DELAYING MEDICARE ENROLLMENT

Late enrollment penalties can increase your monthly premiums for Parts A, B, and D if you delay Medicare enrollment *without* other eligible coverage.

The Centers for Medicare & Medicaid Services (CMS) determine the amount you pay in premiums for the different parts of Medicare each year. Check Medicare.gov for this year's premiums.

People younger than 65 and on Social Security Disability Insurance (SSDI) are automatically enrolled in Part A with no premium. Delaying Part A can result in loss of SSDI benefits.

There are some conditions that allow you to delay enrolling in Parts B and D. There are strict criteria for notifying Medicare about the delay, as well as certain special enrollment periods when people may later sign up to avoid financial penalties.

How Delaying Enrollment Affects Your Premiums

Part A = 10% increase for 2 X number of years delayed after eligibility

Part B = 10% increase for each 12-month delay for as long as you have Part B or until you turn 65 with Medicare based on disability

Part D = 1% of Medicare-determined national average premium for the number of months without Part D

Do you have access to an employer-based health plan?

If you or your spouse are actively working AND are eligible for employer group insurance, you have options to consider when you become Medicare eligible.

You may choose to delay Medicare enrollment for Part B and/or D, or you may be able to use both your employer-based health plan and Medicare.

Before you make any decisions, talk to your employer plan's administrator.

If you are thinking about delaying Part B, keep in mind…

- Rules differ if you have an employer plan based on active employment (you or your spouse is currently working), former employment (COBRA), or retiree coverage.
- Before you delay Part B, find out how your employer-based coverage coordinates with Medicare. For example, will your employer-sponsored group health plan coverage pay claims first or will it pay after Medicare, and what are the plan's rules if you are eligible for Medicare but do not sign up for Part A and/or Part B?

If you are thinking about delaying Part D, keep in mind…

- Employer-sponsored prescription coverage must be considered "creditable coverage."
- Your employer might have its own restrictions for Medicare-eligible enrollees. For example, some retiree plans require you to enroll in Medicare Part D, otherwise you risk losing medical benefits.

When you (or your spouse) leave your employer, you likely will lose their health plan coverage. When this happens, you will have a special enrollment period (SEP) to sign up for the parts of Medicare you delayed based on your situation.

- If you delay enrolling in Part B when you are first eligible because you are covered by an employer health plan, you have 8 months to apply for Part B from the date you, your spouse or family member stops working, or the date the group health plan's coverage ends — whichever is earlier. If you enroll in Medicare Part B during this SEP, you will not be required to pay a late enrollment penalty. You can also sign up for Medicare Part B at any time while you are covered under the group plan.
- For Medicare Part D, your chance to join lasts for 2 full months after the month your coverage ends.

Resources
Medicare.gov
cff.org/insurance
cff.org/navigatingcfplaylist

Connect with Compass. CF Foundation Compass case managers can help with many questions related to Medicare for people with CF. Call 844-COMPASS (844-266-7277) or email compass@cff.org.

COMPASS®

COORDINATION OF BENEFITS WITH MEDICARE AND OTHER INSURANCE

If you have Medicare and another type of insurance, rules apply for how claims are filed and in which order they will be paid. You should know which insurance will be primary — or pay a claim first — and which will pay second.

How Benefits Are Coordinated

There are various rules for coordinating benefits, and they mostly are based on the other type of insurance a person has – such as a retiree or employee group, Veterans Administration, Marketplace, COBRA, or Medicaid.

For example:

- If you have an employer group plan through your spouse and have Medicare, the primary coverage is decided based on your age and the size of the company that employs your spouse.
  - If you are younger than 65, the employer plan is primary only if the company has 100 or more employees.
  - If you are 65 or older, the employer plan becomes primary when the company has only 20 or more employees.
- Marketplace plans will not coordinate with Medicare.
- Medicaid will always pay last.

How Claims Are Paid

Each of your plans will provide a document about how it paid each claim. For most insurance companies, this is called an Explanation of Benefits or EOB. Medicare's document is called Medicare Summary Notice or MSN. These documents help you see how each insurer paid a claim. They also help you see if the services were billed correctly or if a bill you received should have been sent to a different insurer instead of you.

The EOB or MSN has valuable information that you'll need for many reasons, especially if payment is denied for a service or treatment, and you need to appeal the denial instead of paying a bill you may have received in error.

Help is available!

Compass case managers deal with insurance coverage for cystic fibrosis every day. So reach out. They can help you consider plan options when you are eligible for Medicare, understand coordination of benefits, maximize payment of claims, minimize payment delays, and deal with any coverage issues that may arise with Medicare or other insurers. And if you get a bill that doesn't seem right, they can help you look into it before you pay it.

