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# Medicare Changes that May Impact You

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Roseville Cedarholm Community Building | Ramsey County Library (Roseville)

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# Learning Objectives

- Understand the ABCDs of Medicare
- Recognize Medicare changes that impact your coverage
- Acquire resources to help you evaluate your options



# Medicare Facts and Figures

- Created by Congress in 1965
- Approximately, every 8 seconds an individual becomes eligible for Medicare in the United States
  - 10,000 per day
  - 4,000,000 per year
- The Center for Medicare and Medicaid Services reports over 59 million Medicare recipients in 2018
- Designed for acute care
  - All services must be medically reasonable or necessary to treat and illness or injury
  - Preventative services are relatively new to coverage



## Categories of Eligibility

- Age 65 or older
- Disabled
  - Evidenced through receipt of SSDI or Railroad Retirement Disability benefits; and
  - Collecting said benefits for 24 months
- Diagnosed with End Stage Renal Disease (kidney failure)
  - Generally begins on the first day of the third month of a course of renal dialysis treatment
- Diagnosed with ALS (Lou Gehrig's Disease) and receive SSDI – No 24 month waiting period
- Noncitizen, permanent residents age 65 or older, that have lived in the US for 5 consecutive years and buy in



# Enrollment

- Social Security Administration administers Medicare enrollment while Center for Medicare and Medicaid Services (CMS) administers the benefits
- *Eligible* beneficiaries receiving Social Security benefits, will get automatically enrolled in Part A and Part B
- An increasing number of people are not retiring at age 65
  - Full retirement age for Social Security purposes is gradually increasing (65 to 67)
  - These individuals will actively need to enroll



# Enrollment

- Analysis for individuals 65+ and working:
  - Are you covered by an employer group health plan?
  - If so, is the group health plan based on you or your spouse's current, active employment?
  - If so, how many employees does the employer have?
    - Under 20 employees, then Medicare will be primary and you must enroll or face a penalty
    - Over 20 employees, then Medicare will be secondary and it is okay to enroll later without penalty



# Enrollment

- Analysis for 65+ and working:
  - Act of retirement changes whether group health plan is primary or secondary
  - A change to current, active employment will impact need for Part B enrollment
  - Retiree coverage is secondary to Medicare



# Enrollment Period

- Initial Enrollment Period
  - 3 months prior to Eligibility (Month of 65<sup>th</sup> Birthday), with enrollment effective the first day of the month of eligibility
  - 3 months after Eligibility, with enrollment effect the first day of the month following application
- General Enrollment Period
  - First 3 months of a calendar year, with enrollment effective July 1<sup>st</sup>





# Enrollment Period

- Special Enrollment Period
  - Designed for “working elderly”
  - Individuals over age 65 who are covered by an employer group health plan of their own, or from their spouse’s employment have the option to enroll in Medicare past age 65
  - Can enroll while still covered by GHP or in the 8 months following GHP coverage end date



# Enrollment Period

- Annual Coordinated Election Period (commonly referred to as Open Enrollment Period)
  - October 15 through December 7
  - Time period that Medicare beneficiaries can enroll in, switch, or disenroll from Medicare Advantage (Part C) Plans or Prescription Drug (Part D) Plans



# Enrollment Period

- Failure to Enroll
  - Issue for Working Elderly
  - Can result in a 10% per year surcharge assessed on premiums
  - Could result in individual's being unable to enroll in until the next *general enrollment*
    - Remember, benefits would not begin until July 1 following general enrollment
    - Gap in coverage = \$\$\$\$\$



# Medicare Program

- Four Parts
  - Part A and Part B
    - Traditional Medicare, Original Medicare, Core Medicare, Fee for Service Medicare
  - Part C
    - Private Medicare, Medicare Advantage, MA
  - Part D
    - Prescription Drug Coverage



## Traditional Medicare

- Part A: Hospital Insurance (Required)
  - Free for individuals age 65 or older with approximately 10 years of work history
  - Individuals with less work history may still be eligible, but will require a premium
- Part B: Supplemental Medical Insurance (Optional)
  - Physician services, outpatient, preventative
  - Standard premium is \$134 in 2018
    - Standard premium applies to individuals with incomes below \$85,000 per year



## Part A: Overview

- Part A is often referred to as Hospital Insurance (HI)
- Coverage includes:
  - Inpatient care in a hospital
  - Skilled nursing facility care
  - Inpatient care in a skilled nursing facility (not custodial or long-term care)
  - Hospice care
  - Home health care



