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UNDERSTANDING MEDICARE, MEDICAID & MEDICARE SUPPLEMENTS

Congress created Medicare and Medicaid in 1965 to provide health coverage to two fairly distinct groups of Americans: workers who reach age 65 (senior citizens) and certain groups of low-income people. While much has remained constant in Medicare and Medicaid in the past 40 years, both programs have evolved significantly. Collectively, they have come to play a major role in providing health care coverage and long-term services and supports for people of all ages with disabilities.

Medicare and Medicaid provide health coverage and long-term services and supports to roughly one-third of the estimated 53 million people with cognitive, developmental, physical, and/or mental disabilities in the United States. Generally, these are people with severe disabilities and extensive need for health and long-term services.

This course is not intended to provide a complete understanding of every aspect and complexity of the Medicare and Medicaid programs. Rather, it is intended to provide agents with the basics of Medicare and Medicaid and the insurance policies to supplement them.

Agents need to learn enough about these complex programs to understand and explain these programs to their clients as well as structuring private insurance products to coordinate with them to meet the needs of clients more effectively.

National Health Care Expenditures

Historical Overview

Health spending in the United States has grown rapidly over the past few decades. From $27 billion in 1960, it grew to $888 billion in 1993, increasing at an average rate of more than 11 percent annually. This strong growth boosted health care’s role in the overall economy, with health expenditures rising from 5.1 percent to 13.4 percent of the gross domestic product (GDP) between 1960 and 1993.

Between 1993 and 1999, however, strong growth trends in health care spending subsided. Over this period health spending rose at a 5-percent average annual rate to reach $1.2 trillion in 1999, and the share of GDP going to health care stabilized, with the 1999 share measured at 13.2 percent.

Between 2000 and 2002, growth picked up again, increasing 7.1 percent in 2000, 8.5 percent in 2001, and 9.3 percent in 2002, reaching $1.5 trillion in 2002. Health spending as a share of GDP increased sharply from 13.3 percent in 2000 to 14.9 percent in 2002, as strong growth in health spending outpaced economy-wide growth. For the 286 million people residing in the United States, the average expenditure for health care in 2002 was $5,440 per person.

Health care is funded through a variety of private payers and public programs. Privately funded health care includes individuals’ out-of-pocket expenditures, private health insurance, philanthropy, and non-patient revenues (such as revenue from gift shops and parking lots), as well as health services that are provided in industrial settings. For the years 1974-1992, these private funds paid for 57 to 60 percent of all health care costs. By 1996, however, the private
The share of health costs had declined to 54 percent of the country's total health care expenditures, due primarily to the falling share of out-of-pocket spending, and remained relatively stable at 54-55 percent between 1996 and 2002. The share of health care provided by public spending increased correspondingly during the 1992-1996 period, falling slightly during the period 1997-2002.

Public spending represents expenditures by Federal, State, and local governments. Of the publicly funded health care costs for the United States, each of the following accounts for a small percentage of the total: the Department of Defense health care program for military personnel, the Department of Veterans' Affairs health program, non-commercial medical research, payments for health care under Workers' Compensation programs, health programs under State-only general assistance programs, and the construction of public medical facilities. Other activities that are also publicly funded include maternal and child health services, school health programs, subsidies for public hospitals and clinics, Indian health care services, migrant health care services, substance abuse and mental health activities, and medically related vocational rehabilitation services. The largest shares of public health expenditures, however, are made by the programs run by the Centers for Medicare & Medicaid Services (CMS)—Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

Together, Medicare, Medicaid, and SCHIP financed $522 billion in health care services in 2002—one-third of the country's total health care bill and almost three-fourths of all public spending on health care. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements in the provision of health care services to our nation's aged, disabled, and disadvantaged.

Projected Expenditures

The latest update of the annual projections of national health spending consists of projections from 2003 through 2013. These projections are made using National Health Expenditure (NHE) historical data through 2002, which were released by CMS in January 2004. The Medicare and Medicaid projections and economic and demographic assumptions are based on the 2003 Medicare Trustees Report and the 2003 Old-Age and Survivors Insurance and Disability Insurance Trustees Report, updated with available information through November 2003. These projections were completed before the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) was signed into law.

National health expenditures are projected to reach $3.4 trillion in 2013, up from $1.6 trillion in 2002. From 2002 through 2013, health care spending is projected to grow at an average annual rate of 7.3 percent, roughly 2.2 percentage points faster than the GDP rate. As a percentage of GDP, national health spending is projected to reach 18.4 percent by 2013, up from 14.9 percent in 2002. After increasing 9.3 percent in 2002, NHE growth is projected to be 7.8 percent in 2003 and 7.2 percent in 2004, following 6 consecutive years of accelerating spending growth.

Private personal health care spending growth is expected to decelerate from 8.8 percent in 2002 to 7.2 percent in 2003, and to gradually fall to 6.7 percent in 2013.

Growth in private health insurance premiums per enrollee is projected to peak at 11.4 percent in 2002, after increasing 10.9 percent in 2001. Private health insurance benefits per enrollee are projected to slow in 2003 to 8.9 percent, from 10.1 percent in 2002.
Out-of-pocket (OOP) spending is expected to grow more rapidly over the projection period in comparison to the previous decade because of efforts by employers and insurers to share costs with employees. However, the growth rate of total health spending is still expected to be higher than the growth rate of OOP spending, causing the OOP share of total health expenditures to fall from 13.7 percent in 2002 to 13.0 percent in 2013.

Growth in spending on hospital care, the largest health care sector in 2002, rose sharply from 3.0 percent in 1998 to 9.5 percent in 2002, driven by higher labor costs and increased hospital leverage in pricing. Hospital spending growth is projected to slow to 6.5 percent in 2003 and to 6.2 percent in 2005, as both use and price are anticipated to grow less rapidly than they did in 2002.

Spending on prescription drugs--still the fastest growing sector, at 13.4 percent, in 2003--is expected to continue its recent deceleration, partly due to increasingly broad use of tiered co-payments and fewer drug introductions. By 2013, prescription drug spending is expected to account for 15.5 percent of total health expenditures, up from 10.5 percent in 2002.

Source: National Health Statistics Group in the Office of the Actuary (OACT), the Centers for Medicare & Medicaid Services (CMS).

OUT-OF-POCKET SPENDING ON HEALTH CARE BY MEDICARE BENEFICIARIES AGE 65 AND OLDER

The impacts of out-of-pocket health care costs—and prescription drug costs in particular—on the family budget have been a national concern for many years. In an effort to address these expenses, policymakers have added a prescription drug benefit to Medicare starting in 2006.

As prescription drugs make up only one component of out-of-pocket costs, Medicare cost-sharing, premiums, and the costs of other health care goods and services must also be considered to provide a comprehensive picture of beneficiaries’ out-of-pocket spending. The 2003 projections of out-of-pocket health care spending for non-institutionalized Medicare beneficiaries age 65 and older highlights the key role that prescription drugs play in beneficiaries’ overall health care costs, and illuminates other products and services that contribute—sometimes greatly—to beneficiaries’ spending. It also shows how beneficiaries’ out-of-pocket spending can vary by demographic characteristics, income, and supplemental insurance status.

Out-of-Pocket Spending on Health Care

- In 2003, non-institutionalized Medicare beneficiaries age 65 and older spent an average of $3,455,3 or 22 percent of their income, on health care.
- Almost half (45 percent) of beneficiaries’ total out-of-pocket health care expenses were for premiums for Medicare Part B, private Medicare plans (primarily HMOs), and private supplemental insurance (Figure 1).
Spending on prescription drugs averaged $830 (24 percent of out-of-pocket spending), making it the category of product or service with the largest spending.

- Part B Premiums 17%
- Private Premiums 28%
- Hospital Services 6%
- Physician/Supplier/Vision 12%
- Dental 7%
- Prescription Drugs 24%
- Nursing Facility* 6%

**Out-of-Pocket Spending and Demographic Characteristics**

**Age**

- Just over half (51 percent) of noninstitutionalized beneficiaries age 65 and older in 2003 were between 65 and 74 years old; an additional 12 percent of beneficiaries were age 85 and older.
- Average out-of-pocket spending on health care tends to increase with age. Indeed, beneficiaries age 65-74 spent the least out-of-pocket ($2,920), and beneficiaries age 85 and older spent the most ($4,615).
- Compared to other age groups, the youngest group of beneficiaries (i.e., age 65-74) also had the lowest out-of-pocket expenses as a percent of income (18 percent), while beneficiaries age 85 and older had the highest (30 percent).
Gender

- More than half of beneficiaries age 65 and older in 2003 were women (57 percent).
- Women spent, on average, about $400 more out-of-pocket on health care than men ($3,630 vs. $3,225).
- Women also spent more than men on health care as a percent of their income compared with men, who spent an average of 19 percent of their income, women spent 24 percent of their income.

Health Status

- Almost one-quarter of noninstitutionalized beneficiaries age 65 and older (23 percent) in 2003 reported their health to be fair or poor, and 44 percent rated their health as very good or excellent.
- Beneficiaries in fair or poor health faced the highest average out-of-pocket health care costs of the health status groups, both in dollars and as a percent of income ($4,000 and 29 percent of income).
- Beneficiaries with excellent health spent $2,845, or 16 percent of their income, on health care in 2003.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Out-of-Pocket Spending by Medicare Beneficiaries* by Select Characteristics, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent of Medicare Beneficiaries Age 65+ (N=34.7 million)</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>65-74 years</td>
<td>51%</td>
</tr>
<tr>
<td>75-84 years</td>
<td>37%</td>
</tr>
<tr>
<td>85+ years</td>
<td>12%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>43%</td>
</tr>
<tr>
<td>Women</td>
<td>57%</td>
</tr>
<tr>
<td>Health Status</td>
<td></td>
</tr>
<tr>
<td>Fair or Poor</td>
<td>22%</td>
</tr>
<tr>
<td>Good</td>
<td>33%</td>
</tr>
<tr>
<td>Very Good</td>
<td>28%</td>
</tr>
<tr>
<td>Excellent</td>
<td>16%</td>
</tr>
</tbody>
</table>

*Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP Public Policy Institute projections using the Medicare Benefit Model, v. 3.305.
Out-of-Pocket Spending and Income

In 2003, of the 34.6 million noninstitutionalized beneficiaries age 65 and older, 18 percent had income below 135 percent of poverty (Figure 2). More than one-quarter had incomes greater than 400 percent of poverty.

Out-of-pocket spending on health care tends to rise with income. Those with incomes above 400 percent of poverty spent an average of $3,785, the highest among the income categories presented, while those with incomes below 135 percent of poverty spent the least (Figure 3).

---

**Figure 2**
Distribution of Medicare Beneficiaries, by Income as a Percent of Federal Poverty Level, 2003

- 400+% of FPL, 28%
- <135% of FPL, 18%
- 135-200% of FPL, 17%
- 200-400% of FPL, 36%

*Non-institutionalized Medicare beneficiaries age 65 and older.
Note: In 2003, the federal poverty thresholds for persons age 65 and older were $8,825 (for individuals) and $11,122 (for couples).
Source: AARP PFI analysis using the Medicare Benefits Model, v. 5.306.

**Figure 3**
Average Out-of-Pocket Spending on Health Care by Medicare Beneficiaries, by Income as a Percent of Federal Poverty Level, 2003

<table>
<thead>
<tr>
<th>Percent of FPL</th>
<th>Average Out-of-Pocket Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;135%</td>
<td>$2,995</td>
</tr>
<tr>
<td>135-200%</td>
<td>$3,360</td>
</tr>
<tr>
<td>200-400%</td>
<td>$3,475</td>
</tr>
<tr>
<td>400+%</td>
<td>$3,785</td>
</tr>
</tbody>
</table>

*Non-institutionalized Medicare beneficiaries age 65 and older.
Note: In 2003, the federal poverty thresholds for persons age 65 and older were $8,825 (for individuals) and $11,122 (for couples).
Source: AARP PFI analysis using the Medicare Benefits Model, v. 5.306.
When examining out-of-pocket spending as a percent of income, the pattern reverses. Spending as a share of income is highest among those with the lowest income and lowest among those with the highest income. Beneficiaries with incomes below 135 percent of poverty spent an average of 33 percent of their income on health care, compared to beneficiaries with incomes above 400 percent of poverty, who spent 12 percent of their income on health care (Figure 4).

![Figure 4](image)

Average Out-of-Pocket Spending on Health Care as a Percent of Income by Medicare Beneficiaries, by Income as a Percent of Federal Poverty Level, 2003

- Percent of Income:
  - <135%: 33%
  - 135-200%: 28%
  - 200-400%: 21%
  - 400+: 12%

Note: In 2003, the federal poverty thresholds for persons age 65 and older were $8,825 (for individuals) and $11,122 (for couples).

Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

+Non-institutionalized Medicare beneficiaries age 65 and older.

Out-of-Pocket Spending and Supplemental Insurance

- In 2003, the vast majority of older noninstitutionalized Medicare beneficiaries had some type of supplemental insurance to pay for some of the health care costs not covered by Medicare.
- Two-thirds of Medicare beneficiaries had supplemental insurance through either an employer or an individually purchased Medigap policy in 2003, and 13 percent enrolled in a private Medicare plan (Figure 5).
- Thirteen percent of beneficiaries had some level of assistance from a state Medicaid program. Four percent were full-year “dual eligibles” who received full Medicaid benefits, four percent either received full-year assistance with premiums and cost-sharing only, and five percent either received full Medicaid benefits for part of the year or received only assistance with Medicare premiums.
- Beneficiaries with Medigap insurance had the highest out-of-pocket spending, averaging over $5,100 (Figure 6).
- Beneficiaries enrolled in a private Medicare plan had average out-of-pocket health care spending of $2,510.
- Beneficiaries with “Medicare only” (i.e., traditional Medicare with no supplemental coverage) had average spending of $2,560. Although their total out-of-pocket spending
was similar to those in private Medicare plans, beneficiaries with "Medicare only" spent a larger share of their out-of-pocket dollars on goods and services, particularly inpatient and outpatient hospital care and prescription drugs (not shown), and a smaller share on premiums. Those with Medicare only, by definition, did not pay supplemental insurance premiums.

- The $1,880 average out-of-pocket spending for beneficiaries with any Medicaid masks the range of spending levels within this supplemental coverage category. For example, those with full-year, full Medicaid coverage spent an average of $525, whereas those with part-year coverage or assistance with only Medicare premiums averaged $3,245 in 2003.

**Figure 5**

Distribution of Medicare Beneficiaries,* by Type of Supplemental Coverage, 2003

- Private Medicare Plan 13%
- Any Medicaid 13%
- Medicare Only 7%
- Other Public Plan 1%
- Medigap 27%
- Employer 39%

*Non-institutionalized Medicare beneficiaries age 65 and older.

Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

**Figure 6**

Average Out-of-Pocket Spending on Health Care by Medicare Beneficiaries,* by Type of Supplemental Coverage, 2003

- $1,880
- $2,510
- $2,325
- $5,130
- $3,300
- $2,560

*Non-institutionalized Medicare beneficiaries age 65 and older.

Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.
- Beneficiaries with supplemental coverage through Medigap in 2003 also had by far the highest out-of-pocket health care spending as a share of their income (32 percent) (Figure 7).
- Medicare beneficiaries with any Medicaid spent an average of 17 percent of income out-of-pocket on health care. However, within that category, those with full-year, full Medicaid benefits had the lowest spending as a share of income (6 percent) (not shown).
- Beneficiaries enrolled in a private Medicare plan spent an average of 17 percent of their income out-of-pocket on health care, which was comparable to those with employer-sponsored policies; those with Medicare only spent an average of 23 percent of income.

![Figure 7](image)

**Figure 7**

Average Out-of-Pocket Spending on Health Care as a Percent of Income by Medicare Beneficiaries, by Type of Supplemental Coverage, 2003

- Any Medicaid: 17%
- Private Medicare Plan: 17%
- Employer: 17%
- Medigap: 32%
- Other Public Plan: 27%
- Medicare Only: 23%

*Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP PFI analysis using the Medicare Beneficiary Model, v. 5.306.

Out-of-Pocket Spending and Supplemental Coverage for Prescription Drugs

- Beneficiaries spent $830, on average, on prescription drugs in 2003.
- The presence of prescription drug coverage greatly affected beneficiaries’ out-of-pocket spending on drugs.
- In 2003, about 69 percent of beneficiaries had some level of coverage for drugs during the year (Figure 8).
- Beneficiaries with some prescription drug coverage in 2003 spent an average of $670, compared with $1,190 for those who lacked any coverage (Figure 9).
Summary

In 2003, beneficiaries age 65 and older spent an average of $3,455 on health care, or 22 percent of their income. Almost half of those costs were for Medicare and private premiums and almost one-quarter were for prescription drugs. Furthermore, out-of-pocket spending levels can vary greatly by demographic characteristics, income, and supplemental insurance. For example, those with Medigap had the highest out-of-pocket spending of any supplemental coverage category, and those with low income were particularly vulnerable to high out-of-pocket spending as a share of their incomes.

These estimates reflect beneficiaries' burdens under current law and do not reflect program changes—especially the new Medicare drug benefit and associated low-income protections—that were included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Regardless of the level of assistance with prescription drug costs that beneficiaries may receive in 2006 (when the Medicare prescription drug benefit is implemented), out-of-pocket spending on health care in general will likely continue to account for a substantial share of many beneficiaries' incomes.
Out-of-Pocket Spending.

Out-of-pocket spending for Medicare Advantage enrollees, including premiums and cost-sharing, has nearly tripled since 1999, from $429 to $1,260 in 2003.

Prescription Drugs.

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Nearly one third (31%) of Medicare Advantage enrollees are in plans that do not provide drug coverage (up from 16% in 1999). During this same time period, average annual out-of-pocket drug costs for enrollees rose from $234 to $512.

Enrollees in plans with drug coverage faced restrictions on these benefits in 2003: 19% of enrollees had an annual cap of $750 or less, and 28% of enrollees were in plans that covered only generic drugs.
Medicare

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled," is commonly known as Medicare. Medicare is the federal health insurance program for almost all Americans age 65 and older and for many adults with permanent disabilities. Medicare is administered by the Centers for Medicare & Medicaid Services within the Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program. Knowing the basics about Medicare can help people make good decisions about health coverage and care. It is a source of health coverage for one in seven Americans.

When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2004, almost 42 million people are enrolled in one or both of Parts A and B of the Medicare program, about 5 million of whom have chosen to participate in a Medicare Advantage plan.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise not-covered aged persons who elect to pay a premium for Medicare coverage.

Health insurance coverage is important to people of all ages, but it is especially important for those with permanent disabilities and those with chronic health care diseases and conditions associated with aging. Health problems, medical needs, and health care expenses are major concerns – especially for the elderly and disabled persons covered by Medicare. For most people decisions about health insurance are often difficult because they affect the kind of care they get and their financial security and the Medicare system is fairly cumbersome and difficult to understand.

Medicare Health Plan Choices

Just like the choices working Americans have in getting their health care, Medicare provides choices to meet individual health care needs. The Medicare Modernization Act of 2003 brought more choices in how to get Medicare health care.

Medicare health plans provide different ways to get health care coverage in the Medicare program. The Medicare health plan chosen is very important because it affects many things like cost, benefits, doctor choice, convenience, and quality. Medicare health plan choices include:

The Original Medicare Plan

This is the traditional fee-for-service Medicare plan that is available nationwide. Participants can see any doctor or provider and no referrals are necessary. The Original Medicare Plan covers most health care services and supplies, but it doesn’t cover everything. For additional coverage, a Medigap (Medicare Supplement Insurance) policy can be purchased. These supplemental policies are the subject of a later section of this course.

Out-of-pocket Costs in the Original Medicare Plan depend on:

- Whether people have Part A and/or Part B (most people have both).
- Whether the doctor or supplier accepts “assignment”.
- How often they need health care.
- What type of health care they need.
- Whether they choose to get services or supplies not covered by Medicare.
- Whether they have other health insurance coverage.
- Whether they plan to travel abroad extensively. (In most cases, Medicare doesn’t pay for health care received while traveling outside of the United States.)

**Medicare Advantage Plans**

Medicare Advantage is the new name for Medicare + Choice. Medicare Advantage Plans are available in most areas of the country. People must have both Medicare Part A and Part B to join one of these plans. They may pay lower copayments and get extra benefits, however some plans may charge an additional premium and may have copayments or deductibles for some coverages.

**Medicare Advantage Plans include:**

- **Medicare Managed Care Plans (HMOs)**—Participants see doctors in the plan’s network. A primary doctor coordinates their health care. Referrals are required for most services and to see doctors out of the plan’s network.
- **Medicare Preferred Provider Organization Plans (PPOs)**—Participants can see any doctor, but it costs less to see doctors in the plan’s network. No referrals are necessary.
- **Medicare Private Fee-for-Service Plans**—Participants can see any doctor that accepts the plan’s payment. No referrals are necessary.
- **Medicare Specialty Plans**—A special type of plan that provides more focused health care for specific people.

Choices may be different for those are enrolled in Medicaid, employer or union coverage, veterans or military retiree benefits, or those who have End-Stage Renal Disease (permanent kidney failure).

Medicare Advantage Plans and the Original Medicare Plan are both part of the Medicare program. No matter how people get their health care coverage

- Medicare pays for most health care services and supplies, but it doesn’t pay for all health care costs.
- People get at least all the Medicare Part A-covered services.
- People get at least all the Medicare Part B-covered services if they pay the monthly Part B premium ($78.20 in 2005).

**Information to help make health care choices**

Choosing the right health care coverage is an important, but sometimes difficult, decision. Consumers can get personalized information two ways:

- Call 1-800-MEDICARE (1-800-633-4227) and a Customer Service Representative will help them with the “Medicare Personal Plan Finder.”
Things to consider when choosing a Medicare Plan

- **Cost**—What is paid out-of-pocket.
- **Benefits**—Extra benefits and services, like eye exams or hearing aids may be covered.
- **Doctor choice**—Can they see the doctor(s) they want to see? Do they need a referral to see a specialist?
- **Convenience**—Where are the doctors’ offices? What are their hours? Is there paperwork?
- **Quality of care**—All plans must meet quality standards. Medicare measures the quality of the care people get in many Medicare health plans.

**MEDICARE AND HOW IT IS STRUCTURED**

**Medicare Parts**

Medicare consists of several program components, or parts, and each provides different benefits and services. Medicare consists of Hospital Insurance (Part A) protection, Medical Insurance (Part B) protection, Medicare Advantage (Part C), and the Voluntary Prescription Drug Benefit Program (Part D).

<table>
<thead>
<tr>
<th>Medicare Consists of Multiple Parts</th>
<th>Mandatory or Voluntary</th>
<th>Type of Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>Mandatory</td>
<td>Hospital Insurance, including skilled nursing, some home health, and hospice services</td>
</tr>
<tr>
<td><strong>Hospital Insurance (Part A)</strong></td>
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<td></td>
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<tr>
<td>provides institutional care, including inpatient hospital care, skilled nursing home care, post-hospital home health care, and, under certain circumstances, hospice care. <strong>Part A</strong>, the Hospital Insurance program, paid for 46% of benefits in 2004. Part A is financed for the most part by a 1.45% Social Security payroll tax paid by employees and employers which are deposited in the Federal Hospital Insurance Trust Fund. Medicare beneficiaries also participate in the financing of Part A by paying deductibles, coinsurance and premiums.</td>
<td></td>
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</tr>
<tr>
<td>Part B</td>
<td>Voluntary</td>
<td>Physician and outpatient services, some home health care, durable medical equipment, and ambulance services</td>
</tr>
<tr>
<td><strong>Medical Insurance (Part B)</strong></td>
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</tr>
<tr>
<td>is a voluntary program of health insurance which covers physician's services, outpatient hospital care, physical therapy, ambulance trips, medical equipment, prosthesis, and a number of other services not covered under Part A. <strong>Part B</strong>, Supplementary Medical Insurance, accounted for over one-third of Medicare benefit spending in 2004. It is financed (25%) through monthly premiums paid by those who enroll ($78.20 in 2005) and (75%) contributions from the federal government. The government's share of the cost far exceeds that paid by those enrolled.</td>
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<tr>
<td>Part C</td>
<td>Voluntary</td>
<td>Alternative to receiving traditional Medicare. Beneficiaries enroll in a Medicare Advantage health plan</td>
</tr>
<tr>
<td><strong>Medicare Advantage (Part C)</strong></td>
<td></td>
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</tr>
<tr>
<td>permits contracts between the Centers for Medicare &amp; Medicaid</td>
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</table>
Services and a variety of different managed care and fee-for-service entities. The type of entities that may be granted contracts under Part C include:

- **Coordinated care plans**, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs). A PSO is defined as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk.

- **Private fee-for-service plans** which reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115% of the plan's payment schedule (which may be different from the Medicare fee schedule).

*Part C* refers to managed care plans that provide Part A and B benefits to enrollees, accounting for 14% of benefit spending in 2004. Formerly called “Medicare+Choice,” Part C has been renamed “Medicare Advantage.”

<table>
<thead>
<tr>
<th>Part D</th>
<th>Voluntary</th>
<th>Prescription drug benefit (beginning 01/01/2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare (Part D)</strong> refers to the new outpatient prescription drug benefit that will be implemented in 2006, enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The <strong>Voluntary Prescription Drug Benefit Program (Part D)</strong> provides for a drug discount cards through 2005 and a prescription drug benefit starting in 2006.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**(Part D)** will be financed through beneficiary premiums (25.5%) and general revenues (74.5%). Congressional Budget Office (CBO) estimates the average monthly Part D premium will be $35 in 2006, although premiums are expected to vary across plans.

**Medicare Benefit Payments by Type of Service**
Medicare helps to pay for a broad array of routine, acute, and preventive care; rehabilitation, mental health, and home health services; and durable medical equipment essential to the health and independence of such beneficiaries. However, Medicare’s coverage of long-term care is limited to post-acute care through its skilled nursing facility benefit and home health care benefit.

Accessing these services and supports is crucial to enabling millions to avoid far more costly hospitalization and long-term institutionalization. Without Medicare, millions of Americans—especially people with disabilities and chronic conditions—likely would be unable to obtain or afford any health insurance at all.

**WHO IS COVERED UNDER MEDICARE?**

Medicare covers a diverse population:

- 37% have incomes below 150% of the federal poverty level ($14,355/single; $19,245/couple in 2005).
- 29% say their health status is fair or poor.
- More than a third (36%) report needing assistance with at least one activity of daily living.
- 23% have cognitive impairments.
- A quarter (24%) live in rural areas.
MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003

Medicare has traditionally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B. A third part of Medicare, known as Part C, is the Medicare Advantage program, which was established as the Medicare+Choice program by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiaries’ options for health care plans.

The MMA also established a fourth part of Medicare: a new prescription drug benefit, also known as Part D, beginning in 2004.

The Medicare Modernization Act of 2003 is bringing many new and exciting changes to the Medicare program. These new changes will provide even more choices in health care benefits, including:

- Medicare-approved drug discount cards that started in 2004
- Preventive benefits starting in 2005
- Medicare prescription drug plans starting in 2006

Following is a brief discussion of these changes and new benefits. More detailed information is available throughout this course.

Prescription Drug Benefits

Beginning in 2006, people on Medicare will face additional choices when the new Medicare drug benefit takes effect. Agents need to help clients understand how the drug benefit works, how to choose a drug plan that meets their needs, and how to get additional help with drug costs if they are on a limited income.
**Medicare-approved drug discount card—Available 2004-2005**

**Medicare-Approved Drug Discount Cards** became available beginning in 2004 to help people save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare’s seal of approval can help save 10–25% on prescription drugs. Enrollment, which began in May 2004 and continues through December 31, 2005, is optional. Medicare will provide information with details about how to enroll.

**People in the greatest need will have the greatest help available to them.** Those with income in 2004 that is no more than $12,728.10 for a single person, or no more than $17,063.90 for a married couple, might qualify for a $600 credit on the discount card to help pay for prescription drugs. These income limits change every year and the limits for 2005 will be available soon. Different rules may apply in Puerto Rico or a U.S. territory. (People can’t qualify for the $600 if they already have drug coverage from Medicaid, TRICARE for Life or an employer group health plan.)

**Medicare prescription drug plans—Starting in 2006, enrollment starts in 2005**

Prescription drug benefits will be added to Medicare in 2006. All people with Medicare will be able to enroll in plans that cover prescription drugs. Plans might vary, but in general, this is how they will work:

- Participants will choose a prescription drug plan and pay a premium of about $35 a month.
- Participants will pay the first $250 (called a “deductible”).
- Medicare then will pay 75% of costs between $250 and $2,250 in drug spending. They will pay only 25% of these costs.
- Participants will pay 100% of the drug costs above $2,250 until you reach $3,600 in out-of-pocket spending.
- Medicare will pay about 95% of the costs after they have spent $3,600.

Some prescription drug plans may have additional options to help pay the out-of-pocket costs.

People with Medicare in the greatest need, who have incomes below a certain limit won’t have to pay the premiums or deductible for prescription drugs. The income limits will be set in 2005. Those who qualify will only pay a small co-payment for each prescription.

Other people with low incomes and limited assets will get help paying the premiums and deductible. The amount they pay for each prescription will be limited.

**New health plan choices**

- Medicare Advantage health plans—Available Now
- Regional Preferred Provider Organization plans—Starting in 2006

Medicare Advantage is the new name for Medicare + Choice plans. Medicare Advantage rules and payments are improved to provide more health plan choices and better benefits. All of these options are voluntary.
The Balanced Budget Act (BBA) of 1997 expanded the role of private plans under “Medicare+Choice” to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) renamed the program “Medicare Advantage” (MA) and created another option: regional PPOs.

Beneficiaries have historically had an option to enroll (as long as the plan is accepting new enrollees) and disenroll from a plan at any time during the year. Beginning in 2006, there will be a “lock in”: beneficiaries will be able to disenroll or change plans only once a year and only during a six-month period; shortened to a three-month period in later years.

Medicare Advantage plan choices will be expanded to include regional preferred provider organization plans (PPOs). Regional PPOs will help ensure that all people with Medicare have multiple choices for Medicare health coverage, no matter where they live. PPOs can help save money by choosing from doctors and providers on a plan’s “preferred” list, but usually don’t require a referral. PPOs are among the most common and popular plans right now for working Americans.

New Preventive Benefits—Available January 1, 2005

Starting on January 1, 2005, Medicare will begin covering some additional preventive services:

- Cardiovascular screening blood tests
- Diabetes screening tests
- “Welcome to Medicare” physical examination

These benefits add to the many preventive services that Medicare already covers, such as cancer screenings, bone mass measurements and vaccinations.

Other Upcoming Changes

Health Savings Accounts (HSA)

Starting immediately, Americans under age 65 will be able to set aside money each year, tax-free, in Health Savings Accounts. The savings accounts can be used to pay for medical expenses, and money not spent would stay in the account and gain interest tax-free, just like an Individual Retirement Account (IRA). For more information see our course on Health Savings Accounts.

Increased Part B Deductible

The Part B deductible, which has been set at $100 since 1991, increased to $110 in 2005 and will increase every year after that to keep up with the costs of Part B spending.

Changes in Part B Premium

The Part B premium is currently the same for all people on Medicare ($78.20 per month in 2005). Beginning in 2007, it will be higher for people with incomes over $80,000 single or $160,000 per couple.
MEDICARE ELIGIBILITY

Medicare Eligibility Basics

Medicare is a program for eligible workers and retirees. Persons are eligible for Medicare when they turn 65 if they (or their spouse) have worked and paid into the Social Security system. Persons are eligible for Medicare if they are a U.S. citizen or have been a permanent legal resident for five continuous years, and:

- Are 65 years or older and eligible to receive Social Security; or
- Are under 65, permanently disabled, and have received Social Security disability insurance payments for at least 2 years; or
- Get continuing dialysis for permanent kidney failure or need a kidney transplant; or
- Have Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease).

Spouses who are different ages won’t be able to go on Medicare at the same time. For example, if the husband turns 65 and becomes eligible for Medicare when the wife is 63, he can enroll in Medicare. She, however, will have to wait two years until age 65 to enroll.

Persons age 65 and over can receive Medicare benefits even if they continue to work. Enrollment in the program while working will not affect the amount of their future Social Security benefits. Even if the full retirement age for Social Security or Railroad Retirement benefits is older than age 65, eligibility for Medicare is still age 65.

A dependent or survivor of a person entitled to Hospital Insurance benefits (Part A), or a dependent of a person under age 65 who is entitled to retirement or disability benefits, is also eligible for Hospital Insurance benefits if the dependent or survivor is at least 65 years old. For example, a woman age 65 or over who is entitled to a spouse's or widow's Social Security benefit is eligible for benefits under Hospital Insurance.

Disabled Persons

A Social Security disability beneficiary is covered under Medicare after entitlement to disability benefits for 24 months or more. Those covered include disabled workers at any age, disabled widows and widowers age 50 or over, beneficiaries age 18 or older who receive benefits because of disability beginning before age 22, and disabled qualified railroad retirement annuitants.

These individuals, however, must wait for 29 months from the time the Social Security Administration determines they have a severe and permanent disability until they can begin to receive benefits. This period includes the 24 months that they must be receiving payments as well as the 5 month waiting period for those benefits to begin after they are determined to the permanent disabled by the government.

The Medicare law exempts two groups of nonelderly individuals from the waiting period: persons with amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease) and persons with end-stage renal disease (ESRD or kidney failure). These individuals qualify for Medicare coverage soon after they have been determined to have a permanent disability.
A person who becomes reentitled to disability benefits within five years after the end of a previous period of entitlement (within seven years in the case of disabled widows or widowers and disabled children) is automatically eligible for Medicare coverage without having to wait another 24 months. However, if the previous period of disability ends after March 1, 1988, a person is covered under Medicare without again having to meet the 24 month waiting period requirement, regardless of not meeting the five year (or seven year) requirement if the current impairment is the same as (or directly related to) that in the previous period of disability.

**End-Stage Renal Disease**

Insured workers (and their dependents) with end-stage renal disease who require renal dialysis or a kidney transplant are deemed disabled for Medicare coverage purposes even if they are working. Coverage can begin with the first day of the third month after the month dialysis treatments begin. This three-month waiting period is waived if the individual participates in a self-care dialysis training course during the waiting period. Coverage is provided under Medicare for the self-administration of erythropoietin for home renal dialysis patients.

Medicare coverage based on transplant begins with the month of the transplant or with either of the two preceding months if the patient was hospitalized during either of those months for procedures preliminary to transplant. If entitlement could be based on more than one of the factors the earliest date is used.

Medicare is the secondary payer during a period (generally 30 months) for individuals who have Medicare solely on the basis of their end-stage renal disease, if they have employer group health plan coverage themselves or through a family member. During this period, if an employer plan pays less than the provider's charges, then Medicare may supplement the plan's payments.

**Government Employees**

Federal employees who were not covered under Social Security (e.g., temporary workers have been covered since 1951) began paying the portion of Social Security tax that is creditable for Medicare Hospital Insurance (Part A) purposes in 1983. Those covered under Social Security pay the Hospital Insurance tax as well as the OASDI tax. A transitional provision provides credit for retroactive hospital quarters of coverage for federal employees who were employed before 1983 and also on January 1, 1983.

State and local government employees hired after March 31, 1986, are covered under Medicare coverage and tax provisions. A person who was performing substantial and regular service for a state or local government before April 1, 1986 is not covered provided he was a bona fide employee on March 31, 1986, and the employment relationship was not entered into in order to meet the requirements for exemptions from coverage. State or local government employees whose employment is terminated after March 31, 1986, are covered under Medicare, however, if they are later rehired.

Beginning after June 30, 1991, state and local government workers who are not covered by a retirement system in conjunction with their employment, and who are not already subject to the Medicare Hospital Insurance tax, are also automatically covered and must pay such taxes. A retirement system is defined as a pension, annuity, retirement, or similar fund or system established by a state or by a political subdivision of a state.
Individuals are not automatically covered under Medicare if employed by a state or local government:

1. to relieve them of unemployment;
2. in a hospital, home, or institution where they are inmates or patients;
3. on a temporary basis because of an emergency such as a storm, earthquake, flood, fire or snow;
4. if the individuals qualify as interns, student nurses or other student employees of District of Columbia government hospitals, unless the individuals are medical or dental interns or medical or dental residents in training.

State governments may voluntarily enter into agreements to extend Medicare coverage to employees not covered under the rules above.

**Eligibility for benefits under Part B Medical Insurance**

All persons entitled to premium-free Hospital Insurance (Part A) or premium Hospital Insurance (Part A) for the working disabled under Medicare may enroll in Medical Insurance (Part B). Social Security and Railroad Retirement beneficiaries, age 65 or over, are, therefore, automatically eligible. However, any other person age 65 or over may enroll provided only that he or she is a resident of the United States and is either: (1) a citizen of the United States, or (2) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the five years immediately prior to the month in which he or she applies for enrollment.

Disabled beneficiaries (workers under age 65, widows aged 50-64, and children aged 18 or over disabled before age 22) who have been on disability benefits for at least two years are covered in the same manner as persons age 65 or over. This includes disabled railroad retirement beneficiaries.

Ninety-five percent of Part A beneficiaries voluntarily enroll in Part B. Persons who are still working at age 65, and believe they may not need Part B because they have health coverage under an employer plan, should check with their local Social Security office before declining Part B to be sure they will not have to pay a penalty for late enrollment if they lose their employer coverage. Individuals may elect to delay Part B enrollment at age 65 if they are still working for a company with 20 or more employees and they have health coverage under an employer plan. They will then avoid duplicating Part B coverage and paying the Part B monthly premium. Such persons will not incur any premium penalties for waiting to enroll in Part B, as long as they do so before they lose coverage under their employer plan or within eight months after losing their employer coverage.

**Minors can receive Medicare**

Dependent minor children of Social Security beneficiaries (including legally adopted children and dependent step children or grandchildren) are eligible for dependent benefits when a parent starts receiving Social Security benefits. If the parent dies, children can continue receiving benefits (called survivor benefits). Dependent and survivor benefits are provided to all dependent children, without regard to whether or not the children have disabilities. Social Security benefits for dependent children normally stop when a child reaches age 18 (or 19 if the child is a full-time student).
These benefits can continue to be paid into adulthood, however, if the child is disabled. To qualify for these benefits, an individual must be eligible as the child of someone who is getting Social Security retirement or disability benefits (or Medicare), or the child of someone who has died, and that child must have a disability that began before age 22.

Because such children are nonelderly, however, the Medicare waiting period applies. Medicare eligibility rules for persons under age 65 with disabilities require individuals to be totally and permanently disabled according to the government’s strict rules for five months before becoming eligible for Social Security disability benefits. Once they have received Social Security disability for 24 months Medicare coverage can begin. Therefore, the earliest age that such a young adult can start to be covered by Medicare is 20.

In very limited circumstances, minors are eligible to enroll in Medicare at any time in their youth if they have end stage renal disease (ESRD) and are not subject to the waiting period.

The process for applying for Medicare for people under age 65 with disabilities

The first step in establishing eligibility for Medicare for persons under age 65 is to apply for and receive Social Security Disability Insurance (SSDI). To do this, an individual should go to their nearest Social Security field office.

SSDI provides monthly cash payments for individuals whose disabilities prevent them from working. Payments are based on the worker’s contributions to Social Security through payroll tax deductions.

People under age 65 must be certified to be disabled for five months before receiving SSDI payments. An individual becomes eligible for Medicare only after he or she has received SSDI for 24 months. Therefore, an individual must wait 29 months from first being determined to be disabled until he or she qualifies for Medicare.

Social Security pays only for total disability. No benefits are payable for partial or short-term disability. For an adult to be considered disabled, the SSA must determine that the individual cannot engage in any “substantial gainful activity” because of a physical or mental impairment that is expected to result in death or to continue for at least 12 months. Since children do not work, there is a modified disability standard for children.