Resources

Medicare.gov
When Medicare is Primary and Secondary on medicareinteractive.org
cff.org/insurance
cff.org/navigatingcfplaylist

Connect with Compass. CF Foundation Compass case managers can help with many questions related to Medicare for people with CF. Call 844-COMPASS (844-266-7277) or email compass@cff.org.

COMPASS®

MANAGING THE HIGH COST OF MEDICARE WITH CF

The decision to go on Medicare often has major financial effects for people with cystic fibrosis, especially for those who become eligible for Medicare through Social Security Disability Insurance (SSDI) before age 65. Medicare does not start until after 24 months of SSDI payments, so you may need to pay for a plan through the Marketplace, COBRA, or a family member's employer until then. Add to that the high out-of-pocket costs and that you cannot use manufacturer copay assistance with Medicare, and the expenses can be overwhelming. You'll want to investigate all possible options to assist with Medicare's costs.

Medicare Supplement Insurance (Medigap) is an option for those who have Original Medicare.

With Original Medicare, a Medicare supplement – or Medigap – policy can help with some of the high out-of-pocket costs associated with Part A and Part B covered services, but it will NOT help with Part D costs. Medigap plans are sold by private insurance companies, and you'll pay an additional monthly premium, which can be expensive. There are 10 standardized Medigap plans – A through N – and each lettered plan offers the same benefits no matter which insurer you select. So it is important to compare prices. Here is a helpful chart from Medicare.gov.

Federal law does not require companies to sell Medigap plans to people younger than 65 in all states. So, purchasing a Medigap plan may not be an option where you live. And Medigap isn't available to people younger than 65 with end stage renal disease (ESRD).

✔ = Plan covers 100% ✖ = Plan doesn't cover % = Amount the plan covers

Medigap plans

Benefits	A	B	C	D	F	G	K	L	M	N
Part A coinsurance & hospital costs	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Part B copays/coinsurance	✔	✔	✔	✔	✔	✔	50%	75%	✔	✔
Blood (first 3 pints)	✔	✔	✔	✔	✔	✔	50%	75%	✔	✔
Part A hospice	✔	✔	✔	✔	✔	✔	50%	75%	✔	✔
Skilled nursing facility	✖	✖	✔	✔	✔	✔	50%	75%	✔	✔
Part A deductible	✖	✔	✔	✔	✔	✔	50%	75%	50%	✔
Part B deductible	✖	✖	✔	✖	✔	✖	✖	✖	✖	✖
Part B excess charges	✖	✖	✖	✖	✔	✔	✖	✖	✖	✖
Foreign travel emergency	✖	✖	80%	80%	80%	80%	✖	✖	80%	80%

Source: Medicare.gov - "Benefits offered by each Medigap plan"

Other Options

Medicaid is a type of public health insurance. Each state runs its own Medicaid program, which means eligibility requirements and benefits can vary from state to state. Medicaid can help people on Medicare with certain costs. If you are eligible for both Medicare and Medicaid – known as dual eligibility – your state Medicaid may cover Medicare costs such as the Part B coinsurance for covered services and your Part B premium. Those who are dual eligible are automatically enrolled in Medicare Extra Help (below) to lower Part D copays. It is important to remember that Medicaid is managed by your state. If you go to another state for care, your state's Medicaid may not cover the out-of-state providers. There are also specially designed managed care plans for those who are dual eligible and have Medicare Advantage.

Medicare Extra Help is offered through the Social Security Administration. It helps people with limited income and resources lower the costs related to a Medicare Part D prescription drug plan, including assistance with monthly premiums, annual deductibles, most copays, and coinsurance.

Medicare Savings Programs (MSP) are federally funded but state-administered programs for people on Medicare who have limited income and resources to pay for out-of-pocket Medicare costs. These programs are not Medicaid. Instead, they help with Medicare costs such as Part B premiums, and in some cases, deductibles and coinsurance. Enrollment in one of the four MSPs automatically qualifies you for Medicare Extra Help. The programs, names, and requirements vary by state, and they are not available in Puerto Rico or the U.S. Virgin Islands. Connect with Compass or your social worker or you can contact your state Medicaid office or check its website to find out about eligibility requirements.

Copay assistance programs through nonprofit organizations may be available if you meet the eligibility requirements. Most manufacturer copay assistance programs are not available when you are on Medicare.

Resources

Medicare.gov
cff.org/insurance
cff.org/navigatingcfplaylist

Connect with Compass. CF Foundation Compass case managers can help with many questions related to Medicare for people with CF. Call 844-COMPASS (844-266-7277) or email compass@cff.org.

