Understanding Medicare Fundamentals

A Healthcare Cost Planning Overview

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Medicare is health insurance provided by the federal government for people over 65 and people with certain disabilities. Congress created Medicare in 1965; it is primarily funded by Medicare insurance premiums plus payroll taxes paid by employees and employers.

Originally Medicare was a two part insurance program, but Medicare now has four parts.

- **Part A:** Hospital Insurance that pays for care in hospitals, skilled nursing facilities, hospices and some home health care programs. Part A does have deductibles and co-payments, but is premium free for most retirees.
- **Part B:** Medical Insurance providing direct payment for physicians' services, outpatient hospital care and a variety of other medical services. Part B has deductibles, co-payments, and monthly sliding scale premium of $105 to $336.
- **Part A and Part B together are known as "Original Medicare."**
- **Part C:** Medicare Advantage was added in 1997 and offers expanded insurance options including a wide variety of private health plans from both health maintenance organizations (HMO) and preferred provider organizations (PPO). Medicare Advantage premiums are in addition to Part B premiums, and can range from zero to several hundred dollars a month.
- **Part D:** This prescription drug plan was added in 2003 and is offered by Medicare-approved private insurance companies. Part D has deductibles, co-payments, and premiums based on an income adjusted sliding scale.

People may choose Original Medicare (Part A and Part B) or Medicare Advantage (Part C). Both insurance coverage options cover similar basic services but work differently.

In Original Medicare, the government makes health care payments directly to the doctors and hospitals and is sometimes known as "fee for service." With Original Medicare, one can also join a Medicare Prescription Drug Plan (Part D) to add drug coverage, and/or buy a private Medigap Medicare Supplement policy to help fill coverage gaps in Parts A and B.

Medicare Advantage Plans combine and replace coverage of Part A and Part B, and often include Part D prescription drug insurance. Advantage Plans are operated by private companies approved and regulated by Medicare. Medicare pays a subsidy to the Advantage Plan insurance company for each enrolled beneficiary and the company directly handles all payments to doctors, hospitals and other medical providers.

Medicare Parts

Part A	Part B	Part C	Part D	Medigap
Hospital Inpatient	Doctor Visits	Replaces A & B	Prescription Drugs	Not Medicare
Skilled Nursing	Labs & Tests	Privately Run	Privately Run	Privately Run
Home Health Care	Medical Devices	Extra Coverages	Various Coverage	Gap Coverage
Hospice Care	Outpatient Care	Drug Plans	Drug Discounts	10 Standard Plans

Medicare Options

Many factors influence consumers' Medicare decisions. Understanding Medicare coverage basics, including potential premiums, co-pay costs, cost sharing, and the out of pocket limits for each option is an important part of making these choices.

Medicare Part A: Hospital Insurance through Part A helps pay for "medically necessary" inpatient hospital stays and skilled nursing facility services following a qualifying hospital stay, as well as hospice care and some approved levels of skilled home health care. Part A is free for anyone who (or whose spouse) has made payroll contributions to Social Security for at least ten years (40 quarters). If someone has not worked enough quarters, Part A insurance coverage can be purchased with a monthly premium per month.

Medicare does not cover 100% of medical costs. Before Part A begins paying a share of costs for hospital in-patient stay, patients must first pay a deductible. 2014 Part A deductible is $1,216 and is paid for each hospital stay within a 60 day period, subject to certain limits. Daily co-payments for services may also apply, after a certain number of days. For hospital stays, the daily co-pay is $304 (2014) for days 61-90 and $608 for days beyond 91. In a skilled nursing facility, co-pay is $152 (2014) for days 21-100 and all costs beyond day 100. Part A does not cover long-term care, custodial care, or private rooms.

Medicare Part B: Medical Insurance through Part B helps cover costs of doctor office visits and other medical services. This includes physician services, durable medical equipment, emergency room service, urgent care, diagnostic tests, screenings, lab services, outpatient services, under-observation hospital stays, mental health services, and preventive care.

Costs under Part B include a premium, deductible, co-pay and co-insurance. The Part B premium varies according to income and can be affected by late enrollment penalties. For individuals with annual income less than $85,000, the 2014 premium is $104.90 per month. For incomes over $85,000, premiums range up to $335.70 per month. Part B has a late-enrollment penalty if an individual does not sign up when first eligible, unless an exception applies. Premiums are increased 10% for each year of delayed enrollment, and the penalty continues to affect the premium as long as the individual has Part B.

