

Medicare is not “One-Size-Fits-All”

The information you need
to choose a Medicare plan



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About The Author

Charles Bradshaw assists people who are going on Medicare or who are already on Medicare in choosing the right Medicare plan for their needs and budget.

After graduating from the University of Tennessee, Charles worked around the country in Finance, Marketing and executive-level positions helping such companies as Disney, Nestle, Procter and Gamble, DirecTv and Hilton Hotels. He spent enough time doing this work to realize that there was a lot more important decisions affecting people's lives made by real people around kitchen tables than phony people around boardroom tables.

Charles has met with and helped thousands of seniors understand their Medicare options and helped them choose the right plan for their needs. Besides helping people with their Medicare and making a difference in their lives, he considers his greatest professional accomplishment to not having been bitten by any of his clients' dogs though he once was pecked by one of their chickens.

Foreward

Thank you for taking the time to request and read “Medicare is not ‘One-Size-Fits-All’”.

I hope it is helpful in helping you fully understand the many options you have for accessing your Medicare benefits and guarding against the financial risk of a costly health condition.

Most important, I hope it helps you make a good decision about your Medicare plan.

I have met with hundreds of people who made mistakes in choosing a Medicare plan. Sometimes it impacted their ability to get the health care they needed. Sometimes it resulted in them paying thousands of dollars more than they would have if they had made a better decision when selecting a Medicare plan. Many times it did both.

With some of these people I was able to help them correct their mistakes. With others it was too late since some Medicare plan options are only available when someone turns 65.

I hope this book helps people going on Medicare avoid such mistakes in the future.

I am very grateful to the many people who assisted me in this book whether they knew they were doing so or not.

Most importantly, the hundreds of Medicare beneficiaries who have invited me into their homes and allowed me to assist them with their Medicare choices. By meeting you and seeing time and again the real-life impacts of your Medicare choices, I have been able to become a better Medicare insurance agent and do a better job helping others.

I very much appreciate the many referrals you have given to your friends, neighbors and family. Nothing tells me I have done a good job helping you like you recommending me to someone else.

I also appreciate all of the Medicare insurance agents who are helping Medicare beneficiaries every day make the right Medicare decision based on their unique needs. The very few agents who do not do the always do the right thing for their clients are far outnumbered by those who do their job with utmost integrity and concern for their clients.

I am proud to be one of you.

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Going on Medicare

It begins a little more than six months before you turn 65 years old. A few pieces of mail begin arriving each day showing lots of happy people doing lots of happy things...without a lot of detail about why they are happy and what it has to do with you.

Your phone starts to ring regardless of any “Do Not Call” list you may have joined.

Occasionally, a stranger may even knock on your door in the same way college students sold encyclopedias years ago to pay their tuition.

The onslaught begins to build for several months until your dining room table is stacked with all sorts of mail pieces. You no longer answer calls from unknown numbers on the assumption it is another sales person calling from another boiler room in some faraway state. And the unexpected doorbell or knock on your door is ignored.

To your dismay, you may make a critical tactical error and actually respond to a piece of mail or call a phone number. Like a leak in a dam, this innocent act can lead to a massive response of phone calls, emails, letters and more knocks on your door.

So begins the Medicare sales process...a game practiced by players with only one intention - to get you - a soon-to-be-Medicare beneficiary - to select their plan and thereby award them a commission from you every year for the foreseeable future.

Despite all of the direct mail, phone calls, emails, advertisements and knocks on doors, many people new to Medicare make a mistake when choosing a Medicare plan when they first turn 65. Many do not choose the plan that is best for their health needs or financial needs and often both.

Many do not choose a plan that most reflects their lifestyle or personal preferences.

Even worse, many make a mistake that cannot be corrected later.

This book will help you avoid those mistakes and make the right decision about your Medicare.

Choosing a Medicare Plan

For most people, going on Medicare requires reaching the age of 65 after a lifetime of working and paying into the Medicare system. Unless they have an older spouse or relative or close friend who has already gone on Medicare, the majority of people this age have a fairly limited understanding of how Medicare works. Yet they have to quickly make a very important decision about how to receive their Medicare benefits as well as how to manage the costs and financial risks associated with Medicare.

To make matters a little more urgent, someone going on Medicare has choices at age 65 that they may not have as little as 6 months later.

Choosing a Medicare insurance plan is a very personal and unique decision. The correct decision for one person can be an incorrect decision for another. In fact, what is right for a husband may not be right for his wife.

The title of this book makes a point that is very important to remember - “Medicare is not “one-size-fits-all.”

Choosing a Medicare insurance plan requires a careful and thorough process to

1. Understand all of your options
2. Identify how your individual needs and preferences align with the available options and
3. Decide which options best meets your needs and financial risk tolerance in both the short and long-term.

In this book, we will discuss the information you need to understand and choose the type of Medicare insurance plan that best meets your needs. Once you know which type of plan you need, you will have the knowledge necessary to evaluate the specific plan options available where you live and make the right choice for you.

How Medicare Works

What Medicare Covers

Medicare covers most health care services - hospital stays, surgeries, doctor visits, tests, home health care, medications, rehabilitation and many more.

Medicare generally does not cover such services as dental care, cosmetic services, routine vision, hearing and long-term custodial care due to chronic conditions or cognitive impairment.

When you are on Medicare you can generally go to any doctor or medical facility that takes Medicare at any location throughout the United States. You do not need referrals to see specialists and you do not have to choose a Primary Care Doctor.

Medicare has three parts - Part A, Part B and Part D. Part A and Part B have been the primary parts of Medicare since it was created by Congress in 1965. Part D drug plans were added by Congress in 2006.

Medicare Part A

Medicare Part A consists of the costs of going into a hospital as an in-patient, the costs of facility-based skilled nursing care and the costs of three pints of blood. There is no monthly premium for Part A and one becomes automatically eligible for Part A the first day of the month in which they turn 65 providing they or their spouse have worked the minimum time and paid accordingly into the Medicare system during their working lives.

The costs the Medicare beneficiary must pay under Medicare Part A are substantial. When one goes into the hospital as an in-patient, the deductible is \$1,184. What this means is a one-night hospital stay can result in a bill for the Medicare member of \$1,184. For skilled nursing care, after 20 days the Medicare member pays \$148 per day. A Medicare beneficiary in a skilled nursing facility for the full 100 days for which Medicare will pay would be responsible for paying \$11,840.

Since Medicare generally requires a skilled nursing stay be preceded by a hospital stay, a Medicare member who goes into the hospital for a period of time and then spends the maximum 100 days in a skilled nursing facility would be responsible for a total bill of \$13,024.

Medicare Part B

Medicare Part B consists of all other Medicare-covered services such as doctor visits, outpatient services, x-rays, lab work, home health care, preventive screenings and Part B medications which are medications administered in a medical facility such as a doctor's office or hospital.

With Part B, there is a premium which in 2013 is \$104.90 per month. For people who collect Social Security, the monthly premium is deducted from their monthly Social Security check.

