2024

MEDICARE EXPLAINED

Knowledge series

This material is unbiased and intended to impart general information regarding 65+ Medicare benefit basics including Medigap Supplemental Insurance in an easy-to-understand educational based format.

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Section 1.

Original Medicare Simplified

Original Medicare includes Part A and Part B, and is a Fee-for-Service payment arrangement where each particular service rendered is billed separately. Anyone on Medicare is called a "Medicare Beneficiary." Medicare Part A is known as hospital insurance and covers inpatient hospitalization, skilled nursing home, hospice, blood, and home health services. If you had to purchase Part A coverage today it would cost up to $505 each month. You usually do not have to pay a premium if you or your spouse have paid Medicare taxes while working, and there is a $1,632 deductible per 60-day benefit period. For an example, if you were admitted to a hospital on the 15th. of January, that would start a 60-day benefit period requiring a $1,632 deductible. If you had to be readmitted again on April 15th. because your heart could not take paying all those taxes. Another 60-day benefit period begins requiring another $1,632 deductible.

Medicare Part B is known as medical insurance and covers medically-necessary services like doctors' services, outpatient care, and home health services. You must pay a premium based upon your income which starts at $174.70 per month, and has a $240 annual deductible. After meeting your annual deductible, Medicare pays 80% of the Medicare-approved amount and the Medicare beneficiary pays the remaining 20%. Doctors and providers who do not accept assignment may charge more than the Medicare-approved amount, but there is a ceiling called the limiting charge. This sets the maximum for excessive charges, which can be no more than 15%.

If you do not sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but did not sign up for it. Usually, you do not pay a late enrollment penalty if you meet certain conditions, such as ending Employer Group coverage.

Generally, when you apply for Social Security benefits you will automatically get Part A and Part B starting the first day of the month you turn 65. If your birthday is on the first day of the month, Part A and Part B will start the first day of the previous month. The Red, White, and Blue Medicare card will usually arrive in the mail 3-months before your 65th birthday. If you are age 65 not getting Social Security benefits, and/or you are still working and you

want Medicare Part A and Part B. You will still need to sign up, and you will need to pay the Part B premium by check or bank draft until your Social Security benefits begin. If you **do not** sign up for Medicare Part A and Part B when you are first eligible, you can sign up between January 1st. and March 31st. each year, and the coverage will begin July 1. But you can sign up anytime while you or your spouse are covered under an Employer Group Health Plan through eithers current employment, or during the 8-month period that begins the month after employment or group health coverage ends, whichever happens first. When ending Employer Group coverage, it wise to consult with the Employer's Group administrator to verify how it could affect spousal coverage and whether spousal coverage can be retained.

2024 Part B Premiums are Based upon 2023 Annual Income		
File Individual Tax Return	**File Joint Tax Return**	**Monthly Premium**
$103,000 or less	$206,000 or less	$174.70
$103,000 up to $129,000	$206,000 up to $258,000	$244.60
$129,000 up to $161,000	$258,000 up to $322,000	$349.40
$161,000 up to $193,000	$322,000 up to $386,000	$454.20
$193,000 up to $500,000	$386,000 up to $750,000	$559.00
$500,000 and up	$750,000 and up	$594.00

Help Paying for Part B Premiums and Costs

There may be help available through the Medicare Savings Programs that will pay for the Medicare Part B cost(s). Eligibility is determined by completing a paper or online application known as the Medicare Buy-in. The online application process will usually result in a faster answer, as long as the information requested was complete. Otherwise, the response received could be for more detailed information and/or documentation. Qualifying for the Medicare Buy-in is based upon Means Testing over income and asset limits. If a Medicare beneficiary has excessive income or resources over a certain threshold, they will not qualify.