Part B has a deductible for each calendar year. The deductible for 2014 is $147 and adjusts annually. After the deductible, Part B generally pays 80% of Medicare approved charges for any service and the beneficiary pays 20%. Outpatient hospital services co-pays will vary by region, hospital and services. For some screenings and preventative services, co-pays, co-insurance and the Part B deductible does not apply, so the beneficiary will pay nothing.

Part B focuses on helping to pay the costs of medically necessary care when a beneficiary is sick or injured. Part B does not cover most routine foot care, examinations for hearing aids, examinations for eyeglasses, routine dental care or false teeth, acupuncture, cosmetic surgery, experimental medical procedures or long term care. Part B offers the same benefits throughout the United States but generally does not cover medical care expenses outside of the United States.

Medicare Part C: People with Medicare can get their health coverage through Original Medicare (Parts A and B) or a Medicare Advantage plan. Medicare Advantage plans ***replace*** Original Medicare and Medigap supplement insurance, and are offered by private companies that contract with Medicare. They provide single plan coverage for hospital costs, doctor's visits, other medical services, plus prescription drug coverage, if desired. Some Medicare Advantage plans may also offer extra benefits and options such as hearing, vision, and dental, or services such as medical transportation and gym memberships. Most Medicare Advantage plans also include Medicare prescription drug coverage (Part D).

In order to be eligible for a Medicare Advantage plan, one must be enrolled in Medicare A and B, must live in the plan's service area, and may not have End-Stage Renal Disease at the time of enrollment. There are five different types of Medicare Advantage Plans:

1. **Medicare Managed Care Plans (HMOs)**: Members must see doctors in the plan's network. In most cases, a primary care doctor coordinates health care.
2. **Medicare Preferred Provider Organization Plans (PPOs)**: Members may see any doctor but it costs less to see doctors within the plan's provider network.
3. **Private Fee-for-Service Plans**: Members may visit any Medicare-approved doctor or hospital if that care provider agrees to the plan's terms and conditions of payment before treatment. The plan decides how much it will pay the providers and the cost sharing for the beneficiary.
4. **Medicare Special Needs Plans**: These plans provide health care coverage for special needs, such as chronic illness, people in institutions and people with Medicaid.
5. **Medicare Medical Savings Account Plans**: These plans have two parts: a Medicare Advantage Plan with a high deductible and a Medical Savings Account into which Medicare deposits money that people can use to pay health care costs.

Medicare Advantage plan participants continue to pay the Part B premium, and Part A premium, if applicable. Additional premiums for Medicare Advantage plans can vary widely, as can their coverages, deductibles, co-pays and co-insurance. All Medicare Advantage plans are required to have a cap on the amount participants pay each year for the Part A and Part B services provided through the plan. Insurers can change premiums and other terms of the plan from year to year.

A cost estimate and coverage comparison tool is available at the Medicare web site: www.medicare.gov

Medicare Part D: Prescription Drug Coverage under Part D is insurance from a company under contract with Medicare. Part D may either be a stand-alone plan to combine with Part A & B, or the Part D coverage may be included in a Medicare Advantage plan.

Monthly premiums for Part D drug plans vary widely, even for similar coverage. If a beneficiary's income is above $85,000, there will be an income-related adjustment amount added to the premium. If one does not sign up for Medicare Part D coverage as soon as eligible, the premium goes up 1% of the national base monthly premium for each month of delay. In 2014, the base monthly premium is $32.42. The late enrollment premium penalty continues as long as one is enrolled in Medicare Part D.

Under Medicare Part D, participants pay a share of drug costs. Cost sharing with Part D might include an annual deductible before coverage begins. In 2014, no Part D plan may have a deductible more than $310. Most plans require a co-payment for each prescription.

Medicare Part D cost sharing changes once drug expenses reach the coverage gap, or "donut hole." Not everyone will enter the coverage gap. This occurs after all costs for covered drugs, paid by the Part D plan and the beneficiary combined, in a year reach a certain level ($2,850 in 2014). In 2014, in the coverage gap, the beneficiary must pay 47.5% of the plans' cost for covered brand name prescription drugs, and 72% of generic drugs, up to a yearly limit ($4,550). Some plans offer coverage in this gap for generic prescriptions.