Just like Part A, one becomes eligible for Part B the first day of the month in which they turn 65. However, people who choose to continue their insurance through an employer may choose not to take Part B when they first turn 65. Someone who chooses to defer Part B due to continuing employer coverage will be able to select it once they leave the employer coverage in the future.

Part B has an annual deductible of \$147. After this \$147 deductible is reached, Medicare plays 80 percent of Part B expenses while the Medicare beneficiary is responsible for the remaining 20 percent.

While a 20 percent cost share may not seem substantial, in reality it can result in large bills for the Medicare beneficiary. For example, if someone had cancer and had a sizable amount of chemotherapy, the costs can easily add up to tens of thousands of dollars of which 20 percent would be a large amount.

Very importantly, there is no out-of-pocket maximum with Medicare as there is with many other types of health insurance.

Medicare Part D

Medicare Part D consists of drug coverage in which Medicare beneficiaries pay co-pays rather than the full costs of medications. Part D plans have monthly premiums and can either be purchased as a stand-alone plan or can be included in a Medicare Advantage plan. Medicare beneficiaries are eligible to enroll in a Part D plan once they become eligible for Part A.

Summary

Medicare covers most, though not all, of the type of medical services Medicare beneficiaries may need. However, it does not cover these services with little or not cost to the beneficiary.

Most Medicare beneficiaries will need some type of additional Medicare insurance coverage to protect them from substantial and unexpected costs. The remainder of this book will focus on these types of plans and how the Medicare beneficiary can evaluate what type of plan is right for them as well as which specific plan is best for them.

Covering Your Medicare Costs

Medicare Insurance Plans

As we just discussed, while Medicare covers most health-related services and pays a majority of the cost, the Medicare beneficiary is still responsible for a substantial portion that can be very large with certain medical conditions and treatments. Most Medicare beneficiaries choose to enroll in an additional Medicare insurance plan rather than risk huge, unlimited and unexpected bills.

There are two primary types of Medicare insurance plans that limit the financial exposure of Medicare beneficiaries while still providing access to the Medicare benefits they may need. The first type is a traditional Medicare Supplement. A Medicare Supplement is a simple plan. In return for the Medicare beneficiary paying a monthly premium, a private insurance carrier assumes the financial responsibility for all or part of the Medicare beneficiary's share of Medicare costs.

With a Medicare Supplement, the Medicare beneficiary essentially locks in his or her costs so these costs will not fluctuate regardless of the type of health year they experience. For example, with a Medicare supplement the Medicare beneficiary would incur no more medical costs during a year in which they may have been hospitalized numerous times than a year in which they had no health issues at all and only visited their doctors for an annual checkup.

While many Medicare beneficiaries choose the Medicare Supplement approach to managing their Medicare costs, others choose a relatively new type of plan called Medicare Advantage.

Medicare Advantage plans work almost exactly the opposite of the way Medicare Supplements work. With a Medicare Advantage plan, a Medicare beneficiary pays little or no monthly premium but instead pays co-pays and co-insurance as they receive medical care. Unlike regular Medicare, there is an out-of-pocket maximum for what the beneficiary can pay in total co-pays and co-insurance. In addition, many Medicare Advantage plans provide additional benefits beyond those provided by regular Medicare and Medicare Supplements.

How do Medicare Supplements Work?

Medicare Supplements are the simplest type of Medicare insurance. Medicare Supplements pay all or part of the Medicare beneficiary's share of Medicare costs.

When a Medicare beneficiary has a Medicare Supplement, they provide both their government-issued Medicare card as well as the carrier-provided Medicare Supplement card whenever they receive medical services. The provider then bills Medicare for its share and the Medicare Supplement carrier for its share.

Medicare Supplement Plan Types

There are different versions of Medicare Supplements that are standardized across the various insurance carriers that offer them. For example, Plan F pays all co-pays, co-insurance and deductibles so that the Medicare beneficiary never pays anything out of pocket for Medicare-covered services other than the monthly premium.

Very importantly, Plan F provides the same coverage regardless of which insurance carrier provides it.

Another Medicare Supplement version - Plan G - pays all costs except for the annual Part B deductible of \$147. However, the annual premiums for Plan G are often several hundred dollars less than the comparable premium for Plan F. By selecting Plan G, the Medicare beneficiary can often save substantial money over the course of the full year.

Another Medicare Supplement plan - Plan N - requires Medicare beneficiaries to pay a \$20 co-pay when visiting the doctor. However, as with Plan G, the additional out-of-pocket costs is usually outweighed by the savings in monthly premiums over the full year.

Medicare Supplement Rates

Medicare Supplement rates are based on a number of factors including:

1. Age
2. Gender
3. Location
4. Tobacco use
5. Discounts for married couples
6. Payment frequency and method

Very importantly, Medicare Supplement rates can and likely will increase over times based on three different factors:

1. The increasing age of the Medicare beneficiary
2. The overall claims experience of all people in the plan
3. Inflation in the health care economy

When evaluating a Medicare Supplement, it is important to examine not only the current rates at age 65 or whatever age at which Medicare beneficiary is considering enrollment but also to review the rate at which the rates increase with age.

Some carriers have lower rates at age 65 than other carriers but more than make up for it with higher age-based increases in the future. At any time, a prospective Medicare Supplement enrollee can review not only the rates for his or her age but the rates for all ages.

Medicare Supplement Underwriting

Medicare Supplements are underwritten based on the enrollee's health. This means when one applies for a Medicare Supplement, they are required to disclose any pre-existing health conditions they may have. Having conditions such as insulin-dependent diabetes, heart problems or obesity will likely cause someone to be declined for coverage.

There is one major exception to this underwriting. When someone is first going on Medicare Part B - usually at age 65 - they have a 6-month window in which to enroll in any Medicare Supplement without being asked any health questions.

This means that someone with chronic health problems who could greatly benefit from the "no out-of-pocket costs" structure of a Medicare Supplement can get this coverage only at this point in his or her life. Importantly, once they are enrolled in a Medicare Supplement they can continue the coverage the rest of their life as long as they pay their premiums.

This also means that someone who may be in good health when first going on Medicare Part B but who may want such "no out-of-pocket costs" coverage in the future in case they do develop serious health problems can only be certain of being approved for such coverage when they first go on Medicare Part B.

Medicare Part D with Medicare Supplements

While there is a later chapter dedicated to Medicare Part D plans, it is important to understand that with a Medicare Supplement, it is also necessary for most Medicare beneficiaries to enroll in a separate Medicare Part D drug plan. Medicare Supplements only cover the Medicare beneficiary's share of Medicare Parts A and B.

The Medicare Part D drug plan will allow the beneficiary to pay only smaller co-pays instead of full price for any medications they use. This plan will also allow the Medicare beneficiary to meet the government's requirement for maintaining credible drug coverage and therefore avoid a late enrollment penalty in the future.

Medicare Advantage

How does Medicare Advantage work?