QMB Medicare Savings Program Qualified Medicare Beneficiaries

For 2024 single Medicare beneficiaries must have monthly income less than $1,275 with resources less than $9,430, and married Medicare beneficiaries must have monthly household income less than $1,724 with resources less than $14,130. Medicare beneficiaries with (QMB) status qualify to have their Medicare Part B premiums paid as well as the Medicare Part B deductibles and co-insurance within the prescribed limits. A (QMB) beneficiary automatically qualifies for Extra Help for Medicare Part D drug costs.

SLMB Medicare Savings Program Special Low-income Medicare Beneficiary

For 2024 single Medicare beneficiaries must have monthly income less than $1,526 with resources less than $9,430, and married Medicare beneficiaries must have monthly household income less than $2,064 with resources less than $14,130. Medicare beneficiaries with (SLMB) status only qualify to have their Medicare Part B premiums paid for, and no Medicare Part B deductibles or co-insurance. (SLMB) beneficiaries automatically qualify for Extra Help for Medicare Part D drug costs.

QI Medicare Savings Program Qualifying Individuals

(QI) is funded by a block grant and is available on a "first come" basis which is also contingent upon the availability of funds**.** For 2024 single Medicare beneficiaries must have monthly income less than $1,715 with resources less than $9,430, and married Medicare beneficiaries must have monthly household income less than $2,320 with resources less than $14,130. Medicare beneficiaries with (QI1) status only qualify to have their Medicare Part B premiums paid for, and automatically qualify for Extra Help for Medicare Part D drug costs.

Resources Defined

Resources are defined as the value of the things you own, such as rental property and other real estate, or investment property; cash, checking and savings accounts, or certificates of deposit (CDs); stocks, bonds, savings bonds, mutual funds, and brokerage accounts; and retirement accounts such as (IRAs). Some examples of what is not counted as a Resource is the primary residence (homestead), personal possessions, primary vehicle, and basic home furnishing.

Assignment

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

If your doctor, provider, or supplier accepts assignment they agree to charge you only the Medicare deductible and coinsurance amount and wait for Medicare to pay its share before asking you to pay your share. They must submit your claim directly to Medicare for payment.

Certain doctors or providers who do not want to work with Medicare can opt out of Medicare. If you choose to work with an opt-out provider you will have to set up the payment terms that you both agree upon through a private contract or arrangement.

What is Not Covered under Original Medicare

Original Medicare does not cover Part D Drug Coverage, Long Term Care, routine Dental care, Dentures, Cosmetic surgery, Acupuncture, Hearing Aids or exams for fitting Hearing Aids. You cannot be covered under Original Medicare Fee-for-Service and Medicare Part C (Medicare Advantage) at the same time.

Referrals

You do not need referrals from a Primary Care Physician to access care from a Specialist or for a procedure, and you are not restricted to networks.

HSAs and Medicare

HSA stands for Health Savings Account. HSAs are usually available to any individual covered by a qualified high deductible health plan.

HSA contributions (including employer-provided ones) are disallowed when other coverage is in place, including Medicare Part A. Workers can still use funds already in HSAs for eligible expenses. They just cannot contribute further once enrolled in Medicare. There is a 6-month lookback period (but not before the month of reaching age 65), therefore it is a best practice for workers to stop contributing to their HSA six months before enrolling in Medicare to avoid penalties. Ineligible HSA contributions that are considered disallowed are not tax deductible and subject to a 6% excise tax (penalty). However, excess contributions to your HSA can be removed, if removed before the federal income taxes are due. You will still be liable for the regular income taxes due on the excess removed from your HSA, but without the excise tax (penalty).

Funds already in the HSA can still be used for qualified medical expenses upon enrollment in Medicare, including to reimburse taxpayers for Medicare premiums (but not premiums for Medicare Supplemental Insurance).

If you defer Medicare past the age of 65, the taxpayer must be enrolled in an employer-based group health plan. An HSA eligible plan through the private marketplace, COBRA, or a health care exchange **does not qualify**, and in that case, they must cease contributions to the HSA upon reaching age 65 and enroll in Medicare to avoid lifetime late-enrollment penalties.

