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The Hidden Costs of Medicare

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Watch out for these unexpected Medicare costs.

Certain Medicare Part D plans might require you to try similar lower-cost drugs before covering a more expensive medication that you're prescribed.

Some of the out-of-pocket costs Medicare beneficiaries face are fairly predictable, such as their monthly premiums, annual deductible and the copays and coinsurance associated with various Medicare services. However, there are other Medicare costs that are far more difficult to discern that could lead to surprise medical bills in retirement. Here are some Medicare costs you might unexpectedly incur in retirement:

Your free annual checkup might not be free. During the first 12 months you have Medicare Part B, you can get a free "Welcome to Medicare" preventive care doctor's visit, and after that retirees are eligible for a free annual wellness checkup. However, depending on what tests or services your doctor orders during this visit, you may still end up with a bill. While Medicare covers a variety of preventive care services with no cost-sharing requirements, if your doctor recommends a test or procedure that isn't considered preventive or you get a test more often than Medicare covers it, you may have to pay coinsurance and the Part B deductible may apply. "If the doctor orders a test and it falls under Part B, you could very well have to pay 20 percent of those test costs," says Allison Hoffman, an assistant professor of law at the UCLA School of Law. However, supplemental plans such as Medigap and Medicare Advantage plans may fill in some of these cost-sharing requirements.

Preventive services may trigger other costs. Medicare covers many, but not all, preventive care screenings with no out-of-pocket costs for retirees. However, if a screening test finds something concerning that requires additional tests or services, you will likely face a variety of out-of-pocket costs. "The copay is reduced to zero for the preventive service, but once that part of the service is no longer preventive, now we are treating something and you are going to hit the 20 percent copay," says Jack Hoadley, a health policy analyst at Georgetown University. For example, a colonoscopy is covered once every 120 months for most Medicare beneficiaries and typically costs nothing for the recipient. However, if a polyp or other suspicious tissue is discovered and removed during the colonoscopy, you may have to pay 20 percent of the Medicare-approved amount for the doctor's services and a copayment to the medical establishment where the procedure was performed.

No annual limit on out-of-pocket costs. With original Medicare, retirees can expect to pay a Part B deductible, copays and coinsurance amounting to 20 percent of the Medicare-approved amount for most services. There's no annual limit on what retirees could be expected to pay out-of-pocket. "There are types of situations where out-of-pocket costs can go extremely high," Hoadley says. "If you have major cardiac surgery, your 20 percent coinsurance could be thousands of dollars or possibly tens of thousands of dollars." Supplemental insurance policies can protect retirees from these sometimes catastrophically high costs.

Penalties for late enrollment. You can sign up for Medicare Part B at any time during the seven-month period that begins three months before the month you turn 65. But if you don't sign up during this initial enrollment period, you might have to pay a late enrollment penalty for the rest of your life. Your monthly Part B premium will increase by 10 percent for each 12-month period you were eligible for benefits but didn't sign up for them. For example, a retiree whose initial enrollment period ended Sept. 30, 2010, but who didn't sign up for Medicare Part B until March 2013 will pay 20 percent higher premiums due to the two full years he delayed signing up. People who are still working after age 65 and are covered by an employer's group health plan can avoid this late enrollment penalty by signing up for Medicare Part B within eight months of the employment or coverage ending. COBRA coverage and retiree health plans are not considered coverage based on current employment for the purpose of avoiding the late enrollment penalty.

You could lose your right to purchase Medigap coverage. Medigap policies, which are sold by private insurance companies, generally pay for some of the health care services Medicare doesn't cover. However, you only have a small window in which you are guaranteed the right to buy a Medigap policy. There is a one-time Medigap open enrollment period that begins the first month you're 65 and enrolled in Part B. It lasts for six months, during which you have the right to buy any Medigap policy sold in your state regardless of your current health. After this enrollment period ends, you may no longer have the option to buy a Medigap policy, or it could cost significantly more. "If you sign up in that initial period, they can't look at your whole health history and decide to charge you more because you have had cancer in the past or had heart disease," Hoffman says. "If you don't sign up in the initial enrollment period, then they can underwrite you. They can charge you more because of your particular health characteristics." If you delay enrolling in Part B due to group health coverage provided by an employer, your Medigap open enrollment period begins when you sign up for Medicare Part B.

Part D late enrollment penalty. Medicare Part D also has a late enrollment penalty if you don't sign up when you are first eligible to do so or you go 63 or more days in a row without prescription drug coverage, and the penalty increases the longer you go without coverage. "If you become entitled to Medicare and you decide you don't want to sign up for a Part D plan – for example, if you are not taking very many medications, if down the road you get sick and you start needing some medications, you will face a late enrollment penalty unless you have had drug coverage that was at least as good," says Juliette Cubanski, a Medicare policy analyst at the Kaiser Family Foundation. "It makes sense to sign up for Part D when you are first eligible or when you first lose coverage so as to avoid those late enrollment penalties." The late enrollment penalty is calculated by multiplying 1 percent of the national base beneficiary premium ($31.17 in 2013) by the number of months you went without Medicare Part D or other prescription drug

coverage after becoming eligible for Medicare, and is then added to your monthly premiums for as long as you have Medicare Part D. For example, a retiree who was first eligible for coverage on May 1, 2009, but elected to delay signing up for a Part D plan until Jan. 1, 2013, and didn't have other coverage during those 43 months will be charged a monthly penalty of $13.40 in 2013 in addition to her plan's monthly premium.

Drug restrictions. Medicare Part D plans have formularies that list which drugs are covered and the cost-sharing requirements. Some Part D plans also require prior authorization before you can fill certain prescriptions or might require you to try similar lower-cost drugs before a plan will cover a more expensive prescribed drug. There may also be quantity limits on how much medication you can get at a time.

Medicare Part D has a coverage gap. Most Medicare drug plans have a coverage gap that begins after a retiree incurs $2,850 in prescription drug costs and ends when drug costs reach $6,691 in 2014 and catastrophic coverage kicks in. In the coverage gap, retirees are responsible for 47.5 percent of the cost for brand-name drugs and 72 percent of the cost for generic medications in 2014. "Part D has the famous 'doughnut hole' that it going to be closed, but there's a sizable liability there for people who have substantial prescription drug costs," Palmer says. Some Part D plans offer additional gap coverage in exchange for higher premiums. The coverage gap is scheduled to be eliminated by 2020.

Little long-term care coverage. Don't expect Medicare to pick up the tab for a nursing home or many other types of long-term care. Only short-term nursing home stays of up to 100 days after a three-day hospital stay are covered. If you need nursing home care for longer than that, you will be responsible for all costs. "Many people who have a need for long-term care services end up spending down whatever resources are available to them and may, at that point, end up qualifying for Medicaid," Cubanski says. "While Medicare does not cover long-term care expenses, if someone is permanently living in a nursing home or some other type of assisted living facility, Medicaid does cover some of those long-term care expenses. And people can purchase private long-term care insurance that can help cover long-term care."