Not all physical and mental impairments meet the standard of disability. For example, drug addiction and alcoholism are not qualifying conditions. Further, people with certain disabling conditions only meet the criteria once the conditions are in an advanced stage. For example, persons with HIV generally do not qualify until they have advanced HIV/AIDS. The same is true for persons with multiple sclerosis and other progressively disabling conditions.

Individuals can apply for SSDI in one of three ways:

- Complete an application online at www.ssa.gov/applyforbenefits/.
- Call SSA on its toll-free telephone number, 1-800-772-1213. Persons who are deaf or hard of hearing, can call TTY 1-800-325-0778.
- Call or visit the local Social Security office.

Necessary Information to Apply for SSDI and Medicare
To make the application process go as smoothly and as quickly as possible, people applying for SSDI and Medicare should gather as much of the information and medical documentation as they can before they begin the application process.

- Their Social Security number and proof of age
- Names, addresses, and phone numbers of doctors, hospitals, clinics, and institutions that have treated the individual and the dates of treatment
- Names of all medications they are taking
- Medical records from doctors, therapists, hospitals, clinics, and caseworkers
- Laboratory and test results
- A summary of where they worked and the kind of work they did
- The most recent W-2 form, or their tax return if self-employed

Information about Family Members:
- Social Security numbers and proof of age for each person applying for benefits
- Dates of prior marriages if the spouse is applying

Persons will need to submit original documents or copies certified by the issuing office. They can mail or bring them to the Social Security office which will make photocopies and return the original documents to them. If they don't have all the documents needed. Social Security will help them get the information they need.

Work Incentives for Disabled People

Under certain conditions a person with a disability on Medicare and/or Medicaid can be employed. Until fairly recently, federal law has made it extremely difficult for individuals with disabilities to be employed and still retain vital Medicare- or Medicaid-funded benefits that often make work possible. To correct this, Congress has added several "work incentives" to the Social Security Act that enables beneficiaries to:

- Receive education, training and rehabilitation to start a new line of work;
- Keep some or all SSDI or SSI cash benefits while working;
- Obtain or retain vital Medicaid coverage while working; and,
- Retain existing Medicare coverage while working.

Social Security evaluates the work activity of persons claiming or receiving disability benefits under Social Security Disability Insurance. In 2005, a Social Security Disability beneficiary can earn $830 per month and remain eligible for benefits ($1,380/month for persons who are blind). SSA uses the term “substantial gainful activity” (SGA) to determine if work is substantial enough to make a person ineligible for benefits. Under the new rule, monthly SGA earnings limits are automatically adjusted annually based on increases in the national average wage index. This amount applies to people with disabilities other than blindness.

For more information on how these incentives can enable beneficiaries to work:

- For information on SSDI and SSI work incentives as well as health coverage options refer to the Social Security Administration’s 2004 Red Book, available online at http://www.ssa.gov/work/ResourcesToolkit/redbook.html.
Call the Social Security Administration at 1-800-772-1213, or for the hearing impaired, 1-800-325-0778 (TTY/TTD).

**Medicare Enrollment**

This section provides an introduction to Medicare enrollment. For more detailed information see Medicare Part B later in this course. All citizens (and certain legal aliens) age 65 or over, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B. In 2003, Part B provided protection against the costs of physician and other medical services to about 38 million people (33 million aged and 5 million disabled). Part B benefits totaled $123.8 billion in 2003.

Those who are already receiving Social Security benefits when they turn 65, will automatically be enrolled in both Parts A and B of Medicare, effective on the first day of the month that they turn 65. A Medicare card will arrive in the mail about three months before they birthday. The Part B premium will be deducted from their Social Security check each month. They can choose to decline Part B coverage, but should take it in order to have full Medicare benefits and avoid paying a Part B premium penalty later on (unless they have health care coverage through their (or their spouse’s) current employer).

Those who are not receiving Social Security benefits when they turn 65, must apply for Medicare and will not be enrolled automatically. They may apply at any Social Security office during the initial enrollment period, which begins three months before turning 65 and ends three months after their 65th birthday. Those who do not enroll in Medicare during the initial enrollment period, must enroll during a general enrollment period, which is January 1st through March 31st of every year. Coverage will begin on July 1st of the year they sign up. After the initial enrollment period, they may have to pay a penalty for each year they delayed enrollment. This penalty will be added permanently to the Part B premium.

Those still working when they turn 65, who have health coverage through an employer, may be able to delay enrolling in Part B without paying a late enrollment penalty. This will allow them to avoid duplicating Part B coverage and paying the Part B monthly premium. To avoid a late enrollment penalty they must enroll in Part B within 8 months of the time that they or their spouse stop working or lose the employer-sponsored health insurance, (Special Enrollment Period). Coverage will begin the month after they enroll. Persons should check with their local Social Security office before declining Part B to be sure they will not have to pay a penalty for late enrollment.

Those who have continuation health care coverage from a former employer, sometimes called COBRA, should still enroll in Medicare Parts A and B during the initial enrollment period. Health insurance under COBRA typically ends as soon as they are eligible for Medicare.
Original Medicare Plan

The Original Medicare Plan has two parts:

### Medicare Part A
(Hospital Insurance)

**What it covers:** Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not unskilled or long-term care). It also covers hospice care and some home health care. They must meet certain conditions to get these benefits.

**What patients pay:** Most people don’t have to pay a monthly payment, called a premium, for Medicare Part A. This is because they or a spouse paid Medicare taxes while they were working.

They also pay a Part A deductible as well as copayments. (See details below)

### Medicare Part B
(Medical Insurance)

**What it covers:** Medicare Part B helps cover doctor’s services, outpatient hospital care, and some other medical services that Medicare Part A doesn’t cover, such as some of the services of physical and occupational therapists, and some home health care. Medicare Part B helps pay for these covered services and supplies when they are medically necessary. It also covers some preventive services.

**What patients pay:** Most people pay the monthly premium of $78.20 (in 2005) for Medicare Part B. However, the cost will go up 10% for each full 12-month period that they could have had Part B but didn’t sign up for it, except in special cases. They usually have to pay this amount as long as they have Part B.

They also pay a Part B deductible each year before Medicare starts to pay its share.

### BENEFITS AND PREMIUMS

#### Summary of Benefits for Traditional Medicare, 2005

<table>
<thead>
<tr>
<th>Part A Benefit</th>
<th>Beneficiary Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Days 1-60</td>
<td>A total of $912 deductible</td>
</tr>
<tr>
<td>Days 61-90</td>
<td>$228/day</td>
</tr>
<tr>
<td>Days 91-150</td>
<td>$456/day</td>
</tr>
<tr>
<td>Days 150+</td>
<td>All costs</td>
</tr>
<tr>
<td><strong>Skilled nursing facility</strong></td>
<td></td>
</tr>
<tr>
<td>Days 1-20</td>
<td>No coinsurance</td>
</tr>
<tr>
<td>Days 21-100</td>
<td>$114/day</td>
</tr>
<tr>
<td>Days 101+</td>
<td>All costs</td>
</tr>
<tr>
<td><strong>Home health</strong></td>
<td>No coinsurance, but pays 20% of Medicare-approved amount for durable medical equipment</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>Up to $5 for outpatient prescription drugs and 5% of Medicare-approved amount for inpatient respite care</td>
</tr>
</tbody>
</table>

**Part B**

<table>
<thead>
<tr>
<th>Benefit</th>
<th><strong>Beneficiary Pays</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$110/year</td>
</tr>
<tr>
<td><strong>Physician and other medical services</strong></td>
<td></td>
</tr>
<tr>
<td>MD accepts assignment</td>
<td>*20% of Medicare-approved amount</td>
</tr>
<tr>
<td>MD does not accept assignment</td>
<td>20% of Medicare-approved amount + (up to) 15% over Medicare amount</td>
</tr>
<tr>
<td><strong>Outpatient hospital care</strong></td>
<td>Coinsurance that varies by service</td>
</tr>
<tr>
<td><strong>Ambulatory surgical services</strong></td>
<td>20% of Medicare-approved amount</td>
</tr>
<tr>
<td><strong>X-rays; durable medical equipment</strong></td>
<td>20% of Medicare-approved amount</td>
</tr>
<tr>
<td><strong>Physical, speech, and occupational therapy</strong></td>
<td>20% of Medicare-approved amount for services in hospital outpatient facilities. In other settings, there is a $1,590 coverage limit for occupational therapy and for physical and speech-language therapy services combined</td>
</tr>
<tr>
<td><strong>Clinical diagnostic laboratory services</strong></td>
<td>No coinsurance</td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td>No coinsurance, but pays 20% of Medicare-approved amount for durable medical equipment</td>
</tr>
<tr>
<td><strong>Outpatient mental health services</strong></td>
<td>50% of Medicare-approved amount</td>
</tr>
<tr>
<td><strong>Preventive services</strong></td>
<td>20% of Medicare-approved amount and no coinsurance for certain services, including flu and pneumococcal vaccinations</td>
</tr>
<tr>
<td><strong>Bone mass measurement, diabetes monitoring, glaucoma screening</strong></td>
<td>20% of Medicare-approved amount</td>
</tr>
</tbody>
</table>


* assignment—provider agrees to accept the Medicare-approved amount as payment in full for the good or service.
Part A - HOSPITAL INSURANCE

All Medicare beneficiaries participate in the Part A program. Medicare Part A pays for hospital expenses, including hospitalizations in specialty psychiatric hospitals. Medicare Part A also pays for up to 100 days in a skilled nursing facility and for skilled home health services. For persons with a life expectancy of six months or less, it pays for hospice services.

Part A Hospital Insurance is a compulsory program

Every person who works in employment or self-employment covered by the Social Security Act, or in employment covered by the Railroad Retirement Act, must pay the Hospital Insurance tax and will be eligible for Hospital Insurance benefits if fully insured when he reaches age 65, receives disability benefits for more than 24 months, or has end-stage renal disease.

Part A Eligibility

Most persons who reached age 65 before 1968 are eligible to enroll for Hospital Insurance without paying premiums even if they have no coverage under Social Security. Also eligible for enrollment under this transitional provision are persons age 65 and over with specified amounts of earnings credits less than that required for cash benefit eligibility.

Not eligible under the transitional provision are:

- retired federal employees covered by the Federal Employees' Health Benefits Act of 1959,
- non-residents of the United States, and
- aliens admitted for permanent residence (unless lawfully admitted for permanent residence in the United States continuously during the five years immediately preceding the month in which they apply for enrollment).

Part A Hospital Insurance Premium

Most people don’t pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Most persons age 65 or over who are citizens or permanent residents and otherwise ineligible for Hospital Insurance may enroll voluntarily and pay a monthly premium, provided the individual:

- has attained age 65,
- is enrolled in Part B Medical Insurance
- is a resident of the United States and is either:
  - a citizen, or
  - an alien lawfully admitted for permanent residence who has resided in the United States continuously during the five years immediately preceding the month in which he applies for enrollment, and
- is not otherwise entitled to Hospital Insurance benefits.
However, they must pay a monthly premium for Part A benefits ($206/month for persons with 30–39 quarters of coverage, and $375/month for persons with less than 30 quarters of coverage, in 2005). The reduction in premium payments will also apply to the surviving spouse or divorced spouse of an individual who had at least 30 quarters of coverage under Social Security.

Disabled individuals under age 65 may also be able to obtain Hospital Insurance coverage through monthly premiums. Eligibility is extended to individuals under age 65 who qualify for Hospital Insurance benefits on the basis of a disabling physical or mental impairment, but who have earnings that exceed the eligibility limit for Social Security disability benefits and are not otherwise entitled to Hospital Insurance benefits.

The premium for an individual who enrolls after the close of the initial enrollment period or who reenrolls is increased by 10% if there were at least 12 months of delayed enrollment, regardless of how late the individual enrolls. The initial enrollment period starts the first day of the third month prior to eligibility and ends seven months later. The increased-premium paying period is limited to twice the number of years an individual delayed enrolling. The premium then reverts to the standard monthly premium in effect at that time.

Certain state and local government retirees are no longer required to pay the premium to receive Hospital Insurance benefits.

**Medicare Card**

The Medicare Card will usually arrive in the mail about three months prior to their 65th birthday. The card will indicate whether they have Part A, Part B, or both.

![Medicare Card Sample](image)

*Participants can replace a Medicare card,* or order a new Medicare card, at www.socialsecurity.gov on the web. Or, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. Or the Railroad Retirement Board, call the local RRB office or 1-800-808-0772, or look at www.rrb.gov on the web.

**How Hospital Insurance is financed**

Part A is financed by a separate Hospital Insurance tax imposed upon employers, employees, and the self-employed. The tax must be paid by every individual, regardless of age, who is subject to the regular Social Security tax or to the Railroad Retirement tax. It must also be paid
by all federal employees and by all state and local government employees: (1) hired after March 1986, or (2) not covered by a state retirement system in conjunction with their employment.

The tax is imposed upon all earnings. The rates of the Hospital Insurance Tax are 1.45% each for employees and employers, and 2.90% for the self-employed. (2005 rates)

There is a special federal (and generally following through to state) income tax deduction of 50% of the OASDI/Hospital Insurance self-employment tax. This income tax deduction, which is taken directly against an individual's gross income to determine adjusted gross income, is designed to treat the self-employed in much the same manner as employees and employers are treated for Social Security and income tax purposes.

**Benefits provided under Part A Hospital Insurance**

In addition to hospital inpatient care, Part A covers some skilled nursing facility (SNF), home health, and hospice care. For those entitled to Part A, there is no monthly or annual premium charge, but there is a charge for most health care services. Also specific requirements must be met before receiving coverage for some services, such as home health care, skilled nursing facility care, and hospice care.

Over and above the "deductibles" and "coinsurance" amounts which must be paid by the patient, Medicare Part A (Hospital Insurance) helps cover medically necessary:

**Inpatient Hospital Services Paid for Under Part A**

Except for the deductible amount that must be paid by the patient, Medicare helps pay for inpatient hospital services for up to 90 days in each "benefit period." Medicare will also pay (except for a coinsurance amount) for 60 additional hospital days over each person's lifetime.

Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in the room. It also doesn't include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

Medicare pays for hospital care if the patient meets the following four conditions:

- a doctor prescribes inpatient hospital care for treatment of the illness or injury,
- the patient requires the kind of care that can only be provided in a hospital,
- the hospital is participating in Medicare, and
- the Utilization Review Committee of the hospital, a Quality Improvement Organization (QIO), or an intermediary does not disapprove of the stay.

**For each benefit period the individual pays (2005):**

- A total of $912 for a hospital stay of 1–60 days
- $228 per day for days 61–90 of a hospital stay (1/4 of the deductible)
- $456 per day for days 91–150 of a hospital stay (1-2 of the deductible)
- All costs for each day beyond 150 days
The coinsurance amounts are based on those in effect when services are furnished, rather than on those in effect at the beginning of the beneficiary's spell of illness (benefit period).

**Services Covered:**

- **Bed and board in a semi-private room** (two to four beds) or a ward (five or more beds). Hospital Insurance will pay the cost of a private room only if it is required for medical reasons. If the patient requests a private room, Hospital Insurance will pay the cost of semi-private accommodations; the patient must pay the extra charge for the private room.
- **All meals**, including special diets.
- **Nursing services** provided by or under the supervision of licensed nursing personnel (other than the services of a private duty nurse or attendant).
- Services of the hospital's medical **social workers**.
- Use of **regular hospital equipment**, supplies and appliances, such as oxygen tents, wheel chairs, crutches, casts, surgical dressings, and splints.
- **Drugs and biologicals** ordinarily furnished by the hospital. A limited supply of drugs needed for use outside the hospital is also covered, but only if medically necessary in order to facilitate the patient's departure from the hospital and the supply is necessary until the patient can obtain a continuing supply.
- **Diagnostic or therapeutic items and services** ordinarily furnished by the hospital or by others (including clinical psychologists, as defined by the Centers for Medicare & Medicaid Services), under arrangements made with the hospital.
- **Operating and recovery room** costs, including hospital costs for anesthesia services.
- Services of **interns and residents in training** under an approved teaching program.
- **Blood transfusions**, after the first three pints. Hospital Insurance helps pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If the patient receives blood as an inpatient of a hospital or skilled nursing facility, Hospital Insurance will pay for these blood costs, except for any nonreplacement fees charged for the first three pints of whole blood or units of packed red cells per calendar year. The nonreplacement fee is the amount that some hospitals and skilled nursing facilities charge for blood that is not replaced.
- **X-rays** and other radiology services, including radiation therapy, billed by the hospital.
- **Lab tests**.
- **Respiratory or inhalation therapy**.
- **Independent clinical laboratory services** under arrangement with the hospital.
- **Alcohol detoxification and rehabilitative services** when furnished as inpatient hospital services.
- **Dental services** when the patient requires hospitalization because of the severity of the dental procedure or because of his underlying medical condition and clinical status.
- Cost of **special care units**, such as an intensive care unit, coronary care unit, etc.
- **Rehabilitation services**, such as physical therapy, occupational therapy, and speech pathology services.
- **Appliances** (such as pacemakers, colostomy fittings, and artificial limbs) that are permanently installed while in the hospital.
- **Lung and heart-lung transplants**.
Hospital Insurance does not pay for:

- **Services of physicians and surgeons**, including the services of pathologists, radiologists, anesthesiologists, and psychiatrists. (Nor does Hospital Insurance pay for the services of a physician, resident physician or intern—except those provided by an intern or resident in training under an approved teaching program.)

- **Services of a private duty nurse or attendant**, unless the patient's condition requires such services and the nurse or attendant is a bona fide employee of the hospital.

- **Personal convenience items supplied at the patient's request**, such as television rental, radio rental, or telephone.

- **The first three pints of whole blood (or packed red blood cells)** received in a calendar year.

- **Supplies, appliances and equipment for use outside the hospital**, unless continued use is required (e.g., a pacemaker).

Medicare beneficiaries have the right to receive the hospital care necessary for the proper diagnosis and treatment of their illness or injury. A beneficiary's discharge date must be determined solely by his medical needs. Beneficiaries have the right to be fully informed about decisions affecting their Medicare coverage and payment for their hospital stay and any post-hospital services. They also have the right to request a review by a Quality Improvement Organization (QIO) of any written notice of noncoverage they receive from the hospital. QIOs are groups of doctors who are paid by the federal government to review medical necessity, appropriateness, and quality of hospital treatment furnished to Medicare patients.

**Inpatient Hospital Benefits for Care in a Psychiatric Hospital**

Benefits for psychiatric hospital care are subject to a lifetime limit of 190 days. Furthermore, if the patient is already in a mental hospital when he becomes eligible for Medicare, the time he has spent there in the 150-day period before becoming eligible will be counted against the maximum of 150 days available in such cases (including any later period of such hospitalization when he has not been out of a mental hospital for at least 60 consecutive days between hospitalizations). However, this latter limitation does not apply to inpatient service in a general hospital for other than psychiatric care.

**Special Provisions for Care in a Religious Nonmedical Health Care Institution**

Benefits are payable for services provided by certain religious nonmedical health care institutions. In general, these institutions may participate in the plan as a hospital and the regular coverages and exclusions relating to inpatient hospital care apply. Thus, in 2005, the patient pays a $912 deductible for the first 60 days, and coinsurance of $228 a day for the next 30 days (plus $456 a day for the 60 lifetime reserve days). A religious nonmedical health care institution may also be paid as a skilled nursing facility. However, extended care benefits will be paid for only 30 days in a benefit period (instead of the usual 100 days), and the patient must pay the coinsurance amount ($114 a day) for each day of service (instead of only for each day after the 20th day).

**Doctor Certification for Hospitalization is Required**
Initial certification is not required except for inpatient psychiatric hospital services and inpatient tuberculosis hospital services. For prolonged hospital stays, however, certification by a doctor may be required.

**Hospital or Health Maintenance Organization Qualification for Medicare Payments**

The hospital of HMO must meet certain standards and must enter into a Medicare agreement with the federal government. However, provision is made for paying nonparticipating hospitals in cases of emergency. Medicare also may pay for partial hospitalization services if the doctor certifies that it will avoid more costly inpatient treatment in a hospital.

**Skilled Nursing Facility (SNF) Care under Part A**

The Medicare SNF benefit will pay for short-term skilled care that is required to recover from being hospitalized for an illness or injury. The SNF benefit may reduce the time someone is hospitalized after an illness, injury, or surgery by providing skilled care in a less expensive post acute care setting.

Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 3-day hospital stay).

For each benefit period the individual pays (2005):

- Nothing for the first 20 days
- Up to $114 per day for days 21–100 (1/8 of the deductible)
- All costs beyond the 100th day in the benefit period

A 100-day stay during 2005 will cost the patient $9,120

For questions about SNF care and conditions of coverage, call the Fiscal Intermediary.**

**Services Covered**

Except for a coinsurance amount payable by the patient after the first 20 days, Part A Hospital Insurance will pay the reasonable cost of post-hospital care in a skilled nursing facility for up to 100 days in a benefit period. The following items and services are covered:

- Bed and board in a semi-private room (two to four beds in a room), unless the patient's condition requires isolation or no semi-private rooms are available.
- Nursing care provided by, or under the supervision of, a registered nurse (but not private-duty nursing).
- Drugs, biologicals, supplies (such as splints and casts), appliances (such as wheelchairs), and equipment for use in the facility.
- Medical social services.
- Medical services of interns and residents in training under an approved teaching program of a hospital.
- Other diagnostic or therapeutic services provided by a hospital with which the facility has a transfer agreement.
- Rehabilitation services, such as physical, occupational, and speech therapy.
- All meals, including special diets furnished by the facility.
• Blood transfusions.
• Such other health services as are generally provided by a skilled nursing facility.

There is no lifetime limit on the amount of skilled nursing facility care provided under Hospital Insurance. Except for the coinsurance (which must be paid after the first 20 days in each spell of illness), the plan will pay the cost of 100 days post-hospital care in each benefit period, regardless of how many benefit periods the person may have. After 100 days of coverage, the patient must pay the full cost of skilled nursing facility care.

Eligibility for Care

In order to qualify for skilled nursing facility benefits, the patient must meet all five of the following conditions:

1. The patient's condition requires daily skilled nursing or skilled rehabilitative services, which, as a practical matter, can only be provided in a skilled nursing facility.
2. The patient has been in a hospital at least three days in a row (not counting the day of discharge) before being admitted to a participating skilled nursing facility.
3. The patient is admitted to the skilled nursing facility within a short time (generally within 30 days) after leaving the hospital.
4. The patient's care in the skilled nursing facility is for a condition that was treated in the hospital, or for a condition that arose while receiving care in the skilled nursing facility for a condition which was treated in the hospital.
5. A medical professional certifies that the patient needs, and receives, skilled nursing or skilled rehabilitative services on a daily basis.

Skilled nursing facility coverage is permitted without regard to the three-day prior hospital stay requirement if there is no increase in cost to the program involved, and the acute care nature of the benefit is not altered. Persons covered without a prior hospital stay may be subject to limitations in the scope of or extent of services. The Department of Health and Human Services will decide when to lift the three-day hospital stay requirement.

If a patient leaves a skilled nursing facility and is readmitted within 30 days, the patient does not need to have a new three-day stay in a hospital for care to be covered, however they reserve the coverage left in their current benefit period. For example if they had already spent 18 days in the SNF they would only be entitled to two additional days without a co-payment (total of 20 days). From the 3rd day on they would have to pay a daily co-payment.

Medicare also pays for medical social work and discharge planning services that can help an individual make the necessary arrangements for leaving a SNF once he or she is able to do so. This can include helping the person find, apply for, and schedule services and supports needed to move out of the facility and live in the community. A medical social worker and discharge planner also can help a person leaving a SNF to arrange for ramps, grab bars, and other needed modifications to make his or her home or apartment accessible and livable and to find a new, accessible home or apartment to move into after leaving the SNF.

People who are in the hospital, when told that they will be discharged from the hospital, can ask to speak to a discharge planner or social worker to arrange for an evaluation by a home health agency (HHA). Their doctor may be able to initiate this process for them.
Nursing Home vs. Skilled Nursing Facility

Many residents of nursing homes will not qualify for Medicare coverage because coverage is restricted to patients in need of skilled nursing and rehabilitative services on a daily basis. Most nursing homes are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare. Medicare does not pay for custodial care when it is the only kind of care needed. Custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. That type of care may be paid for by the patient out-of-pocket, by long-term care insurance or by Medicaid for those who qualify.

A skilled nursing facility is a specially qualified facility that specializes in skilled care. It has the staff and equipment to provide skilled nursing care or skilled rehabilitative services and other related health services. An institution which is primarily for the care and treatment of mental diseases or tuberculosis is not a skilled nursing facility.

A skilled nursing facility may be a skilled nursing home, or a distinct part of another institution, such as a ward or wing of a hospital, or a section of a facility which is an old-age home. Not all nursing homes will qualify; those which offer only custodial care are excluded. The facility must be primarily engaged in providing skilled nursing care or rehabilitation services for injured, disabled or sick persons. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitative services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

At least one registered nurse must be employed full-time and adequate nursing service (which may include practical (or vocational) nurses) must be provided at all times. Every patient must be under the supervision of a doctor, and a doctor must always be available for emergency care. Generally, the facility must be certified by the state and must also have a written agreement with a hospital that is participating in the Medicare program for the transfer of patients.

Skilled Home Health Services under Part A

Part A Hospital Insurance covers the cost of 100 home health visits made on an "intermittent" basis during a home health spell of illness under a plan of treatment established by a physician. Coverage includes only home health visits following a hospital or skilled nursing facility stay. Some coverage for home health visits is provided under Part B.

Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

The individual pays:

- Nothing for Medicare-approved services.
- 20% of the Medicare-approved amount for durable medical equipment.

For questions about home health care and conditions of coverage, call the Regional Home Health Intermediary.**
The patient pays nothing for the first 100 home health visits. Medicare pays the full approved cost of all covered home health visits. The patient may be charged only for any services or costs that Medicare does not cover. However, if the patient needs durable medical equipment, the patient is responsible for a 20% coinsurance payment for the equipment. Durable medical equipment includes iron lungs, oxygen tents, hospital beds and wheelchairs. The home health agency will submit claims for payment. The patient does not send in any bills.

Both Part A Hospital Insurance and Part B Medical Insurance cover home health visits. The BBA of 1997 transferred from Part A to Part B those home health services furnished on or after January 1, 1998 that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Part A and Part B has no co-payment and no deductible.

**Services Covered**

Under such a plan of care, a beneficiary can receive both skilled care and a limited number of home health aide visits each week. Home health aides can assist a person with such tasks as bathing, dressing, using the bathroom, and eating.

Home health aids, whether employed directly by a home health agency or made available through contract with another entity, must successfully complete a training and competency evaluation program or competency evaluation program approved by the Department of Health and Human Services.

Part A Hospital Insurance will pay for these services:

- Part-time or intermittent skilled nursing care.
- Physical therapy.
- Speech therapy.

If a person needs part-time or intermittent skilled nursing care, physical therapy, or speech therapy, Medicare also pays for:

- Part-time or intermittent services of home health aides.
- Medical social services.
- Medical supplies.
- Durable medical equipment (80% of approved cost; patient pays remaining 20%).
- Occupational therapy.

Medicare pays for this assistance but only when the individual has an underlying skilled care need. In other words, the Medicare home health benefit does not pay for home health aide services for those whose sole need is for personal assistance with the types of daily activities just mentioned.

There are also other limits on the amount of service available under the Medicare home health benefit. As a rule, services cannot exceed eight hours a day or 35 hours a week. Depending on an individual’s need, Medicare home health services may be provided for only a few days or over a period of several years if these basic qualifying requirements continue to be met.
Medicare does not cover home care services furnished primarily to assist people in meeting personal, family, and domestic needs. These non-covered services include general household services, preparing meals, shopping, or assisting in bathing, dressing, or other personal needs.

The following home health services are not covered by Medicare:

- 24-hour-a-day nursing care at home
- Blood transfusions
- Meals delivered to the home
- Homemaker services

**Eligibility for Care**

The physician must send a referral or letter of certification to a Medicare-certified home health agency. After receiving this referral, the home health agency sends a nurse to the individual’s home to evaluate him or her and establish a plan of care. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in the home.

Hospital Insurance pays for home health visits if all six of the following conditions are met:

1. The care is post-institutional home health service.
2. The care provided includes intermittent skilled nursing care, physical therapy, or speech therapy.
3. The person is confined at home (homebound).
4. The person is under the care of a physician who determines the need for home health care and sets up a home health plan for the person.
5. The home health agency providing services participates in Medicare.
6. The services are provided on a visiting basis in the person's home, or if it is necessary to use equipment that cannot be readily made available in the home, on an outpatient basis in a hospital, skilled nursing facility, or licensed rehabilitation center.

To obtain home health services, a doctor must certify that a person needs skilled nursing care or therapy services on a part-time or intermittent basis. Medicare defines skilled care as medically reasonable and necessary care performed by a skilled nurse or therapist. Examples of skilled nursing care can include wound care, (for example, treating pressure sores) catheterization, or changing a tracheotomy tube.

**The Homebound Rule**

Enacted in the early 1970s, the homebound rule defines who is eligible to receive Medicare home health services. To be considered “homebound:”

1. The individual must have “a normal inability to leave home.”
2. Leaving home must require “a considerable and taxing effort by the individual,” typically by relying on a wheelchair, cane, or the assistance of another person.
3. The person may leave home for any reason, but most absences outside the home must be of an “infrequent or of relatively short duration.”
A patient is considered "confined to the home" if he or she has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another person or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the patient has a condition such that leaving home is medically contraindicated. While a patient does not have to be bedridden to be considered "confined to home," the condition should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

The law also specifically permits an individual to be absent from his or her home, at any time, to receive health care or to attend adult day care or religious services.

While the patient must be homebound to be eligible for benefits, payment will be made for services furnished at a hospital, skilled nursing facility, or rehabilitation center if the patient's condition requires the use of equipment that ordinarily cannot be taken to the patient's home. However, Medicare will not pay the patient's transportation costs.

**Hospice Care under Part A**

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to persons who are terminally ill. Medicare pays for services every day and also permits a hospice to provide appropriate custodial care, including homemaker services and counseling. Hospice care under Medicare includes both home care and inpatient care, when needed, as well as a variety of services not otherwise covered under Medicare.

Hospice care is provided to persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only palliative hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program, but does pay small coinsurance amounts for drugs and inpatient respite care.

For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in the home (which may include a nursing home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).

- Patients pay a co-payment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care. The amount paid for respite care can change each year. Medicare generally doesn't pay for room and board except in certain cases. For example, room and board aren't covered for general hospice services while a resident of a nursing home or a hospice's residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays.

For questions about hospice care and conditions of coverage, call the Regional Home Health Intermediary.**
Services Covered

The following are covered hospice services:

- Nursing care provided by or under the supervision of a registered nurse.
- Medical social services provided by a social worker under a physician's direction.
- Counseling (including dietary counseling) with respect to care of the terminally ill patient and adjustment to his approaching death.
- Short-term inpatient care, including respite care, provided in a participating hospice, hospital or skilled nursing facility.
- Medical appliances and supplies.
- Services of a home health aid and homemaker services.
- Drugs, including outpatient drugs for pain relief and symptom management.
- Physical therapy, occupational therapy, and speech-language pathology services to control symptoms or to enable the patient to maintain activities of daily living and basic functional skills.

Eligibility for Care

The amount paid by Medicare is equal to the reasonable costs of providing hospice care or based on other tests of reasonableness as prescribed by regulations. No payment may be made for bereavement counseling, and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

There are no deductibles under the hospice benefit. The beneficiary does not pay for Medicare-covered services for the terminal illness, except for small coinsurance amounts for outpatient drugs and inpatient respite care. The patient is responsible for 5% of the cost of outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays $5 per day such care is provided.

Hospice care is usually provided in the home (which may include a nursing facility if this is their home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest). Respite care as an inpatient in a hospice (to give a period of relief to the family providing home care for the patient) is limited to no more than five days in a row.

The hospice benefit period consists of two 90-day periods followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team would have to re-certify that the beneficiary is terminally ill at the beginning of the 60-day periods. Prior to August 5, 1997, the benefit period consisted of two 90-day periods and one 30-day period.

Persons must be certified as terminally ill within two days after hospice care is initiated. However, if verbal certification is provided within two days, written certification may occur within eight days after care is initiated.

Blood Coverage under Part A

Pints of blood received at a hospital or skilled nursing facility during a covered stay.
• Patients pay for the first three pints of blood, unless they or someone else donates blood to replace what is used.

**Part A Benefit Period**

An important component of Part A is the 90-day benefit period starts again with each spell of illness. The patient's first benefit period starts the first time the patient receives inpatient hospital care after Hospital Insurance begins. A benefit period ends when the patient has been out of a hospital or other facility primarily providing skilled nursing or rehabilitative services for 60 days in a row (including the day of discharge). If a patient remains in a facility (other than a hospital) that primarily provides skilled nursing or rehabilitative services, a benefit period ends when the patient has not received any skilled care there for 60 days in a row. After one benefit period has ended, another one will start whenever the patient again receives inpatient hospital care.

There is no limit to the number of 90-day benefit periods a person can have in a lifetime (except in the case of hospitalization for mental illness). However, the lifetime reserve of 60 days is not renewable. Each of these days of coverage can only be used once in the patient's lifetime. Thereafter when the patient has used up their 90 days in a benefit period, they will have to pay for additional days in the hospital out of pocket, unless they have supplemental insurance coverage. Also, special limited benefit periods apply to hospice care.

**Medicare Part B (Medical Insurance)**

Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies only when they are medically necessary. Most Medicare beneficiaries receive the Part B benefit. The Part B program provides medical insurance that pays for doctors’ visits/services, skilled home health services, durable medical equipment, outpatient hospital services, ambulance services, and lab tests. The Part B program also covers certain preventive health care services.

**Medicare Part B Premium and Deductible**

For those who choose to enroll in Part B, the premium is usually taken out of the monthly Social Security, Railroad Retirement, or Office of Personnel Management Retirement payment. Those who don’t get any of these payments will receive a bill for the Part B premium every three months.

In some cases, this premium may be higher for those who didn’t sign up for Part B when they first became eligible. The cost of Part B may go up 10% for each full 12-month period that could have had Part B but didn’t sign up for it, except in special cases (Special Enrollment Period). They will have to pay this extra amount as long as they have Part B.

There is also a $110 (in 2005) Part B deductible each year before Medicare starts to pay its share. The Part B deductible will increase each year. Some people may be able to get help from their state to pay the premium and deductible. Beginning in 2007 the Part B premium will be higher for people who have income above a certain level.
Most people pay a monthly premium for Part B. The Part B program is voluntary. When enrolling in Medicare, individuals decide whether they wish to pay a premium ($78.20/month in 2005) and receive Part B benefits.

Persons with limited income and resources, may get help form their state to pay for Part A or Part B. For more information, look at www.socialsecurity.gov or call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

Those receiving Social Security or Railroad Retirement Board benefits are sent the new premium and deductible rates each December with the cost of living adjustment notice. The premium and deductible rates are also available at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**Medicare as Secondary Payer**

Medicare benefits are secondary to benefits payable by a large group health plan for services furnished during any month in which the individual:

- is entitled to Medicare Part A benefits on the basis of disability,
- is covered under a large group health plan, and
- has large group health plan coverage by virtue of his own or a family member's current employment status.

The Centers for Medicare & Medicaid Services must mail questionnaires to individuals before they become entitled to Part A Hospital Insurance benefits or enroll in Part B Medical Insurance to determine whether they are covered under a primary plan. Benefits, however, will not be denied for covered services solely on the grounds that the beneficiary failed to note the existence of other health plan coverage in the questionnaire. Providers and suppliers are required to provide information on claim forms regarding potential coverage under other plans. Civil monetary penalties are established for an entity that knowingly, willfully, and repeatedly fails to complete a claim form with accurate information.

There are limitations on Medicare payments for services covered under group health plans. Medicare is secondary payer, under specified conditions, for services covered under any of the following:

1. Group health plans of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status with an employer or the current employment status of a spouse of any age.
2. Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have end stage renal disease. Generally, group health plans are always primary payers throughout the first 30 months of end stage renal disease based on Medicare eligibility or entitlement.
3. Large group health plans (that is, plans of employers that employ at least 100 employees) that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer.
Group health plans and large group health plans may not take into account that the individuals described above are entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of end stage renal disease. Group health plans of employers with 20 or more employees must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that they provide to employees and spouses under 65. The requirement applies regardless of whether the individual or spouse age 65 or older is entitled to Medicare. Group health plans may not differentiate in the benefits they provide between individuals who have end stage renal disease and other individuals covered under the plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner.

Medicare is also the secondary payer:

1. When medical care can be paid for under no-fault insurance or liability insurance (including automobile insurance).
2. If the individual is entitled to veterans benefits.
3. If the individual is entitled to black lung benefits.
4. If the individual is covered by workers' compensation.

Medicare becomes primary if the services are:

- furnished to Medicare beneficiaries who have declined to enroll in the group health plan,
- not covered under the plan for the disabled individual or similarly situated individuals,
- covered under the plan but not available to particular disabled individuals because they have exhausted their benefits under the plan,
- furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement, or
- covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

An employee may reject the employer's plan and retain Medicare as the primary payer, but regulations prevent employers from offering a health plan or option designed to induce the employee to reject the employer's plan and retain Medicare as primary payer.

An employer or insurer is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, primary to Medicare. The prohibition precludes offering to Medicare beneficiaries an alternative to the employer primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary coverage through his own or a spouse's employer.

**Enrollment in Medical Insurance (Part B)**

Enrolling in Part B is voluntary. Those already receiving Social Security or Railroad Retirement benefits are automatically enrolled in Part B starting the first day of the month they turn age 65. Those under age 65 and disabled are automatically enrolled in Part B after receiving Social Security or Railroad Retirement benefits for 24 months.* The Medicare card will be mailed about three months before their 65th birthday or the 25th month of disability benefits. Those who don't want Medicare Part B can follow the instructions that come with the Medicare card.
Those who aren’t automatically enrolled in Medicare Part B will need to contact the Social Security Administration to get enrolled. They can enroll by:

- Calling or visiting the local Social Security office. The address and telephone number are in the local telephone book.
- Calling the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. Those who get benefits from the Railroad Retirement Board (RRB) will need to call the local RRB office or 1-800-808-0772 to apply.
- Looking at the Social Security Administration’s website at www.socialsecurity.gov on the web. Some people who meet certain conditions are able to enroll by computer.


### Medicare Part B Enrollment Periods

There are three times to enroll for Medicare Part B:

1. Initial Enrollment Period
2. General Enrollment Period
3. Special Enrollment Period

#### Initial Enrollment Period

The initial enrollment period is a period of seven full calendar months, the beginning and end of which is determined for each person by the day on which he is first eligible to enroll. The Initial Enrollment Period

- begins three months before the month they turn age 65, and
- ends three months after the month they turn age 65.

For example, if a person's 65th birthday is April 10, 2005, the initial enrollment period begins January 1, 2005 and ends July 31, 2005.

Although the eligibility age to get full Social Security or Railroad Retirement benefits now depends on the year born, the eligibility age to get Medicare is **still age 65**.

#### Initial Enrollment Period

<table>
<thead>
<tr>
<th>3 months before the month they turn 65</th>
<th>2 months before the month they turn 65</th>
<th>1 month before the month they turn 65</th>
<th>The month they turn 65</th>
<th>1 month after the month they turn 65</th>
<th>2 months after the month they turn 65</th>
<th>3 months after the month they turn 65</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>
People should sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month they turn 65, they must sign up during these first three months. If they wait until these last four months of their Initial Enrollment Period to sign up for Medicare Part B, the start date for their coverage will be delayed.

