

# Basic Introduction of Medicare: What Pharmacy Personnel Need to Know

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## Financial Disclosure

This CE program was supported by grant number 90SAP0058 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201 and Alabama Department of Senior Services as part of the C.A.R.E.S. program (<https://alpharmacycares.org>). We have no other relevant affiliations or financial relationships with a commercial interest to disclose.

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Technicians: 0001-9999-23-041-H04-T



**Credit:** 1.0 hour (0.10 ceu)

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**Target Audience:** Pharmacists and pharmacy technicians.

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## Introduction

Medicare is the nation's largest health insurance program, currently covering over 62 million Americans.<sup>1</sup> Medicare was traditionally established to cover hospital and medical insurance needs. However, after observing the difficulty patients experienced in affording prescription drugs, the Medicare Modernization Act of 2003 (MMA) was enacted to expand this coverage to include brand-name and generic prescription drugs for Medicare beneficiaries.<sup>2</sup> With the addition of Medicare Part D, patients are able to choose from a number of prescription drug plans ranging from 40-60 plans depending on the patient's location.<sup>3</sup> Many patients are overwhelmed with the choices available to them, leaving them confused, frustrated, and seeking help in comparing their options.<sup>4, 5</sup> These patients often seek the help of healthcare professionals in evaluating their plans. In fact, 25% of Medicare patients indicated they would be very likely to seek help from their pharmacist in evaluating their Medicare plans and 75% expect their pharmacist to be at least somewhat knowledgeable about the Medicare Part D plan choices available.<sup>6</sup> This places pharmacists in a unique position to assist their patients. However, in order to meet patients' needs, pharmacists should be equipped with the skills and knowledge needed to help their patients make educated decisions.

Therefore, after reading this continuing education article, the learner should be able to:

1. Describe the Medicare Program and enrollment process including the late enrollment penalty
2. Describe the purpose of Medigap and identify what Medigap may cover
3. Discuss how the quality of Medicare Part D plans is measured
4. Discuss the need for yearly plan evaluation for Medicare Advantage and prescription drug plans.

## Medicare Parts A and B

### *Medicare Part A*

Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid Services and is available for individuals 65 years of age and older, under age 65 with certain disabilities, and individuals of any age who have End-Stage Renal Disease.<sup>7</sup> Coverage under Medicare is comprised of four parts including Medicare Part A, B, C, and D (see Table 1).<sup>8</sup> Medicare Part A is commonly known as hospital insurance and covers hospitalization, skilled nursing facilities for a limited duration following a hospital stay, hospice care, and home health care following a hospital stay.

A premium is the amount a beneficiary pays to purchase health insurance. Most Medicare beneficiaries don't pay a monthly premium for Part A if they or their spouse worked and paid into Social Security for at least 10 years.<sup>9</sup> However beneficiaries are responsible for Part A cost-sharing in the form of a deductible and co-payments if they seek medical care. Part A deductible is for each benefit period. A benefit period is used to determine a beneficiary's

*Table 1. Medicare Coverage and Cost<sup>8</sup>*

Medicare	Coverage	Cost
Part A	Inpatient hospitalizations, skilled nursing facility care and home health care	Part A premium (most people don't pay) Deductible and copayment
Part B	Doctors' services, outpatient care, preventive services, durable medical equipment	Part B premium Deductible and coinsurance
Part C	All services covered by Parts A and B and possibly vision, hearing, dental, and prescription drug benefits	Part B Premium Part C Premium Deductible and coinsurance
Part D	Prescription drugs	Part D premium Deductible and coinsurance

cost sharing. A Part A benefit period will begin the day a patient is admitted to a hospital and continues until the patient has not received any inpatient hospital care for 60 days in a row (see Table 2). During this time, the patient will pay their deductible (\$1,600 in 2023) for days 1-60. After day 60, the patient will begin paying a co-pay (\$400 per day) for days 61-90, and \$800 per day for days 91-150. If the patient is hospitalized for more than 150 days, the patient is responsible for the full cost of the hospital stay for days 151 and beyond. Also, if the patient has exhausted their lifetime reserved days, they would begin to pay the full cost of hospital stay, starting from Day 90. Medigap policies are available to absorb some of the out-of-pocket costs of Medicare Part A (see Table 3 below and we will explain about Medigap later in this program). As illustrated in Table 2, beneficiary's cost-sharing may not be affordable for many Medicare beneficiaries, especially considering the fact that many beneficiaries are on limited income.<sup>10, 11</sup>

*Table 2. Hospitalization Out-of-Pocket Costs<sup>9</sup>*

Length of Stay	Beneficiary Out-of-Pocket (year 2023)
Days 1-60	\$1,600 deductible, then nothing
Days 61-90	\$400 per day
Days 91-150 <sup>a</sup>	\$800 per day
After 150 days	The full cost of hospital stay

<sup>a</sup>Lifetime reserve days – Medicare will only pay for these 60 days once in beneficiaries' lifetime.

