# Helping Clients Choose How to Receive Medicare Coverage– Frequently Asked Questions

**1. What is Medicare?**

Medicare is the federal government program that provides health care coverage for those 65 or older, those under 65 who receive Social Security Disability Insurance (SSDI) for a certain amount of time, or those under 65 who have End-Stage Renal Disease (ESRD).

An individual 65 or older qualifies for Medicare if they

- Collect or qualify for collect Social Security or Railroad Retirement benefits
- **OR,** are a current U.S. resident and either
    - A U.S. citizen
    - **OR,** a permanent resident having lived in the U.S. for five years in a row prior to applying

An individual under 65 qualifies for Medicare if

- They have received SSDI or Railroad Disability Annuity checks for total disability for at least 24 months
    - Exception: If the individual has amyotrophic lateral sclerosis (ALS), there is no waiting period, and they are eligible for Medicare when they start receiving SSDI
- **OR**, they have ESRD, and they or a family member have enough Medicare work history

An individual has the choice to receive their Medicare benefits through Original Medicare (see question 4) or through a Medicare Advantage Plan (see question 5).

**2. What does Medicare cover?**

Different parts of Medicare cover different services.

**Medicare Part A (hospital insurance)** covers most medically necessary inpatient hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B (medical insurance)** covers most medically necessary physicians' services, preventive care, durable medical equipment, prosthetics and supplies, hospital outpatient services, laboratory tests, x-rays, mental health care, home health care, and some limited ambulance services.

**Medicare Part D** (see question 9) is the part of Medicare that provides outpatient drug coverage. Part D covers medically necessary prescription drugs, including insulin and related supplies.

### 3. What are Medicare-excluded services?

Medicare does not cover all health care services. Services excluded from Medicare coverage include, but are not limited to:

- Most dental care
- Most vision care
- Routine hearing care
- Most foot care
- Most long-term care
- Alternative medicine
- Most care received outside the U.S.
- Personal care or custodial care if there is no need for skilled care
- Most non-emergency transportation

Medicare Advantage Plan may cover these services, but this varies by plan. A beneficiary should ask their plan if it covers any additional services.

### 4. What does Medicare cost?

An individual's Medicare costs depends on the type of coverage they have, but there are some Medicare costs for which all beneficiaries are responsible.

- **Part B premium:** All Medicare beneficiaries are responsible for the monthly Part B premium, regardless of how they receive their Medicare coverage. The Part B premium in 2019 is $135.50 per month.

- **Part A premium, depending on the circumstance:** If an individual or their spouse does not have at least 40 calendar quarters (10 years) of work during which they paid Social Security taxes in the U.S., they will be responsible for a monthly Part A premium.
    - Part A is **premium-free** for individuals who have 10 years of work history in the U.S.
    - Part A costs **$240 per month** if an individual of their spouse worked between 30 and 39 quarters (7.5 and 10 years) in the U.S.
    - Part A costs **$437 per month** if an individual of their spouse worked fewer than 30 quarters (7.5 years) in the U.S.

  An individual should contact the Social Security Administration at 800-772-1213 to learn if they or their spouse has enough work history to qualify for premium-free Part A.

**Original Medicare costs**

In addition to the Part B premium (and Part A premium, if applicable), an Original Medicare beneficiary is responsible for:

- **Part A hospital deductible:** $1,364 per benefit period
- **Part A daily hospital coinsurance**
    - $0 for first 60 days of inpatient care each benefit period
        - A **benefit period** is the period that begins the day a beneficiary begins getting inpatient care, and it ends when the beneficiary has not received inpatient hospital or skilled nursing facility care for 60 days in a row.
    - $341 per day for days 61-90 each benefit period
    - $682 per lifetime reserve day after day 90 in a benefit period (beneficiaries have 60 non-renewable lifetime reserve days)
- **Part A daily SNF coinsurance**
    - $0 for first 20 days of inpatient care each benefit period
    - $170.50 per day for days 21-100 each benefit period
- **Part B annual deductible:** $185 in 2019
- **Part B coinsurance:** 20% of Medicare-approved cost for covered services

**Medicare Advantage Plan costs**

A beneficiary enrolled in a Medicare Advantage Plan is responsible for the Part B premium and Part A premium, if applicable. They are also responsible for any costs associated with their plan, including:

- **Medicare Advantage Plan premium:** Many Medicare Advantage Plans charge a premium in addition to the Part B premium.
- **Medicare Advantage Plan cost-sharing:** This can include deductibles, copayments, and/or coinsurance charges. Each plan has a different cost-sharing structure, and a beneficiary should contact a plan directly to learn about its specific costs.

