Understanding Medicare Part B health insurance benefits

A guide to how your health plan may cover outpatient drugs given by infusion

Not actual patients

REGENERON®

About this guide

This guide provides an overview of the different ways you may choose healthcare coverage through Medicare and how Medicare Part B may help pay for treatments that require infusions—medicine that is injected directly in your veins and given at your doctor's office or hospital outpatient setting.

In addition, included is a list of websites that may help you learn more about your coverage through Medicare (see page 15).

This material is provided for informational purposes only, is subject to change, and should not be construed as legal or medical advice.

If you have any questions about the information in this guide, be sure to ask your doctor.

Table of contents

Health insurance overview 4

Options for enrolling in Medicare 6

Coordinating benefits: having insurance through more than 1 health plan 8

How your health insurance helps you pay for care 10

What you may pay for outpatient drugs given by infusion 11

Additional resources 15

References 17

Health insurance overview

Health insurance is a type of insurance coverage that helps pay for most medical procedures and prescription drugs.[1] If you have health insurance, you are likely insured through 1 of the 2 main types available in the United States:

Private insurance[2]

(Sometimes called "commercial insurance") insures those who receive their health insurance:

- Through their job (their employer or union)
- On their own, directly through an insurance company. This includes insurance purchased through the Affordable Care Act exchanges
- Through TRICARE

Public insurance[2]

Insures patients through health plans that are paid for by the government. These include programs like Medicare, Medicaid, Veterans Affairs, and CHAMPVA

This resource focuses on how Medicare benefits may be set up to help pay for drugs given by infusion that your doctor may prescribe and administer in their office or hospital outpatient setting

Medicare basics

Medicare is the federal health insurance program for[3]:

- People 65 or older
- Certain younger people with disabilities
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

CHAMPVA=Civilian Health and Medical Program of the Department of Veterans Affairs.

The 4 parts of Medicare

Medicare helps pay for healthcare services through 4 categories[3,4]:

Part A - Hospital insurance

Helps pay for hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare

Part B - Medical insurance

Helps pay for certain doctors' services, outpatient care, medical supplies, preventive services, and most infusion services, such as chemotherapy and other medications administered in your doctor's office or hospital outpatient setting

Part C - Medicare Advantage

Offered by private managed care companies that contract with Medicare to provide Part A and Part B benefits, and (often) Part D drug benefits. Medicare Advantage (Part C) plans may charge lower out-of-pocket costs (copayments, deductibles, or coinsurance) than Original Medicare, but may require patients to use doctors who are in the plan's network

Part D - Medicare prescription drug coverage

An optional benefit offered by private insurance companies that must follow rules set by Medicare. A Part D plan helps pay for most self-administered prescription drugs covered through a prescription drug plan. For more information, please refer to the Medicare Part D brochure developed by Regeneron

Most Medicare plans cover drugs given by infusion in the doctor's office or hospital outpatient setting through the Part B benefit.[4] Outpatient infused drugs that are administered in the patient's home by a home health nurse may be covered under Medicare Part D[5]*

*Note that, beginning in 2025, annual out-of pocket costs will be capped at $2,000 for people with Medicare Part D as a result of the Inflation Reduction Act.[6]

Options for enrolling in Medicare

Patients insured through Medicare have 2 types of plans to choose from[3]:

Original Medicare

(Part A and Part B, commonly called Fee-for-Service Medicare)

Patients may also purchase extra, supplemental insurance from a Medicare supplemental insurance company (often called Medigap) or from a former employer or union

or

Medicare Advantage

(also known as Part C)

The information on page 7 describes how coverage works when you are insured in each of these plan types.

