly premium.
- Usually charge set copayments (such as $15) for doctors’ visits instead of 20% coinsurance.
Medicare Private Health Plan Concerns

- Usually have additional rules, restrictions and costs, which may vary, even if same plan type (like an HMO or PPO).
  - Plans may:
    - Limit patients to a doctor and hospital network;
    - Charge more for care obtained from an out-of-network provider;
    - Charge more than Original Medicare for some types of care;
    - Require patients to get permission for services;
    - Increase their premiums, copayments and change their benefits from one year to next; or
  - Doctors/hospitals can leave plan any time, but patients can only change plans at certain times of year.
  - Patients cannot buy a Medigap policy to cover their out-of-pocket costs.

Types of Medicare Private Health Plans

- Three major types of Medicare private health plans:
  - Health Maintenance Organizations (HMO)
  - Preferred Provider Organizations (PPO)
  - Private Fee-For-Service Plans (PFFS)
- You may also see:
  - Point of Service Plans (POS)
  - Provider-Sponsored Organizations (PSO)
  - Special Needs Plans (SNP)
  - Medicare Medical Savings Accounts (MSA)
  - Cost Plans
Important Considerations—HMOs

- In most Medicare HMOs, patients:
  - Must generally stay within a network of doctors, hospitals and pharmacies;
  - Need primary care doctor referral to see specialists;
  - May need plan’s permission to get certain types of care (prior authorization);
  - Have no coverage away from home unless emergency or urgent care; and
  - Must get Part D drug coverage through the same plan.

Important Considerations—PPOs

- In most Medicare PPOs, patients:
  - May pay more if they obtain care from an out-of-network doctor, hospital or pharmacy;
  - Do not need referral to see specialists;
  - May need plan’s permission to get certain types of care (prior authorization);
  - May have coverage away from home through out-of-network benefit; and
  - Must get Part D drug coverage through the same plan.
Important Considerations—PFFS

- In most Medicare PFFS plans, patients:
  - Can go to any doctor and any hospital as long as they accept the plan’s terms and conditions;
  - Do not need referral to see specialists;
  - May need plan’s permission to get certain types of care (prior authorization);
  - May have coverage away from home as long as the doctor/hospital accepts the terms of the plan; and
  - Can get Part D drug coverage through the same plan, or a stand-alone Part D plan if the health plan does not offer drug coverage.

Quiz!

Which of these statements about Medicare private health plans is true?

A) Even plans of the same type (for example, Medicare HMOs) have different rules.

B) Medicare private health plans only cover services that are covered by Original Medicare.

C) Patients can disenroll from a Medicare private health plan if their doctor leaves the plan’s network.

D) Patients do not have to pay the Part B premium if they are enrolled in a Medicare private health plan.
Answer

A) Even plans of the same type (for example, Medicare HMOs) have different rules.

Even Medicare private health plans of the same type may have different rules for how patients can get care and how much they pay. No matter what type of plan a patient is interested in, it's important to understand how the specific plan works.

The other answers are false: Medicare private health plans can choose to provide additional benefits that are not covered by Medicare. Patients will generally continue to pay the Part B premium even if they join a Medicare private health plan. And, patients can generally only disenroll from a Medicare private health plan during certain times of the year.

Section 5:
Changes for 2010
Changes for 2010

- Plan design changes
- Standardization of plan names
  - PPO: Plan Name (PPO)
  - PDP: Plan Name (PDP)
- Utilization management criteria will be posted on plan Web sites
- Expanded MTM programs

Section 6:
Questions Patients Should Ask Before Joining a Medicare Private Health Plan
Choosing a Private Health Plan

- Patients should:
  - Consider whether they want to stay with Original Medicare.
  - Consider where they live (may have several plan options).
  - Consider each plan separately.
  - Do their homework.
  - Understand they are limited in when and how often they can switch Medicare health plans.

Switching Medicare Health Plans

- Annual Coordinated Election Period
  - November 15-December 31
  - Can make any change to health or drug coverage.

- Open Enrollment Period
  - January 1-March 31
  - Can change health plan but not add or drop Part D.

