Turning 65 and What People May Not Know

A Guide for Agents on What People Need to Know About Their Medicare Plan Options

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Introduction

Out of the 67 million people enrolled in Medicare, almost 90% are age 65 or older. And when someone turning 65 takes their first steps into the world of Medicare, there's an array of details they're bound to miss.

Licensed agents must be equipped to fill these knowledge gaps, highlighting areas many often overlook when signing up for Medicare and choosing their plan.

The choices a beneficiary must make concerning Original Medicare, Medicare Advantage (MA), and Medicare Supplement (Medigap) plans can be overwhelming. Many people don't know about Medicare's specific enrollment periods and the penalties for missing them, and Medicare terminology can sometimes be confusing.

"Almost 90% of Medicare enrollees are 65 or older."

What They Must Do Before and After 65

While there's plenty a person nearing 65 might not know about Medicare, there are four basic things they'll need to act on:

1. **Enroll in Medicare**
   You must sign up for Medicare Parts A and B during the IEP, starting three months before turning 65, including your birth month, and ending three months later. If you receive Social Security, you will be automatically enrolled.

2. **Choose coverage**
   Decide between Original Medicare, with or without a Medigap plan, or an MA plan.

3. **Add prescription drug coverage**
   Consider enrolling in a Medicare Part D plan for prescription drug coverage if not included in their chosen Medicare plan.

4. **Review annually**
   The annual review is one of the most important meetings for customer retention. Every plan is required to send an Annual Notice of Change (ANOC) to current members each year. The ANOC summarizes changes to their coverage and costs that will take effect Jan. 1. The two weeks leading up to AEP, Oct. 1-14, is a prime time for agents to review ANOC letters with beneficiaries to help them review the new plan year's options.

   By understanding these steps and guiding people turning 65 through Medicare, licensed agents can help ensure a smoother transition and the most appropriate coverage selection for their needs.

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What You Might Need to Help Them With

When you have a potential customer turning 65, there are several things you can start doing for them right away, no matter the time of year. You can help them now by assisting with...

1. **Reviewing current coverage**
   Learn their current health insurance coverage, including employer or retiree plans. Explain how it interacts with Medicare.

2. **Researching Medicare parts**
   Explain Medicare parts A, B, C (Medicare Advantage), and D. Laying it out part by part can help them make more informed decisions about coverage options.

3. **Comparing plans**
   Compare the pros and cons of Original Medicare, MA, and Medigap plans to determine which suits their healthcare needs and budget.

4. **Considering additional coverage**
   Educate them about options for supplemental coverage — like a Part D drug plan, hospital indemnity, or long-term care — to fill gaps in their Medicare coverage. For MA and Part D plan sales, other products that may be discussed are limited to what can be covered and what was agreed upon on the Scope of Appointment (SoA) form.

5. **Checking provider networks**
   Determine whether their preferred doctors and hospitals are in-network for MA plans, should they go that route.

6. **Understanding costs**
   Estimate out-of-pocket costs, including premiums, deductibles, copayments, and coinsurance.

"Laying (Medicare) out part by part can help them make more informed decisions about coverage options."

What Many Don't Know When Turning 65

By understanding the following common pitfalls and overlooked aspects of Medicare, agents can be a source of support, helping their customers make the best decisions for their health and future:

1. **Timing Matters**
   Many people don't realize the importance of signing up for Medicare on time. Missing deadlines can lead to penalties and gaps in coverage.

   - **Explain the IEP:** Make sure they understand that missing Medicare's Initial Enrollment Period (IEP) can lead to coverage gaps and potential penalties. The IEP starts three months before their 65th birthday, includes their birthday month, and ends three months after.
   - **Late enrollment penalties:** If they miss their IEP and don't have other qualifying health coverage, they could face a late enrollment penalty for Part B. This penalty increases their premiums by 10% for each 12-month period they were eligible for but didn't enroll — and this extra cost continues if they have Part B.
   - **Special Enrollment Periods (SEP):** If your customers or their spouses are still working and have employer health coverage, they might not need to enroll in Part B immediately. Educate them about the SEP, which allows them to enroll in Part B anytime while they are still covered by the employer plan or within eight months after the job or coverage ends, without facing late penalties.
   - **Employer size considerations:** It's important for people working in small companies (fewer than 20 employees) to know that Medicare becomes their primary coverage at 65. They should enroll during their IEP to avoid coverage gaps, as their employer's plan will only cover what Medicare does not.

2. **Coverage gaps**
   Medicare doesn't cover everything. There are gaps in coverage for things that individuals may not be aware of.

   - **Long-term care:** Medicare does not cover custodial care, including help with daily activities like bathing and dressing at home or in a nursing facility. This can be a potentially very costly surprise. Some may consider looking into long-term care insurance or a life insurance policy with a long-term care rider to help cover these costs.
   - **Prescription drugs:** While Medicare Part D covers prescription drugs, there are gaps here, too, like the coverage gap known as the "Donut Hole." This gap means that after spending a certain amount on medication, the beneficiary will pay more out-of-pocket for prescriptions until they reach the catastrophic coverage threshold. They must understand this to budget accordingly.