Patients enrolled in Medicare Advantage (Part C) can change plans/type based on Open Enrollment Periods.[3] The Open Enrollment Period is from October 15 through December 7 for coverage effective January 1 of the next year. Patients can also switch to another Medicare Advantage (Part C) plan or switch back to Original Medicare (if they choose) from January 1 through March 31 each year. This is called the Medicare Advantage (Part C) Open Enrollment Period[3]

Medicare enrollment options[3,7]

	Original Medicare	Medicare Advantage (Part C)
What it covers	Medicare Part A and Part B Medicare Part D is not included, but you can sign up for a separate Part D plan for prescription drug coverage	Sometimes referred to as Medicare Part C, Medicare Advantage is an "all-inclusive" option, which includes Medicare Part A, Part B, and usually Part D These plans may cover extra benefits that Original Medicare does not, such as vision and hearing benefits
Your out-of-pocket costs	If you or your spouse paid Medicare taxes for a certain amount of time while working, you do not pay a monthly premium. If this does not apply to you, you may be able to buy Part A Part A may require a deductible and coinsurance for most hospital stays You will need to pay a premium every year for Part B. In addition, Part B usually requires patients to pay a deductible and then 20% of the Medicare-approved cost for most outpatient care and services Unless you have supplemental coverage, there is no yearly limit on what you pay out of pocket (see below)	Costs, including whether you must pay a premium, vary depending on your plan's benefit design. Some plans may have lower out-of-pocket costs than Original Medicare Plans have a yearly limit on what you pay out of pocket for Medicare Part A- and B-covered services. Once you reach your plan's limit, you will not pay anything for Part A- and Part B-covered services for the rest of the year. Out-of-pocket limits in 2024 are $8,850 for in-network care and $13,300 for in- and out-of-network care combined (though these limits may be lower depending on the health plan)[7]
Can you purchase supplemental, or extra insurance?	Yes, you can purchase a **supplemental** plan (often called **Medigap**) offered by private companies, or you can use coverage from a former employer, union, or Medicaid, which helps pay for some of your out-of-pocket costs	No, you are not able to purchase supplemental insurance
Which doctors can you see for care?	You can see any doctor or go to any hospital in the United States that accepts Medicare patients	You usually need to go to doctors who are in your Medicare Advantage (Part C) plan's provider network

Coordinating benefits: having insurance through more than 1 health plan

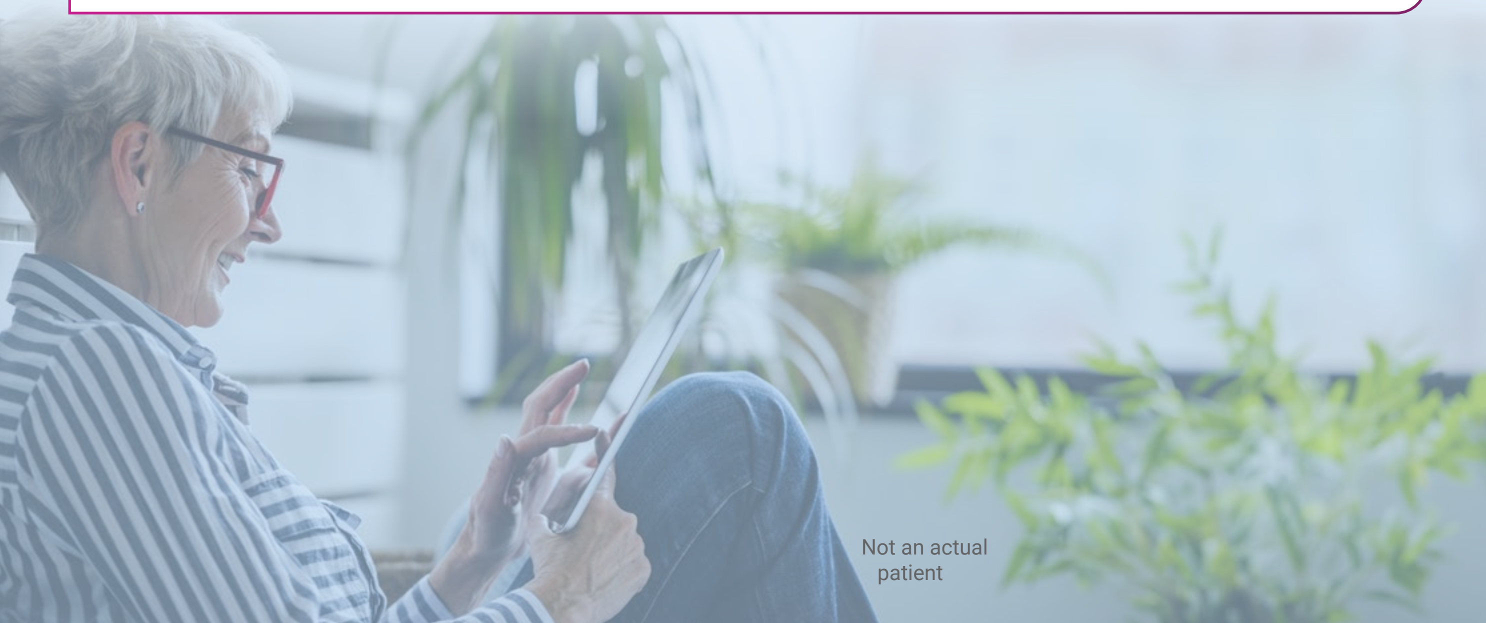
Some people are insured by more than 1 health plan. For example, if you are retired and insured through Medicare, you may also have retiree insurance through your former employer, which will help pay for the cost of your care.[8]

