Understanding Your Medicare Options

Medicare Buyers Guide

Your Medicare Options

There are basically five (5) options you have when receiving Medicare benefits. In this section we will discuss these five alternatives and give you a simple guideline to help you determine which option meets your needs.

What You Will Get In This FREE Report

Option #1: Original Medicare

Option #2: Original Medicare with Work Insurance

Option #3: Original Medicare and Medicare Supplement Insurance Plans

Option #4: Medicare Advantage Plans

Option #5: Medicare and Medicaid

Disclaimer: We are not a government agency nor do we work for Medicare or any related companies. We are a for-profit business specializing in Medicare insurance and Medicare related products. We are regulated by the Federal Government and Licensed by the State. Our goal is help our clients make better decisions by educating them on their Medicare options.

Option #1
Original Medicare

Let's begin here since we just took a look at what Medicare Parts A & B cover.

Your first option is to just depend on your Red, White & Blue card (Medicare A&B) to meet all your healthcare needs. We call this "Original Medicare" to distinguish it from Medicare Part C – Medicare Advantage Plans.

While Original Medicare is a great service for retiree's, before you make the decision to just rely on this to meet ALL your needs, you need to be aware of the fine print. What follows is not a complete overview of all the details of Original Medicare, but simply a sketch so you are aware of several variables.

Variable #1 – Deductibles.

Both parts of Medicare (A&B) have deductibles. A deductible is what you have to pay BEFORE Medicare pays their part. The current **deductible for 2021** is as follows:

- Part A - $1484.00 deductible each benefit period (we will discuss this in a minute)
- Part B - $203 annually

Variable #2 – Benefit Periods and Coinsurance Costs

A Medicare benefit period begins the day you enter the hospital or skilled nursing facility and doesn't end until you have been out of the hospital or facility for 60 days in a row. Once you go past that designated time, a new benefit period begins and your Part A deductibles must be met again.

Here's how it is stated on the Medicare website:

- Days 1–60: $0 coinsurance for each benefit period.
- Days 61–90: $371 coinsurance per day of each benefit period.
- Days 91 and beyond: $742 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- Beyond lifetime reserve days: all costs.

Simply put, if you are in the hospital for more than 60 days, you will pay $371 each day for days 61-90. If you stay longer than 90 days, the daily cost increases to $742 per day.

It is also worth noting that you could potentially have to pay your Part A deductible 6 times in any given year.

Before making a decision to use only original Medicare as your healthcare coverage, it is important to understand the breakdown of these costs.

Variable #3 – Lifetime Reserve Days

Lifetime reserve days are additional days Medicare will pay for when you are in the hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. Once you use your lifetime reserve days, you must cover ALL COST for Part A charges. And don't forget, you also have to pay 20% of all your Part B charges.

As you can imagine, this could get very costly. So before you opt to only use Original Medicare as your coverage, take into account all deductibles, limit on days and lifetime reserve days.

Our advice is to seek some type of 'extra' coverage in light of these downsides.

Meet Karen

One of our clients – we will call her Karen – came to us for help with her Medicare troubles. She was getting ready to turn 66 and had already used up all her lifetime reserve days. She had been hospitalized the week she turned 65 for several months. She had gone home for further recovery but was again hospitalized as she started a new benefit period. All deductibles began again. This time she was in the hospital for several more months incurring a growing coinsurance bill for the days she spent over the coverage limit.

When all was said and done, she came to us with a hefty medical bill AND the realization that she was out of lifetime reserve days.

While we could not undo the past, we did get her on the right track to insure that whatever happened in the future she knew her worst case scenario. Not only was this acceptable to her, she loved it. She had the peace of mind that going forward she knew she would never have to spend more than a certain amount of money on her health care cost in any given year.

Key Note about Original Medicare

Our firm never recommends only having Original Medicare. With the options that are available, there is no need in exposing yourself to the potential financial crisis that Medicare presents. There are several reasons for this:

- There are options available at zero or low premium that offer more protection.
- There are limits on days through original Medicare that are covered under other plans
- Since Medicare is 80/20 insurance (they pay 80%, you pay 20%), your financial exposure is great
- There is no cap to what a Medicare bill could run

With this in mind, we always encourage beneficiaries to look at the options available to offset the risk associated with Original Medicare.