For more detailed information on Health Savings Accounts, Refer to the following publication:

IRS Publication 969

Health Savings Accounts and Other Tax-Favored Health Plans

Employer-provided Group Health Plans and Medicare

Group Health plans for Employers with 20 or more employees are required by law to offer workers and their spouses who are age 65 or older the same health benefits that are provided to younger employees. If you currently have coverage under an employer-provided Group Health plan. You should consult with your human resources office before you sign up for Medicare Part B, because Medicare Part B requires you to pay a premium. The size of your employer determines whether your coverage will be creditable once you retire and are ready to enroll in Medicare Part B. If your employer has 20 or more employees, Medicare will deem your group coverage creditable, and you can avoid the Medicare Part B late enrollment penalty by providing evidence of having creditable coverage.

If you have Medicare and other health coverage, each type of coverage is called a "payer." When there is more than one payer. The Coordination of Benefits rules decide who pays first. The "primary payer" pays what it owes on your bills first, and then you or your health care provider sends the rest to the "secondary payer" to pay.

If you are age 65 or older and have Group Health plan coverage based on your, or your spouse's current employment status. The Coordination of Benefits rules are as follows:

- If the employer has 20 or more employees. The Group Health plan is the primary payer and pays first, and Medicare pays second.
- If the employer has fewer than 20 employees and is not part of a multi-employer or multiple employer group health plan. Then Medicare is the primary payer and pays first, and the group health plan pays second.
- If the employer has fewer than 20 employees, but is part of a multi-employer or multiple employer Group Health plan. The Group Health plan is the primary payer and pays first and Medicare pays second.

The Coordination of Benefits rules can vary based upon your circumstance.

- ✓ You are under age 65 and disabled, or have End-stage Renal Disease.
- ✓ You receive Indian Health Services.
- ✓ You are under workers compensation, or no-fault liability is involved.
- ✓ You are a veteran with Veteran's benefits, or TriCare.
- ✓ You are covered under the Black Lung program.
- ✓ You have COBRA, or you have a Medigap policy.

NOTE: Employers and Unions are not required to provide retiree coverage, and they can change benefits, premiums, or even cancel coverage at any time.

The 3-day Rule

This is important because Medicare Part A covers Inpatient admission into a Skilled Nursing Home Facility for recovery only after a minimum of at least **three consecutive days of an Inpatient Hospital admission.** This 3-day rule does not include the discharge day or pre-admission time spent in an Emergency Room or when considered **Under Observation.** A patient who has met the Medicare 3-day formal admission requirement, and then must move into a skilled nursing facility for recovery is covered at 100% for the first 20-days if under Original Medicare.

The 2-Midnight Rule

Just because you may stay overnight at a hospital does not mean that you were admitted as an Inpatient. If you do not stay beyond 2-Midnights in the hospital you would be considered to have been **Under Observation** and billed under Medicare Part B. Patients leaving the hospital for a nursing facility after an observation stay may have to pay the full amount of the out-of-pocket costs unless the patient meets certain low-income requirements. If you have been Under Observation verses being admitted as an Inpatient for at least 24-hours. Hospitals must give you a Medicare Outpatient Observation Notice explaining why you are under observation.

You Have Rights

As a Medicare beneficiary you have certain Guaranteed Rights. You have the right to be treated with dignity and respect at all times, to have your questions about Medicare answered, to be protected from discrimination, to have access to doctors and specialists and hospitals, to learn about all of your treatment choices and participate in treatment decisions, to get information in a way you understand from Medicare and health care providers, to receive emergency care when and where you need it, to get a decision about a health care payment or service and/or prescription drug coverage, to get a review or appeal of certain decisions about a health care payment or coverage of services or prescription drug coverage, to file complaints (also called grievances) including complaints about the quality of your care, and to have your personal and health information kept private.

Key Takeaway

In most cases you can go to any doctor, hospital, medical facility or use any supplier that accepts Original Medicare. For more detail, refer to the **Medicare and You** handbook.