When you are insured by more than 1 health plan, "**coordination of benefits**" is required to decide the order in which each health plan will pay your medical bills. One of your health plans will be considered your "primary payer," meaning it will pay your bills first (up to the limit of the coverage it allows). If there are charges the primary payer did not pay, the doctor will send a bill to your "secondary payer," which may cover some of the remaining charges.[8] Determining which payer pays your bills first depends on the type of plans you are covered by.

Your doctor will help you coordinate your benefits with the health plans that insure you. Be sure to tell your doctor if you are covered by more than 1 plan.

If you have questions about how your health plans will help pay for your coverage[8]:

- Check your insurance policy—it may provide information about which health plan will pay for your care
- Call the Benefits Coordination & Recovery Center (BCRC) at **1-855-798-2627**. TTY users should call **1-855-797-2627**
- Contact your employer or union benefits administrator if you have coverage through a current or former employer



Not an actual patient

Which plan pays first?

Below are some examples of how health plans may coordinate benefits to pay for your care[8]:

If you...	The plan that pays first	The plan that pays second
Are aged 65 or older and have retiree insurance through a former employer	Medicare	Retiree coverage from your former employer
Are 65 or older, entitled to Medicare, and you or your spouse has health insurance through a job that has:		
Less than 20 employees	Medicare	The employer's health plan
More than 20 employees	The employer's health plan	Medicare
Are covered by Medicare and Medicaid (ie, dual-eligible beneficiary)	Medicare	Medicaid
Have ESRD and a group health plan coverage (including a retirement plan)	Your employer's health plan for the first 30 months of eligibility or entitlement to Medicare	Medicare
	Medicare after 30 months of eligibility of entitlement to Medicare	Your employer's health plan

The above table provides examples of some situations in which a beneficiary may have both Medicare and other health insurance coverage, and is not intended to be comprehensive. Please contact your doctor or your health plan for detailed information regarding coordination of benefits.