Next: Original Medicare with Work Insurance

Option #2
Original Medicare with Work Coverage

If you have coverage through your work or company and they offer to continue your health care coverage, you may opt to keep your work coverage. There are several things to consider:

1. **The cost of your work/employee coverage.**

There may be other options that are less expensive if the cost of employee coverage is high. This is when it is best to consult a qualified advisor who is knowledgeable about Medicare.

2. Are all the benefits coordinated?

When you have two sources of coverage, each is called a 'payer' by Medicare. When there's more than one payer, "coordination of benefits" rules decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. In some cases, there may also be a third payer.
The important thing to know is the limits of the coverage with each payer.

3. Who pays first?

Each company and employee coverage is different as to who pays first. Why is this important? Medicare puts it this way:

What it means to pay primary/secondary

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The one that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) may not pay all the uncovered costs.

If your employer insurance is the secondary payer, you may need to enroll in Medicare Part B before your insurance will pay.

In a nutshell, paying "first" means paying the whole bill **up to** the limits of the coverage. If your company insurance pays first, you need to know the 'limits' of the coverage.

For example, let's say that your employee coverage is the primary payer and Medicare is secondary. For the sake of illustration (these are fictitious numbers used only for the sake of illustrating the point) let's suppose you have a procedure that cost $100,000 and your insurance covers 80% of the bill leaving your secondary insurance to pay the

remaining 20%. In our illustration, the cost of services is $100,000 and your insurance pays their portion equaling $80,000. This leaves Medicare owing $20,000.

The problem comes in with the issue of 'Assignment" with Medicare. 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.

So let's suppose that Medicare has stated that the procedure you went through is only worth $70,000 and they will only pay that amount. Since your insurance has already paid $80,000 for the procedure, Medicare says that they will not pay (since they are the second payer) because your primary insurance has already MORE than they have set as the legal amount for the service.

While this may seem unlikely and extreme, there are cases where this type scenario has happened and people were stuck with the bill, or at best having to negotiate with the doctor or hospital.

So who pays first can be of great significance when considering whether to keep your employee coverage.

Meet Ken and Mary

I met Ken and Mary several years ago. Ken was getting ready to retire and wasn't sure how this would affect his health care cost. His company was offering coverage and he had been pleased with it in the past. It was going to cost a little money each month to keep it, but it was less expensive than a Medicare Supplement (which he had inquired about).

In the end, Ken and Mary decided to stick with the company plan. About a year later Ken called me and asked me to come visit with he and Mary again. When I arrived he explained that he felt like his company plan wasn't what he thought it would be. He was being charged for some procedures one time, and then the next time he wouldn't get a bill. There was infrequency in the charges and he wondered if I could help him figure out what was going on.

It took some time (several weeks), but after getting the right documents about his coverage from the HR department at his former employer, we discovered that his work coverage was primary payer and Medicare was secondary. While this was certainly not the only issue at stake, it was significant enough that Ken and Mary decided to go a different route with their health care.

Ken dropped his work coverage (which had gone up in price as well) and took out a Medicare Supplement Plan F which covered all his health care needs. We will look at Medicare Supplements next.

Key Questions for Work Coverage

1. Who pays first?

2. What are the limits of coverage by the primary payer?

3. Does the employee coverage coordinate with Medicare?

Next: Original Medicare with Medicare Supplement Insurance

Option #3
Original Medicare with Medicare Supplement Plans

A Medicare Supplement is an insurance product that coordinates with Medicare to pay what Medicare doesn't pay. Because it is a supplement to Medicare, it by nature pays second to supplement Medicare.

Here is how it works with Medicare.

Each Medicare Supplement insurer has a contract with Medicare to cover what Medicare doesn't on all Medicare approved charges. (Note: Nothing pays if Medicare says it is not a Medicare covered issue
Some things to consider:

First is standardization. While there are several plans to choose from in a Medicare Supplement (for example, Plan F or Plan G), each plan is the same with every company. Plan F works the same with company ABC as it does with company XYZ. One company can't add extra benefits to entice you to join their plan over the other company. They all have a standard they must meet. So each company covers the exact same things.

Second is how they are paid. Each company has a contract with Medicare to pay their part of the bill once the bill is approved by Medicare. So the cycle works like this: Once a procedure is done, the doctor sends the bill the Medicare. Medicare either approves the bill or disapproves it. If it is approved as a legitimate service, Medicare pays their part. Once they pay their part, they send the remainder of the bill to the insurance company you have on record. That company, by law, has to pay their part. They have agreed ahead of time to pay what Medicare sends them.