In order to obtain coverage at the earliest possible date, a person must enroll before the beginning of the month in which age 65 is reached. The start date for Medicare Part B will be delayed for people sign up the month they turn age 65 or during the last three months of the Initial Enrollment Period. For a person who enrolls during the initial enrollment period, the effective date of coverage is as follows:

1) If the person enrolls before the month in which age 65 is reached, coverage will commence the first day of the month in which age 65 is reached.
2) If the person enrolls during the month in which age 65 is reached, coverage will commence the first day of the following month.
3) If the person enrolls in the month after the month in which age 65 is reached, coverage will commence the first day of the second month after the month of enrollment.
4) If the person enrolls more than one month (but at least within three months) after the month in which age 65 is reached, coverage will commence the first day of the third month following the month of enrollment.

Those who wait until after the Initial Enrollment Period is over, may have to pay more for their Medicare Part B premium, except in special cases. (See Special Enrollment Period.)

**General Enrollment Period**

Those who didn't sign up for Medicare Part B when they first became eligible may sign up during the General Enrollment Period:

- The General Enrollment Period runs from January 1 through March 31 of each year.
- To apply, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778 or the Railroad Retirement Board (RRB), call the local RRB office or 1-800-808-0772.
- Medicare Part B coverage will start on July 1 of the year they sign up.

The cost of Medicare Part B will go up 10% for each full 12-month period that they could have had Medicare Part B but didn’t take it, except in special cases. This extra amount will have to be paid as long as they have Medicare Part B.

**Special Enrollment Period**

The special enrollment period is a period of seven full calendar months beginning with the first month during which a person's employer plan coverage ends, or employment ends, whichever occurs first. This period is available for those who are eligible for Medicare and waited to enroll in Medicare Part B because they or their spouse were working and had group health plan coverage through an employer or union based on this current employment. If this applies they can sign up for Medicare Part B:
• anytime they are still covered by an employer or union group health plan, through they or their spouse’s current employment, or
• during the eight months following the month that the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

In the case of an individual entitled to Medicare because of a disability, the special enrollment period begins:

• when the individual is no longer enrolled as an active individual in a large group health plan (one that covers 100 or more employees),
• when the employment status ends, or
• when the plan coverage is terminated.

For example, if a 67 year-old retires on July 1, 2005, the special enrollment period will begin on July 1, 2005, and run through January 31, 2006.

The special enrollment period generally begins with the month in which coverage under the private plan ended. Coverage under Medical Insurance will begin with the month after coverage under the private plan ends, if the individual enrolls in such month, or with the month after enrollment, if the individual enrolls during the balance of the special enrollment period.

If a person declines to enroll (or terminates enrollment) at a time when Medicare is secondary payer to an employer group health plan, the months in which he is covered under the employer group health plan (based on current employment) and Hospital Insurance will not be counted for the purpose of determining if the premium amount should be increased above the basic rate.

Those who are still working and plan to keep their employer’s group health coverage, should talk to their benefits administrator or their State Health Insurance Assistance Program to help them decide the best time to enroll in Medicare Part B. When they sign up for Medicare Part B, they automatically begin their Medigap (Medicare Supplement Insurance) open enrollment period. Once their Medigap open enrollment period begins, it can’t be changed or restarted.

For more information about the Medicare Special Enrollment Period, get a free copy of Enrolling in Medicare (CMS Pub. No.11036).

Special Enrollment Period for TRICARE for Life

Those who are military retirees, or the spouse or dependent child of either a military retiree or an active duty sponsor and are entitled to Medicare Part B between January 2001 and December 2005, and are paying more than $78.20 a month for Medicare Part B, the Medicare Part B premium will be reduced to $78.20 beginning January 2005. They will get a refund for any excess premiums paid. They don’t have to do anything; the premium reduction and refund will be done automatically.

Medicare Part B Premium Penalty

Most people who sign up for Medicare Part B during a Special Enrollment Period don’t pay higher premiums. However, those who are eligible but don’t sign up for Medicare Part B during the Special Enrollment Period will only be able to sign up during the General Enrollment Period, and the cost of Medicare Part B may go up.
The premium will be higher for a person who fails to enroll within 12 months, or who drops out of the plan and later reenrolls. The monthly premium will be increased by 10% for each full 12 months during which he could have been, but was not, enrolled. They will have to pay this extra amount (called a premium surcharge) as long as they have Medicare Part B.

Example: Those who delayed enrolling in Medicare Part B for **24 months** will have to pay a **20%** premium surcharge (10% for each full 12-month period that they could have been enrolled), plus the standard Medicare Part B monthly premium ($78.20 in 2005). These amounts might change each year. $78.20 2005 Medicare Part B standard premium + $45.64 (20% of $78.20 is $15.64. In this example, this amount is rounded down.) $93.84 will be the Medicare Part B monthly premium for 2005.

Note: The example above is if they delayed enrolling in Medicare Part B for 24 months. People don’t pay a premium surcharge if they enroll before a full 12-month period has passed.

**Part B and COBRA Coverage**

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that may allow people to retain employer group health plan coverage for a limited period of time after employment ends or after they lose coverage as a dependent of the covered employee. Even those who elect to get COBRA coverage when employer coverage ends should still consider enrolling in Medicare Part B at the same time because they won’t get another Special Enrollment Period. They will have to sign up for Medicare Part B within eight months after the group health plan coverage ends or when they lose coverage.

Those who don’t sign up for Medicare Part B during the eight-month period (SEP) after employment ends or when they lose coverage, whichever comes first will only be able to sign up during the General Enrollment Period and the cost of Medicare Part B may be higher.

For those aged 65 or older who are covered under COBRA, their employer group health plan may require them to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is before employment ends or they lose the employer’s coverage. If they wait to sign up for Medicare Part B during the eight months after employment or coverage ends, the employer could make them pay for services that Medicare would have paid for if they had signed up earlier.

For those who have COBRA coverage when first enrolling in Medicare, the COBRA coverage may end. The employer has the option of canceling COBRA coverage if Medicare enrollment is after the date a person elected COBRA coverage.

Those who have Part B and then drop it because they have group health plan coverage through the employer or union, can sign up for Part B again during a Special Enrollment Period. It’s important to make sure that the group health plan coverage is in effect before dropping Part B. In this case, the cost of Part B won’t go up when they get it again. Remember, when they drop Part B, coverage ends the last day of the next month. Also, those who drop Part B after age 65 won’t get another Medigap open enrollment period when they restart Part B.

Before electing COBRA coverage, it may be helpful to talk with the State Health Insurance Assistance Program about whether buying a Medigap policy would be better than electing COBRA coverage.
Covered Services and supplies in Part B

Eligibility for Care

Copayments and Deductibles

- $110 (in 2005) deductible (once per calendar year). This amount can change each year.
- 20% of the Medicare-approved amount after the deductible (if the doctor, provider, or supplier accepts “assignment.”).
- 20% for all outpatient physical, occupational, and speech-language therapy services.
- 50% for most outpatient mental health care.

To be covered, all services must be either medically necessary or one of several specific preventive benefits. Part B services are generally subject to a deductible and coinsurance. Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical, speech, or occupational therapy services performed in settings other than hospitals), and higher cost-sharing requirements (such as those for outpatient treatments for mental illness).

Benefits provided under Medical Insurance

Part B covers:

- medical and surgical services, including anesthesia,
- diagnostic tests and procedures that are part of the patient’s treatment,
- radiology and pathology services by doctors while the patient is a hospital inpatient or outpatient,
- treatment of mental illness (Medicare payments are limited),
- X-rays,
- services of the doctor’s office nurse,
- drugs and biologicals that cannot be self-administered,
- transfusions of blood and blood components,
- medical supplies, and
- physical/occupational therapy and speech-language pathology services.
## Part B

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Individual Pays (in 2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium</strong></td>
<td>$78.20 per month</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$110 a year</td>
</tr>
<tr>
<td><strong>Physician and other medical services</strong></td>
<td></td>
</tr>
<tr>
<td>MD accepts assignment*</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>MD does not accept assignment</td>
<td>20% coinsurance plus up to 15% over Medicare-approved fee (1)</td>
</tr>
<tr>
<td>Doctors’ services (not routine physical exams), outpatient medical and</td>
<td></td>
</tr>
<tr>
<td>surgical services and supplies, diagnostic tests, ambulatory surgery</td>
<td></td>
</tr>
<tr>
<td>center facility fees for approved procedures, and durable medical</td>
<td></td>
</tr>
<tr>
<td>equipment (such as wheelchairs, hospital beds, oxygen, and walkers).</td>
<td></td>
</tr>
<tr>
<td>Also covers a second and third surgical opinion for surgery that isn’t</td>
<td></td>
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<tr>
<td>an emergency, outpatient mental health care, and outpatient physical</td>
<td></td>
</tr>
<tr>
<td>and occupational therapy, including speech-language therapy. (These</td>
<td></td>
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<tr>
<td>services are also covered for long-term nursing home residents.)</td>
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<tr>
<td><strong>Outpatient hospital care</strong></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Hospital services and supplies received as an outpatient as part of a</td>
<td></td>
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<tr>
<td>doctor’s care.</td>
<td></td>
</tr>
<tr>
<td>Coinsurance or co-payment amount may vary according to the service.</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulatory surgical services</strong></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>X-rays; durable medical equipment</strong></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>Physical, speech and occupational therapy</strong></td>
<td>20% coinsurance (2)</td>
</tr>
<tr>
<td><strong>Clinical diagnostic laboratory services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Laboratory Services</strong></td>
<td>No coinsurance</td>
</tr>
<tr>
<td>Blood tests, urinalysis, some screening tests, and more.</td>
<td></td>
</tr>
<tr>
<td>No co-pays for Medicare-approved services.</td>
<td></td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td></td>
</tr>
<tr>
<td>Part-time or intermittent skilled nursing care and home health aide</td>
<td>Home Health Care Co-Payments and Deductibles</td>
</tr>
<tr>
<td>services, physical therapy, occupational therapy, speech-language</td>
<td>• Nothing for Medicare-approved services.</td>
</tr>
<tr>
<td>therapy, medical social services,</td>
<td>• 20% of the Medicare-approved amount</td>
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</tbody>
</table>
durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

For questions about home health care and conditions of coverage contact the Regional Home Health Intermediary.**

<table>
<thead>
<tr>
<th><strong>Outpatient mental health services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Care</strong></td>
</tr>
<tr>
<td>Medicare Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Medicare Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, or clinical social worker, and lab tests. Medicare Part B also covers partial hospitalization services for people who need intensive coordinated outpatient care to help them avoid inpatient treatment.</td>
</tr>
<tr>
<td>Medicare Part B pays for many mental health services. When services are delivered specifically for the people managing their mental health, however, the individual must pay half of the cost. Unlike the 80 percent-20 percent cost-sharing structure for other Medicare Part B services, mental health services require patients to typically pay half of the total cost of service.</td>
</tr>
<tr>
<td>Medicare Part B however pays 80 percent of the Medicare-approved amount for some medical services that may be related to mental health, including:</td>
</tr>
<tr>
<td>- Initial diagnostic services;</td>
</tr>
<tr>
<td>- Appointments with the doctor to monitor and adjust prescription medication;</td>
</tr>
<tr>
<td>- Medical management services for people living with Alzheimer’s and related disabilities; and</td>
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<tr>
<td>- Services provided when participating in a partial hospitalization program.</td>
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</table>

<table>
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<tr>
<th><strong>Preventive services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Flu shots; pneumococcal vaccines; colorectal</td>
</tr>
</tbody>
</table>
cancer screenings; mammograms; Pap smears; pelvic exams  
-Bone mass measurement; diabetes monitoring; glaucoma screening  
waived for certain preventive services  
20% coinsurance  

(1) Referred to as the Medicare Limiting Charge Law, the limit on the percentage above the Medicare-approved amount that a physical can charge is less than 15% in some states.  

(2) There is currently no coverage limit on Medicare outpatient therapy services. A $1,590 limit per year for occupational therapy services, and a $1,590 limit per year for physical and speech-language therapy services combined is set to begin on January 1, 2006.  

* Assignment - physicians agree to accept Medicare's predetermined fee as payment-in-full; patients are responsible for 20% co-payment but no more.  


Blood  
Pints of blood received as an outpatient or as part of a Part B covered service.  

Patient pays for the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless they (or someone else) donate blood to replace what they use.  

Actual amounts they must pay may be higher if the doctor or supplier doesn’t accept assignment, and they may have to pay the entire charge at the time of service. Medicare will then send them its share of the charge.  

For general questions about Medicare Part B, call the Medicare carrier. For questions about durable medical equipment, including diabetic supplies, call the Durable Medical Equipment Regional Carrier (DMERC). For their telephone numbers, look at www.medicare.gov on the web. Select “Helpful Contacts.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.  

Services and Items that Medicare Covers  
These services and items are covered no matter what kind of Medicare health plan, however, the amount Medicare pays for these services and items depends on the type of health plan.  

Fees and Services Covered by Medical Insurance:  

- **Doctors' services** wherever furnished in the United States. This includes the cost of house calls, office visits, and doctors' services in a hospital or other institution. It includes the fees of physicians, surgeons, pathologists, radiologists, anesthesiologists, psychiatrists, and osteopaths.  
- **Home health services** not directly related to hospital or skilled nursing facility stays.
• Services of **clinical psychologists** are covered if they would otherwise be covered if furnished by a physician (or as an incident to a physician's service).

• Services by licensed **chiropractors** for manual manipulation of the spine to correct a subluxation (when one or more of the bones of the spine moves out of position). Medical Insurance does not pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

• Fees of **podiatrists** are covered, including fees for the treatment of plantar warts, but not routine foot care. Common problems covered by Medical Insurance include ingrown toenails, hammer toe deformities, bunion deformities, and heel spurs. Care not covered by Medical Insurance includes cutting or removal of corns and calluses, trimming of nails, and other hygienic care. Medical Insurance does help pay for some routine foot care if the patient is being treated by a medical doctor for a medical condition affecting the patient's legs and feet (such as diabetes or peripheral vascular disease) which requires that a podiatrist or doctor of medicine or osteopathy perform the routine care. The cost of treatment of debridement of mycotic toenails (i.e., the care of toenails with a fungal infection) is not included if performed more frequently than once every 60 days. Exceptions are authorized if medical necessity is documented by the billing physician. Foot exams are covered for those who have diabetes-related nerve damage and meet certain conditions. Medical Insurance also helps pay for therapeutic shoes and shoe inserts for people who have severe diabetic foot disease.

• Services from certain **specially qualified practitioners** who are not physicians but are approved by Medicare, such as clinical social workers, physicians assistants, and nurse practitioners.

• The cost of routine physicals, most vaccine shots, and examinations for eyeglasses and hearing aids is **not** covered. But the cost of diagnosis and treatment of **eye and ear ailments** is covered. Also covered is an optometrist's treatment of **aphakia**.

• **Plastic surgery** for purely cosmetic reasons is excluded; but plastic surgery for repair of an accidental injury, an impaired limb or a malformed part of the body is covered.

• **Radiological or pathological services** furnished by a physician to a hospital inpatient are covered.

• The cost of **blood clotting factors** and supplies related to their administration for hemophilia patients.

• **Outpatient physical therapy and speech-language pathology services** received as part of a patient's treatment in a doctor's office or as an outpatient of a participating hospital, skilled nursing facility, or home health agency; or approved clinic, rehabilitative agency, or public health agency, if the services are furnished under a plan established by a physician or physical therapist. A physician is required to review all plans of care. A podiatrist (when acting within the scope of his practice) is a physician for purposes of establishing a plan for outpatient physical therapy. A dentist and podiatrist are also within the definition of a physician for purposes of outpatient ambulatory surgery in a physician's office. Services of **independent physical therapists** are limited to a maximum of $1,500 in approved charges in any one year. Services of **independent occupational therapists** are covered up to a maximum of $1,500 in approved charges for such services in a calendar year.

• **Services and supplies relating to a physician's services and hospital services rendered to outpatients**; this includes drugs and biologicals which cannot be self-administered.
• A physician who includes charges for independent clinical laboratory services in his bill is entitled to the lesser of: (1) the approved charge of the laboratory, or (2) the amount actually charged by the physician. The physician's charge can include a small fee for handling the specimen.

• Dentists' bills for jaw or facial bone surgery, whether required because of accident or disease, are covered. Also covered are hospital stays warranted by the severity of the noncovered dental procedure, and services provided by dentists which would be covered when provided by a physician. However, Medicare doesn't cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. In rare cases, Medicare Part B will pay for certain dental services. In addition, Medicare Part A may pay for certain hospital stays for severe or complicated dental procedures, even when the dental care itself isn't covered. Some Medicare Advantage Plans may offer additional dental coverage.

• The cost of psychiatric treatment outside a hospital for mental, psychoneurotic or personality disorders is covered, but with 50% coinsurance instead of the usual 20% (except that the latter applies when services are provided on a hospital-outpatient basis if, in the absence of treatment outside a hospital, hospitalization would have been required).

• Radiation therapy with X-ray, radium or radioactive isotopes.

• Surgical dressings required for the treatment of a wound, splints, casts and other devices for reduction of fractures and dislocations; rental or purchase of durable medical equipment, such as iron lungs, oxygen, hospital beds, walkers and wheel chairs, for use in the patient's home; prosthetic devices, such as artificial heart valves or synthetic arteries, designed to replace part or all of an internal organ (including ostomy supplies) (but not false teeth, hearing aids, or eye-glasses); arm, leg, back, and neck braces, artificial limbs (and their replacement parts) (but not orthopedic shoes), artificial eyes, Breast prostheses (after mastectomy).

**Medicare’s policy for covering durable medical equipment (DME)**

Under Medicare Part A Hospital and SNFs provide medical equipment to individuals who are admitted to their facilities. Coverage for DME outside of a hospital or SNF comes under the Part B program. The DME benefit category covers a broad range of items needed by people with disabilities, such as wheelchairs, augmentative communication devices, and glucose monitors.

Medicare’s DME benefit also covers orthotics and prosthetics (O&P). These devices are considered medically necessary when they replace or support a body part. Certain medical supplies are also covered as DME, including oxygen, catheters, ostomy supplies, and test strips for people with diabetes.

DME or supplies not covered by Medicare include:

- Raised toilet seat
- Shower/commode wheelchair
- Grab bars and other safety equipment for the bathroom
- Hearing aids
- Examination gloves
- Catheters
Assignment and DME

When a DME vendor is said to accept “assignment,” it means that the provider agrees to accept the Medicare-approved amount as payment in full for the good or service.

A Medicare-certified supplier who does not take assignment can still sell medical equipment to people with Medicare. They can also charge more than the Medicare-approved amount, but they cannot charge in excess of 15 percent more than the Medicare-approved amount. Medicare-certified suppliers also have the option of taking assignment on a case-by-case basis.

If the supplier does not take assignment, patients must pay the full cost up front. The supplier then submits a claim to Medicare, and Medicare refunds 80 percent of its approved amount directly to the patient. In this case, they will end up paying 20 percent of the Medicare approved amount plus any extra amount the supplier charges.

For more information, contact a Durable Medical Equipment Regional Carrier (DMERC), which pays DME claims, in the state (http://www.medicare.gov/Contacts/Home.asp).

- **Ambulance service** when it’s medically necessary to be transported by ambulance to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger one’s health. Medicare pays for ambulance transport to the nearest hospital or skilled nursing facility that provides the services needed.
- Comprehensive **outpatient rehabilitation facility service** performed by a doctor or other qualified professionals in a qualified facility. Therapy and supplies are covered.
- Under certain circumstances, **antigens** prepared for the patient by a doctor.
- The cost of **pneumococcal, hepatitis B, and flu vaccines**.
- **Heart, lung, kidney, pancreas, intestine, and liver transplants** (under certain conditions and in Medicare-certified facilities only), and bone marrow and cornea transplants (under certain conditions). Oral immunosuppressive drugs if the transplant was paid for by Medicare, or paid by an employer group health plan that was required to pay before Medicare. Must have been entitled to Part A at the time of the transplant and entitled to Part B at the time they receive immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility.
- Certified **nurse-midwife services** and such services and supplies as are incident to nurse-midwife service. The service must be authorized under state law. Coverage includes services outside the maternity cycle. The amount paid by Medical Insurance is based upon a fee schedule but cannot exceed 65% of the prevailing charge allowed for the same service performed by a physician.
- **Partial hospitalization services** incident to a physician's services. Partial hospitalization services are items and services prescribed by a physician and provided in a program under the supervision of a physician pursuant to an individualized written plan of treatment.
- **Screening pap smears** for early detection of cervical cancer. Coverage is provided for a screening pap smear, but only once every three years, except in cases where the Centers for Medicare & Medicaid Services has established shorter time periods for testing women at high risk of developing cervical cancer. The patient is not required to pay the deductible for pap smears.
• **Screening mammography** and **Diagnostic mammography** are covered. Medicare covers an annual screening mammogram for all women age 40 and over. The Part B deductible for screening mammography is waived.

• The cost of an **injectable drug** approved for the treatment of a bone fracture related to **post-menopausal osteoporosis** under the following conditions: (1) the patient's attending physician certifies that the patient is unable to learn the skills needed to self-administer or is physically or mentally incapable of self-administering the drug, and (2) the patient meets the requirements for Medicare coverage of home health services.

• One pair of conventional **eyeglasses** with standard frames or conventional **contact lenses** that replace the natural lens of the eye following cataract surgery with insertion of an intraocular lens.

• Services of **nurse practitioners** and **clinical nurse specialists** in rural areas for the services that nurse practitioners and clinical nurse specialists are authorized to perform under state law and regulations.

• **Oral cancer drugs** if they are the same chemical entity as those administered intravenously and covered prior to 1994. In addition, off-label anti-cancer drugs are covered in some cases.

• **Lung transplants** for beneficiaries with progressive end-stage pulmonary disease when performed by facilities that: (1) make an application to the Centers for Medicare & Medicaid Services, (2) supply documentation showing their compliance with federal regulations on lung transplants, and (3) are approved by the Centers for Medicare & Medicaid Services under criteria based on federal regulations. Medicare also covers lung transplantation for end-stage cardiopulmonary disease when it is expected that transplant of the lung will result in improved cardiac function.

• **Heart-lung transplants** for beneficiaries with progressive end-stage cardiopulmonary disease when they are provided in a facility that has been approved by Medicare for both heart and lung transplantation.

• **Prescription drugs used in immunosuppressive therapy** that have been approved by the Federal Drug Administration for preventing or treating the rejection of a transplanted organ or tissue. Coverage is available only for prescription drugs used in immnosuppressive therapy, furnished to an individual who receives an organ or tissue transplant for which Medicare payment is made, for 36 months. When eligible for drugs that are covered, make sure the pharmacy is enrolled in the Medicare program or Medicare won’t pay.

• **Prostate cancer screening**, including digital rectal exams and prostate specific blood antigen (PSA) tests.

• **Colorectal screening** procedures, including fecal occult blood test, flexible sigmoidoscopy for persons at high risk for colorectal cancer, screening colonoscopy.

• **Diabetes screening**, including coverage of diabetes outpatient self-management services to individuals with diabetes. Medicare covers glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases). There may be limits on supplies or how often received. Participants should ask if the pharmacy or supplier is enrolled in the Medicare program. Syringes and insulin (unless used with an insulin pump) aren’t covered.

• **Bone mass measurement** for certain individuals.

• **Screening pelvic exams**. There is no deductible.

• **Rural health clinic services**.

• **Ambulatory surgical services**.
Charges imposed by an immediate relative (e.g., a doctor who is the son/daughter or brother/sister of the patient) are not covered.

**Medicare Preventive Services**

An important way to stay healthy is to use preventive services provided by doctors and health care providers. Preventive services can find health problems early when treatment works best and can keep someone from getting certain diseases or illnesses. Preventive services include exams, lab tests, and screenings. They also include shots, monitoring, and information to help people take care of their own health. Medicare pays for many preventive services to keep people healthy.

The preventive services are covered no matter what kind of Medicare health plan people have, however, the amount paid for these services varies depending on the type of health plan. This section explains the way preventive services are covered by Part B under the Original Medicare Plan (sometimes called fee-for-service). Coverage may be different under other types of Medicare health plans.

**Newly-covered Preventive Services**

Medicare already covers many different preventive services. Starting January 1, 2005, Medicare covers these three additional preventive services:

- One-time “Welcome to Medicare” Physical Exam
- Cardiovascular Screening
- Diabetes Screening to check for diabetes

**NEW—“Welcome to Medicare” Physical Examination:**

For Medicare Part B coverage that begins on or after January 1, 2005, Medicare will cover a one-time preventive physical exam within the first six months of Part B. The exam will include a thorough review of health, education and counseling about the preventive services needed like certain screenings and shots, and referrals for other care if needed. The “Welcome to Medicare” physical exam is a great way to get up-to-date on important screenings and shots and to talk with a doctor about family history and how to stay healthy. Many people going onto Medicare may not have had a comprehensive physical examination for several years.

What is Covered? Includes measurement of height, weight and blood pressure, an EKG, education, and counseling.

- **How often is it covered?** One time only within the first six months of Part B coverage
- **For whom?** All people whose Medicare Part B begins on or after January 1, 2005
- **Costs in the Original Medicare Plan?** 20% of the Medicare approved amount after the yearly Part B deductible

**New - Cardiovascular Screening**

Medicare covers cardiovascular screenings that check cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase risk for heart disease and stroke. These
screenings will reveal high cholesterol. Lifestyle changes (like changing diet) may lower cholesterol.

- **What is covered?** Tests for cholesterol, lipid, and triglyceride levels beginning January 1, 2005
- **How often is it covered?** The doctor determines how often
- **For whom?** The doctor to see if someone qualifies
- **Costs in the Original Medicare Plan?** Individuals pay nothing

**Breast Cancer Screening Mammograms**

Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer can usually be successfully treated when found early. Medicare covers screening mammograms and digital technologies for screening mammograms to check for breast cancer before the individual or a doctor may be able to feel it.

- **How often is it covered?** Once every 12 months
- **For whom?** All women with Medicare age 40 and older can get a screening mammogram every 12 months. Medicare also pays for one baseline mammogram for women with Medicare between ages 35 and 39.
- **Costs in the Original Medicare Plan?** Individuals pay 20% of the Medicare approved amount with no Part B deductible
- **Who is at high risk for breast cancer?**

  The risk of developing breast cancer increases for those who…

  - had breast cancer in the past
  - have a family history of breast cancer (like a mother, sister, daughter, or two or more close relatives who have had breast cancer)
  - had their first baby after age 30
  - have never had a baby

**Cervical and Vaginal Cancer Screening**

Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare covers a clinical breast exam to check for breast cancer.

- **How often is it covered?** A Pap test and pelvic exam are covered by Medicare once every 24 months. However, for those of childbearing age who have had an abnormal Pap test within the past 36 months, or who are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.
- **For whom?** All women with Medicare
- **Costs in the Original Medicare Plan?** Individuals pay nothing for the Pap lab test.

  For Pap test collection and pelvic and breast exams, 20% of the Medicare approved amount with no Part B deductible.

- **Who is at high risk for cervical cancer?**
The risk for cervical cancer increases for those who...

- have had an abnormal Pap test
- have had cancer in the past
- have been infected with the Human papillomavirus (HPV)
- began having sex before age 16
- have had many sexual partners
- had mothers who took DES (Diethylstilbestrol), a hormonal drug, while pregnant with them

Colorectal Cancer Screening

Colorectal cancer is usually found in people age 50 or older, and the risk of getting it increases with age. Medicare covers colorectal screening tests to help find pre-cancerous polyps (growths in the colon) so they can be removed before they turn into cancer. Treatment works best when colorectal cancer is found early.

- HOW OFTEN IS IT COVERED?
  
  - **Fecal Occult Blood Test**—Once every 12 months
  - **Flexible Sigmoidoscopy**—Once every 48 months
  - **Screening Colonoscopy**—Once every 24 months (if at high risk) Once every 10 years, but not within 48 months of a screening sigmoidoscopy (if not at high risk)
  - **Barium Enema**—A doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months for those who are at high risk for colorectal cancer and every 48 months for those who aren’t at high risk.
  - **For whom?** All people with Medicare age 50 and older, except there is no minimum age for having a screening colonoscopy
  - **Costs in the Original Medicare Plan?** Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible.

If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department, 25% of the Medicare-approved amount after the yearly Part B deductible.

- **Who is at high risk for colorectal cancer?**

  Risk for colorectal cancer increases if they or a close relative have had colorectal polyps or colorectal cancer, or if they have inflammatory bowel disease (like ulcerative colitis or Crohn’s disease).

Prostate Cancer Screening

Prostate cancer can often be found early by testing the amount of PSA (Prostate Specific Antigen) in the blood. Another way prostate cancer is found early is when a doctor performs a rectal exam. Medicare covers both of these tests so that prostate cancer can be detected and treated early.

**HOW OFTEN IS IT COVERED?**
- Digital Rectal Examination—Once every 12 months
- Prostate Specific Antigen (PSA) Test—Once every 12 months

- **For whom?** All men with Medicare age 50 and older (coverage for this test begins the day after their 50th birthday)
- **Costs in the Original Medicare Plan?** Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. There is no coinsurance and no Part B deductible for the PSA Test.

**Who is at high risk for prostate cancer?**

While all men are at risk for prostate cancer, the risk increases if a father, brother, or son has had prostate cancer. The list below shows the people at risk for prostate cancer from higher to lower amount of risk:

- African Americans
- Whites
- Hispanics
- Asians
- Pacific Islanders
- Native Americans

**Shots (Flu, Pneumococcal, Hepatitis B)**

Medicare covers flu, pneumococcal, and Hepatitis B shots. Flu, pneumococcal infections, and Hepatitis B can be life threatening to an older person. All adults 65 and older should get flu and pneumococcal shots. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot. People at medium to high risk for Hepatitis B should get Hepatitis B shots.

**Flu Shot**

- **How often is it covered?** Once a year in the fall or winter
- **For whom?** All people with Medicare
- **Costs in the Original Medicare Plan?** Nothing

**Pneumococcal Shot**

- **How often is it covered?** Most people only need this shot once in their lifetime
- **For whom?** All people with Medicare
- **Costs in the Original Medicare Plan?** Nothing

**Hepatitis B Shots**

- **How often are they covered?** Three shots are needed for complete protection. The doctor determines when to get these shots and who qualifies to get them.
- **For whom?** People with Medicare at medium to high risk for Hepatitis B
- **Costs in the Original Medicare Plan?** 20% of the Medicare approved amount after the yearly Part B deductible
  - **Who is at high risk for Hepatitis B?**
Common factors that put people at medium to high risk for Hepatitis B include…

- hemophilia
- End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)
- a condition that lowers resistance to infection

Other factors may also increase the risk for Hepatitis B.

Bone Mass Measurements

Medicare covers bone mass measurements to determine whether someone is at risk for a fracture (broken bone). People are at risk for fractures because of osteoporosis. Osteoporosis is a disease in which bones become weak.

In general, the lower the bone density, the higher the risk is for a fracture. Bone mass measurement test results will help determine the best way to keep bones strong.

- **How often is it covered?** Once every 24 months (more often if medically necessary)
- **For whom?** All people with Medicare who are at risk for osteoporosis
- **Costs in the Original Medicare Plan?** 20% of the Medicare approved amount after the yearly Part B deductible
  - **Who is at risk for osteoporosis?**

  The risk for osteoporosis increases for those who…

  - are age 50 or older
  - are a woman
  - have a family history of broken bones
  - have a personal history of broken bones
  - are White or Asian
  - are small-boned
  - have low body weight (less than about 127 pounds)
  - smoke or drink a lot
  - have a low-calcium diet

Diabetes Screening, Supplies, and Self-Management Training

Diabetes is a medical condition in which the body doesn’t make enough insulin or has a reduced response to insulin. Diabetes causes blood sugar to be too high because insulin is needed to use sugar properly. A high blood sugar level is not good for health. For all people with Medicare, Medicare covers screenings to check for diabetes. For people with diabetes, Medicare covers certain supplies and self-management training to find and treat diabetes.

**New - Diabetes Screening (Fasting Plasma Glucose Test)** beginning January 1, 2005

- **How often is it covered?** Talk with the doctor
- **For whom?** Talk with the doctor
- **Costs in the Original Medicare Plan?** Nothing
**Diabetes Glucose monitors, test strips, and lancets**

- **For whom?** All people with Medicare who have diabetes
- **Costs in the Original Medicare Plan?** 20% of the Medicare approved amount after the yearly Part B deductible

**Diabetes Self-Management Training**

- **For whom?** This training is for certain people with Medicare who are at risk for complications from diabetes. A doctor must request this service.
- **Costs in the Original Medicare Plan?** 20% of the Medicare approved amount after the yearly Part B deductible

**Glaucoma Tests**

Glaucoma is an eye disease caused by high pressure in the eye. It can cause people to gradually lose sight without warning and often without symptoms. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

- **How often is it covered?** Once every 12 months
- **For whom?** People with Medicare at high risk for glaucoma
- **Costs in the Original Medicare Plan?** 20% of the Medicare approved amount after the yearly Part B deductible
- **Who is at high risk for glaucoma?**

  The risk for glaucoma increases for those who…

  - have diabetes
  - have a family history of glaucoma
  - are African American and age 50 or older

**Clinical Trials**

- Routine costs take part in a qualifying clinical trial. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it’s safe. It’s important to ask what costs are involved before signing up for a clinical trial.
- **Note:** Medicare doesn’t cover the cost of experimental care, such as the drugs or devices being tested in a clinical trial.

**Emergency Room Services**

- Medicare covers emergency room services. (A medical emergency is when an individual believes that their health is in serious danger—when every second counts. It may be a bad injury, sudden illness, or an illness quickly getting much worse.)

**Hearing and Balance Exams**
• These exams are covered if a doctor orders them to see if medical treatment is needed. Routine screening exams aren’t covered.

**Kidney Dialysis Services**

• Kidney dialysis, and services and supplies, either in a facility or at home.

**Long-term Care**

• Most long-term care, in a nursing home or at home, is custodial care (help with activities of daily living such as bathing, dressing, using the bathroom, and eating). Medicare doesn’t cover long-term care, since it can’t cover custodial care when that is the only kind of care needed. Medicare Part A only covers skilled care given in a certified skilled nursing facility or in the home. Persons must meet certain conditions for Medicare to pay for skilled care when released from the hospital.

**Medical Nutrition Therapy Services**

• These services are covered for people who have diabetes or kidney disease (unless you are on dialysis) with a doctor’s referral. Medical nutrition therapy services are covered for three years after a kidney transplant.

**Second Surgical Opinions**

• Second surgical opinion by a doctor (in some cases). Sometimes, a third opinion may be covered.

**Telemedicine**

• Services in some rural areas.

**Travel (outside the United States)**

• Except for some emergency services in Mexico and Canada, the Original Medicare Plan doesn’t cover health care when traveling outside the United States. Some Medicare Advantage Plans, Medigap policies, and the Railroad Retirement Board have different rules.

**Urgently Needed Care**

• Medicare Part B covers urgently needed care. (care needed for sudden illness or injury that isn’t a medical emergency)

**Not Covered by Medicare**

Part B does not cover:

• most routine physical examinations, and tests directly related to such examinations (except some Pap smears and mammograms),
most routine foot care and dental care,
• examinations for prescribing or fitting eyeglasses and hearing aids,
• immunizations (except flu shots, pneumococcal pneumonia vaccinations or immunizations required because of an injury or immediate risk of infection, and hepatitis B for certain persons at risk), and
• cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body.

The Original Medicare Plan doesn’t cover everything. Items and services that aren’t covered include, but aren’t limited to:

- Acupuncture.
- Deductibles, coinsurance, or copayments.
- Dental care and dentures (with only a few exceptions).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Health care while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams for the purpose of fitting a hearing aid.
- Hearing exams (screening) unless ordered by their doctor.
- Long-term care, such as custodial care in a nursing home.
- Orthopedic shoes (with only a few exceptions).
- Outpatient prescription drugs (with only a few exceptions).
- private rooms in a hospital or nursing home—(unless required for medical reasons),
- private nursing,
- Routine foot care (with only a few exceptions).
- Routine eye care and most eyeglasses.
- Routine or yearly physical exams. (If your Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time physical examination within the first six months you have Part B.)
- Screening tests and labs except those listed.
- services required as a result of war,
- services covered by workers' compensation,
- Shots (vaccinations) except those listed.
- Some diabetic supplies (like syringes or insulin unless it is used with an insulin pump).

Using Doctors Who Don’t Accept Medicare

Some doctors don’t accept Medicare payments. To get care from a doctor who doesn’t accept Medicare payment, patients may be asked to sign a private contract. A private contract is a written agreement with a doctor who has decided not to participate in the Medicare program. The private contract only applies to the services received from the doctor (such as a physician, dentist, podiatrist, or optometrist). Patients can’t be asked to sign a private contract in an emergency situation or for urgently needed care.

Those who sign a private contract with a doctor

- will have to pay whatever this doctor or provider charges for the services. Medicare’s limiting charge won’t apply.
- no claim should be submitted to Medicare, and Medicare won’t pay if one is submitted.
• must divulge whether Medicare would pay for the service from another doctor who participates in Medicare.
• must divulge if he or she has opted out of, or been excluded from, the Medicare program.
• Medicare health plans won’t pay any amount for the services from this doctor.
• A Medigap policy, if there is one, won’t pay anything for this service.

Individuals may want to talk with someone in the State Health Insurance Assistance Program before signing a private contract.

**How Part B Medical Insurance is financed**

Medical Insurance is voluntary and is financed through premiums paid by the people who enroll and through funds from the federal government. Each person who enrolls must pay a basic monthly premium of $78.20 per month in 2005. Premium rates may be increased from time to time if program costs rise. In September of each year, the government announces the premium rate for the 12-month period starting the following January. The Part B premium is set so that it will cover 25% of the program's costs for the year. The other 75% comes from general tax payer’s funds.

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<th>Basic Monthly Premium Medical Insurance (Part B)</th>
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The premium rate for a person who enrolls after the first period when enrollment is open, or who reenrolls after terminating coverage, will be increased by 10% for each full 12 months the person stayed out of the program.
Persons covered will have the premiums deducted from their Social Security, railroad retirement, or federal civil service retirement benefit checks. Persons who are not receiving any of these government benefits will pay the premiums directly to the government.

The portion of the cost that must be borne by the patient

The patient pays the first $110 of covered expenses incurred in each calendar year. Medicare pays 80% of the balance of the approved charges (50% for out-of-hospital psychiatric or mental health services) over the $110 deductible. However, there is no cost-sharing for the following services:

- the cost of second opinions for certain surgical procedures when Medicare requires a second opinion,
- the cost of home health services except the 20% coinsurance charge applies for durable medical equipment (except for the purchase of certain used items),
- pneumococcal and flu vaccines, and
- outpatient clinical diagnostic laboratory tests performed by physicians who take assignments, or by hospitals or independent laboratories that are Medicare-certified.

Part C - MEDICARE ADVANTAGE

Medicare Advantage (Part C) provides an expanded set of options for the delivery of health care under Medicare. While all Medicare beneficiaries can receive their benefits through the original fee-for-service program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Advantage plan instead. The Part C program is a voluntary program providing options to enroll in a Medicare managed care program. The Balanced Budget Act of 1997 established Medicare Part C, the Medicare+Choice program. Legislation in 2003 renamed this program Medicare Advantage.

Medicare Advantage permits contracts between the Centers for Medicare & Medicaid Services and a variety of different managed care and fee-for-service entities. Organizations that seek to contract as Medicare Advantage plans must meet specific organizational, financial, and other requirements. Following are the primary Medicare Advantage plans:

- Coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law.

- Private, unrestricted fee-for-service plans, which allow beneficiaries to select certain private providers. Providers are authorized to charge enrolled beneficiaries up to 115% of the plan's payment schedule (which may be different from the Medicare fee schedule). For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor does it vary payment rates based on utilization.

Those who decide to join a Medicare Advantage Plan will use the health care card issued by their Medicare Advantage Plan (provider) to access health care. These plans often provide more choices and, sometimes, extra benefits, like extra days in the hospital. They may also be subject to additional premiums or co-payments.
Due to changing payment rates and other factors, the number of participating plans has declined in the last several years, as have the supplemental benefits offered by the plans.