Pursuant to the Patient Protection and Affordable Care Act of 2012, each year, the discount percentages on covered drugs will increase until the donut hole is completely eliminated in 2020. Additionally, once out-of-pocket drug costs reach the yearly limit ($4,550 for 2014), the beneficiary enters Catastrophic Coverage, which means there is only a very small co-payment for each drug for the rest of the year.

The federal government has created guidelines for drugs that must be covered and set minimum benefit standards that all Part D plans must meet. Drugs covered, co-payment amounts, deductibles and gap coverage are different for each plan. Each year in October, the insurance companies announce the details of their plans for the coming year and beneficiaries have an opportunity to change plans.

Medicare Supplemental Insurance – Medigap: Although Original Medicare (Parts A and B) pays for many health care services and supplies, there are still some out-of-pocket costs incurred by Medicare beneficiaries—referred to as "gaps". A Medicare Supplement or Medigap policy helps eliminate these coverage gaps by paying some costs Original Medicare won't pay (deductibles, co-insurance, and co-payments). Medigap policies are not government benefits, like Parts A and B, but are private health insurance policies sold by private companies. There are standardized Medigap policies, which are usually lettered A-N in most states. Medigap insurance companies can decide which of these policies they sell in your state, under the conditions imposed by the state insurance department.

Medigap policies are designed to be combined with Original Medicare coverage. If one has Original Medicare and purchases a Medigap policy, Medicare pays its portion of medical costs covered under Part A and B first, and then the Medigap policy covers its portion of deductibles and co-pays. Those with Part C Medicare Advantage plans should not buy Medigap coverage because it does not supplement Medicare Advantage plans.

There are ten different Medigap plans, named with letters from "A" to "N." The different plan types vary in which coverage gaps they will fill. All policies with the same letter offer the same benefits. As a general rule: the more generous the coverage, the higher the premium. Other factors that could affect premiums include, age, gender, health history and tobacco use. Medigap premiums may also rise over time. Even though the federal government defines standard benefits for the plans, prices do vary among companies. Two companies may charge very different prices, or premiums, for identical coverage.

One can apply for a Medigap policy at any time after joining Original Medicare, but there are only some periods within which a Medicare beneficiary is guaranteed the right to purchase any available Medigap policy they choose. The six-month period following the 65th birthday is called the open enrollment period. During an applicant's open enrollment, the insurer cannot consider medical history or current health in setting a premium. Certain other situations can trigger guaranteed-issue windows during which an insurance company must sell a policy regardless of health.

Medigap policies are "guaranteed renewable" annually, so long as the beneficiary pays the premium on time. Changing into a different Medigap policy is complicated because after open enrollment ends, insurers can generally refuse coverage or charge a higher premium based on health conditions. There are limited situations, which might vary by state, in which you have the right to buy a Medigap policy regardless of your health condition.

Because Medigap policies can close all the cost-sharing gaps in Original Medicare, they can be a very good choice for individuals needing frequent or high cost care. Moreover, there are no "networks" with Medigaps, and no referrals are required. One can go to any healthcare provider that accepts Medicare. Parts A&B plus Medigap might work well for travelers or "snow birds" that may frequently be out of an Advantage Plan's service area.

Medicare Enrollment: There are four types of enrollment in Medicare: automatic enrollment, initial enrollment, open or general enrollment and special enrollment period.