If they don't, they won't stay in business because Medicare will terminate their contract.

What this means to you:

I've had clients and potential clients make decisions on which company to carry their Medicare Supplement
because in their mind "Company ABC pays their claims!" The fact is, they all pay the same; if they don't they go out of business. ***Every company has to play by the same rules.***

Another way it affects you is that no company has a better Plan F than another. Every Plan F is the same. Every Plan G is the same. And down the line. This is what it means for plans to be standardized.

So if they are all the same, and they all pay their claims the same, what is the difference in Company A and Company B? There are several factors:

- The price they charge as a premium for their plan.
- How well they manage their business in terms of underwriting, the health of new clients aging in, and other actuarial issues.
- Inflation and increase healthcare costs.
- Claim experience of people who purchased their policy; ie. How often claims are made by the entire population of those who hold policies.

Let's explore a couple of these issues.

The reality is some companies charge more for the same policy - let's say a Plan F - than other companies simply because they can. Perhaps they are a band name company that people recognize, so people will pay a higher premium just because it is with Company A.

When you understand that all plans pay the same, it doesn't make sense to pay more for a Plan F with Company A vs Company B unless…

UNLESS…

If Company B has a history of raising their rates, it might make sense to go with a higher company. For example, some companies enter into a new area offering discounted plans at cheap rates, only to raise those rates in the following year making them equal (or sometimes even higher) than their competitors.

Meet Bob and Sara

I first met Bob and Sara through another client. They were referred by someone we helped navigate the Medicare maze.

When they came to us, they weren't sure what their options were, or how to go about getting the information they needed to make an intelligent choice. They were confused from all the mail they were getting, and were having difficulty understanding the information they were reading online. The bottom line was - in their words - they wanted to talk to a real person.

When we sat down, the first thing I did was ask questions to find out what their concerns were and ascertain their biggest need.

Then I gave them an overview of how Medicare works and their basic options. This is something that I do with every client. I want to make sure they know ALL their options, not just the ones that individual companies want them to know.

The first thing I discovered was that their needs were vastly different. Sara's situation was crucial. She had chronic health issue that required the oversight of several

different type doctors. She was concerned about losing her doctors if she joined a plan. Another issue (more of a [reference) was she did not want to have copays when she went to see her doctors. She liked the fact that with a Medicare Supplement she could pay one fee each month and not have to worry about copays, or other cost sharing. A final issue was they liked to travel; so she wanted to make sure that no matter where she was, she would be covered, even if she simply wanted to get a routine check up while they were out of town.

So here are the factors we took into consideration when finding a plan to meet Sara's needs:

She wanted to keep all her doctors and not have to worry about staying within a certain network

She wanted to be able to go see a doctor out of town if they were traveling or staying with their daughter for several months

She did not want to worry about copays or have extra charges related to her health care; she wanted a one-time-monthly premium to cover her health care costs

Armed with this knowledge we found a relatively inexpensive Medicare Supplement that fit her needs and lifestyle perfectly.all

Along with this we enrolled her in a Prescription Drug Plan that allowed her to take the medications (brand names, etc) that were working for her.

Bob's needs were different, so we will take a look at his solution next.

Key Questions for Medicare Supplements

1. Do you have doctors that are in different networks, states or geographic areas that might require coordination?

2. Does having copays when you go to a doctor, hospital or specialist concern you? Would you prefer a one-time-monthly premium, as opposed to copays?

3. Do you travel or live in different parts of the United States during part of the year?

Next: Medicare Advantage Plans

Option #4

Medicare Advantage Plans

Medicare Advantage plans are offered by private companies who contract with Medicare to carry out your Medicare coverage. It's important to know that you DO NOT LOSE your Medicare when you enroll in a Medicare Advantage plan; you simply agree that the provider will carry out your Medicare coverage for you.

There are rules in place that protect you. For example, when you join a Medicare Advantage plan, that plan must cover everything that Medicare covers. So you don't have to worry about having sub-standard coverage compared to Original Medicare. Here's what Medicare.gov says:

Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you're in a Medicare Advantage Plan. In all types of Medicare Advantage Plans, you're always covered for emergency and urgently needed care.

The plan can choose not to cover the costs of services that aren't medically necessary under Medicare. If you're not sure whether a service is covered, check with your provider before you get the service.