COMPASS®

MEDICARE AND CF MEDICATIONS

Prescription medications are an integral part of cystic fibrosis treatment. However, prescription coverage under Medicare can be confusing. Most CF medications are covered under Part D, but some inhaled or nebulized medications people with CF need and the devices to use them are covered under Part B. Here's a closer look:

If your medication is covered under Part D	If your medication is covered under Part B
Your out-of-pocket costs depend on: · Monthly premium + any deductible · Plan's formulary (list of covered drugs) · Pharmacy used: in- or out-of-network · The covered drug's "tier" (generic, preferred brand, non-preferred brand, specialty) · Your Part D benefit phase	You will pay the usual 20% Part B coinsurance for: · Most inhaled medications · Durable medical equipment (DME) with limitations on how often it can be replaced · Diabetic strips, lancets, lancet devices, blood sugar control solutions, and meters · Insulin pumps
In 2023, there is no out-of-pocket maximum for Medicare part D. However, **there are major changes coming to Medicare in 2024. Compass can walk you through these updates and answer your questions.**	Original Medicare (which includes Part B) has no out-of-pocket maximum. If you have a Medicare Advantage plan, Part B covered prescriptions will apply to your Part B out-of-pocket maximum.
Injectable insulin pen or vial with syringe (not used with an insulin pump) is covered under Part D.	Important: Some pharmacies cannot bill Medicare Part B. To do so, a pharmacy must have a contract directly with Medicare as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider. Some pharmacies – especially retail pharmacies – may not have that contract to bill for Part B covered drugs.

To meet their needs, most people with CF need either Original Medicare plus a Part D prescription drug plan, or a Medicare Advantage plan that includes drug coverage.

Medicare may NOT cover

- Vitamins and supplements
- Hypertonic saline
- Home health visits for home IV administration when not homebound
- Off-label inhaled antibiotic use
- Durable Medical Equipment replacement within 5 years

Whether your prescription is covered under Part D or B, manufacturer copay assistance programs are not available to people on Medicare. Connect with your CF care team or a Compass case manager to learn more about resources that may be available to you, as well as their requirements.

Four Stages for Part D Coverage

- **Phase 1: Annual Deductible** The amount you pay for prescriptions before your Medicare drug plan pays.
- **Phase 2: Initial Coverage** You pay copays or coinsurance based on the drug tier.
- **Phase 3: Coverage Gap (aka Donut Hole)**
- **Phase 4 Catastrophic Coverage** You pay a 5% coinsurance or fixed copay for the remainder of the year.

More About Part D Benefit Phases

There are four Part D benefit phases or stages, and the amount you pay for a medication will change depending on your benefit phase at the time you fill the prescription. The Centers for Medicare & Medicaid Services (CMS) sets phase thresholds annually.

If you fill an expensive medication, such as a modulator, your copay may be high for the first month's fill. With this first fill, you typically will spend enough out of pocket to move through stages 1, 2, and 3 and enter the Catastrophic Coverage stage (Phase 4).

Once you've paid a determined amount – which changes annually but is always several thousand dollars – you have to pay either a 5% coinsurance or a fixed dollar copay – whichever is larger – for every one of your medications for the remainder of the year. For many common CF medications, people with CF will have to pay a 5% coinsurance.

Important Changes Are Coming to Part D

The 2022 Inflation Reduction Act took aim at the high costs of Part D prescription plans with significant impacts for people living with CF.

Starting in 2024, the 5% coinsurance in the Catastrophic Coverage phase will be eliminated. You will still have to reach this benefit phase by meeting a dollar amount specified by CMS (estimated out-of-pocket costs approximately $3,250). As described above, many people with CF reach the Catastrophic Coverage phase early in the year because of the high cost of common medications. Once you meet the threshold for Catastrophic Coverage, however, your Part D covered prescription costs will be capped.

Starting in 2025, all Part D plans will have an annual out-of-pocket maximum. This cap will be determined annually. You may be able to spread costs over the year rather than pay all at once. In 2025 the out-of-pocket cap will be set at $2,000.

Resources

Medicare.gov
cff.org/insurance
cff.org/navigatingcfplaylist

Connect with Compass. CF Foundation Compass case managers can help with many questions related to Medicare for people with CF. Call 844-COMPASS (844-266-7277) or email compass@cff.org.

COMPASS®

MEDICARE AND MAJOR HEALTH TRANSITIONS

Some people with cystic fibrosis may require coverage for additional services such as oxygen, home IVs, CF-related diabetes, tube feeds, long-term care, or even hospice. As you assess Medicare plans and options, consider how these potential transitions could affect your life.

Oxygen

Medicare covers home oxygen therapy as part of a five-year contract. Medicare pays a monthly rental fee that includes all equipment, oxygen, supplies, and maintenance for 36 months of that 5-year contract, and you pay 20% of the monthly rental fee. For the last 24 months of the contract, the medical supplier bears all (or most) of the costs of providing home oxygen.