## Part A: Hospital Insurance

- Hospital Insurance Coverage Includes:
  - In-patient hospitalizations that have 24-hour availability of physician, special equipment, and no waiting days
  - Coverage is limited by length and cost-sharing liability
    - Maximum of 150 days of coverage per benefit period
    - Cost sharing figures in 2018 (if no other coverage)
      - Day 0: \$1,340
      - Day 1-60: \$0
      - Day 61-90: \$335 per day
      - Day 91-150: \$670 per day



## Part A: Skilled Nursing Facility

- Skilled Nursing Facility Coverage
  - Requires 3-day, inpatient hospital stay (3 midnights)
  - Care must be reasonable and necessary
  - Individual must need daily skilled care based on daily evaluations
    - Amounts to 7 days per week in a SNF
    - Amounts to 5 days per week of outpatient therapy
    - Amounts to 7 days per week of SNF and therapy
  - Cost Considerations:
    - No copays for first 20 days, 21 days – 100 (\$167.50 in 2018)





## Part A: Benefit Period

- Hospital and SNF Coverage
  - Limited by “Benefit period” (spell of illness)
    - A benefit period begins on the first day a beneficiary is admitted to the hospital and does not end until the beneficiary has not received a hospital or skilled nursing facility level of care for 60 days



## Part A: Benefit Period

- Benefit Period Continued
  - Example: A Medicare recipient is hospitalized for 3 weeks (21 days). The recipient is discharged to TCU/SNF. He receives skilled care and therapy 7 days per week for 3 weeks (21 days). The recipient is discharged from the TCU/SNF. If the recipient is rehospitalized in less than 60 days, then the benefit period continues. This means that the recipient's cost sharing is determined on day 22 of coverage (\$167.50/day).



## Part A: Home Health Care

- Home Health Coverage
  - Common misperception that Medicare does not cover home care or if it does it must be limited in duration
  - This is FALSE and could greatly impact your clients
    - *Area of advocacy and education!*



## Part A: Home Health Care

- Home Health Continued
  - Services must be ordered by a physician
  - Must be reasonable and necessary
  - Beneficiary must be *homebound* (not bedbound)
    - Examples: Beneficiary needs a cane, walker, or assistance of another person to leave home or cannot leave home without a considerable taxing effort.
    - Examples of absences that are not counted against beneficiary: Adult day, medical appointments, religious services



## Part A: Home Health Care

- Home Health Continued
  - There must be a need for skilled care (nursing must be intermittent)
  - Does not generally provide daily care, but may cover up to 28-35 hours/week of skilled nursing and home health aid services
  - Some dependent coverage included
  - Not limited in duration!
  - No co-pays or deductibles
  - Does not require hospitalization first!
    - Could be a community admission
  - Little to no cost sharing



## Part A: Hospice

- Hospice Care Coverage:
  - For individuals that have been determined by a physician to have 6 months or less to live
  - No skilled or homebound requirement
  - No durational limits, but subject to reevaluations that should not result in a service interruption
  - Services must be reasonable and necessary for the comfort and management of a terminal illness
  - Palliative in nature rather than curative
  - Elect to forego treatment for illness that is making you terminal



## Part A: Hospice

- Hospice Coverage Continued
  - Does not generally pay for room and board in a facility
  - Limited inpatient coverage to stabilize condition and provide respite to caregivers and loved ones
  - Limited co-pays (medication and respite care)



## Part B: Overview

- Part B: Health Insurance
- Coverage Includes, but is not limited to:
  - Physicians services
  - Outpatient care
  - Lab tests
  - X-rays
  - Medical supplies
  - Durable medical equipment
  - Ambulance services





## Part B: Overview

- Coverage also includes some preventative care coverage, such as:
  - Welcome to Medicare exam
  - A free annual wellness visit that includes personalized prevention plan
- Coverage does not include:
  - An annual physical exam
  - Prescription drugs
    - Note: Medications that cannot be self administered are generally included
  - Routine dental care
  - Hearing aids