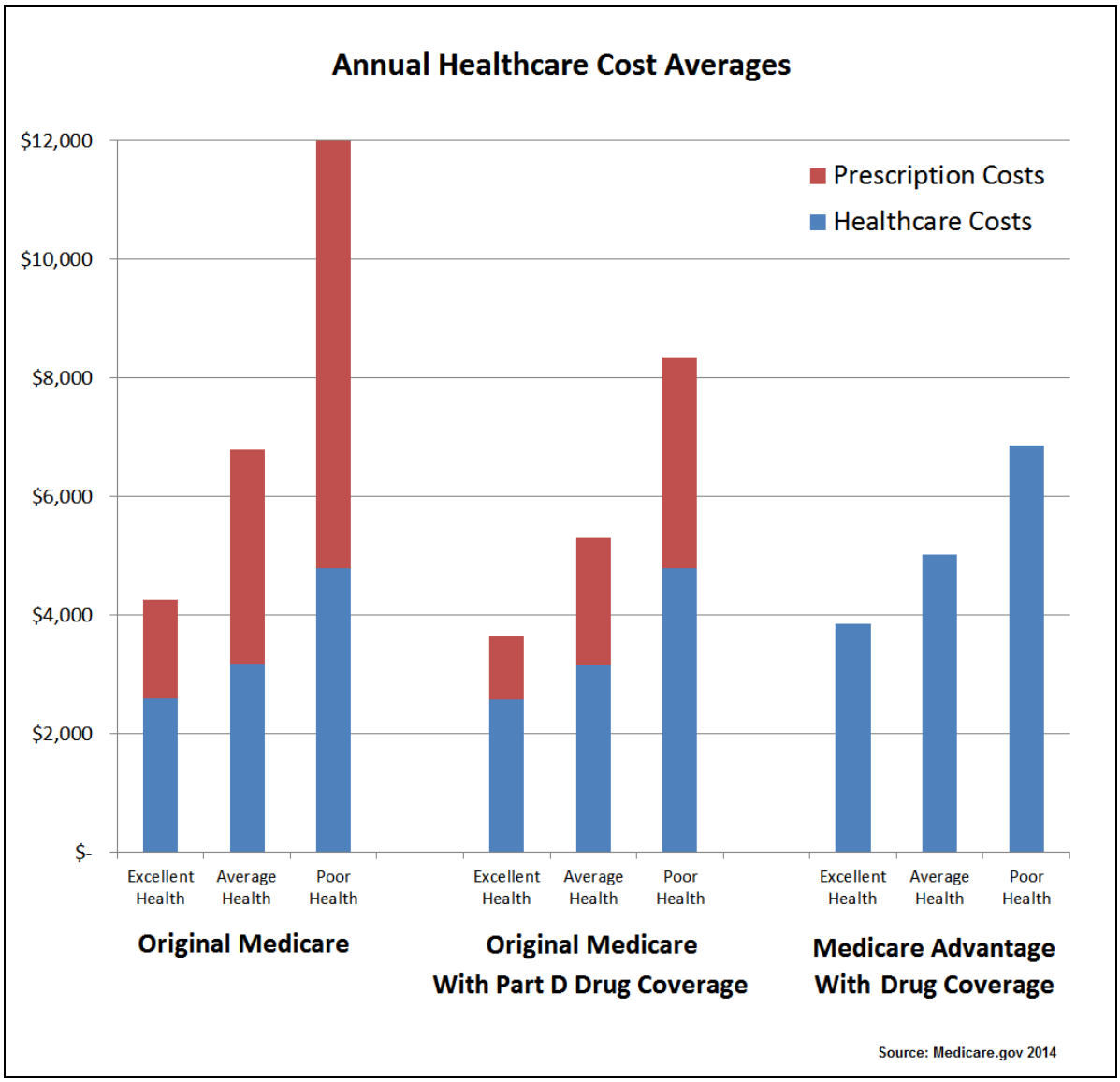
A person will automatically be enrolled in Medicare Parts A and B if they have been receiving benefits from Social Security or the Railroad Retirement Board before they turn 65. Benefits will automatically commence the month the beneficiary turns 65. Automatic enrollment also occurs when a person under age 65 has been receiving Social Security Disability Insurance for at least 24 months. Automatic enrollment never occurs in Part C, Part D, or Medigap. Those plans' coverage will only begin if a beneficiary initiates them.

People most commonly enroll in Medicare during their initial enrollment period. For Parts A-D, initial enrollment surrounds a person's 65th birthday. A person can enroll in Parts A-D during the 7 month period beginning 3 months before their birthday month through 3 months after their birthday month. For a Medigap policy, the best time to purchase a policy is during the guaranteed issue six month open enrollment period after which the individual is both 65 and enrolled in Medicare Parts A and B.

If an individual delays enrollment beyond the initial enrollment period, he or she can still sign up during specific general or open enrollment periods, but premiums may be higher for Parts B and D, unless they qualify for an exception. Original Medicare (Parts A and B) has a general enrollment period from January 1 to March 31 each year, with coverage beginning July 1. If a person enrolls during this period, they may also enroll in Parts C or D between April 1 and June 30, with coverage effective July 1. There is also an annual open enrollment period for Parts C and D between October 15 to December 7 each year, with coverage beginning January 1 of the following year.

Beneficiaries who qualify for special enrollment are not limited to enrolling during the general enrollment period. However, they should enroll as soon as possible within the special enrollment period to avoid gaps in coverage. With special enrollment, coverage usually starts the month after the election is made, and usually no late premium penalty is assessed. The most common special enrollment is where the beneficiary or spouse is working and has group health plan coverage through the employer or union.

