Medicare: The Fundamentals

Medicare is a U.S. federally funded health insurance program for people over the age of 65, those who are deemed disabled, and anyone with End-Stage Renal Disease (ESRD). It was initiated in July of 1965 by President Lyndon B. Johnson and later grew to become the largest insurance program in the United States. Today, there are more than 900,000 Medicare beneficiaries in the state of Tennessee alone and the number is rising rapidly.

Medicare Part A

Medicare Part A is Hospital Insurance. Most people do not pay a monthly premium for Part A. Medicare Part A covers a variety of hospital related services such as: blood, inpatient care in hospitals, inpatient stays in a skilled nursing facility, hospice care services, and home health care services.

If you are not receiving Social Security benefits, you will need to contact your local Social Security office and sign up for Part A at least three months in advance. You can also buy Part A during the following times, if you are not eligible for premium-free Part A: Initial Enrollment Period (three months before and three months after you turn 65), Special Enrollment Period (if you or your spouse is working and has insurance through your employer), and Special Enrollment Period for International Volunteers (if you are serving as a volunteer in a foreign country).

Medicare Part B

Medicare Part B is Medical Insurance. Medicare Part B helps cover services which are deemed “medically-necessary,” such as: doctors’ services, outpatient care, and other medical services. Medicare Part B also helps cover services which are preventive, such as: Pap tests, flu shots, and prostate cancer screenings.

You will automatically get Part B starting the first day of the month you turn 65 if you get benefits from Social Security. If you are not receiving any Social Security Benefits, you will need to apply for benefits at the local SSA office. If you are under the age of 65 and disabled, you will automatically get Part B after you have received disability benefits from Social Security for 24 months. About three months before your 65th birthday or around your 25th month of disability, you will get your Medicare card in the mail. If you do not want Part B, you need to simply follow the instructions that come with the card and send the card back. If you keep the card, you will keep Part B and you will pay Part B premiums.

If you did not sign up for Part B when you first became eligible, you may be able to sign up for Part B during one of the following times:

- General Enrollment Period (between January 1 – March 31 of each year for a July 1st enrollment date),
- Special Enrollment Period (if you have group health coverage – you can sign up any time while you have the coverage or during the 8-month period that begins the month the employment ends), and
- Special Enrollment Period for International Volunteers.

A late fee may apply if you choose to enroll during the General Enrollment Period and have not had other forms of health insurance. You need to call your local Social Security office or 1-800-772-1213 for more information about enrolling in Part B. Most people pay a monthly Part B premium. For 2022, the monthly Part B premium is $170.10 for most individuals. For those with higher incomes, see Social Security's website on Medicare premiums for 2022 at: https://www.ssa.gov/benefits/medicare/medicare-premiums.html#anchor5

The Part B deductible for 2022 is $233.00 per year. If this deductible applies, you are responsible for all costs until you meet that yearly deductible. Once that deductible is met, Medicare begins to pay its share. At that time, you typically pay 20% of the Medicare-approved amount of the service you received. Some Medicare supplements will help with the costs of the Part B deductible and coinsurance.

Update: Due to the new Affordable Care Act, most preventive services will not have a cost-share or deductible to meet with Part B. Here are some details:

The following preventive services that Medicare currently covers will be provided free of charge to the patient, including:

- Mammograms every 12 months for eligible beneficiaries age 40 and older.
- Colorectal cancer screening, including flexible sigmoidoscopy or colonoscopy.
- Cervical cancer screening, including a Pap smear test and pelvic exam.
- Cholesterol and other cardiovascular screenings.
- Diabetes screening.
- Medical nutrition therapy to help people manage diabetes or kidney disease.
- Prostate cancer screening.
- An annual flu shot, a vaccination against pneumococcal infection (that may cause pneumonia), and the hepatitis B vaccine.
- Bone mass measurement.
- Abdominal aortic aneurysm screening to check for a bulging blood vessel.
- HIV screening tests for people of who are at increased risk or who ask for the test.

