Medicare Grants

2024 Session 1 Initial Counselor Training

Medicare Grants Coordinator

AGENDA

9:00 **WELCOME** – Sign In,

Pre-Test

Agenda Review, Introductions

Medicare - Part A, Part B,

Medicare Advantage Plans Part C

Prescription Drug Coverage A & B

Medicare Prescription Drug Coverage – Part D

LUNCH? (1 hour please)

Assistance programs

Medicare Supplements

Coordination of Benefits

Closing – Resource Information, Next Steps, Questions?

3:00 **Thank you for your attention and time today!!**

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SHIP State Health Insurance Assistance Program
Navigating Medicare

SMP Senior Medicare Patrol
Preventing Medicare Fraud

Medicare Grants Training Program 2024 Initial Training Session 1 – Medicare Basics

Medicare Grants Coordinator

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Welcome to Training

- Welcome to 2024 SHICK/SMP/MIPPA Counselor Training
- The training begins at 9:00
- Introductions
- Agenda Review
- Complete the Session 1 Pre-test through the SHIPTA Center
- Required paperwork
- https://kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/shick-counselor-training/shick-training-materials

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Training Record/Memorandum of Understanding

- You will need to successfully complete the Training Record/Confidentiality Agreement/Memorandum of Understanding to receive session credit. The quiz at the end is not required.
  - Training Record – Maintaining contact information and required demographics for counselor
  - Memorandum of Understanding – an agreement to abide by all program guidelines and regulations, signed annually.
  - Confidentiality Agreement for Unique ID
  - https://kdads.ks.gov/shick-tr-mou-form

https://kdads.ks.gov/shick-tr-mou-form

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Medicare Grants

- KDADS has three Medicare Grant programs awarded through the HHS Administration for Community Living (ACL)
  - Senior Health Insurance Counseling for Kansas (SHICK) - State Health Insurance Assistance Program (SHIP) for Kansas
  - Senior Medicare Patrol (SMP)
  - Medicare Improvements for Patients and Providers Act (MIPPA)

We will cover these program basics in depth during Session 2

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What *is* Medicare

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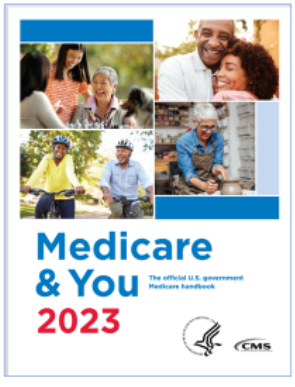
Medicare

Health insurance for people

- 65 and older
- Under 65 with certain disabilities
  - ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) without a waiting period
- Any age with End-Stage Renal Disease (ESRD)

NOTE: To get Medicare they must be a U.S. citizen or lawfully present in the U.S. Must reside in the U.S for 5 continuous years.



CMS Product No. 10050

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What Agencies are Responsible for Medicare?

Handle Enrollment, Premiums

Social Security enrolls most people in Medicare

Railroad Retirement Board (RRB) enrolls railroad retirees in Medicare

Federal retirees' premiums are handled by the **Office of Personnel Management** (OPM)

We Handle the Rest

Centers for Medicare & Medicaid Services (CMS) administers the Medicare Program

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The Four Parts of Medicare

Original Medicare		Medicare Advantage Part C	Medicare Prescription Drug Coverage
Part A Hospital Insurance	**Part B** Medical Insurance	Part A + Part B + **Part D** (Usually)	**Part D** Medicare prescription drug coverage
Inpatient hospital stays, skilled nursing facility care, home health care, and hospice care	Medically necessary services like doctor's visits and outpatient care. Also covers many preventive services, diagnostic tests, some therapies, and durable medical equipment	Private insurance companies approved by Medicare cover medically necessary services. Can charge different copayments, coinsurance, or deductibles for these services.	Outpatient prescription drugs.

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Medicare Options

Original Medicare

- ☑ Part A
- ☑ Part B

You can add:

- ☐ Part D

You can also add:

- ☐ Supplemental coverage

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (Part C)

- ☑ Part A
- ☑ Part B

Most plans include:

- ☑ Part D
- ☑ Some extra benefits

Some plans also include:

- ☐ Lower out-of-pocket costs

NOTE: Medicare Supplement Insurance (Medigap) policies only work with Original Medicare.

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Automatic Enrollment—Part A & Part B

- **Automatic enrollment for people who get:**
  - Social Security benefits
  - RRB benefits
- **Get Ready for Medicare Package**
  - Mailed 3 months before:
    - 65, or
    - 25th month of disability benefits
  - Includes their Medicare card

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Some People Must Take Action to Enroll in Medicare

If they aren't automatically enrolled in Part A and Part B:

- they need to enroll with Social Security
  - Visit socialsecurity.gov, or
  - Call 1-800-772-1213; TTY: 1-800-325-0778
- If they retired from a railroad, enroll with the RRB
  - Call their local RRB office at 1-877-772-5772; TTY: 1-312-751-4701

NOTE: The age for full Social Security retirement benefits is increasing. Medicare eligibility age is still 65.

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Medicare Card

- Keep it and accept Medicare Part A and Part B
- To refuse Part B, follow instructions in the "Get Ready for Medicare" package
  - Let their doctor, hospital, or other health care provider see their card when they need health care
  - Need a replacement card?
    - Visit Medicare.gov/account to log into their secure Medicare account and print an official copy
    - Call 1-800-MEDICARE (1-800-633-4227); TTY 1-877-486-2048

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When to Sign Up or Make Changes to their Medicare Coverage

If they don't already have Medicare:

- Initial Enrollment Period (IEP)
- Special Enrollment Period (SEP) (in certain circumstances)
- General Enrollment Period (GEP)

If they already have Medicare and want to change how they get their coverage:

- Open Enrollment Period (OEP)
- Medicare Advantage OEP
- 5-Star Enrollment Period
- Special Enrollment Period (SEP) (in certain circumstances)

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Initial Enrollment Period (IEP)

7-Month Period

If they apply **before** they turn 65, their coverage starts the month they turn 65.

If they apply **during** the month, they turn 65 or the following three months, their coverage starts the next month.

If they enroll after their IEP, they may pay a late enrollment penalty

NOTE: their 6-month Medigap OEP starts when they're both 65 and have Part B.

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Special Enrollment Period (SEP)

Starts after Medicare IEP and having GHP coverage based on current employment

Continues for 8 Months after GHP Coverage Based on Current Employment Ends

they can sign up for Part A (if they have to pay for it) and/or Part B:

- Anytime they're still covered by the GHP
- During the 8-month period that begins the month after the employment ends or the coverage ends

Usually no late enrollment penalties

NOTE: they have 6 months from the Part B effective date to buy a Medigap policy (must have Part A and Part B).

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Additional Special Enrollment Periods (SEP) Part A & Part B

Special Enrollment Period	Occurs From	Ends	Coverage Starts
Individual, or individual authorized representative, legal guardian, or caregiver was impacted by a disaster or emergency	The day the Federal, state or local government declares the emergency or disaster, or the date in that declaration (whichever is earlier).	6 months after whichever of these happens later: ✓ The end date in the original declaration ✓ The last day of any extensions to the declaration ✓ The date the government revokes or announces the end of the declaration	The month after enrollment is submitted

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Special Enrollment Periods for Part A & Part B (continued)

Special Enrollment Period	Occurs From	Ends	Coverage Starts
Health Plan or Employer Error	The day the individual notifies Social Security that the health plan or employer misrepresented or provided incorrect information	6 months after individual notifies Social Security	The month after enrollment
Formerly Incarcerated Individuals	The day the individual is released from incarceration	The last day of the 12th month after the month the individual is released	The month after enrollment or, the individual can choose retroactive back to their release date (not to exceed 6 months)
Termination of Medicaid Coverage	The day the individual is notified that Medicaid coverage is ending	6 months after Medicaid coverage ends	The month after enrollment unless the individual elects a start date of the first day of the month they lost Medicaid and agrees to pay all prior premiums
Other exceptional conditions	Once Social Security decides whether the individual qualifies for a SEP	Minimum 6-month duration	The month after enrollment

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General Enrollment Period (GEP)

3-Month GEP each year

They can sign up for:

- Part A (if they have to buy it)
- Part B

May have late enrollment penalties

Individuals who are not entitled to premium-free Part A and who enroll in Part B during the GEP

Can enroll in:

- Medicare Advantage Plan (if they have Part A and Part B)
- Part D (if they have Part A and/or Part B)
- SEP begins when their premium-Part A or Part B application submitted and continues first 2 months of enrollment in premium Part A or Part B.
- MA or Part D plan enrollment effective the first of the month following the month the MA or Part D plan receives the enrollment request.

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Yearly Open Enrollment Period (OEP) for People with Medicare

7-Week Period

- 7-week period each year where they can enroll in, disenroll, or switch Medicare Advantage Plans or Medicare drug plans
- This is a time to review health and drug plan choices

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Medicare Advantage Open Enrollment Period

Annual Medicare Advantage OEP
January 1—March 31

Newly Eligible Medicare Advantage OEP
1st 3 months of entitlement to Medicare Part A and Part B

They can:

- Switch to another Medicare Advantage Plan, with or without drug coverage
- Drop their Medicare Advantage Plan and return to Original Medicare. If they do:
  - they can enroll in a Medicare drug plan
  - Coverage begins the 1st of the month after they enroll in the plan

NOTE: they need to be in a Medicare Advantage Plan to use this enrollment period.

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5-Star Special Enrollment Period (SEP)

They can:

- Switch to 5-star Medicare Advantage Plan (with or without drug coverage), or a drug plan
- Enroll once per year from December 8–November 30

Keep in mind:

- New plan starts 1st day of month after enrolled
- Star ratings assigned in October and effective January 1

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Other Medicare Special Enrollment Periods (SEPs) Part C & Part D

- Move out of their plan's service area
- Are in a plan that leaves Medicare or reduces its service area
- Get, lose, or have a change in dual/LIS-eligibility status
- Enter, live at, or leave a long-term care facility (like a nursing home)
- Have Medicaid and Medicare or qualify for a low-income subsidy
- Are sent a retroactive notice of Medicare entitlement

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Part A (Hospital Insurance) Covers

- Inpatient care in a hospital, including:
  - Semi-private room
  - Meals
  - General nursing
  - Drugs (including methadone to treat an opioid use disorder)
  - Other hospital services and supplies
- Inpatient care in a skilled nursing facility (SNF) after a related 3-day inpatient hospital stay
- Blood (inpatient)
- Hospice care
- Home health care

Part A
Hospital Insurance

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Part A (Hospital Insurance) Covers (continued)

Part A helps cover:

- Inpatient care in a religious nonmedical health care institution (RNHCI)
  - Religious nonmedical health care institutions provide care and services to people who don't accept conventional medical care because of their religious beliefs.

Part A
Hospital Insurance

What's not covered?

- Private-duty nursing
- Private room (unless medically necessary)
- Television and phone in their room (if there's a separate charge for these items)
- Personal care items, like razors or slipper socks

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Medicare Part A Premium - 2024

- Most people get Part A premium free
  - If they or their spouse paid FICA taxes at least 10 years (40 credits)
    - FICA - Federal Insurance Contributions Act
      - Medicare Part A is financed by FICA taxes
- Premium Part A - If they paid FICA less than 10 years
  - pay a premium to get Part A
    - Under 30 credits - $505
    - Between 30 and 39 credits - $278
- Can have penalty if not bought when first eligible
  - Penalty for Medicare Part A is rare
    - 10% increase payable for twice the number of full 12-month periods the beneficiary could have been but was not enrolled in Medicare Part A.

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Part A—What they Pay in 2024

- Deductible—$1,632 for inpatient hospital stays (days 1-60)
  - For inpatient hospital stays longer than 60 days
    - $408 per day for days 61-90
    - $816 per each day beyond 90
      - "lifetime reserve days" (up to 60 in their lifetime)
    - All costs after 150 days
- Out-of-pocket maximum—None in Original Medicare
- Skilled Nursing Facility Care
  - Days 1 – 20 - $0
  - Days 21 – 100 - $204 daily copay
  - After Day 100 – all costs

NOTE: Part B pays for most of their doctor services when they are an inpatient.