All types of Medicare Advantage Plans (see question 7) have a limit on out-of-pocket costs. This is known as the maximum out-of-pocket limit (MOOP). In 2019, the MOOP is $6,700, but some plans may have a lower limit. This amount is the maximum that a beneficiary will pay in deductibles, coinsurances, and copayments for the year. The limit is high, but afterward, the plan pays 100 percent of the cost of needed care.

### 5. What is Original Medicare?

Original Medicare consists of Part A, hospital insurance, and Part B, medical insurance. It is administered by the federal government. Enrolling in Original Medicare means:

- A beneficiary will receive a red, white, and blue Medicare card to show to their providers
- Most doctors in the country take their insurance

- Medicare limits how much a beneficiary can be charged if they visit participating and non-participating providers (except for non-participating durable medical equipment suppliers), but it does not limit how much they can be charged if they visit providers who opt out of Medicare
- A beneficiary can see a specialist without prior authorization
- A beneficiary is usually responsible for Original Medicare cost-sharing, which may include premiums, deductibles, and coinsurance charges
- A beneficiary is eligible to enroll in a Medigap policy, which can help reduce their out-of-pocket costs

If a beneficiary signs up for Original Medicare and later decides they would like to try a Medicare Advantage Plan—or vice versa—they should be aware that there are only certain enrollment periods when they are allowed to make coverage changes (see question 14).

Original Medicare does not include the prescription drug benefit (Part D), which is only offered through private companies. A beneficiary should consider signing up for a separate Part D plan to ensure that they have coverage for their prescription drug needs (see question 9).

**6. What is a Medigap policy?**

Medigaps are health insurance policies that offer standardized benefits to work with Original Medicare (**not** with Medicare Advantage Plans). They are sold by private insurance companies. If a beneficiary has a Medigap, the Medigap pays part or all of certain remaining costs after Original Medicare pays first.

Medigaps may cover outstanding deductibles, coinsurance, or copayments. Medigaps may also cover health care costs that Medicare does not cover at all, like care received when travelling abroad. A beneficiary is responsible for a monthly premium for the Medigap insurance company.

Depending on where a beneficiary lives, they can choose from up to 10 different Medigap policies: A, B, C, D, F, G, K, L, M, and N (policies in Wisconsin, Massachusetts, and Minnesota have different names). Each policy offers a different set of standardized benefits, meaning that policies with the same letter name offer the same benefits. However, premiums can vary from company to company.

Federal law restricts Medigap enrollment to certain times, but states may have other protections that give their residents additional opportunities to enroll in a Medigap. A beneficiary should contact their State Health Insurance Assistance Program (SHIP) at www.shiptacenter.org or 877-839-2675 or the State Department of Insurance to ask about state-specific Medigap rights.

The two federally protected times to purchase a Medigap are:

- **Medigap open enrollment period.** Generally, the best time for a beneficiary to enroll in a Medigap is during their open enrollment period. Under federal law, a beneficiary has a six-month open enrollment period that begins the month they are 65 or older and enrolled in Medicare Part B. During this period, Medigap companies must sell the beneficiary a policy at the best available rate regardless of their health status and they cannot deny the beneficiary coverage. If a beneficiary purchases a Medigap during their open enrollment period, policies are limited in their ability to exclude coverage for a pre-existing condition, meaning conditions a beneficiary had before enrolling.
- **Guaranteed issue right.** If a beneficiary misses their Medigap open enrollment period, they can also buy a Medigap if they have a guaranteed issue right. If a beneficiary is 65 or older, they have a guaranteed issue right to purchase a Medigap within 63 days of when they lose or end certain kinds of health coverage. When a beneficiary has a guaranteed issue right, companies must sell the beneficiary a policy at the best available rate regardless of their health status and they cannot deny the beneficiary coverage. A guaranteed issue right also prevents companies from imposing a waiting period for pre-existing conditions.
    - See full list of guaranteed issue rights here: https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/guaranteed-issue-rights-scenarios.html