### *Medicare Part B*

Most beneficiaries with Part A will also receive Part B. However, Part B is an optional benefit and requires a monthly premium.<sup>9</sup> The standard premium is \$164.90 per month in 2023. If patients' gross income is above a certain limit, they will pay the standard premium plus an income-related monthly adjustment amount. For example, for a single individual making between \$97,000 – \$123,000, they would pay Part B premium in the amount of \$230.80 in 2023. These monthly premiums and a combination of general tax revenues finance Part B. In addition

to monthly premiums, beneficiaries must also pay a Part B deductible (\$226/year in 2023) and coinsurance of 20% of the Medicare approved amount should they seek medical care. Patients with a certain Medigap policy (discussed below) may not have to pay this 20% coinsurance (Table 3) for Part B services. Covered Part B services include medical, clinical laboratory services, and outpatient hospital services. In addition, Part B enrollees are eligible for many preventive care services at no cost to them.<sup>12</sup> These include the Welcome to Medicare visit, an annual wellness visit, mammograms, smoking cessation, and vaccinations (COVID-19, influenza, pneumococcal and Hepatitis B vaccines), among others.

### *Enrollment in Parts A and B*

In most cases, if an individual is receiving social security or Railroad Retirement benefits (RRB), they will automatically be enrolled in Part A and Part B.<sup>12</sup> This automatic enrollment will begin the first day of the month they become 65 years of age. Individuals under the age of 65 who are disabled will automatically be enrolled in Parts A and B after they have received benefits from Social Security or RRB for 24 months. However, if an individual is diagnosed with Amyotrophic Lateral Sclerosis (ALS), they will automatically receive Parts A and B the month their disability benefits begin. If an individual is automatically enrolled, they will receive the welcome to Medicare package three months before their 65<sup>th</sup> birthday (or 25<sup>th</sup> month of disability benefit). This will include the traditional red, white, and blue Medicare card with both Part A and Part B. Because Part B is an optional benefit, individuals may decline enrollment in Part B by following instructions within the package to send the card back. If they choose to keep the card, they will keep Part B and therefore be responsible for paying Part B premiums.

If an individual is not automatically enrolled, they must sign up themselves.<sup>7</sup> Most enrollment takes place through the Social Security Administration (SSA) or the RRB if the individual is a railroad retiree. Individuals should contact the SSA or RRB three months before their 65<sup>th</sup> birthday to begin the enrollment process. Timely enrollment is crucial, as individuals who do not enroll when they first become eligible may have to pay a late enrollment penalty for as long as they are covered.<sup>9</sup> If an individual does not qualify for premium free Part A and they do not enroll when they are first eligible, their monthly premium may be increased by 10%.<sup>9</sup> They will be required to pay the penalty for twice the number of years they waited to sign up (Example 1). Part B also has a late enrollment penalty. Patients who delay enrolling in Part B are required to pay a 10% higher premium for each full 12-month period they could have had Part B but did not enroll (Example 2).<sup>9</sup> Further, the Part B penalty continues for as long as the individual is enrolled.

**To illustrate the late enrollment penalties associated with Parts A and B, we will use the following examples:**

Example 1: Medicare Part A Late Enrollment Penalty

Mary doesn't qualify for premium-free Part A. She was eligible for Part A in 2020 but signed up late in 2023. Because she signed up three years late, she will be required to pay a 10% higher premium penalty, in addition to the Part A premium, for 6 years.

#### Example 2: Medicare Part B Late Enrollment Penalty

Jim became eligible for Part B in September 2020 but waited to sign up until March 2023 (30 months or two full 12-month periods). Because he waited two full 12-month periods, he will be required to pay a 20% higher premium. In 2023, the standard premium is \$164.90, which means Jim will pay \$32.98 late enrollment penalty plus a standard premium. He will continue to pay a 20% higher premium for as long as he is enrolled in Part B.