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Benefit Periods in Original Medicare

- **Each benefit period:**
  - Begins the day they first get inpatient care in hospital or SNF
  - Ends after being home for 60 days in a row (not in a hospital or skilled care in a SNF)
- They pay Part A deductible for each benefit period
- No limit to number of benefit periods they can have

Benefit periods can span across calendar years

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Inpatient or Outpatient?

- Hospital status affects how much a beneficiary pays out-of-pocket, what is covered by Part A and/or Part B, and whether Medicare will cover subsequent skilled nursing facility (SNF) care.
- Medicare Outpatient Observation Notice (MOON) – provided when in observation status longer than 24 hours, but before 36th hour

Inpatient – When a beneficiary is formally admitted to the hospital with a doctor's order. The day before discharge is the last inpatient day.

Outpatient – When the doctor hasn't written an order to admit a patient, even if they spend the night.

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Medicare Part B (Medical Insurance) Covers

- Doctors' services
- Outpatient medical and surgical services and supplies
- Clinical lab tests
- Durable medical equipment (DME) (like walkers and wheelchairs)
- Diabetic testing equipment and supplies
- Preventive services (like flu shots and a yearly wellness visit)
- Home health care
- Medically necessary outpatient physical and occupational therapy, and speech-language pathology services
- Outpatient mental health care services

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Medicare Part B–Covered Preventive Services

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings and counseling
- Bone mass measurements
- Cardiovascular behavioral therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings
- Counseling to prevent tobacco use and tobacco-caused disease
- Covid vaccine and boosters
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- Hepatitis B Virus infection screening
- Hepatitis C screening tests
- HIV (Human Immunodeficiency Virus) screenings
- Lung cancer screenings
- Mammograms
- Medicare Diabetes Prevention Program
- Nutrition therapy services
- Obesity behavioral therapy
- Pneumococcal shots
- Prostate cancer screenings
- Sexually transmitted infection (STI) screenings & counseling
- "Welcome to Medicare" preventive visit
- Yearly "Wellness" visit

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Assignment

- Beneficiaries can get the lowest cost if their doctor or other health care provider accepts the Medicare-approved amount as full payment for a covered service. This is called “accepting assignment.”
- These providers are consider “participating”
  - If a provider accepts assignment, it’s for all Medicare-covered Part A and Part B services.
- Some providers who don’t accept assignment still choose to accept the Medicare-approved amount for services on a case-by-case basis. These providers are called "non-participating.“ If the doctor, provider, or supplier doesn't accept assignment:
  - Might have to pay the full amount at the time of service.
  - Providers should submit a claim to Medicare for any Medicare-covered services they provide, and they can’t charge for submitting a claim. If they refuse to submit a Medicare claim, beneficiaries can submit their own claim to Medicare.

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Limiting Charge

- Non-participating providers can charge up to 15% over the Medicare-approved amount for a service, but no more than that. This is called "the limiting charge“ or Excess charges.
- The limiting charge only applies to certain Medicare-covered services. It doesn't apply to some supplies and durable medical equipment, so their costs could be higher.
  - If DME suppliers aren’t participating and don’t accept assignment, there’s no limit on the amount they can charge they.

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Part B Premiums

- 2024 Premiums
  - Standard premium—$174.70 (or higher depending on their income)
  - The Medicare hold harmless provision prohibits Medicare Part B premiums from reducing the amount of an individual's Social Security benefits year over year.
  - Beneficiaries who were subject to the “hold harmless” provision will pay less, as the increase in their Social Security benefits will not be large enough to cover the increased Part B premium.

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Medicare Part B Costs for Most People

Yearly Deductible	$240.00
Coinsurance for Part B Services	▪ 20% coinsurance for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for some preventive services ▪ 20% coinsurance for outpatient mental health services, and copayments for hospital outpatient services

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Monthly Part B Standard Premium — Income-Related Monthly Adjustment Amount for 2024

Yearly Income in 2022			They Pay
File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	
$103,000 or less	$206,000 or less	$103,000 or less	$174.70
above $103,000 up to $129,000	above $206,000 up to $258,000	Not applicable	$244.60
above $129,000 up to $161,000	above $258,000 up to $322,000	Not applicable	$349.40
above $161,000 up to $193,000	above $322,000 up to $386,000	Not applicable	$454.20
above $193,000 and less than $500,000	above $386,000 and less than $750,000	above $103,000 and less than $397,000	$559.00
$500,000 or above	$750,000 or above	$397,000 or above	$594.00

NOTE: they may pay more if they have a Part B late enrollment penalty.

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Medicare Drug Coverage Monthly Premium & Income-Related Monthly Adjustment Amounts (IRMAA)

What's IRMAA?	It's an extra amount some people have to pay in addition to their plan premium.
Does everyone pay IRMAA?	No. It's based on income. Fewer than 7% have to pay it.
What if they owe Part D IRMAA but don't pay it?	They'll be disenrolled from Medicare drug coverage.
Where does the money go?	The IRMAA amount goes to the government for the Medicare Trust Fund.

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Paying the Part B Premium

- Deducted monthly from
  - Social Security benefit payments
  - Railroad retirement benefit payments
  - Federal retirement benefit payments
- If not deducted
  - Billed every 3 months
  - Medicare Easy Pay to deduct from bank account
- Contact Social Security, the Railroad Retirement Board, or the Office of Personnel Management about premiums

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Part B Late Enrollment Penalty

- See how their insurance works with Medicare
  - Contact the employer/union benefits administrator
- Penalty for not signing up when first eligible
  - 10% more for each full 12-month period
  - May have a penalty as long as they have Part B
- Sign up during a Special Enrollment Period
- Usually no penalty if they sign up within 8 months of employer coverage ending
- If a beneficiary has age or disability Medicare with a Part B late enrollment penalty (LEP) before developing ESRD, they can eliminate the LEP, by enrolling in ESRD Medicare which waives the Part B LEP.

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Part B Special Enrollment Period Employer or Union Coverage

- May affect Part B enrollment rights
  - May want to delay enrolling in Part B if
    - have employer or union coverage and
    - The employer has 20 or more employees if employee is over 65, or 100 or more employees if disabled
    - beneficiary or spouse, or family member if disabled, are still working
- See how employer insurance works with Medicare
  - Contact employer/union benefits administrator
  - Don't make assumptions

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When Employer or Union Coverage Ends

- When employment ends
  - May get a chance to elect COBRA
    - COBRA – not insurance based on active employment
  - May get a Special Enrollment Period
    - Sign up for Part B without a penalty

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When One Must Have Part B

- Want to buy a Medigap policy
- Want to join a Medicare Advantage Plan
- Eligible for TRICARE for Life (TFL) or CHAMPVA
- Employer coverage requires it when become eligible for Medicare (less than 20 employees)
  - Talk to employer's or union benefits administrator
- Veterans Affairs (VA) benefits are separate from Medicare
  - Will pay a penalty if sign up late or if don't sign up during Medicare Initial Enrollment Period

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What's Not Covered by Part A & Part B?

- Most dental care
- Vision (for prescription glasses)
- Dentures
- Cosmetic surgery
- Massage therapy
- Routine physical exams
- Hearing aids and exams for fitting them
- Long-term care
- Concierge care
- Covered items or services you get from an opt out doctor or other provider

They may be covered if you have other coverage, like Medicaid or a Medicare Advantage Plan that covers these services.

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Medicare Advantage Plans

- ☑ Part A
- ☑ Part B

Most plans include:

- ☑ Part D
- ☑ Some extra benefits

Some plans also include:

- ☐ Lower out-of-pocket costs

- A Medicare Advantage Plan is another way to get Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) coverage (sometimes called "Part C")
- Offered by Medicare-approved private companies that must follow rules set by Medicare
- If they join a Medicare Advantage Plan, they'll still have Medicare but will get Part A and Part B coverage from the Medicare Advantage Plan, not Original Medicare
  - In most cases, they'll need to use health care providers who participate in the plan's network (some plans offer out-of-network coverage)

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How Medicare Advantage Plans Work

In a Medicare Advantage Plan, they:

- Are still in Medicare with all rights and protections
- Still get services covered by Part A and Part B
- May choose a plan that includes drug coverage
- Can be charged different out-of-pocket costs
- Can't be charged more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility (SNF) care
- May choose a plan with extra benefits like vision, dental or fitness and wellness benefits
- Have a yearly limit on out-of-pocket costs

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How Medicare Advantage (MA) Plans Work (Continued)

- Each plan has a service area in which its enrollees must live
- They (or a provider acting on their behalf) can request to see if an item or service will be covered by the plan in advance (called an organization determination)
  - Contact their plan for more information
- Medicare pays a fixed amount for coverage each month to the companies offering Medicare Advantage Plans
- Each plan can have different rules for how members get services
  - These rules can change each year
- Hospice care is covered, but by Original Medicare Part A

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Original Medicare vs. Medicare Advantage Doctor and Hospital Choice

Original Medicare	Medicare Advantage (Part C)
Can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.**	In many cases, members will need to use **doctors and other providers who are in the plan's network** (for non-emergency care). Some plans offer non-emergency coverage out-of-network, but typically at a higher cost.
In most cases, **don't need** a referral to see a specialist.	Members **may need** to get a referral to see a specialist.

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Original Medicare vs. Medicare Advantage - Cost

Original Medicare	Medicare Advantage
For Part B-covered services, **will usually pay 20% of the Medicare-approved amount** after they meet their deductible. This is called their coinsurance.	**Out-of-pocket costs vary**—plans may have different out-of-pocket costs for certain services.
Will **pay a premium (monthly payment) for Part B**. If choosing to join a Medicare drug plan, will pay that premium separately for Medicare drug coverage (Part D).	Will pay the monthly **Part B premium** and may also have to **pay the plan's premium**. Plans may have a $0 premium and may help pay all or part of Part B premium. Most plans include Medicare drug coverage (Part D).
There's **no yearly limit** on what out-of-pocket payments, unless have supplemental coverage—like Medicare Supplement Insurance (Medigap).	Plans have a **yearly limit** on what out-of-pocket for services Medicare Part A and Part B covers. Once plan's limit is reached, will pay nothing for services Part A and Part B covers for the rest of the year.
Can get Medigap to help pay remaining out-of-pocket costs (like 20% coinsurance). Or can use coverage from a former employer or union, or Medicaid.	**Can't buy and don't need** Medigap.

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Original Medicare vs. Medicare Advantage - Coverage

Original Medicare	Medicare Advantage (Part C)
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams.	Plans must cover all of the medically necessary services that Original Medicare covers. Most plans offer some **extra benefits that Original Medicare doesn't cover**—like some routine exams and vision, hearing, and dental services.
Can join a **separate Medicare drug plan** to get drug coverage (Part D).	**Medicare drug coverage (Part D) is included in most plans**. In most types of Medicare Advantage Plans, can't join a separate Medicare drug plan.
In most cases, don't have to get a service or supply approved ahead of time for Original Medicare to cover it.	In some cases, will have to get a service or supply approved ahead of time for the plan to cover it.

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When One Can Join or Switch Medicare Advantage Plans

Initial Enrollment Period	▪ 7-month period begins 3 months before the month they turn 65 ▪ Includes the month they turn 65 ▪ Ends 3 months after the month they turn 65
Medicare Open Enrollment Period "Open Enrollment"	▪ October 15–December 7 ▪ Coverage begins January 1
Medicare due to a Disability	▪ 7-month period begins 3 months before the 25th month of disability. ▪ Ends 3 months after the 25th month of disability.
Special Enrollment Periods (SEP)	▪ They can make changes to their Medicare Advantage and Medicare prescription drug coverage when certain events happen in their life, like if moving or losing other insurance coverage. Rules are different for each SEP.
Medicare Advantage Open Enrollment Period (MA-OEP)	▪ January 1 – March 31 - Medicare Advantage Plan members

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Medicare Advantage Open Enrollment Period (MA-OEP)

- January 1st through March 31st annually.
- This is in addition to the Fall Open Enrollment Period
- The Medicare Advantage OEP is somewhat more limited than the Fall Open Enrollment Period.
- Allows individuals ***enrolled in an MA plan to make a one-time election*** during this three-month period to go to another MA plan or Original Medicare.
- If they enrolled in a Medicare Advantage Plan during their Initial Enrollment Period, they can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months they have Medicare.
- Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage.