Medicare Advantage plans work very different than Medicare Supplements. Most Medicare Advantage plans have little or no monthly premium. However, unlike with a Medicare Supplement, the member is responsible for co-pays and co-insurance as he or she receive health care services. However, the co-pays and co-insurance are generally much lower than they would be with regular Medicare.

Unlike regular Medicare, Medicare Advantage plans have out-of-pockets maximums which protect the member from unlimited costs in the event of a serious and expensive health condition. For most plans, out-of-pocket maximums tend to be anywhere from \$3,000 to \$7,000.

Many Medicare Advantage plans provide additional benefits not covered by regular Medicare such as dental and routine vision. Some Medicare Advantage plans even provide hearing aids, transportation to and from a doctor and health club memberships.

Most Medicare Advantage plans also include the Medicare Part D drug coverage so members are not required to pay for a separate drug plan.

In return for lower co-pays and co-insurance, out-of-pocket maximums and additional benefits, Medicare Advantage members agree to receive their routine medical care from the provider's network of doctors and hospitals. Depending on the specific Medicare Advantage plan, members may also agree to other requirements such as identifying a Primary Care Physician and getting referrals prior to seeing a specialist.

Does Medicare Advantage save money?

For most people who are in average or better health, choosing a Medicare Advantage plan will likely save them money over the course of their life. The reason for this is the cumulative cost of co-pays and co-insurance tends to be considerably less than the cumulative savings of not paying a monthly premium.

This cost savings is not guaranteed because if the member experiences costly health conditions the co-pays and co-insurance can exceed the savings from not paying a premium. Because of the structure of co-pays and co-insurance, there is less cost certainty with a Medicare Advantage plan than with a Medicare Supplement. In normal health years, members may only spend a couple of hundred dollars or even less. In years in which a member may be hospitalized or have extensive medical tests, procedures or treatment, he or she could pay much more up to the out-of-pocket maximum.

Types of Medicare Advantage plans

There are two primary types of Medicare Advantage plans: Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

In an HMO, all health care other than emergency or urgent care must be obtained from the plan's provider network. When the member has an emergency or urgent health care need, they can receive care at any provider and it will be considered in-network.

With most HMOs, the member is usually required to designate a Primary Care Provider. With many, but not all HMOs, the member must get a referral from the Primary Care Provider prior to seeing a specialist.

In a PPO, members can choose to receive care from a non-network provider though their share of the cost will usually be higher than with an in-network provider. As with an HMO, treatment for an emergency or urgent care situation is considered in-network regardless of where it is received.

With a PPO, members usually are not required to designate a Primary Care Physician nor are they required to get referrals prior to seeing a specialist.

Supplements Or Advantage

Which one is right for me?

Medicare is not a “one-size-fits-all” product. The best plan for one person can be the wrong plan for someone else.

The correct approach to choosing a Medicare plan is to go through a careful process that identifies one’s needs and preferences and then aligns them with the plan and carrier available in their area that best meets those needs and preferences.

The following are overall guidelines for choosing between a Medicare Supplement and a Medicare Advantage plan:

Health

When someone has chronic health conditions at age 65 that require significantly higher than average health care services, one should choose a Medicare Supplement if they can afford it.

There are two reasons for this. First, when one is turning 65, they have a once-in-a-lifetime opportunity to enroll in a Medicare Supplement without having to disclose existing or past health conditions. Chronic conditions such as diabetes, COPD or Congestive Heart Failure or even past conditions such as many types of cancer can make someone ineligible for a Medicare Supplement once they are 6 months past their 65th birthday.

While someone can switch from a Medicare Supplement to a Medicare Advantage plan in the future, a person with chronic health conditions will likely be unable to switch from a Medicare Advantage plan to a Medicare Supplement.

The second reason someone with chronic health conditions should choose a Medicare Supplement is it is possible the cumulative cost of their co-pays will exceed what they would have paid during the year for a Medicare Supplement that would have paid all of their out-of-pocket expenses.

Taken together, these two reasons make it likely a Medicare Supplement is the best choice for someone with serious chronic health conditions.

Finances

If one cannot afford the monthly premiums required of a Medicare Supplement and a stand-alone Medicare Part D Drug plan, then a Medicare Advantage plan is likely the right approach.

It does not make sense for someone to pay a premium for a Medicare Supplement to avoid the costs of catastrophic health conditions and then not be able to afford their monthly medicines, groceries or utilities.

Doctors and hospitals are much more willing to work with someone to pay co-pays over time than pharmacies, grocery stores or utility companies.

Lifestyles

Someone who travels extensively out of their home area should consider a Medicare Supplement. While Medicare Advantage plans allow for members to receive emergency or urgent care outside of their provider network and have it billed as in-network, there are many types of routine care that someone may wish to receive while away from home. This is particularly true for someone who spends a large part of the year at a second home a considerable distance from their primary home.

Personal Preferences and Choices

A person who wants maximum choice and flexibility concerning their health care should probably choose a Medicare Supplement. Of course, the price for this choice and flexibility is the likely higher cumulative premiums with a Medicare Supplement than the sum of co-pays and co-insurance with a Medicare Advantage plan.

If someone wants the flexibility to go to the Mayo Clinic or Johns Hopkins or a nationally-renowned Orthopedic surgeon, a Medicare Supplement is likelier to provide that option than a Medicare Advantage plan.

While Medicare Advantage plans are committed to providing the health care needed to keep their members healthy, not all procedures and treatment require the best known physicians and hospitals in the country.

Medicare Part D Drug Plans

How Part D Drug Plans Work

Medicare Part D drug plans allow Medicare beneficiaries to purchase medications paying co-pays rather than the full of the medication. These drug plans can either be purchased as a stand-alone plan - usually by a Medicare beneficiary with a Medicare Supplement - or as part of a Medicare Advantage plan.

Medicare requires all Medicare beneficiaries to be enrolled in a Medicare Part D drug plan unless the beneficiary has alternative coverage that meets the Medicare standard coverage criteria. This criteria is often called “credible coverage.”

Medicare members can have credible coverage outside of a Medicare Part D drug plan through such sources as group coverage through an employer or through Veterans’ Administration (VA) drug benefits for beneficiaries with VA benefits.

Medicare Part D Late Enrollment Penalty

If a Medicare beneficiary does not choose to enroll in a Medicare Part D drug plan when first eligible and does not have credible coverage through an alternative source, Medicare will impose a Late Enrollment Penalty if they enroll in a plan in the future. This penalty will be 1 percent of the national average Medicare Part D monthly premium for every month they were eligible for coverage but did not elect coverage. This penalty is assessed for the remainder of one's life.

This means if someone enrolls in a Medicare Part D drug plan 5 years - or 60 months - after they were first eligible, they will pay a penalty equal to 60 percent of the Medicare Part D base beneficiary monthly premium. In 2013, average monthly premium for a Medicare Part D drug plan is \$31.17. This means the beneficiary assessed this penalty due to not enrolling for 5 years will pay \$18.70 ($.01 \times 60 \times \31.17) for the rest of their life.