Annual Wellness Exam

Also, you will receive an "Annual Wellness Exam" every year. Here are the details:

- **How often is it covered?**

After you've had Part B for longer than 12 months, you can get a yearly wellness exam to develop or update a prevention plan just for you, based on your current health and risk factors. This exam is covered once every 12 months.

- **Who's eligible?**

All people with Medicare. If you got the "Welcome to Medicare" physical exam, you have to wait 12 months before you can get your first yearly wellness exam.

- **Your costs in Original Medicare:**

You pay nothing for the yearly wellness exam.

Medicare Advantage Plans

Medicare Advantage Plans may also offer extra coverage. This may include vision, hearing, dental, and/or health and wellness programs. Most Medicare Advantage Plans also include prescription drug coverage, but that drug coverage usually comes at an extra cost. Keep in mind that you may also need a referral in order to see a specialist.

Medicare Advantage Plans are health plan options which are approved by Medicare. Medicare Advantage Plans are sometimes referred to as "Part C" or "MA Plans." Medicare Advantage Plans are run by private companies and are part of the Medicare program. These plans provide Medicare health coverage and usually Medicare drug coverage in one package. In order to join a Medicare Advantage Plan, you must have Part A and Part B and you must live in the plan's geographic service area. Because not all Medicare Advantage Plans work the same way, be sure to find out the plan's rules before joining.

With Medicare Advantage Plans, all of your Part A (Hospital Insurance) and Part B (Medical Insurance) are covered. Even though Medicare Advantage Plans must cover at least all the services Original Medicare covers, each Medicare Advantage Plan can charge different out-of-pocket costs. It is very important to contact any plan before joining. You should find out the plan's rules, what your costs will be, and be sure that the plan can meet your needs.

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If your Medicare Advantage Plan has provider networks, you may only be able to see doctors who belong to the plan or go to certain hospitals to get covered services. If you see a doctor or other provider who does not contract or participate with the plan, your services may not be covered at all, or your costs will likely be higher. Be sure to check

with your doctors or hospitals to find out if they accept the Medicare Advantage Plan. Please note that Medicare supplements, or Medigap policies, DO NOT work with Medicare Advantage Plans.

Medicare Advantage Plans include:

- Preferred Provider Organization (PPO) Plans
- Health Maintenance Organization (HMO) Plans
- Medical Savings Account (MSA) Plans
- Special Needs Plans (SNP)

Medicare Part D

If you have Medicare, you can get prescription drug coverage (Part D) through Medicare. In order to get Medicare Part D, you must join an approved insurance company. Each plan varies in cost and in the drugs which they cover. If you want Medicare Part D, you need to choose a plan that works with your health coverage.

Two ways to get Medicare prescription drug coverage are: stand-alone Medicare Prescription Drug Plans (these add drug coverage to Original Medicare), and Medicare Advantage Plans (all of your Part A and Part B coverage, including Part D are included in these plans).

Even if you take little to no prescription medications at this time, you should still consider joining a Medicare drug plan. If you choose not to join a Medicare drug plan when you are first eligible, and you do not have other creditable prescription drug coverage, you will likely pay a late enrollment penalty (this results in higher premiums) if you choose to join later.

You can join, switch, or drop a Medicare Part D Plan during the following times: when you first become eligible for Medicare or between October 15 and December 7 of every year (your coverage will begin on January 1 of the following year). In certain situations you may be able to join, switch, or drop Medicare Part D Plans during a special enrollment period (like if you lost creditable drug coverage, move out of the service area, or if you qualify for “extra help”).

You can choose a Medicare Part D plan by calling your local State Health Insurance Assistance Program (SHIP) and having them compare Part D Plans that are right for you. Once you choose a Medicare Drug Plan, you join by calling the plan or enrolling online. Depending on your situation, you can also switch to a new Medicare Part D plan by joining another plan during one of the times mentioned above. You do not need to cancel your old Medicare Part D plan or send them any information.

