The Basics of Medicare

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Medicare and Medicaid are government-sponsored healthcare programs in the United States. The programs differ in terms of how they are governed and funded, as well as in terms of whom they cover. **Medicare,** the focus of this article, is a health insurance program that primarily covers seniors ages 65 and older and disabled individuals who qualify for Social Security. **Medicaid** is an assistance program that covers low- to no-income families and individuals. Some people may be eligible for both Medicaid and Medicare, depending on their circumstances.

ObamaCare (aka The Affordable Care Act) is a new U.S. law aimed at reforming the American health care system. ObamaCare's main focus is on providing more Americans under the age of 65 with access to affordable health insurance, improving the quality of health care and health insurance, regulating the health insurance industry, and reducing health care spending in the U.S.

How Do I Sign Up For Medicare?

If you sign up for Social Security prior to age 65 (you can sign up to received Social Security benefits as early as age 62) you automatically enroll for Medicare. The easiest way to sign up for Social Security is online at:
http://www.ssa.gov/retirement/about.htm

If you delay taking Social Security payments until age 65 or later, you must sign up for Medicare at least three months prior to age 65. You can do this online at:
http://www.ssa.gov/medicare/apply.html

What Do I Get From Medicare?

Medicare is a health insurance policy almost everyone has to have once they reach age 65. Prior to the month of your 65th birthday, you will receive you Medicare Card in the mail. This card covers you for what is called Medicare Parts A and B. Part A is paid for by the Federal Government (it's free to you), Part B this year costs $104.90 per month. This cost may go up every year. This premium is taken directly out of your Social Security check (if you are receiving Social Security). If you are not yet receiving Social Security, you will have to pay the government the monthly premium. For additional information, see this website:
http://www.medicare.gov/your-medicare-costs/paying-parts-a-and-b/pay-parts-a-and-b-premiums.html

While you are initially enrolled for Medicare Parts A and B, there are actually 4 parts of Medicare:

Part A: Hospital insurance

Part B: Physician and outpatient coverage
Part C: Medicare Advantage plans - these are private plans run through Medicare that, by law, must at least be "equivalent" to regular Part A and Part B coverage.
Part D: Coverage for prescription drugs

Medicare Parts A and B are mandatory for almost everyone. Parts C and D are optional. **Medicare Parts A and B together will pay roughly 80% of your typical medical costs. If you only have Parts A and B, that coverage may leave you UNINSURED for about 20% of your total medical costs, including no prescription coverage!**

How Do I Get Coverage For The Remaining 20%?

This is where the health insurance discussion turns "fuzzy" because people have different situations that determine how they provide for the "remaining 20%" of health insurance coverage. Generally, one of five scenarios will occur:

1 - Some people will continue to use their employer insurance, for us it's the West Genesee BC/BS plan

Some people in our district will continue to use the West Genesee BC/BS plan as a type of coinsurance with Medicare. If you go to a doctor or hospital, you will present you Medicare Card Parts A and B as your primary health coverage and your West Genesee BC/BS card as you secondary coverage. The doctor/hospital will bill Medicare first, and any remaining part of the bill will be submitted to BC/BS. You will still have the typical copays and deductibles; prescriptions will continue to be covered as usual.

NOTE: The WG BC/BS plan is complementary to Medicare. When you turn age 65, and assuming you are still using the District's BC/BS plan, in effect you are continuing to use the active teachers health plan. Because you are using complementary coverage you might be eligible to elect NOT to accept Medicare's Part B coverage at age 65. (EVERYONE has to use Medicare Part A at age 65.) Complementary coverage must be equal to or greater coverage that Medicare Part B AND not be a separate retiree plan AND not be a COBRA plan. Being able to NOT sign up for Part B of Medicare while you have WG's BC/BS coverage will save you the cost of Medicare Part B coverage, right now that's a savings of $104.90 per month. To ensure that you can use your WG BC/BS coverage in place of Part B at age 65 -- you MUST check first with Jenny Provost at District Office.

The West Genesee BC/BS health plan with prescription coverage is a contractually negotiated item and provided at no cost for retirees (and dependents) **provided** the retirees meet the appropriate contractual provisions. In general, retirees receive 5 district paid years of BC/BS health insurance, plus up to an additional 2 years if the retiree has the appropriate number of sick days (see the WG Teacher Contract for all the specifics of this benefit).

