MEDICARE OVERVIEW

WHAT IS ORIGINAL MEDICARE?

- A federal health insurance program for US citizens and permanent legal residents

Consists Only of Part A and Part B:

- **Part A** helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care

- **Part B** helps cover services from doctors and other health care providers, many preventative services (like screenings, shots/vaccines and yearly Wellness visits), outpatient care, home health care, durable medical equipment such as wheelchairs, walkers, hospital beds, blood sugar self-testing equipment & supplies, insulin pumps, and therapeutic shoes or inserts.

****NOTE: Prescription drugs are NOT included in Original Medicare**

- **COST OF ORIGINAL MEDICARE**: About 99% of Medicare beneficiaries **DO NOT** have a Part A premium since they have at least 40 quarters of Medicare-covered employment. The **Part A deductible** beneficiaries pay if admitted to the hospital is **$1,556** which covers their share of costs for the first 60 days of Medicare-covered inpatient hospital care, meaning the deductible is per benefit period instead of annual. The **Part B premium** for most beneficiaries for 2022 **is $170.10** *(higher for individuals making $91k or greater/couples earning $182k or greater annually)* and the **Part B annual deductible is $233.** After a beneficiary has paid the annual $233 deductible, then Part B of Original Medicare covers 80% of covered costs while **the beneficiary will be responsible for 20% with no limit or cap on that amount which could be financially devastating if they get sick.**

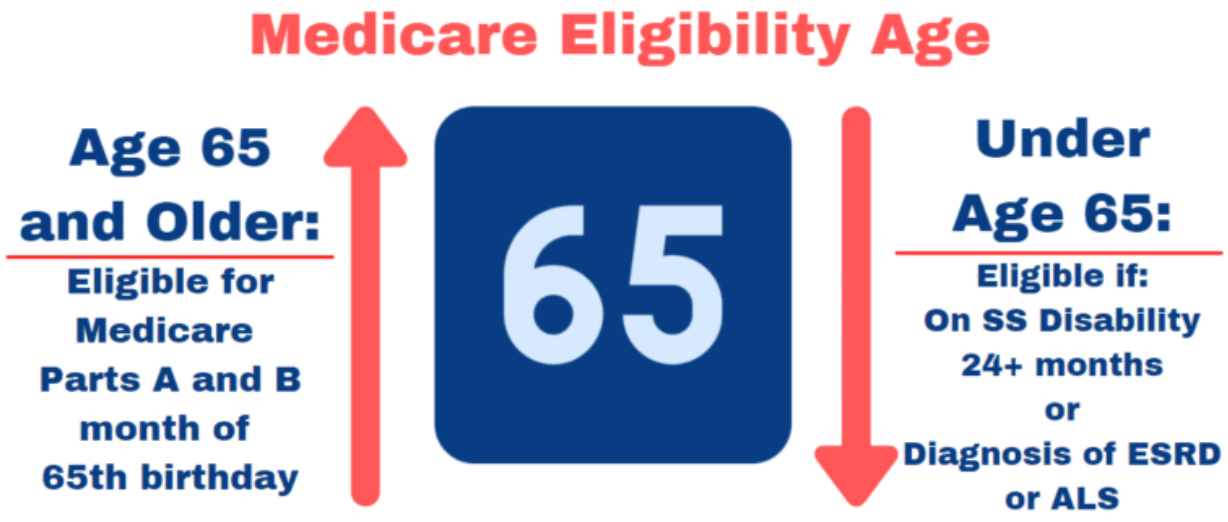
WHO QUALIFIES FOR ORIGINAL MEDICARE?

If 65 years or older you qualify for full Medicare benefits if:

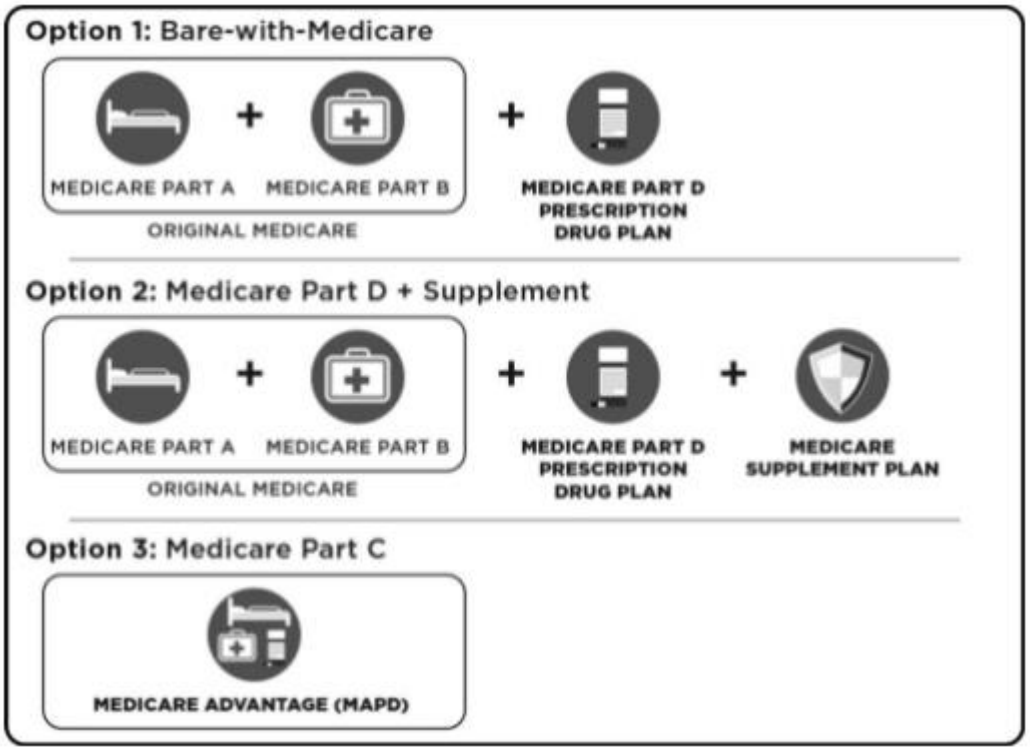
- **You are a U.S. citizen** or a permanent legal resident who has lived in the United States for at least five years and
- **You are receiving Social Security or railroad retirement benefits or have worked long enough to be eligible for those benefits but are not yet collecting them.**
- **You or your spouse is a government employee** or retiree who has not paid into Social Security but has paid Medicare payroll taxes while working.

If younger than 65 you still may be eligible for full Medicare benefits if:

- **You have been entitled** to Social Security disability benefits for at least 24 months (that need not be consecutive); or
- **You receive a disability pension** from the Railroad Retirement Board and meet certain conditions; or
- **You have Lou Gehrig's disease,** also known as amyotrophic lateral sclerosis (ALS), which qualifies you immediately; or
- **You have permanent kidney failure** requiring regular dialysis or a kidney transplant — and you or your spouse has paid Social Security taxes for a specified period, depending on your age.



Medicare is not free and it does not pay for everything. Beneficiaries can cover the gaps of Medicare and get extra benefits not offered by Original Medicare depending on which SOLUTION they choose:



SOLUTION 1: ORIGINAL MEDICARE + PART D (DRUG COVERAGE)

Private companies offer Part D plans to help cover the cost of prescription drugs, including many recommended shots or vaccines. **Beneficiaries may purchase a Part D prescription plan (PDP) in addition to Original Medicare (Part A and Part B), or in addition to a Medicare Supplement (Medigap) plan. Part D drug coverage is optional but highly recommended** for those with only Original Medicare or a Medicare Supplement plan. Failure to enroll in a Part D drug plan when eligible may result in a lifetime penalty for the beneficiary.

COST FOR PART D: Premiums vary by plan and can be as low as $10 per month up to a couple hundred dollars. The maximum yearly deductible a plan can charge a beneficiary in 2022 is $480. Depending on which tier a medication is listed in on a plan's formulary there may be additional co-pay amount for the beneficiary.

SOLUTION 2: ORIGINAL MEDICARE + A MEDICARE SUPPLEMENT PLAN (MEDIGAP) + PART D DRUG PLAN

Extra insurance beneficiaries can purchase from a private company that "fills in the gaps" of Original Medicare and helps pay their share of costs. Policies are standardized across most states and are named with letters (eg: Plan G, Plan N, Plan F). The benefits in each lettered plan are the same across nearly all states (except for MA, MN and WI) no matter which insurance company sells it. So, a Plan G in Florida sold by Company 1 is the exact same as a Plan G in Texas sold by Company 2 **– THE ONLY DIFFERENCE IS PRICE.** Therefore, you will want to find the lowest cost plan in your prospect or client's area.