## Original Medicare

Original Medicare is the combination of Parts A and B together and is structured as a fee-for-service plan managed by the Federal Government. In 2023, about 49% of the total Medicare population are enrolled in the Original Medicare Plan.<sup>13</sup> Beneficiaries are responsible for the Part B premium, deductibles, and co-payments or co-insurance as previously discussed. Patients enrolled in Original Medicare have a variety of choices when selecting their providers. However, out-of-pocket costs can be significant as described previously.<sup>14</sup> Therefore, many beneficiaries add optional supplemental coverage to their Original Medicare, known as a Medigap policy.<sup>15</sup>

Medicare Supplement Insurance, known as Medigap are private insurance policies that assist beneficiaries in paying for patient cost sharing as required by Original Medicare coverage such as deductibles, coinsurance, and copayments.<sup>15</sup> In order to purchase a Medigap policy, the beneficiary must be enrolled in both Parts A and B and willing to pay an additional monthly premium to purchase the Medigap policy of their choice. These policies must follow federal and state laws that are designed to protect the beneficiary. This means that companies offering Medigap policies must offer standardized options for benefits as described in the Table 3 below. It is also important to note that Medigap plans do not work with Medicare Advantage Plans.

Table 3. Medicare Supplement Insurance (Medigap)<sup>16</sup>

Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G*	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	x	x	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	x	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	x	x	✓	x	✓	x	x	x	x	x
Part B excess charge	x	x	x	x	✓	✓	x	x	x	x
Foreign travel exchange (up to plan limits)	x	x	80%	80%	80%	80%	x	x	80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	\$6,490 in 2023	\$3,470 in 2023	N/A	N/A

\* Plan F and G also offers a high-deductible plan. If patients choose this option, this means they must pay for Medicare-covered costs up to the deductible amount of \$2,700 in 2023 before their Medigap plan pays anything.

\*\* After patients meet their out-of-pocket yearly limit and their yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

\*\*\* Plan N covers 100% of the Part B coinsurance with the exception of a copayment of up to \$20 for some office visits and a copayment of up to \$50 for emergency room visits that do not result in inpatient admission.

## Medicare Advantage (Part C)

As healthcare costs continue to rise, 51% (30.8 million) of Medicare beneficiaries in 2023 chose to enroll in Medicare Advantage plans rather than Original Medicare.<sup>13</sup> This represents a significant increase over the 19% enrollment rate in 2007. Medicare Advantage plans, or Medicare Part C plans, are health plans approved by Medicare and managed by private health insurance companies.<sup>17</sup> Private managed care organizations are paid a capitated fee by the federal government to provide coverage equivalent to Original Medicare for their enrollees. However, most Medicare Advantage plans offer benefits beyond what Original Medicare covers including vision, dental, hearing, and prescription drug coverage.<sup>8</sup> While individuals who choose to enroll in a Medicare Advantage plan are still required to pay the Part B premium, the cost-sharing within Medicare Advantage plans are typically less than that of Original Medicare.<sup>8</sup> Research

suggests that on average, Medicare Advantage plans offer coverage that is often of higher quality for a lower cost than Original Medicare.<sup>18, 19, 20, 21, 22</sup>

The annual open enrollment period for patients to sign up for a plan or switch a plan is between October 15 – December 7 for a plan that will begin in a subsequent year. Further, the Medicare Advantage Open Enrollment Period that takes place in the 1<sup>st</sup> quarter of each year (January 1<sup>st</sup> – March 31<sup>st</sup>) will allow patients to switch from one Medicare Advantage plan to another or leave a Medicare Advantage Plan to go back to Original Medicare. However, people with Original Medicare cannot sign up for a Medicare Advantage Plan during this Medicare Advantage Open Enrollment Period. That is, if patients are dissatisfied with their Medicare Advantage plan during the first 3 months of the year, they should consider switching to a different Medicare Advantage Plan or go to Original Medicare plan.