Of the more than 41 million people are covered by the Medicare program. Fewer than five million people with Medicare are enrolled in a Medicare Advantage plan (HMO, PPO or PFFS). Most people with Medicare who have joined a Medicare Advantage plan are in health maintenance organizations (HMOs), which have been available under Medicare since the mid-1980s.

Most people with Medicare – about 60% – live in an area with at least one Medicare HMO or PPO plan. Yet only 11% of people with Medicare are now enrolled in a Medicare private plan. – MedPAC, 2004

Plan participation and enrollment has fluctuated over the past year. In 2004, there are:

- 145 Medicare Advantage plans, a drop from 346 in 1998.
- 4.6 million enrollees (11%), down from 6.3 million (16%) in 2000.
- 60% of beneficiaries with access to a private Medicare plan, down from 71% in 1999 (MedPAC, 2004).

With the new drug law, Medicare Advantage plans are expected to receive additional payments of $1.3 billion in 2004-2005 and over $14 billion between 2004-2013. CBO estimates that enrollment will rise slightly to 12%.

Nearly seven out of ten Medicare HMO enrollees are in a plan that offers prescription drug benefits under their “basic” option, but the level of drug coverage offered by Medicare HMOs varies from plan to plan. – Achman and Gold, Mathematica Policy Institute, 2003

The Administration estimates 31% of Medicare beneficiaries will enroll in MA plans by 2009, while CBO estimates an enrollment rate of 12% in 2009.
Plan enrollment varies widely across states. Less than 1% of Medicare beneficiaries are enrolled in plans in 18 states and D.C., while at least 25% are enrolled in CA, AZ, OR, and RI. Nationwide, over one-fourth of all Medicare HMO enrollees live in California.

The vast majority of Medicare Advantage plans are HMOs. To encourage PPO participation, the Centers for Medicare and Medicaid Services (CMS) created a demonstration with enhanced payment and risk-sharing arrangements. As of February 2004, there were 89,000 PPO enrollees concentrated in a small number of plans. There are fewer than 29,000 Medicare beneficiaries in private fee-for-service plans nationwide.

**What Medicare Advantage plans cover**

Managed care is a way of getting Medicare services through a health plan that coordinates many aspects of care. Instead of finding their own doctors and going to see any doctor who accepts Medicare, persons with Medicare Advantage agree to see only providers in the MCO’s network and to follow the rules of the health plan.

Medicare Advantage plans must provide all current Medicare-covered items and services. They may incorporate extra benefits in a basic package or they may offer supplemental benefits priced separately from the basic package.

Medicare Advantage Plans are available in many areas of the country. They manage the Medicare coverage for their members. Medicare pays a set amount of money for care every month to these private health plans. If Medicare Advantage Plans are available in their area, and they have Medicare Part A and Part B, they can join one and get Medicare-covered benefits through the plan.

In most of these plans, persons can only go to doctors, specialists, or hospitals on the plan’s list except in an emergency. This is called the plan’s “network.” They may also have to choose a primary care doctor and get referrals to see a specialist. They may pay lower copayments and get extra benefits, such as coverage for extra days in the hospital.

These are the general rules for how Medicare Managed Care Plans work. For some of these rules, plans may differ slightly, so it’s important to read plan materials carefully before enrolling:
In most Medicare Managed Care Plans, there are doctors and hospitals that join the plan (called the plan’s “network”). Persons may need to get most of their care and services from the plan’s network. Call or get a list from the plan to see which doctors and hospitals are in the plan.

To see a doctor or use a hospital out-of-network, consult the plan and the doctor or hospital as to what the costs will be.

People may be asked to choose a primary care doctor. If they want to keep seeing their current doctor, they should call and ask if he or she is in the Medicare Managed Care Plan. If not, ask them for a recommendation.

To change the primary care doctor, ask the plan for the names of other plan doctors in the area.

Doctors can join or leave Medicare Managed Care Plans at any time. If their primary care doctor should leave the plan, they will be notified in advance and allowed to pick a new doctor.

They get health care outside the plan’s service area, they may pay more, or it may not be covered. The service area is where the plan accepts members and where plan services are provided.

Special rules might apply for emergency or urgently needed care out of the managed care plan’s service area.

Patients usually need a referral to see a specialist (such as a cardiologist). A referral is a written OK from the primary care doctor to see a specialist or get certain services.

There are special rules for certain services. Women can go once a year, without a referral, to a specialist in the network for Medicare-covered routine and preventive women’s care services. If the type of specialist needed isn’t available, the plan will arrange for care outside the network.

Medicare Managed Care Plans may leave the Medicare program or change their benefits and premiums. However, new plans may be available.

Some Medicare Managed Care Plans offer a Point-of-Service option. This allows patients to go to other doctors and hospitals who aren’t a part of the plan (“out-of-network”), but they may pay more.

A few Medicare Managed Care Plans aren’t Medicare Advantage Plans. Generally, these plans still work as described, but some rules may be different. For instance, patients may be able to get non-emergency covered services from doctors and other health care providers that aren’t in the plan’s network.

**Medicare Health Maintenance Organizations (HMOs)**

Medicare HMOs cover the same doctor and hospital services as the original Medicare program, but out-of-pocket costs for these services are usually different. HMOs appeal to some people with Medicare because they may provide additional benefits, such as prescription drugs and eyeglasses, which are not covered by the traditional Medicare program. Those who choose an HMO may be able to get some help with these additional benefits. Typically, Medicare HMOs charge a premium that must be paid in addition to the Part B monthly premium.

Medicare HMO enrollees generally can only use doctors, hospitals, and other providers in the HMO’s network. For an additional fee, some HMOs offer point-of-service (POS) benefits that partially cover care received outside the network. Those who join a Medicare HMO will usually have to select a primary care doctor who is responsible for deciding when they should see a specialist, and which specialist they should see. Neither Medicare nor the HMO will pay for unauthorized visits to specialists in the plan, or to providers outside the HMO’s network, or for non-emergency care outside the HMO’s service area.
Medicare Preferred Provider Organization Plans (PPO)

Preferred Provider Organization Plans (PPOs) are among the most common and popular health plans right now for working Americans, and many retirees are familiar and comfortable with these plans.

In most of these plans, people can use doctors, specialists, and hospitals on the plan’s list (network) and pay lower copayments and get extra benefits, such as coverage for extra days in the hospital. They can also go to doctors, specialists, or hospitals not on the plan’s list, but it may cost extra and benefits may be more restricted.

They don’t need referrals to see doctors, specialists, or go to hospitals who aren’t part of the plan’s network. However, those who go to doctors, hospitals, or other providers who aren’t part of the plan ("out-of-network" or "non-preferred") may pay more. Every PPO plan is different in terms of what covered out-of-network is and how much participants will have to pay. Contact the PPO plan to find out more.

Medicare PPOs or "Preferred Provider Organizations" are very similar to Medicare HMOs, however, HMOs and PPOs differ in three key ways:

- Medicare PPOs will cover some of the costs of care if people use doctors and hospitals outside the network.
- Medicare PPOs will generally charge higher monthly premiums than Medicare HMOs.
- Medicare PPOs generally do not require them to see a primary care physician before going to a specialist.

Regional PPO Medicare Advantage Plans – New in 2006

New regional plans will be available to everyone with Medicare in the region they serve. Other plans can decide, with Medicare’s approval, to be open to everyone with Medicare in a state, or be open only in certain counties or parts of counties.

Between 10 and 50 regions will be established, and plans wishing to participate must serve an entire region. There are provisions to encourage plan participation, and a fund will be established that can be used to encourage plan entry and limit plan withdrawals.

In 2006, the Medicare Modernization Act will allow regional PPOs to give all people with Medicare choices for Medicare health care coverage. In a regional PPO, members will have an added protection. PPOs will limit the maximum amount that members pay for care outside the network.

Other Medicare Advantage Plans

Three additional private plan options may be available under the Medicare Advantage program. These include provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. Not all Medicare private plan options are available everywhere. To date, HMOs remain the primary alternative to traditional Medicare. For additional information about Medicare Advantage plans, call 1-800-MEDICARE, or get information about Medicare options on the Medicare Personal Plan Finder website, http://www.medicare.gov/MPPF/home.asp.
Medicare Private Fee-for-Service Plans

Medicare Private Fee-for-Service Plans are fee-for-service plans offered by private companies. The general rules for how Medicare Private Fee-for-Service Plans work are below.

- Patients can go to any Medicare-approved doctor or hospital that is willing to provide care and accepts the terms of the plan’s payment.
- Patients may get extra benefits not covered under the Original Medicare Plan, such as extra days in the hospital.
- The private company, rather than the Medicare program, negotiates with providers to decide how much it will pay and what participants pay for the services received.
- Patients may have to pay a premium to join a Medicare Private Fee-for-Service Plan. They may also have to pay other costs (such as a co-payment or coinsurance) for the services received. These costs may be different from those in the Original Medicare Plan.
- At the end of each year, the companies offering Medicare Private Fee-for-Service Plans may decide to join, stay with, or leave Medicare, or change their benefits or premiums.

Medicare Specialty Plans

These plans, if available, provide more focused health care for specific people. These plans provide all Medicare health care as well as more focused care to manage a specific disease or condition.

Medicare is working to create specialty plans, which are new ways to provide more focused health care for specific people. For example, these plans may be for people in certain long-term care facilities or people eligible for both Medicare and Medicaid. These Medicare specialty plans are designed to provide Medicare health care, as well as more focused care that is specially designed to treat specific groups of people or people with certain medical conditions. The goal is to provide health care in an efficient, effective, high quality manner to treat the special needs of the specific covered group.

Choosing a Medicare Advantage Plan

Medicare Advantage health plans attract Medicare beneficiaries by promising better service and, in some cases, reduced cost-sharing or additional benefits that traditional Medicare does not cover. Whether original Medicare, a Medicare HMO, or another Medicare plan is right will depend on individuals unique needs and circumstances. Here are some topics to consider:

Receiving care from the doctor and hospital of their choice

Under original Medicare, people can use whatever specialists and hospitals they choose, whenever they need, and without a referral from another doctor. Medicare Advantage plans could limit the ability to get care from the doctor or hospital of choice, or there may be extra charges for out-of-network care. If provider choice is a priority, people should consider original Medicare with added protection from a Medicare supplemental insurance policy, sometimes known as Medigap, or from an employer-sponsored or union retiree health plan, if one is offered.

People with disabilities or chronic health conditions often have complex needs that can be difficult to address by health care programs that provide services to mostly healthy people.
Some features of managed care, however, create special challenges for people with disabilities. One of the key features of managed care plans is that they frequently limit beneficiaries to a closed network of providers. Since there are often only a few qualified providers with the specialized skills for and experience in treating people with specific types of disabilities in a community, closed networks create a risk that people with disabilities will not have access to all of the types of providers they need, or they may not be able to continue seeing their current doctor.

People who are willing to limit their choice of doctors and hospitals may be able to reduce health care expenses and get coverage for additional benefits through a Medicare Advantage plan. It is important to review the scope and limits of additional benefits when choosing among available plans. It is also important to look at how much the out-of-pocket costs will be. For example, some Medicare private plans charge a deductible for each hospital admittance, while original Medicare only charges a deductible once per benefit period.

Those who join a Medicare Advantage Plan

- are still in the Medicare program
- still have Medicare rights and protections
- still get all the regular Medicare-covered services
- may be able to get extra benefits, such as coverage for extra days in the hospital

Out-of-pocket spending in a Medicare Advantage Plan depends on:

- whether the plan charges a monthly premium in addition to the monthly Part B premium ($78.20 in 2005)
- whether the plan reduces the monthly Part B premium
- how much is paid for each visit or service
- the type of health care needed and how often
- the types of extra benefits needed, and whether the plan covers them

Saving on the Medicare Part B Premium

As of 2003, Medicare Advantage plans are permitted to reduce Part B premiums as an extra benefit. In February 2004, six plans offered this option, making it available to 4% of Medicare beneficiaries.

Medicare Advantage Plans may pay all or part of the Medicare Part B premium. If a plan offers this benefit, it may save money. People should read the plan materials carefully before joining to see if the Medicare Advantage Plan offers lower premiums. Plans decide each year if they will reduce part or all of the Medicare Part B premium.

Medicare Advantage and Other Insurance

Sometimes other insurance pays health care bills first and the Medicare Advantage Plan pays second. Other insurance that may have to pay first includes: employer group health plan coverage (under certain conditions), no-fault insurance, liability insurance, black lung benefits, and workers’ compensation. It’s important to inform the doctor and hospital about other insurance so they will know how to handle bills correctly.
For questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information about who pays first, get a free copy of Medicare and Other Health Benefits: Your Guide to Who Pays First (CMS Pub. No.02179).

**Enrollment in Medicare Advantage**

Individuals can choose to enroll in the Part C program by enrolling in a Medicare Advantage health plan (also called a managed care organization or MCO) as an alternative to receiving Part A and Part B benefits through traditional Medicare. Medicare beneficiaries are not required to enroll in Medicare Advantage health plans.

Beneficiaries entitled to Medicare Part A and enrolled in Medicare Part B are eligible to enroll in a plan that services the geographic area in which they reside, except beneficiaries with end-stage renal disease (although beneficiaries who develop end-stage renal disease may remain in the plan if already enrolled). Medicare Part B only enrollees are ineligible for Medicare Advantage, but those who are already in a Medicare Managed Care Plan and have only Part B, may stay in the plan.

They have to pay the monthly Medicare Part B premium of $78.20 (in 2005) to Medicare. In addition, they might have to pay a monthly premium to the Medicare Advantage Plan for the extra benefits they offer. People should call the Medicare Advantage Plan they’re interested in to find out what extra benefits are offered and how much the monthly premium will be.

**When Beneficiaries May Enroll or Disenroll in Medicare Advantage Plans**

When first joining Medicare, people can join a Medicare Advantage Plan if one is available in their area and is accepting new members. People who have been in the Original Medicare Plan and later choose to join a Medicare Advantage Plan can join:

- generally, at any time in 2005 and coverage begins the first day of the month after the plan gets the enrollment form.
- between November 15 and December 31, if the Medicare Advantage Plan only accepts new members during this election period.

Some Medicare Advantage Plans stop accepting new members when they reach their membership limit.

Beneficiaries may enroll or disenroll in Medicare Advantage at any time of the year through 2005. In 2006, beneficiaries will be permitted to enroll or disenroll from Medicare Advantage only during the first six months of the year. After 2006, beneficiaries may enroll or disenroll only during the first three months of the year.

A person can’t join more than one Medicare Advantage Plan at the same time. If they try to join more than one Medicare Advantage Plan with the same starting dates, they may not be enrolled in either plan and may remain in the Original Medicare Plan.

A letter from the plan will be sent advising enrollees when coverage begins. Persons who join a Medicare Advantage Plan, should get a membership card with the name of the plan on it. If not sure if they are in a Medicare Advantage Plan, they can call the telephone number listed on the
membership card. Those who get benefits from the Railroad Retirement Board (RRB), should contact the local RRB office or 1-800-808-0772 to check if they are in a Medicare Advantage Plan.

**Special Rules for People with End-Stage Renal Disease**

Those who have End-Stage Renal Disease (ESRD) usually can't join a Medicare Advantage Plan. However, those already in a plan can stay in the plan or join another plan offered by the same company in the same state. Those who have had a successful kidney transplant may be able to join a plan.

Those with ESRD who are in a Medicare Advantage Plan, which leaves Medicare or no longer provides coverage in their area, have a one-time right to join another Medicare Advantage Plan. They don't have to use the one-time right to join a new Medicare Advantage Plan immediately. If they change directly to the Original Medicare Plan after the plan leaves or stops providing coverage, they will still have a one-time right to join a Medicare Advantage Plan at a later date as long as the plan is accepting new members.

**Medigap (Medicare Supplement Insurance) Policies and Medicare Advantage Plans**

Those in a Medicare Advantage Plan don't need a Medigap policy because Medicare Advantage Plans generally cover many of the same benefits that a Medigap policy would cover. A medical policy may cost a lot and people may get little or no benefit from it while in a Medicare Advantage Plan. The State Health Insurance Assistance Program can provide help deciding whether to keep the Medigap policy. Those who drop their Medigap policy may not be able to get it back, except in certain situations. If they join a Medicare Advantage Plan when they first become eligible for Medicare at age 65, or if this is the first time enrolled in a Medicare Advantage Plan, they may have special Medigap protections that provide a right to buy a Medigap policy later if desired. For more information on Medigap policies and protections, get a free copy of *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (CMS Pub. No.02110).

**Medicare Advantage Plan and Union Coverage**

Those who join a Medicare Advantage Plan and also have employer or union coverage, may, in some cases, still be able to use this coverage along with the Medicare Advantage Plan coverage. People should consult their employer or union benefits administrator about the rules that apply, since if employer or union coverage is dropped, they may not be able to get it back.

**Leaving a Medicare Advantage Plan**

In 2005, persons may leave a Medicare Advantage Plan at any time for any reason. After they request to leave, the plan will let them know, in writing, the date coverage ends. Generally, this date will be the first day of the month after they ask the plan to disenroll them.

**Joining a New Medicare Advantage Plan**

Persons can leave a Medicare Advantage Plan to join a new Medicare Advantage Plan by enrolling in the new plan. It is not necessary for them to tell their old plan they are leaving or send them anything. They will be disenrolled automatically from the old plan when the new plan
coverage begins. They should get a letter from the new plan advising when coverage starts. This right will be restricted to the first 6 months of the year in 2006 and to the first 3 months of the year in 2007 and beyond.

**Returning to the Original Medicare Plan**

People can leave the Medicare Advantage Plan and return to the Original Medicare Plan in one of three ways:

- Write or call the plan
- Call 1-800-MEDICARE (1-800-633-4227)
- Visit, call, or write the Social Security Administration

Those who get benefits from the Railroad Retirement Board (RRB) and want to leave a Medicare Advantage Plan should call the local RRB office or 1-800-808-0772. The plan should send them a letter with the date that coverage ends. If a letter is not received, they should call the plan and ask for the date.

Those who want to change to the Original Medicare Plan and buy a Medigap policy, need to leave the Medicare Advantage Plan in one of the three ways listed above. Simply signing up for the Medigap plan won’t end Medicare Advantage Plan coverage.

**Moving Out of the Plan’s Service Area**

Persons who move out of the plan’s service area may have to leave the plan. However, they can call the health plan to see if they can stay in the plan. Those who must leave the plan can choose to join another Medicare Advantage Plan, if one is available in their new area and is accepting new members, or, they can choose the Original Medicare Plan, and may also have the right to buy a Medigap policy.

**Medicare Advantage Plan leaves the Medicare program**

If a Medicare Advantage Plan leaves the Medicare program, members will be sent a notification letter. The letter will include whether there are other Medicare Advantage Plans in the area that they may join. They will automatically be returned to the Original Medicare Plan if they don’t choose to join another Medicare Advantage Plan. They may have the right to buy a Medigap policy. No matter what choice they make, they are still in the Medicare program and will get all Medicare covered services. For more information, get a free copy of *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (CMS Pub. No. 02110).

**Medicare Advantage Plan Reduces its Service Area**

A Medicare Advantage Plan may decide not to provide services in all counties or ZIP codes in an area. If a Medicare Advantage Plan reduces its service area and there are no other Medicare Advantage Plans in the area, they may be able to keep their coverage. In this case, they must agree to travel to the plan’s service area to get all services (except for emergency and urgently needed care). If the plan doesn’t offer this option, they will automatically return to the Original Medicare Plan on January 1. In this case, they may have the right to buy a Medigap policy.

**Appealing a Medicare Advantage Plan’s Decisions**
Those with Medicare have certain guaranteed rights. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. No matter what kind of Medicare health plan they choose, participants always have the right to appeal. Some of the reasons for appeal are when

- a service or item isn’t covered, and they think it should be.
- a service or item is denied, and they think it should be paid.
- they question the amount that Medicare paid.

Patients have the right to file an appeal if the plan won’t pay for, doesn’t allow, or stops a service that they think should be covered or provided. After filing an appeal, the plan will review its decision. If waiting for a decision could harm health, the plan must answer within 72 hours. If the plan doesn’t decide in their favor, it will send the appeal to a review organization that isn’t part of the plan. The plan’s membership materials should provide details about appeal rights and how to file an appeal. Persons have a right to ask for a copy of their file containing their medical history and other information about the appeal. For more information about appeal rights, get a free copy of Your Medicare Rights and Protections (CMS Pub. No.10112).

**Part D - PRESCRIPTION DRUG BENEFIT**

The cost of prescription drugs has been going up rapidly year after year. People who rely on prescription drugs to maintain their health have been under increasing financial pressure, especially if they do not have insurance that helps cover the cost of their medicines.

Concerns about seniors lacking prescription drug coverage and the rising cost of drugs led to the enactment of the new Medicare Part D prescription drug benefit. The Voluntary Prescription Drug Benefit Program consists of two parts: Medicare-approved drug discount cards, which are available in 2004 and 2005, and prescription drug benefits, which begin in 2006.

- More than one in five seniors say they did not fill a prescription or skipped doses of a prescription medicine due to cost. *Kaiser/Commonwealth/Tufts-New England Medical Center 2001 Survey of Seniors in Eight States, 2002*
- About one in three Medicare beneficiaries will qualify for low-income assistance under the new Part D benefit (including people who are already enrolled in Medicaid). - *Congressional Budget Office, 2003*
- Generic drugs typically cost 30% to 60% less than the brand-name drugs they replace. Generics use the same active ingredients, have the same medical effect, and meet the same quality standards as brand-name drugs, according to the FDA. – *Congressional Budget Office, 1998*

For individuals entitled to Part A and/or enrolled in Part B (except those entitled to Medicaid drug coverage), the new Part D initially provides access to prescription drug discount cards, at a cost of no more than $30 annually. For low-income beneficiaries, Part D initially provides transitional financial assistance (of up to $600 per year) for purchasing prescription drugs, plus a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and will phase out on December 31, 2005.

Medicare will pay for outpatient prescription drugs through private plans beginning in January 2006. Beneficiaries can remain in traditional Medicare and enroll separately in a private prescription drug plan, or they can enroll in a Medicare Advantage plan that also covers prescription drugs.
**Medicare Drug Discount Card**

As an interim measure before the drug benefit begins, people with Medicare can purchase Medicare-approved drug discount cards that may help lower the cost of some prescriptions in years 2004 and 2005.

The Medicare-approved drug discount card program is intended to help people with Medicare with drug costs before the new benefit becomes available in 2006. Companies offering Medicare-approved discount cards can charge up to $30 per year to enroll. In exchange, card sponsors will offer discounts on the cost of specific prescription drugs – both brand name and generic – through retail pharmacies and in some cases, mail order. Anyone with Medicare, except those with drug coverage through Medicaid, are eligible to enroll. In addition, people whose incomes are below $1,060.68 a month ($12,728.10 per year) in 2005, if single, and $1,421.99 a month ($17,063.90 per year) in 2005, if married, may be eligible for up to $1,200 towards the cost of their drugs ($600 in calendar year 2004 and another $600 in 2005). Any savings realized are not counted as part of income in qualifying for the $600.

To get the $600 credit, people have to apply for a Medicare-approved drug discount card AND for the $600 credit. For those who qualify, Medicare will put the credit on their Medicare-approved drug discount card, which they can use it to get prescriptions. (While using the $600 credit, they will still have to pay a small coinsurance amount for each prescription.) When they have used all of the $600 credit, they can still use the Medicare-approved drug discount card to save money by getting discounted prices on covered prescription drugs.

The amount of the credit people get will depend on when they join as shown by the chart below:

<table>
<thead>
<tr>
<th>Apply between</th>
<th>Get a</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1–March 31, 2005</td>
<td>$600 credit</td>
</tr>
<tr>
<td>April 1–June 30, 2005</td>
<td>$450 credit</td>
</tr>
<tr>
<td>July 1–September 30, 2005</td>
<td>$300 credit</td>
</tr>
<tr>
<td>October 1–December 31, 2005</td>
<td>$150 credit</td>
</tr>
</tbody>
</table>

**Note:** In Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, different rules apply.

In addition to people with incomes over the limits, persons can't get the $600 credit if they already have outpatient prescription drug coverage from any of the following:

- Medicaid
- TRICARE for Life (military health insurance)
- FEHB (health insurance coverage for Federal employees and retirees)
- Employer group health plan or other health insurance (except through Veteran’s benefits, Medicare Advantage Plans, or a Medigap policy)
- Medicare Managed Care Plan that isn’t a Medicare Advantage Plan, and offers an outpatient prescription drug benefit to its members

Enrollees can sign up for only one Medicare-approved card per year. A person with prescription drug coverage under Medicaid or an employer health plan is not eligible for the $600 credit.

Discount cards do not provide coverage for prescription drugs, but they do offer a discount off the full retail price of some drugs. Drug card sponsors negotiate discounts with pharmacies and drug stores. If married, both spouses must each apply for their own card. They may not share or use each other’s cards. If they use different prescription drugs, they may find that it makes sense to enroll in different card programs. Or they may find that a card makes sense for one but not for the other. Manufacturers are expected to pass savings along to card program enrollees.

Discount cards may not provide as much cost relief as insurance coverage for prescription drugs, but they are likely to provide savings for those without any drug coverage, compared to the full retail price they would otherwise pay. Medicare-approved drug discount cards are estimated to produce savings of 10 percent to 25 percent overall, although no minimum discount is required.

Those who decide to enroll in a discount card must enroll directly with the company offering the card – not through Medicare. Some companies may allow application by phone or on the Internet. Other companies may use a mail in form. Once enrolled in a card program, enrollees are not allowed to switch cards. Those who are eligible and haven’t enrolled yet can enroll anytime until December 31, 2005.

The drugs that are discounted and the amount of the discount offered vary among different cards and can change, so consumers should compare the Medicare-approved drug discount cards carefully. There are no guaranteed minimum discounts. How much is saved will depend on which card is chosen, the specific drugs taken, willingness to shift to lower-cost generics or cheaper, equivalent drugs and willingness to change pharmacies and/or use mail order.

Any discount card sponsor can change its list of discounted drugs, and the level of discounts, as often as once a week. Card sponsors are not required to tell anyone about these changes unless they ask. However, the company must make current drug prices available on its website and by phone. Medicare also makes this information available through the Medicare website (www.medicare.gov) and the toll-free phone number, 1-800-MEDICARE.

Some cards may offer discounts only at certain pharmacy chains. Some may offer discounts in only one state. Individuals should find out what a card’s pharmacy rules are before signing up, and make sure they will be able to use the card where they want to use it. Each drug discount card has a list of pharmacies where the discount card can be used. Consumers must go to a pharmacy that accepts their Medicare-approved drug discount card to get the discounted price.

For those who are enrolled in a Medicare Advantage Plan or a state program that helps pay for prescriptions, different rules might apply. They should contact their Medicare Advantage Plan or state program for more information.

Once the enrollment form has been processed and accepted, the company will send its Medicare-approved drug discount card. Enrollees can start using the card the first day of the month after the month in which they enrolled. People can have only one Medicare-approved drug discount card at a time. Those who have non-Medicare-approved drug discount cards may use these and Medicare-approved drug discount card, but not on the same prescription at the same time.
To get discount information, people can call 1-800-MEDICARE and Medicare operators can provide some information over the phone and mail information about the discounts available on the drugs they take at the pharmacies in their area. They can find the same information at www.medicare.gov/AssistancePrograms. Another option is to talk with a counselor at the State Health Insurance Assistance Program (SHIP). They can also contact card sponsors directly to ask about their discounts for specific drugs. Card sponsor contact information is available through the Medicare website or phone number. For more information about Medicare-approved drug discount cards look at www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) and get a free copy of the booklet Guide to Choosing a Medicare-Approved Drug Discount Card (CMS Pub. No. 11062).

Those who are in a skilled nursing facility or a nursing facility, or who get their prescriptions through special pharmacies for American Indians or Alaska Natives, may have special options. Call 1-800-MEDICARE (1-800-633-4227) to find out more. TTY users should call 1-877-486-2048. Or, look at www.medicare.gov on the web. Select “Prescription Drug and Other Assistance Programs.”

**Medicare Prescription Drug Coverage**

On January 1, 2006, Medicare-approved drug discount cards will begin to phase out and the new Medicare prescription drug plans will begin. Drug benefits, not just discounts, will be provided through private plans. Medicare will contract with private companies to offer this drug coverage. These companies will most likely offer a variety of options, with different covered prescriptions, and different costs.

Starting November 15, 2005, beneficiaries can begin signing up for Part D coverage. Those who want to remain in original Medicare (the traditional fee-for-service program) for their Medicare benefits will be able to sign up for drug coverage under stand-alone, private prescription drug plans (PDPs). Others may choose to get all Medicare benefits, including new prescription drug benefits, from Medicare Advantage plans.

Each plan will set its own premium and benefits, within certain guidelines established by Medicare. Like the prescription drug discount cards, each plan may limit coverage to a specific list of drugs, and the list may change during the year. For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage. (Late enrollment penalties may apply under certain circumstances.)

Part D covers most FDA-approved prescription drugs and biologicals. Those specific drugs currently covered in Parts A and B will still be covered there.
In 2006, under the standard Part D benefit, beneficiaries will pay:

- The first $250 in drug costs (deductible);
- 25% of total drug costs between $250 and $2,250;
- 100% of drug costs between $2,250 and $5,100 in total drug costs (the $2,850 gap), equivalent to a $3,600 out-of-pocket limit;
- The greater of $2 for generics, $5 for brand drugs, or 5% coinsurance after reaching the $3,600 out-of-pocket limit ($5,100 catastrophic threshold).

The deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending. As a result, the benefit gap is projected to increase from $2,850 in 2006 to $5,066 in 2013.
Plans are permitted to offer an alternative benefit design provided the alternative plan is actuarially equivalent and does not increase the Part D deductible or out-of-pocket limit. Plans are required to provide drugs in each therapeutic class or category but have flexibility to establish preferred drug lists. They may also create a preferred network of pharmacies and reduce beneficiary cost sharing for drugs dispensed by preferred pharmacies.

Some people may want to supplement the Medicare Part D drug benefit with additional coverage and will be able to buy supplemental drug coverage from the same company that provides the basic drug benefit.

**Enrolling**

The first chance to enroll will be in November 2005. The new drug benefit is voluntary, but if people don’t enroll when first become eligible, they may have to pay a late-enrollment penalty to sign up at a later date. This penalty will be added to their premium each month for the whole time they are enrolled in Medicare Part D. The longer they delay their Part D enrollment, the higher the penalty. However, they won’t have to pay this penalty if they have other drug coverage that is at least as comprehensive as Part D coverage.

Those who already have prescription coverage from other insurance can keep that coverage. If that coverage offers the same or better benefits as described above, they won’t have to pay a higher premium if they join later. They should check with the other insurance to see how the coverage compares.

To enroll, people must have Medicare Part A or Part B. They can first enroll from November 15, 2005 through May 15, 2006. This is called the “initial open enrollment period.” After this initial open enrollment period, people can change their plan during the open enrollment period, which will be from November 15 through December 31 each year. Their Medicare prescription drug plan will begin January 1 of the following year.

To join, they will need to decide how they want to get their prescriptions. People can

- get all their health care benefits and prescriptions through a Medicare Advantage Managed Care Plan that offers optional coverage for prescription drugs,
- get their health care benefits through the Original Medicare Plan and choose a Medicare prescription drug plan, or
- get their health care benefits through another type of Medicare Advantage health plan or a Medicare Managed Care Plan that isn’t a Medicare Advantage Plan. In these kinds of plans, they may be able to choose a Medicare prescription drug plan.

Information for People with Lower Incomes

Those with low incomes and limited assets will get extra help to pay for prescriptions. People with low incomes will not be required to pay the monthly premiums or the deductibles, and will pay smaller co-payments as well.

To help ensure that everyone who qualifies for this assistance will be enrolled on time, the Social Security Administration (SSA) and local Medicaid offices will begin accepting applications from people with low incomes as early as summer 2005. By submitting the application early, they can ensure that the assistance with their Medicare prescription drug plan premiums and deductibles will start when the program begins on January 1, 2006.

Other Ways to Save Money

Some people may be able to save money on prescription costs by choosing generic drugs instead of more expensive brand names. Generic drugs are approved by the Food and Drug Administration (FDA) and go through the same rigorous review process as their brand name alternatives. Generic drugs are just as safe and effective as their brand-name counterparts. From quality and performance to manufacturing and labeling, all drugs that the FDA approves, including generic drugs, must meet the exact same high standards. The key difference is that increased competition means that generic drugs often cost much less than most brand name drugs.

Some persons may be able to enroll in a free discount card that is not participating in the “Medicare-approved” program or purchase discounted drugs from companies that offer mail-order services to the general public. Enrollees can only use one card at a time and may not combine more than one discount on a single prescription.

How Current Drug Coverage May Be Affected by Discount Cards

Whether a person should get a Medicare-approved discount card depends on what type of health and drug coverage they have, and how it would interact with a discount card. For those who currently have prescription drug coverage, it is important to understand how the new law will affect it and what steps to take to make sure they achieve the greatest savings on the purchase of medications. This section offers some help in understanding how the new law will affect sources of drug coverage for those who currently have drug benefits.

Drug Coverage From a Former or Current Employer

To encourage employer and union plans to continue to offer prescription drug coverage to Medicare retirees, Part D also provides for certain subsidies to those plans that meet specific criteria.
In most cases, employer coverage will provide far more generous assistance with drug costs than a Medicare-approved discount card, so most people will want to stick with employer coverage.

In 2006, employers that elect to provide prescription drug benefits comparable to Part D will receive subsidies from Medicare, which will pay 28% of costs between $250 and $5,000 in drug expenses per retiree. As a result of the new law, CBO estimates that nearly 20% of Medicare beneficiaries with retiree coverage would lose drug benefits from an employer plan.

Many employers are expected to continue providing drug coverage exactly as they had before the Part D benefit goes into effect. Others may opt to wrap around the Medicare drug benefit and/or pay the monthly premium for Medicare drug coverage. Prior to 2006, people should ask their employer what to expect when the Medicare Part D benefit goes into effect.

**Medicare Advantage Plan with Drug Coverage**

People enrolled in a Medicare Advantage Plan should ask the managed care plan whether a Medicare-approved discount card can be used along with current coverage. Many plans are offering their own discount cards to their enrollees.

In 2006, all Medicare Advantage organizations will offer a plan with a prescription drug benefit under Medicare Part D. This benefit package may be different from the one they have now. Those who want to enroll in Part D may choose the prescription drug plan offered by their managed care plan, switch to a different Medicare Advantage plan, or choose traditional Medicare and enroll in a PDP, a private plan that offers the drug benefit. Because the program is voluntary, people can choose not to enroll in Part D, but at a later date, those who decide they want Part D coverage will be charged a delayed enrollment fee for every month they did not sign up for Part D coverage.

**Medigap Policy that Covers Drugs (Plan H, I, or J)**

Until 2006, consumers may use both a Medicare-approved discount card and Medigap coverage (although they cannot be used simultaneously to purchase a prescription). Beginning in 2006, Medigap insurers will no longer be allowed to issue new policies that include or supplement Part D coverage.

Beneficiaries who already have Medigap policies with drug coverage may keep those policies. People need to decide, however, whether to keep Medigap coverage for prescription drugs or enroll in Medicare Part D. They cannot do both. Those who keep Medigap drug coverage but decide later that they want to enroll in Part D may have to pay a late enrollment penalty. Those who choose to enroll in Part D can switch to another Medigap plan that does not include drug coverage. Advice on this decision is available from the local State Health Insurance Assistance Program (SHIP).

**Drug Coverage through Medicaid**

Until 2006, nothing changes for those with drug coverage under Medicaid. By law, people will keep drug coverage through the Medicaid program, as long as they remain eligible for the program. They are not eligible to sign up for a Medicare approved discount card because their coverage is already better than what they would get from a discount card. These people who contact state’s Medicaid program with any questions about Medicaid coverage.
In 2006, drug coverage for dual eligibles will change from Medicaid to Medicare, and people must enroll in a private drug plan under Medicare Part D in order to have drug coverage. Enrollees will pay up to $1 for generic prescriptions and up to $5 for brand-name prescriptions, depending on income.

States will pay Medicare a share of the aggregate amount they would have spent on prescription drugs for dual eligibles if the law had not been enacted, resulting in an $88.5 billion “claw back” 2006-2013. Medicaid spending is projected to decrease by $17 billion across all states over this period, mostly after 2008. States may only use state dollars, not federal Medicaid matching funds, to help with cost-sharing or to cover drugs that are not on a Part D plan’s formulary.

The drug coverage provided under Medicare Part D will not necessarily be the same as that currently received under Medicaid. It is important that people choose a plan carefully and select the best plan available to meet their needs by January 1, 2006. Those who don’t sign up by that date will be assigned to a plan.

State Pharmacy Assistance Program

State Pharmaceutical Assistance Programs, serving 1.3 million elderly and under-65 disabled beneficiaries in 2002, will be permitted to supplement Part D coverage. Leading up to 2006, people should ask for information about how the program will work with the Part D benefit when it goes into effect in 2006. Many states are working out the details about how their prescription drug assistance programs will coordinate with the Part D benefit.

LOW-INCOME ASSISTANCE

Low-income beneficiaries will have to meet both an income and asset test to receive assistance for the first time in Medicare. An estimated 1.8 million beneficiaries who meet the income test will not qualify for assistance as a result of the asset test (CBO).

Medicare will provide additional assistance to beneficiaries who qualify based on low incomes and limited assets. CBO estimates 14.1 million beneficiaries will be eligible for such assistance.

- **Beneficiaries who are eligible for full Medicaid benefits (approximately 6.3 million dual eligibles)** will begin to receive drug benefits under Medicare rather than Medicaid in 2006. They will pay no premium or deductible, and no drug costs above the out-of-pocket threshold.

  Below that threshold, those with incomes under 100% of poverty will pay $1 to $3 copays; those above the poverty line will pay $2 to $5 copays.

- **Beneficiaries with incomes below 135% of the poverty level and assets** under $6,000/single; $9,000/couple (approximately 5.8 million people) will receive a subsidy to cover the average premium for basic coverage in their region. They will pay $2 to $5 copays with no deductible and no cost-sharing above the out-of-pocket threshold.

- **Beneficiaries with incomes below 150% of the poverty level and assets** under $10,000/single; $20,000/couple (approximately 1.9 million people) will receive premium subsidies on a sliding scale. They will pay a $50 deductible, 15% coinsurance up to the out-of-pocket threshold, and $2 to $5 copays above the threshold.
Estimated Cost of the New Prescription Drug Coverage -- Part D

Congressional Budget Office (CBO) estimates the new law will increase direct spending outlays by $395 billion between 2004 and 2013. The legislation consists of an estimated $409.8 billion for the prescription drug benefit, which includes $192 billion in low-income subsidies and $71 billion in direct subsidies for employers. In addition, the legislation includes $14.2 billion for Medicare Advantage plans and $19.9 billion for rural providers. Offsets include beneficiary premiums ($131 billion); state Medicaid “clawback” payments (-$88.5 billion); efforts to address waste, fraud, and abuse (-$31.3 billion); provisions to income-relate the Part B premium (-$13.3 billion); and indexing the Part B deductible (-$11.6 billion).


Note: Other sources and government agencies have estimated the cost of this program to the US public to be over $700 billion.
GENERAL MEDICARE INFORMATION

Over-all Limit to the Benefits under Medicare

Under the Part A Hospital Insurance plan, benefits begin anew each "benefit period." In addition, there are no dollar limits under Part B Medical Insurance except for psychiatric care and independent physical and occupational therapy. Under Hospital Insurance, care in a psychiatric hospital is subject to a lifetime limit of 190 days. (The time a patient has spent in a hospital for psychiatric care immediately prior to becoming eligible for Medicare counts against the special 150-day limit in the first hospitalization period, but not against the 190-day life-time limit.) Under Medical Insurance, coverage of psychiatric treatment outside a hospital is subject to an annual benefit limit of $1,100 and services of independent physical therapists are reimbursable to no more than $1,500 per calendar year (as also applies to the services of independent occupational therapists).