Once the West Genesee retiree's district paid BC/BS health coverage is used up, one option a retiree has is to keep using the district's BC/BS plan. If the retiree continues the BC/BS plan they must pay the ENTIRE cost of that BC/BS coverage at his or her own expense. The good news is that this is a "Cadillac" health plan and offers excellent protection plus prescription coverage. The bad news is that it is not designed to be a supplemental Medicare insurance plan. Medicare Parts A and B are designed to cover about 80% of most medical bills (not including prescriptions). Supplemental Medicare plans that people can purchase on their own should ONLY have to cover most of the remaining 20% of medical expenses and should cost less than the all-encompassing West Genesee BC/BS plan.

According to the District, there are approximately 125 retirees utilizing the WG BC/BS plan, many of them using it as their SECONDARY coverage for Medicare. These people are essentially paying 100% for the cost of a BC/BS health care plan that only covers 20% of their actual medical expenses. Switching to a Medicare supplemental plan would most likely save many current retirees money. However, many retirees are reluctant to switch from the WG BC/BS plan to a Medicare supplemental plan because of the confusing array of choices, many of those choices are NOT as good as the current WG plan, and once a retiree leaves the WG plan they can no longer rejoin it.

To give you an idea of the cost of maintaining the WG BC/BS plans, a recently retired teacher with a spouse might receive approximately $6,500 of NET monthly ($78,000 yearly) income from the NYS Teachers' Retirement System and Social Security (this figure depends on a lot of circumstances which go far beyond the scope of this document). Currently, the WG BC/BS plan for a retiree and spouse costs around $16,620 per year. Thus purchasing the WG BC/BS plan for a couple requires paying OVER 2 months of their net income, or around 21.3% of their total net yearly income. If you calculate in the yearly cost of Medicare Part B coverage ($104.90/month times 2 people) and the districts dental and vision coverage ($116.50 per month for both people), the employee and dependent total jumps to approximately $20,535.60 per year and represents 26.3% of a couple's net income.

In other words, if a retired WG teacher with a spouse elects to continue the district's BC/BS health, dental and vision coverage, the associated costs would take a bit more that 1 out of every 4 dollars of their net retirement income from NYSTRS and Social Security!

Nationwide, around 31% of Medicare users utilized employment based coverage (with the employer paying anywhere from NONE to ALL of the health insurance costs). Another 4% of the population have employer-sponsored insurance because they are still working past age 65. (Source: Kaiser Family Foundation, 2010)

2 - Some people will elect to have NO supplemental coverage

Approximately 14% of the retired population will elect to have NO health coverage other than that provided by Medicare Parts A and B (Kaiser, 2010). They have elected to be responsible for the additional 20% of medical costs not covered by Parts A and B; in addition they are also responsible for their own prescription costs, dental and vision coverage. Obviously, unless one is independently wealthy, this is very financially risky.

3 - Some retirees are on Medicaid

Approximately 16% of the retired population is covered under Medicaid (Kaiser, 2010). Medicaid is an assistance program that covers low- to no-income families and individuals. These are people that have a very low net worth or have medical expenses so extreme that they qualify for Medicaid help. Qualifications are also determined on a host of other criteria, many of which vary from state to state.

4 & 5 - Some people will buy a supplemental Medicare insurance plan – Either a Medicare Advantage Plan or a Medigap (Medicare Supplement) Plan

To get the additional 20% of insurance coverage needed that Medicare Part A and B does not cover, some people will purchase a supplemental Medicare insurance plan. This type of insurance is less expensive than employer-sponsored insurance, but it complicated by the dizzying array of complicated vocabulary and acronyms needed to understand and choose the coverage appropriate for each individual's circumstances. Roughly 34% of all retirees will purchase a supplemental Medicare coverage, 19% choose Medicare Advantage Plans and 15% choose a Medigap Plan. (Kaiser, 2010).

Medicare Advantage Plans

There are several different types of Medicare Advantage plans: HMO (Health Maintenance Organization), PPO (Preferred Provider Organization), PFFS (Private Fee-for-Service), SNP (Special Needs Plan), HMO-POS (Health Maintenance Organization Point-of-Service), and MSA (Medical Savings Account). Generally, HMOs and PPOs maintain provider (i.e. doctor) networks. You must go to a doctor within the companies network. PFFS plans have no provider network but may be hard to find in some areas. PPOs cover out-of-network providers but costs may be higher. Some plans require a referral by your doctor to see a specialist.

Costs: Typically you have to pay copayments for most medical services. Many plans have an out-of-pocket annual maximum. You still pay your Medicare Part B premium. If you want drug coverage make sure your selected plan includes those drugs before you enroll in a Medicare Advantage plan. Some plans include routine dental and vision.

Who this plan works best for: Medicare Advantage Plans work best for people who otherwise can't find a Medicare provider. You may save money with this type of plan unless you need frequent appointments or treatments.