Section 2.

Medigap (Medicare Supplement Insurance)

Medigap policies are offered by licensed Insurance companies through their state appointed agents or brokers. A Medigap policy is also known as a Medicare Supplement policy. Medigap policies can help pay some of the health care costs "gaps" that Original Medicare does not cover. Medigap policies are standardized and identified as Plan A through Plan N. Plan E, H, I, and J are no longer available for sale, but any existing in force plans are still good. The standardized plans are guaranteed renewable even if you have health problems. This means the insurance company cannot cancel your Medigap policy as long as you pay the premiums. You must have both Medicare Part A and Part B. You pay a premium for a Medigap policy in addition to the monthly Medicare Part B premium, and a Medigap policy only covers one person.

New to Medicare Plan Coverage Comparison	**2024 Medigap Plans vary in Coverage and Premium**									
	A	B	C	D	F	G	K	L	M	N
Part A Deductible		x	x	x	x	x	50%	75%	50%	x
Part A Co-insurance	x	x	x	x	x	x	x	x	x	x
Part B Deductible										
Part B Co-insurance	x	x	x	x	x	x	50%	75%	x	x
Part B Excess Charges					x	x				
Skilled Nursing Co-insurance			x	x	x	x	50%	75%	x	x
Blood First 3 Pints	x	x	x	x	x	x	50%	75%	x	x
Foreign Travel			80%	80%	80%	80%			80%	80%

Plan F and **Plan G** also offers a high-deductible plan where a $2,800 deductible must be paid first before the plan starts paying. However, the premium is lower.

Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for doctor's office visits and up to a $50 copayment for Emergency Room visits

Medicare SELECT

Medicare SELECT is a type of Medigap policy sold that requires you to use hospitals, and in some cases, doctors within it a network to be eligible for full insurance benefits (except in an emergency). However, the premium is lower.

Medigap policies do not cover Long-term Care, like care in a custodial nursing home, Vision or Dental care, Hearing aids, Eyeglasses, and Private-duty nursing. Medigap policies are not Medicare Advantage Plans, like an HMO, PPO, or a Private Fee-for-Service Plan, and they do not include Medicare Prescription Part D drug coverage.

A Medigap policy is designed to supplement Original Medicare. They are not for Medicare beneficiaries on Medicaid, and not for Medicare beneficiaries on a Medicare Advantage Plan, or with TRICARE Veteran's benefits.

Rate Calculations for Medigap Policies

Community rated is where the rates are not based upon age. Generally, everyone regardless of age pays the same premium. Premiums may go up because of inflation and other factors but not because of your age.

Issue age rated is where the rates are based upon your age when you buy. Typically, premiums are lower for people who buy at a younger age and they won't change as you get older. Premiums may go up because of inflation and other factors but not because of your age.

Attained age rated is where the rates are based upon your current age and go up as you get older. Premiums are lower for people who are younger but increase as they get older and may also go up because of inflation and other factors.

Key Takeaway

For most individuals new to Medicare, a Medigap policy offers great value compared to Employer Group Health Insurance or a pre-65 Individual Health Insurance Policy. When comparing the majority of Medigap Plans available, a Medicare beneficiary with a Medigap policy pays low or zero out-of-pocket when they use the plan. Yes, they pay an up-front premium, but this also allows them to remain independent by giving them the option to choose any doctor, hospital, medical facility, or supplier who accepts Original Medicare. Besides providing the freedom to choose, they have less hassle. Medigap Plans do not require referrals or prior authorizations before care is provided. Since Medigap policies are guaranteed renewable they provide no surprise - predictable coverage.

Section 3.