Medicare Advantage Plans may offer extra coverage, like vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B premium, you usually pay a monthly premium for the Medicare Advantage Plan.

Most people pay the Part B premium of $104.90 each month (this amount won't change in 2015).

IMAGE HERE

How Medicare Advantage Works

The big question at this point in the conversation is HOW? How can they do all they do with such a low or zero premium?

Well, when you understand how the money flows it makes sense. **Here it is in a nutshell**:

When you turn 65 (or retire, or begin to receive your social security benefits), social security writes you check for your retirement benefits. They also pay money into the Trust Funds set up to provide Medicare benefits. There are two trust funds that congress oversees that pay into Medicare.

The Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. The HI Trust Fund receives money from Social Security through taxes. The SMI Trust Fund is funded by Part B and Prescription Drug premiums. Both of these Trust Funds make up the true cost of your Medicare coverage.

So, money flows into Social Security from taxes. And money flows into CMS through those taxes via the Trust Funds designed to provide Medicare benefits.

When you enroll in a Medicare Advantage plan, CMS pays the Insurance Company (The Plan) to carry out your Medicare benefits. You DO NOT LOSE your Medicare benefits; the Plan simply becomes your Medicare provider. They are funded by the Center for Medicare and Medicaid Services.

Here's what the Medicare website states about Medicare Advantage Plans:

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

However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to only doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care). These rules can change each year.

Meet Bob...Again

We discussed Bob's wife Sara in the previous segment; now let's take a look at Bob's needs.

While Sara had several doctors in various geographic areas, and she did not like to have copays, Bob looked at things a little different. He rarely, because of good health, went to the doctor and he did not see any specialists. Bob wanted a plan that did not cost very much; in fact he had heard about zero premium plans, and wanted to know more about them.

Here's a snapshot of Bob's need:

Low to zero premium
Didn't care about doctor networks

Wanted his drug plan to be included
Was used to paying copays (this is how his work coverage had been for years)
Wanted to keep his health care cost as low as possible but wanted to know that there was a cap on how much he would have to spend if he had an emergency

In understanding Bob's needs I presented an overview of Medicare Advantage plans in his area. He liked the idea because it met all the criteria he was looking for. We found a plan that his primary care doctor accepted and enrolled Bob.

Both Bob and Sara were extremely happy with their healthcare plans even though they approached them from different perspectives.

Key Questions for Medicare Advantage

1. Do you want a low to zero monthly premium?

2. Do you mind having copays for doctor, hospital or other services?

3. Do you want coverage for catastrophic events with little or no monthly cost outlay?

4. Do you mind if your doctors are confined to a local network of providers where you will receive your care?

5. Do you mind if your doctor must refer you to a specialist?

Next: Medicare and Medicaid [State Assistance]

Option #5
Medicare and Medicaid

Another option - one that pertains to a select group of people - is coordinating Medicare with various levels of Federal and State assistance.

There are programs available on both the Federal and State level. They are designed to offset some of the cost of health care for those who fall within a certain income bracket.

On The Federal Level

On the Federal level is a program offered through Social Security created to assist certain individuals with prescription drug cost. It is called Extra Help or LIS, which stands for Low Income Subsidy. This program only helps with prescription drugs, not medical or hospital.

On The State/Federal Level

States have programs for people with limited income and resources that pay some or all of Medicare's premiums and may pay Medicare deductibles and coinsurance. Each state is a little different in how they coordinate help, so make sure you check with your state for details. Or better, work with a qualified agent who is licensed, certified and knowledgeable with these programs.

SNP Plans

Medicare Special Needs Plans (SNPs) are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies (list of covered drugs) to best meet the specific needs of the groups they serve.

Types of SNP's

- Chronic Condition SNP (C-SNP): You have one or more severe or disabling chronic conditions.
- Institutional SNP (I-SNP): You live in an institution (like a nursing home), or you require nursing care at home.
- Dual Eligible SNP (D-SNP): You have both Medicare and Medicaid.

Here is the link to www.medicare.gov where you can download a brochure: https://www.medicare.gov/Pubs/pdf/10126.pdf

Meet Lucile

One of our clients – we will call her Karen – came to us for help with her Medicare troubles. She was getting ready to turn 66 and had already used up all her lifetime reserve days. She had been hospitalized the week she turned 65 for several months. She had gone home for further recovery but was again hospitalized as she started a new benefit period. All deductibles began again. This time she was in the hospital for several more months incurring a growing coinsurance bill for the days she spent over the coverage limit.