When you stop working for an employer where you have a group health plan, you qualify for an eight month special enrollment period. Be aware, the eight months starts when your employment ends, not when your group coverage terminates. Extended benefits or COBRA do not affect the eight month special enrollment period.



Conclusion

Choosing Medicare coverage is an important decision. Medicare is not one size fits all. With many options, coverages, and important differences between the available plan combinations and choices, consumers will need to be properly informed and consider their individual needs in order to find the best match with what is available and affordable for their particular set of circumstances and coverage needs.

- Original Medicare, Parts A & B, when combined with Part D Drug coverage and a Medigap policy offer flexible hospital, medical, and drug insurance coverage good all over the United States wherever Medicare is accepted.
- Medicare Advantage plans offer differing levels of comprehensive HMO and PPO group medical services and Prescription Drug coverage that replaces Medicare Parts A & B.
- People most commonly enroll in Medicare during their initial enrollment period beginning 3 months before their 65th birthday month through 3 months after their birthday month.
- There may be significant premium penalties for late enrollment unless an individual has a special enrollment exception, such as having been working and had insurance coverage through an employer or union group health plan.
- Individuals should plan to review their Medicare coverage once a year to see if it still meets their needs. During the Annual Election Period between October 15 and December 7, one can add, drop, change, or renew Medicare Part D prescription drug coverage and/or Medicare Advantage plan.

A cost estimate and coverage comparison tool is available at the Medicare web site: www.medicare.gov

Addendum

Healthcare costs and insurance premiums vary by region, by coverage options selected, by prescriptions needed, and as a function of the amount and kind of healthcare services used in the course of any individual year. While there are many variables affecting expenses, it may be useful to know some of the averages and ranges for planning purposes.

Original Medicare: The annual estimated average health costs for a Medicare beneficiary in good health with Original Medicare is $6,180, including premiums, deductibles and out-of-pocket cost sharing. Of that amount, $2,868 is for prescription medications. For a person with excellent health, the annual average estimate is $3,960, with $1,320 for prescriptions. For a person with poor health, the average estimate is $12,030, with $6,864 for prescriptions.

Original Medicare Plus Part D: The annual average estimated **prescription drug costs** for a Medicare beneficiary in good health on Original Medicare and without prescription drug coverage is estimated to be $2,868. Estimated annual average drug costs for an average Medicare beneficiary with Original Medicare and a Part D prescription drug plan and a 97330 zip code is between $1,330 and $2,880, depending on which of the 33 plans are selected. This includes premium costs. The out of pocket costs will differ depending on the person's zipcode, income, age and health status and which prescriptions they are on.

Medicare Advantage Plan: The costs for Medicare Advantage Plans (MAP) coverage and the cost sharing vary significantly by zip code. For the Oregon zip code 97330, there are 14 Advantage Plans that include prescription drug coverage. Premiums range from $0 to $205 per month. The estimated annual health and drug costs (including Part B and Advantage Plan premiums, deductibles and out-of-pocket) for an average person is between $3,540 for the least expensive MAP to $5,890 for the most expensive. For a person with excellent health, estimated annual health and drug costs ranges from $2,810 to $5,230 depending which plan is selected. For a person with poor health, the estimated annual health and drug costs ranges from $5,040 to $7,510, depending on which plan selected.

Medigap Policies:
Medigap policies can work to make the effect of deductibles, co-payments, and other cost sharing effects more predictable by allowing individuals to purchase coverage for these expenses for an agreed upon regular premium amount. Premiums for Medigap Policies can vary by plan type as well as from company to company. Coverage and cost-sharing varies according to which plan selected.

Some Key Medicare Factors to Consider When Evaluating Medicare Coverage Choices

A. Who are you medically? Do you enjoy good health, or have high medical costs?
B. What coverage will you need? Basic? Flexible? HMO? PPO? Prescription Drugs?
C. When is your enrollment period, or your annual coverage modification windows?
D. Where do you need coverage? HMO and PPO plans may have area limitations.
E. How much can you afford? Plans have many various premiums and coverages.