### 7. What is a Medicare Advantage Plan?

Medicare Advantage Plans are private plans that contract with the federal government to provide Medicare benefits. About one-third of Medicare beneficiaries are enrolled in a Medicare Advantage Plan.

Medicare Advantage Plans must offer, at a minimum, the same benefits as Original Medicare (those covered under Parts A and B), but can do so with different costs and coverage restrictions. A beneficiary typically also gets Part D as part of their Medicare Advantage benefits package. There are many types of Medicare Advantage Plans available (see question 8). A beneficiary enrolled in a Medicare Advantage Plan usually pays a monthly premium for this coverage, in addition to their Part B premium.

Enrolling in a Medicare Advantage Plan means:

- A beneficiary will receive a plan membership card to use to show their providers instead of the red, white, and blue card
- A beneficiary will likely have to use in-network providers to receive covered services at the lowest cost
- A beneficiary's plan limits their out-of-pocket costs each year
- A beneficiary may have to get a referral from the primary care physician to see a specialist

- A beneficiary is usually responsible for Medicare Advantage costs, which may include premiums, deductibles, and copayments or coinsurance charges
- A beneficiary may have coverage for services typically excluded from Medicare coverage, such as dental cleanings

If a beneficiary signs up for a Medicare Advantage Plan and later decides they would like to try Original Medicare—or vice versa—they should be aware that there are only certain enrollment periods when they are allowed to make coverage changes (see question 14).

### 8. What are the different types of Medicare Advantage Plans?

There are a number of different types of Medicare Advantage Plans. Each type of plan has a different structure that can affect the way a beneficiary accesses their Medicare benefits. Not all types of Medicare Advantage Plans are available in all regions throughout the U.S. A beneficiary can call 1-800-MEDICARE or use the Medicare Plan Finder (see question 14) to learn about the Medicare Advantage Plans available in their area.

**Health Maintenance Organizations (HMOs)**

In most HMOs, a beneficiary must see in-network providers to receive coverage, unless they need emergency medical treatment. Some HMOs offer a point-of-service (POS) option, which allows a beneficiary to go out of network for certain services. In these cases, a beneficiary will be covered but usually at a higher cost.

A beneficiary enrolled in an HMO will have to choose a primary care physician (PCP) to coordinate their care. They must usually get the PCP's referral before seeing a specialist.

Many beneficiaries are enrolled in HMOs, and HMOS are available throughout the country. HMOs tend to have lower premiums than other types of Medicare Advantage Plans, but they also have more restrictive provider networks.

**Preferred Provider Organizations (PPOs)**

A beneficiary enrolled in a PPO pays the least for covered services they receive from in-network providers. PPOs also cover care from out-of-network providers, but the beneficiary pays more for the services.

There are two types of Medicare PPO plans:

- Regional PPOs, which service a single state or multi-state area determined by Medicare
- Local PPOs, which serve a single county or group of counties chosen by the plan and approved by Medicare

A beneficiary enrolled in a PPO is not required to select a PCP and does not need a PCP referral to see a specialist.

**Private fee-for-service (PFFS) plans**

Most PFFS plans have provider networks, and a beneficiary may pay less for care when they use an in-network provider. All PFFS plans must cover out-of-network care, but the beneficiary may pay a higher cost than for in-network care.

If a beneficiary plans to receive care from an out-of-network provider, they or their provider can request an advance organization determination (also called an advance coverage determination) from their plan. This advance determination is a request for the plan to confirm that a service is medically necessary and will be covered. If a beneficiary plans to receive a costly service from an out-of-network provider, requesting an advance organization determination can help them avoid unexpected denials.