Medicare Part D Formulary

All Medicare Part D drug plans have a formulary which lists the medications that are covered under the plan as well as the tier to which they are assigned. Medications that are not included in the formulary are not covered. However, a member's doctor can request a non-covered medication be covered using a process called a Formulary Appeal.

With a Formulary Appeal, the plan will consider the request based on the individual situation of the member and the explanation provided by the doctor as to why the member needs the uncovered medication instead of a medication included in the formulary.

Medicare Part D Coverage Phases

Medicare Part D Drug plans have four distinct phases of coverage - the Deductible Phase (if applicable), the Initial Coverage Phase, the Coverage Gap (also called the Donut Hole) and the Catastrophic Phase.

Deductible Phase

Some, but not all, Medicare Part D drug plans have a deductible. The standard deductible in 2013 is \$325. This means the Medicare beneficiary will pay the full cost of their medication until they pay a total of \$325. Some plans have a lower deductible and many have no deductible at all.

Initial Coverage Phase

During the Initial Coverage Phase, Medicare Part D members pay co-pays for their medications based on the tier to which the medication is assigned in the formulary.

In 2013, the Initial Coverage Phase lasts from after the annual deductible has been met until \$2,930 worth of medications have been used. It is important to note the \$2,930 is a actual value of the medications - not the amount of co-pays paid by the member.

As an example, if the medication has a retail price of \$160 but the member pays a co-pay of \$40 based on it being a Tier 3 medication in the plan's formulary, the amount that counts toward the \$2,930 threshold is \$160.

Coverage Gap - Or “Donut Hole”

After the threshold of \$2,930 has been reached, the member enters into phase known as the Coverage Gap. This phase is also commonly known as the “Donut Hole.”

Fortunately, the Coverage Gap is not now as penal as it has been in the past.

In earlier years, members would pay 100 percent of the retail cost of their medications during the Coverage Gap. In the aforementioned example, the member would go from paying \$40 in the Initial Coverage Phase to \$160 in the Coverage Gap.

In 2013, a member will pay 47.5 percent of the retail cost of the medication during the Coverage Gap. Therefore, instead of paying the \$160 in the example, the member would pay 47.5 percent of \$160 - or \$76.

Catastrophic Phase

After the member spends \$4,750 in True Out-of-Pocket costs (TROOP) on medications, he or she will enter into the Catastrophic Phase in which their costs will decrease dramatically.

In the Catastrophic Phase, members pay the greater of 5 percent of the retail cost of their medication or \$2.65 for generics and \$6.60 for brand-name medications.

Importantly, the calculation of the \$4,750 TROOP is not the actual cost the member spends. Instead, the member receives credit for 100 percent of the retail price of medications purchased while in the Coverage Gap though the member only actually paid 47.5 percent of the retail price.

Because of this additional credit given to the member, the actual money spent by the member prior to reaching the Catastrophic Phase is significantly less than \$4,750.

In fact, for a plan with no deductible, the actual amount spent prior to reaching the Catastrophic Phase is likely between \$2,600 and \$2,800. For a plan with a deductible of \$325, the actual amount spent is likely between \$2,750 and \$2,950.

Though the estimated out-of-pocket cost is higher for plans with a deductible, this difference is usually more than offset by the lower monthly premium for the plan with the deductible. Monthly premiums do not count toward the TROOP calculation.

Ways To Minimize Drug Costs

There are three key strategies a Medicare beneficiary can use to minimize the amount spent every year on prescription medications.

www.medicare.gov

The Center for Medicare and Medicaid Services (CMS) - the government department that administers Medicare - offers a website that provides a tremendous amount of information for Medicare beneficiaries.

This website - www.medicare.gov - includes an online tool through which Medicare beneficiaries can input their medications and dosages and the website will produce a report showing the Medicare Part D drug plan that will cost the least for them. This report includes all total costs including monthly premiums, deductibles and co-pays as well as costs through all coverage phases.

The website also allows the Medicare beneficiary to review the CMS quality ratings for plans as well as enroll online.

If the Medicare beneficiary is interested in a Medicare Advantage plan, he or she can also receive a report showing their estimated drug costs under the Medicare Part D drug plans included with the Medicare Advantage plans offered in their area.

Use of Generic Medications

More and more brand name medications are becoming generic due to the expiration of the patents held by the pharmaceutical companies that originally developed them. This includes popular medications such as Lipitor (Atorvastatin), Plavix (Clopidogrel) and Singulair (Montelukast).

A Medicare beneficiary should migrate to a generic any time the opportunity exists. This includes not just switching from a brand to its generic but also, if appropriate and working closely with their doctor, evaluating switching from a brand to a generic of the same medication class even if the generic does not have identical active ingredients.

Most Medicare Part D plans will actively encourage their members to migrate to generic medications when possible as a way of bringing down the overall cost for everyone.

Having said this, it is not always possible to switch to a generic of the same medication class due to such individual considerations as interactions with other medications, allergies as well as past history which may have shown a brand medication to work better than a generic substitute.

Delaying or Avoiding the Coverage Gap

When a Medicare beneficiary uses medications that subjects him or her to entering the Coverage Gap (Donut Hole), an effective strategy to reducing costs can be to obtain generics without using his or her Medicare Part D coverage.

Pharmacies such as Wal-Mart, Walgreens and Target offer many of the same generic medications used by Medicare beneficiaries with co-pays comparable or even lower than required under the member's Medicare Part D plan.

However, if the member gets generics from a pharmacy such as Wal-Mart and does not provide his or her Medicare Part D card, these generics will not count toward the annual Coverage Gap calculation.

This can help the member delay or sometimes even avoid reaching the Coverage Gap at which time medication costs increase.

Importantly, because pharmacies will keep a customer's insurance information in their computer system, it is a good idea to use two separate pharmacies when employing this strategy. Use one pharmacy for medication in which the member uses his or her Medicare Part D coverage and another pharmacy such as Wal-Mart or Target for generics not using the Medicare Part D coverage.

Medicare Enrollment Periods

There are specific times during which a Medicare beneficiary can enroll in a Medicare plan or change their plan.

Medicare Part A

Providing the potential Medicare beneficiary or their qualifying spouse has met the minimum requirements for contributing to the Medicare system through Medicare payroll taxes during their working career, a person becomes eligible for Medicare Part A the first day of the month in which they turn 65 years old.

For example, a person born on September 15, 1948 will be eligible for Medicare Part A beginning September 1, 2013.

Interestingly, if someone's birthday falls on the 1st day of the month, their Medicare Part A will begin on the 1st day of the previous month. As an example, a person who was born on November 1, 1948 will be eligible for Medicare Part A on October 1, 2013.

Generally, CMS will send a new Medicare beneficiary their Medicare card showing their effective dates around 3.5 months prior to their Medicare Part A effective date.

Medicare Part B - Turning 65

The effective date for Medicare Part B is a little more complicated than Part A.