Medicare may limit benefit payments for services for which other third party insurance programs (e.g., workers’ compensation, auto or liability insurance, and employer health plans) may ultimately be liable. Medicare has the right to:

- bring an action against any entity which would be responsible for payment with respect to such item or service,
- bring an action against any entity (including any physician or provider) which has been paid with respect to such item or service, or
- join or intervene in an action against a third party.

Choice of Doctor or Hospital under Medicare

Generally, patients are free to choose their own doctor or other supplier of services. However, except for hospital care in emergency cases, Medicare will pay only "qualified" hospitals, extended care facilities and home health agencies.

Use of a foreign hospital by a U.S. resident is authorized only when such hospital is closer to the patient's residence or is more accessible than the nearest United States hospital. But such hospitals must be approved. Medicare also authorizes payment for emergency care in a foreign hospital when the emergency occurred in the United States or in transit between Alaska and other continental states. Necessary physicians’ services in connection with such foreign hospitalization are authorized under Medical Insurance.

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
<th>Medicare Pays</th>
<th>A Person Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITALIZATION Semiprivate room and board, general nursing, and other hospital services and supplies</td>
<td>First 60 days</td>
<td>All but $912</td>
<td>$912</td>
</tr>
<tr>
<td></td>
<td>61st to 90th day</td>
<td>All but $228 a day</td>
<td>$228 a day</td>
</tr>
<tr>
<td></td>
<td>91st to 150th day¹</td>
<td>All but $456 a day</td>
<td>$456 a day</td>
</tr>
<tr>
<td></td>
<td>Beyond 150 days</td>
<td>Nothing</td>
<td>All costs</td>
</tr>
</tbody>
</table>

¹ Effective after January 1, 2005.
<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
<th>Medicare Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKILLED NURSING FACILITY CARE</td>
<td>First 20 days</td>
<td>100% of approved amount</td>
<td>Nothing</td>
</tr>
<tr>
<td></td>
<td>Additional 80 days</td>
<td>All but $114 a day</td>
<td>$114 a day</td>
</tr>
<tr>
<td></td>
<td>Beyond 100 days</td>
<td>Nothing</td>
<td>All costs</td>
</tr>
<tr>
<td>POST-HOSPITAL HOME HEALTH CARE</td>
<td>First 100 days in spell of illness</td>
<td>100% of approved amount; 80% of approved amount for durable medical equipment</td>
<td>Nothing for services; 20% of approved amount for durable medical equipment</td>
</tr>
<tr>
<td>HOSPICE CARE</td>
<td>For as long as the doctor certifies need</td>
<td>All but limited costs for outpatient drugs and inpatient respite care</td>
<td>Limited costs for outpatient drugs and inpatient respite care</td>
</tr>
<tr>
<td>BLOOD</td>
<td>Unlimited if medically necessary</td>
<td>All but first 3 pints per calendar year</td>
<td>For first 3 pints</td>
</tr>
</tbody>
</table>

1. 60 Reserve days may be used only once in a lifetime.
2. Neither Medicare nor private Medigap insurance will pay for most nursing home care.
3. Blood paid for or replaced under Part B of Medicare during the calendar year does not have to be paid for or replaced under Part A.

**TABLE OF MEDICAL INSURANCE (PART B) BENEFITS**
**Effective after January 1, 2005**

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
<th>Medicare Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL EXPENSE</td>
<td>Unlimited if medically necessary.</td>
<td>80% of approved amount (after $110 deductible). Reduced to 50% for most outpatient mental health services.</td>
<td>$110 deductible, plus 20% of approved amount and limited charges above approved amount.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Coverage Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLINICAL LABORATORY SERVICES</td>
<td>Unlimited if medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood tests, urinalyses, and more</td>
<td>Generally 100% of approved amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nothing for services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOME HEALTH CARE</td>
<td>Unlimited but covers only home health care not covered by Hospital Insurance (Part A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.</td>
<td>100% of approved amount; 80% of approved amount for durable medical equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nothing for services; 20% of approved amount for durable medical equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT HOSPITAL TREATMENT</td>
<td>Unlimited if medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for the diagnosis or treatment of illness or injury.</td>
<td>Medicare payment to hospital based on hospital cost.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% of whatever the hospital charges (after $100 deductible).¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLOOD</td>
<td>Unlimited if medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% of approved amount (after $110 deductible and starting with 4th pint).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>First 3 pints plus 20% of approved amount for additional pints (after $110 deductible).³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMBULATORY SURGICAL SERVICES</td>
<td>Unlimited if medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% of pre-determined amount (after $110 deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$110 deductible, plus 20% of pre-determined amount</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Once a person has $110 of expense for covered services in 2005, the Part B deductible does not apply to any further covered services received for the rest of the year.
2. A person pays for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.
3. Blood paid for or replaced under Part A of Medicare during the calendar year does not have to be paid for or replaced under Part B.

**MEDICARE EXPENDITURES AND FINANCING**

Medicare benefit payments accounted for 19% of total spending for personal health services in the U.S. in 2002. Medicare also financed 31% of the nation’s hospital services and 21% of physician and clinical services.
Payments Under Medicare

The government has appointed organizations engaged in the health insurance field (mainly insurance companies or Blue Cross and Blue Shield organizations) to act as contractors in administering Medicare. Using federal guidelines, a contractor determines the approved charges and makes payments, either directly or by way of reimbursement, to participants and suppliers of services.

Hospitals, skilled nursing facilities, and home health agencies are paid directly by the contractors. However, a hospital may collect deductibles and coinsurance amounts directly from the patient. Payment of a doctor's fees (or charges of another individual supplier of services) may be handled in either of two ways. The patient may submit an itemized bill (receipted or unpaid) to the contractor and receive payment (or the doctor may do this for the patient). Or, with the doctor's approval, the patient may assign his right to payment to the doctor or other supplier of services (and such doctor or other supplier agrees to limit the charges to what Medicare determines). This is called the "assignment" method.

Under the first method, the patient will receive 80% of what the contractor determines is an approved charge for the services after the $110 deductible (2005)—regardless of the actual charge. If the doctor or other suppliers of services accepts an assignment, his combined charge to Medicare and the patient cannot exceed what the contractor determines is an approved charge for his services.

Benefits are permitted to be paid to a health benefits plan, provided the beneficiary agrees and the physician or other supplier accepts the plan's payment as payment in full. This indirect payment procedure is available to group, as well as non-group, employers and non-employment health benefits plans such as employers, unions and insurance companies.

Program Financing, Beneficiary Liabilities, and Provider Payments
The following sections describe Medicare’s financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Medicare spending growth has generally been slower than the corresponding rise in private health care spending. For the years 1985-2002, spending for benefits commonly covered by Medicare and private health insurance grew at an annual rate of 5.8% in both Medicare versus 7.4% for private plans (Levit et al., 2004). Medicare has also had lower administrative costs, accounting for less than 2% of total Medicare spending in 2002 (CBO, 2003), compared to 13% for private health insurers (Levit et al., 2004).

**Program Financing**

All financial operations for Medicare are handled through two trust funds, one for HI (Part A) and one for SMI (Parts B and D). These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities.

The HI trust fund is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by Part A and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The Part A tax rate is 1.45 percent of earnings, to be paid by each employee and a matching amount by the employer for each employee, and 2.90 percent for self-employed persons. Beginning in 1994, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The Part A tax rate is specified in the Social Security Act and cannot be changed without legislation.

Part A also receives income from the following sources:

- a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries;
- premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily;
- reimbursements from the general fund of the U.S. Treasury for the cost of providing Part A coverage to certain aged persons who retired when Part A began and thus were unable to earn sufficient quarters of coverage (and those Federal retirees similarly unable to earn sufficient quarters of Medicare-qualified Federal employment);
- interest earnings on its invested assets; and
- other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

According to the 2004 Trustees’ Report, the Part A trust fund is projected to be exhausted in 2019. Looking at the Medicare program as a whole, over half (56%) of spending in 2003 was funded by payroll taxes and interest on the trust funds. General revenues accounted for 30% of the total and premiums represented 10%. The MMA established a new measure requiring Congress to take action when, for two years in a row, general revenues are projected to fund more than 45% of Medicare’s program costs within the next seven years. The Administration projects that general revenues will fund more than 45% of Medicare’s program costs beginning in 2012.
The SMI trust fund differs fundamentally from the HI trust fund with regard to the nature of its financing. SMI is now composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The nature of the financing for both parts of SMI is similar, in that both parts are primarily financed by beneficiary premiums and contributions from the general fund of the U.S. Treasury.

Part B is financed through premium payments ($78.20 per beneficiary per month in 2005) and contributions from the general fund of the U.S. Treasury. (Penalties for late enrollment may apply.) Beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Therefore, the contributions from the general fund of the U.S. Treasury are the largest source of Part B income.

Similarly, Part D, once under way in 2006, will be financed primarily through premium payments and contributions from the general fund of the U.S. Treasury, with general fund contributions accounting for the largest source of Part D income, since beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage. The premiums and general fund contributions for Part D will be determined separately from those for Part B. (In 2004 and 2005, the general fund of the U.S. Treasury will finance the transitional assistance benefit for low-income beneficiaries by providing funds to a Transitional Assistance account within the SMI trust fund. The proceeds will be transferred to the Part D account at the conclusion of the temporary program.)

The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. For both Parts B and D separately, beneficiary premiums and general fund payments are redetermined annually, to match estimated program costs for the following year. Beginning in 2007, the Part B premium will be increased for beneficiaries meeting certain income thresholds.

Capitation payments to Medicare Advantage plans are financed from both the HI trust fund and the Part B account within the SMI trust fund in proportion to the relative weights of Part A and Part B benefits to the total benefits paid by the Medicare program.

**PAYMENTS TO HMO PLANS**

Medicare pays plans to provide Part A and B benefits for each enrollee, which totaled $36.3 billion in fiscal year 2003. The level of plan payments has been a source of controversy. For many years, Medicare payments to HMOs were generally set at 95% of fee-for-service costs in a given county. Beginning in 1997, Congress made a number of changes to Medicare's payment structure, and in the years that followed, the number of participating plans dropped by more than half.

To encourage plan participation, MMA increased aggregate payments to plans by $1.3 billion for 2004 and 2005. In 2004, Medicare paid plans the **highest** of:

- A minimum, or “floor,” for rural ($555/month) or urban ($614/month) counties;
- 100% of fee-for-service costs in the county;
- A minimum update over 2003 rates: 2% or the national growth rate percentage (6.3% in 2004), whichever is greater; or
- A blended payment rate update.
In 2005, plans will be paid the 2004 rate, updated by the greater of 2% or the national growth rate percentage.

This increases the average monthly payment to plans from $620/enrollee in 2003 to $688/enrollee in 2004, an average increase of 10.9% (weighted by plan enrollees). In some counties, the increase is more than 40% (Achman and Gold, 2004). Plans report they will spend 42% of additional funds to strengthen provider networks, 31% to lower premiums, and 17% for additional benefits (CMS, 2004).

A number of studies have shown that Medicare beneficiaries enrolled in managed care plans are, on average, in better health and have lower medical costs than those in the traditional program. To modify payments accordingly, Medicare began implementing a new risk-adjustment system in 2003. Today, 30% of plan payments are risk-adjusted; by 2007 all plan payments will be risk-adjusted.

Beginning in 2006, plans will be paid under a new bidding process. If a plan’s bid is higher than the costs of FFS Medicare for the plan’s area, the enrollee will pay the difference. If lower, 75% of the difference will go to the enrollee as extra benefits or as a rebate; the remaining 25% will be retained by the government. CBO estimates that between 2006 and 2013, plans will receive an additional $12.9 billion as a result of the MMA changes.


**Beneficiary Payment Liabilities**

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of both Part A and Part B. These liabilities may be paid (1) by the Medicare beneficiary; (2) by a third party, such as an employer-sponsored retiree health plan or private “Medigap” insurance; or (3) by Medicaid, if the person is eligible. The term
"Medigap" is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by various health insurance companies.

For beneficiaries enrolled in Medicare Advantage plans, Part C the beneficiary's payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such beneficiaries pay the monthly Part B premium and may, depending on the plan, pay an additional plan premium.

For hospital care covered under Part A, a fee-for-service beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($912 in 2005). This deductible covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($228 per day in 2005) are required through the 90th day of a benefit period. Each Part A beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments ($456 per day in 2005) are required.

For skilled nursing care covered under Part A, Medicare fully covers the first 20 days of SNF care in a benefit period. But for days 21-100, a co-payment ($114 per day in 2005) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of his or her spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the 2005 Part A monthly premium rate is $375; for those with 30 to 39 quarters of coverage, the rate is reduced to $206. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom cash benefits have ceased due to earnings in excess of those allowed for receiving cash benefits. (Penalties for late enrollment may apply.)

For Part B, the beneficiary's payment share includes the following: one annual deductible ($110 in 2005); the monthly premiums; the coinsurance payments for Part B services (usually 20 percent of the medically allowed charges); a deductible for blood; certain charges above the Medicare-allowed charge (for claims not on assignment); and payment for any services that are not covered by Medicare. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charges.

For Part D, standard coverage is defined for 2006 as having a $250 deductible with 25 percent coinsurance (or other actuarily equivalent amounts) for drug costs above the deductible and below an initial coverage limit of $2,250. The beneficiary is then responsible for all costs until a $3,600 out-of-pocket limit is reached. For higher costs, there is catastrophic coverage that requires enrollees to pay the greater of 5 percent coinsurance or a small copay ($2 for generic or preferred brands and $5 for any other drug). After 2006, these benefit parameters are indexed to the growth in per capita spending in Part D. In determining out-of-pocket costs, only
those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted. The exception to this provision is cost-sharing assistance from Medicare’s low-income subsidies and from State Pharmacy Assistance programs. The monthly premiums required for Part D coverage are described in the previous section.

**Provider Payments**

**For Part A Services and Some Part B Services**

The provider of the covered service such as a hospital or home health agency must send a claim to the Fiscal Intermediary or the Regional Home Health Intermediary.

**For Part B Services and Supplies**

The provider of the covered service or supply must send a claim to the Medicare Carrier or the Durable Medical Equipment Regional Carrier.

**Billing Requirements**

After October 1, 2005, if Medicare contracts with any new Medicare claim processing companies, the companies will be called Medicare Administrative Contractors (MACs) instead of Fiscal Intermediaries (FI), Medicare Carriers, Durable Medical Equipment Regional Carriers (DMERC), or Regional Home Health Intermediaries (RHHI).

In most cases, doctors, suppliers, and providers must send claims electronically to one of these Medicare claims processing contractors for Medicare-covered services or supplies. If the doctor, supplier, or provider bills them, they should

- call the doctor or supplier directly and ask the doctor or supplier to file a Medicare claim electronically.
- call 1-800-MEDICARE (1-800-633-4227) if the doctor or supplier still doesn’t file a Medicare claim electronically after they have called and asked. The Medicare Carrier or MAC will contact the doctor or supplier to make the doctor or supplier aware of their responsibility for filing a Medicare claim electronically.

There is a time limit for filing a Medicare claim. If a claim isn’t filed within this time limit, Medicare can’t pay its share. The time limit may be as short as 15 months or as long as 27 months depending on when the service or supply was received.

For Part A, before 1983, payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under PPS, a specific predetermined amount is paid for each inpatient hospital stay, based on each stay’s diagnosis-related group (DRG) classification. In some cases the payment the hospital receives is less than the hospital's actual cost for providing the Part A-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays. Payments for skilled nursing care, home health care, inpatient rehabilitation, and long-term hospital care are made under separate prospective payment systems. Payments for psychiatric hospital care are currently reimbursed on a reasonable cost basis, but a prospective payment system is expected to be implemented in the near future, as required by the BBA.
For Part B, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician's actual charge; (2) the physician's customary charge; or (3) the prevailing charge for similar services in that locality. Beginning January 1992, allowed charges were defined as the lesser of (1) the submitted charges, or (2) the amount determined by a fee schedule based on a relative value scale (RVS). Payments for DME and clinical laboratory services are also based on a fee schedule. Most hospital outpatient services are reimbursed on a prospective payment system, and home health care is reimbursed under the same prospective payment system as Part A.

If a doctor or supplier agrees to accept the Medicare-approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full for that service. The provider may not request any added payments (beyond the initial annual deductible and coinsurance) from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by Medigap insurance). Limits now exist on the excess that doctors or suppliers can charge. Physicians are "participating physicians" if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since Medicare beneficiaries may select their doctors, they have the option to choose those who participate.

For Part C, Medicare payments to Medicare Advantage plans are based on a blend of local and national capitated rates, generally determined by the capitation payment methodology described in section 1853 of the Social Security Act. Actual payments to plans vary based on demographic characteristics of the enrolled population. New "risk adjusters" based on demographics and health status are currently being phased in to better match Medicare capitation payments to the expected costs of individual beneficiaries. The Medicare Advantage program will undergo changes beginning in 2006. Plan bids will be replacing the current payment structure for Medicare Advantage plans.

For Part D, in 2006 and later, PDPs (including the prescription drug portion of Medicare Advantage plans) will pay for most FDA-approved prescription drugs and biologicals under the benefit structure described in the previous section. Plans may set up formularies for their prescription drug coverage, subject to statutory standards.

Medicare Claims Processing

Medicare's Part A and Part B fee-for-service claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal Government. These claims processors are known as intermediaries and carriers. They apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare intermediaries process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. They also process outpatient hospital claims for Part B. Examples of intermediaries are Blue Cross and Blue Shield (which utilize their plans in various States) and other commercial insurance companies. Intermediaries' responsibilities include the following:

- Determining costs and reimbursement amounts.
- Maintaining records.
- Establishing controls.
- Safeguarding against fraud and abuse or excess use.
- Conducting reviews and audits.
• Making the payments to providers for services.
• Assisting both providers and beneficiaries as needed.

Medicare carriers handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a State, and various commercial insurance companies. Carriers’ responsibilities include the following:

• Determining charges allowed by Medicare.
• Maintaining quality-of-performance records.
• Assisting in fraud and abuse investigations.
• Assisting both suppliers and beneficiaries as needed.
• Making payments to physicians and suppliers for services that are covered under Part B.

Claims for services provided by Medicare Advantage plans (claims under Part C) are processed by the plans themselves.

Once Part D begins in earnest in 2006, plans will be responsible for claims processing, as is the case under Part C. However, there are a number of complex Part D claims processing provisions, and the administration of some of these provisions is not yet fully resolved.

**Quality Improvement Organizations (QIOs)**

Quality improvement organizations (QIOs; formerly called peer review organizations, or PROs) are groups of practicing health care professionals who are paid by the Federal Government to generally oversee the care provided to Medicare beneficiaries in each State and to improve the quality of services. QIOs educate other health care professionals and assist in the effective, efficient, and economical delivery of health care services to the Medicare population. The ongoing effort to combat monetary fraud and abuse in the Medicare program was intensified after enactment of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), which created the Medicare Integrity Program. Prior to this 1996 legislation, the Centers for Medicare & Medicaid Services (CMS) was limited by law to contracting with its current carriers and fiscal intermediaries to perform payment safeguard activities. The Medicare Integrity Program provided CMS with stable, increasing funding for payment safeguard activities, as well as new authorities to contract with entities to perform specific payment safeguard functions.

**Administration**

The Department of Health and Human Services (DHHS) has the overall responsibility for administration of the Medicare program. Within DHHS, responsibility for administering Medicare rests with CMS. SSA assists, however, by initially determining an individual’s Medicare entitlement, by withholding Part B premiums (and, once applicable beginning in 2006, Part D premiums) from the Social Security benefit checks of beneficiaries, and by maintaining Medicare data on the master beneficiary record, which is SSA’s primary record of beneficiaries. The Internal Revenue Service in the Department of the Treasury collects the Part A payroll taxes from workers and their employers.

A Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the Federal Government, oversees the financial operations of the HI and SMI trust funds. The Secretary of the Treasury is the managing trustee. The Board of
Trustees reports to Congress on the financial and actuarial status of the Medicare trust funds on or about the first day of April each year.

State agencies (usually State Health Departments under agreements with CMS) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate in the Medicare program. In consultation with CMS, these agencies then certify the facilities that are qualified.
How Approved Charges for Covered Medical Services are Determined

The Centers for Medicare & Medicaid Services, whose central office is in Baltimore, Maryland, directs Medicare and Medicaid programs. The Social Security Administration processes Medicare applications and claims, but it does not set Medicare policy. The Centers for Medicare & Medicaid Services sets the standards that hospitals, skilled nursing facilities, home health agencies, and hospices must meet in order to be certified as qualified providers of services.

Before January 1 of each year, the Centers for Medicare & Medicaid Services must establish fee schedules for payment amounts for physicians' services in all fee schedule areas. The fee schedule must include national uniform relative values for all physicians' services. The relative value of each service must be the sum of relative value units (RVUs) representing physician work, experience, and the cost of malpractice insurance. Nationally uniform relative values are adjusted for each locality by a geographic adjustment factor (GAF).

The Department of Health and Human Services contracts with private insurance companies for the processing of payments to patients and health care providers. These private insurance companies are called fiscal intermediaries under Part A and are selected by the health care providers. Under Part B, these private insurance companies are called carriers and are selected by the Department of Health and Human Services.

The Medicare Summary Notice (MSN)

Medicare patients get a Medicare Summary Notice (MSN) for Part A and for Part B services. The MSN lists all the services or supplies that were billed to Medicare for a 30-day period. Check this notice to be sure all the services were received, medical supplies, or equipment that providers billed to Medicare.

Medicare has a new service in some areas. The electronic Medicare Summary Notice (e-MSN) is a simple and convenient way to get a copy of MSNs. They can look at the MSNs on the web and print copies right from their own computer, 24 hours a day, seven days a week. The e-MSN doesn’t replace the paper MSN currently mailed each month when a claim is processed. They will still get a paper copy.

This service is being tested in some areas to evaluate its benefit before Medicare makes it available for all people with Medicare. To see if e-MSNs are available in their area, look at www.medicare.gov on the web. Select “Frequently Asked Questions” and search for “e-MSN.”
How Medicare Decides What Is Covered

At times, Medicare makes a decision about whether a medical service or medical equipment is covered. Medicare does this after reviewing information about how a service or equipment improves health or helps manage a health problem. If Medicare makes a decision that applies to all people with Medicare, it's called a “National Coverage Determination.” They can get a list of all the national coverage determinations Medicare made in the last year. Medicare will also tell...
them how to get information on each determination. To see all the national coverage
determinations, go to www.cms.hhs.gov/mcd on the web.

If there isn’t an existing national coverage determination for a certain service or equipment, the
Medicare Fiscal Intermediary, Carrier, or Medicare Administrative Contractor sets rules for the
way Medicare claims in the local area are reviewed. These rules are also followed to decide
whether a claim will be paid. The local rules can’t disagree with any existing national coverage
determinations. However, they can be different from one area to another. These rules are called
“Local Coverage Determinations.” Before December 2003, local coverage determinations used
to be called “Local Medical Review Policies.” They can find out if there is a local coverage
determination or local medical review policy for a specific service or item. Look at
www.medicare.gov on the web. Select “Your Medicare Coverage” and the item or service they
need. To see all the local coverage determinations or local medical review policies, go to
www.cms.hhs.gov/mcd on the web. They can also call 1-800-MEDICARE (1-800-633-4227) to
get this information. TTY users should call 1-877-486-2048.

How Bills Get Paid When There Is Other Health Insurance

Sometimes their other insurance pays health care bills first and the Original Medicare Plan pays
second. Other insurance that may pay first includes: employer group health plan coverage
under certain conditions, no-fault insurance, liability insurance, black lung benefits, and workers’
compensation. In most cases, these types of insurance must pay first.

In some cases, if the insurance that is supposed to pay first doesn’t pay promptly (that is, within
120 days), the Original Medicare Plan may make a “conditional” payment. The Medicare
payment is “conditional” because it must be repaid to Medicare when the insurance that is
supposed to pay first makes a payment.

It’s important to tell the doctor and hospital that there is other insurance so they will know how to
handle bills correctly. For questions about who pays first, call the Coordination of Benefits
Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

For more information, get a free copy of Medicare and Other Health Benefits: Your Guide to

Assignment

Assignment is an agreement between people with Medicare, their doctors and suppliers, and
Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment
from Medicare for covered Part B services, equipment, and supplies. Doctors or suppliers who
agree to (or must by law) accept assignment from Medicare can’t try to collect more than the
proper Medicare deductible and coinsurance amounts from the person with Medicare, their
other insurance, or anyone else.

If assignment isn’t accepted, doctors and providers may charge more than the Medicare-
approved amount. For most services, there is a limit on the amount over the Medicare-approved
amount doctors and providers can bill. The highest amount of money they can be charged for a
Medicare covered service by doctors and other health care providers who don’t accept
assignment is called the limiting charge. The limiting charge is 15% over Medicare’s approved
amount. The limiting charge applies only to certain services and doesn’t apply to supplies and
equipment. In addition, they may have to pay the entire charge at the time of service. Medicare will send them its share of the charge when the claim is processed.

In some cases, health care providers and suppliers must accept assignment. For example, if they get Medicare-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare program, the pharmacy or supplier must accept assignment. If persons get Medicare-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, Medicare won’t pay.

Doctors and suppliers must submit claims to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can’t charge individuals for this service. Patients can’t send in the claim themselves.

For more information about assignment, get a free copy of Does your doctor or supplier accept “assignment?” (CMS Pub. No.10134). To find physicians and suppliers who participate in Medicare, look at www.medicare.gov on the web. Select “Participating Physician Directory” or “Supplier Directory.” Consumers can also call 1-800-MEDICARE (1-800-633-4227) for this information.

**MEDICARE APPEAL RIGHTS**

Information on how to file an appeal is on the Medicare Summary Notice (in the Original Medicare Plan) or in health plan materials (in a Medicare Advantage Plan). Those filing an appeal can ask the doctor or provider for any information that may help their case. They can also call the State Health Insurance Assistance Program for help filing an appeal.

People in the Original Medicare Plan are protected from unexpected bills. A doctor or supplier may provide a notice that says Medicare probably (or certainly) won’t pay for a service. Those who still want to get the service will be asked to sign an agreement that they will pay for the service themselves if Medicare doesn’t pay for it. This is called an Advance Beneficiary Notice. Advance Beneficiary Notices are used in the Original Medicare Plan. Medicare Advantage Plans have other ways of providing this information.

Persons who aren’t sure if Medicare was billed for the services can write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service received from that provider within 30 days. Also, the Medicare Summary Notice will show if the service was billed to Medicare. If someone is in a Medicare Advantage Plan, and calls their plan to find out if a service or item will be covered, the plan must tell them.

**Medicare Rights Fast-Track Appeals**

Those enrolled in a Medicare Advantage Plan, have the right to a fast-track appeals process. They can get a quick review whenever receiving services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. They will get a notice from the provider or plan explains how to ask for an appeal if they believe that the services are ending too soon. They will be able to obtain a quick review of this decision, with independent doctors looking at the case and deciding if their services need to continue. They may have additional rights if in the hospital or a skilled nursing facility, or if home health care ends. People with Medicare enrolled in the Original Medicare Plan are expected to get fast-track appeal rights during 2005.
What if Medicare Will Not Pay for a Medicare Part A Service

Private companies, known as Medicare claims processing contractors, administer Medicare payments for the federal government. Beneficiaries can file an appeal with a Medicare claims processing contractor within 60 days of receiving notice that payment for a claim is being denied. For individuals to protect their legal rights, they must read and save all correspondence and information they are given related to the services they receive and the payment for these services. If individuals receive a notice that their payment is denied, the notice will include information about how to file an appeal. Individuals must also make sure they follow the appeal rules, including filing an appeal within the time allowed.

Beneficiaries Rights if They are Discharged From Hospital Before it is Medically Appropriate

Medicare beneficiaries who have been hospitalized have legal protections if they are notified that the hospital or their MCO attempts to discharge them and they do not believe this is medically appropriate. This is called an immediate peer review organization (PRO) review. Medicare relies on PROs to conduct an independent assessment of whether a hospital discharge is appropriate. The right to an immediate PRO review is the same for Medicare beneficiaries in traditional Medicare and for enrollees in a Medicare Advantage MCO.

To request an immediate PRO review, beneficiaries must submit a request in writing or by telephone by noon of the first working day after they have received written notice that the MCO or hospital has determined that their care is no longer medically necessary. The PRO is authorized to review medical records and to receive other pertinent documents from both the MCO and the hospital, and it is required to solicit the views of the enrollee. It is then required to notify the enrollee, the hospital, and the MCO of its decision by close of business on the first working day after it receives all necessary information from the MCO and the hospital.

For Medicare Advantage participants, if a beneficiary files a request for an immediate PRO review on time, and the MCO authorized the initial hospital coverage, then the MCO remains liable for all covered hospital expenses until noon of the calendar day following the PRO decision. If the enrollee wins at this level, the MCO remains liable for hospital expenses until the facility is legally able to discharge the enrollee on the basis that the hospital stay is no longer medically necessary.

What if Medicare Will Not Pay for a Medicare Part B Service

Beneficiaries and Part B physicians and suppliers can file an appeal within six months of receiving notice that payment for a claim is being denied.

Part B disputes for claims totaling at least $100 can be appealed further within six months to claims processing contractors’ in-house hearing officers. Disputes over at least $100 for home health claims and at least $500 for all other claims can be appealed within 60 days to an administrative law judge (ALJ). As with Part A appeals, these ALJ decisions can be appealed within 60 days to the Health and Human Services Departmental Appeals Board, which can turn down appeals or review cases on its own. Within 60 days, these decisions involving at least $1,000 can be appealed further in federal district court.

What if a Medicare Advantage Plan Will Not Authorize or Pay for a Service
Enrollees should file an appeal in such cases, if, for example, their doctor won’t order a treatment that they think they need and that is covered by Medicare; if they have a problem getting a referral; if their MCO does not approve tests or procedures recommended by their primary care provider; or if their MCO will not approve a second opinion for surgery.

Medicare beneficiaries can appeal a decision by a Medicare Advantage MCO:

- to deny payment for emergency services;
- to deny payment to a provider that is not part of the MCO’s network;
- to refuse to provide a covered service that a Medicare beneficiary believes is medically necessary; or
- to discontinue a service if the beneficiary believes that the service is still needed.

Enrollees may file a grievance if, for example, they believe the MCO’s facilities are inaccessible, inadequate, or in poor condition, or if they did not like the way their doctor treated them. Every Medicare Advantage MCO is required to establish and operate a grievance process that provides for timely hearing and resolution of grievances. Grievances tend to involve issues that are less serious than appeals—which involve actual denials of care—and enrollees do not have a right to an external hearing of their grievances.

**Other Medicare Rights**

In addition, Medicare participants have rights to

- get information
- get emergency room services
- see doctors; specialists, including women’s health specialists; and go to Medicare-certified hospitals
- participate in treatment decisions
- know treatment choices
- get information in a culturally competent manner in certain circumstances (for example, get information in languages other than English from Medicare, and its providers and contractors)
- file complaints
- nondiscrimination
- have personal and health information kept private

For more information about rights and protections, get a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112).

**Notice of Privacy Practices for the Original Medicare Plan**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out (“disclose”) your personal medical information held by Medicare.
Medicare must use and give out your personal medical information to provide information

- to you or someone who has the legal right to act for you (your personal representative),
- to the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- where required by law.

Medicare has the right to use and give out your personal medical information to pay for your health care and to operate the Medicare program. For example:

- Medicare Carriers use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies.

Medicare may use or give out your personal medical information for the following purposes under limited circumstances

- to State and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs),
- for public health activities (such as reporting disease outbreaks),
- for government health care oversight activities (such as fraud and abuse investigations),
- for judicial and administrative proceedings (such as in response to a court order),
- for law enforcement purposes (such as providing limited information to locate a missing person),
- for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- to avoid a serious and imminent threat to health or safety,
- to contact you about new or changed benefits under Medicare, and
- to create a collection of information that can no longer be traced back to you.

By law, Medicare must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn’t set out in this notice. You may take back (“revoke”) your written permission at any time, except if Medicare has already acted based on your permission. By law, you have the right to

- see and get a copy of your personal medical information held by Medicare.
- have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.
- get a listing of those getting your personal medical information from Medicare. The listing won’t cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Medicare operations, or that was given out for law enforcement purposes.
- ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
• ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare program.

Please note that Medicare may not be able to agree to your request.

• get a separate paper copy of this notice.

Look at www.medicare.gov on the web for more information on

• exercising your rights set out in this notice.
• filing a complaint, if you believe the Original Medicare Plan has violated these privacy rights. Filing a complaint won’t affect your benefits under Medicare.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa or contact the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Medicare is required to follow the terms in this privacy notice. Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

**Sharing Information for Research Studies and Clinical Trials**

Research studies and clinical trials help doctors and researchers find better ways to operate the Medicare program or to prevent, diagnose, or treat diseases. Medicare may contact you about taking part in a study. Medicare may also share personal medical information with some organizations that conduct these studies to help them find people who qualify to take part in these studies. These organizations must meet all privacy law requirements.

They might use the information Medicare gives them to contact you directly about their studies. It is your choice to take part or not. You may want to talk to your doctor about clinical trials.

**Protection from Discrimination**

Every company or agency that works with Medicare must obey the law. Patients can’t be treated differently because of race, color, national origin, disability, age, religion, or sex under certain conditions. Also, rights to health information privacy are protected. If they think that they haven’t been treated fairly for any of these reasons, call the Office for Civil Rights in their state or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. They can also look at www.hhs.gov/ocr on the web for more information.

**Medicare Fraud**

Most doctors and health care providers who work with Medicare are honest. There are a few who aren’t honest. Medicare is working very hard with other government agencies to protect the Medicare program.

Medicare fraud happens when Medicare is billed for services never received. Medicare fraud takes a lot of money every year from the Medicare program. Consumers pay for it with higher
premiums. A fraud scheme can be carried out by individuals, companies, or groups of individuals.

Use this three step approach if fraud is suspected:

- Call the health care provider.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call the Inspector General’s hotline 1-800-HHS-TIPS (1-800-447-8477).

When they get health care in the Original Medicare Plan, they get a Medicare Summary Notice from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. They should check the notice for mistakes. Make sure that Medicare wasn’t charged for any services or supplies that they didn’t get. If they see a charge on their bill that may be wrong, call the health care provider and ask about it. The bill may be correct, and the person they speak to may help them to better understand the services or supplies received. Or, they may have discovered an error in billing which needs to be corrected. If they aren’t satisfied after speaking with their provider, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

They can also call the Inspector General’s hotline 1-800-HHS-TIPS (1-800-447-8477) to report Medicare fraud. Medicare won’t use their name if they ask that it not be used.

Fighting fraud can pay. People may get a reward of up to $1,000 if:

- they report Medicare fraud, and
- the report leads directly to the recovery of at least $100 of Medicare money, and
- the fraud they report isn’t already being investigated.

For more information about this program, get a free copy of Pay it Right! Protecting Medicare from Fraud (CMS Pub. No. 10111).

Other Insurance and Ways to Pay Health Care Costs

Other Health Insurance

Agents should review all of their clients health care coverage. In addition to Medicare, persons may already have or be eligible for other health care coverage such as employer or retiree coverage. They also might be able to lower out-of-pocket costs by buying other supplemental health coverage. The coverage they have will affect how much they pay, what benefits they may have, which doctors they can see, and other things that may be important to them.

For more information about how other kinds of insurance work with Medicare, get a free copy of Medicare and Other Health Benefits: Your Guide to Who Pays First (CMS Pub. No. 02179).

Employer or Union Health Coverage

Those who have coverage from an employer or union may change the benefits or premiums, and may also cancel the coverage if they choose. If they drop their employer or union group health coverage, they may not be able to get it back. For information people can call the
benefits administrator at their or their spouse’s current or former employer or union and ask if they have or can get health care coverage based on past or current employment.

**COBRA**

People who are eligible for COBRA because they have stopped working or because they qualify for other reasons should still consider enrolling in Part B. They won’t get another Special Enrollment Period when their COBRA coverage ends, and they may have to pay more for Part B if they join later.

**Veterans’ Benefits**

Those who are veterans or have had any U.S. military service should call the U.S. Department of Veterans Affairs at 1-800-827-1000 for information about veterans’ benefits and services available in their area.

**Military Retiree Benefits**

TRICARE is a health care program for active duty and retired uniformed services members and their families. It includes TRICARE Prime, TRICARE Extra, TRICARE Standard, and TRICARE for Life (TFL).

Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses have access to expanded medical coverage known as TRICARE for Life. They must have Medicare Part A and Part B to get TFL benefits.

In general, Medicare pays first for Medicare-covered services. If Medicare doesn’t pay all of the bill, TRICARE might pay some of the costs as the second payer. TRICARE will also pay the Medicare deductible and coinsurance amounts, and for any services not covered by Medicare that TRICARE covers. They are also eligible for pharmacy benefits through the TRICARE Senior Pharmacy Program.

For more information about the TRICARE programs, call 1-800-538-9552 or look at www.tricare.osd.mil on the web.

**Medicare Savings Programs (Part of the State Medical Assistance Program)**

There are programs that help millions of people with Medicare save money each year. States have programs for people with limited income and resources that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance.

**Persons can apply for these programs if they:**

- have Medicare Part A. (If they are paying a premium for Medicare Part A, the Medicare Savings Program may pay the Medicare Part A premium for them.) and
- are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds. and
- are an individual with a monthly income of less than $1,076.63, or are a couple with a monthly income of less than $1,443.38 in 2005. If they live in Alaska or Hawaii, income limits are slightly higher.

Individual states may have more generous income and/or resource requirements. People should call the State Medical Assistance Office. Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if they think they qualify for any of these Medicare Savings Programs, even if they aren’t sure.

Medicare Savings Programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

**Medicaid**

Those whose income and resources are limited may qualify for Medicaid. Most of their health care costs are covered if they have Medicare and Medicaid. Medicaid is a joint Federal and State program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for things like nursing home care, home health care, and outpatient prescription drugs that aren’t covered by Medicare. For more information about Medicaid, call their State Medical Assistance Office.

**State Prescription Drug Assistance Programs**

There are programs that may offer discounts or free medication. For more information, look at www.medicare.gov on the web. Select “Prescription Drug and Other Assistance Programs.”

**The PACE Program (Program of All-inclusive Care for the Elderly)**

PACE combines medical, social, and long-term care services for frail people. PACE might be a better choice for people than getting care through a nursing home. PACE is available only in states that have chosen to offer it under Medicaid.

To find out if they are eligible and if there is a PACE site near them, or for more information, people should call the State Medical Assistance Office. They can also look at www.medicare.gov/Nursing/Alternatives/PACE.asp on the web for PACE locations and telephone numbers. Those who are currently enrolled in PACE and have questions about Medicare approved drug discount cards should contact the PACE organization.

**Long-Term Care Insurance**

Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care to help people with their personal care needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare doesn’t pay for long-term care.

For more information about the types of long-term care, get a free copy of *Choosing Long-Term Care: A Guide for People with Medicare* (CMS Pub. No. 02223). For additional information about long-term care insurance, refer to *A Shopper’s Guide to Long-Term Care Insurance* from either your State Insurance Department or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600. Or, call the State Health Insurance Assistance Program.
**Additional Information Sources**

**www.medicare.gov on the web**

Here are some of the tools people can use to get quick answers to questions on Medicare’s website:

**Medicare Personal Plan Finder**

Compare health plan options (including Medicare Advantage and supplemental insurance plans) in the area.

**Prescription Drug and Other Assistance Programs**

Identify programs that may help with prescription drug and other health care costs, including information on Medicare-approved drug discount cards.

**Participating Physician Directory**

Locate Medicare participating doctors in their area.

**Medicare Eligibility Tool**

Determine their Medicare eligibility and enrollment status.
Publications

View, order, or download Medicare publications.