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Types of Medicare Health Plans

- Health Maintenance Organization (HMO)
  - HMO Point-of-Service (HMO-POS)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- Medicare Medical Savings Account
- Programs of All-Inclusive Care for the Elderly (PACE) Plans
- Medicare Cost Plan

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Medicare Health Maintenance Organization (HMO) Plan

Can they get their health care from any doctor, other health care provider, or hospital?	No. they generally must get their care and services from doctors, other health care providers, or hospitals in the plan's network (except for emergency care, out-of-area urgent care, or temporary out-of-area dialysis, which is covered whether it's provided in the plan's network or outside the plan's network). However, some HMO plans, known as HMO Point-of-Service (HMOPOS) plans, offer an out-of-network benefit.
Are prescription drugs covered?	In most cases, yes. If they want Medicare drug coverage, they must join an HMO plan that offers drug coverage.
Do they need to choose a primary care doctor?	In most cases, yes. However, if a plan network provider believes that their best treatment for a condition should be obtained out-of-network, this provider may refer they outside the network.
Do they need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
What else do they need to know about this type of plan?	▪ If their doctor or other health care provider leaves the plan's network, their plan will notify they. they may choose another doctor in the plan's network. ▪ If they get health care outside the plan's network, they may have to pay the full cost. ▪ It's important that they follow the plan rules, like getting prior approval for a certain service when needed. ▪ Check with the plan for more information.

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Medicare Preferred Provider Organization (PPO) Plan

Can they get their health care from any doctor, other health care provider, or hospital?	Yes. PPO plans have network doctors, specialists, hospitals, and other health care providers they can use, but they can also use out-of-network providers for covered services, usually for a higher cost. they're always covered for emergency and urgent care.
Are prescription drugs covered?	In most cases, yes. If they want Medicare drug coverage, they must join a PPO plan that offers drug coverage. If they join a PPO plan without drug coverage, they can't join a separate Medicare drug plan.
Do they need to choose a primary care doctor?	No.
Do they need a referral to see a specialist?	In most cases, no. But if they use plan specialists (in-network), their costs for covered services will usually be lower than if they use non-plan specialists (out-of-network).
What else do they need to know about this type of plan?	▪ Because certain providers are "preferred," they can save money by using them. ▪ A PPO plan isn't the same as Original Medicare or Medicare Supplement Insurance (Medigap). ▪ It usually offers extra benefits than Original Medicare, but they may have to pay extra for these benefits. ▪ Check with the plan for more information.

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Medicare Private Fee-for-Service (PFFS) Plan

Can they get their health care from any doctor, other health care provider, or hospital?	they can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat they. If they join a PFFS plan that has a network, they can also see any of the network providers who have agreed to always treat plan members. they can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but they may pay more.
Are prescription drugs covered?	Sometimes. If their PFFS plan doesn't offer drug coverage, they can join a separate Medicare drug plan to get drug coverage.
Do they need to choose a primary care doctor?	No.
Do they need a referral to see a specialist?	No.

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Medicare Private Fee-for-Service (PFFS) Plan (continued)

What else do they need to know about this type of plan?	▪ The plan decides how much they pay for services. The plan will tell they about their cost sharing in the "Annual Notice of Change" and "Evidence of Coverage" documents that it sends each year. ▪ Some PFFS plans contract with a network of providers who agree to always treat they, even if they've never seen them before. ▪ Out-of-network doctors, hospitals, and other providers may decide not to treat they, even if they've seen them before. ▪ In a medical emergency, doctors, hospitals, and other providers must treat they. ▪ For each service they get, make sure to show their plan member card before they get treated. ▪ Check with the plan for more information.

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Medicare Special Needs Plans (SNPs)

Can they get their health care from any doctor, other health care provider, or hospital?	Some SNPs cover services out-of-network and some don't. Check with the plan to see if they cover services out-of-network, and if so, how it affects their costs.
Are prescription drugs covered?	Yes. All SNPs must provide Medicare drug coverage.
Do they need to choose a primary care doctor?	Generally, yes.
Do they need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

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Medicare Special Needs Plans (SNPs) (continued)

What else do they need to know about this type of plan?	▪ They're eligible to enroll in a SNP if: • They live in certain institutions (like nursing homes), or require nursing care at home (also called an "Institutional SNP" or "I-SNP"). • They're eligible for both Medicare and Medicaid (also called a "Dual Eligible SNP" or "D-SNP"). D-SNPs contract with their state Medicaid program to help coordinate their Medicare and Medicaid benefits. • They have specific severe or disabling chronic conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia (also called a "Chronic condition SNP" or "C-SNP"). Plans may further limit membership. ▪ A SNP provides benefits targeted to its members' special needs, including care coordination services. ▪ Visit Medicare.gov/plan-compare to find and compare Medicare Advantage Plans and see if SNPs are available in their area. ▪ Check with the plan for more information.

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Medicare Medical Savings Account (MSA) Plans

Can they get their health care from any doctor, other health care provider, or hospital?	Yes. MSA plans don't always have a network of doctors, other health care providers, and hospitals.
Are prescription drugs covered?	No. If they join a Medicare MSA plan and need drug coverage, they'll have to join a separate Medicare drug plan.
Do they need to choose a primary care doctor?	No.
Do they need a referral to see a specialist?	No.

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Medicare Medical Savings Account (MSA) Plans (continued)

What else do they need to know about this type of plan?	The plan deposits money into a special savings account. The amount of the deposit varies by plan. they can use this money to pay their Medicare-covered health care costs before they meet the deductible (including health care costs that aren't covered by Medicare). Money left in their account at the end of the year stays there, and may be used for health care costs in future years. If they keep their plan the following year, their plan will add any new deposits to the amount left over. ▪ MSA plans don't charge a premium, but they must continue to pay their Part B premium. ▪ Some plans may cover extra benefits, like dental, vision, and hearing. they may pay a premium if they use these services. ▪ For more information about using their MSA plan, visit Medicare.gov, or check with their plan. ▪ Visit Medicare.gov/plan-compare to see if MSA plans are available in their area.

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Other Health Plans—Medicare Cost Plans

- They can join even if they only have Part B
- If they have Part A and Part B and go to a non-network provider, their services are covered under Original Medicare
  - They'll pay the Part A and Part B coinsurance and deductibles
- They can join anytime the plan accepts new members
- They can leave anytime and return to Original Medicare
- They can either get their Medicare drug coverage from the Cost Plan (if offered) or they can join a Medicare drug plan

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Medicare Cost Plans

- Defined in Section 1876 of the Social Security Act, and Title 42, Part 417 of the Code of Federal Regulations, "Cost Plans":
  - Aren't Medicare Advantage Plans
  - Can enroll people with Part A and Part B, or Part B only
  - May offer Medicare drug coverage or non-qualified coverage but not both
  - Available in limited areas
  - No new Cost Plans accepted by the Centers for Medicare & Medicaid Services (CMS)
- People with Medicare enrolled in a Cost Plan:
  - Aren't restricted to the Health Maintenance Organization (HMO) network to get covered Part A and Part B services
    - May use non-HMO plan sources and are reimbursed separately by Original Medicare
  - Don't have to take the Cost Plan's drug coverage, and can choose to get drug coverage from a separate Medicare drug plan

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Other Health Plans—Programs of All-inclusive Care for the Elderly (PACE)

- To qualify, they must meet these conditions:
  - They're 55 or older
  - They live in the service area of a PACE organization
  - They're certified by their state as needing a nursing home-level of care
  - At the time they join, they're able to live safely in the community with the help of PACE services
- Covers all Medicare- and Medicaid-covered care and services
- If they have Medicaid, they won't have to pay a monthly premium for the long-term care portion of the benefit
- If they have Medicare, but not Medicaid, they'll be charged a monthly premium to cover the long-term care portion of the benefit and a premium for Medicare Part D drugs

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Expanded Health-Related Extra Benefits

- An item or service is considered "primarily health-related" if it's used to:
  - Diagnose, prevent, or treat an illness or injury
  - Compensate for physical impairments
  - Improve the functional/psychological impact of injuries or health conditions
  - Reduce avoidable emergency and health care use
- Benefit must focus on enrollee's health care needs and be recommended by a licensed medical professional as part of a care plan, if not provided by one

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Allowable Extra Benefits

- Dental services
- Vision services
- Hearing services
- Extra inpatient days
- Routine foot care
- Wellness benefits
- Adult day care services
- Home-based palliative care
- In-home support services
- Support for caregivers of enrollees
- Medically-approved non-opioid pain management
- Stand-alone memory fitness benefit
- Home and bathroom safety devices and modifications
- Non-emergency transportation
- Over-the-counter (OTC) benefits

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Special Benefits for the Chronically Ill

Medicare Advantage Plans may offer additional benefits that aren't "primarily health-related" benefits:

- To enrollees who are "chronically ill enrollees."
- When the additional benefits have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

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Non-Primarily Health-Related Items or Services Examples

"Non-primarily health-related" item or service examples that may meet the criteria if the statute requirements are met:

- Home-delivered meals, food, and produce
- Complementary therapies
- Transportation for non-medical needs
- Services supporting self-direction
- Pest control
- Structural home modifications
- Indoor air quality equipment and services
- General supports for living
- Social needs benefits

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Drug Coverage Under Medicare

- Some prescription drugs are covered under either Part A or Part B, but coverage is limited
- For more comprehensive drug coverage, may sign up for Medicare drug coverage (Part D)
- If have a Medicare health plan with drug coverage, will get all Medicare-covered health care (Part A and Part B) from the plan, including covered prescription drugs (Part D)
- Which part of Medicare covers prescription drugs, depends on:
  - Medical necessity
  - Health care setting
  - Medical indication (why it is needed)
  - Relevant law
  - Any special drug coverage requirements, like immunosuppressive drugs following a transplant

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Part A & Part B Prescription Drug Coverage

- Part A generally pays for all drugs during a covered inpatient stay received as part of treatment in a hospital or skilled nursing facility
  - Drugs used in hospice care for symptom control and pain relief only
- Part B covers limited outpatient drugs
  - Most injectable and infusible drugs given as part of a doctor's service
  - Drugs and biologicals used for the treatment of End-Stage Renal Disease (ESRD)
  - Drugs used at home with some types of Part B-covered durable medical equipment (DME)
  - Some oral drugs with special coverage requirements
  - Some antigens
  - Blood clotting factors

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Part B Immunization Coverage

If they meet the criteria, Part B covers the:

Part B
Medical
Insurance

- COVID-19 vaccine and boosters
- Flu shot
- Pneumococcal shot (to prevent certain types of pneumonia)
- Hepatitis B shot
- Tetanus shot and other vaccines they get to treat an injury or if they've been exposed directly to a disease or condition

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Part B Immunosuppressive Drug (Part B-ID) Coverage

If bene loses (or will lose) Part A coverage 36 months after a kidney transplant, they may be able to get Part B immunosuppressive drug (Part B-ID) coverage

Part B
Immunosuppressive
Drug Coverage

- They can't be enrolled in certain other types of health coverage
- Coverage can't be earlier than January 1, 2023
- Only applies to immunosuppressive drugs; won't get Medicare coverage for any other items or services

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Part B Immunosuppressive Drug (Part B-ID) Coverage (continued)

Part B-ID:

- Doesn't have specific enrollment periods. If an individual qualifies, they can enroll, disenroll, or re-enroll at any time on a monthly basis.
- Requires applicant to attest that they don't have and don't expect to get certain other types of health coverage.
- Has a lower premium than the standard Part B premium, and doesn't have late enrollment penalties.
  - $103.00 premium for 2024
  - Premium amount may be more depending on income
  - Part B deductible and 20% coinsurance apply

NOTE: if also qualify for Medicare Savings Programs (MSPs), they may help to pay the premium, deductible, and/or coinsurance for Part B-ID

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Insulin Paid for by Medicare Part B

If someone takes insulin through a traditional pump covered under Medicare's DME benefit, that insulin is covered under Medicare Part B. These benefits go into effect on July 1, 2023.