Understanding Medicare Part C

The passage of Balanced Budget Act of 1997 gave Medicare beneficiaries the option to receive their Medicare benefits through private health insurance plans verses Original Medicare Part A and Part B. These plans were known as Medicare Part C or Medicare + Choice plans. In 2003 after the passage of the Medicare Prescription Drug, Improvement, and Modernization Act, "Medicare + Choice" became known as "Medicare Advantage" or (MA) plans. Original Medicare is also known as Traditional Medicare and/or Medicare Part A and Part B. Original Medicare is a "fee-for-service" arrangement. A Medicare beneficiary goes to a doctor, and the doctor gets paid a fee for their service which is based upon a codified Medicare approved dollar amount. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a fixed dollar amounts every month. Then the plan contracts with Primary Care doctors and Hospitals and negotiates either a fee-for-service agreement or a risk contract. Risk contracts are also known as "capitation" where the Primary Care doctor receives a fixed payment each and every month per member that is assigned to their practice. The fixed amount they receive is based upon the amount of risk they want to participate in. The more risk, the more they receive per member per month. Out of the amount a Primary Care doctor receives under this capitation agreement they must pay out a portion to specialists used by the plan member. That is why a Medicare beneficiary on a (MA) coordinated care plan is required to use providers in a network, and to get referrals and/or prior authorizations for medical procedures. Should a Medicare beneficiary under one of these arrangements choose not to use providers in the network, or to not get a referral and/or a prior authorization; they could end up being responsible for 100% of the charges.

To be eligible for a Medicare Advantage plan you must have both Medicare Part A and Part B, and live in the Plan's service area. A Medicare beneficiary cannot be enrolled in Original Medicare Part A and Medicare Part B and a Medicare Advantage Part C plan at the same time. Enrollment in a Medicare Advantage plan does not mean that you are no longer on Medicare, or that you will lose your Medicare. It simply means that the Medicare Advantage plan is now responsible for paying for your health care while enrolled in the plan, verses Original Medicare. Medicare Advantage plans must provide all the benefits and services that Original Medicare offers.

Medicare Advantage plans are not Original Medicare or a Medigap policy. When on a Medicare Advantage plan the members will use the issued member ID card from the Medicare Advantage plan verses the Red, White and Blue Original Medicare card. Medicare Advantage is Medicare's managed care option with the emphasis on Preventative Care that provides Medicare beneficiaries another choice on how they would like to receive and pay for their health care. Medicare Advantage plans usually have co-payments verses deductibles and co-insurance. There are several types of Medicare Advantage plan arrangements.

HMO (Health Maintenance Organization) Very Common

An HMO is also known as a Coordinated Healthcare Plan that is involved in how your health care is delivered. This type of managed care refers you to providers that participate in the health plan's network. Most HMO plans require referrals and prior authorizations for medically necessary procedures. Unless the plan has a POS (Point of Service) option, the plan member must use network providers. A plan that has POS may still require the member to coordinate all of their out-of-network care though their in-network Primary Care doctor, and may still require referrals and prior authorizations. Anytime a member chooses to go out-of-network though the POS option they will pay higher out-of-pocket costs.

An HMO may also include additional value-added services not covered under Original Medicare such as Dental and Vision care, and Part D Prescription Drug coverage. An HMO including Part D prescription drug coverage is known as a MAPDP (Medicare Advantage Prescription Drug Plan). The MAPDP-HMO without POS is the most common type of Medicare Advantage plan.

PPO (Preferred Provider Organization) Very Popular

A PPO operates like an HMO with a POS option. This type of managed care offers both in-network and out-of-network options for the participating member. A PPO plan also allows the member to access specialist's and other medically necessary care without referrals or coordination though a Primary Care doctor, but they still may require prior authorizations. Anytime a member chooses to go out-of-network they will pay higher out-of-pocket costs.

There are two types of Medicare Advantage PPOs: There are Local PPOs and Regional PPOs. The Regional PPO has added protection for Medicare Part A and Part B covered benefits.

A PPO may also include additional value-added services not covered under Original Medicare such as Dental and Vision care, and Part D Prescription Drug coverage. A PPO including Part D prescription drug coverage is also known as a MAPDP (Medicare Advantage Prescription Drug Plan).