- **COST FOR A MEDICARE SUPPLEMENT**: Medicare Supplement plans typically have premiums ranging from $80 per month up to hundreds of dollars per month depending on the plan letter, state and company, with the average monthly premium around $160.
  Medicare supplements cover costs not covered by Original Medicare, such as the Part A deductible, coinsurance or copays for Parts A and B, excess costs for Part B, healthcare costs during foreign travel. The beneficiary will still have to pay the Part B premium every month in addition to a Part D prescription drug plan, if purchased. Therefore, for those on a Medicare Supplement, they will have three premiums to pay: one for the Medigap plan itself – the premium will go up every anniversary on the plan – a second for Part B and a third for Part D prescription drug coverage**. Costs associated with dental, vision (including eyeglasses) and hearing aids will have to paid totally OUT OF POCKET** (beneficiaries can pay as they go for these services or purchase an additional insurance policy to cover them) as these are not covered by either Original Medicare or any Medicare Supplement plan. **Medicare Supplements also DO NOT include prescription drug coverage,** so those costs will also be 100% the responsibility of the beneficiary which is why **purchasing a Prescription D drug plan** is highly recommended to both contain drug costs and avoid incurring a lifetime penalty for not enrolling in Part D when eligible.

SOLUTION 3: PART C/MEDICARE ADVANTAGE DRUG PLANS (MAPD)

Part C is also known as Medicare Advantage, which is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. **These "bundled" plans include everything offered in Original Medicare (Parts A & B) PLUS most Medicare Advantage plans also INCLUDE Part D prescription coverage also known as Medicare Advantage Prescription Drug (MAPD) plans.**

Medicare Advantage is very similar to the employee health plans most people are familiar with in that typically the beneficiary will need to use their plan's network of doctors.

Medicare Advantage Plans may have lower out-of-pocket costs than Original Medicare and usually **offer extra benefits that Original Medicare does not cover – like vision, hearing, and dental services**.

- **COST OF PART C/MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS (MAPD):** These are "all in one" bundled plans that include everything offered under Original Medicare plus extras. Many Medicare Advantage plans have **$0 monthly premium and/or $0 deductibles**, although beneficiaries must continue to pay their Part B premium. The costs of most Medicare Advantage plans are found in co-pays and co-insurance, similar to traditional employee health plans most people are familiar with. Most of these plans have drug plans embedded in them, making it unnecessary to purchase an additional Part D drug plan. **Other extras such as preventative dental, vision and hearing services, over the counter are also typically embedded in many if not most MAPDs**.

COMPARE ORGINAL MEDICARE & MEDICARE ADVANTAGE/PART C:

	Original Medicare	Medicare Advantage
Cost	Premiums, copays, deductible, and coinsurance.	Premiums, copays, deductible, and coinsurance.
Coinsurance	Members usually pay 20% of the total cost of services, which means the amount they pay will fluctuate based on the cost of the service.	Members usually have a set dollar copayment amount, so they can expect what to pay.
What members pay out-of-pocket	No limit to how much members may have to spend.	A set maximum out-of-pocket limit per calendar year.
Prescription drugs	Must buy Part D for prescription coverage.	Most plans include prescription drug coverage.
Supplemental benefits	None.	Some plans include: dental, vision, hearing aids, and an allowance for over-the-counter items.

DUAL ELIGIBLE BENEFICIARIES

There is a huge crossover between the Final Expense demographic and the Dual Eligible population. If you have sold someone a Final Expense policy previously, there is a good chance they may qualify for either a Medicare Advantage (Part C) Dual Special Needs Plan (DSNP) or for Extra Help with their Part D (prescription drug) costs. If a prospect qualifies for a DSNP, then your focus as an agent should be on comparing the "extras" that come with it. These are benefits such as "over-the-counter" and healthy food cards that reload every month, quarter, or year, depending on the plan. Additional benefits typically include $0 copay transportation, dental, vision and hearing. These are the benefits you want to emphasize to your dual eligible prospects.