The Medicare Advantage plans are regulated by each state, there are roughly 20 companies approved to sell Medicare Advantage policies in NYS. These companies range from BC/BS to AARP. Each company has different levels of coverage from bare bones to Cadillac plans; each plan costs different amounts. By "bare bones" I mean that there are some plans out there that JUST offer a tiny bit more than the Part A and B coverage, leaving YOU to pay the 20% that Medicare Parts A and B do not cover (plus you may have to pay most of your prescriptions). The up side to those plans is that some don't cost you anything (yes - some are free!). The downside is that you are basically uninsured for 20% of your entire doctor and hospital bills, and almost all prescription costs. Other Medicare Advantage plans cover more and more items, but also cost more and more money. Some plans won't cover you outside of the USA; some might not cover you even out of state.

Medicare Advantage plans are required to provide at minimum the same array of benefits as traditional Medicare parts A and B. Many Advantage plans offer extra benefits -- things like gym memberships, vision exams or generous cost sharing -- that have contributed to escalating program costs.

Use this website to find Medicare Advantage Plans available to residents of NY -- by county: http://www.q1medicare.com/MedicareAdvantage-PartCHealthPlanMAPDHMOPPONewYork.php

Medigap (Medicare Supplement) Plans

Medigap (also known as Medicare Supplement Insurance or Medicare Supplemental Insurance) refers to various private health insurance plans sold to supplement Medicare in the United States. Medigap insurance provides coverage for many of the co-pays and some of the co-insurance related to Medicare-covered hospital, skilled nursing facility, home health care, ambulance, durable medical equipment, and doctor charges. Medigap's name is derived from the notion that it exists to cover the difference or "gap" between the expenses reimbursed to providers by Medicare Parts A and B for the preceding named services and the total amount allowed to be charged for those services by the United States Centers for Medicare and Medicaid Services (CMS).

Medigap offerings have been standardized by the CMS into ten different plans, labeled A through N and sold and administered by private companies. Each Medigap plan offers a different combination of benefits. The coverage provided is roughly proportional to the premium paid. Marketing for plans E, H, I and J have been stopped as of May 31, 2010. Medigap plans M and N took effect on June 1, 2010, bringing the number of offered plans to ten (Plans currently offered are: A, B, C, D, F, G, K, L, M and N).

The next link downloads a PDF document from NYS that outlines the different Medigap Plans IN DETAIL:
http://www.dfs.ny.gov/consumer/medplan/Medsup_coverage.pdf

Here is a comparison of the various Medigap policies:
http://www.medicare.gov/supplement-other-insurance/compare-medigap/compare-medigap.html

*NOTE: Medigap **Plans** A – N are DIFFERENT from Medicare **Parts** A, B, C and D.*

Typically Medigap premiums may vary with gender and health and may go up with age. The premium for the same plan may differ from company to company. Generally, there are no copayment costs at time of service. There is no out-of-pocket maximum. You still have to pay for Medicare Part B.

You can go to any doctor or other health care provider that accepts Medicare. Usually referrals by your doctor are not required when you need to see a specialist. Medigap insurance may be used for treatments at major medical facilities (such as Mayo Clinics). You can get medical services in any state or US territory. Prescription drug coverage is not included. If you want prescription coverage you may enroll in a stand-alone Medicare Part D Prescription Drug Plan.

Who these plans work best for: Medigap plans work best for travelers or those with vacation homes in a different state. These plans may save money for people needing high-cost or frequent care.

There are ten types of standardized Medigap plans; each plan is labeled with a letter (such as Plan F). Once you decide which plan you want, you should compare different companies offering the same plan. For example, if you choose Plan F, you can (and should) look at the prices and any extra options that different companies might have for Plan F.

Medigap plans essentially begin where original Medicare leaves off, picking up some or all of out-of-pocket expenses such as the $1,156 deductible for hospitalization under Part A or the 20 percent coinsurance for outpatient and physician care under Part B. With most Medigap policies, this coordination is automatic: after Medicare has paid its share of the bill, it forwards the claim to your Medigap carrier to pay its share.

The most popular plan is Medigap Plan F which picks up pretty much every out-of-pocket expense for Medicare Parts A and B, and is by far the most common choice among the nearly 10 million Americans who buy Medigap plans, with 51 percent of the market, according to the most recent data from America's Health Insurance Plans. The runner-up, Plan C, which is slightly less generous, has 14 percent of the market.

Medigap plans do not cover prescription drugs. Therefore you must also purchase a stand-alone Part D plan if you want drug coverage. Prescription Part D costs typically varies from $20 - $60 per month.