- **Excess charges and copays:** Medicare Part B covers 80% of the cost of healthcare services, but your customer will be on the hook for the remaining 20% after their deductible. This can add up, especially if they need a lot of care. Medigap can help cover these costs.
- **Overseas coverage:** Anyone who loves to travel should know that Medicare generally doesn't cover medical care abroad, except in minimal circumstances. Medigap plans C, D, F, G, M, and N provide some coverage for emergency care overseas, which can be a lifeline when traveling.

3. **Out-of-pocket costs**
   Medicare has deductibles, copayments, and coinsurance that individuals may not fully understand until they use their benefits.

   - **Deductibles:** These are the amounts a beneficiary will need to pay before Medicare starts to pay its share. For example, in 2024, the Part A deductible for hospital stays is $1,632 per benefit period; for Part B, the annual deductible is $240.
   - **Copayments and coinsurance:** After meeting the deductible, they'll still be responsible for copayments and coinsurance. In Part A, if they're hospitalized for more than 60 days, they'll pay $408 per day for days 61-90 and $816 per day beyond the 90th day during each benefit period. For Part B, once the deductible is met, they generally pay 20% of the Medicare-approved amount for most services.
   - **No out-of-pocket maximum:** Original Medicare (parts A and B) does not have an out-of-pocket maximum. This means there's no cap on what someone can pay in a year, which can lead to significant medical expenses if they have a severe health issue.
   - **MA Maximum-out-of-pocket (MooP):** Unlike Original Medicare, MA plans have a maximum out-of-pocket, which can protect people from excessive costs. In 2024, this limit varies by plan but caps the amount people would pay for covered services in a year. Once they reach this limit, the plan pays 100% of covered services.
   - **Medigap can help:** For those on Original Medicare, purchasing a Medigap policy can help cover some out-of-pocket costs, like deductibles, copayments, and coinsurance. It's a good option for those looking for more predictable costs.

"Many people don't realize the importance of signing up for Medicare on time."

4. **Network limitations**
   People with traditional Medicare can go to any doctor or hospital that accepts Medicare anywhere in the U.S. Almost all doctors and hospitals accept Medicare. However, MA plans often have networks of doctors and hospitals, which can raise out-of-pocket costs and limit care provider choices if not researched properly.

   - **Types of networks:** Most MA plans are either...
     - *Health Maintenance Organizations (HMOs)* usually require choosing a primary care physician and getting referrals to specialists, all within the network.
     - Or *Preferred Provider Organizations (PPOs)*, which provide more flexibility, allowing visits to out-of-network providers, though at a higher cost.
   - **Network size and quality:** The size and quality of provider networks can vary significantly between MA plans.
   - **Changing networks:** Provider networks can change annually, which means a doctor or hospital covered one year might not be included the next. This can be particularly challenging for enrollees requiring consistent chronic care.
   - **Access to information:** Finding up-to-date and reliable information about plan networks can be challenging. Provider directories are often outdated, and it may not be easy to compare the networks of different MA plans directly. This makes it essential for beneficiaries to verify the network status of their preferred doctors and hospitals each year during enrollment.

5. **Drug formularies**
   Medicare Part D plans have formularies that list covered medications. Individuals should check whether their medications are covered before enrolling.

   - **Understanding formularies:** Formularies are organized into different tiers, determining the cost-sharing amount the beneficiary pays for each medication. Typically, lower-tier drugs are generic and cost less, while higher-tier drugs are brand-name medications and cost more.
   - **Checking coverage:** A similar drug might be available if a medication is not listed on the plan's formulary. However, it's essential to consult with a healthcare provider to ensure it's suitable.
   - **Changes to formularies:** Medicare Part D plans can change their formularies during the year. These changes could include adding or removing drugs or altering the tier placement of a drug, which could affect the out-of-pocket cost. Plans will notify enrollees of any significant changes that could impact their coverage. Always encourage individuals to review their Medicare Part D coverage each year during the Annual Enrollment Period (AEP).

6. **Plan changes**
   Medicare plans can change their coverage and costs annually. Individuals must review their plans during AEP to ensure they meet their needs.

   - **Key documents for review:** The primary documents to review are the "Evidence of Coverage" (EOC) and the "Annual Notice of Change" (ANOC). These documents are typically sent by the plan providers and contain detailed information about any changes in the plan's costs, coverage, and provider networks.
   - **Timing of notices:** Plan members should receive the ANOC in September, before the start of AEP in October.
   - **Next steps:** If the changes to the Medicare plan are not satisfactory, individuals can switch plans during AEP.

"MA network limitations … can raise out-of-pocket costs … if not researched properly."

Navigating Medicare can be complex, especially for those approaching 65. Timely enrollment is crucial to avoid penalties and coverage gaps. Choosing between Original Medicare, Medicare Advantage, and Medigap plans requires careful consideration of cost, coverage, and network preferences. As a knowledgeable, licensed agent, you can guide upcoming beneficiaries through these decisions, ensuring they understand their options and navigate overlooked aspects, like prescription drug coverage and long-term care. Your guidance may be just what someone needs to secure adequate health coverage and safeguard their financial and physical well-being.

Your Support Could Be the Key to Their Success

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