PFFS (Private Fee for Service) Not so Common

A PFFS plan is not a Medigap plan even though it may resemble one by charging a premium. A PFFS plan is a Medicare Advantage plan that does not require plan members to use a network of providers or to get referrals, and may not require prior authorizations. Medicare beneficiaries with a PFFS plan can see any provider, hospital, or medical facility eligible to receive payment from Medicare, and that agrees to accept the payment terms from the PFFS plan. Therefore, it is always best to verify acceptance of payment prior to using any plan benefits. Some PFFS plans may also including Part D prescription drug coverage. PFFS is not a commonly offered MA plan type and not available in all MA service areas.

MSA (Medical Savings Account) Not so Popular

A MSA plan is a type of Medicare Advantage plan that combines a high-deductible health plan with a Medical Savings Account. MSA plan members initially use their savings account to help pay for health care, and then will have coverage through a high-deductible insurance plan after they have paid the deductible. MSA plans do not include Part D prescription drug coverage. MSA is not a commonly offered MA plan type and not available in all MA service areas.

Three Areas of Concern

There are Three Areas of Concern when considering a Medicare Advantage plan. A plan's Summary of Benefits provides all the information needed for this comparison. The Medicare web-site also provides online comparison tools.

Three Areas of Concern

BENEFITS

SAVINGS

ACCESS

Benefits

If a Medicare beneficiary's main area of concern or emphasis is on Benefits, they are usually comparing the maximum out-of-pocket, and looking for what is included, such as Diabetic supplies, Part D drug coverage, or Dental and Vision care. They are interested in whether they need a referral, about in-network and out-of-network coverage, and the plan's Star rating. Medicare rates each plan by a Star rating and is based upon an overall measure of quality, which includes quality of care, responsiveness, and satisfaction.

Savings

If a Medicare beneficiary's main area of concern or emphasis is on Savings, they are usually interested in plans that have zero monthly plan premiums, and are looking for low out-of-pocket costs and/or co-payments. They are also interested in whether they qualify for any state or federal subsidies, or if the plan reduces the Medicare Part B premium as a plan benefit also referred to as a "giveback."

Access

If a Medicare beneficiary's main area of concern or emphasis is on Access, they are interested in what Primary Care Physicians (PCPs), Specialists, and Hospitals are participating with the plan (also known as being in the network), and/or the limitations on out-of-network coverage.

A Medicare beneficiary will never find a plan that has all the whistles and bells (Benefits), and zero out-of-pocket (Savings), with every doctor and hospital (Access). The bottom line is that focus on one or two areas of concern will diminish or take away from the other(s). There is no level playing field here.

Enrollment Periods

ICEP & IEP are both Initial Coverage Election Periods that begin 3-months before an individual is first entitled to both Medicare Part A and Part B (as described in Section 1) and ends 3-months after the first month of eligibility.

AEP The Annual Enrollment Period begins October 15th. and runs through December 7th., and is when a Medicare beneficiary may change or join a stand-alone Part D drug plan or a Medicare Advantage plan for a January 1st. effective date.

SEP The most common types of Special Election Periods are for beneficiaries who have state or federal subsidized benefits, who have changed a county of residence, for those individuals coming off Employer Group or Union coverage, or for those who may have certain chronic illnesses.

OEP The Open Enrollment Period begins January 1st. and runs through March 31st. The OEP is for Medicare Advantage plan members only. Who want to switch back to Original Medicare and select a stand-alone Part D drug plan if they had MAPDP, or switch from one Medicare Advantage plan to another (like to like). A beneficiary cannot switch from Original Medicare to a Medicare Advantage plan, or switch from one Stand-alone Prescription Drug plan to another.

Key Takeaway

Medicare Advantage plans are a viable option for those beneficiaries who would rather pay as they need care verses pre-paying with a Medigap policy.

Section 4.

Medicare Part D Drug Coverage

Medicare Part D is Medicare's Prescription Drug coverage. Eligibility is based upon having either Medicare Part A and/or Part B. It can be purchased as a Stand-alone Drug Plan in addition to Original Medicare, or it may be included in a Medicare Advantage plan.