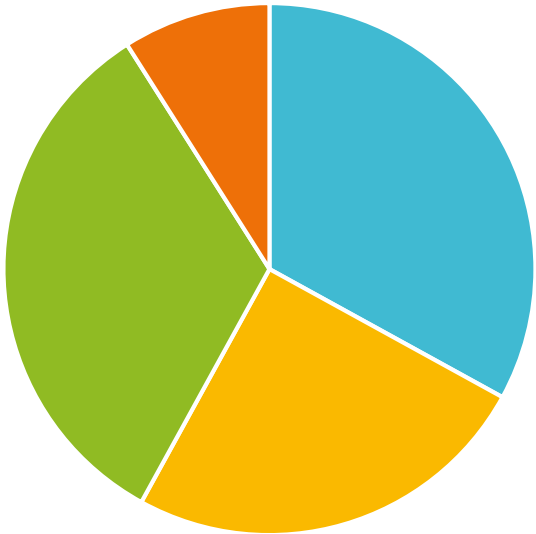


## Part B: Costs

- Costs include an annual deductible (\$183 in 2018)
- Costs also include standard premiums (\$134 in 2018)
  - Generally deducted from Social Security check
  - Standard premiums are calculated based on income
    - > \$85,000 - \$107,000 individual or > \$170,000 - \$214,000 couple (\$187.50 in 2018)
    - > \$107,000 - \$133,500 individual or > \$214,000 - \$267,000 couple (\$267.90 in 2018)
    - > \$133,500 - \$160,000 individual or > \$267,000 - \$320,000 couple (\$348.30 in 2018)
    - > \$160,000 individual or > \$320,000 couple (\$428.60 in 2018)
- Increase of cost sharing due to Medicare Modernization Act



Types of Coverage Supporting 2/3 of Traditional Medicare  
Recipients



- Employer Based Coverage
- Medigap and Medicare Savings Programs
- Medicare Advantage Plan
- Other Coverage, such as Military Coverage and Medicaid

Traditional  
Medicare +



# Medigap

- Medigap Policies
  - Also known as Medicare Supplement Insurance
  - Sold by private insurance companies
  - Helps you pay for some of the health care costs that Original Medicare does not cover
    - Coinsurance
    - Copays
    - Deductibles



## Part C: Medicare Advantage Plans

- Part C is administered exclusively by private plans
  - It defines alternate delivery systems for Traditional Medicare services through Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs)
  - Private companies offering Medicare Advantage plans contract with and are approved by CMS to administer your Medicare benefits



## Part C: Medicare Advantage Plans

- Cost of Medicare Advantage Plans
  - MA Plans require cost sharing that is actuarially equivalent to Traditional Medicare
  - Cannot charge more in the aggregate than what that same beneficiary would need to pay for Traditional Medicare
    - May have higher cost sharing for certain services
  - Pay a monthly capitated amount
  - Now required to cap individual's out of pocket expenses (\$6,700 per year)



## Part C: Medicare Advantage Plans

- Part C is *not* supplemental insurance
  - Individuals may not receive Traditional Medicare and Medicare Advantage plans
  - You may change or switch coverage during Open Enrollment Period
- Cannot be sold a Medigap policy (*Medigap is supplemental insurance*)
- Care is often subject to preapproval
- Network providers is a hallmark of the plans



## Part C: Medicare Advantage Plans

- Medicare Advantage plans *must* cover same as Traditional Medicare (floor and not ceiling on coverage)
- Impact on consumers?
  - Cons include:
    - Sicker/Critically ill enrollees could face loss of coverage or increase pricing structures
    - Hard to return to Traditional Medicare
  - Pros include:
    - One Stop Shopping: MA plans combine Part A, Part B, and sometimes Part D coverage
    - Cost conscious option





# Medicare Cost Plans

- Medicare Cost Plans are hybrid Medicare plans that share features from Medicare Advantage plans and Medigap plans
- Historically thought to offer the “best of both worlds” for older adults
  - Flexibility of Traditional Medicare while allowing access to out-of-network providers
- Served areas of the country that had few Medicare Advantage plans



# Medicare Cost Plans

- In 2003, Congress created a competition requirement for Medicare Cost plans
  - CMS will not renew Medicare Cost plans in counties where there are 2+ MA plans with a certain number of members
  - Plans cannot be offered in service areas where there is significant competition to MA plans
  - Implementation was delayed until 2019
- Impact on Minnesotans
  - 20,000,000 people covered by MA plans
  - 630,587 people are enrolled in Medicare Cost plans
  - 400,000 of people enrolled in Medicare Cost plans are in MN



# Guaranteed Issue Rights

- Guaranteed Issue Rights = Medigap Protections
  - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy even if you have health problems (“pre-existing conditions”)
  - Examples of when it may be used:
    - When your plan is leaving Medicare
    - Within 12 months of trial of MA



## Part D: Prescription Drug Coverage

- Part D provides outpatient prescription drug coverage
  - Part D is administered *exclusively* by private insurers
  - Voluntary Program: you must affirmatively enroll
    - Annual coordinated election period (10/15 – 12/7)