"Dually eligible beneficiaries" generally describes beneficiaries enrolled in Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A and/or Part B and getting full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through the Medicare Savings Program (MSP):

- **Qualified Medicare Beneficiary (QMB) Program**: Helps pay Part A, Part B, or both Program premiums, deductibles, coinsurance, and copayments

- **Specified Low-Income Medicare Beneficiary (SLMB) Program**: Helps pay Part B premiums

- **Qualifying Individual (QI) Program**: Helps pay Part B premiums but is limited to a first-come, first-served basis

- **Qualified Disabled Working Individual (QDWI) Program**: Pays Part A premiums for certain disabled and working beneficiaries under 65 not getting Medicaid and who meet certain income and resource limits set by their state.

Medicare pays covered dually eligible beneficiaries' medical services first, because Medicaid is generally the payer of last resort. Medicaid may cover medical costs Medicare may not cover or partially covers (such as nursing home care, personal care, and home- and community-based services). Coverage for dually eligible beneficiaries varies by State. Some States offer Medicaid through Medicaid managed care plans, while others provide Fee-For-Service Medicaid coverage. Some States contract with health plans that include all Medicare and Medicaid benefits. Federal law defines Medicaid and MSP income and resource standards, but States can effectively raise those limits above the Federal floor (except for

QDWIs). Annually, the Centers for Medicare & Medicaid Services (CMS) releases eligibility standards for dually eligible beneficiaries.

Who Qualifies for a Medicare Savings Program?

To qualify for an MSP, you first need to be eligible for Part A. For those who don't qualify for full Medicaid benefits, your monthly income must also be below the limits in the following chart.

2022 Monthly Income Limits for Medicare Savings Programs		
Medicare Savings Program	**Monthly Income Limits for Individual**	**Monthly Income Limits for Married Couple**
QMB	$1,153	$1,546
SLMB	$1,379	$1,851
QI	$1,549	$2,080
QDWI	$4,339	$5,833
*Please note: the above income limits are subject to change in 2023		

In addition to the income limits, you must have limited resources to qualify for an MSP.

What Are Countable Resources for Medicare Savings Programs?

To qualify for the MSPs above, the dollar value of your countable resources must be below the limit for the type of assistance you're looking to receive. See the chart below for the limit for each program.

2022 Resource Limits for Medicare Savings Programs

Medicare Savings Program	Resource Limits for Individual	Resource Limits for Married Couple
QMB	$8,400	$12,600
SLMB	$8,400	$12,600
QI	$8,400	$12,600
QDWI	$4,000	$6,000

*Please note: the above income limits are subject to change in 2023

The term countable resources means any money in bank accounts (checking or savings), stocks, and bonds. Your home, one car, a burial plot, up to $1,500 already saved for burial expenses, and personal belongings aren't included when countable resources are considered.

How to Apply for a Medicare Savings Program

Visit Medicare.gov or call your local Medicaid office to determine if you're eligible for an MSP in your state. You can also call 1-800-MEDICARE to ask about financial assistance with your Medicare premiums. They can also provide you with the phone number for the Medicaid office in your state, and you can determine whether you're dual-eligible.

If your income and/or resources exceed those listed above, but you think you could still qualify, filling out an application is recommended. The limits are subject to increase each year.

When applying for an MSP, you'll need documentation. The list of what's needed varies by state, but you'll want to make sure to furnish recent bank statements in order to substantiate your need for the program.

Extra Help for Part D (LIS – Low Income Subsidy)

What's the Low Income Subsidy (LIS)?

The Low Income Subsidy (LIS) helps people with Medicare pay for prescription drugs, and lowers the costs of Medicare prescription drug coverage.

2022 LIS Resource Limits

Applicant(s)	Resource Limit	Resource Limit with Burial Expenses
Individual (Full)	$8,400	$9,900
Married Couple (Full)	$12,600	$15,600
Individual (Partial)	$14,010	$15,510
Married Couple (Partial)	$27,950	$30,950

Applying for Medicare Low-Income Subsidy

Social Security or your State Medicaid office will determine your eligibility for a Low-Income Subsidy. Yet, if you're denied, you'll receive a Pre-Decisional Notice, explaining why you aren't eligible.

Then, you have ten days to correct the information. Social Security will send you a Notice of Award, explaining your level of coverage. If you don't meet the qualifications, you'll get a Notice of Denial.

If you disagree with the denial, you have 60 days from the time of rejection to request an appeal hearing. You can ask for a case review, and you may send in any other information you feel is pertinent.

Who Should Complete An Application For Extra Help With Medicare Prescription Drug Plan Costs?