## Medicare Part D

In 2003, the Medicare Modernization Act (MMA) was passed, creating Medicare Part D, an optional prescription drug coverage benefit that was implemented in 2006.<sup>2</sup> Since its implementation, Part D has improved access to prescription drugs for many Medicare beneficiaries.<sup>23, 24</sup> Medicare prescription drug plans are offered by private companies, which receive capitated payments from the federal government.<sup>7</sup> Any beneficiary enrolled in Medicare Part A and/or Part B is eligible to enroll in a Part D plan. This includes dual eligible beneficiaries (those who qualify for both Medicaid and Medicare). In 2021, approximately 48 million Medicare beneficiaries were enrolled in a Part D plan.<sup>25</sup> Fifty percent of these beneficiaries were enrolled in a stand-alone prescription drug plan (PDP), while the remaining 50% were enrolled in a Medicare Advantage drug plans.<sup>25</sup>

As part of the MMA, a standard drug benefit was designed that sets a minimum coverage level that all Part D plans must offer.<sup>26</sup> However, very few plans offer a true standard benefit. Most offer an alternative benefit design that is equal if not greater in value to the standard benefit. As a result, plans will vary in terms of formulary, monthly premiums, deductibles, and cost-sharing. However in order to ensure that Medicare beneficiaries are able to obtain the prescriptions they need, all plans are required to cover a range of drugs in the most commonly prescribed categories.<sup>26</sup> Generally, all plans must cover at least two drugs per drug category, but plans may choose which specific drugs they cover. Coverage and rules vary by plan, so drugs that are covered in one plan may be more expensive or not covered by another plan. While plans have some flexibility within these most commonly prescribed categories, all plans must cover all available prescription drugs in the following six protected categories including cancer medications, HIV/AIDS treatments, antidepressants, antipsychotics, anticonvulsants, and immunosuppressants.<sup>24</sup> Further, plans must cover all commercially available vaccines, such as Shingles, Respiratory Syncytial Virus (RSV), and Tdap, except those covered under Medicare Part B, which include influenza, pneumococcal, COVID-19, and hepatitis B vaccines.<sup>26</sup> Because coverage and rules vary by plan and can change annually, prior to enrolling in a Part D plan, beneficiaries should ensure that the plan covers the medications they need. For many

beneficiaries, Medicare costs can pose a substantial financial burden. As a result, the Inflation Reduction Act which was enacted in August 2022, included measures aimed at reducing the cost of prescription drugs for Medicare beneficiaries.<sup>27,28</sup> Although the implementation of the provisions began in 2023, a good number of them will take effect in subsequent years. For example, in 2025, out-of-pocket spending on Part D drugs is capped at \$2,000.

The quality of Part D plans is measured and made available to beneficiaries to assist in their decision-making. This quality metric is available on the Medicare Plan Finder and CMS website.<sup>3</sup> Plans' quality is rated between 1 and 5 stars, 1 star being poor and 5 stars being excellent. High-performing plans with 5 stars are permitted to enroll beneficiaries at any time during the year. Plans that receive a 3-star rating or less for three consecutive years are considered to be low performing. These star ratings are assigned through an assessment of various measures including the plan's customer service, member complaints, member experience, and drug safety and accuracy of drug pricing. Drug safety metrics should be of particular concern to pharmacists as they can directly impact these measures for the plan. Drug safety measures that can be impacted by pharmacists include: 1) blood pressure medication adherence (RAS antagonists), 2) cholesterol medication adherence (statins), 3) diabetes medication adherence (oral diabetes medications), 4) medication therapy management completion rate, and 5) statin use among people with diabetes. In order to improve these measures, Part D plans are allowed by law to establish networks of preferred pharmacies, or preferred cost-sharing pharmacies. The number of Part D plans with preferred pharmacy networks increased from 7% of plans in 2011 to 85% of plans in 2016.<sup>29</sup> Specifically, by 2022, it was estimated that 98% of standalone Medicare Part D prescription drug plans would have a preferred pharmacy network.<sup>30</sup>

### *Enrollment in Part D*

As Medicare Part D is an optional benefit, most individuals must actively enroll in a plan.<sup>17</sup> Beneficiaries can select a Medicare Part D plan using the Medicare Plan Finder tool available at [medicare.gov](https://www.medicare.gov).<sup>3</sup> If an individual delays enrollment in a Part D plan, they may be required to pay a late enrollment penalty.<sup>9</sup> This penalty, an additional 1% of the national base beneficiary premium (\$32.74 in 2023)<sup>31</sup> for each month they were eligible and not enrolled, will be added to their Part D premium and continue for as long as they are enrolled (Example 3). However, if an individual has comparable prescription coverage (eg, through their spouse or employer), they can generally maintain that coverage and won't be required to pay a penalty if they do decide to enroll in a Part D plan as long as they enroll within 63 days after their previous coverage ends. Any eligible individual may join, switch, or drop a Medicare Part D plan during the Open Enrollment Period (October 15<sup>th</sup> to December 7<sup>th</sup> each year).<sup>32</sup>