- Insulin is capped at $35 for a one-month supply of insulin
- No deductible will be applied to Part B-covered insulin

NOTE: if they use a **disposable** pump, the insulin for that pump is covered under Medicare Part D

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Self-Administered Drugs in Hospital Outpatient Settings

Part B
Medical Insurance

Part B **doesn't cover** self-administered drugs in a hospital outpatient setting

Part D
Medicare drug coverage

If enrolled, Medicare drug coverage (Part D) **may cover** the self-administered drugs:

- If aren't admitted as an inpatient in a hospital
- May have to pay and submit for reimbursement
- The drug needed must be on drug plan's formulary (list of covered drugs)

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Medicare Drug Coverage (Part D)

Part D
Medicare drug coverage

Plans that offer Medicare drug coverage are:

- Approved by Medicare
- Run by private companies
- Available to everyone with Medicare

In most cases, must take action to join a plan.

There are 2 ways to get coverage:

- Medicare drug plans
- Medicare Advantage Plans or other Medicare health plans with drug coverage

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Medicare Drug Coverage

Must offer at least a standard level of coverage set by Medicare.
These plans can differ in:

Combinations of coverage and cost-sharing

Benefit structures, including "tiers" of copayments and coinsurance

Costs for different types of drugs

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Medicare Drug Coverage Costs

In 2024, most people will pay:

- Monthly premium
- Yearly deductible

Costs vary by plan

During initial coverage

Will pay copayments or coinsurance

During coverage gap ("donut hole")

Will pay no more than **25%** of the cost for covered prescription drugs once bene and plan spend **$5,030** combined on covered drugs, including the deductible

During catastrophic coverage

Will pay no co-pay once out-of-pocket spending reaches **$8,000**

NOTE: Starting in 2024, people with Medicare won't have to pay any coinsurance or copayments in the catastrophic coverage phase for covered Medicare prescription drugs

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Medicare Part D – 2024-2025 Comparison

Part D Benefit Parameters	2024	2025
Standard Benefit		
Deductible	$545	$590
Initial Coverage Limit	$5,030	Not Applicable
Out-of-Pocket Threshold	$8,000	$2,000
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries	$11,477.39	
Estimated Total Covered Part D Spending for Applicable Beneficiaries	$12,447.11	

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True Out-of-Pocket (TrOOP) Costs

What are TrOOP costs?	They're expenses that count toward the out-of-pocket threshold of $7,400 (for 2023).
If they pay for a drug out of pocket because it's less expensive, can it count as part of TrOOP?	Yes. Pharmacists have to tell bene if a better price is available without going through their plan.
Where can I find my TrOOP costs to date?	Check Explanation of Benefits (EOB).
What happens after they reach the threshold?	They get catastrophic coverage.
What if they switch plans during the year?	Their TrOOP balance transfers to their new drug plan.

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What Payments Count Toward True Out-of-Pocket (TrOOP)?

Payments made by:

- Beneficiary
- Family members or friends
- Qualified State Pharmacy Assistance Programs (SPAPs)
- Medicare's Extra Help (LIS)
- Indian Health Service (IHS)
- Most charities
- Drug manufacturers providing discounts on brand-name drugs under the Medicare coverage gap discount program
- AIDS Drug Assistance Programs (ADAPs)

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What Payments Don't Count Toward True Out-of-Pocket (TrOOP)?

- Amount paid by a drug plan
- Monthly drug plan premium
- Drugs purchased outside the U.S. and its territories
- Drugs not covered by the plan
- Drugs excluded from the definition of a Part D drug
- Over-the-counter drugs or most vitamins

- Payments made by, or reimbursed to you by:
  - Group health plans (GHP) or retiree coverage
  - Government-funded programs
  - Other third-party groups
  - Patient Assistance Programs (PAPs) operating outside the Part D benefit
  - Other types of insurance

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2025 Part D Improvements and Maximum Out-of-Pocket Cap for People with Medicare

In CY 2025, the structure of the Part D benefit is updated to reflect provisions of the IRA that become effective on January 1, 2025. The CY 2025 updates include the following:

- A newly defined standard Part D benefit design consisting of three phases: annual deductible, initial coverage, and catastrophic coverage;
- A lower annual out-of-pocket (OOP) threshold of $2,000;
- The sunset of the Coverage Gap Discount Program (CGDP) and establishment of the Manufacturer Discount Program (Discount Program);
- Changes to the liability of enrollees, Part D sponsors, manufacturers, and CMS in the newly defined standard Part D benefit design.

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Out-of-Pocket Spending Cap for Medicare Part D

- Reduces the government reinsurance in the catastrophic phase of Part D coverage for applicable drugs from 80% to 20%; and for non-applicable drugs (generics) from 80% to 40%.
  - The term "applicable drugs" includes brand drugs, biologicals, and biosimilars, but excludes "selected drugs" during their "price applicability period" under the new Drug Price Negotiation Program.
  - Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug, such as generic drug

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Additional 2025 Part D Changes

- Eliminates the coverage gap phase and coverage gap discount program,
- Replaces it with a manufacturer discount program that requires manufacturers to provide discounts on their "applicable drugs" (brand drugs, biologics, biosimilars, but not "selected drugs" during their price applicability period under the new Drug Price Negotiation Program) both in the initial coverage phase and in the catastrophic phase of the Part D benefit.
- In general, manufacturers must provide a 10% discount in the initial phase and a 20% discount in the catastrophic phase; however, the manufacturer discounts are phased-in over a period of 5 to 7 years (2025 through 2029 or 2031) for certain drugs dispensed to low-income subsidy (LIS) beneficiaries) and certain small manufacturers meeting certain criteria.

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Additional 2025 Part D Changes (cont.)

- Creates a new Selected Drug Subsidy Program under which the government provides a subsidy (equal to 10% of the drug's negotiated price) to Part D sponsors with respect to "selected drugs" dispensed to the sponsor's enrollees who are in their initial phase of the Part D benefit.
- Requires Part D sponsors to provide their plan enrollees with the option to pay out-of-pocket costs under the plan in monthly amounts that are spread out throughout the year, beginning in plan year 2025. The plan must determine a maximum monthly cap for plan enrollees electing to spread their out-of-pocket costs in monthly amounts.

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Part D Improvements (cont.)

- Eliminates the coverage gap phase and coverage gap discount program, and replaces it with a manufacturer discount program that requires manufacturers to provide discounts on their "applicable drugs"
- Creates a new Selected Drug Subsidy Program under which the government provides a subsidy (equal to 10% of the drug's negotiated price) to Part D sponsors with respect to "selected drugs" dispensed to the sponsor's enrollees who are in their initial phase of the Part D benefit
- Provides all Part D beneficiaries an option to elect to pay cost sharing including coinsurance and the deductible up to the annual out-of-pocket (OOP) threshold for Part D-covered drugs in monthly amounts to allow the beneficiaries to spread their OOP costs over several months during the plan year

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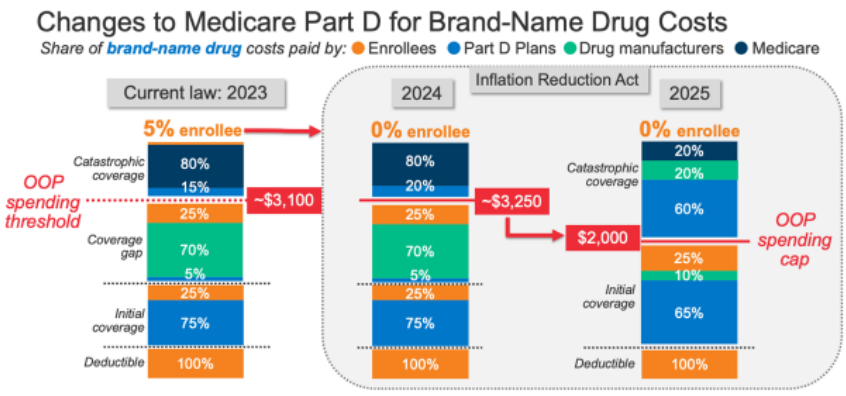
How it will work



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Part D Income-Related Monthly Adjustment Amount (IRMAA) - 2024

Yearly Income in 2022			Will Pay
$103,000 or less	$206,000 or less	$103,000 or less	your plan premium
above $103,000 up to $129,000	above $206,000 up to $258,000	Not applicable	$12.90 + your plan premium
above $129,000 up to $161,000	above $258,000 up to $322,000	Not applicable	$33.30 + your plan premium
above $161,000 up to $193,000	above $322,000 up to $386,000	Not applicable	$53.80 + your plan premium
above $193,000 and less than $500,000	above $386,000 and less than $750,000	above $103,000 and less than $397,000	$74.20 + your plan premium
$500,000 or above	$750,000 or above	$397,000 or above	$81.00 + your plan premium

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Medicare Drug Coverage: Covered Drugs

- Prescription brand-name and generic drugs must be:
  - Approved by the U.S. Food & Drug Administration (FDA)
  - Used and sold in U.S.
  - Used for medically accepted indications
- Includes prescription drugs, biological products, and supplies associated with injection of insulin
- Plans must cover a range of drugs in each category

Coverage and rules vary by plan.

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Required Coverage

All drugs in 6 protected classes

1. Cancer drugs (Antineoplastic)
2. HIV/AIDS drugs (Antiretroviral)
3. Antidepressants
4. Antipsychotics
5. Anticonvulsants
6. Immunosuppressants

- All commercially available vaccines
- People with Medicare drug coverage (Part D) pay nothing out of pocket for vaccines for adults (including the shingles vaccine) that are recommended by the Advisory Committee on Immunization Practices (ACIP)
- Some vaccines are covered under Medicare Part B (Medical Insurance), like the flu, COVID-19, and pneumococcal shots

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Drugs Excluded by Law from Medicare Drug Coverage

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Over-the-counter drugs

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How Plans Manage Access to Drugs

Formulary	▪ All plans must cover a wide range of prescription drugs that people with Medicare take ▪ A plan's list of covered drugs, sorted into tiers
Prior Authorization	▪ You or your prescriber must contact the plan for prior approval and show medical necessity before drug will be covered ▪ Prescriber may request an exception
Step Therapy	▪ Must first try similar, less expensive drug ▪ Prescriber may request an exception
Quantity Limits	▪ Plan may limit drug quantities over a period of time for safety and/or cost ▪ Prescriber may request an exception if an additional amount is medically necessary

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Formulary Tiers

Plans may have tiers that cost different amounts.

Tier Structure Example

Tier(s)	You Pay	Prescription Drugs Covered
1 and 2	Lowest copayment	Preferred generics and generics
3	Medium copayment	Preferred, brand-name
4	High copayment	Non-preferred, brand-name
5 (Or Specialty)	Highest copayment or coinsurance	Unique, very high cost

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Formulary Changes

Medicare plans:

May only change therapeutic categories and classes at the beginning of each plan year

Usually notify you 30 days before changes or when you request a refill and will provide you a month's refill

May immediately remove drugs from the formulary (without notice and at any time) for various reasons

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Formulary Changes (continued)

Plans can remove or change the price for a brand-name drug if:

- The **generic drug became available** on the market after the plan submitted its initial formulary
- It **adds a therapeutically equivalent generic drug** to the formulary

Plans must report changes to:

- All plan members and prospective enrollees
- The Centers for Medicare & Medicaid Services (CMS) and other entities in advance
- Affected enrollees

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Exception Requests

- Two types of exceptions
  1. Formulary exceptions
     - Drug not on plan's formulary, or
     - Access requirements (for example, step therapy)
  2. Tier exceptions
     - For example, getting a tier 4 drug at tier 3 cost
- Exception may be valid for rest of year

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Elimination of Gag Clauses

Ask your pharmacist if there's a less expensive option.