A beneficiary enrolled in a PFFS plan is not required to select a PCP and does not need a PCP referral to see a specialist.

**Special Needs Plans (SNPs)**

SNPs are plans designed to meet specific care needs, and a beneficiary can only join a SNP if they fit the special needs category the plan serves. SNPs may provide care and coverage coordination services not offered by other types of Medicare Advantage Plans. There are three types of SNPs:

- Chronic Condition SNPs (C-SNPs): For individuals with specific chronic conditions, such as cancer, dementia, diabetes, HIV/AIDS, stroke, ESRD, and certain neurologic disorders.
- Institutional SNPs (I-SNPs): For individuals who live in an institution, such as a nursing home, long-term care skilled nursing facility (LTC SNF), intermediate care facility, or assisted living facility.
- Dual Eligible SNPs (D-SNPs): For individuals enrolled in Medicare and Medicaid (dually eligible individuals).

Plans may help manage a beneficiary's care by providing:

- Access to a care manager who assesses the beneficiary's needs and providers supervision
- Coordination of Medicare and Medicaid benefits, in the case of a D-SNP

A SNP may be an HMO or PPO. Depending on the plan, a beneficiary may need to see in-network providers to receive coverage, or they may have the option of going out of network. A beneficiary should check with the plan to learn about networks and costs.

**Medicare Medical Savings Account (MSA) plans**

Medicare MSA plans are a type of plan that includes both a high deductible health plan (HDHP) and a bank account to help pay medical costs.

HDHPs have large deductibles that a beneficiary must meet before receiving coverage. This means that if a beneficiary has an HDHP, they will pay in full for most health care services until they reach their deductible for the year.

MSA plans also include a bank account where the beneficiary's plan deposits funds once each year for their medical expenses. The beneficiary uses these funds to pay for their deductible.

- The plan chooses the bank account and the amount it contributes. Generally, the plan's contribution is lower than the full deductible.
- Funds contributed to an MSA are not taxed, as long as they are used for qualified medical expenses.
  A beneficiary cannot deposit more money into the account. Once they have used the money in the account, they have to pay out of pocket until they reach their deductible.
- A beneficiary will typically have higher out-of-pocket costs for their care until they reach the deductible. After reaching their deductible, the MSA plan covers 100 percent of the cost for Medicare-covered services.

A beneficiary cannot join an MSA plan if they have any other type of health insurance, including Medicaid, Veterans Affairs benefits, Federal Employee Health Benefits, or many kinds of employer or retiree insurance.

MSA plans may have provider networks. A beneficiary may pay less for their care when using in-network providers. All MSA plans also must cover out-of-network care, but the beneficiary may pay a higher cost.

### 9. What is Medicare Part D?

Medicare Part D, the prescription drug benefit, is the part of Medicare that covers most outpatient prescription drugs. Part D is offered through private companies either as a stand-alone plan for those enrolled in Original Medicare, or as a set of benefits included in a Medicare Advantage Plan.

Each Part D plan has a list of covered drugs, called its formulary. Part D does not cover drugs that are covered by Medicare Parts A and B, such as drugs a beneficiary receives as part of inpatient hospital treatment (Part A), chemotherapy drugs (Part B), or certain vaccines (Part B).

There are various costs associated with a beneficiary's Part D plan. A beneficiary may have a monthly premium, an annual deductible, and coinsurance or copayments for their covered drugs.

- **Premium:** The amount a beneficiary pays monthly to have drug coverage. In 2019, the average Part D premium is $33.19.

- **Deductible**: The amount a beneficiary pays annually before their plan begins to cover their prescription drugs. Not all Part D plans have a deductible. In 2019, the maximum deductible is $415.
- **Coinsurance or copay**: The amount a beneficiary pays out of pocket for their covered drugs. A coinsurance is a percentage of the cost of the drug. If a plan charges a 15% coinsurance for covered generic drugs, that means the beneficiary pays 15% of the cost each time they fill a generic prescription. A copay is a set amount, such as a $20 copay for a covered generic drug.