The Social Security Administration (SSA) manages enrollment in Medicare Part B. When an imminent Medicare beneficiary approaches their Medicare Part A effective date - the first day of the month in which they turn 65 years old - SSA makes an assumption about whether the beneficiary wishes to have their Medicare Part B take effect based on whether they have begun to collect Social Security.

If the imminent Medicare beneficiary has begun to collect Social Security by the 65th birthday, SSA assumes they wish to have their Medicare Part B take effect. Accordingly, when CMS sends the new Medicare beneficiary their new Medicare card, it will show an effective date for Medicare Part B as the same effective date for Medicare Part A.

However, if the new Medicare beneficiary is not collecting Social Security benefits by the time they reach age 65, SSA assumes they do not wish to have Medicare Part B take effect at the same time as Medicare Part A. The reason for this is SSA assumes the new Medicare beneficiary is still working and is receiving health insurance through their employer.

Importantly, this assumption is not correct for many new Medicare beneficiaries.

Many new Medicare beneficiaries want or need to have their Medicare Part B take effect at the same time as their Medicare Part A but are delaying the start of their Social Security benefits.

Conversely, many new Medicare beneficiaries have started to collect Social Security benefits but have alternative health coverage through their or their spouse's employer and do not need Medicare Part B to take effect at the same time as they become eligible for Medicare Part A.

A Medicare beneficiary who is not automatically enrolled in Medicare Part B due to not yet collecting Social Security benefits will need to enroll either by going online at www.socialsecurity.gov, calling Social Security at (800) 772-1213 or by visiting their local Social Security office.

While it may not be the most convenient, visiting the local Social Security can eliminate some snags sometime experienced with on-line or telephonic enrollment. It is recommended to call ahead and make an appointment. Also, the first and the last days of the month tend to be more crowded at the Social Security office than other days.

Medicare Part B - Special Enrollment Periods

If a Medicare beneficiary does not elect Medicare Part B when they are first eligible because they still have health coverage from an employer, they will be allowed to enroll using a Special Election Period (SEP) when they lose or disenroll from such employer coverage. In most situations, such Medicare beneficiaries can leave employee coverage at any time and choose to enroll in Medicare Part B.

If a Medicare beneficiary does not elect Medicare Part B when first eligible but does not have other credible coverage, they can enroll in Medicare Part B in the future only during specific times of the year. These times are between January and March of each year for Medicare Part B coverage that will take effect the following July 1.

Medicare may assess a Medicare Part B Late-Enrollment Penalty in a situation where a Medicare member did not have credible alternative coverage when first eligible for Medicare Part B.

Medicare Supplements

Most Medicare Supplement carriers allow a new Medicare beneficiary to enroll up to 6 months prior to their Medicare Part B effective date. Obviously, the coverage does not become active until both Medicare Part A and Medicare Part B are effective. Most carriers require the first month's premium be collected at the time of enrollment.

It is important to note, since most Medicare beneficiaries who choose a Medicare Supplement will also need a stand-alone Medicare Part D plan, CMS does not allow new Medicare beneficiaries to enroll in a Medicare Part D plan until they are within 3 months of their Medicare Part A effective date.

Medicare Advantage and Medicare Part D - Turning 65

Medicare beneficiaries who elect Medicare Part B when they are first eligible have a 7-month window to enroll in a Medicare Advantage or Medicare Part D drug plan. This 7-month window includes the three months prior to the month in which they turn 65 and go on Medicare Part B, the actual month they turn 65 and go on Medicare Part B and the three months after they turn 65 and go on Medicare Part B.

Medicare Advantage and Medicare Part D - Annual Enrollment Period

Medicare Beneficiaries can either enroll in, disenroll from or change a Medicare Advantage or Medicare Part D drug plan during the Annual Enrollment Period. For 2013, the Annual Enrollment Period begins on October 15 and lasts until December 7.

Medicare Advantage and Medicare Part D - Special Election Period

There are several situations that provide a Medicare beneficiary a chance to make a change in his or her Medicare Advantage or Medicare Part D coverage outside of the Turning 65 or Annual Enrollment Period. These Special Election Periods (SEPs) include:

- Someone who receives extra financial help to pay for either prescriptions, premiums or co-pays due to low income
- Someone who moves from one county to another
- Someone who disenrolls from other health insurance such as employer's insurance

Extra Assistance

States provide extra assistance for Medicare beneficiaries who have incomes below certain thresholds.

In 2013 those thresholds and the qualifying assistance is as follows:

Monthly Income Single/Married	Benefit	Assistance
\$1,436/\$1,938	Low Income Subsidy (LIS)	Pay only \$1.10, \$2.65 or \$6.60 for Part D medications
\$1,159/\$1,671	Specified Low-Income Medicare Beneficiary (SLMB)	LIS benefits plus State pays \$104.90 monthly Medicare Part B Premium
\$978/\$1,313	Qualified Medicare Beneficiary (QMB)	LIS and SLMB benefits plus State pays co-pays, coinsurance and deductibles

There are also additional asset limitations that must not be exceeded to qualify for extra assistance.

Someone who believes they may qualify for extra assistance should contact their state Medicaid office or can start by calling 1-800-MEDICARE.

Working With an Insurance Agent

Medicare insurance agents can provide a tremendous amount of assistance both in understanding and selecting Medicare plan options as well as continuing to evaluate Medicare options going forward.

However, Medicare insurance agents are only useful if they are compensated based on what is best for the Medicare beneficiary rather than what is best for the insurance carrier that is paying them.

Captive Agents

Captive agents are insurance agents who only represent one insurance carrier and often only one plan. These are often newly-licensed agents who have been selling Medicare insurance less than a year or two and are hired to sell a specific plan rather than assist the Medicare beneficiary in choosing the best plan for their needs.

A captive agent will often have a conflict between the plan that is best for the Medicare beneficiary and a different plan that is the only one he or she is able to sell.

It is not in the best interest of any Medicare beneficiary to rely on a captive agent to assist them in selecting a Medicare insurance plan.

Independent Agents

Unlike captive agents, independent agents usually do represent many different plan types and carriers and are in a position to assist a Medicare beneficiary in selecting the best plan for their needs. Even with an independent agent, it is a good idea for the Medicare beneficiary to ask the agent both what plan types and carriers they represent as well as which ones they do not represent.

If there is a plan type or carrier they do not represent, the Medicare beneficiary may not learn about the plan type or carrier that best meets his or her needs.

A Medicare beneficiary can always call SeniorAssured Insurance at (800) 385-9160 or visit www.seniorassured.com to talk with an independent agent who represents all plan types and major carriers.

Bonus Section:

Top Ten Mistakes When Going On Medicare

MISTAKE #1

Working with a Medicare insurance agent who only represents one plan or carrier

Many Medicare insurance agents represent only one plan. They may listen to you talk about your needs and may ask good questions about your medications and financial preferences. However, the reality is they are trying to convince you to say “yes” to the only plan they have to sell you.