The Know the Lowest Price Act:

- **Prohibits** Medicare drug plans from restricting or penalizing a pharmacy for disclosing price information to an enrollee
- **Allows** pharmacies to disclose the difference between the negotiated price and a lower price available without using any health insurance coverage
- **Gives** enrollees the option to pay cash at the pharmacy and submit claim to plan for reimbursement and true out-of-pocket (TrOOP) counting

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Insulin Products & Medicare Drug Plans

The cost of a month's supply of each Part D-covered insulin is capped at $35, and you don't have to pay a deductible for insulin

- If you get a 60- or 90-day supply of insulin, your costs can't be more than $35 for each month's supply of each covered insulin

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If Your Prescription Changes

- Get up-to-date formulary information from your plan
- Have your prescriber check which drugs your drug plan covers
- If the new drug isn't on the plan's formulary, you:
  - Can request an exception from the plan
  - May have to pay full price if plan still won't cover the drug
  - May consider changing your drug plan when permissible to one that does cover the drug
  - Can ask your doctor for any therapeutic alternative
  - Can appeal

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Medicare Drug Coverage Eligibility Requirements

You need to have	You must also	You can't
▪ Medicare Part A (Hospital Insurance) and/or Part B (Medical Insurance) to join a Medicare drug plan ▪ Part A and Part B to join a Medicare Advantage Plan with drug coverage	▪ Join a plan to get drug coverage (in most cases) ▪ Live in the plan's service area	▪ Be incarcerated ▪ Be unlawfully present in the U.S. ▪ Live outside the U.S.

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Creditable Drug Coverage

Coverage that's expected to pay, on average, at least as much as Medicare's standard drug coverage:

Each year, plans inform you if your coverage is "creditable" or "non-creditable"

Any lapse of 63 days or more in creditable coverage, and you may have to pay a late enrollment penalty if you join Medicare drug coverage later

NOTE: if your drug coverage is creditable, you can choose to keep it

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When they Can Join or Switch Plans

- During their Initial Enrollment Period when they first become eligible for Medicare or when they turn 65.
- During certain enrollment periods that happen each year.
  - Open Enrollment Period (OEP) October 15 – December 7 annually
  - Medicare Advantage Open Enrollment Period January 1 – March 31 annually
- Under certain circumstances that qualify they for a Special Enrollment Period (SEP)
  - General Enrollment Period Part D SEP would begin when the individual submits their premium-Part A or Part B application and would continue for the first 2 months of enrollment in premium Part A or Part B. The MA or Part D plan enrollment would be effective the first of the month following the month the MA or Part D plan receives the enrollment request.

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Special Enrollment Period (SEP)

- Life events that allow an SEP include
  - Permanently move out of plan's service area
  - Lose other coverage
  - Weren't properly told that other coverage wasn't creditable, or other coverage was reduced and is no longer creditable
  - Enter, live at, or leave a long-term care facility
  - Belong to a State Pharmaceutical Assistance Program (SPAP) (not available in Kansas)
  - Join or switch to a plan that has a 5-star rating
  - Gain, lose, or have a change in dual eligible (including partial duals) or Extra Help status
  - Have been assigned into a plan by Medicare or the state
  - Other exceptional circumstances

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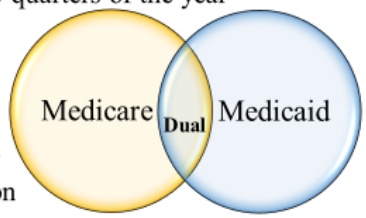
Extra Help, Dual and Partial Dual Eligible Special Enrollment Period (SEP)

If they have Medicare and any form of Medicaid (full assistance, have a Medicare Savings Program, and/or get Extra Help), they

- Can change plans one time per calendar quarter in the first 3 quarters of the year (January–March, April–June, and July–September)
- Can use Annual OEP in the fourth quarter
- Have another 3-month SEP following:
  - A gain, loss, or change to Medicaid or Extra Help status
  - Notification of a CMS or state-initiated enrollment action



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Extra Help & Dual Eligible Special Enrollment Period (SEP) Limitations

Drug management programs (DMPs) help enrollees use opioids safely

Individuals considered "potentially at risk" or "at risk" for opioid misuse **can't** use the Extra Help and Dual Eligible SEP

Other enrollment periods are still available—OEP, other SEPs

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Consistently Low Performing Plans

Low performing star rating status

- Given to plans that have an overall star rating of "poor" or below "average"
- Low Performing Icon (LPI) appears on Plan Finder
- Plans may not attempt to discredit their LPI status by showcasing a separate higher rating
- CMS mails a notice to plan members in October so they can consider changing plans during the OEP

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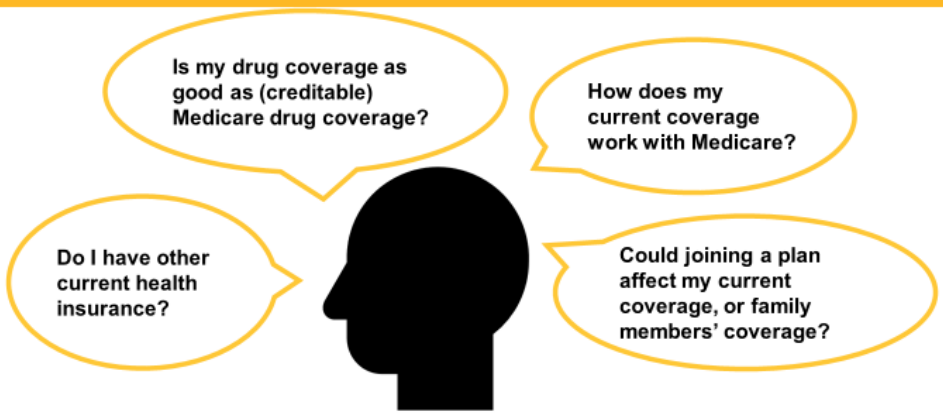
Things to Consider Before Joining a Plan



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Annual Notice of Change (ANOC) & Evidence of Coverage (EOC)

All Medicare plans must send to members:

ANOC

No later than September 30:

- Letter explaining any changes to your current plan (like premiums and cost-sharing)
- Benefits summary
- Notification of availability of electronic materials
- Provider and pharmacy directory
- "Opt-in" email option for future notices
- Copy of the formulary for the upcoming year

EOC

No later than October 15:

- Plan's service area details
- Benefits
- Formulary
- How to get information, benefits, and Extra Help
- How to file an appeal

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Part D Late Enrollment Penalty

- You may have to pay more if you wait to enroll, unless you have:
  - Creditable drug coverage
  - Extra Help
- Your Medicare plan is required to tell you if you owe a penalty
  - 1% for each full month eligible and without creditable drug coverage
  - Multiply percentage by base beneficiary premium ($34.70 in 2024)
  - Amount changes every year

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Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize their search to find plans that meet their needs
- Compare plans based on star ratings, benefits, costs, and more
- Visit https://www.medicare.gov/plan-compare

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What Is Extra Help?

- Program to help people pay for Part D drug costs
  - Also called the low-income subsidy (LIS)
- For people with limited income and resources
  - Low income and resources
    - Pay no premiums or deductible and small or no copayments
- They won't enter the coverage gap or pay late enrollment penalty if they qualify
- If they reach catastrophic coverage limit ($8,000) and have Extra Help, they'll pay nothing for covered drugs for the rest of the year in 2024. Eliminated in 2025
- Residents of U.S. territories aren't eligible

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Qualifying for Extra Help

- Automatically qualify for Extra Help if they get
  - Full Medicaid coverage
  - Supplemental Security Income (SSI)
  - Help from Medicaid paying their Medicare premiums (Medicare Savings Program)
- All others must apply
  - Online at socialsecurity.gov
  - Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)
    - Ask for "Application for Help with Medicare Prescription Drug Plan Costs" (SSA-1020)
  - Contact a SHICK counselor

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Extra Help – Income & Resource Limits (2024)

Type of Limit	Individual (Per Year)	Married Couple (Per Year)
Income (below 150% of the federal poverty level (FPL), based on family size)	$22,590*	$30,660*
Resources	$15,720	$31,360
Resources adjusted for burial expenses	$17,220	$34,360

Income and Resource limits for the Medicare Savings Program (MSP) are different from Extra Help limits.

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Medicare Part D – 2024-2025 Comparison
Part D Benefit Parameters - FBDE

Full Subsidy – Full Benefit Dual Eligible (FBDE) Individuals (category code 3)	2024	2025
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL (category code 2)		
Generic/Preferred Multi-Source Drug/Biosimilar	$1.55	$1.60
Other	$4.60	$4.80
Over 100% FPL (category code 1)		
Generic/Preferred Multi-Source Drug/Biosimilar	$4.60	$4.90
Other	$11.20	$12.15

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Medicare Part D – 2024-2025 Comparison Non-FBDE

Part D Benefit Parameters	2024	2025
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI, or income at or below at or below 150 % FPL for 2024 and beyond and resources ≤ $15,720 (individuals) or ≤ $31,360 (couples) [category code 1]		
Deductible	$0.00	$0.00
Generic/Preferred Multi-Source Drug/Biosimilar	$4.60	$4.90
Other	$11.20	$12.15

(Resources do not include burial exclusion allowance of $1500 per person)

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Extra Help

- How to apply
  - Go to https://www.ssa.gov/extrahelp
  - Call Social Security at 1-800-772-1213
  - Apply at the nearest Social Security office
  - Call a SHICK counselor and apply over the phone or schedule an appointment with a local counselor
    - SHICK hotline phone number

1-800-860-5260

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What are Medicare Savings Programs

- Programs administered through KDHE (KanCare)
- Assistance with the cost of Medicare Part B for Medicare Beneficiaries including those over the age of 65 and those eligible for Medicare who receive SSA disability.
  - Savings may amount to up to $2,500 a year for an individual depending on which MSP they qualify for.
  - Medicare Savings Program are not subject to Estate Recovery.
    - This means that the home and assets will not be recouped by the state when one only receives funding through MSP, unlike Medicaid.

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Medicare Savings Programs

- Three different Levels:
  - Qualified Medicare Beneficiary (QMB)
    - Part B Premium
    - Medicare deductibles, co-pays, and co-insurance
  - Low-Income Medicare Beneficiary (LMB or SLMB)
    - Part B Premium only
  - Expanded Low-Income Medicare Beneficiary (ELMB or QI-1)
    - Part B Premium only
- Income determines which level one will be at, the lower the income the more benefits covered.

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Medicare Savings Programs in 2024

- Monthly Income Limits
  - QMB - $1255/individual; $1703/married couple
  - LMB - $1506/individual; $2044/married couple
  - ELMB - $1694/individual; $2300/married couple
- 2024 Resource limits - $9,430/individual; $14,130/couple*
  - Resources include, bank accounts, stocks, bonds and life insurance.
  - Not counted: their home, personal belongings, vehicle

*Does not include the $1500 per person burial exclusion

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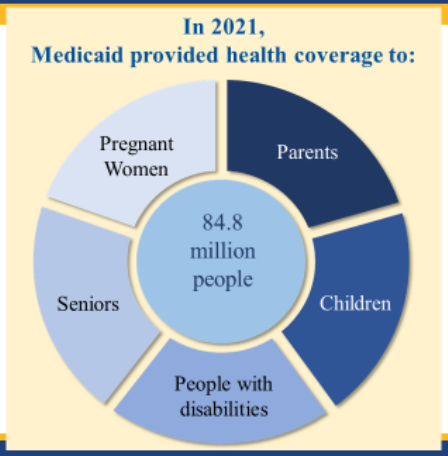
What's Medicaid?