You should complete this application for Extra Help on the Internet if:

- You have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance); and
- You live in one of the 50 States or the District of Columbia; and
- Your combined savings, investments, and real estate are not worth more than $30,950, if you are married and living with your spouse, or $15,510 if you are not currently married or not living with your spouse. **(Do NOT count your home, vehicles, personal possessions, life insurance, burial plots, irrevocable burial contracts or back payments from Social Security or SSI.)** If you have more than those amounts, you may not qualify for the extra help. However, you can still enroll in an approved Medicare prescription drug plan for coverage.

EXCEPTION: Even if you meet these conditions, **DO NOT** complete this application if you have Medicare **and** Supplemental Security Income (SSI) or Medicare **and** Medicaid because you automatically will get the extra help.

How Can You Get The Extra Help?

To get extra help with Medicare Prescription Drug plan costs, you **must complete and submit an application**. (https://secure.ssa.gov/i1020/Ee006b) We will review your application and send you a letter to let you know if you qualify for extra help.

NOTE: To apply, you must live in one of the 50 States or the District of Columbia.

If you need help completing this application, call Social Security toll-free at **1-800-772-1213** (TTY **1-800-325-0778**).

You also may be able to get help from your State with other Medicare costs under the Medicare Savings Programs. By completing this form online, you will start your application process for a Medicare Savings Program. We will send information to your State who will contact you to help you apply for a Medicare Savings Program unless you tell us not to when you complete this application.

What is IRMAA?

For Medicare beneficiaries who earn over $91,000 a year – and who are enrolled in Medicare Part B and/or Medicare Part D – it's important to understand the income-related monthly adjusted amount (IRMAA), which is a surcharge added to the Part B and Part D premiums.

How is my income used in my IRMAA determination?

IRMAA is determined by income from your income tax returns two years prior. This means that for your 2022 Medicare premiums, your 2020 income tax return is used. This amount is recalculated annually. The IRMAA surcharge will be added to your 2022 premiums if your 2020 income was over $91,000 (or $182,000 if you're married), but as discussed below, there's an appeals process if your financial situation has changed.

You will receive notice from the Social Security Administration to inform you if you are being assessed IRMAA.

How much are Part B IRMAA premiums?

Table 1. Part B – 2022 IRMAA		
Individual	**Joint**	**Monthly Premium**
$91,000 or less	$182,000 or less	$170.10
> $91,000 – $114,000	> $182,000 – $228,000	$238.10
> $114,000 – $142,000	> $228,000 -$284,000	$340.20
> $142,000 – $170,000	> $284,000 – $340,000	$442.30
> $170,000 – $500,000	> $340,000 – $750,000	$544.30
Greater than $500,000	Greater than $750,000	$578.30

How much are Part D IRMAA surcharges?

For Part D, the IRMAA amounts are added to the regular premium for the enrollee's plan (Part D plans have varying prices, so the full amount, after the IRMAA surcharge, will depend on the plan).

Note that if you are a Medicare Advantage policy member – and that plan includes prescription drug benefits – then both Part B and Part D IRMAAs are added to the plan premium (Medicare Advantage enrollees always pay the Part B premium in addition to any premium charged by their Advantage plan).

The following income levels (based on 2020 tax returns) trigger the associated IRMAA surcharges in 2022:

Table 2. Part D – 2021 IRMAA		
Individual	**Joint**	**Monthly Premium**
$91,000 or less	$182,000 or less	Your Premium
> $91,000 – $114,000	> $182,000 – $228,000	$12.40 + Plan Premium
> $114,000 – $142,000	> $228,000 -$284,000	$32.10 + Plan Premium
> $142,000 – $170,000	> $284,000 – $340,000	$51.70 + Plan Premium
> $170,000 – $500,000	> $340,000 – $750,000	$71.30 + Plan Premium
Greater than $500,000	Greater than $750,000	$77.90 + Plan Premium

Can I appeal the IRMAA determination?

You can appeal the IRMAA determination – filing for a redetermination – if you believe that your calculation is erroneous. In addition, if you have had a life-changing event such as a loss of income or divorce, then you can refile or you can file for a redetermination using Form SSA-44.

If you do not agree with a redetermination, there is a formalized appeal process – the third level of appeal – technically called the Decision by Office of Medicare Hearings and Appeals (OMHA). (Note that this a different procedure from the appeal or grievance procedure when you receive denials of service from Medicare Parts A, B, or D.)