If you need oxygen, it is crucial to work closely with your care team to identify appropriate suppliers that can meet both your needs and Medicare's requirements. For example, oxygen suppliers are required to provide both stationary and portable solutions for Medicare beneficiaries, if medically necessary. However, not all suppliers carry the portable oxygen solution that a person with CF may be prescribed or prefer. So, it is important to know a supplier's portable solution options are before signing a contract.

Home IVs

When it comes to coverage for home IVs, it is important to talk to an infusion pharmacy or home care company – as well as your care team or Compass – to clarify your insurance coverage. Only certain drugs and biologicals that are given intravenously or subcutaneously through an external infusion pump are covered under Medicare Part B. And the service component – such as home visit nursing service, training, and education – is not covered at all by original Medicare unless you are deemed homebound.

CF-Related Diabetes (CFRD)

If you have CFRD, it is helpful to know what Medicare pays for and what your financial responsibility may be. If you give yourself insulin injections or use an insulin pen, these are generally covered under Part D, and the copay is capped at $35 per month, as long as the insulin product you take is on the plan formulary – or list of covered drugs. Supplies such as needles, alcohol swabs, gauze, or testing strips and lancets are only covered at limited quantities or may not be covered at all.

> Starting in 2023, the Inflation Reduction Act limited the cost of insulin to $35 per month for those who have Medicare, including if you use an insulin pump.

Medicare now covers continuous glucose monitors (CGMs) for all people with diabetes on any type or manner of insulin treatment, as well as those not on insulin but with a history of reoccurring hypoglycemia. Also, six-month CGM follow-up visits can be done via telehealth. Under this updated policy, Medicare beneficiaries with CF related diabetes have increased access to CGMs.

Tube Feeds

Under Medicare, CF is a "supported diagnosis" for home tube feeding equipment and supplies, but getting coverage for formula can be challenging. This is particularly true if you are able to eat by mouth during the day. Supplies may be covered with limited quantities through Original Medicare and some Medicare Advantage plans. If you have feeding tube needs, connect with your CF care team or Compass to better understand your specific coverage.

Long Term Care

Under Medicare, long term care has very limited coverage under Part A: up to 100 days total at a skilled nursing facility under strict medical necessity review. Those who are dual-eligible with both Medicare and Medicaid get coverage through Medicaid beyond Medicare's 100-day limit.

> Long term care has limited coverage under Part A. If you are dual eligible you may have longer coverage.

Hospice Care

To receive hospice care and benefits under Medicare, the hospice organization must be Medicare-approved, and a physician must certify the person has six months or fewer to live. Services may be provided in your home or in a facility.

If you receive hospice care in a facility, most charges are covered except for room and board. For hospice services at home or in another outpatient setting, you will have a small copay for each prescription of pain and symptom-management medication. CF medications may or may not continue to be covered under hospice care. Medicare also covers respite care for short-term relief for the primary caregiver.

Some people with CF may hesitate to enroll in hospice because of concerns about having to stop routine CF medications, such as modulators or some aerosols. It is important for people with CF and their families to discuss these and all concerns with the hospice organization and their physicians.

If you're considering hospice care, discuss all of your concerns with the hospice organization and your care team.

Medicare Alone is Not Enough for Transplant.

- Transplant coverage and costs vary.
- Most transplant programs require that you have additional coverage
- Talk with facility's financial counselor.

Transplant

Transplant can be hard for people living with cystic fibrosis and their families. Dealing with insurance during this time can feel overwhelming. It is important to understand your health plan's transplant coverage, how it may affect your ability to receive a transplant, and what your out-of-pocket costs will be.

- If you have Medicare before transplant surgery, Part A hospital coverage pays for organ transplant in a Medicare-approved facility. Parts A and B cover:
  - o Necessary tests, labs, and examinations before surgery
  - o Organ procurement
  - o Follow-up care after transplant
  - o Immunosuppressant drugs
- Medigap plans help pay for costs remaining after Parts A and B cover their portion and could provide an additional 365 days of inpatient hospital care.
- Whether coverage is through an optional drug plan or a Medicare Advantage plan, Medicare Part D may cover immunosuppressive drugs if Medicare did not pay for the transplant.
- Medicare Advantage plans have specific provider networks, and they may not cover services received outside the plan's network or out of state.
  - o Be sure to check your plan's network for transplant centers and transplant providers.
  - o Check your plan's formulary for transplant medications.

With so many financial variables, including coverage limits and out-of-pocket responsibility for deductibles and coinsurance, it's important to discuss these factors with your transplant team's financial counselor. Your CF care team, transplant team, and CF Foundation Compass case managers are valuable resources during this process.

Resources

Medicare.gov
cff.org/insurance
cff.org/navigatingcfplaylist

Connect with Compass. CF Foundation Compass case managers can help with many questions related to Medicare for people with CF. Call 844-COMPASS (844-266-7277) or email compass@cff.org.

COMPASS®