- Joint federal and state program
- Helps pay health care costs for people with limited income and resources, or whose medical expenses exceed their available income
- Some people qualify for Medicare and Medicaid
- May cover services that Medicare may not or may partially cover, like nursing home care, personal care, and home- and community-based services



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How Are Medicare & Medicaid Different?

Medicare	Medicaid
National program that's consistent across the country	Statewide programs that vary among states
Administered by the federal government	Administered by state governments within broad federal rules (federal/state partnership)
Health insurance for people 65 and older, people under 65 with certain disabilities, or any age with End-Stage Renal Disease (ESRD)	Health insurance for people based on need—financial and non-financial requirements
Nation's primary payer of inpatient hospital services to the disabled, elderly, and people with ESRD	Nation's primary public payer of acute health care, mental health, and long-term care services

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KanCare

- In Kansas, Medicaid is called KanCare, http://www.kancare.ks.gov/
  - Administered by the Kansas Department of Health & Environment (KDHE)
  - Application is through the KanCare Clearinghouse
- Children's Health Insurance Program (CHIP)
  - Covers uninsured children up to age 19 and may cover pregnant women when
    - Family income too high for Medicaid
  - In Kansas, this is also a part of KanCare

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How to Apply

How to Apply for Medicaid or MSP:

- Apply on-line at: http://www.kancare.ks.gov/consumers/apply-for-kancare.
  - Call KanCare Clearinghouse – Family Medical 1-800-792-4884 for more information
- The MSP only application is available for download at the link above.
- Fill out the paper application and mail to:
  KanCare Clearinghouse
  P. O. Box 3599
  Topeka KS 66601
- Or they can fax their application to 1-844-264-6285.
- When applying for Extra Help, SSA will automatically send application information to the state to automatically apply for a Medicare Savings Program unless they opt out.

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Medicare's Limited Income Newly Eligible Transition (NET) Program

- LI-NET is a point-of-sale program which provides drug coverage for low-income individuals who are new to Medicare or newly eligible for Extra Help and don't have a Part D prescription plan already
- Gives temporary drug coverage until a beneficiary has enrolled in a Medicare prescription drug plan
- Administered by Humana, https://www.humana.com/pharmacy/pharmacists/linet

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Limited Income Newly Eligible Transition (LI NET) Program?

Auto-enrollment by CMS	• CMS auto-enrolls you if you have Medicare and get either full Medicaid coverage or SSI benefits.
Point-of-Sale (POS) Use	• You may use Medicare's LI NET program at the pharmacy counter.
Submit a Receipt	• You may submit pharmacy receipts (not just a cashier's receipt) for prescriptions already paid for out-of-pocket during eligible periods.

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Regional Low-income Subsidy Benchmark and De Minimis Amount

- No monthly plan premium if they qualify for full Extra Help and select a plan at or below the regional low-income subsidy benchmark
- If they enroll in a plan that has a premium above the benchmark amount, they may have to pay a portion of the monthly premium
- Plans can choose to waive a "de mimimis" premium amount above the regional benchmark
- 2024 de minimis amount is $2
- The Kansas regional benchmark amount is $43.31
- Regional benchmark amounts and de minimis amounts are updated each year

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LIS Consumer Mailings

- A guide to consumer mailings from CMS, Social Security, & plans is available from the CMS website, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf
- It includes several mailings regarding the LIS, or Extra Help, program.

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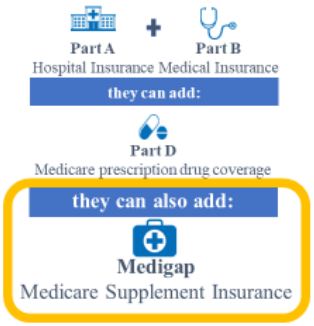
Medicare Supplement Insurance (Medigap) Policies



- Medigap is private health insurance that supplements Original Medicare
  - they must have Part A and Part B
  - Helps pay some health care costs that Original Medicare doesn't cover
  - Medicare will pay its share of the Medicare-approved amounts for covered health care costs
    - Then their Medigap policy pays its share
  - **A Medigap policy covers one person**
- they pay a monthly premium for the Medigap policy
- they pay their Medicare Part B premium

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Medigap Plans

Medigap Policy

- Standardized plans identified by a letter (except in MA, MN, WI (waiver states))
- Plans with the same letter must offer all the same benefits
- Companies don't have to sell all plans
- Plans C & F are not available for individuals who are new to Medicare on or after 1/1/2020.

Plans Currently Sold	Plans that Exist, But Are No Longer Sold
A, B, C, D, F, G, K, L, M, and N	E, H, I, and J

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Medigap Plan Types

Medicare Supplement Insurance (Medigap) Plans										
Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limit in 2024**							$7,060	$3,530		

*Plans F & G are also offered as a high-deductible plan by some insurance companies in some states. If they choose this option, this means they must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,800 in 2024 before their policy pays anything.
**For Plans K and L, after they meet their out-of-pocket yearly limit and their yearly Part B deductible ($240 in 2024), the Medigap plan pays 100% of covered services for the rest of the calendar year.
***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

Full page chart in appendix page 67

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Original Medicare & Medigap Rights

- When they have Original Medicare, this includes the right to buy a Medigap or Medicare Supplemental Insurance policy
  - Medigap policies must follow federal and state laws that protect the consumer
  - Medigap policy must be clearly identified as "Medicare Supplement Insurance"
  - Standardized policies in Kansas identified by letters A, B, C, D, F, G, K, L, M, N
  - The beneficiary has a right to buy a Medigap policy during their Medigap open enrollment period
  - The right to buy a policy for six months but the company may be able to make they wait for coverage for a pre-existing condition

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Gaps in Original Medicare Coverage

- Original Medicare doesn't cover everything
  - Original Medicare pays a share
  - they pay a share
    - Deductibles
    - Coinsurance/Copayments
    - Monthly Premiums
- Medigap insurance policies
  - Pay all or part of their share
  - Coverage depends on the supplement plan they buy

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Buying a Medigap Policy

- They must have both Medicare Parts A and B
- They pay a monthly premium for Medigap
- They still pay the Medicare Part B premium
- Medigap policies cover one person
- Benefits are standardized
- Costs vary by plan and by company
- Do not cover prescription drugs if issued after January 1, 2006.

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Medigap Pricing Based on Age

Type of Rating	Description
No-age-rated (community-rated)	▪ Everyone pays same regardless of age if 65 or older ▪ Generally least expensive over lifetime
Issue-age-rated	▪ Based on age when purchased ▪ Doesn't go up automatically as they get older
Attained-age-rated	▪ Premium based on current age ▪ Costs less when they're 65 ▪ Cost goes up each year as they get older

Premiums may go up due to inflation and other factors. Not all states allow all 3 types of ratings.

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The Best Time to Buy a Medigap Policy

- The 6-month Open Enrollment Period (OEP) begins when they're 65 or older and enrolled in Part B (some states have more generous rules)
- May buy a Medigap policy any time an insurance company will sell they one

Medigap
Medicare Supplement Insurance

During their Medigap OEP	NOT During their Medigap OEP
Best time buy	May have pre-existing condition waiting period
Guaranteed Issue Period	May cost more
Companies must sell they any policy they sell for the same price even if they have a pre-existing condition	Companies can deny coverage

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Delayed Medigap Open Enrollment Period

- If they delay enrolling in Medicare Part B
  - Because they or their spouse is still working, and
  - they have group health coverage
- Medigap OEP is delayed
  - Until they are enrolled in Part B
  - No late enrollment penalty
- Notify Social Security to delay Medicare Part B

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Pre-Existing Conditions and Medigap

- Health problem they had before the new insurance policy starts
  - Treated or diagnosed six months before coverage start date
- Pre-Existing Condition Waiting Period
  - Insurance companies can refuse to cover out-of-pocket costs for excluded condition for up to six months ("look back period")
    - Without 6 months of prior creditable coverage
    - With no break in coverage more than 63 days

NOTE: The Affordable Care Act does not impact the pre-existing condition waiting period for Medigap coverage.

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Medigap for People with a Disability or ESRD

- People with a disability or ESRD may not be able to buy a policy until they turn 65 in some states
- Kansas requires Medigap insurers to sell policies to people with a disability or ESRD
- Have same six-month OEP when Part B is effective
- An additional Medigap OEP at age 65

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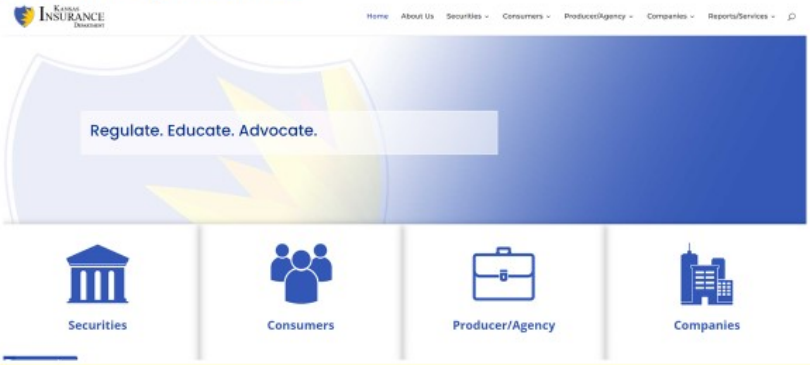
Finding a Medigap Plan In their Area

- https://insurance.kansas.gov/medicare



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Switching Medigap Policies

- They might switch policies if
  - They're paying for benefits they don't need
  - They need more benefits now
  - They want to change their insurance company
  - They find a cheaper policy
- If not in their Medigap open enrollment period
  - They may pay more for the new policy
  - There might be medical underwriting
  - Could have delay in coverage for pre-existing condition
  - Might not sell them a policy

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When Can they Switch Medigap Policies?

- Right under Federal law to switch **only**
  - During their Medigap open enrollment period
  - If they have a guaranteed issue right
  - If their state has more generous requirements
  - If they move out of their Medigap SELECT service area
- A 30-day *free look* period – pay both premiums
- Any time insurance company will sell they one

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Guaranteed Issue Rights to Buy Medigap

- Federal protections in certain situations
  - they have the right to buy a Medigap policy
  - Companies must sell they a Medigap policy
  - All pre-existing conditions must be covered
  - Can't be charged more
  - Must apply within 63 days of date other coverage ends

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Guaranteed Issue Rights

- You lose employer group health plan benefits
  - You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) OR union coverage. The employer group or you are terminating coverage.
- You lose your Medicare Advantage coverage
  - You have a Medicare Advantage plan and:
    - Your plan is leaving Medicare.
    - Your plan stops giving care in your area.
    - You move out of the plan's service area.
- You move out of a Medicare Select policy's service area
  - You have Original Medicare and a Medicare Select policy. You move out of the Medicare Select policy's service area. You can keep your Medicare Supplement policy, however the hospitals in your new area may not be a network provider, or you may want to switch to another Medicare Supplement policy.
- You want to switch from an advantage plan to Original Medicare
  - (Trial right) You joined a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) when first eligible for Medicare Part A at age 65, and within the first year of joining you decide to switch to Original Medicare.

