Deck the halls with Medicare options

By Corrie Borde

Beginning last month and into the holidays, health care season is upon us, particularly as it relates to Medicare.

The time period for annual election in Medicare is Oct. 15 to Dec. 7.

My advice: If you think you may need a little help with decisions, seek professional assistance now.

Original Medicare (Parts A and B):

For those unfamiliar, Medicare (a.k.a. Original Medicare) is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, along with those who suffer from permanent kidney failure. Generally speaking, the insurance is divided into Part A (hospital insurance), Part B (medical insurance) and Part D (prescription drug). They don't cover all costs, but they can significantly reduce your financial burden.

More specifically, Medicare Part A hospital insurance covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery and home health care. Medicare Part B covers medically necessary services and preventive services such as clinical research, ambulance services, durable medical equipment (DME), mental health, inpatient, outpatient, getting a second opinion before surgery and limited outpatient prescription drugs. Medicare Part D's prescription drug coverage effectively works to offset the monthly expenses of medications.

If you are enrolled in original Medicare you can go to any doctor or hospital in the United States that accepts Medicare. Original Medicare does not have a "network." Referrals are not needed to see specialists and there is no prior authorization required to obtain services.

Medicare Supplement (Medigap):

Those above descriptions have remained the same for years. There are, however, important related changes on the horizon.

Most notably, starting Jan. 1, 2020, Medicare Supplement plans, typically referred to as "Medigap," will no longer be available for plans C and F, which cover the Part B deductible. Essentially, Congress believes that having all Medicare members pay their part B deductible will help reduce medical overuse. So, Plan C and Plan F will be eliminated.

Stated another way, with those two popular Medigap plan options ending in the near future, things can become complicated for consumers. Yet, there are ways to ensure future coverage.

The Medicare Supplement Plan F covers 100 percent of Medicare parts A and B copays, deductibles, coinsurance and excess charges (balance billing), and allows for some foreign travel emergency coverage. Currently, with the Medigap Plan F still being available, recipients already on Medicare who medically qualify or who are in a special enrollment period (SEP), and recipients who are aging into Medicare (turning 65) prior to Jan. 1, 2020, can be grandfathered in with a guaranteed renewable life and portable policy administered by an appointed insurance carrier.

For recipients, relief Medigap plans work directly with Medicare parts A and B; therefore, there is no such thing as in-network or out-of-network. Medigap plans are accepted anywhere and for any reason that Medicare parts A and B are accepted.

Medicare Advantage (Part C, MA or MAPD):

Medicare Part C comprise of HMOs, PPOs, SNPs and PFFS plans administered by insurance carriers. Medicare Advantage Plans cover all Medicare services. Most Medicare Advantage Plans also offer extra discounted coverage, like vision, hearing and dental coverage.

Medicare pays a subsidy for your care each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare.

Each Medicare Advantage Plan can charge different out-of-pocket costs of which Medigap policies can't work in conjunction with. They can also have different rules for how you get services; if you are enrolled in a Medicare Advantage plan you may be limited by the MA plan to using a network of specific providers in order for the plan to cover your care. You may have to choose a primary care physician, obtain referrals to see specialists, and get prior authorization for certain services. Certain MA plans may cover care you get outside of the network, but you will likely have to pay more. Plans may only cover emergency and urgent care if you are out of the service area; you must return to the service area for follow up or routine care. Network providers can join or leave a plan's provider network anytime during the year but, generally, you must wait until the next year's open enrollment period to opt to leave the plan. The MA plan can also change the providers in the network anytime during the year.

Medicare Part D:

Another critical Medicare consideration involves Medicare Part D and what's called the "donut hole." Important note: Understand the donut hole and get introduced to resources that can help reduce and/or eliminate the out-of-pocket costs related to being in the donut hole. Under certain circumstances, this impacts the percentage of total prescription costs a person must pay. If you fall into this donut hole, you will be responsible for 25 percent to 37 percent of the full retail cost of combined drugs — until the total you have spent for your prescriptions reaches a certain annual out-of-pocket spending limit, which is currently set at $5,100.

Stages of the Medicare Part D

Stage 1 — initial coverage stage. The patient is responsible for 25 percent (post $415 deductible where applicable) up to the full retail combined drug cost, reaching $3,820 in 2019.

Stage 2 — coverage gap (donut hole). After total spending on drugs by the beneficiary, by certain subsidy programs and by the plan, reaches $3,820, the beneficiary pays for 37 percent of generic drug costs and 25 percent of brand-name drug undiscounted costs (drug manufacturers provide a 70 percent discount on brand-name drugs).

Stage 3 – catastrophic coverage. Once beneficiary expenditures (including drug manufacturer discounts) reach a total of $5,100, the beneficiary is through the coverage gap and reaches catastrophic coverage. On any future prescriptions, the beneficiary pays either a copay of $3.40 for generic drugs or $8.50 for brand-name drugs, or a coinsurance of 5 percent, whichever is greater.

At the very least, sit down with a professional independent agent who works with multiple carriers and take an unbiased approach; explore options to see if you qualify where applicable and what options makes sense for your needs.

Before seeking such help, here are a few things to ask yourself: What are my health concerns, both individually and for the family? What's my budget? Does my primary physician and specialist accept the plan? What is my premium preference — high monthly premium with low deductible or vice versa?

Explore your options. For example, with respect to prescription drug co-pays, there are many resources that have the ability to significantly reduce or eliminate your financial outlay. And remember those deadlines.

Professional help is available!

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