**To illustrate the late enrollment penalty associated with Part D, we will use the following example:**

Example 3: Medicare Part D Late Enrollment Penalty

[HTTPS://ALPHARMACYCARES.ORG](https://ALPHARMACYCARES.ORG)



Betty chose to enroll in Original Medicare in 2019 when she first became eligible. However she did not choose to add prescription drug coverage and she did not have a credible coverage. She joined a Medicare drug plan during the 2022 Open Enrollment Period and coverage began January 1<sup>st</sup>, 2023. Since Betty did not have coverage from any other source for a total of 38 months, she will have to pay a Part D late enrollment penalty. This penalty is 1% the national base beneficiary premium of \$32.74 (in 2023) multiplied by 38 months. Therefore her penalty will be \$12.44 added to her Part D premium each month for as long as she is enrolled in Part D. Since the national base beneficiary premium changes every year, this penalty amount could increase.

During the Open Enrollment Period (October 15 – December 7), individuals are encouraged to reevaluate their Medicare Advantage and prescription drug plan and ensure that it will meet their needs for the upcoming year.<sup>32, 33, 34</sup> However, this evaluation process is often difficult for Medicare beneficiaries due to multiple reasons including: limited e-health literacy (the ability to seek, find, understand, and appraise health information from electronic sources and apply the knowledge gained to addressing or solving a health problem), low Medicare and insurance literacy (the ability to understand Medicare and insurance), and limited Internet access.<sup>6, 35, 36, 37</sup> As a result, most maintain enrollment in their current plan.<sup>5</sup> In fact, a national survey found that 80% of respondents age 65 and older found Part D plan selection to be too complicated, and 75% requested a fewer Part D plans be offered.<sup>36</sup> The overwhelming nature of Part D plan selection is often compounded by Medicare beneficiaries' limited knowledge of Part D and the benefit structure.<sup>5, 38</sup> Further, many Medicare beneficiaries do not use the internet and are therefore unable to access the Medicare Plan Finder tool to compare plans.<sup>35, 39</sup> Only approximately 5.2% of beneficiaries choose the cheapest plan; and on average, Medicare beneficiaries spend \$368 more annually than they would if they had selected the optimal, least expensive plan.<sup>34</sup>

Given the difficulty Medicare beneficiaries may encounter when re-evaluating their plan, they are in need of assistance comparing available Part D plans, which creates an opportunity for community pharmacists and pharmacy technicians. During the open enrollment period, pharmacists and technicians should encourage their patients to evaluate their prescription drug plans to ensure that they select the best plan that is appropriate for their needs. Alabama's State Health Insurance Assistance Program (SHIP) counselors are available to provide unbiased assistance in comparing plans and can help patients make an informed decision.

## Conclusion

Medicare is the nation's largest health insurance program. The Medicare benefits,

enrollment process, and cost-sharing mechanisms can be complex and overwhelming for Medicare beneficiaries. Further, because the coverage and benefit structure vary among Medicare prescription drug plans, selecting the right plan can be challenging to many Medicare beneficiaries. Pharmacists and pharmacy technicians are uniquely positioned to encourage their patients to evaluate their plans annually and answer any questions that may arise.

**Interested in Learning More?** In addition to this CE activity, you are invited to complete other C.A.R.E.S. (Certified Aging Resource Educated Specialist) Training programs. Any Alabama pharmacy with at least one full-time pharmacist who has completed at least 3 credit hour ACPE approved training through the C.A.R.E.S. program can be enrolled in the C.A.R.E.S. Pharmacy Network. This training and network is available free of charge to you and your pharmacy, as this program is funded by Alabama Department of Senior Services. This network will provide pharmacies with an easy and efficient referral system so that staff who encounter a potentially eligible patient can refer the patient to a local agency to be screened for program eligibility. More information about this program can be found at <https://alpharmacycares.org>.

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