All Medicare Part D Plans must provide at least a standard level of coverage set by Medicare. That being said, exact coverage and costs differ from plan to plan. Your

actual drug plan costs will vary depending on the drugs you take, the plan you choose, whether you go to a pharmacy in your plan's network, and whether you qualify for "extra help" paying your Part D costs. The following are descriptions of the payments you make throughout the year in a Medicare Part D Plan:

- **Monthly premium:** A monthly premium is the amount a drug plan charges per month; fees vary by plan. You pay this premium in addition to the Part B premium. If you belong to a Medicare Advantage Plan that includes prescription drug coverage, the monthly premium may include an amount for the prescription drug coverage.
- **Yearly deductible:** A deductible is the amount you will pay out-of-pocket for your prescriptions before your Medicare Part D plan begins to pay. Some plans do not have a deductible.
- **Copayments or coinsurance:** These are the amounts you pay for your prescriptions after you have met your deductible.
- **Coverage gap:** Most Medicare Part D Plans have a coverage gap. The coverage gap occurs when you and your plan have spent a certain amount of money for covered drugs. During this time, you have to pay 45% of costs out-of-pocket for your brand-name drugs up to a limit. You will pay 58% towards generic drugs. The yearly deductible, the co-payments, and what you pay in the coverage gap all count toward this out-of-pocket limit. Be sure to check with your plan to see if your drugs will be covered during the gap.
- **Catastrophic coverage:** "Catastrophic coverage" begins once you reach your plan's out-of-pocket limit during the coverage gap. Catastrophic coverage assures that once you have spent up to your plan's out-of-pocket limit for covered drugs, you are only responsible for paying a small copayment for the rest of the year.

For a free, non-biased drug comparison, fill out the part D worksheet found on our resources page and mail it to your local SHIP office.

Supplemental Insurance

Not all health care services and supplies are paid for in full by Original Medicare. A Medigap policy (sold by private insurers) can help pay some of the health care costs that Original Medicare does not cover (such as copayments, coinsurance, and deductibles). If you have Original Medicare and you choose to buy a Medigap policy, both plans will pay their share of the Medicare-approved amounts for health care costs that are covered. Medigap policies don't cover long-term care (like care in a nursing home), vision or dental care, hearing aids, eyeglasses, and private-duty nursing.

In most states, insurance companies can only sell "standardized" Medigap policies. These policies are identified by letters (Medigap Plans A through N). Medigap Plan F offers a high-deductible option. The benefits in any Medigap Plan A through N are the

same for any insurance company. However, the cost for a policy may be different depending on the insurance company.

Generally speaking, you must have Part A and Part B in order to buy a Medigap policy. You must pay a monthly premium for your Medigap policy, in addition to your monthly Part B premium. It is important to compare all Medigap policies; costs vary and may go up as you get older. The best time to buy a Medigap Policy is during the 6-month period that begins on the first day of the month in which you are both eligible for Medicare and enrolled in Part B. Your option to buy a Medigap policy may be limited after this initial enrollment period.

For more information on each plan, please contact your local SHIP office.

Please note that insurance companies price their plans different ways. Here is a breakdown of how they can set prices:

- *Community-rated:* Also referred to as “no-age rated.” It is priced as the same monthly premium charged to everyone who has the policy, regardless of age. Premiums are not based on age and may go up with inflation or other factors.
- *Issue-age-rated:* The premium is based on the age you are when you buy or are “issued” the policy. Policies may go up due to inflation, but not because of age.
- *Attained-age rated:* The premium is based on your current age (the age you have attained) and goes up as you get older. These policies also may go up due to inflation and other factors and can start at the least expensive, but may become the most expensive as you get older. Most policies sold in Tennessee are attained-age-rated.**ATTENTION Medicare Beneficiaries Under Age 65:**Starting January 1, 2011, Medicare Beneficiaries under the age of 65 now have the right to purchase a Medicare Supplement Policy. On May 27, 2010, Chapter 978 of the Tennessee Public Acts was signed into law. New beneficiaries have the same 6-month open enrollment period as those over age 65 beginning the first month they are eligible for Medicare and are enrolled in Part B.