Many Part D plans use tiers to price drugs listed on their formularies. Drugs on lower tiers are less expensive, and drugs on higher tiers are more expensive. A sample tier structure may be:

- Tier 1: Generic drugs
- Tier 2: Preferred brand-name drugs
  Tier 3: More expensive brand-name drugs
- Tier 4: Specialty drugs

**Note:** These are not official drug tiers. In practice, some plans may place generic drugs on higher tiers.

**10. What should a beneficiary consider when deciding between Original Medicare and Medicare Advantage?**

To make a decision between Original Medicare and a Medicare Advantage Plan, a beneficiary may want to consider how they value some of the following factors:

- **Flexibility** to see out-of-network doctors. If a beneficiary enrolls in a Medicare Advantage Plan and sees an out-of-network provider, they will likely have to pay for the entire cost of the service out of pocket. Original Medicare does not have networks—instead, a beneficiary can see any provider who accepts Original Medicare in order to have the lowest cost for their health care. Many providers accept Original Medicare.

- **Risk** of out-of-pocket expenses without a MOOP limit. Original Medicare does not have MOOP limit, but Medicare Advantage Plans do. This means that if a beneficiary is enrolled in a Medicare Advantage Plan, they will not owe anything for services once they have paid a certain amount in out-of-pocket costs. MOOP limits are high, but they can protect beneficiaries who have many out-of-pocket costs.

- **Predictability** of set copays with a Medicare Advantage Plan, as compared to Original Medicare coinsurances. Coinsurances are percentages of the cost of a service, so if a health care service is expensive, the coinsurance will be higher. If a beneficiary picks a

Medicare Advantage Plan that has copays, they will know the set copay amount for visits to their primary care physician and specialists.

This is not an exhaustive list of everything a beneficiary should consider, but it provides a starting point for beneficiaries to begin the decision process.

### 11. What questions should a beneficiary ask when choosing a Medicare Advantage Plan?

When a beneficiary is choosing between Medicare Advantage Plans, here are some questions to keep in mind.

**Providers, hospitals, and other facilities**

- Will the beneficiary be able to use their doctors? Are they in the plan's network?
- Do the doctors and providers the beneficiary wants to see in the future take new patients who have this plan?
- If the beneficiary's providers are not in-network, will the plan still cover their visits?
- Which specialists, hospitals, home health agencies, and skilled nursing facilities are in the plan's network?

**Costs**

- What costs should the beneficiary expect for their coverage (premium, deductibles, copayments)?
- What is the annual maximum out-of-pocket limit?
- How much will beneficiary have to pay out of pocket before coverage starts (what is the deductible)?
- How much is the copayment for services the beneficiary regularly receives, such as PCP or specialist care?
- How much will beneficiary pay if they visit and out-of-network provider?
- Are there higher copays for certain types of care, such as hospital stays or home health care?

**Benefits**

- Does the plan cover any services that Original Medicare does not?
    - Dental services
    - Vision care
    - Hearing aids
- Are there any rules or restrictions the beneficiary should be aware of when accessing benefits?

**Prescription drugs**

- Does the plan cover outpatient prescription drugs? (See question 12 for more questions regarding drug coverage.)

**Coordination of benefits**

- How does the plan work with current coverage the beneficiary may have?
    - Contact benefits administrator or human resources department to learn more.
- If the beneficiary joins a plan, would they lose their job-based insurance or retiree coverage?

## 12. What questions should a beneficiary ask when choosing a Part D prescription drug plan?

When choosing a Part D plan—whether a stand-alone Part D plan or Medicare Advantage Plan that includes drug coverage—here are some questions to keep in mind.

- Are the beneficiary's prescriptions on the plan's formulary?
- Does the plan impose any coverage restrictions?
- What costs should the beneficiary expect to pay for their coverage (premiums, deductibles, copayments)?
- How much will the beneficiary have to pay for brand-name drugs? How much for generic drugs?
- What will the beneficiary pay for drugs during the coverage gap (time of the year when a beneficiary has higher drug costs)?
- Will the beneficiary be able to use their pharmacy? Can they get their drugs through mail order?
- Will the plan cover prescriptions when the beneficiary travels?