How your health insurance helps you pay for care

The amount of money you pay for your care depends on your health plan's coverage policies. Common ways to share the cost of your care with the health plan include:

Premium: A premium is paid every month, quarter, or year to your health plan to ensure your insurance coverage is in effect when you go to the doctor or fill a prescription[9]

Out-of-pocket costs: These are extra costs you pay in addition to your premium.[10] When you use your health insurance to go to the doctor or receive medication, you usually need to pay a part of the cost for that service

Types of out-of-pocket costs[9]

Deductible: An up-front amount that some plans require you to pay for your care each year before the health plan starts to pay for its share. The amount of the deductible a health plan requires you to pay depends on the health plan. Note that your deductible may not apply to all of the healthcare services you receive

Once your deductible is met, you are responsible for…

Copay: A flat cost that is commonly paid at the time of care. For example, if the total cost of your care is $100 and you have a $20 copay, you pay $20 and the health plan pays the remaining $80

or

Coinsurance: A percentage of the total cost for which you are responsible. For example, if a service costs $500 and you have a 20% coinsurance, you are responsible for paying $100 and the health plan pays the rest of the cost

You continue to pay the balance of your deductible and any copays and/or coinsurance until you reach your plan's out-of-pocket maximum, which is the most you have to pay for covered healthcare services per year. Out-of-pocket maximums vary by health plan.

What you may pay for outpatient drugs given by infusion

How much will I pay?

Coverage for drugs given by infusion is likely included under your health plan's **medical benefit, which falls under Medicare Part B**. Part B covers drugs that are injected or infused by a doctor in their office or in a hospital outpatient setting.[4] However, the *amount* you pay for your infusions is likely to differ depending on which plan you choose. Factors that may affect how much you pay for care include:

- **How your health plan has set up how you pay for coverage:** For example, some plans may have **lower monthly premiums and higher out-of-pocket costs**. Other plans may charge **higher monthly premiums but offer lower out-of-pocket costs**.[11] See the previous page of this guide for an explanation of out-of-pocket costs, which include deductibles, copays, and coinsurance

- **If you have more than 1 insurance plan:** You may have more than 1 health insurance plan, or, if you have chosen Original Medicare, you may have purchased Medigap insurance to help pay for some of the costs that your Original Medicare does not cover[3,8]

- **How your Medicare Advantage (Part C) plan manages your infusion drug:** If you have Medicare Advantage (Part C), the cost of your prescribed drug may differ depending on where it is placed on a plan's **formulary**. A formulary is a list of medications health plans implement to encourage the use of the safe, effective, and affordable medications.[10,12] In addition, in many cases, your doctor must receive approval from your health plan to use the drug they prescribed or may be required to use drugs on the plan's formulary first. This is called **prior authorization**[10]

Once your doctor prescribes a treatment for you, your health insurance will issue a **summary of benefits**, which will give you information about your coverage and the cost of your treatment. Information will include your annual deductible, any copays and/or coinsurance[13]

What you may pay for outpatient drugs given by infusion (cont'd)

Examples of what your out-of-pocket costs may be for an outpatient drug given by infusion

Like other medical services, the cost of drugs given by infusion is likely to vary by health plan. The following examples* describe what your out-of-pocket costs may be when your doctor prescribes a treatment that requires you to receive an infusion in the doctor's office or a hospital outpatient setting.

Example 1

Mary is insured through a Medicare Advantage (Part C) plan. Mary's doctor just prescribed an infusion drug to treat her medical condition. Her health plan requires that, in addition to the premium that is paid every month, she must pay her deductible ($1,000) and a coinsurance (20%) for the treatment when she receives it at her doctor's office. The cost of the infusion is $10,000. Because this is her first visit to her doctor for the year, Mary has not met her deductible yet.

What are Mary's out-of-pocket costs for her treatment?

Cost of the infusion - $10,000		
Deductible $1,000	20% coinsurance of the remaining cost of the drug $1,800	Out-of-pocket maximum $5,000
What this means: Mary must pay her deductible of $1,000 and her 20% coinsurance of $1,800. Since she has not met her out-of-pocket maximum for the year, **Mary owes $2,800** toward the cost of the infusion, and her **health plan pays $7,200**.		

Example 2

Mary's doctor prescribed the same infusion drug to treat her medical condition. Her coverage is the same as in the last example, but this time, Mary has been treated for a previous condition this year, which cost her $5,000 in out-of-pocket costs.

What are Mary's out-of-pocket costs for her infusion?