A few months ago a Medicare beneficiary in Houston called me after a friend from his church recommended he do so. Let’s call him “Joseph.”

Joseph had cancer a few years ago and still takes monthly injections. Under the Medicare Advantage plan he was sold, he pays 20 percent of the cost of the injections. He has received bills totaling more than \$4,000 in the first 8 months he has been on Medicare and the Medicare Advantage plan. Unfortunately for Joseph, he could have selected a Medicare Supplement plan when he first turned 65 years old that would have paid all of his share of the cost of the injections. He would have spent around \$110 per month or even less but that would have been much better than the \$4,000 in bills he received. In a little more than 8 months being in the wrong plan has cost Joseph more than \$3,000 he simply did not have to pay.

What was Joseph’s mistake? He worked with an agent who only could sell one type of plan and sold him his one plan despite the fact another type of plan he did not represent was clearly better for Joseph.

MISTAKE #2

Choosing a Medicare Advantage Plan when you turn 65 when you may one day want or need a Medicare Supplement

Making a mistake at age 65 concerning your Medicare plan can become a permanent mistake after only a few months.

Medicare Supplements are plans that pay all or most of the co-pays and co-insurance someone on Medicare may have. They cost more than Medicare Advantage plans but, for many people either now or in the future, may be better options than Medicare Advantage plans requiring co-pays and co-insurance.

Here is the issue. Medicare Supplements are underwritten based on your health. This means that when you apply you will be asked questions about your health and some conditions such as diabetes, atrial fibrillation or cancer may disqualify you from being approved for coverage.

There is one exception to this health underwriting for Medicare Supplements. This exception is when someone first goes on Medicare Part B - usually when they turn 65 years old - and the 6 months immediately following. During this 6 months - called "Open Enrollment" - someone can have any type of health condition and still be approved for any Medicare Supplement.

Since none of us know what the future may bring, if you think you may want a Medicare Supplement which pays all of your costs at any time now or in the future, the only time you can be sure of being accepted is when you first go on Medicare.

MISTAKE #3

Choosing a Medicare Advantage Plan at age 65 when you have serious health problems

I meet with many Medicare members who enrolled in a Medicare Advantage plan when they turned 65 despite the fact they had health conditions that guaranteed their out-of-pocket costs would be higher than their premium for a Medicare Supplement through which they would pay no out-of-pocket costs.

People who have serious chronic health conditions such as Congestive Heart Failure, Insulin-Dependent Diabetes or Chronic Obstructive Pulmonary Disease (COPD) at age 65 are likelier to have higher health care costs than the average 65 year old.

This fact, combined with the six month underwriting-free window discussed earlier in Mistake #2, makes a Medicare Supplement instead of a Medicare Advantage plan a more appropriate choice for someone going on Medicare with serious health problems.

At age 65 in most states, someone with severe illnesses can cover all of their medical costs and drug plan premiums for less than \$2,000 per year. I realize \$2,000 is a lot of money.

However, the out-of-pocket maximums for Medicare Advantage plans are much higher than this. For someone with a condition such as Congestive Heart Failure or COPD who is likely to have several hospitalizations and many doctor visits each year, the cumulative co-pays under a Medicare Advantage plan can equal the out-of-pocket maximum very quickly each year.

For many of these people, the Medicare Supplement is a much better option that can save thousands of dollars each year. And, very importantly, this is an option that is unlikely to be available with most carriers after they have been on Medicare Part B for more than 6 months.

In addition to serious chronic conditions such as Congestive Heart Failure and COPD, there are many conditions that require expensive treatments that are very expensive with a Medicare Advantage plan.

I recently met with a Medicare member who had inquired about switching from a Medicare Supplement to a Medicare Advantage plan in order to save money. Unfortunately, this lady had an eye condition that requires monthly injections that cost more than \$3,000 per month and for which her cost share under a Medicare Advantage plan would be more than \$600 per month.

Switching to a Medicare Advantage plan would have been a financial disaster for this lady.

Unfortunately, had she called an agent who only sold Medicare Advantage plans, that agent would have had to choose between what would have been right for his client's situation versus what would pay him a commission.

While I would like to think any Medicare Advantage agent would have done what was clearly in the best interest of the Medicare member, I have seen many situations where the agent did not.

MISTAKE #4

Choosing an HMO if you want more control of your health care decisions

Health Maintenance Organizations (HMOs) started several decades ago as a way to reduce health care costs among their members. The basic idea was to move away from the idea of members going to doctors they choose and, instead, replaced it with the concept of the patient choosing among doctors the plan HMO would make available.

HMOs have evolved a great deal since those days but the basic concept is still the same - less choice in providers means lower costs.

In today's Medicare world, the core rule with an HMO is that if you choose to go outside a plan's network for anything except emergency or urgent care, your costs will not be covered and you will pay 100 percent of the cost.

Most of the time, this is not a big deal. A member may make sure their doctors are with an HMO plan when they enroll and they receive the care they need year after year.

The problem can come about when the member gets sick and wants to choose a specialist based on their unique condition. Maybe a member has a heart problem and wants to use a heart surgeon they know to be recognized as the best in their community. Or perhaps they have an advanced form of cancer and want to go to a international cancer leader such as M.D. Anderson Cancer Center in Houston.

With an HMO, in all likelihood they would be unable to go to these doctors or hospitals if they were not in their HMO network. To be able to go to the doctors they want and have the costs even partly covered would require a special approval from someone at their insurance carrier. Such approval is anything but routine. After all, a major objective of an HMO is reducing costs and the best specialists in the world usually are not the least expensive.

Can you imagine finding out you have a rare cancer and learning that the doctor you think gives you the best chance to survive is not available to you?

This issue does not mean that HMOs are bad choices. In fact, they are very good choices for many Medicare members. What is does mean is that the time to find out about the reduced choice you have with an HMO is not at the time you become sick and want more control over your health care decisions.

MISTAKE #5

Choosing an HMO when one travels a lot

Medicare Advantage Plans can either be Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs). These two plans are very different - particularly in terms of how much choice you have in doctors as well as your ability to receive routine health care away from home.

Routine Care is defined as any type of health care that where your health may not be threatened by not getting care as quickly as possible. Care where time is of the essence is usually called **Emergency Care** or **Urgent Care**.

If you have Medicare Advantage Plan that operates as an HMO, if you receive routine care from a doctor or medical facility that is not part of your plan's network, your plan will not cover it at all. You will be responsible for 100 percent of the cost. If you have a Medicare Advantage Plan that operates as a PPO, such routine care would be covered although you would usually pay a higher share of the cost than if you used a network doctor or medical facility.

Very importantly, if you receive Emergency Care or Urgent Care, you will pay in-network rates regardless of where you receive the care.

Here's the major issue. I have many clients who spend a significant percentage of their time away from their home area. I'm not really talking about a couple with an RV that tours the country year-round and usually only stops back home to collect their mail every couple of months.

I'm talking more about a couple who live in Tennessee or Georgia but have kids, and especially grandkids, in places like Texas or Florida or anywhere else outside of their Medicare Advantage plan's network area.