Frequently Asked Questions

Locate answers to questions about Medicare.

Your Medicare Coverage

Learn about health care coverage in the Original Medicare Plan.

Compare Quality

Get information about the quality of care provided by certain types of health care providers, anywhere in the country. Look at Nursing Home Compare, Home Health Compare, Dialysis Facility Compare, and the Medicare Personal Plan Finder.

1-800-MEDICARE Helpline (TTY users should call 1-877-486-2048)

Medicare is always working to improve its service. The 1-800-MEDICARE helpline has replaced the touch-tone system with a speech-automated system to make it easier to get the information they need 24 hours a day, including weekends. The system will ask them questions that they answer with their voice to direct the call automatically.

Free Booklets About Medicare and Related Topics

Medicare tries to provide information to help people make good health care decisions. They can look at or order free booklets from Medicare to learn more about the topics with detailed information about important subjects.

To Obtain These Booklets

- Look at www.medicare.gov on the web, and select “Publications.” Persons can read, print, or order some booklets. This is the fastest way to get a copy.
- Call 1-800-MEDICARE (1-800-633-4227). Follow the instructions to get a publication. TTY users should call 1-877-486-2048. They will get their copy within three weeks.
- Put their name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select “Mailing List” at the top of the page.
- Many booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). Look at www.medicare.gov on the web for a list of available Medicare publications.

Available Medicare Booklets

Below is a list of detailed booklets covering some of the topics discussed in this course. Booklets on other topics may also be available.
- Enrolling in Medicare (CMS Pub. No. 11036)
- Guide to Answering your Medicare Questions on the Web (CMS Pub. No. 11063)
- Getting a Second Opinion Before Surgery (CMS Pub. No. 02173)
- Medicare & Clinical Trials (CMS Pub. No. 02226)
- Medicare and Home Health Care (CMS Pub. No. 10969)
- Medicare and Your Mental Health Benefits (CMS Pub. No. 10184)
- Medicare Coverage of Ambulance Services (CMS Pub. No. 11021)
- Medicare Coverage of Diabetes Supplies & Services (CMS Pub. No. 11022)
- Medicare Coverage of Durable Medical Equipment (CMS Pub. No. 11045)
- Medicare Coverage of Skilled Nursing Facility Care (CMS Pub. No. 10153)
- Medicare Coverage Outside the U.S. (CMS Pub. No. 11037)
- Medicare Hospice Benefits (CMS Pub. No. 02154)
- Guide to Medicare’s Preventive Services (CMS Pub. No. 10110)
- The Facts About Medicare Advantage (CMS Pub. No. 11061)
- Your Medicare Benefits (CMS Pub. No. 1016)
- Your Medicare Rights and Protections (CMS Pub. No. 10112)

### Important Contacts

Check the list below to see whom to call for help with questions. Telephone numbers are provided for organizations that provide nationwide services. For local organizations, information is provided for how to get their telephone number.

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<th>For questions about:</th>
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<td>Address/name changes</td>
<td>Social Security Administration</td>
<td>1-800-772-1213</td>
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<td>TTY 1-800-325-0778</td>
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<td>Railroad Retirement Board (RRB</td>
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### Privacy
**Medicare privacy rights and protections**

**Privacy complaints**
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- Department of Health and Human Services (Office for Civil Rights)

**Publications (Medicare-related)**
- The Medicare Helpline

**Railroad Retirement benefits**
- Railroad Retirement Board

**Skilled Nursing Care**
- Fiscal Intermediary

**Social Security benefits**
- Social Security Administration

**TRICARE for Life**
- Department of Defense

**Veteran’s benefits**
- Department of Veterans Affairs

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### FUTURE ISSUES
The role of private plans in Medicare is likely to increase in the years to come. Whether higher payments to plans and the addition of prescription drug benefits will stabilize plan participation and enrollment or improve the quality of care will be important to monitor. To date, the evidence on quality of care and satisfaction in private plans is mixed. Striking the right balance between controlling spending growth, setting payments to plans fairly, and meeting beneficiaries’ health care needs will be an ongoing challenge.

### BENEFIT CHANGES UNDER THE MMA
The new law also includes other changes for beneficiaries, including new preventive benefits, increases in the Part B deductible (beginning in 2005); and, beginning in 2007, increases in the Part B premium for beneficiaries with incomes over $80,000 (single) and $160,000 (couple).

- **The Part B deductible**, set at $110 since 1991, increased to $110 in 2005 and will rise by the annual percentage increase in Part B expenditures thereafter.
- **The Part B premium** ($78.20 in 2005) covers 25% of Part B costs and is currently uniform for all beneficiaries. Beginning in 2007, it will be higher for those with incomes over $80,000/single ($160,000/couple). CBO estimates this will affect 1.2 million beneficiaries in 2007 (2.8 million by 2013).
- **Preventive benefits**, including an initial routine physical examination, cardiovascular blood screening tests, and diabetes screening tests and services, added in 2005.

**MEDICARE’S OUTLOOK**

Issues related to implementation of the new prescription drug benefit are the most immediate challenges for Medicare. In the future, the aging of the baby-boom generation, the decline in the number of workers per beneficiary, and the continued rise in national health care spending will present additional challenges.

Greater resources will be required over time to maintain current benefits and meet the needs of the growing number of beneficiaries.

Note: Estimates are based on 1996-2001 MCBS “Access to Care” files and represent point-time estimates pertaining to aged and disabled Medicare beneficiaries living in a community setting who were enrolled in Medicare for the entire calendar year. Estimates exclude beneficiaries who were not enrolled in Medicare for the entire calendar year.

**SOURCES:** Bearing Point analysis for Kaiser Family Foundation, 2004.
Medicaid

Medicaid is a nationwide program funded jointly by the federal government and the states. Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program is a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America’s poorest people.

Since its enactment in 1965, Medicaid has improved access to health care for low-income individuals, financed innovations in health care delivery, and functioned as the nation’s primary source of long-term care financing. Medicaid plays a major role in the U.S. health care system, accounting for 1 of every 6 dollars spent on personal health care and nearly half of all spending on nursing home care (Figure 1).

Medicaid is the nation’s major public health insurance program for low-income Americans, financing health and long-term care services for over 52 million people, including children and many of the sickest and poorest in our nation. Medicaid pays for health care, institutional long-term care, and community living services. No other public or private insurance plan covers such a comprehensive range of health care, institutional long-term care, and community living services.

In general, private health insurance is not an option for the Medicaid population; low-income workers often do not have access to coverage through their employers, or cannot afford it even if it is offered, and private insurers often exclude individuals with disabilities and chronic illnesses. In the absence of the Medicaid program, the vast majority of its beneficiaries would be uninsured.

**Medicaid Summary and Trends**

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has
been expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and economic recessions.
- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase Federal payments to States.
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low-birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in drug costs and the availability of new expensive drugs.
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41 percent of the total cost of care for persons using nursing facility or home health services in 2001. National data for 2001 show that Medicaid payments for nursing facility services (excluding ICFs/MR) totaled $37.2 billion for more than 1.7 million beneficiaries of these services—an average expenditure of $21,890 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled $3.5 billion for more than 1.0 million beneficiaries—an average expenditure of $3,475 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow Statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided States a new option to use managed care. The
number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 59 percent in 2003.

In FY 2003, total outlays for the Medicaid program (Federal and State) were $278.3 billion, including direct payment to providers of $197.3 billion, payments for various premiums (for HMOs, Medicare, etc.) of $52.1 billion, payments to disproportionate share hospitals of $12.9 billion, and administrative costs of $16.0 billion. Outlays under the SCHIP program in FY 2003 were $6.1 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach $445 billion and $7.5 billion, respectively, by FY 2009.

Medicaid is often referred to as America's safety net for its poor. For millions of children, adults, and older Americans with disabilities, it's that and far more.

In 2003, Medicaid provided coverage to:

- 25 million children
- 14 million adults (primarily low-income working parents)
- 5 million seniors
- 8 million persons with disabilities

Although low-income children and parents make up three quarters of the Medicaid population, they account for only 31% of Medicaid spending. The majority of Medicaid spending (69%) is attributable to the elderly and people with disabilities, who make up only one-quarter of the Medicaid population (Figure 2).
The recent economic downturn has caused more families to qualify for Medicaid, as income has fallen. Medicaid is also a key source of coverage for low-income working families, who often do not have access to health insurance through their jobs (Figure 4). Nearly one in four children in America relies on Medicaid for coverage, and two-thirds of all Medicaid enrollees are in low-wage working families.

The federal and state governments jointly finance Medicaid, and the states administer it. The federal contribution to Medicaid spending ranges from 50% to 77%, depending on state per capita income. In 2003, the federal government financed 57% of the $266 billion in total Medicaid spending.

Because every state plays a significant role in financing Medicaid services, each one has broad discretion in designing and administering its Medicaid program. Within broad national guidelines set by the federal government each state:
1. Establishes its own eligibility standards.
2. Determines the type, amount, duration, and scope of services it will provide.
3. Sets the rate of payment for services.
4. Administers its own program.

Medicaid policies for eligibility, services, and payment are complex and vary considerably among states. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.

**Medicaid as an Entitlement**

Medicaid’s entitlement means that all people who meet Medicaid eligibility requirements have an enforceable right to enroll in Medicaid and receive Medicaid services on a timely basis. This means that a state cannot deny Medicaid coverage to individuals if more people enroll than a state expects, nor can states have waiting lists. The exception to this applies to those receiving Medicaid services under any type of Medicaid waiver.

People enrolled in Medicaid have a right to receive all Medicaid covered services that are medically necessary, as determined by the state. To meet this standard, a physician or qualified health professional must determine that a service is needed and the individual may also need to meet certain clinical or functional criteria.

Medicaid is also an entitlement to the states. This means that if states follow Medicaid rules, they have a legal right to have the federal government pay its share of Medicaid expenses. The federal share of a state’s Medicaid spending is called the federal medical assistance percentage (FMAP). The FMAP formula is based on average per capita income. States with per capita incomes above the national average receive lower matching percentages. By law, the minimum FMAP is set at 50 percent, and the maximum is set at 83 percent.

**Medicaid Eligibility**

In general, Medicaid provides coverage for three basic groups of Americans: children and their parents, the elderly, and people with disabilities. Individuals must have low incomes, have few assets and meet immigration and residency requirements.

To qualify for Medicaid, an individual must meet financial criteria and also belong to one of the groups that are “categorically eligible” for the program, including children, parents of dependent children, pregnant women, people with disabilities, and the elderly. Federal law guarantees Medicaid eligibility for individuals within these groups who fall below specified income levels. At the same time, states have broad optional authority to extend Medicaid eligibility beyond these minimum standards. States have expanded Medicaid coverage extensively, but variably; as a result, Medicaid eligibility and coverage differ widely from state to state.

In most states, aged or disabled adults who are eligible for Supplemental Security Income (SSI) are also eligible for Medicaid. In 2005, the federal SSI limits for individuals are $579 per month in countable income and no more than $2,000 in countable assets.

Special income eligibility rules pertain to persons who receive Medicaid long-term care services in a nursing home or through a waiver program. Individuals whose income is not adequate to
cover their health and long-term care costs, but exceeds the SSI standard, can usually qualify for these long-term care services. However, these individuals must contribute nearly all their income to pay for their care.

In addition to meeting financial eligibility criteria, participants must meet the state’s medical eligibility criteria to receive Medicaid-covered long-term care services. State criteria vary, but generally include health status as well as physical and cognitive functioning.

Since Medicaid rules can vary dramatically from one state to another, the best way to find out the specific eligibility requirements is to contact the Medicaid office in each state. Telephone, fax, and internet contact information can be found at www.cms.hhs.gov/medicaid/allStateContacts.asp. Or, for the phone numbers for the Medicaid program in the state.

State Medicaid programs must provide Medicaid to some people, called mandatory populations. These include pregnant women and children under age 6 with family incomes less than 133 percent of the poverty level ($1,783.31 per month in 2005 for a family of three) and older children (age 6 to 18) with family incomes less than 100 percent of poverty ($1,340.83 per month in 2005 for a family of three). States must also cover some low-income parents, as well as people with disabilities and the elderly who are eligible for the Supplemental Security Income (SSI) program or similar state set requirements. For people with disabilities to qualify for SSI, their income must be below $579 per month in 2005 for a single individual (roughly 74% of the poverty level). In addition, states are required to assist certain low-income Medicare beneficiaries by paying their Medicare Part B premiums ($78.20/month in 2005) and, in some cases, cost-sharing.

Federal funds are not provided for State-only programs. Following are the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided.

The following describes information about Medicaid eligibility.

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are:

- Low income families with children, as described in Section 1931 of the Social Security Act, who meet certain of the eligibility requirements in the State's AFDC plan in effect on July 16, 1996;
- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996.
- Supplemental Security Income (SSI) recipients (or in States using more restrictive criteria—aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the State's approved Medicaid plan as of January 1, 1972);
- infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she were still pregnant;
• children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level. (The minimum mandatory income level for pregnant women and infants in certain States may be higher than 133 percent, if as of certain dates the State had established a higher percentage for covering those groups.) States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 (or such earlier date as the State may choose) in families with incomes at or below the Federal poverty level. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income. States are not required to have a resource test for these poverty level related groups. However, any resource test imposed can be no more restrictive than that of the AFDC program for infants and children and the SSI program for pregnant women;

• Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL).

• Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).

• All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL.

• recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;

• Recipients of adoption or foster care assistance under Title IV of the Social Security Act.

• certain Medicare beneficiaries (described later); and

• certain Medicare beneficiaries.

• special protected groups who may keep Medicaid for a period of time. Examples are: persons who lose SSI payments due to earnings from work or increased Social Security benefits; and families who are provided 6 to 12 months of Medicaid coverage following loss of eligibility under Section 1931 due to earnings, or 4 months of Medicaid coverage following loss of eligibility under Section 1931 due to an increase in child or spousal support.

• Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).

• States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. Examples of the optional groups that States may cover as categorically needy (and for which they will receive Federal matching funds) under the Medicaid program are:

• Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI).

• infants up to age one and pregnant women not covered under the mandatory rules whose family income is below 185 percent of the Federal poverty level (the percentage to be set by each State);

• optional targeted low income children;

• certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level;

• children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;

• institutionalized individuals with income and resources below specified limits;
• persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers;
• recipients of State supplementary payments; and
• TB-infected persons who would be financially eligible for Medicaid at the SSI level (only for TB-related ambulatory services and TB drugs)
• low-income, uninsured women screened and diagnosed through a Center's for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast or cervical cancer.

Groups of People Which States Can Choose to Cover Under Medicaid

States also have the option to cover other people, called optional populations. These include certain other groups of low-income children and their parents, people with disabilities, and the elderly with low to moderate incomes above mandatory coverage limits.

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which States will receive Federal matching funds for coverage under the Medicaid program include the following:

• Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each State).
• Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their State on July 16, 1996.
• Institutionalized individuals eligible under a "special income level" (the amount is set by each State--up to 300 percent of the SSI Federal benefit rate).
• Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers.
• Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
• Recipients of State supplementary income payments.
• Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.
• TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs).
• Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid.
• "Optional targeted low-income children" included within the State Children's Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33).
• "Medically needy" persons.

“Medically needy” Programs
The medically needy (MN) option allows States to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately or may "spend down" by incurring medical expenses that reduce their income to or below their State's MN income level. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

Thirty-five states plus the District of Columbia operate medically needy programs. States often use the medically needy program to expand coverage primarily to persons who spend down by incurring medical expenses so that their income minus medical expenses falls below a state-established medically needy income limit (MNIL). The opportunity to spend down is particularly important to elderly individuals living in nursing homes and children and adults with disabilities who live in the community and incur high prescription drug, medical equipment, or other health care expenses, either following a catastrophic incident or due to a chronic condition.

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a State elects to have a MN program, there are Federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A State may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program. As of August 2002, thirty-five States plus the District of Columbia have elected to have a MN program and are providing at least some MN services to at least some MN beneficiaries. All remaining States utilize the "special income level" option to extend Medicaid to the "near poor" in medical institutional settings.

Medicaid Buy-In Eligibility Groups

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)--known as the "welfare reform" bill--made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are State options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of the new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstated by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides States with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits States to impose a wide range of other requirements as well--in particular, those related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the
AFDC requirements in effect on July 16, 1996 generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a new program initiated by the BBA. In addition to allowing States to craft or expand an existing State insurance program, SCHIP provides more Federal funds for States to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which States may select to provide health care coverage for more children, as prescribed within the BBA's Title XXI program.

**BBA Eligibility Group**

Section 4733 of the Balanced Budget Act of 1997 (BBA) allows States to provide Medicaid coverage to working individuals with disabilities who, because of their earnings, cannot qualify for Medicaid under other Statutory provisions. Section 4733 allows States to provide Medicaid coverage to these individuals by creating a new optional categorically needy eligibility group.

In response to BBA, many States implemented more liberal income and resource methodologies than are used by SSI and have premium payments and cost sharing charges set on a sliding scale based on income.

**Rules that Apply to All States Implementing BBA Eligibility Group**

- Family Income Standard – Net family income below 250 percent of the Federal poverty level for a family of the size involved.
- Except for earned income (which is completely disregarded) the individual must meet all SSI eligibility criteria, including:
- Unearned income not exceeding the SSI income standard (currently $579 a month for an individual; $869 for a couple).
- Resources not exceeding SSI resource standard ($2,000 for an individual; $3,000 for a couple).
- Disabled as defined under the SSI program.
- SSI income and resource methodologies are used to determine eligibility.

**Options Available to States under BBA**

- Use of more liberal income and resource methodologies than are used by SSI (Section 1902(r)(2) of the Act).
- Use of more restrictive eligibility criteria than are used by SSI (209(b) States).
- States can require payment of such premiums or other cost-sharing charges, on a sliding scale based on income, as the State may determine.
TWWIIA Eligibility Groups

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Those with higher incomes may pay a sliding scale premium based on income.

Similar to the BBA Group, the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), created two new optional categorically needy Medicaid eligibility groups: (1) the Basic Coverage Group; and (2) the Medical Improvement Group.

The Basic Coverage Group is similar to the BBA group, except that there is no 250 percent of the Federal poverty level family income limit, there is an age limit (at least 16 but not more than 64 years of age), AND under these new groups States are free to establish their own income and resource standards, or have no income and resource standards if they choose.

Rules that Apply to All States Implementing Basic Coverage Group

- Individuals covered must be at least 16 but not more than 64 years of age.
- Individuals covered must be disabled as SSI defines the term.
- Earned income is not automatically disregarded.
- No federally required income and resource standards.
- If States establish income and resource standards, SSI income and resource methodologies are used to determine eligibility.

Rules that Apply to All States Implementing Medical Improvement Group

- Individuals covered must be 16 but not more than 64 years of age.
- Individual covered must have a medically improved disability.
- Individual covered must have been eligible under the Basic Coverage Group but lost that eligibility because his or her medical condition has improved to the point where it is determined at the time of a regularly scheduled continuing disability review that he or she is no longer disabled as SSI defines the term.
- Earned income is not automatically disregarded.
- No federally required income and resource standards.
- If States establish income and resource standards, SSI income and resource methodologies are used to determine eligibility.

Options Available to States under TWWIIA

- States are free to establish their own income and resource standards, or have no income and resource standards if they choose.
- Use of more liberal income and resource methodologies than are used by SSI (Section 1902(r)(2) of the Act).
- Use of more restrictive eligibility criteria than are used by SSI (209(b) States).
- States can require payment of such premiums or other cost-sharing charges, on a sliding scale based on income, as the State may determine.

To assist States in their implementation of the work incentives eligibility groups, the following link provides information about the eligibility rules and policies each State covering the BBA or TWWIIA eligibility groups has adopted in three areas; income, resources, and payment of...
premiums or other cost-sharing charges. Using the rules that apply to all States as the baseline, these three constitute the areas in which States can exercise eligibility options.

States that have Implemented a Work Incentives Eligibility Group under BBA or TWWIIA – Link to map:  http://www.cms.hhs.gov/twwiiia/statemap.asp

Medicaid Eligibility Summary

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the groups designated above. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds. Categorically needy persons who are eligible for Medicaid may or may not also receive cash assistance from the TANF program or from the SSI program. Medically needy persons who would be categorically eligible except for income or assets may become eligible for Medicaid solely because of excessive medical expenses.

States may use more liberal income and resources methodologies to determine Medicaid eligibility for certain groups. The more liberal income methodologies cannot result in the individual's income exceeding the limits prescribed for Federal matching.

Most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No Federal funds are provided for State-only programs. Significant changes were made in the Medicare Catastrophic Coverage Act (MCCA) of 1988 which affected Medicaid. The law also accelerated Medicaid eligibility for some nursing home patients by protecting assets for the institutionalized person's spouse at home at the time of the initial eligibility determination after institutionalization. Before an institutionalized person's monthly income is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted from the institutionalized spouse's income to bring the income of the community spouse up to a moderate level.

Medicaid coverage may begin as early as the third month prior to application--if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows States to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

MEDICAID SERVICES

Medicaid requires states to cover certain mandatory services, which include coverage for physician visits and hospitalizations. The early and periodic screening, diagnostic, and treatment (EPSDT) benefit for children is mandatory and ensures that children on Medicaid are screened regularly, and if a disability or health condition is diagnosed, the state must cover its treatment, even if the state does not provide the same services to adults in Medicaid.

Other mandatory services include laboratory and X-ray services, nursing home coverage, and home health services (including durable medical equipment) for persons entitled to nursing home coverage.

Mandatory Medicaid Services
Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Hospital care (inpatient and outpatient)
- Services involving short- or long-term institutional stays

**Mandatory versus Optional Benefits**

Medicaid is a state and Federal entitlement program that finances medical assistance to certain persons with low income. Each state has a great deal of flexibility to design and administer its Medicaid program within broad Federal guidelines. There are services the state is required to provide (called mandatory services) and services the state may choose to provide (called optional services). Prior to October 1, 1990, Medicaid had a mandatory skilled nursing facility (SNF) benefit that was comparable to the Medicare SNF benefit. In addition, it had an optional intermediate care facility (ICF) benefit that a state could choose to include in its Medicaid state plan. The ICF benefit included health-related care and services for persons who required care and services above the level of room and board that could only be available through an institutional facility.

The nursing home reform provisions that were enacted in 1987 repealed the skilled nursing facility and intermediate care facility benefits (except for the intermediate care facility benefit for persons with mental retardation or related conditions) and replaced by a new mandatory nursing facility (NF) benefit. This new benefit combined the total services that had previously been covered under the ICF and the SNF benefits.

**Items and Services Which May Not be Charged to the Resident**

During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

- Nursing services.
- Dietary services.
- An activities program.
- Room/bed maintenance services.
- Routine personal hygiene items and services, as required, to meet the needs of residents, including, but not limited to: hair hygiene supplies, comb., brush, bath soap, disinfecting soaps or specialized cleansing agents, when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins, and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.
- Medically-related social services.
- Physician services
- Laboratory and X-ray services
- Family planning services
- Health center and rural health clinic services
- Nurse midwife and nurse practitioner services
• Early and periodic screening, diagnostic, and treatment (EPSDT) services and immunizations for children and youth under age 21
• Nursing home care

Items and Services Which May be Charged to the Resident

Items and services that the facility offers which are not included in the facility payment may be charged to the resident. The resident must be informed when changes are made to the items, services, and costs. General categories and examples of items and services that the facility may charge to residents' funds, if: they are requested by a resident, the facility informs the resident that there will be a charge, and payment is not made by Medicaid or Medicare:

• Telephone
• Television/radio for personal use.
• Personal comfort items, including smoking materials, notions and novelties, and confections.
• Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.
• Personal clothing.
• Personal reading materials.
• Gifts purchased on behalf of a resident.
• Flowers and plants. Social events and entertainment offered that are not part of the activities program.
• Non-covered special care services, such as privately hired nurses or aides.
• Private room, except when therapeutically required (for example, isolation for infection control).
• Specially prepared or alternative food requested instead of the food generally prepared by the facility.

Contact:

Jan Earle (410) 786-3326 or jearle@cms.hhs.gov

MEDICAID INSTITUTIONAL REIMBURSEMENTS FOR NURSING FACILITY SERVICES

In 1965, Congress enacted the Medicare and Medicaid programs making health care available to a large number of people who previously did not have health care coverage. Prior to 1980, Medicaid and Medicare reimbursed nursing facilities (NFs) on a retrospective reasonable cost basis. In 1980, the Boren Amendment was passed changing the reimbursement method for NF services.

Under the Boren Amendment, a State plan for medical assistance was required to provide for payment of NF services through the use of rates which were reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

In addition, the regulations required States to publish a public notice if the changes made to the State plan amendment were significant.
In 1997, the Balanced Budget Act repealed the Boren requirements and replaced them with a requirement that States implement a public process when changes in payment rates or methodologies are proposed. The new public process requirement applies to rates established on or after the October 1, 1997 effective date. CMS is in the process of developing regulations regarding the implementation of this change.

The statutory authority for this provision is found at section 1902(a)(13)(A) of the Social Security Act.

Payment Summary

States have flexibility to develop Medicaid reimbursement methodologies that conform to the Federal laws and regulations. Consequently, there is no requirement that States develop and use a single payment methodology for all facilities providing NF services.

NF payments are generally made using one of three payment systems; i.e., cost based, per diem and case mix. There is a greater use of prospective payment systems (per diem or case mix) than cost based systems for NF services. It is important to note that although the payment systems can be categorized in general terms, the specific methodology varies from State to State. Moreover, payment systems within a State may also vary between providers and provider types.

For more information about State specific NF payment systems, including beneficiary eligibility, coverage policy, how to apply, etc. contact the State Medicaid Agency. You can find the number of your State Medicaid Agency in your local telephone directory, usually the color coded sections.

- Home health services (including DME) for those eligible for nursing home care

Home Health Services

Home health services are a mandatory benefit for individuals who are entitled to nursing facility services under the State’s Medicaid plan. Services must be provided at a recipient's place of residence, and must be ordered by a physician as part of a plan of care that the physician reviews every sixty days. Home health services must include nursing services, as defined in the State's Nurse Practice Act, that are provided on a part-time or intermittent basis by a home health agency, home health aide services provided by a home health agency, and medical supplies, equipment, and appliances suitable for use in the home. Physical therapy, occupational therapy, speech pathology, and audiology services are optional services that States may choose to provide.

To participate in the Medicaid program, a home health agency must meet the conditions of participation for Medicare.

- Transportation services for doctor, hospital, and other health care visits*

*Although not included in the Medicare law as a mandatory service, transportation services are required by federal regulations.
Medicaid uses public dollars to buy services, often in the private health care system. The program covers a variety of benefits to meet the complex needs of the diverse populations it serves. Most Medicaid beneficiaries are entitled to coverage for any of these services whenever they are medically necessary, as determined by the state.

Optional Medicaid Services

All states provide coverage for some optional services, however the specific services covered and the limitations place on a benefit provided vary substantially. To find out which optional services are available in each state (as of January 2003), the Kaiser Commission on Medicaid and the Uninsured and the National Conference of State Legislatures have developed an easy-to-use web-based tool for determining which services each state covers. Go to www.kff.org/medicaidbenefits.

States have the option of covering additional services with federal matching funds. Commonly covered optional services include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care, and intermediate care facilities for the mentally retarded (ICF/MR). The majority of state spending on optional services goes toward elderly and disabled beneficiaries. Over two-thirds of optional spending is for long-term care and prescription drugs.

In addition to matching state Medicaid spending for services, the federal government also matches the supplemental payments that states make to hospitals serving a disproportionate share of indigent patients (DSH).

Basic medical and health care services

- Prescribed drugs
- Clinic services
- Emergency hospital services
- Diagnostic services
- Screening services

Services that support people with disabilities to live in their communities

- Personal care services

Medicaid personal care services, defined in Federal regulations at 42 CFR 440.167, are an optional Medicaid benefit provided to individuals who are not inpatients or residents of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease. Personal care services must be:

1. Authorized by a physician in accordance with a plan of treatment or, at the state’s option, otherwise authorized in accordance with a service plan approved by the state;
2. provided by a qualified individual as defined by the state who is not a member of the individual’s family; and
3. furnished in a home or other location outside the home (in the community).

Personal care services may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or as cueing so that the person performs the task by him/herself. Such
assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc. Personal care services can be provided on a continuing basis or on episodic occasions. For those individuals desiring to do so, many states allow services to be directed by the consumer or by a family member or other person on the individual's behalf. Skilled services that may be performed only by a health professional are not considered personal care services.

Family members are defined by the Federal Medicaid program to be "legally responsible relatives." Thus, spouses of recipients and parents of minor recipients (including stepparents who are legally responsible for minor children) are included in the definition of family member. This definition necessarily will vary based on the responsibilities imposed under State law or under custody or guardianship arrangements. Thus, a State could restrict the family members who may qualify as providers by extending the scope of legal responsibility to furnish medical support.

Because personal care services are an optional Medicaid benefit, not all states provide this Medicaid service. Those states that do provide personal care services can define the scope of the benefit to include specific services and exclude others.

More detailed information about Medicaid personal care services may be found in the State Medicaid Manual, Part 4 (Services), Section 4480.

Information on the scope of a particular state's Medicaid benefits can be obtained through the state. See state contact information below.

**Federal CMS Contact:**

Lavern Ware, (410) 786-5480 or Lware@cms.hhs.gov

- Rehabilitative and/or clinic services

Medicaid Rehabilitation services, defined in the Code of Federal Regulations at 42 CFR 440.130(d), are an optional Medicaid state plan benefit that must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functional level. The services may be provided in any setting (at the state's option) and can include occupational and physical therapy services, as well as mental health services such as individual and group psychological therapies, psychosocial services, and addiction treatment services.

Because rehabilitation services are an optional Medicaid benefit, not all states provide this Medicaid service. Those states that do provide rehabilitation services can define the scope of the benefit to include specific services and exclude others.

- Case management services

States may provide optional targeted case management services to recipients under its Medicaid State plan. The statute defines targeted case management services as "services which assist an individual eligible under the plan in gaining access to needed medical, social, educational and other services." This section enables States to reach out beyond the bounds of
the Medicaid program to coordinate a broad range of activities and services necessary to the optimal functioning of a Medicaid client. States desiring to provide these case management services may do so by amending their State plans. Given the targeted nature of the program, States must submit a separate plan amendment for each target group.

- Small group homes that operate as intermediate care facilities for persons with mental retardation and developmental disabilities (ICFs/MR) for 15 or fewer residents

**Aids, Therapies, and Related Professional Services**

- Podiatrists’ services
- Prosthetic devices
- Optometrists’ services
- Eyeglasses
- Dental services
- Dentures
- Psychologists’ services
- Respiratory care services
- Physical therapy

Physical therapy services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a recipient by or under the direction of a qualified physical therapist. Included are any necessary supplies and equipment.

- Occupational therapy

Occupational therapy services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist. Included are any necessary supplies and equipment.

- Speech, hearing, and language therapy

Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a Medicaid qualified speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. Included are any necessary supplies and equipment.

All of the above-mentioned therapy services, defined in the Code of Federal Regulations at 42 CFR 440.110, are optional Medicaid services states may choose to provide.

Because therapy services are an optional Medicaid benefit, not all states provide these Medicaid services. Those states that do provide therapy services can define the scope of the benefit to include specific services and exclude others.

Information on the scope of a particular state’s Medicaid benefits can be obtained through the state. See state contact information below.

**Federal CMS Contacts:**
Institutions for Mental Diseases (IMD)

- Inpatient psychiatric hospital services for children and young people under age 21
- Nursing facility services for children and young people under age 21
- At large intermediate care facilities for persons with mental retardation and developmental disabilities (ICFs/MR) with more than 15 residents
- Inpatient hospital services for persons age 65 or older with mental illness in institutions for mental diseases (IMDs)
- Nursing facility services for persons age 65 or older with mental illness in institutions for mental diseases (IMDs)

An IMD is defined in the Code of Federal Regulations at 42 CFR 435.1009 as a facility of more than 16 beds that is primarily engaged in providing treatment services for individuals diagnosed with mental illness. The Federal Medicaid program does not provide for payment of services for any individual who is age 21-64 who is a patient in an IMD (42 CFR 440.1008). This payment exclusion has been part of Federal Medicaid law since its inception and was designed to assure that states, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility while the individual is a patient in the IMD.

For individuals aged 65 and older, States may provide optional coverage for individuals who are in hospitals or nursing facilities that are institutions for mental diseases. (42 CFR 440.140)

States may also provide optional coverage for individuals under age 21 in psychiatric facilities with JCAHO accreditation, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State. (42 CFR 440.160)

More detailed information about IMDs can be found in the State Medicaid Manual, Part 4 (Services), Sections 4390 – 4390.1.

State-specific information concerning IMDs can be obtained by contacting your State Medicaid Agency directly. See state contact information below.

Federal CMS Contacts:

Linda Peltz, 410-786-3399 or Lpeltz@cms.hhs.gov

End-of-Life Care

- Hospice care services

Basic Benefit Requirements

The hospice service benefit is an optional benefit which States may choose to make available under the Medicaid program. The purpose of the hospice benefit is to provide for the palliation of
or management of the terminal illness and related conditions. Under Federal guidelines, the hospice benefit is available to individuals who have been certified by a physician to be terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less. Individuals who meet these requirements can elect the Medicaid hospice benefit if provided by the State. To check whether a State provides this benefit, please refer to the contacts below.

In order to receive payment under Medicaid, a hospice must meet the Medicare conditions of participation applicable to hospices and have a valid provider agreement. The provision of care is generally in the home to avoid an institutional setting and to improve the individual's quality of life until he or she dies. However, individuals eligible for Medicaid may reside in a nursing facility (NF) and receive hospice care in that setting.

**What is Covered**

In order to be covered, a plan of care must be established before services are provided. The following are covered hospice services: nursing care; medical social services; physicians' services; counseling services; home health aide; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Additionally, there are other services that may be provided under the hospice benefit, subject to special coverage requirements. Continuous home care may be provided in a period of crisis. This consists of primarily nursing care to achieve palliation or management of acute medical symptoms. A minimum of 8 hours of care must be provided during a 24-hour day.

Also, short-term, inpatient care is covered, as long as it is provided in a participating hospice unit or a participating hospital, or NF that additionally meets hospice standards. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management, which cannot be provided in other settings. Respite care is short-term, inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. It may only be provided on an occasional basis and may not be reimbursed for more than 5 days at a time. Respite care may not be provided when the hospice patient is a nursing home resident.
Dual Eligibles

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) modified the Medicaid statute relating to hospice services. Prior to OBRA 90, when a Medicaid eligible individual elected the Medicaid hospice benefit, he or she waived the right to Medicaid payment for services other than those described earlier. As modified, the law would allow an individual to receive payment for Medicaid services related to the treatment of the terminal condition and other medical services that would be equivalent to or duplicative of hospice care, so long as the services would not be covered under the Medicare hospice program. This means that Medicaid can cover certain services which Medicare does not cover.

Hospice Rates

Medicaid reimbursement for hospice care will be made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments, other than an optional application of a "cap" on overall payments and the limitation on payments for inpatient care, if applicable. The rate paid for any particular day would vary, depending on the level of care furnished to the individual. The four levels of care are classified as routine home care, continuous home care, inpatient respite care, or general inpatient care. Payment rates are adjusted for regional differences in wages.

Reimbursement Limitations

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished under Medicaid. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that period. The State may exclude recipients with AIDS in making this calculation. Any excess reimbursement must be refunded by the hospice. Additionally, if a Medicaid hospice patient resides in a NF, the State must pay an amount equal to at least 95 percent of the NF rate to the hospice to pay for the room and board services provided by the NF.

Special treatment for children

Through the Early, and Periodic, Screening, Diagnosis, and Treatment (EPSDT) requirement, states must provide children access to all Medicaid covered services (including optional Services) when they are medically necessary, whether or not they cover such services for adult beneficiaries.

PACE

The BBA included a State option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 or older who require a nursing facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and XIX, without amount, duration, or
Amount and Duration of Medicaid Services

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

Medicaid rules are intended to ensure that all people applying for Medicaid and receiving it are treated fairly. This includes requirements that services generally must be provided statewide, so that states cannot offer services to individuals in one part of the state and deny them to individuals in another. Generally, services must also be comparable. This means that, except in limited circumstances, whatever services a state covers, it must provide them equally to all Medicaid beneficiaries when they are medically necessary. This protection ensures that services are provided based on medical need and one group of Medicaid beneficiaries is not treated more favorably than others.

In general, States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) Medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan; and (2) States may request "waivers" to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, States have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, States may not provide room and board for the beneficiaries). With certain exceptions, a State's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

Medicaid “consumer protections”

Services must be provided in an amount, duration, and scope that are reasonably “sufficient” to achieve their intended purpose. States do have discretion to vary the amount, duration, or scope of the services they cover, but in all cases the service must be “sufficient in amount, duration, and scope to reasonably achieve its purpose.” Hence, this requirement provides some protection to those on Medicaid from receiving inadequate services. But states are often left to interpret on their own whether they are satisfying this critical requirement.

State Medicaid programs cannot reduce the amount, duration, or scope of mandatory services to a beneficiary “solely because of the diagnosis, type of illness, or condition.” This protects beneficiaries from arbitrary limitations on services and ensures that covered services are provided at an adequate level to be effective. The Medicaid program also guarantees Medicaid applicants and beneficiaries due process rights to ensure that individuals are treated fairly and that they have the right to appeal any decisions denying them eligibility or services if they disagree with these decisions.
The Americans with Disabilities Act (ADA) and Medicaid

Like all other public programs, the ADA requires that states administer Medicaid in a manner that does not discriminate against individuals with disabilities who are eligible for the health care and long-term services the program offers. To do this, states must take steps to ensure that persons on Medicaid with disabilities receive such services in the most integrated setting appropriate to their needs. This is known as the ADA integration mandate.

In its Olmstead v. L.C. decision, the U.S. Supreme Court ruled that the needless and unjustified institutionalization of people with disabilities is discriminatory, saying that institutionalizing a person who could live in his or her community with services and supports is a form of discrimination and segregation banned by the ADA. The Court further held that the practice violates the ADA requirement that services be provided to such individuals in the most integrated setting appropriate to their needs. To meet their obligations under the ADA, states must both remedy such discrimination when it has occurred and prevent it from taking place in the future.

The Court’s decision did not prohibit the institutional placement of Medicaid beneficiaries, and the ADA does not require states to make “fundamental alterations” in its services or programs. Further, the Court provided a defense against lawsuits claiming a violation of the standards articulated in the Olmstead decision by saying that a comprehensive, effectively working plan for placing qualified individuals in less restrictive settings, with a waiting list that moves at a reasonable pace not controlled by a state’s efforts to keep its nursing homes full, would meet the requirements of the Olmstead decision. But the key requirement of the decision, and the ADA, itself, is to take reasonable actions to rectify the discrimination today.

Managed Care and Medicaid

Managed care is a way of getting services through a health plan that coordinates many aspects of your care. Instead of finding their own doctors and seeing any doctor who accepts Medicaid, individuals must agree to follow the managed care organization’s (MCO) rules, which often include seeing only certain providers who participate in the MCO’s network. Individuals generally also have a primary care provider (PCP) who is their main doctor and who must give his or her approval before an individual can see specialists.

While managed care exists in many forms, there are two dominant models for such care: capitated managed care and primary care case management (PCCM) programs.