Stand-alone Part D Drug Plans (PDP)

Stand-alone Part D Drug Plans are offered by State Regulated Insurance Companies and have premiums. Drug plan premiums will vary by company, and by plan. Part D Drug Plan premiums are in addition to Part B premiums.

2024 Part D Premiums are Based upon 2023 Annual Income		
File Individual Tax Return	**File Joint Tax Return**	**Monthly Premium**
$103,000 or less	$206,000 or less	Plan Premium only
$103,000 up to $129,000	$206,000 up to $258,000	Plan Premium plus $12.90
$129,000 up to $161,000	$258,000 up to $322,000	Plan Premium plus $33.30
$161,000 up to $193,000	$322,000 up to $386,000	Plan Premium plus $53.80
$193,000 up to $500,000	$386,000 up to $750,000	Plan Premium plus $74.20
$500,000 and up	$750,000 and up	Plan Premium plus $81.00

Stand-alone Part D Drug Plans have a deductible to meet before entering the Initial Coverage Period. The deductible for 2024 is $545.

Medicare Advantage (MAPDP)

Medicare Advantage with Part D Drug Coverage is known as MAPDP. MAPDP plans may or may not have premiums for the Part D portion of coverage, and may or may not have a deductible.

Enrollment

Both Stand-alone Part D Drug plans and Medicare Advantage plans with

Part D Drug Coverage follow the same enrollment guidelines that regulate Medicare Advantage Part C Enrollment Periods as identified on Page 11.

2024 TrOOP Threshold is $8,000 before Catastrophic Coverage begins.

TrOOP stands for True-out-of-Pocket. TrOOP expenses are the payments that count towards the Medicare drug plan's out-of-pocket costs that determines when a beneficiary's Catastrophic Coverage begins. The drug plan keeps track of each member's TrOOP costs. Each month that a person fills prescriptions covered by their plan, they will get an "Explanation of Benefits" (EOB) in the mail showing the TrOOP costs to date.

The annual Deductible and Coinsurance and/or Copayments during the Initial Coverage Period count towards the TrOOP, as well as the beneficiary's out-of-pocket and Manufacturer's discounted payments during the Coverage Gap.

The Initial Coverage Period

This is a shared level between the beneficiary and the plan, meaning both the beneficiary and their plan are responsible for paying a share of the costs which are defined by the plan's Summary of Benefits. Once the total paid of the covered prescription drugs reaches $5,030, the beneficiary enters the Coverage Gap even if the plan paid 100% of these costs. For an example let us assume a beneficiary takes ten generic drugs, and the beneficiary for this example pays ($0.00) a zero (tier 1) co-payment. However, for this example each drug costs $50.30 which is paid for by the plan. Therefore, the beneficiary for this illustration would enter the Coverage Gap after ten months. 10 x $503 = $503 x 10 months = $5,030.

Not every beneficiary with Part D Drug coverage with enter the Coverage Gap.

The Coverage Gap is also known as the "Donut Hole"

Once you reach the Coverage Gap, you will pay no more than 25% of the cost for your plan's covered brand-name and generic prescription drugs. Some plans may even offer you lower costs in the Coverage Gap. Although you may pay no more than 25% of the cost for the covered drugs, almost the full price of the drug's cost will count toward the TrOOP.

Catastrophic Coverage Period

When the beneficiary's combined out-of-pocket costs paid exceeds the TrOOP threshold of $8,000 for 2024. They enter the Catastrophic stage of coverage. Then the beneficiary will pay $0.00 for covered generic drugs and $0.00 for covered brand drugs for the remainder of the calendar year. When January 1st. rolls around again, so begins a new Initial Coverage Period.