- Special Enrollment Periods
  - Exceptional circumstances
  - Choices for change depend on the SEP circumstances.
Choosing the Right Plan

- When looking at Medicare private health plans, patients should consider the following:
  - Provider networks (doctors, hospitals and pharmacies)
  - Access to health care
  - Cost
  - Prescription drug coverage
  - Coordination with other benefits
  - Enrollee satisfaction

Provider Networks

- Patients should ask:
  - Will I be able to use my doctors? Are they in the plan’s network and are they taking new patients (specifically patients that have this insurance)?
  - What will happen if my doctor(s) leave the plan?
  - Which specialists, hospitals, home health agencies, skilled nursing facilities and pharmacies are in the plan’s network?
  - What service area does the plan cover?
  - What kind of coverage do I have if I travel outside of the service area?
Access to Health Care

- Patients should ask:
  - Do I need to choose a Primary Care Physician (PCP)?
  - How long will I have to wait for an appointment with my PCP or a specialist?
  - Do I need a referral to see a specialist? How easy is it to get referrals to see specialists? How long does a referral last?
  - Does my doctor need to get approval from the plan to admit me to a hospital?
  - Does the plan provide an incentive for my doctor to deny or reduce services? For example, does it cost my doctor money if she provides costly services to me?
  - If I have or develop a complex illness, what disease-related services are covered?

Cost

- Patients should ask:
  - Do I have to pay a monthly premium? If so, how much is it?
  - How much is my copayment for a visit with my PCP or a visit with a specialist?
  - How much will I pay for a hospital stay?
  - How much will I pay if I use a non-network doctor or hospital?
  - Are there higher copays for certain types of care, such as hospital stays or cancer treatment?
  - Is there an annual out-of-pocket maximum? (After you spend a certain amount will your care be free or very low-cost?) Are all services included in the out-of-pocket maximum?
Prescription Drug Coverage

- Patients should ask:
  - Are my prescription drugs on the plan’s formulary?
  - Are there any restrictions on when the plan will cover my prescription drugs, like step therapy, prior authorization or quantity limits?
  - Do I have to pay a deductible before the plan will cover my drugs?
  - How much will I pay for brand-name drugs? How much for generic drugs?
  - Will the plan cover my drugs during the coverage gap?
  - Will I be able to use my pharmacy? Is it in the plan’s network? Does the plan use mail order for maintenance medications?
  - Can I fill my prescriptions if I travel away from the plan’s network?

Coordination With Other Benefits

- Patients should ask:
  - How does the plan work with my current coverage?
    - Employer/Union Coverage
    - Medicaid
    - Medigap
  - Note: If patients have employer/union coverage, they could lose it by joining a Medicare private health plan and may not be able to get it back.
Enrollee Satisfaction

- Patients should ask:
  - How often do members leave or disenroll from the plan?
  - How do members rate the health care they get from the plan?
  - How satisfied are members in general? Members with complex illnesses?

Marketing Fraud

- Marketing fraud is when an insurance company deceives an enrollee about what the plan covers and/or costs.
- CMS rules prohibit plans from:
  - Enrolling beneficiaries over the phone unless the beneficiary initiates the call;
  - Calling beneficiaries and asking for payment or financial or personal information;
  - Visiting beneficiaries without an invitation; or
  - Sending beneficiaries unsolicited emails.
- Advise your patients to report fraud to your State Insurance Department or State Attorney General Consumer Helpline.
- If a patient is fraudulently enrolled in a plan, they may be able to disenroll, even if annual enrollment periods have ended.
Quiz!

Mrs. D is concerned about a phone call she received from a Medicare private health plan. Which of the following is a health plan NOT allowed to do?

A) Call Mrs. D and enroll her over the phone in the same conversation.

B) Follow up on the phone call by visiting Mrs. D’s home without an invitation.

C) Call Mrs. D and ask her for her social security number.

D) All of the above.

Answer

D) All of the above.