## Part D: Prescription Drug Coverage

- Cost Associated with Part D
  - Beneficiaries pay monthly premiums and cost sharing, which is based on annual income
  - Donut/Doughnut Hole: Gap in coverage when your total drug costs reaches a certain limit (\$3,750 in 2018)
    - In 2019, ACA closes donut hole or gap in coverage under part D
  - Part D low income subsidy, extra help that provides assistance with premiums and cost sharing amounts



# Part D: Standard Benefit Chart\*

\*Chart created by Center for Medicare Advocacy

	2018	2019
Annual Deductible Maximum	\$405	\$415
Member pays 25% of the next...	\$3,345 (25% = \$836.25)	\$3,405 (25% = \$851.25)
Initial Benefit Period Maximum (what the member <u>AND</u> the plan have spent)	\$3,750 (\$405 + \$3,345)	\$3,820 (\$415 + \$3,405)
DONUT HOLE Member pays 100% of the next...	\$3,758.75 (Brand name drugs: 35% co-pay + 15% plan "subsidy;" + 50% manufacturer discount*. Generic drugs: 44% co-pay + 56% subsidy) * discount counts toward true out of pocket expenses	\$3,833.75 (Brand name drugs: 25% co-pay + 5% plan "subsidy;" + 70% manufacturer discount*. Generic drugs: 37% co-pay + 63% subsidy) * discount counts toward true out of pocket expenses
Catastrophic Coverage Begins when <u>member</u> (NOT plan) has spent a total of...	\$5,000 (true out of pocket – "TrOOP") (\$405 + \$836.25 + \$3,758.75)	\$5,100 (true out of pocket – "TrOOP") (\$415 = \$851.25 + \$3,833.75)
Cost sharing during Catastrophic Coverage	\$3.35 / \$8.35 or 5% (whichever is greater)	\$3.40 / \$8.50 or 5% (whichever is greater)



# Medicare Appeals

- What happens when you have been denied Medicare coverage? Appeal!
  - Expedited Appeals: Address whether the provider's termination of Medicare-covered services was proper
  - Standard Appeals: Address whether any subsequent services the beneficiary chose to receive are coverable
- Five Level Review Framework
  - 1<sup>st</sup> Level: Redetermination (Rubber stamp denials?)
  - 2<sup>nd</sup> Level: Reconsideration (Rubber stamp denials?)
  - 3<sup>rd</sup> Level: ALJ Hearing
  - 4<sup>th</sup> Level: Medicare Appeals Council
  - 5<sup>th</sup> Level: Federal Court
- Appeal Toolkits: See Center for Medicare Advocacy Website



# Jimmo Settlement

- Myth of “Improvement Standard”:
  - Medicare only pays if the beneficiary is expected to *improve...* your condition or function must get better
  - This is not a requirement in the statute or regulations
- *Jimmo v. Sebelius*
  - Medicare coverage is improperly denied for skilled nursing or rehabilitation when the denial is based on an individual’s stable or chronic condition
  - There is no expectation of improvement in a reasonable period of time
  - Applies to SNF, HH, Outpatient Therapy, Inpatient Rehabilitation Facilities
  - Corrective Action Plan, includes webpage and *change of practice*





# Observation Status

- Care in hospital is generally indistinguishable for inpatients and outpatients/observation status
- Observation status or outpatient has become status quo
  - Financial motive of observation status is more linked to the fear of losing money than making money
- If an individual is not inpatient then:
  - Denied Part A coverage for Part A hospital stay (if no Part B)
  - Denied Part A coverage for SNF stay
  - Denied Part A coverage prescription drug coverage while hospitalized
- *No way to appeal observation status*



# Observation Status

- What are your rights?
  - Individuals are entitled to a MOON Notice (Medicare Outpatient Observation Notice) within 36 hours
  - You may argue with hospital about designation/status, but any changes may not occur retroactively
    - A community physician could also advocate and serve as an ally if enlisted



# Home Health Benefit

- Access to this benefit has been historically underutilized
  - Often due to a lack of understanding about current law and policy by providers and consumers
  - Important to educate yourself
- May allow individuals to move away from Medicaid/Medical Assistance planning



# Home Health Benefit



## Resource Library

- Senior Linkage Line: [www.seniorlinkageline.com](http://www.seniorlinkageline.com)
- Official Medicare Website: [www.medicare.gov](http://www.medicare.gov)
- Center for Medicare Advocacy: [www.medicareadvocacy.org](http://www.medicareadvocacy.org)
- Medicare Insurance Brokers



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# Thank You!

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