The Late Enrollment Penalty

Should a Medicare beneficiary choose to not have Part D drug coverage when they first become eligible, or they go 63-days without Creditable Coverage they may be subject to a penalty. The penalty is calculated by multiplying the number of months without coverage by 1% of the national average cost of a Part D drug plan, and will last for as long as you are on Medicare. The exception to this is if the beneficiary qualifies for Extra Help or has Creditable Coverage at the time of enrolling in Part D. Creditable Coverage is prescription coverage from a current or former Employer or Union's Group plan that is on average as good as a current Medicare Standard Prescription Drug Plan. VA Drug coverage from the Veteran's Administration is considered to be credible coverage.

VA Benefits

Veterans with VA Benefits may join a Stand-alone Medicare Drug plan or a Medicare Advantage Plan with Prescription Drug coverage, but they cannot use both types of coverage for the same drug at the same time.

CHAMPVA

Veterans with CHAMPVA may join a Stand-alone Medicare Drug plan or a Medicare Advantage Plan with Prescription Drug coverage, but they will not be able to use the Meds by Mail program which can provide their maintenance drugs at no charge (no premiums, deductibles, and no copayments).

TRICARE

Veterans with TRICARE do not need to join a Stand-alone Medicare Drug plan, but if they do the Medicare plan will pay first and TRICARE will pay second. If the Veteran with TRICARE joins a Medicare Advantage Plan with Prescription Drug coverage, and the plan's network pharmacy is also a TRICARE network pharmacy. The pharmacy may coordinate benefits, otherwise the Veteran would have to file their own claim to get reimbursed for their out-of-pocket costs.

Indian Health Service (IHS)

Many Indian Health Facilities participate in the Medicare Part D drug program. Joining a Stand-alone Medicare Drug plan or a Medicare Advantage Plan with Prescription Drug coverage may help your Indian Health Facility because the plan will pay the Indian Health Facility for the cost of your prescription drugs. Using Medicare does not affect your ability to get services through the IHS or Tribal Health Facilities.

Prescription Lookup Tools

All plans use formularies. A Formulary is a list of Medications covered by the plan. While a Plan is not required to cover every prescription drug on the market, they are required to include prescription drugs for every drug category. All plans use networks of pharmacies, and have a Utilization Review Process in place for Prior Authorizations, Quantity Limits, and Step Therapy.

Prescription and Pharmacy Network Lookup Tools are available on the Medicare website as well as on the Plan Provider's website.

2024 Extra Help Paying for the Part D Costs

Extra Help is also known as the "Low Income Subsidy," and is available by making application through Social Security. Extra Help can help pay for a Medicare Part D drug plan's monthly premium, any yearly deductible, coinsurance, and/or copayments. The Coverage Gap is eliminated, and late enrollment penalties do not apply.

Qualifying for the Extra Help is based upon eligibility. For a single person their annual income must be less than $22,590 with Resources less than $17,220. For a married person living with a spouse and no other dependents the annual household income must be less than $30,660 with Resources less than $34,360. Resources are defined on page 3.

Part D Senior Savings Model (The Insulin Savings Program)

In 2024, the cost of a one-month supply of each Part D covered insulin will be capped at $35, and you will not have to pay a deductible for insulin. This applies to everyone who takes insulin, even if you get Extra Help. Starting July 1, 2023 similar caps on costs will apply for insulin used in traditional insulin pumps covered by Medicare

Pharmaceutical Drug Assistance Programs

Many drug manufacturers have no-cost or low-cost prescription drugs for those who meet certain requirements. Your doctor or pharmacist should be able to identify a drug's pharmaceutical manufacturer. Eligibility is determined by contacting the manufacturer in order to find out the qualifying details.

Key Takeaway

A Medicare beneficiary's best resource concerning their Part D prescription usage is their Pharmacy or through their plan's "Explanation of Benefits." Their best resource concerning covered Part D prescription medications is their plan's online formulary and/or the plans prescription Lookup Tools.

Medicare Explained

This material is an easy-to-understand Educational Based Resource to be used as a reference, and not as a substitute for the **Medicare and You Handbook.**

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