Capitated managed care programs transfer the risk for paying for health care services from the payor (that is, the state Medicaid agency) to organizations that contract with the payor to deliver health care services, called managed care organizations (MCOs). Commonly, MCOs, in turn, often transfer some of the risk for paying for health care services from the MCO to physicians or other health care providers. Capitation involves paying an established fee on a per person per month basis for all persons enrolled in an MCO, whether or not an individual receives any services. In exchange, the MCO accepts responsibility for delivering all medically necessary services covered under the contract between the state Medicaid agency and the MCO. PCCM programs use many of the management techniques of MCOs, and Medicaid programs pay the PCCM agency a fee for providing management services. Unlike capitated programs, however, PCCMs are not at risk for the cost for health services, and Medicaid agencies continue to pay for health care services on a fee-for-service basis.
Congress enacted the Balanced Budget Act of 1997 (BBA), which paved the way for greater use of managed care in Medicaid. Previously, states that wanted to require Medicaid beneficiaries to enroll in managed care programs had to request federal permission, through a waiver. Now, states can require most Medicaid beneficiaries, except children with special health care needs and dual eligibles (i.e. persons enrolled in both Medicare and Medicaid), to enroll in an MCO without getting federal approval for this requirement.

**MEDICAID APPEAL RIGHTS**

Medicaid beneficiaries must receive “due process” whenever benefits are denied, reduced, or terminated. The Supreme Court has defined essential components of due process for Medicaid to include: prior written notice of adverse action, a fair hearing before an impartial decision-maker, continued benefits pending a final decision, and a timely decision measured from the date the complaint is first made.

Medicaid also gives applicants and beneficiaries additional rights:

1. The right to request a fair hearing by a state agency for any individual who has been found ineligible for benefits, has been denied benefits, or whose request for services has not been acted upon with reasonable promptness.
2. The right to file an internal grievance within an MCO.
3. Medicaid beneficiaries may enforce their rights in federal court through a private right of action. This refers to an individual filing suit against a state Medicaid program in federal court claiming the state is denying him or her a right guaranteed by federal law.

**A Medicaid fair hearing**

There are fairly detailed requirements mandating how states can satisfy the fair hearing requirement. Medicaid applicants have the right to a hearing if they believe their application has been denied or if the states have not given them a decision within a reasonable amount of time. Beneficiaries who have enrolled in Medicaid have a right to a hearing if they believe the state Medicaid agency has made an incorrect decision, such as denying coverage for a service they believe they need. In most states, the state fair hearing decision can be appealed in state court.

**Additional appeals rights of persons enrolled in a Medicaid MCO**

Medicaid beneficiaries can dispute MCO decisions or other features of the MCO in two ways: they can appeal an action or they can file a grievance. An action includes MCO activities, such as denying a service, refusing to pay for a service, reducing or suspending the amount of a service it will authorize, or failure to act in a timely manner on a request for a service. MCO enrollees can also file a grievance if they are dissatisfied with activities of the MCO that are not actions. For example, if a health care worker treats an MCO enrollee rudely, or if the enrollee is unhappy with the quality of services received, the enrollee can file a grievance.

MCOs are required to give enrollees reasonable assistance in completing forms and taking other procedural steps. This includes providing interpreter services, when necessary, and ensuring access to toll-free TTY/TDD telephone lines.

MCOs must consider and resolve grievances and appeals as quickly as the enrollee’s health requires, within state-established time frames. The maximum time an MCO has to resolve a grievance is 90 days, and the maximum time to resolve an appeal is 45 days. There is also a
process for expedited appeals if a regular appeal would “seriously jeopardize the enrollee’s life or health or ability to attain, maintain, or regain maximum function.” The general standard for expedited appeals is three working days.

The relationship between the managed care grievance and appeal process and the right to a fair hearing

Medicaid beneficiaries enrolled in MCOs have a right to a state fair hearing, but the state is permitted to decide whether it will require beneficiaries to go through the managed care appeals process before having access to a fair hearing. This is called an exhaustion requirement.

In states without an exhaustion requirement, the state must allow individuals to request a fair hearing within a reasonable time frame (decided by the state). At a minimum, the state must allow an individual to request a fair hearing not less than 20 days from the date of notice of the MCO’s action. In no case can a beneficiary request a fair hearing more than 90 days after the date of notice of the MCO’s action.

States with an exhaustion requirement can set a reasonable time frame for allowing individuals to request a fair hearing that is no less than 20 days and no more than 90 days from the date of notice of an MCO’s resolution of an appeal.

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. During 1988-1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. Under legislation passed in 1991, 1993, and again within the BBA of 1997, the Federal share of payments to DSH hospitals was somewhat limited. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554) increased DSH allotments for 2001 and 2002 and made other changes to DSH provisions that resulted in increased costs to the Medicaid program.

States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from co-payments for emergency services and family planning services.

Federal Government Share
The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. The Federal Government pays States a higher share for children covered through the SCHIP program. This "enhanced" FMAP averages about 70 percent for all States, compared to the general Medicaid average of 60.2 percent.

The Federal Government also reimburses States for 100 percent of the cost of services provided through facilities of the Indian Health Service, provides financial help to the twelve States that furnish the highest number of emergency services to undocumented aliens, and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the SCHIP program, the Qualifying Individuals (QI) program, and DSH payments, Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal Government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into Public Law 106-113, the appropriations bill for the District of Columbia for FY 2000) increased the amount that certain States and the territories can spend on DSH and SCHIP payments, respectively.

Future Challenges Affecting Medicaid

Recent growth in Medicaid spending has been driven primarily by enrollment growth due to the economic downturn. As the economy begins to recover, the rate of growth of Medicaid spending is slowing; however, increasing health care costs and demographic trends, coupled with the expiration of temporary federal fiscal relief in June 2004, will mean sustained pressure on state budgets. Between FY 2002 and 2005, all states reduced provider rates and implemented prescription drug cost controls, 38 states reduced eligibility, and 34 states reduced benefits. While these measures have helped to constrain spending, they have also placed additional burden on Medicaid beneficiaries and the providers who serve them.

Despite fiscal pressures, the Medicaid program helps to secure access to acute and long-term care services for more than 52 million Americans. Proposals to restructure Medicaid merit careful consideration, as reductions in benefits or eligibility could compromise assistance to those who have great medical needs and expenses, lead to a greater number of uninsured Americans, and undermine economic recovery.

LTC Issues and Concerns

Although most people who need long-term care prefer to remain at home, Medicaid spending for long-term care, however, remains heavily weighted toward institutional care. States have increased services in home- and community-based settings; however, more progress is needed. In 2002, Medicaid provided nursing home services to nearly 1 million persons (most of them age
65 and older). In 1999, home- and community-based waiver programs for the aged and disabled served 426,626 persons.

Because Medicaid was designed as a program for the poor, its eligibility criteria is quite restrictive. Many individuals must deplete their life savings before they can qualify for Medicaid to pay for the services they need.

Finally, some policymakers believe that individuals attempt to shelter or give away their assets to qualify for Medicaid. Federal law requires a three-year “look-back” period to document that assets were not transferred for less than fair market value or for the purpose of qualifying for Medicaid. Some policymakers advocate a longer “look-back.”

Individuals who are unaware of these Medicaid rules may inadvertently disqualify themselves for a period of time by failing to anticipate the protracted recordkeeping requirements.

MEDICAID AND LONG-TERM SERVICES FOR OLDER PEOPLE

The Medicaid program was designed to provide coverage for health care and services to the poor. Today, approximately one-third of all Medicaid spending pays for long-term care (LTC), making Medicaid our nation’s largest source of payment for such services and supports.

Medicare covers few long-term care services. Therefore, Medicaid’s role in providing coverage for long-term care is critically important to older people with disabilities.

Of the $266 billion in total Medicaid spending in 2003 (Figure 5):

- Acute-care services comprised over half (58%)
- Long-term care services made up 36%
- Payments for Medicare premiums accounted for about 2%
- DSH payments represented about 5%
Medicaid accounts for 43% of total long-term care spending and finances care for nearly 60% of nursing home residents. While more than half of Medicaid long-term care spending goes toward institutional services, home and community-based services (HCBS) account for a growing proportion of Medicaid spending on long-term care.

Each state’s Medicaid program must pay for nursing home care for eligible persons age 21 and older. Medicaid is also required to pay for home health services (skilled nursing and, at the state’s option, a number of therapies) for individuals who would qualify for nursing facility coverage.

State Medicaid programs have the option of covering other long-term care services including personal care (help with daily activities such as bathing and dressing), intermediate care facilities for the mentally retarded (ICF/MR), and home- and community-based services (HCBS) under a “waiver” of federal Medicaid rules. Using the Medicaid waiver option, states provide a range of services, which may include personal care; transportation; respite care; and homemaker, chore, and other related services.

Because the average cost of nursing home care is $56,000 per year, most people with an extended stay rely on Medicaid for at least a portion of the cost. About one-third of people who enter a nursing home are eligible for Medicaid upon admission; another third deplete their assets paying for care and then turn to Medicaid to pay for the portion of care that exceeds their income.

**Nursing Facility Services for Individuals Age 21 and Older**

Nursing facility services for individuals age 21 and older is a mandatory Medicaid benefit. Nursing facilities are institutions which primarily provide:

- **Skilled nursing care** and related services for residents who require medical or nursing care;
- **Rehabilitation services** for the rehabilitation of injured, disabled or sick persons; or
- **Health-related care and services**, on a regular basis, to individuals who because of their mental or physical condition require care and services, above the level of room and
board, which can be made available to them only through institutional facilities. A nursing facility that participates in Medicaid must provide, or arrange for, the full range of services for residents who need them. Nursing facilities are required to meet a number of requirements relating to provision of services, residents’ rights, provision of information, and administration. Certain items and services are included in the facility payment, and others may be charged to the resident.

For Specific Information

The Medicaid program is a state/federal partnership, administered by state Medicaid agencies. Contact your state Medicaid agency for information about specific nursing facility services. Information for state Medicaid agencies including web sites and toll free telephone numbers is available at http://www.cms.hhs.gov/medicaid/mcontact.asp. You may also contact the Department of Health in a particular state. You will find the listing in the government section of the telephone directory.

Information on the scope of a particular state’s Medicaid benefits can be obtained through the state. See state contact information below.

Federal CMS Contacts:

Linda Peltz, (410) 786-3399 or Lpeltz@cms.hhs.gov
Pat Prete, (410) 786-3246 or Pprete@cms.hhs.gov

State Contact Information:

http://medicaid.aphsa.org/members.htm

Medicaid waivers

Waivers are programs that allow the Secretary of Health and Human Services to permit individual states to receive federal matching funds without complying with certain Medicaid rules (such as the consumer protections described above). Unlike regular Medicaid services, waiver services can be provided to specific targeted populations or to persons in limited parts of a state.

One of the shortcomings of Medicaid is that it has an institutional bias, meaning Medicaid funds are more likely to pay for institutional services rather than those that are provided in someone’s home and community. This is because nursing home coverage is mandatory, but coverage of the same types of services that are available in the community is optional.

While waivers have enabled states to experiment with different ways of providing community-based services, using them invariably results in significant inequities both across and within states in what people with disabilities receive. This, in turn, has led to long waiting lists to receive services in the community.

Medicaid Home and Community-Based Services Waiver Program
This section provides history, program overview and other pertinent information pertaining to the home and community-based services (HCBS) waiver program. The Medicaid home and community-based services waiver program is an alternative to providing long-term care in institutional settings.

**Home- and Community-Based Services (HCBS) Waivers and How they differ from Regular Medicaid Programs**

The 1915(c) waiver, also called the home and community-based services (HCBS) waiver, is the most frequently used waiver for providing services in the community.

These waivers are available to Medicaid-eligible individuals who, without the waiver services, would be institutionalized in a hospital or nursing facility. This type of waiver allows the Secretary to waive certain financial eligibility requirements and the Medicaid requirement that services must be “comparable” among beneficiaries and must be provided statewide. The Secretary also has the authority (which is regularly invoked) to impose enrollment caps to ensure the budget neutrality of HCBS waivers. This is done to prevent waivers from increasing federal Medicaid costs.

**Program History**

In 1981, former President Ronald Reagan signed into law Public Law 97-35. Section 2176 of PL 97-35 established section 1915(c) of the Social Security Act (the Act), the Medicaid Home and Community-Based Services (HCBS) Waiver program. Prior to the passage of this legislation, Medicaid long-term care benefits were limited to home health and personal care services and to institutional facilities: hospitals, nursing facilities (NF), intermediate care facilities for persons with mental retardation (ICF/MR). The HCBS legislation provided a vehicle for states, for the first time, to offer additional services not otherwise available through their Medicaid programs to serve people in their own homes and communities. HCBS waivers afford States the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation. The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Under the original legislation, States were authorized to request and provide with Secretarial approval, homemaker/home health aide services, personal care services, adult day health, habilitation, case management, respite care and "other" services requested by the State as the Secretary may approve. Room and Board is specifically excluded except for institutional respite care and live-in personal caregivers. The initial legislation offered home and community-based services to individuals who absent the waiver would require skilled nursing facility or intermediate care facility services including ICF/MR (now Nursing facility for skilled nursing and intermediate care facility services). Subsequent to the original legislation, Congress has: 1) expanded the waiver authority to individuals who absent the waiver would require hospital level of care; 2) extended the renewal authority from three years to five years; 3) limited waivers of Medicaid statutes to section 1902(a)(10)(B) rather than the broad section 1902(a) waiver offered in the original legislation; 4) added, with exceptions, prevocational, educational and supported employment to habilitation services; and 5) included day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.
Program Design

The home and community-based services (HCBS) waiver program, section 1915(c) of the Social Security Act (the Act) is the Medicaid program alternative to providing long-term care in institutional settings.

States have the flexibility to design HCBS waiver programs to meet the specific needs of defined groups. Federal regulations permit HCBS waiver programs to serve the elderly, persons with physical disabilities, developmental disabilities, mental retardation or mental illness. States may also target HCBS waiver programs by specific illness or condition, such as technology-dependent children or individuals with AIDS, as well as persons with acquired or traumatic brain injury. States can make home and community-based services available to individuals who would otherwise qualify for Medicaid only if they were in an institutional setting. In other words, individuals receiving services under an HCBS waiver program must meet either a hospital, nursing facility or intermediate care facility for persons with mental retardation level of care.

States may offer a variety of services to participants under an HCBS waiver program and are not limited to the number of services that can be provided. States may use an HCBS waiver program to provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, environmental). There are no specific services that must be offered in an HCBS waiver program. Additionally, there is no limit on the number of services that can be offered under a single waiver program as long as the waiver retains cost-neutrality and the services are necessary to avoid institutionalization.

Under section 1915(c) of the Act, States may request waivers of certain Federal requirements in order to develop Medicaid-financed home or community-based treatment alternatives. The three requirements that may be waived are in section 1902 of the Act and deal with statewideness (1902(a)(1)), comparability of services (1902(a)(10(B)) and community income and resource rules for the medically needy (1902(a)(10)(C)(i)(III)).

How to Obtain Approval

To receive approval to implement HCBS waiver programs, State Medicaid agencies must assure CMS that, on an average per capita basis, the cost of providing home and community-based services will not exceed the cost of care for the identical population in an institution. The Medicaid agency must also document and assure that necessary safeguards are in place to protect the health and welfare of beneficiaries. Additional federal requirements for states choosing to implement an HCBS waiver program include:

- Ensuring that measures will be taken to protect the health and welfare of participants
- Providing adequate and reasonable provider standards to meet the needs of the target population
- Ensuring that services are provided pursuant to a plan of care.

An application for an HCBS waiver must be submitted by the State Medicaid agency to the Centers for Medicare and Medicaid Services for review and approval. The State Medicaid Agency has the ultimate responsibility for an HCBS waiver program. However, the State Medicaid Agency may delegate the day-to-day operation of the program to another entity.
Initial HCBS waivers are approved for a three-year period. Waivers may be renewed for five-year intervals.

All states have at least one HCBS waiver program with the exception of Arizona, which operates an equivalent of an HCBS waiver program under section 1115 demonstration waiver authority.

1115 Demonstration Waivers and how they Differ from Regular Medicaid Programs

The 1115 demonstration waiver gives the Secretary the broadest authority to waive compliance with Medicaid rules. While Congress has proscribed the waiving of certain parts of the Medicaid law, the 1115 demonstration authority gives the Secretary broad discretion to approve waiver programs that are "likely to assist in promoting the objectives" of the Medicaid law. States have used 1115 demonstrations to make changes to Medicaid that affect the entire Medicaid program. This type of waiver can also be used to waive Medicaid rules that cannot be waived under the 1915(c) waiver program. Recently, some states have sought to make wholesale changes to Medicaid through this type of waiver, in some cases asking essentially to eliminate the entitlement to Medicaid services. People with disabilities and their advocates have frequently opposed these types of waivers, which have resulted in capped funding for Medicaid services.

For information on Federal Requirements Contact: Deidra Abbott (410)786-0690 or dabbott@cms.hhs.gov

INTERACTION BETWEEN MEDICARE AND MEDICAID

A large share of Medicaid spending (42%) is attributable to “dual eligibles,” low-income Medicare beneficiaries who are also enrolled in Medicaid. Because dual eligibles have significant health needs and few resources to obtain the range of services they require, Medicaid provides critical assistance. Dual eligibles rely on Medicaid to pay for Medicare premiums and cost-sharing and to cover important services that Medicare does not cover, such as long-term care and prescription drugs. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort." Beginning in January 2006, dual eligibles will lose Medicaid prescription drug coverage and will instead be offered drug coverage under new Medicare Part D prescription drug plans.

Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program. There are various benefits available to "dual eligibles" who are entitled to Medicare and are eligible for some type of Medicaid benefit.

For persons who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their State's Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the State's payment limit. Medicaid also covers additional services (e.g., nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids).

Medicare beneficiaries can obtain Medicaid through different eligibility “pathways,” and the kind of assistance that Medicaid provides varies accordingly. The poorest Medicare beneficiaries, including those who have exhausted their resources paying for health and long-term care
(sometimes known as “medically needy” or “spend-down”), receive full assistance with Medicare premiums and cost sharing and coverage of all Medicaid benefits. Most dual eligibles qualify for Supplemental Security Income (SSI) or have incurred nursing home costs and are thus entitled to this comprehensive protection.

For Medicare beneficiaries with more income or resources, Medicaid’s assistance is more limited, primarily covering Medicare premiums. This assistance is referred to as the “Medicare Savings Programs” or “buy-in programs,” and the beneficiaries who qualify for it are known as Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI) – after the provisions that added these programs.

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to the Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes that are above 120 percent and less than 175 percent of the FPL, the BBA establishes a capped allocation to States, for each of the 5 years beginning January 1998, for payment of all or some of the Medicare Part B premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The payment of this QI benefit is 100 percent federally funded, up to the State’s allocation.

The Centers for Medicare & Medicaid Services (CMS) estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million “dual eligibles,” low-income elderly and individuals with disabilities who are enrolled in both Medicaid and Medicare. Eighteen percent of Medicare beneficiaries are dual eligibles receiving supplemental coverage through Medicaid. Dual eligibles account for one in seven Medicaid enrollees, including virtually all the elderly and about one-third of non-elderly beneficiaries with disabilities in Medicaid.

Most dual eligibles are very low-income individuals with substantial health needs: 71% have annual income below $10,000, compared to 13% of all other Medicare beneficiaries. High-cost and sick or frail Medicare beneficiaries are concentrated among the dually eligible.

Nearly one-quarter of dual eligibles are in nursing homes, compared to 2% of other Medicare beneficiaries.
Over half are in fair or poor health, twice the rate among others in Medicare. A third of dual eligibles have significant limitations in activities of daily living, compared to 14% of other Medicare beneficiaries. The prevalence of chronic conditions is also higher among dual enrollees (Fig. 1).

Medicaid helps relieve the financial burdens facing low-income Medicare beneficiaries in several ways. First, it pays their monthly Medicare Part B premium, which now amounts to over $800 per year. Second, Medicaid pays the cost-sharing charged for many Medicare services. Finally, Medicaid covers a range of important benefits excluded from Medicare, such as long-term care, dental and vision care, and other key services.

Because of their extensive health care needs, dual eligibles require and use more services than others in Medicare. On average, total health care costs for dual eligibles are double those of other Medicare beneficiaries. Medicaid covers 38% of total health care costs for dual eligibles – nearly as much as the 43% that Medicare covers – with out-of-pocket spending comprising most of the remainder.

The distribution of Medicare and Medicaid spending also reveals the concentration of need and costs among the dually eligible. Dual eligibles comprised 18% of all Medicare beneficiaries in 2000, but they accounted for 24% of total Medicare spending. Similarly, they represented 16% of all Medicaid enrollees but 42% of program spending.

Dual eligibles rely on a wide range of services, which are paid for by either Medicare or Medicaid (Fig. 2). The majority of Medicaid expenditures for dual eligibles are for long-term care services (65%); prescription drugs accounts for 14% and other acute care services to supplement Medicare account for 15%. Payment of Medicare premiums accounts for 6% of Medicaid expenditures.
Implications of the Medicare Prescription Drug Benefit on Dual Eligibles

On January 1, 2006, the 6.4 million dual eligibles that receive the full Medicaid benefits package will lose their Medicaid prescription drug coverage but can enroll in the Medicare Part D prescription drug benefit. The legislation establishes a low-income subsidy program that will offer substantial assistance with cost-sharing to dual eligibles and other low-income individuals.

Medicare will pay the Part D deductible on behalf of all dual eligibles, as well as their premiums if they enroll in an average or low-cost Part D plan. These subsidies will eliminate the gap in coverage for dual eligibles that other Medicare beneficiaries will face, referred to as the. Dual eligible will face small co-pays ranging from $1-5. Dual eligibles residing in nursing homes or other institutions are exempt from co-pays because they already must contribute all but a small portion of their income to the cost of nursing home care.

The new Medicare law establishes a Medicare prescription drug benefit (Part D) that becomes effective on January 1, 2006. After this date, Medicaid will no longer provide drug coverage. Instead, individuals will have to enroll in a Medicare Part D prescription drug plan. Selecting and enrolling in a Part D plan prior to January 1, 2006 is very important for dual eligibles. Otherwise, these individuals will be randomly assigned to a Part D plan. Starting in January 2006, Medicaid programs are prohibited from receiving federal Medicaid funds to provide prescription drug benefits to persons who are eligible for Medicare.

The drug coverage provided under Medicare Part D will not necessarily be the same as what dual eligibles currently receive under Medicaid and could differ dramatically depending on the state in which they reside and on how Part D is implemented.

Medicaid will no longer provide drug benefits for Medicare beneficiaries. However, dual eligibles will still be able to receive other services through Medicaid, such as long-term care.

Although the new law shifts drug coverage for dual eligibles from Medicaid to Medicare, it does not provide full fiscal relief to states. States are required to finance a large share of the cost of providing the Medicare Part D prescription drug benefit to dual eligibles through payments to the federal government.

Since the Medicare drug benefit and low-income subsidy will replace a portion of State Medicaid expenditures for drugs, States will see a reduction in Medicaid expenditures. To offset this reduction, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public
Law 108-173) requires each State to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006 this payment is 90 percent of the projected 2006 reduction in State spending. After 2006 the percentage decreases by 1-2/3 percent per year to 75 percent for 2014 and later.

It is unclear how dual eligibles will fare under the Medicare Part D prescription drug benefit when it is implemented in 2006. The array of drugs covered by Part D plans may fall short of those currently covered by Medicaid. In about half the states, Medicaid co-pay requirements for dual eligibles currently fall below the levels that most dual eligibles will face when they enroll in Part D plans in 2006. Dual eligibles may find that their out-of-pocket costs for prescription drugs increase when they enroll in Part D plans. Dual eligibles will also have to pay 100% of the costs of drugs that are not covered by their Part D plans. Under the bill, states are not allowed to use federal Medicaid matching funds to supplement prescription drug coverage for dual eligibles under Part D plans, however, a state can choose to use state-only funds to wrap-around the prescription drug benefit.

It will be some time before individual states are able to fully evaluate the effect of the new Medicare prescription drug benefit on their Medicaid budgets and dual eligible populations. Given the health needs of dual eligibles, it will be important to assure adequate safeguards are in place to protect access to prescription drugs for this population as the new Medicare law is implemented and as other options for Medicaid reform are considered.

**List and Definition of Medicare/Medicaid Dual Eligibles**

**Dual Eligibles** - The following describes the various categories of individuals who, collectively, are known as dual eligibles. Medicare has two basic coverages: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

**Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only)** - These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

**QMBs with full Medicaid (QMB Plus)** - These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

**Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only)** - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.
SLMBs with full Medicaid (SLMB Plus) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. FFP equals FMAP.

Qualified Disabled and Working Individuals (QDWIs) - These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. FFP equals FMAP.

Qualifying Individuals (1) (QI-1s) - This group is effective 1/1/98 - 12/31/02. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP at 100%.

Qualifying Individuals (2) (QI-2s) - This group is effective 1/1/98 - 12/31/02. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 135% FPL, but less than 175% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays only a portion of their part B premiums ($2.23 in 1999). FFP equals FMAP at 100%.

Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2) - These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

THE 2005 HHS POVERTY GUIDELINES

There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines.

The poverty thresholds are the original version of the federal poverty measure. They are updated each year by the Census Bureau. The thresholds are used mainly for statistical purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) See “How the Census Bureau Measures Poverty” on the Census Bureau’s web site.
The poverty guidelines are the other version of the federal poverty measure. They are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs.

### 2005 HHS Poverty Guidelines

<table>
<thead>
<tr>
<th>Persons in Family Unit</th>
<th>48 Contiguous States and D.C.</th>
<th>Alaska</th>
<th>Hawaii</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$9,570</td>
<td>$11,950</td>
<td>$11,010</td>
</tr>
<tr>
<td>2</td>
<td>12,830</td>
<td>16,030</td>
<td>14,760</td>
</tr>
<tr>
<td>3</td>
<td>16,090</td>
<td>20,110</td>
<td>18,510</td>
</tr>
<tr>
<td>4</td>
<td>19,350</td>
<td>24,190</td>
<td>22,260</td>
</tr>
<tr>
<td>5</td>
<td>22,610</td>
<td>28,270</td>
<td>26,010</td>
</tr>
<tr>
<td>6</td>
<td>25,870</td>
<td>32,350</td>
<td>29,760</td>
</tr>
<tr>
<td>7</td>
<td>29,130</td>
<td>36,430</td>
<td>33,510</td>
</tr>
<tr>
<td>8</td>
<td>32,390</td>
<td>40,510</td>
<td>37,260</td>
</tr>
</tbody>
</table>

For each additional person, add 3,260 for Alaska and Hawaii.

**SOURCE:** Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

The poverty guidelines are designated by the year in which they are issued. For instance, the guidelines issued in February 2005 are designated the 2005 poverty guidelines. However, the 2005 HHS poverty guidelines only reflect price changes through calendar year 2004; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2004.
<table>
<thead>
<tr>
<th>Pathway</th>
<th>Income Eligibility</th>
<th>Asset Limit</th>
<th>Medicaid Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mandatory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI Cash Assistance*</td>
<td>&lt; 74% of poverty (SSI</td>
<td>$2,000 (individual)</td>
<td>Full &quot;wrap-around&quot; Medicaid benefits, Medicare Part B premium and cost sharing.</td>
</tr>
<tr>
<td></td>
<td>Income Eligibility)</td>
<td>$3,000 (couple)</td>
<td></td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>&lt; 100% of poverty</td>
<td>$4,000 (individual)</td>
<td>No Medicaid benefits. Medicaid pays Medicare Part B premium and cost-sharing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$6,000 (couple)</td>
<td></td>
</tr>
<tr>
<td>Specified Low-Income Beneficiary (SLMB)</td>
<td>100-120% of poverty</td>
<td>$4,000 (individual)</td>
<td>No Medicaid benefits. Medicaid pays for Medicare Part B premium.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$6,000 (couple)</td>
<td></td>
</tr>
<tr>
<td><strong>Optional</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Needy</td>
<td>Individuals who spend their income down to a specified level</td>
<td>$2,000 (individual)</td>
<td>Full &quot;wrap-around&quot; Medicaid benefits which may be more limited than for SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3,000 (couple)</td>
<td></td>
</tr>
<tr>
<td>Poverty-Level</td>
<td>&lt; 100% of poverty</td>
<td>$2,000 (individual)</td>
<td>Full &quot;wrap-around&quot; Medicaid benefits, Medicare Part B Premium and cost sharing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3,000 (couple)</td>
<td></td>
</tr>
<tr>
<td>Special Income Rule for Nursing Home Residents</td>
<td>Individuals in institutions with income &lt; 300% of the SSI level</td>
<td>$2,000 (individual)</td>
<td>Full &quot;wrap-around&quot; Medicaid benefits, Medicare Part B Premium and cost sharing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3,000 (couple)</td>
<td></td>
</tr>
<tr>
<td>Home and Community-Based Services Waivers</td>
<td>Individuals who would be eligible if resided in an institution.</td>
<td>$2,000 (individual)</td>
<td>Full &quot;wrap-around&quot; Medicaid benefits including long-term care and prescription drugs.</td>
</tr>
</tbody>
</table>

*State that elect the so-called (209b) option can set lower levels

Source: Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375

Compiled by Oregon Health Action Campaign/Oregon Health Access Project
How an individual becomes a dual eligible

Individuals are determined to be disabled by the Social Security Administration. People with permanent disabilities who have an adequate work history qualify for Medicare after the waiting period. Most people age 65 and over qualify for Medicare. Certain adults who acquire disabilities in childhood sometimes qualify for Medicare if their parents are covered by Medicare.

Full Benefit Dual Eligibles

The vast majority of dual eligibles (6.4 million) receive full Medicaid benefits. People with disabilities can also qualify for varying levels of assistance from Medicaid if their income is low enough. Persons who receive SSI—or persons in states that have expanded Medicaid eligibility to persons with disabilities up to the poverty level—qualify for full Medicaid coverage that supplements Medicare’s coverage, pays the Part B premium, pays any Medicare cost-sharing, and provides services not covered by Medicare such as long-term care.

SUPPLEMENTAL MEDICAID COVERAGE FOR LOW-INCOME MEDICARE BENEFICIARIES

Medicare beneficiaries with disabilities with slightly higher incomes and limited assets can also qualify for partial benefits from Medicaid:


- Persons with incomes up to 100 percent ($798 per month in 2005) of the poverty level can qualify as Qualified Medicaid Beneficiaries (QMBs, pronounced “quimbies”). These individuals do not receive Medicaid supplemental benefits, but Medicaid does pay their Medicare Part B premium and cost-sharing.
- Persons with incomes between 100 percent and 120 percent ($798–$957 per month in 2005) of the poverty level qualify as Specified Low-Income Beneficiaries (SLMBs, pronounced “slimbies”). Medicaid pays the Part B premium for SLMBs.
- Block grant funding is available to states for Qualifying Individual (QI) coverage for individuals with incomes between 120 percent and 135 percent ($957–$1,176.63 per month in 2005) of the poverty level. Medicaid pays the Part B premium for QIs. Because this program is a block grant, this benefit is subject to having sufficient funding and is not guaranteed to all individuals.

For information and help on determining whether you maybe eligible for this type there assistance, you should contact the State Health Insurance Assistance Program nearest you. For a list of where these programs are located, go to [http://www.medicare.gov/contacts/static/allStateContacts.asp](http://www.medicare.gov/contacts/static/allStateContacts.asp). Or, call 1-800-Medicare (1-800-633-4227), or 1-877-486-2048 TTY.

How dual eligibles differ from other Medicare beneficiaries

Most dual eligible individuals have very low incomes: 77 percent have an annual income below $10,000, compared to 18 percent of all other Medicare beneficiaries.
High-cost and sick or frail Medicare beneficiaries are concentrated among the dual eligibles. Nearly one in four dual eligibles is in a nursing home, compared to 3 percent of other Medicare beneficiaries, and one-third of dual eligibles have significant limitations in their activities of daily living (ADLs), compared to 12 percent of other Medicare beneficiaries.

**Primary and/or Secondary Payor**

When an individual has two sources of payment for the same service, one source must be billed first. This is the primary payor. In the case of dual eligibles, Medicare is the primary payor and Medicaid is the secondary payor, supplementing payments made by Medicare.

Source: The Henry J. Kaiser Family Foundation—Kaiser Commission on Medicaid and the Uninsured, 2004

**Federal Medicaid Eligibility Rules**

**Transfers of Assets**

(Section 1917(c) of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396p(c))

Under the transfer of assets provisions, States must withhold payment for various long term care services for individuals who dispose of assets for less than fair market value. The term "assets" includes both resources and income.

These provisions apply when assets are transferred by individuals in long-term care facilities or receiving home and community-based waiver services, or by their spouses, or someone else acting on their behalf. At State option, these provisions can also apply to various other eligibility groups.

States can "look back" to find transfers of assets for 36 months prior to the date the individual is institutionalized or, if later, the date he or she applies for Medicaid. For certain trusts, this look-back period extends to 60 months.

If a transfer of assets for less than fair market value is found, the State must withhold payment for nursing facility care (and certain other long term care services) for a period of time referred to as the penalty period.

The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the State. Example: A transferred asset worth $90,000, divided by a $3,000 average monthly private-pay rate, results in a 30-month penalty period. There is no limit to the length of the penalty period.

For certain types of transfers, these penalties are not applied. The principal exceptions are:

- Transfers to a spouse, or to a third party for the sole benefit of the spouse,
- Transfers by a spouse to a third party for the sole benefit of the spouse,
- Transfers to certain disabled individuals, or to trusts established for those individuals,
- Transfers for a purpose other than to qualify for Medicaid, and
- Transfers where imposing a penalty would cause undue hardship.
*Note: At the time this book was written, California had not yet fully implemented these provisions and was still using a maximum look-back period of only 30 months for all transfers, including those to trusts.

Contact Person:

For additional information concerning Federal rules on transfers of assets for less than fair market value, contact Roy Trudel (410) 786-3417; E-Mail address, rtrudel@cms.hhs.gov, or Barbara Collins (410) 786-3364; E-Mail address, bcollins@cms.hhs.gov.

If you have questions about how a specific State applies these rules, please contact the State directly.

**Treatment of Trusts**

(Section 1917(d) of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396p(d))

Where an individual, his or her spouse, or anyone acting on the individual's behalf, establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for purposes of determining eligibility for Medicaid.

In determining whether the trust is available, no consideration is given to the purpose of the trust, the trustee's discretion in administering the trust, use restrictions in the trust, exculpatory clauses, or restrictions on distributions.

How a trust is treated depends to some extent on what type of trust it is; for example, whether it is revocable or irrevocable, and what specific requirements and conditions the trust contains. In general, however, payments actually made to or for the benefit of the individual are treated as income to the individual. Amounts that could be paid to or for the benefit of the individual, but are not, are treated as available resources. Amounts that could be paid to or for the benefit of the individual, but are paid to someone else, are treated as transfers of assets for less than fair market value. Amounts that cannot, in any way, be paid to or for the benefit of the individual are also treated as transfers of assets for less than fair market value.

Certain trusts are not counted as being available to the individual. They are:

- Trusts established by a parent, grandparent, guardian, or court for the benefit of an individual who is disabled and under the age of 65, using the individual's own funds.
- Trusts established by a disabled individual, parent, grandparent, guardian, or court for the disabled individual, using the individual's own funds, where the trust is made up of pooled funds and managed by a non-profit organization for the sole benefit of each individual included in the trust.
- Trusts composed only of pension, Social Security, and other income of the individual, in States which make individuals eligible for institutional care under a special income level, but do not cover institutional care for the medically needy.

In all of the above instances, the trust must provide that the State receives any funds, up to the amount of Medicaid benefits paid on behalf of the individual, remaining in the trust when the individual dies.
A trust will not be counted as available to the individual where the State determines that counting the trust would work an undue hardship.

Contact Person:

For additional information concerning Federal rules for treatment of trusts, contact Roy Trudel, (410) 786-3417; E-Mail address, rtrudel@cms.hhs.gov, or Barbara Collins, (410) 786-3364; E-Mail address bcollins@cms.hhs.gov.

If you have questions about how a specific State applies the rules on treatment of trusts, please contact the State directly.

**Spousal Impoverishment**

(Section 1924 of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396r-5)

The expense of nursing home care -- which ranges from $3,000 to $5,000 a month or more -- can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent what has come to be called “spousal impoverishment”, which can leave the spouse who is still living at home in the community with little or no income or resources. These provisions help ensure that this situation will not occur and that community spouses are able to live out their lives with independence and dignity.

**Preventing Spousal Impoverishment**

Special income eligibility rules pertain to nursing home residents whose spouses reside in the community. To prevent the high cost of long-term care from impoverishing the spouses of nursing home residents, Congress enacted special laws that require states to protect the income and assets of communitydwelling spouses. In 2005, each state must allow a spouse to retain $1,562 per month and states may allow a spouse to protect as much as $2,378 per month in 2005. In addition, states must allow the spouse to retain the greater of $19,020 in assets or half the couple’s joint assets up to $95,100. States are allowed to apply these rules to the spouses of individuals who receive home and community-based services under a “waiver,” but not all states exercise this option.

**Resource Eligibility**

The spousal impoverishment provisions apply when one member of a couple enters a nursing facility or other medical institution and is expected to remain there for at least 30 days. When the couple applies for Medicaid, an assessment of their resources is made. The couple’s resources, regardless of ownership, are combined. The couple’s home, household goods, an automobile, and burial funds are not included in the couple’s combined resources. The result is the couple’s combined countable resources. This amount is then used to determine the Spousal Share, which is one-half of the couple’s combined resources.

To determine whether the spouse residing in a medical facility meets the State’s resource standard for Medicaid, the following procedure is used:

From the couple’s combined countable resources, a Protected Resource Amount (PRA) is subtracted. The PRA is the greatest of:
• The Spousal Share, up to a maximum of $95,100 in 2005;
• The State spousal resource standard, which a State can set at any amount between $19,020 and $95,100 in 2005;
• An amount transferred to the community spouse for her/his support as directed by a court order; or
• An amount designated by a State hearing officer to raise the community spouse’s protected resources up to the minimum monthly maintenance needs standard.

After the PRA is subtracted from the couple’s combined countable resources, the remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the State’s resource standard, the individual is eligible for Medicaid. Once resource eligibility is determined, any resources belonging to the community spouse are no longer considered available to the spouse in the medical facility.

Income Eligibility

The community spouse’s income is not considered available to the spouse who is in the medical facility, and the two individuals are not considered a couple for income eligibility purposes. The State uses the income eligibility standard for one person rather than two, and the standard income eligibility process for Medicaid is used.

Post-Eligibility Treatment of Income

This process is followed after an individual in a nursing facility/medical institution is determined to be eligible for Medicaid. The post-eligibility process is used to determine how much the spouse in the medical facility must contribute toward his/her cost of nursing facility/institutional care. This process also determines how much of the income of the spouse who is in the medical facility is actually protected for use by the community spouse.

The process starts by determining the total income of the spouse in the medical facility. From that spouse’s total income, the following items are deducted:

• A personal needs allowance of at least $30;
• A community spouse’s monthly income allowance (between $1,562 and $2,378 for 2005), as long as the income is actually made available to her/him;
• A family monthly income allowance, if there are other family members living in the household;
• An amount for medical expenses incurred by the spouse who is in the medical facility.

The community spouse’s monthly income allowance is the amount of the institutionalized spouse’s income that is actually made available to the community spouse. If the community spouse has income of his or her own, the amount of that income is deducted from the community spouse’s monthly income allowance. Similarly, any income of family members, such as dependent children, is deducted from the family monthly income allowance.

Once the above items are deducted from the institutionalized spouse’s income, any remaining income is contributed toward the cost of his or her care in the institution.
For additional information concerning Federal rules on spousal impoverishment, contact Roy Trudel, 410-786-3417, E-Mail address rtrudel@cms.hhs.gov.; or Barbara Collins 410-786-3364, E-Mail address bcollins@cms.hhs.gov.

If you have questions about how a specific State applies these rules, please contact the State directly.

**Estate Recovery Provision**

Beneficiaries are notified of the Medicaid estate recovery program during their initial application for Medicaid eligibility and annual redetermination process. Individuals in medical facilities (who do not return home) are sent a notice of action by their county Department of Social Services informing them of any intent to place a lien/claim on their real property. The notice also informs them of their appeal rights. Estate recovery procedures are initiated after the beneficiary's death.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 defines estate and requires each State to seek adjustment or recovery of amounts correctly paid by the State for certain Medicaid beneficiaries. The State must, at a minimum, seek recovery for services provided to a person of any age in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution. The State may at its option recover amounts up to the total amount spent on the individual's behalf for medical assistance for other services under the State's plan. For individuals age 55 or older, States are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option of recovering payments for all other Medicaid services provided to these individuals.