Hypothetical Examples with Situation Summary, Possible Choices, and Cost Estimates

[based upon 2014 Cost estimates in 97330 zip code Medicare.gov]

1. 65 year old man, good health, few prescriptions
2. 65 year old woman, poor health, many prescriptions
3. 65 year old couple, good health/poor health, many prescriptions
4. 50 year old couple, good health, how to estimate health costs after 65

Example #1: John just turned 65 and is retired. He is in excellent health and has only a couple of prescriptions. John is budget aware and he is okay with limiting his choice of physicians within a plan's provider network.

John's coverage choice is an HMO type Medicare Advantage Plan (MAP) with a $0 per month premium, which offers a network of local doctors and hospitals and also extras such as basic vision coverage, hearing exams and a discounted fitness club membership. This MAP includes the Part D prescription drug plan in case his prescription drug needs increase later.

John's cost sharing: $104.90 per month Part B premium plus $0 per month Medicare Advantage Plan, for a total of $104.90 per month. John's other costs will depend on the services and prescription drugs actually used. The estimated average annual health care and drug costs, including deductibles and co-pays for an individual in good health in John's MAP is $4,150.

Example #2: Roberta just turned 65 and is retired, with a comfortable pension. Roberta is considered to be in poor health and requires regular medical visits. She takes several medications. She spends a few winter months out of state, where it is warm and sunny.

Roberta's choice is Original Medicare Part A and Part B, plus a stand-alone Part D drug coverage and a Medigap plan F policy, both from well-recognized insurance companies. This allows Roberta full access to physicians and hospitals when she is out of state and provides significant coverage for all her doctor visits and medical costs.

Roberta's cost sharing: $104.90 per month for Part B premium, plus $47.70 per month for Medicare Part D drug coverage, and $146 per month Medigap plan F policy premium, for a total of $298.60 per month. The Medigap policy covers most of the Part A and Part B co-payment cost sharing and Roberta's other co-payment cost sharing will vary depending on prescription drugs used. Her estimated annual drug costs will be $2,468 plus $3,010 for estimated health costs, for a total estimated average cost of $ 5,478.

Example #3: Samuel is 67 and works for a company that provides health insurance to its 100+ employees and dependents. His wife, Joanna, who is retired, just turned 65. Samuel and Joanna have both been continuously covered under Samuel's employer's group health policy. Samuel is having some health issues and has decided to retire. Because he and his wife have been covered by employer group health insurance, they may now enroll in Medicare without any penalty. Samuel is in poor health and takes many prescriptions. Joanna is in excellent health and takes one prescription drug.