These clients routinely spend a week or two at a time several times a year outside of their plan's network area. These are the times of the year they look forward to more than any other and are the rewards for their lifetime of work and savings.

Granted, if one of them has a heart attack or any type of condition that required emergency or urgent care, their treatment would be covered as in-network wherever they received it.

However, most medical care of not defined as emergency or urgent.

There are many types of care that are strictly routine but about which someone doesn't want to wait a week or two to have checked out.

The following example illustrates a situation such as this:

Bill and Barbara have just driven to Houston from their home in Georgia to spend a week with their son Richard, his wife Julie and, most importantly, their grandkids Alex and Taylor.

On their first evening together, Julie notices Barbara getting around more slowly than usual and, after inquiring, learns she has been experiencing some stiffness and pain in her back that has been made worse by the drive from Atlanta.

The next morning, the pain is a little worse. It is not crippling but Barbara admits to Julie that is is frustrating because she doesn't really feel up to doing the physical things she always does with Alex and Taylor and the kids don't understand why.

Julie suggests that she should take Barbara to see the Orthopedic doctor who helped her when she had knee problems last year. When they get there, Barbara provides her Medicare Advantage card that is an HMO plan. Barbara then learns her plan will not cover any of the costs of the office visit because her situation is not an emergency or urgent.

Barbara then calls the customer service number on the back of her Medicare Advantage card and is told she will need to see a doctor in her home network once she gets back to Georgia.

Barbara decides to wait until she gets home to get the care she needs because she doesn't want to pay the full cost of the doctor visit. The rest of Bill and Barbara's visit was not quite as enjoyable as usual because of the Barbara's back pain.

Had Barbara had a Medicare Advantage plan that operated as a PPO or original Medicare with a Medicare Supplement, her visit to the Orthopedic doctor in Houston would have been covered. With the HMO she had, it was not covered.

For people who do not travel often and would only seek medicare care out of their home area in the case of an emergency or urgent situation, the limitations of an HMO regarding getting routine care only in their home network may not be a issue. However, for someone like Barbara, being in an HMO did limit her ability to get the care she needed to live her life to its fullest.

MISTAKE #6

Not enrolling in a Part D Drug plan because you don't take expensive medications

Congress started a new benefit for seniors in 2006 in the form of Medicare Part D drug plans. The concept, while not entirely simple, provides a major benefit for people on Medicare.

As you know, drugs can be very expensive. Prior to the creation of Part D Drug plans, seniors were forced to pay the full costs of drugs they needed for their health. For many seniors, these bills amounted to hundreds or even thousands of dollars a month and were financially devastating.

Prior to Medicare Part D drug plans, many seniors were forced to choose between paying for the drugs they needed and paying for basic necessities such as food, utilities and rent.

With Medicare Part D drug plans, seniors can now pay only a co-pay which is much less than the total cost of the drug for all or most of the year.

Medicare Part D drug plans are available in two forms - either stand-alone which most people would choose with a Medicare Supplement or included in a Medicare Advantage Plan.

In a stand-alone form, the premium on a Medicare Part D drug plan can range from less than \$20 a month to more than \$100 depending on the deductibles and costs and list of drugs covered. Most people choose plans in the range of \$30 to \$50 per month.

There is one very important factor Congress included with the legislation creating Part D drug plans...you can be penalized if you do not enroll in a Part D drug plan when you are first eligible and choose to enroll later.

For example, if you choose to enroll in a Part D drug plan when you are 70 years old instead of when you are first eligible at age 65, you will pay an additional premium the rest of your life based on five years of not having coverage. With today's rates, that would likely be several hundred dollars per year.

Every year, I meet Medicare members who do not have a Medicare Part D drug plan or other credible drug coverage recognized by Medicare. They assumed, or were possibly even told by an insurance agent, they did not need such a plan if they did not take expensive medications.

Words cannot describe how wrong this assumption or advice was.

First, the aforementioned penalty will be assessed for the rest of their life if and when they do need a Part D drug plan.

More importantly, Medicare only allows someone to enroll or change their Part D drug plan once a year during the Annual Enrollment Period (October 15 through December 7) once they are already on Medicare.

What this means is that if someone is prescribed an expensive drug early in the year such as February, they would have to pay the full price of the drug for the rest of the calendar year before they could enroll in and benefit from a Medicare Part D drug plan.

This could amount to thousands of dollars in unplanned but necessary drug costs because of one mistake.

MISTAKE #7

Enrolling in a Medicare Part D Drug Plan that does not cover all of your medications

Medicare Part D drug plans - whether stand-alone or included in a Medicare Advantage plan - include two key elements that determine how much you will pay for your drugs.

The first is a tiering system in which medications are divided into tiers and co-pays are based on the tier in which the drug is assigned. Generally, lower tiers such as Tier I and Tier II are lower cost generic medications while higher tiers are more expensive brand name drugs.

The second key element for a Medicare Part D drug plan is the plan's formulary which lists the drugs covered by the plan. Different Medicare Part D plans have different formularies. A drug covered by one plan may not be covered by another plan and vice versa.

So what happens if a drug you need is not covered by your Medicare Part D drug plan?

First, your drug plan may want you to take a lower cost drug that treats the same condition. Sometimes this is a win/win situation but often your doctor will have you on the more expensive, non-covered drug for a reason and simply switching to a lower cost drug is not an option.

Second, your doctor can file what is called a Formulary Appeal to request your plan make an exception and cover the drug. In this case, he or she will need to explain why you need this particular drug rather than a lower cost drug that is covered under the plan's formulary.

If the plan does approve the formulary appeal, you will still pay a higher co-pay level.

Finally, if the plan does not approve the formulary appeal, you will be forced to choose between paying the full cost of the drug your doctor recommends or taking a medication that is covered that your doctor does not think is the best choice for you.

MISTAKE #8

Staying with an employer health plan instead of going on Medicare

Many people assume if they are not retiring when they turn 65 they do not need to go on Medicare when they are 65.

This is partly the fault of the federal government.

Many people assume there is a eligibility connection between going on Social Security and going on Medicare. There really is no such connection. However, such a misunderstanding is easy.

First, when one is working, what one considers to be their Social Security tax is actually a combination of both separate Social Security tax and Medicare tax.

Second, once one goes on Medicare and begins paying their Medicare Part B premium, this premium is deducted from their Social Security check if they are on Social Security.

Third, the Social Security department actually enrolls someone in Medicare Part B and only automatically does so if they are collecting Social Security at age 65.

Despite these confusing factors, the choice to go on Medicare at age 65 is completely separate from the choice to collect Social Security at age 65.

In fact, choosing not to go on Medicare when first eligible is essentially foregoing a substantial financial benefit for which you have paid your entire working life and for which you are just as entitled as someone fully retired.

If you reach the age of 65 and are continuing to work and continuing to be eligible for group insurance from your employer, it is very possible and even likely your best health insurance choice would be to go on Medicare and choose a Medicare plan.