## 13. What questions should a beneficiary ask when choosing a Medigap policy?

When a beneficiary is speaking to insurance representatives about Medigap policies, here are some questions to keep in mind:

- Is the beneficiary enrolling while they are in their open enrollment period? If not, do they have a guaranteed issue right?
    - Does the beneficiary's state offer other enrollment rights? Contact your SHIP to learn about Medigap enrollment rules in your state. Visit www.shiptacenter.org for your SHIP's contact information.
- What is the Medigap policy's monthly premium?
- Is this premium based on their:
    - Health status
    - Gender
    - Smoking
    - Marital status
    - Or anything else?
- Are the premiums:
    - No-age-rated (community-rated), meaning everyone in their area pays the same premium regardless of their age?

    - Issue-age-rated, meaning the premium is based on how old the beneficiary was when they bought the policy?
    - Attained-age-rated, meaning the premium increases based on the beneficiary age?
- Will the company refuse to sell the beneficiary a Medigap based on their health status?
- Does the policy impose a pre-existing condition waiting period?
    - How long is the waiting period before coverage begins?
    - Does beneficiary have prior creditable coverage to reduce the waiting period?

Other considerations

- If the beneficiary does not have the right to buy a Medigap, they should ask the insurance representative how much extra they will be charged for purchasing one.
- If the beneficiary is under 65, they should make sure the company they are considering sells to individuals under 65.
- Beneficiaries should to keep track of who they spoke with, when they spoke with them, and the outcome of the call.

**14. What is Medicare Plan Finder?**

The Medicare Plan Finder is an online tool that helps you look up and compare plans in your area. To access the Medicare Plan Finder, visit www.medicare.gov and click on the green button that says Find Health and Drug Plans. This takes you to the Plan Finder tool. Once you input a beneficiary's information, you will be able to compare a list of plans available in their area. Before using any of these options, the beneficiary should compile a list of health care professionals they see, drugs they take, and pharmacies where they get their drugs. This will allow you to compare the beneficiary's options. Plan Finder provides cost estimates and coverage overviews for Medicare Advantage Plans and stand-alone Part D plans in a beneficiary's area. If a beneficiary is interested in a plan, they should call the plan directly to confirm any information they read online.

**15. When can an individual enroll in Medicare for the first time?**

An individual can sign up for Medicare for the first time during one of three enrollment periods.

- **Initial Enrollment Period (IEP).** An individual can enroll in Medicare at any time during this seven-month period, which includes the three months before, the month of, and the three months following their 65th birthday. The date when their Medicare coverage begins depends on when they sign up.
    - If they enroll during the first three months of their IEP, coverage begins the month in which they first become eligible for Medicare.
    - If they enroll during the fourth month of their IEP, coverage begins the month following the month of enrollment.

    - If they enroll during the fifth month of their IEP, coverage begins the second month following the month of enrollment.
    - If they enroll during the sixth or seventh month of their IEP, coverage begins the third month following the month of enrollment.
- **Part B Special Enrollment Period (SEP).** SEPs are periods outside of normal enrollment periods, triggered by specific circumstances. The Part B SEP allows an individual to delay enrollment in Part B without penalty if they were covered by insurance based on their or their spouse's current work (job-based insurance) when they first become eligible for Medicare. An individual can enroll in Medicare without penalty for up to eight months after they lose their job-based insurance or they (or their spouse) stop working, whichever comes first. Medicare coverage begins the first month after they enroll. For example, if an individual retires and signs up for Medicare in February, their coverage will begin March 1. To avoid a gap in coverage, an individual should enroll in Medicare the month before their job-based insurance will end.
- **General Enrollment Period (GEP).** If an individual did not enroll in Medicare when they originally became eligible for it (either during their IEP or Part B SEP), they can sign up during the GEP. The GEP takes place January 1 through March 31 each year, with coverage starting July 1. An individual may incur a Part B late enrollment penalty and face gaps in coverage if they sign up during the GEP.