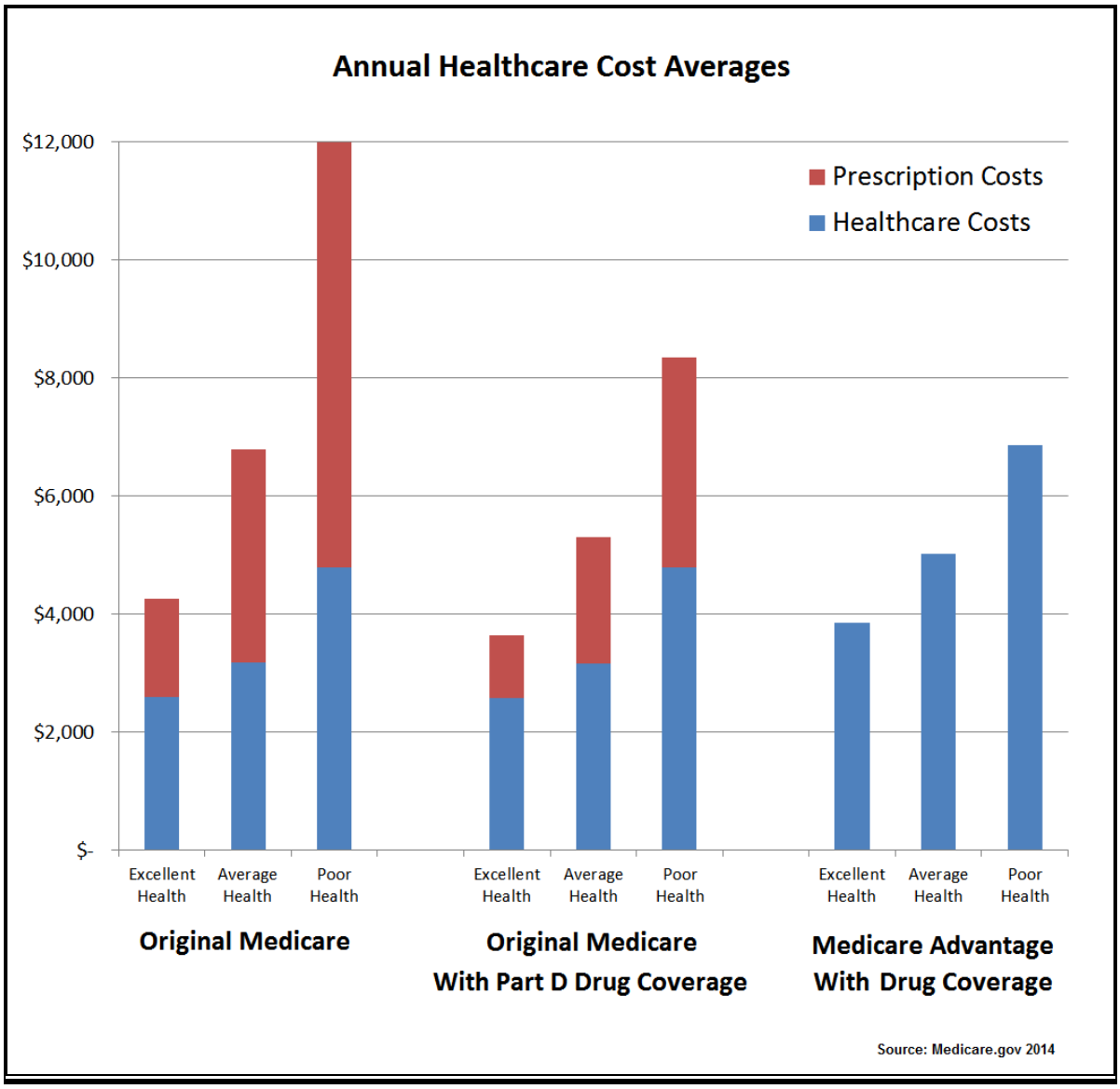
Samuel and Joanna both choose Medicare Part A and Part B, plus a Preferred Provider Organization (PPO) Medicare Advantage Plan. Samuel chooses a PPO plan with a $66 per month premium and Joanna chooses a different PPO plan with a $0 premium. Both Medicare Advantage Plans (MAP) give Samuel and Joanna freedom to choose a doctor from a network of doctors around the state and also allow for visits to a doctor or hospital outside the network for a larger copayment. Both plans include prescription drug coverage and some vision and dental coverage.

Samuel's and Joanna's cost sharing: $104.90 each per month Part B premium, plus $66 per month for Samuel's Medicare Advantage Plan, for a combined total of $275.80 per month. Their combined annual cost for premiums is $3,309.60, plus any deductibles and co-pays. The estimated average annual total health care and drug cost for an individual like Samuel in poor health with his plan's coverage is $7,070. Estimated average annual health care and drug cost for an individual in Joanna's excellent health in her MAP is $2,810. Total estimated average annual health care and drug cost for this couple is $10,880, but will vary according to the prescriptions and medical services needed in any particular year.

Each year, during the Annual Election Period from October 15 to December 7, Samuel and Joanna can reevaluate whether the Medicare Advantage Plans they chose are still adequately meeting their needs. During this period, the couple could choose to change one or both of themselves to a different Medicare Advantage Plan available in their state that might give them more appropriate coverage as their healthcare and/or prescription drug needs change over time.

Example #4: Jennifer and Norman are now both 50 years old, and have just started working with a financial planner. As part of their retirement spending estimate, the advisor is making an estimate of their annual health care costs when they retire at age 65. There are many unknowns; Jennifer and Norman's health at that time, how Medicare and associated insurance may change over time, and how inflation will affect healthcare and prescription costs. Even with all those unknowns, the advisor wants to include a figure in their plan to reasonably represent the unknown future retirement healthcare costs.

Estimated average health cost for a Medicare beneficiary with Original Medicare with average health, including premiums, deductibles and out-of-pocket costs is $3,264 per year. Average cost of Part D drug coverage and co-pays is $2,315. Total average cost estimate for a person of average health is $5,579. This figure needs to be inflated over time, and the expected healthcare inflation rate of 4.9% is higher than the general CPI. [Source: Centers for Medicare and Medicaid Services, 2014]



About the Authors: Pamela K. Edinger and Mark Snodgrass developed this paper to address some of the planning issues associated with healthcare, Medicare, and insurance coverage choices facing Americans preparing for, and managing, their retirement.

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