The reason for this is that in most cases, the government subsidizes your health care more under Medicare than your employer does under their health plan. Your overall premium costs may be a little more under Medicare for some plans but the deductibles you are required to pay under your employer coverage are generally not required under Medicare plans.

In addition, you likely will have additional benefits and preventative services available under Medicare plans not available through your employer coverage.

Very importantly, you do not have to wait for your employer's Annual Election Period to make a change to Medicare. You can disenroll from group coverage to join Medicare at any time to take full advantage of the Medicare benefits to which you are entitled.

There are a couple of notable exceptions to the general advice to go in Medicare rather than staying on an employer plan once you turn 65 years old.

First, if your spouse is not yet eligible for Medicare and is covered under your employer plan, your disenrollment from the employer plan could affect their coverage. You should check with your Human Resources department about this issue.

Second, if your employer plan is a much better than typical plan in which you pay little out of pocket in either premiums or deductibles, your employer plan may be a better plan for you. Because companies have cut back on their health plans in recent years I see this far less than in the past but occasionally I find this to be the case.

Finally, your employer coverage may offer dental, vision, drug or other benefits superior to those available under Medicare. While this considerations are usually not strong enough to change the overall coverage decision, they can be the tipping point if it is an otherwise close call.

MISTAKE #9

Choosing a Medicare Supplement plan based on the premiums at age 65

The coverages for Medicare Supplements are the same across carriers. For example, Plan F with one carrier is the same as Plan F with another carrier. However, the rate structure is very different and the plan with the lowest rate for someone who is 65 years old may not be the best overall value because of how much their rates increase in the future.

Some carriers - particularly smaller ones who may be relatively new to an area - offer lower rates than average for people who are age 65. I often refer to these as “teaser rates.”

Let’s look at two different rate structures for Carrier A and Carrier B. These are actual rates available today in Tennessee.

Married Female Non-Smoker Plan F	Carrier A	Carrier B
65 years old	\$99.50	\$123.19

At first glance, it appears Carrier A is a better option since \$99.50 per month is \$23.69 per month less than \$123.19.

However, by age 75, the rates tell a much different story.

Married Female Non-Smoker Plan F	Carrier A	Carrier B
75 years old	\$178.39	\$162.67

As you can see, Carrier A's rate has increased much more between age 65 and age 75 (\$78.89 per month) - than has Carrier B's (\$39.48). Carrier A's rate at 65 was really a "teaser rate" designed to generate enrollments.

Why does this matter so much? Remember, as we discussed earlier in Mistake #2, Medicare Supplements are underwritten based on one's health once they have been on Medicare Part B for longer than six months. If someone has health conditions that result in them being declined, they may not be able to switch to a lower cost plan in the future.

In other words, someone who enrolls in a plan based on that plan's "teaser rate" for age 65 may end up locked in to that plan for the rest of their life despite that plan costing much more than other plans in the future.

Let's now look at these same carriers' rates at age 84.

Married Female Non-Smoker Plan F	Carrier A	Carrier B
84 years old	\$230.86	\$212.84

As you can see, Carrier A - which had the “teaser rate” at age 65, is now \$18.02 more per month than Carrier B whose rates at age 65 more accurately reflected their overall rate structure.

There is a reason I selected the age of 84 for this comparison. Currently, the average life expectancy of a 65 year old female is to live to be 84 years old.

We can also look at this in terms of cumulative premiums rather than month premiums. In other words, how much will Carrier A cost the Medicare beneficiary during the entire expected life compared to Carrier B.

Married Female Non-Smoker Plan F	Carrier A Cumulative Premiums	Carrier B Cumulative Premiums
84 years old	\$41,072.76	\$38,852.20

As we now see, the 65 year old female who was lured by the lower “teaser rates” when she first went on Medicare would end up paying \$2,220.56 more during her expected time on the plan under the Carrier A than she would under Carrier B.

A major problem with this is the sales tactics used by many insurance agents trying to convince someone to enroll in Carrier A.

Most people who are new to Medicare do not have the advantage you have of reading this book. Instead they rely on a sales person who will only show them the rates for age 65. As you see, this can be a mistake that becomes very costly as one becomes older.

MISTAKE #10

Focusing on the low-premium with a Medicare Advantage plan and not budgeting for unexpected co-pays

Over time, most people spend less money with a Medicare Advantage plan than with a Medicare Supplement. Choosing a Medicare Advantage plan that fits your lifestyle is usually a good financial decision.

However, being fully prepared for all health scenarios requires some financial planning.

The most important thing is for people with a Medicare Advantage plan to have savings to pay co-pays in the event of an expensive health condition.

For many people, they already have savings sufficient to cover unexpected health costs.

For others whose finances may be more limited, it is easy to remember the low premium and forget the costs that could occur. I encourage people in such a situation to create a savings account with the savings they gain from choosing a Medicare Advantage plan. I advise putting at least \$75 or \$100 a month into this fund until the balance reaches the out-of-pocket maximum of their Medicare Advantage plan. After reaching this amount, the member can reasonably choose to reduce their monthly contributions though I still encourage at least \$50 per month.

This approach has several benefits. First, obviously, the savings account will be available to cover unexpectedly high co-pays.

Second, this process helps the Medicare beneficiary understand that, while overall costs with a Medicare Advantage plan are usually less than with a Medicare Supplement, there are still expected costs beyond the premium.

Top Ten Medicare Rules

1. Always ask a Medicare sales person how many different plans and carriers they represent. If the answer to either is “one” thank him for his time but move along.
2. If you think you may want or need a Medicare Supplement that pays everything now or in the future and you can afford the extra premium costs, enroll when you are guaranteed to be accepted when you turn 65 or first go on Medicare Part B.
3. Do not choose a Medicare Advantage if you already know you will have co-pays under the plan that are nearly as much or more than the cost of a Medicare Supplement would be.
4. Make sure the network restrictions that may exist with a Medicare Advantage plan - particularly an HMO - are consistent with the type of flexibility and control you may want with your health care decisions. If a plan does not provide the choice and flexibility you want, don’t enroll in that plan.
5. If you travel often outside of your home area and think you may want to receive routine care while traveling, choose a Medicare Advantage PPO plan or a Medicare Supplement.
6. Always enroll in a Medicare Part D drug plan when first eligible unless you have credible coverage through another source such as the Veterans Administration or an employer plan.

7. Always compare the formularies for different Medicare Part D drug plans available to you to learn which plans cover your medications at what cost and which ones do not.
8. Do not assume your best option is remaining on your employer coverage if you are not retiring at age 65. In many if not most cases, going on Medicare will cost you less money and give you as good or better coverage.
9. When considering a Medicare Supplement, compare the rates for all ages rather than just the age at which you will join.
10. After selecting a Medicare Advantage Plan, make sure you either already have or start building financial reserves to cover unexpected co-pays.

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Feel free to contact Mr. Bradshaw for assistance with your Medicare options