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Guaranteed Issue Rights (continued)

- You move to a Medicare advantage plan and want to switch back
  - (Trial right) You dropped a Medicare Supplement policy to join a Medicare Advantage plan or switch to a Medicare Select policy for the first time; you have been in the plan for less than a year and want to switch back.
- You lose Medicare supplement coverage through no fault of your own
  - Your Medicare Supplement policy ends through no fault of your own, such as bankruptcy by your insurance company.
- Your insurance company commits fraud
  - You leave a Medicare Advantage plan or drop a Medicare Supplement policy because your company has not followed the rules or misled you.
- You lose your Medicaid eligibility
  - You lose your eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

NOTE: More information is available in the workbook appendix

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Coordination of Benefits Overview

- Each type of health insurance coverage is called a "payer"
- When there's more than one payer, coordination of benefits rules determine which pays first
- There may be primary and secondary payers, and in some cases, there may also be a third payer
  - Medicare may be primary payer or secondary payer
  - Medicare may make no payment in some cases

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When Medicare is Primary Payer

- If Medicare is their only insurance
- their other source of coverage is
  - A Medigap policy
  - Medicaid
  - Retiree benefits
  - The Indian Health Service
  - Veterans' benefits
  - TRICARE
  - COBRA continuation coverage
    - Except 30-month coordination period for people with End-Stage Renal Disease (ESRD)

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Medicare Secondary Payer (MSP)

- When Medicare isn't responsible for paying a claim first
- Legislation that protects the Medicare Trust Funds
- Helps ensure Medicare doesn't pay when another insurer should
- Saves $8 billion annually
  - Claims processed by insurances primary to Medicare

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Benefits Coordination & Recovery Center (BCRC)

- Medicare crossover process
  - Assists in coordinating benefits with entities that pay after Medicare
  - The BCRC signs a Coordination of Benefits Agreement (COBA) with insurers
  - If there's no agreement, people with Medicare must coordinate secondary or supplemental payment of benefits with any other insurers
    - In some cases their provider may coordinate
- Medicare secondary payer claims investigation
  - BCRC learns about other insurance
  - Identifies which payer is primary
- Ensures Medicare gets repaid for any conditional payments
- Phone number: 855-798-2627

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Possible Payers Other than Medicare

- Medicaid
- Group Health Plan
- Retiree Group Health Plan
- No-Fault Insurance
- Liability Insurance
- Workers' Compensation
- Federal Black Lung Benefits Program
- COBRA
- Veterans' Coverage
- TRICARE for Life

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Non-Group Health Plans

Medicare doesn't usually pay for services when other insurers may provide coverage, including

- No-fault insurance
- Liability insurance (including self-insurance)
- Work-related injury or illness (workers' compensation)
- Illness related to mining (Federal Black Lung Benefits Program)

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No-Fault Insurance

- Includes automobile insurance, homeowners' insurance, and commercial insurance plans
- Pays regardless of who's at fault
- Medicare is the secondary payer
- Medicare may make a conditional payment
  - If the claim isn't paid within 120 days
  - they won't have to use their own money to pay bill
  - Must be repaid when claim is resolved by the primary payer

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Liability Insurance

- Protects against certain claims
  - Negligence, inappropriate action, or inaction
- Medicare is the secondary payer
  - Providers must attempt to collect before billing Medicare
- Medicare may make a conditional payment
  - If the liability insurer won't pay promptly (within 120 days)
  - Must be repaid when the claim is resolved by the primary payer

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Workers' Compensation

- Medicare generally won't pay for health care related to workers' compensation claims
- If a workers' compensation claim is denied, a claim may be filed for Medicare payment
  - Medicare may pay a claim that relates to a service or item otherwise covered by Medicare
- Workers' compensation claims can be resolved by settlements, judgments, awards, or other payments

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Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)

- Funds from settlement are set aside to pay for future medical or prescription drug services
- Only used for Medicare-covered services
- Funds must only be used for the injury, illness, or disease covered by workers' compensation
- Medicare pays for Medicare-covered services after WCMSA funds are used up

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Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Requires employers with 20 or more employees to let employees and dependents keep group health plan coverage under certain conditions
- Allows certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates
- Coverage can only begin when coverage is lost due to certain specific events
  - Generally for 18 months, but can be longer in special circumstances
- they must pay the entire insurance premium

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COBRA (continued)

If they	Medicare Pays First
Are 65 or older or have a disability and have COBRA continuation coverage	In most cases
Have COBRA continuation coverage and are eligible for Medicare due to ESRD	When their 30-month coordination period ends

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Veterans' Coverage

- If they have Medicare and Veterans' coverage, they
  - Can get treatment under either program
  - Must choose which benefit they'll use each time they get health care
- Medicare pays when they choose to get their benefits from non-Veterans Affairs (VA) providers
- To get services under Veterans benefits
  - they must get their health care at a VA facility, or
  - Have the VA authorize, or agree to pay for, services in a non-VA facility

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TRICARE for Life Coverage (TFL)

- Medical coverage for Medicare-eligible uniformed services retirees 65 or older, their eligible family members and survivors, and certain former spouses
  - Medicare pays first and TFL pays second
- For services covered by TFL but not Medicare
  - TFL pays first and Medicare pays nothing
- For services they get in a military hospital or other federal provider
  - TFL pays first and Medicare generally pays nothing

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Helpful Websites

01	Medicare	Medicare.gov
02	Medicaid	Medicaid.gov
03	Social Security	ssa.gov
04	Health Insurance Marketplace®	HealthCare.gov
05	Children's Health Insurance Program	InsureKidsNow.gov
06	CMS National Training Program	CMSnationaltrainingprogram.cms.gov
07	State Health Insurance Program (SHIP)	shiphelp.org

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Key Points to Remember

- Medicare is a health insurance program
- Medicare doesn't cover all of your health care costs
- You have choices in how you get coverage
- Decisions affect the type of coverage you get
- Certain decisions are time-sensitive
- There are programs for people with limited income and resources

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Helpful Resources

- https://insurance.kansas.gov/ – 800-432-2484
- www.kdads.ks.gov – 800-432-3535
- KanCare Clearinghouse – 800-792-4884
- KanCare Ombudsman – kancare.ombudsman@ks.gov
  https://www.kancare.ks.gov/kancare-ombudsman-office/about-contact-us
  855-643-8180
- SHICK coordinator and counselor resource page - http://www.kdads.ks.gov/shick-coordinator-counselor-information

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What's next?

- You will receive your STARS sign-in information via email from boozallenstarshelpdesk@bah.com
- Attend Session 2 training
- You will complete the final Initial Training test during Session 2

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APPENDIX - Resources and Websites

Kansas Department for Aging and Disability Services
1-800-432-3535
kdads.ks.gov

Kansas Insurance Department
1-800-432-2484 (Kansas only)
https://insurance.kansas.gov/medicare

Centers for Medicare & Medicaid Services (CMS)
1-800-MEDICARE (1-800-633-4227).
TTY: 1-877-486-2048.
Medicare.gov
CMS.gov
Medicaid.gov/

Social Security
1-800-772-1213. TTY: 1-800-325-0778
SocialSecurity.gov/

SSA Red Book
ssa.gov\redbook

Railroad Retirement Board
1-877-772-5772. TTY: 1-312-751-4700
RRB.gov/

Affordable Care Act
HealthCare.gov
HHS.gov/healthcare/about-the-aca/index.html

State Health Insurance Assistance Programs and State Insurance Departments
shiptacenter.org/

Benefits Coordination & Recovery Center
Call 1-855-798-2627. TTY: 1-855-797-2627

U.S. Department of Health and Human Services, Office for Civil Rights
HHS.gov
HHS.gov/ocr/office/index.html
1-800-368-1019. TTY: 1-800-537-7697

Beneficiary Notice Initiative
CMS.gov/Medicare/Medicare-General-Information/BNI
Medicare.gov/claims-and-appeals

Medicare Beneficiary Ombudsman
Medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman
Medicare.gov/what-medicare-covers/part-a/rights-in-snf

Limited Income NET Program (Humana)
Call 1-877-783-1307 or 711 (TRS)
linetoutreach@humana.com

Prescription Drug Benefit Manual
CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html

PD Enrollment and Disenrollment Guidance
CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html

Medicare Premiums: Rules for Higher-Income Beneficiaries
https://www.ssa.gov/benefits/medicare/medicare-premiums.html

CMS Guide to Mailings From CMS, Social Security, and Plans
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf

Medicare Marketing Guidelines
https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines

Medicare Managed Care Manual
CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

U.S. Department of Labor Call 1-866-4-USA-DOL (1-866-487-2365). TTY: 1-877-889-5627 dol.gov/dol/topic/health-plans/cobra.htm **Office of Personnel Management (Federal Employees Health Benefit Program)** opm.gov/healthcare-insurance/healthcare/ **Patient Assistance Program Center** rxassist.org **Medicare/TRICARE Benefit Overview** tricare.mil/Plans/Eligibility?sc_database=web **TRICARE** TRICARE.mil/ **Department of Veterans Affairs** Call 1-800-827-1000. TTY: 1-800-829-4833 va.gov/opa/publications/benefits_book.asp benefits.va.gov/benefits/ **Black Lung Program** https://www.dol.gov/agencies/owcp/dcmwc/regs/compliance/blbenact Call 1-800-638-7072. TTY: 1-877-889-5627 **Senior Medicare Patrol Program** smpresource.org Medicare.gov/fraud **OIG Fraud Hotline** Call 1-800-HHS-TIPS (1-800-447-8477) TTY: 1-800-337-4950 Fax 1-800-223-8162 **Prevention Toolkit** CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html **National Training Program – Partner Job Aids** https://cmsnationaltrainingprogram.cms.gov/	

Common Acronyms for People with Medicare

A	
AAA	Area Agency on Aging
AAA	Abdominal Aortic Aneurysms
AARP	American Association of Retired Persons
A/B MAC	A/B Medicare Administrative Contractor
ABD	Aged, Blind & Disabled
ABN	Advanced Beneficiary Notice
ACA	Affordable Care Act
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADC	Adult Day Care
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center
AEP	Annual coordinated election period (10/15 – 12/7 each year)
AI/AN	American Indian/Alaska Native
AIC	Amount in controversy
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
ALS	Amyotrophic Lateral Sclerosis
ANOC	Plan Annual Notice of Change
AO	Accreditation Organization
AOA	Administration on Aging
APTC	Advanced Premium Tax Credits
ARRA	American Recovery and Reinvestment Act 2009
AVF	Arteriovenous Fistulas
B	
BAE	Best Available Evidence
BBA	Balanced Budget Act (of 1997)
BBRA	Balanced Budget Refinement Act (of 1999)
BC/BS	Blue Cross/Blue Shield
BCRC	Benefits Coordination & Recovery Center
BFCC	Beneficiary and Family Centered Care
BFCC-QIO	Beneficiary and Family-Centered Care Quality Improvement Organization
BHP	Basic Health Program
BMI	Body Mass Index
BP	Benefit Period
BPH	Benign Prostatic Hyperplasia
C	
CAH	Critical Access Hospital
CAL	Compassionate Allowance
CBO	Community-Based Organizations
CBO	Congressional Budget Office
CCN	Claim Control Number
CCRC	Continuing Care Retirement Community
CFC	Conditions for Coverage

CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHIP	Children's Health Insurance Program
CKD	Chronic Kidney Disease
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of benefit(s)
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act (of 1985)
CORF	Comprehensive Outpatient Rehab Facility
COVID-19	Coronavirus Disease 2019
CP	Claims Processing
CPAP	Continuous positive airway pressure
CPI	Center for Program Integrity
CSR	Customer Service Representative
CSR	Cost Sharing Reductions
CVD	Cardiovascular disease
CWF	Current Working File
CY	Calendar Year
D	
DCF	Kansas Department for Children and Families, formerly SRS
DE	Dual-Eligible
DENC	Detailed Explanation of Non-coverage
DES	Diethylstilbestrol
DFC	Dialysis Facility Compare
DHHS	Department of Health & Human Services
DI	Disability Insurance
DME	Durable medical equipment
DME-MAC	Durable Medical Equipment-Medicare Administrative Contractor
DMEPOS	Durable Medicare Equipment Prosthetics, Orthotics and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DOB	Date of Birth
DOD	Date of Death
DOE	Date of Entitlement
DoD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DOS	Date of Service
E	
EGHP	Employer Group Health Plan
EOB	Explanation of Benefits
EOC	Evidence of Coverage
EOMB	Explanation of Medicare Benefits (replaced by MSN)
ERISA	Employee Retirement Income Security Act (of 1974)
ESRD	End-stage renal disease
F	
FAQ	Frequently Asked Questions