When all was said and done, she came to us with a hefty medical bill AND the realization that she was out of lifetime reserve days.

While we could not undo the past, we did get her on the right track to insure that whatever happened in the future she knew her worst case scenario. Not only was this acceptable to her, she loved it. She had the peace of mind that going forward she knew she would never have to spend more than a certain amount of money on her health care cost in any given year.

Key Questions

1. Do I qualify for assistance on my prescriptions drugs? Is my individual income under $1436.00 per month?

2. Do I need assistance in filling out the online application?

3. Do I qualify for any state assistance? Is my income under $1200.00 per month?

Who Are We
And What We Do

In case you missed it, this FREE Guide – the reason I've taken the time to write – is to make you an offer.
First, consider Medicare as a maze…

So what's the offer? **Simple.**

First is my request: I want to meet with you. I want to be YOUR guide through the Medicare maze. I want to help you with your planning and choice selection. *I want you as a client*. While I'm not perfect, I am pretty good at what I do. Why? Because I know the maze. And equally important, I get to know my clients to find out what their goals, dreams, desires and wishes are. Then I help them craft a plan to accomplish those goals while I show them the ends and outs of the maze.

So my offer is…if you give me a call within the next week, I will give you a free consultation and review your current situation and then make suggestions on how you can best make it through the maze.

And here's what I promise:

1. My consultation is free.

2. You can put your checkbook up because I won't ask you for money. I won't sell you anything. All we will do is review so I can research and find out how I can help you the most.

3. I won't hassle you. This will be the easiest sales presentation you've ever witnessed. In fact, it won't be a sales presentation. The reality is I CAN'T sell you anything until I know what you need, want and desire. BUT even after I know those things, I WON'T SELL you. I will simply **offer** a solution. If you don't see the benefit in what I offer, I will walk away. It's that simple.

4. It won't be a waste of your time. Whether we can help or not, you will probably learn something you didn't know before (what price tag is there on knowledge?), or you will feel better about your current plan once we review it.

5. If I can't help you, I walk away. It's that simple. No double-talk. No manipulation. No pressure.

So the question to you is: **Would it be worth 30 minutes of your time to see if we could help you get through the maze?** What do you have to lose? 30 minutes? We usually blow that amount of time watching TV or piddling around the house.

Just call 615-530-6154 and schedule your appointment today!

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Why Should You Meet With Me

So, why should you meet with us? Why take the time to discuss the Medicare Maze with *The Nolan Group?*

1. You won't have to go it alone. This alone makes it worth a FREE consultation. Simply getting our expertise makes it worth it.

2. You won't get a one dimensional view. Too many 'agents' work for the insurance or finance company. So they have the insurance or finance companies agenda on their mind when they meet with you. Not so with us. As I said before, we work for YOU. Not the insurance company. Your agenda is OUR agenda. That's why before you make any decision or move, we want to talk. Then, once you agree with the plan, we start talking about solutions, products and tools to get you where you want to be.

3. You'll find out your true options. The reality is 'One Size Does NOT Fit All.' Every situation is different. That means your situation is unique. We know that, so our approach is different (as I mentioned above).

You have options. My dad used to say "There is more than one way to skin a cat!" There So why not know ALL your options so you can pick the one that feels right to you. Not one that feels right to me. Or your neighbor. Or some insurance institution. One that feels right to you.

This is where knowledge is important. The bible even says, "*My people are destroyed because of a lack of knowledge."* (See Hosea 4:6a) I find this is true when it comes to retirement planning.

4. You'll save tons of time. I can't image having to read all the material you get in the mail just to make an informed decision. Having a guide like *The Nolan Group* can cut through the clutter. We've seen it, read it, and done it all before.

Will You Meet With Me?

So, now that you know a little about who we are, what we do, how we help, and what to expect…the question is, ***Are YOU ready to get out of that maze?***
If you are…

Call Today. Don't put it off. Pick up the phone and call while it is on your mind. I promise it is a simple and easy process. You will love doing business with us. We are on YOUR side.

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I'm waiting to hear from you.

Joseph Douglas Nolan

Medicare Research Sources:

http://medicare.gov/what-medicare-covers/medicare-health-plans/medicare-advantage-plans-cover-all-medicare-services.html

www.medicare.gov/about-us/how-medicare-is-funded/medicare-funding.html

Www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html