**16. When can a beneficiary make changes to their Medicare coverage?**

A beneficiary typically can only enroll in a different Medicare Advantage Plan or switch between Original Medicare and Medicare Advantage during specific times each year.

- **Fall Open Enrollment Period.** A beneficiary can make a number of changes during Fall Open Enrollment, which runs October 15 through December 7 each year. Any changes made take effect on January 1 of the following year. During this time, beneficiaries can make changes to their stand-alone Part D plan or Medicare Advantage Plan. You can help a client find a new plan by using the Medicare Plan Finder tool on www.medicare.gov, calling 1-800-MEDICARE, or contacting the client's SHIP by visiting www.shiptacenter.org or calling 877-839-2675.
- **Medicare Advantage Open Enrollment Period.** A beneficiary can switch from their Medicare Advantage Plan (excluding MSA plans) to another Medicare Advantage Plan, or to Original Medicare with or without a stand-alone prescription drug plan during the MA OEP. The MA OEP occurs each year from January 1 through March 31. A beneficiary can only use this enrollment period if they have a Medicare Advantage Plan. Changes made during this period take effect the first of the following month. For example, if a beneficiary switches to a new Medicare Advantage Plan in February, their new coverage would begin March 1.
- **Special Enrollment Period (SEP).** Under certain circumstances, a beneficiary may be eligible for an SEP. SEPs allow beneficiaries to change their health and/or drug coverage outside normal enrollment periods. The length of the SEP and the effective

date of the new coverage depend on the reason for the SEP. A full list of SEPs is available at https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances/join-plan-special-circumstances.html.

Some examples of SEPs include:

- Extra Help SEP
    - A beneficiary enrolled in Extra Help can change their drug coverage once per quarter for the first three quarters of the year (January through March, April through June, July through September).
- SPAP SEP
    - A beneficiary enrolled in an SPAP can choose a new Medicare Advantage or Part D plan once per year (unless their SPAP automatically enrolled them in a Part D plan).
- Five-star SEP
    - If there is a five-star stand-alone Part D plan or Medicare Advantage Plan in a beneficiary's service area, they can enroll in that plan.

**17. Are there any programs that help pay Medicare costs?**

There are some programs available to Medicare beneficiaries to help pay their health and drug costs. A beneficiary usually must meet income and/or asset limits in order to qualify for these programs.

- **Medicare Savings Programs,** also known as Medicare Buy-In programs, are state programs that assist with paying Medicare costs. These include premiums, deductibles, coinsurance charges, and copayments. There are three MSPs, each with different federal income and asset eligibility limits. States can raise these limits to be more generous, which allows more people to qualify for the benefits. Contact the client's SHIP (www.shiptacenter.org) to learn about MSP income limits in your client's state. All three MSPs cover the Part B premium, which means a beneficiary's monthly Social Security check will increase by around $100 if they qualify for and enroll in one of these programs.
- **Extra Help,** also referred to as the Low-Income Subsidy (LIS), is a federal program that helps pay for Medicare prescription drug coverage. Visit https://www.ssa.gov/benefits/medicare/prescriptionhelp/ to learn more about Extra Help and to help a client apply.
- Some states—but not all—have a **State Pharmaceutical Assistance Program (SPAP)** that helps pay for an individual's drugs. Each SPAP has specific eligibility requirements, application instructions, and rules and conditions that a beneficiary must follow in order to get the benefit. One way to learn whether your client's state has an SPAP is to contact your State Health Insurance Assistance Program (SHIP) or visit www.medicare.gov/pharmaceutical-assistance-programs/state-programs.aspx.

- **Patient Assistance Programs (PAPs)** are pharmaceutical assistance programs that provide discounts on certain drugs. There is a variety of different PAPs, and each generally offers discounts on a specific type of brand-name or generic medication. These discounts are provided by drug manufacturers, not by the state or federal government. In addition, some programs may not be available for beneficiaries who already have Medicare prescription drug coverage. Visit www.needymeds.org or www.rxassist.org to search for a beneficiary's needed drug and learn if there are any PAPs available to them. NeedyMeds also shows you if there are coupons, charities, and/or inexpensive generic options available for the drug(s) you entered.