FBDE	Full Benefit Dual-Eligible
FDA	Food and Drug Administration
FEHBP	Federal Employee Health Benefits Program
FFS	fee-for-service
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FMAP	Federal Medical Assistance Percentage
FPL	Federal poverty level
FPS	Fraud Prevention System
FR	Federal Register
FY	Fiscal year
G	
GAO	Government Accountability Office
GEP	General Enrollment Period (1/1 – 3/31 – each year)
GHP	Group Health Plan
H	
HBV	Hepatitis B Virus
HCBS	Home and Community Based Services
HCBWP	Home and Community Based Waiver Program
HCFA	Health Care Financing Administration (now CMS)
HCV	Hepatitis C Virus
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS (DHHS)	Department of Health and Human Services
HIC	Health insurance claim
HICN	Health insurance claim number (Medicare number)
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIV	Health Care Fraud Prevention and Enforcement Action Team
HMO	Health maintenance organization
HMO-POS	HMO Point-of-Service
HPV	Human Papillomavirus
HSA	Health Savings Accounts
I	
IADL	Instrumental Activities of Daily Living
ICFs/MR	Intermediate care facilities for the mentally retarded
IDE	Investigational Device Exemption
IEP	Initial enrollment period
IHS	Indian Health Service
IPPE	Initial Preventive Physical Examination
IRE	Independent review entity
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
I/T/U	Indian Tribes and Tribal organizations, and urban Indian organizations
IVR	Interactive Voice Response
K	
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment

L	
LEP	Late Enrollment Penalty
LIS	Low-income subsidy
LMB	Low-income Medicare beneficiary (KS-same as SLMB at Fed level)
L-OEP	Limited Open Enrollment Period
LPI	Low Performance Icon
LRD	Lifetime Reserve Days
LTC	Long-term care
LTCF	Long-term care facility
LTR	Lifetime Reserve
LTSS	
M	
M&M	Medicare and Medicaid
MA	Medicare Advantage
MAGI	Modified Adjusted Gross Income
MA-PD	Medicare Advantage with prescription drug plan
MAC	Medicare Administrative Contractor
MAC	Medicare Appeals Council
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAO	Medicare Advantage organizations
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MI	Medical Insurance (Medicare Part B)
MICs	Medicaid Integrity Contractors
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act (of 2003)
MMG	Medicare Marketing Guidelines
MNT	Medical Nutrition Therapy
MOON	Medicare Outpatient Observation Notice
MRI	Magnetic Resonance Imaging
MSA	Medicare Medical Savings Accounts
MSN	Medicare Summary Notice
MSP	Medicare Savings Program
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
MTM	Medication Therapy Management
N	
NAIC	National Association of Insurance Commissioners
NBI	National Benefit Integrity
NCC	National Coordinating Center
NCD	National Coverage Decision
NET	Newly Eligible Transition
NF	Nursing Facility
NIA	National Institute on Aging
NIH	National Institutes of Health

NIMH	National Institute of Mental Health
NOMNC	Notice of Medicare Non-coverage
NPA	National PACE Association
NPI	National Provider Identifier
NTP	National Training Program
O	
O&E	Outreach and Education
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights
OEP	Open enrollment period
OEPI	Open enrollment period for institutionalized individuals
OIG	Office of the Inspector General
OOP	Out-of-Pocket
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
OT	Occupational Therapy
P	
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PAP	Patient Assistance Program
PBA	Pharmacy benefit administrator
PBMs	Pharmacy benefit managers
PDP	Medicare stand-alone prescription drug plan
PFFS	Private fee-for-service plan
PHE	Public Health Emergency
PHI	Protected health information
PhRMA	Pharmaceutical Manufacturers and Researchers of America
POC	Plan of Care
POS	Point-of-Sale
PPACA	Patient Protection and Affordable Care Act 2010
PPO	Preferred provider organization
PPS	Prospective Payment System
PRO	Peer Review Organization (renamed QIO)
PSA	Prostate-specific antigen
PSO	Provider-sponsored organization
PT	Physical Therapy
Q	
Q&A	Questions and Answers
QAPI	Quality Assessment & Performance Improvement
QDWI	Qualified disabled and working individual
QHP	Qualified Health Plans
QI	Qualified Individuals
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization

QMB	Qualified Medicare beneficiaries
QWDI	Qualified Working Disabled Individual (aka QDWI)
R	
RAC	Recovery Audit Contractor
RDF	Renal Dialysis Facility
REACH	Regional Education About Choices in Health
RFI	Request for Information
RHC	Rural Health Center
RHHI	Regional Home Health Intermediary
RNHCI	Religious Non Medicare Health Care Institution
RO	Regional Office
RRB	Railroad Retirement Board
S	
SCE	Subsidy-Changing Event
SEP	Special Enrollment Period
SGS	SafeGuard Services, LLC
SHI	Supplemental Health Insurance
SHICK	Senior Health Insurance Counseling for Kansas
SHIP	State Health Insurance Assistance Programs (SHICK)
SHOP	Small Business Health Options Program
SLMB	Special Low-Income Medicare Beneficiaries (Federal, same as LMB in KS)
SME	Subject Matter Expert
SMI	Supplemental Medical Insurance (Medicare Part B)
SMP	Senior Medicare Patrol
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SOW	Scope of Work
SPAP	State Pharmaceutical Assistance Program (NOT available in KS)
SS	Social Security
SSA	Social Security Act
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SSN	Social Security Number
STI	Sexually transmitted infections
T	
TBD	To Be Determined
TDD	Telecommunications Device for the Deaf
TEFT	Testing Experience and Functional Assessment Tools
TFL	TRICARE for Life
Title I	Grants to State for old age assistance & medical assistance for the aged
Title II	Federal old age, survivors & disability insurance benefits (OASDI)
Title IV	Grants to States for aid & services to needy families with children (TAF)
Title X	Grants to State for aid to the blind (AB)
Title XIV	Grants to States for aid to the permanently & totally disabled (DI)
Title XIX	Grants to States for medical assistance programs (Medicaid)

Title XVI	Grants to States for aid to the aged, blind & disabled (ABD) & Supplemental Security Income (SSI)
Title XVIII	Health Insurance (Medicare)
Title XX	State operated home health care entitlement program
Title XXI	State Child Health Programs
TrOOP	True Out-of-Pocket
TTY	Text Telephones
TWWIA	Ticket to Work & Work Incentives Act (of 1999)
U	
U&C	Usual & customary
V	
VA (DVA)	Department of Veterans Affairs
W	
WCMSA	Workers' Compensation Medicare Set-Aide Arrangement
WPS	Wisconsin Physician Services
X	
XIXED	Title 19 Entitlement Date
Y	
YOB	Year of Birth
YTD	Year to Date
YYYY	Year
Z	
ZPIC	Zone Program Integrity Contractor

2024 Overview of Medicare A & B

Key: Shaded areas – Medicare Pays
White areas – You Pay

A

Premium: *40 work quarters = zero*
less than 30 quarters = $505
30 - 39 quarters = $278

Each benefit period*
In-patient Hospital

First 60 days	$1632 Deductible
Days 61-90	$408 per day co-payment
Lifetime Reserve Days 91-150	$816 per day co-payment
Skilled Nursing Facility	
First 20 days	100% (No co-pay)
Days 21-100	$204 per day co-pay

100% Services
Home Health
Hospice

$5 prescription drug co-pay

5% co-insurance inpatient respite care

* Benefit period ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.

B

Premium: $174.70
Part B-ID - $103.00
Higher for individual $103,000 or couple $206,000.

$226 Deductible
(per calendar year, January 1 to December 31)

80%		**20%**
Physician's Charges (in or out of the hospital)		**COINSURANCE**
Durable Medical Equipment & Supplies		
Ambulance		
Outpatient Hospital		
Blood	The first 3 pints	
Lab Services		

Preventive Services
PAID 100%: Welcome to Medicare Physical Exam, Screening Mammograms, Annual Pap Tests, Diabetes Screening, Bone Mass Measurement, Flu Shots, some Colorectal Cancer Screening, Screening & Counseling for Obesity, Medical Nutrition Therapy, Tobacco Use Cessation, Yearly Wellness Visit

WITH CO-PAY OR DEDUCTIBLE: Abdominal Aortic Aneurysm Screening, Diabetes Supplies & Self-Management, Prostate Cancer Screening, Glaucoma Screening, CCS - Barium enema, HIV Screening

Excess Charges
(15% over Medicare Allowed Charge)

Medicare Supplement Insurance (Medigap) Plans										
Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limit in 2024**							$7,060	$3,530		

Plans C & F are not available for individuals who are new to Medicare on or after 1/1/2020. People new to Medicare are those who turn 65 on or after January 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after January 1, 2020.
*Plans F & G are also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,800 in 2024 before your policy pays anything.
**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($240 in 2024), the Medigap plan pays 100% of covered services for the rest of the calendar year.
***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

YOU HAVE A MEDICARE SUPPLEMENT GUARANTEED ISSUE RIGHT IF...	YOU HAVE THE RIGHT TO BUY...	YOU CAN/MUST APPLY FOR A MEDICARE SUPPLEMENT POLICY...
1 YOU LOSE EMPLOYER GROUP HEALTH PLAN BENEFITS		
You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) OR union coverage. The employer group or you are terminating coverage.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company. If you have COBRA coverage, you can either immediately buy a Medicare Supplement policy or wait until COBRA coverage ends.	No later than 63 calendar days after the latest of these dates: • Date coverage ends • Date on notice telling you coverage is ending (if you get one). • Date on a claim denial, if this is the only way you were informed.
2 YOU LOSE YOUR MEDICARE ADVANTAGE COVERAGE		
You have a Medicare Advantage plan and: • Your plan is leaving Medicare. • Your plan stops giving care in your area. • You move out of the plan's service area.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company. You only have this right if you switch to Original Medicare rather than joining another Medicare Advantage plan.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends. NOTE: Medicare Supplement coverage cannot begin until your Medicare Advantage plan coverage has ended.
NOTE: If you immediately join another Medicare Advantage plan, you can stay in that plan for up to one year and still have the rights described in situations 4 and 5.		
3 YOU MOVE OUT OF A MEDICARE SELECT POLICY'S SERVICE AREA		
You have Original Medicare and a Medicare Select policy. You move out of the Medicare Select policy's service area. You can keep your Medicare Supplement policy, however the hospitals in your new area may not be a network provider, or you may want to switch to another Medicare Supplement policy.	Medicare Supplement policy A, B, C, F, K or L sold by any insurance company in the state to which you are moving.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends.
4 YOU WANT TO SWITCH FROM AN ADVANTAGE PLAN TO ORIGINAL MEDICARE		
(Trial right) You joined a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) when first eligible for Medicare Part A at age 65, and within the first year of joining you decide to switch to Original Medicare.	Any Medicare Supplement policy sold in Kansas by any insurance company.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends. Note: Medicare Supplement coverage can not begin until your Advantage plan coverage has ended.

5	YOU MOVE TO A MEDICARE ADVANTAGE PLAN AND WANT TO SWITCH BACK	
(Trial right) You dropped a Medicare Supplement policy to join a Medicare Advantage plan or switch to a Medicare Select policy for the first time; you have been in the plan for less than a year and want to switch back.	The Medicare Supplement policy you had before you obtained the Advantage plan or Select policy, if the same company you had before still sells it. (Drug coverage will not be included.) If it is not available, you can buy Medicare supplement policy A, B, C, F, K or L sold in Kansas by any insurance company.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends. Note: Your rights may last for an extra 12 months under certain circumstances.
6	**YOU LOSE MEDICARE SUPPLEMENT COVERAGE THROUGH NO FAULT OF YOUR OWN**	
Your Medicare Supplement policy ends through no fault of your own, such as bankruptcy by your insurance company.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company.	No later than 63 calendar days after coverage ends.
7	**YOUR INSURANCE COMPANY COMMITS FRAUD**	
You leave a Medicare Advantage plan or drop a Medicare Supplement policy because your company has not followed the rules or misled you.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company.	No later than 63 calendar days after coverage ends.
8	**YOU LOSE YOUR MEDICAID ELIGIBILITY**	
You lose your eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).	Any Medicare Supplement policy or Medicare Select policy offered by any company in Kansas.	No later than 63 calendar days from the date your coverage ends.