Cost of the infusion - $10,000		
Deductible **$0** (Mary already met her deductible with her other medical costs)	Out-of-pocket maximum **Met** (Mary already reached her out-of-pocket maximum with her other medical costs)	20% coinsurance **of the remaining cost of the drug** **$0** (Mary is no longer responsible for the coinsurance because she reached her out-of-pocket maximum for the year)
What this means: Since Mary has already paid her deductible of $1,000 and has already met her out-of-pocket maximum for the year, she is not responsible for any additional out-of-pocket costs for her infusion. **Her health plan will pay the $10,000 cost for her infusion.**		

Keep in mind, drug manufacturers may offer financial assistance programs to patients who meet certain eligibility criteria to help pay for some of the out-of-pocket costs you may have for your treatment. Be sure to ask your doctor if you have any questions

*All examples in this guide are hypothetical. Contact your health plan or doctor if you have questions about specific healthcare costs.

What you may pay for outpatient drugs given by infusion (cont'd)

Examples of what your out-of-pocket costs may be for an outpatient drug given by infusion (cont'd)

Example 3

Mary is insured through **Original Medicare, and she has no supplemental coverage through Medigap**. If Mary's doctor prescribes an infusion drug to treat her medical condition, her Original Medicare insurance pays 80% of the cost of the infusion (after Mary meets her $200 deductible), and Mary pays the remaining 20% of the cost of the treatment.

What are Mary's costs for her infusion?

Cost of the infusion - $10,000		
Deductible $200	20% coinsurance of the remaining cost of the drug $1,960	Out-of-pocket maximum None
What this means: Mary must meet her Part B deductible of $200 and her 20% coinsurance of $1,960. Because there is no out-of-pocket maximum for Original Medicare, Mary must pay the entire amount of her coinsurance. Medicare pays $7,840.		

Example 4

This time, Mary is insured through **Original Medicare** and has **supplemental Medigap insurance**. When her doctor prescribes an infusion drug to treat her medical condition, Original Medicare insurance pays 80% of the cost of the infusion (after Mary meets her $200 deductible), and the Medigap insurance policy Mary has chosen pays the **remaining 20% of the costs**.

What are Mary's costs for her infusion?

Cost of the infusion - $10,000	
Part B deductible $200	**What this means:** Mary must meet her Part B **deductible of $200**. Original Medicare pays 80% of the cost of her infusion, and her Medigap policy pays the remaining 20% of the cost.*

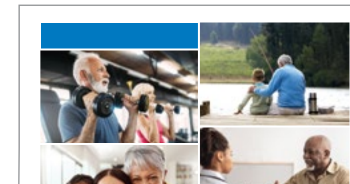
*The amount of coverage offered by Medigap insurance policies varies. For more information about what each policy covers, visit https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies.

Additional resources

There are numerous websites and online tools that can help you find out more information about Medicare and how infusions may be covered through your Part B benefit. In addition, contact your doctor when you have questions. Your doctor is your best source of information about your treatment.

Medicare.gov

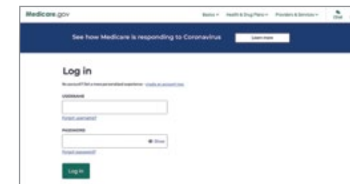
The official government website that provides information about Medicare



***Medicare and You* handbook**

medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf

The official Medicare handbook, which provides information on everything that Medicare covers as well as important updates each year



MyMedicare.gov

A free, secure website that allows people who are enrolled in Medicare to get information about benefits, track claims, receive notices, and chat with an online service representative

Social Security Administration

ssa.gov/medicare

This government organization handles Medicare enrollment applications and, if needed, can replace lost Medicare cards

Kaiser Family Foundation

kff.org

A nonprofit organization focusing on information on national health issues and issues regarding Medicaid, Medicare, health reform, and global health

American Association of Retired Persons

aarp.org

A nonprofit organization geared toward issues affecting Americans aged 50 and older, including healthcare

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