Help With Prescription Costs in NYS

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State program for seniors administered by the NYS Department of Health. It helps more than 250,000 income-eligible seniors aged 65 and older to supplement their out-of-pocket Medicare Part D drug plan costs. Seniors can apply for EPIC at any time of the year and must be enrolled or eligible to be enrolled in a Medicare Part D drug plan to receive EPIC benefits and maintain coverage.

EPIC provides secondary coverage for Medicare Part D and EPIC-covered drugs purchased after any Medicare Part D deductible is met. EPIC also covers approved Part D-excluded drugs once a member is enrolled in Part D.

EPIC helps pay the Medicare Part D drug plan premiums for members with income up to $23,000 if single or $26,000 if married. Higher income members are required to pay their own Part D premiums but EPIC provides premium assistance by lowering their EPIC deductible.

EPIC has two plans based on income. The Fee Plan is for members with income up to $20,000 if single or $26,000 if married. The Deductible Plan is for members with incomes ranging from $20,001 to $75,000 if single or $26,001 to $100,000 if married.

For additional information on EPIC please visit their website at:
https://www.health.ny.gov/health_care/epic/

How Do I Learn More?

Medicare Advantage plans are highly advertised and there is a lot of information available online about those plans. The reason for this is that Medicare Advantage plans are regulated and overseen on a national level. Medicare routinely collects all kinds of information on them about customer satisfaction and quality of care. In addition, the premium of a specific Medicare Advantage plan is the same for each customer. As a result, it's possible to easily compare Medicare Advantage plans in detail.

None of this is true for Medigap plans. While the federal government does set minimum standards for how the plans are priced and sold, the plans themselves are licensed and regulated state by state. Some states don't go beyond the bare minimum of regulation, while others have extensive consumer protections. Also, because Medigap plans don't have provider networks or get directly involved in

whether to cover a treatment or test, there's little to rate them on. To top things off, the cost of a plan can vary greatly depending on which company you buy it from, the premium pricing method the company uses, how old you are when you buy it, and whether you have any pre-existing conditions.

So how do you go about buying a Medigap plan? Start at this Medigap policy search page on Medicare.gov (http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx). When you enter your zip code you'll see a list of the standardized lettered plans. Click on the one you want and you'll get a list of companies that sell it in your location.

Sadly, what you won't see are prices. For that, you'll need to contact the companies one by one. For whatever kind of plan you are interested in, you should work with a trusted independent health insurance broker to help you make informed decisions.

Who Can I Call For Help?

My financial advisor recommended a Medicare expert named Theresa Cangemi. Her website is at: http://mymedicaremadesimple.com. Her phone number is 315-676-4933. She does not charge a fee for consultations; she makes money from insurance companies if she refers them. My advisor has referred her to many clients and they all had very positive things to say about her.

You can also take advantage of free one-on-one counseling available through the New York Health Insurance Information, Counseling and Assistance Program (HIICAP). HIICAP provides free, accurate and objective information, counseling, assistance and advocacy on Medicare, private health insurance, and related health coverage plans. HIICAP helps people with Medicare, their representatives, or persons soon to be eligible for Medicare. The appropriate part of their website is located at: http://www.aging.ny.gov/HealthBenefits/Index.cfm

The local HIICAP office is: Onondaga County Department of Aging & Youth Civic Center - 13th Floor 421 Montgomery Street Syracuse, NY 13202-2911, phone 315-435-2362 Ext.114, e-mail: mkoldin@ongov.net

MORE Information

Some of the places on the Internet that I have found very accurate Medicare information are at:

The Federal Government: http://www.medicare.gov

CBS News: http://www.cbsnews.com/news/retirement-planning-guide/

Consumer Reports:

http://www.consumerreports.org/cro/news/2014/10/medigap-vs-medicare-advantage-consumer-reports/index.htm

Medigap (Medicare Supplemental) Policies and Rates in New York State - with 2013 Rate Tables: http://www.wnylc.com/health/entry/35/

Medicare Advantage Plans Available to Residents of NY -- by county: http://www.q1medicare.com/MedicareAdvantage-PartCHealthPlanMAPDHMOPPONewYork.php

NYS Information on Medicare: http://www.dfs.ny.gov/consumer/caremain.htm

The Fine Print

I am not an insurance expert. This article is not a discussion of all the options available nor does it cover all the laws involving Medicare. Your situation may be much different from anything discussed in this article. **Check with an independent Medicare insurance expert before you make any Medicare health insurance decisions or changes.**

LASTLY – once you have made a tentative choice on Medicare coverage, check with all your doctors and care providers to ensure that they will accept your insurance choice. Do NOT rely on the lists of doctors provided on websites as they have proven to be unreliable.