Agents for Medicare private health plans are not allowed to do any of these things when they market their plans. Remember that the plan can only enroll Mrs. D over the phone or ask her for personal or financial information if Mrs. D calls the plan herself.
Section 7: Enrolling

How Patients Can Enroll

- By calling 1-800-MEDICARE
- Online at www.medicare.gov
- Directly through the plans (phone, Web site, or paper enrollment form)
- Through a licensed insurance agent
For More Information and Help

- Medicare
  - 1-800-MEDICARE (1-800-633-4227)
  - [www.medicare.gov](http://www.medicare.gov)
- Medicare Rights Center
  - 1-800-333-4114
- Medicare Interactive
- Local State Health Insurance Assistance Program (SHIP)
- Local Area Agencies on Aging

Medicare.gov

Pharmacists can help patients enter drug information in the Plan Finder, as well as help patients calculate their annual out-of-pocket costs.
Medicare Interactive

- www.medicareinteractive.org
- Clear, simple language
- Pharmacists can use site as a counseling tool
- Answers to Medicare questions such as:
  - “How do I choose between a Medicare private health plan (HMO, PPO or PFFS) and Original Medicare?”
- State-specific info

Changes in the Law Could Make More People Eligible for Extra Help in 2010:

What You Need to Know
Easier to Qualify for Extra Help in 2010

- New law goes into effect January 1, 2010
- Some things will no longer count as resources or income
- More Medicare beneficiaries may qualify for Extra Help

Resources and Income — Changes for 2010

- Life insurance will no longer count as a resource
- Help received from someone else to pay for household expenses will no longer count as income. Examples:
  - Food
  - Mortgage payment or rent
  - Utilities – heating fuel or gas, electricity, water
  - Property taxes
What are the Limits to Qualify for Extra Help?

For 2009:
- Resources limited to $12,510 for individuals, $25,010 for married couples living together
- Income limited to $16,245 for individuals, $21,855 for married couples living together
- These limits may change in 2010

Should You Apply Now?

- If your current total resources & income are below eligibility limits: Apply now
- If your current total resources & income are above eligibility limits because of life insurance and household assistance: Apply on or after January 1, 2010
Why Wait to Apply?

- If life insurance or household assistance puts you over eligibility limits, you will not qualify until the new law is effective
- If you are over the 2009 eligibility limits and apply before January 1, 2010, you will be denied and will have to apply again

What Else Does the New Law Say?

- Beginning January 1, 2010, when you apply for Extra Help, it can start the application process for the Medicare Savings Programs (MSP)
- Social Security will send your information to your state unless you tell us not to on the Extra Help application
- Your state will contact you to help you complete the MSP application
Advantages of the Medicare Savings Programs

- Help pay for Medicare Part B (medical insurance) premiums
- For some, it may help pay for Part A (hospital insurance) premiums, and Part A & Part B deductibles and co-payments

How do I Apply for Extra Help?

- Complete the Application for Extra Help with Prescription Drug Plan Costs (SSA-1020)
  - Apply online at [www.socialsecurity.gov](http://www.socialsecurity.gov)
  - Call Social Security to apply over the phone or request an application at 1-800-772-1213 (TTY 1-800-325-0778)
- Apply at your local Social Security office
- Social Security will review your application and send you a letter to let you know if you qualify
Why Apply Online?

- Step-by-step help screens guide you through questions
- Apply from any computer at your own pace
- Start and stop at any time—return later to finish
- A relative, friend or caregiver can help
- Online application is secure

Choosing a Medicare Prescription Drug Plan

- You can choose a plan, regardless of whether you qualify for Extra Help
- If you qualify for Extra Help and do not select a plan, the Centers for Medicare & Medicaid Services will select one for you
- If you prefer another plan, you can change plans
- The sooner you join a plan, the sooner you receive benefits
Need More Information About Extra Help?

Visit [www.socialsecurity.gov](http://www.socialsecurity.gov) or
Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)

Need More Information About Medicare?

For information on Medicare Savings Programs, enrolling in specific drug plan, or to get the *Medicare & You, 2009* handbook:

Visit [www.medicare.gov](http://www.medicare.gov) or
Call 1-800-MEDICARE (1-800-633-4227, TTY 1-877-486-2048)
Questions?

www.socialsecurity.gov

Q & A