In addition, States that had State plans approved after May 14, 1993 that disregarded assets or resources of persons with certain types of long-term care insurance policies must recover all Medicaid costs for nursing facility and other long-term care services from the estate of persons who had such policies. California, Connecticut, Indiana, Iowa, and New York are not required to seek adjustment or recovery from a person's estate who had a long-term care insurance policy. These States had State plans approved as of May 14, 1993 and are exempt from seeking recovery from individuals with certain types of long-term care insurance policies. For all other individuals, these States are required to comply with the estate recovery provisions as specified above.

States are also required to establish procedures, under standards specified by the Secretary for waiving estate recovery when recovery would cause an undue hardship.

**Contact:**

Ingrid Osborne (410) 786-4461 or E-mail, iosborne@cms.hhs.gov.

**State Medicaid Contacts**

**Alaska**
Alaska Department of Health and Social Services
Alabama
Medicaid Agency of Alabama
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624
Local: 1-334-242-5000
Toll-Free: 1-800-362-1504
Fax: 1-334-353-5989
Website: Medicaid Agency of Alabama website  http://www.medicaid.state.al.us/

Arkansas
Department of Human Services of Arkansas
P.O. Box 1437, Slot 1100
Donaghey Plaza South
Little Rock, AR 72203-1437
Local: 1-501-682-8292
Toll-Free: 1-800-482-5431 (Eligibility call 1-800-482-8988)
Spanish Phone: 1-800-482-8988
Local TTY: 1-501-682-6789
Fax: 1-501-682-1197
E-mail: Delores.Pinkerton@medicaid.state.ar.us
Website: Department of Human Services of Arkansas website  http://www.medicaid.state.ar.us/

American Samoa
Department of Human Services of Hawaii
P.O. Box 339
Honolulu, AS 96809
Toll-Free: 1-800-882-4608
Local TTY: 1-808-692-7182
Website: Department of Human Services of Hawaii website  http://www.med-quest.us

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Health Care Cost Containment of Arizona
801 E. Jefferson
Phoenix, AZ 85034
Toll-Free: 1-800-962-6690
Spanish Phone: 1-602-417-7700
Local TTY: 1-602-417-4191
Fax: 1-602-252-2136
Website: Health Care Cost Containment of Arizona website  http://www.ahcccs.state.az.us

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Department of Health Care Policy and Financing of Colorado
1570 Grant Street
Denver, CO 80203-1818
Local: 1-303-866-2993
Toll-Free: 1-800-221-3943
Spanish Phone: 1-303-866-1416
Local TTY: 1-303-866-3883
Fax: 1-303-866-4411
Website: Department of Health Care Policy and Financing of Colorado website
http://www.chcfp.state.co.us

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25 Sigourney Street
Hartford, CT 06106-5033
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Toll-Free: 1-800-842-1508
Fax: 1-860-951-9544
E-mail: pgr.dss@po.state.ct.us
Website: Department of Social Services of Connecticut website http://www.dss.state.ct.us

District of Columbia
DC Department of Health
825 North Capitol Street, NE
5th Floor
Washington, DC 20002
Local: 1-202-442-5999
Website: DC Department of Health website http://dchealth.dc.gov/index.asp

Delaware
Delaware Health and Social Services
1901 N. DuPont Highway
P.O. Box 906, Lewis Bldg.
New Castle, DE 19720
Local: 1-302-255-9040
Fax: 1-302-255-4429
E-mail: dhssinfo@state.de.us
Website: Delaware Health and Social Services website http://www.state.de.us.dhss.index.html

Florida
Agency for Health Care Administration of Florida
P.O. Box 13000
Tallahassee, FL 32317-3000
Toll-Free: 1-888-419-3456
Georgia
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
Local: 1-770-570-3300
Toll-Free: 1-866-322-4260
Fax: 1-270-804-7442
Website: Georgia Department of Community Health website
http://www.communityhealth.state.ga.us/

Hawaii
Department of Human Services of Hawaii
P.O. Box 339
Honolulu, HI 96809
Toll-Free: 1-800-882-4608
Local TTY: 1-808-692-7182
Website: Department of Human Services of Hawaii website http://www.med-quest.us/

Iowa
Department of Human Services of Iowa
Hoover State Office Building
5th Floor
Des Moines, IA 50319-0114
Local: 1-515-327-5121
Toll-Free: 1-800-338-8366
Fax: 1-515-281-4597

Idaho
Idaho Department of Health and Welfare
450 West State Street
Boise, ID 83720-0036
Local: 1-208-334-5500
Toll-Free: 1-800-685-3757
Local TTY: 1-208-332-7205
E-mail: FellerG@idhw.state.id.us
Website: Idaho Department of Health and Welfare website http://www2.state.id.us/dhw

Illinois
Department of Public Aid of Illinois
201 South Grand Avenue, East
Springfield, IL 62763
Local: 1-217-782-1200
Toll-Free: 1-800-226-0768
Spanish Phone: 1-217-785-8036
Local TTY: 1-800-526-5812
E-mail: dhswbbts@dhs.state.il.us
Website: Department of Public Aid of Illinois website http://www.dpaillinois.com/

**Indiana**  
Family and Social Services Administration of Indiana  
402 W. Washington Street  
P.O. Box 7083  
Indianapolis, IN 46207-7083  
Local: 1-317-233-4455  
Toll-Free: 1-800-889-9949  
Spanish Phone: 1-317-234-0225  
Fax: 1-317-232-7382  
Website: Family and Social Services Administration of Indiana website  
http://www.in.gov/fsaa/healthcare/

**Kansas**  
Department of Social and Rehabilitation Services of Kansas  
915 SW Harrison Street  
Topeka, KS 66612  
Local: 1-785-274-4200  
Toll-Free: 1-800-766-9012  
Local TTY: 1-785-296-1491  
Fax: 1-785-296-2173  
Website: Department of Social and Rehabilitation Services of Kansas website  
http://www.srskansas.org.hcp

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Cabinet for Health Services of Kentucky  
P.O. Box 2110  
Frankfort, KY 40602-2110  
Local: 1-502-564-4321  
Toll-Free: 1-800-635-2570  
Fax: 1-502-226-1898  
Website: Cabinet for Health Services of Kentucky website  
http://www.chfs.ky.gov/dms/

**Louisiana**  
Louisiana Department of Health and Hospital  
1201 Capitol Access Road  
P.O. Box 629  
Baton Rouge, LA 70821-0629  
Local: 1-225-342-9500  
Fax: 1-225-342-5568  
Website: Louisiana Department of Health and Hospital website  
http://www.dhh.state.la.us

**Massachusetts**  
Office of Health and Human Services of Massachusetts  
600 Washington Street  
Boston, MA 02111  
Local: 1-617-628-4141 (for provider only)  
Toll-Free: 1-800-841-2900  
Fax: 1-617-210-5820  
E-mail: mainquiries@unisys.com
Website: Office of Health and Human Services of Massachusetts website  
http://www.state.ma.us.dma

**Maryland**
Department of Human Resources of Maryland  
P.O. Box 17259  
Baltimore, MD 21203-7259  
Local: 1-410-767-5800  
Toll-Free: 1-800-492-5231  
Fax: 1-410-333-7141  
E-mail: dhrhelp@dhr.state.md.us  
Website: Department of Human Resources of Maryland website  
http://www.dhr.state.md.us/fia/medicaid.htm

**Maine**
Maine Department of Health and Human Services  
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11 State House Station  
Augusta, ME 04333-0011  
Local: 1-207-624-7539 (Eligibility)  
Toll-Free: 1-800-977-6740 (option 2)  
Local TTY: 1-207-287-1828  
Fax: 1-207-287-9229  
Website: Maine Department of Health and Human Services website  
http://www.state.me.us/bms

**Michigan**
Michigan Department Community Health  
Sixth Floor, Lewis Cass Building  
320 South Walnut Street  
Lansing, MI 48913  
Local: 1-517-373-3500  
Local TTY: 1-517-373-3573  
Website: Michigan Department Community Health website  
http://www.michigan.gov/mdch

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Department of Human Services of Minnesota  
444 Lafayette Road North  
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Toll-Free: 1-800-333-2433  
Local TTY: 1-651-296-5705  
Fax: 1-651-296-5690  
Website: Department of Human Services of Minnesota website  
http://www.dhs.state.mn.us

**Missouri**
Department of Social Services of Missouri  
221 West High Street  
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Jefferson City, MO 65102-1527  
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Toll-Free: In-State Calls Only 1-800-392-2161
Mississippi
Office of the Governor of Mississippi
239 North Lamar Street, Suite 801
Robert E. Lee Bldg.
Jackson, MS 39201-1399
Local: 1-601-359-6050
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Fax: 1-601-359-6048
E-mail: excc@medicaid.state.ms.us
Website: Office of the Governor of Mississippi website  http://www.dom.state.ms.us

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Montana Department of Public Health & Human Services-Division of Child and Adult Health Resources
1400 Broadway, Cogswell Building
P.O. Box 8005
Helena, MT 59604-8005
Local: 1-406-444-4540
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Website: Montana Department of Public Health & Human Services-Division of Child and Adult Health Resources website
http://www.dphhs.state.mt.us/www.dphhs.state.mt.us/hpsd/medicare/index.htm

North Carolina
North Carolina Department of Health and Human Services
1918 Umstead Drive
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Dept of Human Services of North Dakota - Medical Services
600 E. Boulevard Avenue
Bismarck, ND 58505-0250
Local: 1-701-328-2321
Toll-Free: In-State Calls Only 1-800-755-2604
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E-mail: sogaph@state.nd.us
Website: Dept of Human Services of North Dakota - Medical Services website
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P.O. Box 95044
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Toll-Free: 1-800-430-3244
Local TTY: 1-402-471-9570
Website: Nebraska Department of Health and Human Services System website
http://www.hhs.state.ne.us

New Hampshire
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857
Local: 1-603-271-4238
Website: New Hampshire Department of Health and Human Services website
http://www.dhhs.state.nh.us/DHHS/DHHS_SITE/default.htm

New Jersey
Department of Human Services of New Jersey
Quakerbridge Plaza, Building 6
P.O. Box 716
Trenton, NJ 08625-0716
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Toll-Free: In-State Calls Only 1-800-356-1561
Spanish Phone: In-State Calls Only 1-609-588-3844
Fax: 1-609-588-3583
E-mail: ann.c.kohler@dhs.state.nj.us
Website: Department of Human Services of New Jersey website
http://www.state.nj.us/humanservices/dmahs

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Sante Fe, NM 87504-2348
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Toll-Free: 1-888-997-2583
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Fax: 1-505-827-3185
Website: Department of Human Services of New Mexico website
http://www.state.nm.us/hsd/mad/index.html

Nevada
Nevada Department of Human Resources, Aging Division
1100 East William Street
Suite 101
Carson City, NV 89701
Local: 1-775-684-7200
Fax: 1-775-687-3893
Website: Nevada Department of Human Resources, Aging Division website
http://www.nvaging.net/

New York
New York State Department of Health
Office of Medicaid Management
Governor Nelson A. Rockefeller Empire State Plaza, Corning Tower Building
Albany, NY 12237
Local: 1-518-747-8887
Toll-Free: 1-800-541-2831
Fax: 1-518-486-6852
E-mail: medicaid@health.state.ny.us
Website: New York State Department of Health website
http://www.health.state.ny.us/nysdoh/medicaid/medicaid.htm

Ohio
Department of Job and Family Services of Ohio - Ohio Health Plans
30 East Broad Street
31st Floor
Columbus, OH 43215-3414
Local: 1-614-728-3288
Toll-Free: 1-800-324-8680
Fax: 1-614-752-3986
Website: Department of Job and Family Services of Ohio - Ohio Health Plans website
http://jfs.ohio.gov/ohp

Oklahoma
Health Care Authority of Oklahoma
4545 N. Lincoln Boulevard
Suite 124
Oklahoma City, OK 73105
Local: 1-405-522-7171 (also (405) 522-7300)
Toll-Free: 1-800-522-0310
Local TTY: 1-405-522-7179
Fax: 1-405-522-7100
Website: Health Care Authority of Oklahoma website http://www.ohca.state.ok.us/

Oregon
Oregon Department of Human Services
500 Summer Street, NE
3rd Floor
Salem, OR 94310-1014
Local: 1-503-945-5772
Toll-Free: 1-800-527-5772
Local TTY: 1-503-945-5895
Fax: 1-503-373-7689
Website: Oregon Department of Human Services website http://www.dhs.state.or.us/

Pennsylvania
Department of Public Welfare of Pennsylvania
Health and Welfare Building, Rm 515
P.O. Box 2675
Harrisburg, PA 17105
Local: 1-717-787-1870
Toll-Free: 1-800-692-7462
Local TTY: 1-717-705-7103
Website: Department of Public Welfare of Pennsylvania website
http://www.dpw.state.pa.us/omap/dpwomap.asp

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Medicaid Office of Puerto Rico and Virgin Islands
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San Juan, PR 00936
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Rhode Island
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600 New London Avenue
Cranston, RI 02921
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Local TTY: 1-401-462-3363
Fax: 1-401-521-4875
Website: Department of Human Services of Rhode Island website
http://www.dhs.state.ri.us/

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South Carolina Department of Health and Human Services
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Columbia, SC 29202-8206
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http://www.dhhs.state.sc.us

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Toll-Free: 1-800-223-3131
Spanish Phone: 1-800-305-9673
Fax: 1-605-773-5246
E-mail: MedElig@state.sd.us
Website: Department of Social Services of South Dakota website
http://www.state.sd.us/social/medical

Tennessee
Department of Finance and Administration of Tennessee
Texas
Health and Human Services Commission of Texas
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4th Floor
Austin, TX 78701
Local: 1-512-424-6500
Toll-Free: 1-888-834-7406
Local TTY: 1-512-407-3250
E-mail: medicaid@hhsc.state.tx.us
Website: Health and Human Services Commission of Texas website http://www.hhsc.state.tx.us

Utah
Utah Department of Health
288 North 1460 West
P.O. Box 143101
Salt Lake City, UT 84114-3101
Local: 1-801-538-6155
Toll-Free: 1-800-662-9651
Spanish Phone: 1-800-662-9651
Fax: 1-801-538-6805
Website: Utah Department of Health website http://health.utah.gov/Medicaid/

Virginia
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219
Local: 1-804-786-7933
Fax: 1-804-225-4512
E-mail: comm@dss.state.va.us
Website: Department of Medical Assistance Services website http://www.dmas.virginia.gov

US Virgin Islands
Medicaid Office of Puerto Rico and Virgin Islands
GPO Box 70184
San Juan, VI 00936
Local: 1-787-765-1230
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Vermont
Agency of Human Services of Vermont
Washington
Department of Social and Health Services of Washington
P.O. Box 45505
Olympia, WA 98504-5505
Local: 1-800-562-6188
Toll-Free: In-State Calls Only 1-800-562-3022
Fax: 1-360-586-1209
Website: Department of Social and Health Services of Washington website
http://www.adsa.dshs.wa.gov

Wisconsin
Wisconsin Department of Health and Family Services
1 West Wilson Street
P.O. Box 309
Madison, WI 53701-0309
Local: 1-608-221-5720
Toll-Free: 1-800-362-3002
Local TTY: 1-608-267-7371
Fax: 1-608-221-8815
E-mail: webmaster@dhfs.state.wi.us
Website: Wisconsin Department of Health and Family Services website
http://www.dhfs.state.wi.us/medicaid/index.htm

West Virginia
West Virginia Department of Health & Human Resources
350 Capitol Street
Room 251
Charleston, WV 25301-3709
Local: 1-304-558-1700
Fax: 1-304-558-2515
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Website: West Virginia Department of Health & Human Resources website
http://www.wvdhhr.org/bms/

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Wyoming Department of Health
147 Hathaway Building
Cheyenne, WY 82002
Local: 1-307-777-7531
Local TTY: 1-307-777-5578
Fax: 1-307-777-6974
E-mail: iolesk@state.wy.us
Website: Wyoming Department of Health website http://dfsweb.state.wy.us

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Medicare Supplement (Medigap) Insurance

The Original Medicare Plan pays for many health care services and supplies, but it doesn't pay all health care costs. There are costs that must be paid, like coinsurance, copayments, and deductibles. These costs create “gaps” in Medicare coverage.

Those who choose coverage under the traditional fee-for-service Medicare program can generally get care from any doctor or hospital and receive coverage for care anywhere in the country. However, traditional Medicare has high cost-sharing requirements and does not currently cover the costs of certain benefits, such as outpatient prescription drugs.

Many people on Medicare purchase a Medigap policy to cover these gaps in Medicare coverage. Some Medigap policies also cover other extra benefits that aren't covered by Medicare, like routine yearly check-ups, at-home recovery, and emergency health care while traveling outside the U.S. A Medigap policy may help save on out-of-pocket costs. With a Medigap policy they will also have to pay a monthly premium to the private insurance company.

Many private insurance companies sell supplement (Medigap) insurance as well as separate long-term care insurance. The federal government does not sell or service insurance, but regulates the coverage offered by Medigap insurance.

Some Medigap Plans or Supplemental Insurance Policies may also pay for additional services that Medicare doesn't pay for at all, such as prescription drugs. A Medigap plan is guaranteed to be renewable and cannot be cancelled because of a person’s health or for any other reason, except for if the premium isn't paid. By law, companies can offer only 10 standardized Medigap benefit packages, labeled A through J. An additional option of a high deductible can be sold with Plans F and J. Plans with this option will pay benefits exactly as F and J pay, except that policy holders must pay a deductible first of $1,730 (in 2005). After that, the plan pays its benefits for that year. This amount increases each year.

A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the original Medicare plan. It will not cover out-of-pocket expenses, such as copayments, in a managed care plan.

The majority of Medicare’s elderly beneficiaries using fee-for-service have private Medigap policies. However, most of the elderly enrolled in managed care plans do not have any other type of coverage.

Nine out of ten people on Medicare rely on some form of insurance – retiree health coverage, Medigap, Medicaid – to supplement Medicare. – Laschober for Kaiser Family Foundation, 2004

**Need for a Medigap policy**

Whether or not someone needs a Medigap policy is a decision that only they can make. Depending on health care needs and finances, some people may want to continue employee or retiree coverage, or join a Medicare Advantage Plan.

Medigap policies only help pay health care costs for those who have the Original Medicare Plan. People don’t need to buy a Medigap policy if they are in a Medicare Advantage Plan (like a
Medicare Managed Care Plan). In fact, it is illegal for anyone to sell someone a Medigap policy if they know they are in one of these plans.

It is also illegal for an insurance company to sell a Medigap policy if someone has health coverage through the State Medicaid program, with certain exceptions.

Those who are in a Medicare Advantage Plan don’t need to buy a Medigap policy. In fact, it’s illegal for anyone to sell them a Medigap policy if they know they are in one of these health plans. For those who have Medicaid, it’s illegal for an insurance company to sell them a Medigap policy except in certain situations.

Some people may be able to get supplemental insurance from a former employer or union (retiree coverage). If not, they can buy Medicare supplemental insurance (Medigap) directly from an insurance company. Depending on their income and savings, they may also qualify for Medicaid.

Because of gaps in Medicare’s coverage, the elderly spent an estimated 22% of their income, on average, for health care services and premiums in 2002 (Maxwell, et al., 2002). To help with Medicare’s gaps, most have some form of supplemental insurance.

In 2001, of non-institutionalized beneficiaries:

- 34% had employer-sponsored benefits (28% as retirees). The share of large employers offering retiree health benefits dropped from 66% in 1998 to 38% in 2003 (KFF/HRET, 2003).
- 23% owned a Medigap policy, but only 7% of all beneficiaries had drug coverage from Medigap.
- 12% were covered under Medicaid, the major public insurance program for low-income Americans.
- 18% were enrolled in Medicare+Choice plans.

**Figure 3**

Sources of Primary Supplemental Insurance Among Noninstitutionalized Medicare Beneficiaries, Fall 2001

- Employer-Sponsored 34%
- Medigap 23%
- Medicare only 11%
- Medicare HMO 18%
- Medicaid 12%
- Other public 2%

Total = 35.5 million non-institutionalized Medicare beneficiaries

Note: Estimates are based on 1996-2001 NCES “Access to Care” files and represent point-time estimates pertaining to aged and disabled Medicare beneficiaries living in a community setting who were enrolled in Medicaid for the entire calendar year. Estimates exclude beneficiaries who were not enrolled in Medicaid for the entire calendar year.

Original Medicare Plan and Medigap Policies

Under the Original Medicare Plan, people use the red, white, and blue Medicare card to get health care. Generally, they must have Medicare Part A and Part B to buy a Medigap policy.

Gaps in Medicare’s Benefits

While Medicare is a major payor for health care services, it has significant gaps in coverage, including:

- Outpatient prescription drugs (until Medicare drug coverage starts in 2006)
- Personal assistance services
- Institutional services
- Dental care and dentures
- Hearing aids
- Routine eye care and eyeglasses
- Routine foot care
- Many screening tests
- Bathroom grab bars and similar equipment
Filling the Gaps in Medicare

A Medigap policy will cover some, but not all the gaps in the Original Medicare Plan.

<table>
<thead>
<tr>
<th>Some Examples of gaps in Medicare-covered services</th>
<th>A Medigap policy may help pay these costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>What Someone Pays in 2005 (These amounts can change each year.)</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Stays</strong></td>
<td>For each benefit period they pay $912 for the first 60 days $228 per day for days 61-90 $456 per day for days 91-150</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Stays</strong></td>
<td>For each benefit period they pay Nothing for the first 20 days Up to $114 per day for days 21-100</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td>They pay the cost of the first three pints</td>
</tr>
<tr>
<td><strong>Medicare Part B Yearly Deductible</strong></td>
<td>They pay the $110 per year deductible</td>
</tr>
<tr>
<td><strong>Medicare Part B Covered Services</strong></td>
<td>They pay: 20% of Medicare-approved amount for most covered services 50% of the Medicare-approved amount for outpatient mental health treatment Co-payment for outpatient hospital services</td>
</tr>
</tbody>
</table>

Not covered by Medigap policies

- Long-term care,
- Vision or dental care,
- Hearing aids,
- Private-duty nursing, or
- “Unlimited” outpatient prescription drugs.

A Medigap policy might help those in the Original Medicare Plan to:

- Lower their out-of-pocket costs, and
- Get more health insurance coverage.

What they pay out-of-pocket in the Original Medicare Plan will depend on the following:

- Whether their doctor or supplier accepts “assignment” (This means he or she takes the Medicare-approved amount as payment in full),
- How often they need health care,
- What type of health care they need,
- Whether they buy a Medigap policy,
- Which Medigap policy they buy, and
- Whether they have other health insurance.

It’s important to compare Medigap policies because costs can vary. Remember, the standardized Medigap policies that insurance companies offer must provide the same benefits.
The only difference between Medigap policies sold by different insurance companies might be the cost. Also, insurance companies that sell Medigap policies don't have to offer each Medigap plan (A through J). Each insurance company decides which Medigap policies they want to sell.

Once they sell a Medigap plan, the insurance company must keep renewing it. The company can't change what the policy pays for and can't cancel it unless they don't pay the premium. The company can, however, increase the premium people pay.

People only need one Medigap policy. It is illegal for an insurer to sell anyone more than one.

Retiree plans offered by former employers or unions do not have to conform to the standardized Medigap requirements. These plans are not called Medigap policies, even though they may work in much the same way as a Medigap plan.

**Medicare Modernization Act of 2003 and Medigap policies**

Starting January 1, 2006, some Medigap policies will change because of the Medicare Modernization Act. Medigap Plans H, I, and J currently cover some outpatient prescription drugs. This will change in 2006. After that date, people won't be able to buy Medigap policies that cover prescription drugs. This is because Medicare will offer prescription drug coverage in 2006. Medigap Plans H, I, and J may still be sold, but without the prescription drug benefit. People who already have a Medigap policy that covers prescription drugs, may be able to keep it under certain conditions. In addition, new types of Medigap policies might be available.

People who have purchased a Medigap policy with drug benefits before this date will have a couple of options. They can (1) keep their Medigap policy with drug coverage if they don’t sign up for Part D; OR (2) buy a new Medigap without drug benefits and sign up for the Medicare Part D prescription drug plan with one of the private companies offering one of those plans in 2006. Their Medigap company will send a notice in September of 2005 that will outline their options for keeping Medigap with prescription drug benefits or changing to one without those benefits.

Those who elect to continue getting their prescription drug benefits through H, I, or J should be aware that they will be subject to a monthly premium penalty if they elect Part D drug coverage at a later date. The penalty may be as high as 12% a year (1% for every month they delay enrollment). Since drug coverage through H, I and J is very limited, benefits are capped and the premiums are generally high, they may be better off enrolling in Medicare Part D.

In addition, two high deductible Medigap plans will be added (K and L). Compared to current Medigap options, these new plans are designed to provide more protection when people are very sick and include less coverage of the initial expenses. For example, neither plan will cover the Part B deductible but both will cover all hospital inpatient costs. The first plan will cover 50% of anything else they owe under Medicare Part A or Part B, and it will pay for everything after they reach an annual out-of-pocket limit of $4,000. The second is similar, but covers 75% of their cost-sharing and everything after they spend $2,000 in one year. In exchange for paying a high deductible, their monthly premium should be lower.

**Medicare Select**
Those who are in the Original Medicare Plan and have a Medigap policy can go to any doctor, hospital, or other health care provider who accepts Medicare. However, those who have the type of Medigap policy called Medicare SELECT must use specific hospitals and, in some cases, specific doctors to get full insurance benefits.

Some insurance companies offer Medigap policies called Medicare Select plans. These plans are like managed care plans. Medicare Select plans must cover the benefits listed in Medigap policies A-J, but they rely on a network (group) of selected providers to provide care. This is different from standard Medigap policies, where people can see any doctor they want.

If they want to use a doctor or hospital outside of a Medicare Select network, Original Medicare will still pay its share of the approved amount, but they may have to pay more than they would inside the network. In addition, some Medicare Select plans have prescription drug benefits that are different from those in other Medigap plans. Medicare Select plans are sometimes less expensive than standard Medigap policies because some benefits are not paid outside the network.

The difference between Medicare SELECT and regular Medigap insurance is that a Medicare SELECT policy may (except in emergencies) limit Medigap benefits to items and services provided by certain selected health care professionals or may pay only partial benefits when the patient gets health care from other health care professionals.

Insurers, including some HMOs, offer Medicare SELECT in the same way they offer standard Medigap insurance. The policies are required to meet certain federal standards and are regulated by the states in which they are approved. State insurance departments have information about Medicare SELECT policies that have been approved for sale in their states.

**Standard Medicare Supplement Benefits**

A Medigap policy is a health insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Medigap policies must follow federal and state laws. These laws protect consumers. The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of 10 standardized policies so they can compare them easily. Each policy has a different set of benefits.

Congress established federal standards for Medigap policies in 1990. Most states have adopted regulations limiting the sale of Medigap insurance to no more than 10 standard policies. One of the 10 is a basic policy offering a “core package” of benefits. These standardized plans are identified by the letters A through J. Plan A is the core package. The other nine plans each have a different combination of benefits, but they all include the core package. The basic policy, offering the core package of benefits, is available in all states.

**Medigap Basic (Core) Benefits (Plan A)**

All 10 standard Medigap policies include the same basic (core) benefits. Medigap Plan A covers only the basic (core) benefits listed below Medigap Plans B through J include the basic (core) benefits and some extra benefits.
• **Hospitalization:** Medicare Part A pays only a portion of the daily costs for hospitalizations. They must pay the coinsurance amounts for those days. This Medicare Supplement benefit pays the Part A coinsurance amount after the 60th day and an additional cost of 365 lifetime days.

• **Blood:** Medicare pays for all blood that is medically necessary except for the first three pints in each calendar year. This Medicare Supplement benefit pays for the first three pints of blood not paid for by Medicare, or equivalent quantities of packed red blood cells, as defined under federal regulations.

• **Medical Expenses:** Generally Medicare Part B pays for 80% of a predetermined amount (called the "Medicare approved" amount) for each procedure, supply, or service billed by their doctor or other provider that is not a hospital. This Medicare Supplement benefit pays the coinsurance generally (20% of the "Medicare approved" amount) under Medicare Part B.

**Medigap Plans A through J basic (core) benefits include:**

<table>
<thead>
<tr>
<th>Basic (core) benefit</th>
<th>What Medigap policies pay in 2005 (these amounts can change each year.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A coinsurance and hospital benefits</td>
<td>Medigap policies pay:</td>
</tr>
<tr>
<td></td>
<td>• $228 per day for days 61-90 of a hospital stay.</td>
</tr>
<tr>
<td></td>
<td>• $456 per day for days 91-150 of a hospital stay.</td>
</tr>
<tr>
<td></td>
<td>• Up to 365 more days of a hospital stay during your lifetime after they use all Medicare hospital benefits.</td>
</tr>
<tr>
<td>Medicare Part B coinsurance or co-payment</td>
<td>Medigap policies cover them after they meet the Part B $110 yearly deductible.</td>
</tr>
<tr>
<td>Blood</td>
<td>Medigap policies pay for the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless they or someone else donates blood to replace what was used.</td>
</tr>
</tbody>
</table>

**10 Standardized Medigap Plans**

These basic benefits are included in all the Medicare plans (A through J). Medigap Plans B through J offer extra benefits. Plan J offers the most benefits. Medigap policies are standardized so consumers can compare them easily.

Medicare Supplement insurance can be sold in only ten standardized plans. There are eight additional benefits that are combined with the basic benefits in various ways to make up the nine remaining plans called Plan B through Plan J.

This chart will show each of the benefits and which ones are covered under each Medigap plan. These charts do not apply to Massachusetts, Minnesota, or Wisconsin. Separate charts for those states appear later in this chapter.
### Benefit Plans

<table>
<thead>
<tr>
<th>Basic Benefits:</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F*</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Part A hospital co-insurance plus 100% of costs for a lifetime maximum of 365 additional hospital days; Part B co-insurance (20% of the Medicare-approved amount); three pints of blood in a calendar year</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The basic benefits (also known as the "core benefits" or Plan A) are the minimum coverage people may buy. Plan A contains only the core benefits listed below. Every other plan contains these core benefits and then adds one or more additional benefits. Although Plan A is the least expensive policy, it may not be a good choice for low-income individuals who may not be able to afford the Medicare Part A hospital deductible when they are hospitalized.

<table>
<thead>
<tr>
<th>Part A Hospital Deductible</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F*</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J*</th>
</tr>
</thead>
<tbody>
<tr>
<td>First day deductible, $912 in 2005 (per benefit period)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

The Part A Deductible: The Medicare Part A deductible is the expense for which they are obligated to pay when admitted to a hospital as an inpatient. Medicare pays eligible benefits above that amount. (The Medicare Part A deductible amount may change yearly). This Medicare Supplement benefit reimburses the deductible amount, no matter what the amount may be. This benefit is included in Plans B through J.

<table>
<thead>
<tr>
<th>Skilled Nursing Facility (SNF) Co-payment</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F*</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$114 per day for days 21-100 of skilled care in a skilled nursing facility (per benefit period)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Skilled Nursing Co-insurance: Medicare Part A pays for the first 20 days of care in a skilled nursing facility following hospitalization, but requires them to pay a co-insurance beginning on the 21st day through the 100th day. This Medicare Supplement benefit pays the co-insurance amount beginning on the 21st day. This benefit is included in Plans C through J.

<table>
<thead>
<tr>
<th>Part B Deductible</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F*</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J*</th>
</tr>
</thead>
<tbody>
<tr>
<td>First $110 of Part B services each year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Part B Deductible: The Medicare Part B deductible is the amount they must pay each year for medical expenses (such as doctor fees) before Medicare begins paying. (The Part B deductible amount may change per year). This Medicare Supplement benefit reimburses the deductible amount. This benefit is included in Plan C, Plan F, and Plan J.

<table>
<thead>
<tr>
<th>Part B Excess Charges</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F*</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J*</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% or 100% of physician charges up to 15% above the Medicare-approved amount</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Part B Excess Charges: Medicare Part B pays 80% of a predetermined amount (called the "Medicare approved" amount) for each procedure performed by
their doctor or other medical care provider. If their doctor accepts Medicare "assignment", the provider may only bill them for the difference between the amount paid by Medicare and the amount approved by Medicare.

Doctors who do not accept Medicare assignment may bill them for the difference between the amount paid by Medicare and the amount they can legally charge (called the "limiting charge"). If they have a Medicare Supplement Policy with the following:

- **Part B Excess Charges (100%)** benefit, the policy will pay the full amount billed by their doctors or other providers who do not take Medicare assignment subject to the limiting charge. *This benefit is included in Plan F, Plan I, and Plan J.*

- **The Part B Excess Charge (80%)** benefit, the policy will pay 80% of the amount they are billed by doctors or other providers. *This benefit is only in Plan G.* Theoretically, they should save money on premium costs if they select the 80% benefit rather than the 100% benefit. Remember that this coinsurance amount is paid by the medical expenses part of the Basic Benefits that are part of every Medicare Supplement insurance policy. All policies sold today must pay 50% coinsurance for outpatient mental health treatment services.

### Foreign Travel Emergencies

80% of emergency care during the first two months of each trip outside the USA after a $250 deductible, for a lifetime maximum of $50,000

**Foreign Travel Emergency**: The original Medicare plan does not pay for medical care outside of the United States, but some Medicare managed care plans, private fee-for-service plans, and some Medicare Supplement plans do. This Medicare Supplement benefit will pay 80% of their expenses for most emergency medical care in a foreign country during the first 60 days of a trip abroad after they pay a $250 deductible. There is a lifetime maximum benefit. *This benefit is in Plan C through Plan J. Check their insurance coverage before they travel.*

### At-Home Recovery

Maximum of $40/visit up to $1600 a year, while receiving Medicare-covered home health care, or up to 8 weeks of home care after SNF care is no longer needed.

**At-Home Recovery**: Under the home health care benefit, Medicare pays for intermittent visits by a nurse...
or other skilled care provider in their home during recovery from an acute illness. Medicare does not pay for custodial care in their home such as homemaker services, (i.e. help with bathing, dressing, laundry, or shopping). This Medicare Supplement benefit pays per home visit. Check their handbook¹ for current benefits for medically necessary custodial care while recovering from an illness, injury, or surgery. An insurance company may limit the number of visits to equal the number of Medicare home health care visits. *This benefit is in Plan D, Plan G, Plan I, and Plan J.*

| Preventive Care | $120 per year for physician-ordered health screenings |
| Preventive Care: Medicare pays for some testing for diagnostic purposes. This Medicare Supplement benefit pays up to $120 per year for certain tests done for screening purposes, routine physical exams, patient education, and other medically appropriate tests or preventive measures not covered by Medicare. *This benefit is included in Plan E and Plan J.* |
| Outpatient Prescription Drugs** |  |
| 1. Basic coverage: 50% of outpatient prescription drug costs, after a calendar year deductible of $250, up to a maximum benefit of $1250 |
| 2. Extended coverage: 50% of outpatient prescription drug costs, after a calendar year deductible of $250, up to a maximum benefit of $3000 |

| Basic Prescription Drug Benefit: Until January 1, 2006 this benefit has an annual limit of $1,250. The extended prescription drug benefit has an annual limit of $3,000. Medicare does not generally pay for outpatient prescription drugs. Each of these Medicare Supplement benefits pays 50% of the cost for outpatient prescription drugs to a maximum of $1,250 or $3,000 per year depending on the plan you purchase. The basic drug benefit is in Plan H and Plan I. The extended drug benefit is in Plan J only. Starting January 1, 2006 plans H, I, and J may be sold without the prescription drug benefit. |

*Plans F and J may be sold with a high deductible option of $1730 in 2005. The benefits remain the same, but the deductible must be met each year before any claims will be paid.*

1) "Benefit Period" begins the day they go to a hospital or a SNF and ends when they have not received hospital or SNF care for 60 consecutive days.

** After January 1, 2006 when the new Medicare Part D drug benefit takes effect, Medigap policies offering drug coverage can no longer be sold. People who have a Medigap policy with drug benefits (such as plans H, I or J ) will receive a letter from their insurance company in September 2005 about their options to keep their policy or buy a new one without drug coverage.
**Medigap policies cover some preventive care that isn’t covered by Medicare**

Starting January 1, 2006, no one will be able to buy Medigap policies covering prescription drugs. For more information about Medigap policies or the new Medicare prescription drug benefit, look at www.medicare.gov on the web. Select “Medicare Personal Plan Finder” or “Prescription Drug and Other Assistance Programs”. Or, call 1-800-MEDICARE (1-800-633-4227).

**Types of Medigap policies: Medigap Plans A through J**

This chart will list all of the Medigap Plans and show which benefits are included in each of them.

The Medigap policies offer the following benefits:

- **Policy A** is the basic core benefit package.

**Basic benefits**

All A-J Medigap policies must offer the following basic benefits:

- Co-insurance for hospital days 61-90 and co-insurance for the 60 lifetime reserve days
- 100% of the cost for hospital care beyond the 150 days covered by Medicare, up to a maximum of 365 lifetime days
- 20% co-insurance for Medicare-approved charges after the $110 Part B Medicare deductible (for 2005) has been paid
- The first three pints of blood
- **Policy B** includes: (1) the basic core benefit package, and (2) the Hospital Insurance (Part A) deductible ($912 in 2005).
- **Policy C** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2005), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 per day in 2005), (4) the Medical Insurance (Part B) deductible ($110), and (5) coverage of foreign travel emergencies.
- **Policy D** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2005), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 a day in 2005), (4) coverage of foreign travel emergencies, and (5) at-home recovery assistance.
- **Policy E** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2005), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 a day in 2005), (4) coverage of foreign travel emergencies, and (5) coverage of preventive screening and care.
- **Policy F** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2005), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 a day in 2005), (4) the Medical Insurance (Part B) deductible ($110), (5) coverage of foreign travel emergencies, and (6) 100% coverage of excess doctor charges under Medical Insurance (Part B).
- **Policy G** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2005), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 a day in 2005), (4) coverage of foreign travel emergencies,
(5) at-home recovery assistance, and (6) 80% of excess doctor charges under Medical Insurance (Part B).

- **Policy H** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2005), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 a day in 2005), (4) coverage of foreign travel emergencies, and (5) coverage of 50% of the cost of outpatient prescription drugs after payment of a $250 deductible, up to a maximum benefit of $1,250.

- **Policy I** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2005), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 a day in 2005), (4) coverage of foreign travel emergencies, (5) at-home recovery assistance, (6) 100% of excess doctor charges under Medical Insurance (Part B), and (7) 50% of the cost of outpatient prescription drugs after payment of a $250 deductible, up to a maximum benefit of $1,250.

- **Policy J** includes: (1) the basic core benefit package, (2) the Hospital Insurance (Part A) deductible ($912 in 2004), (3) the coinsurance for care in a skilled nursing home (days 21-100, $114 a day in 2005), (4) the Medical Insurance (Part B) deductible ($110), (5) coverage of foreign travel emergencies, (6) at-home recovery assistance, (7) 100% of excess doctor charges under Medical Insurance (Part B), (8) preventive screening and care, and (9) 50% of the cost of outpatient prescription drugs after payment of a $250 deductible, up to a maximum benefit of $3,000.

- There is a policy that is the same as Policy F but with a $1,730 deductible (in 2005). This high deductible policy covers 100% of covered out-of-pocket expenses once the deductible has been satisfied in a year. It requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount of $1,730 before the policy begins payment of benefits. After 2005, the deductible increases by the percentage increase in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year.

- There is also a policy that is the same as Policy J but with a $1,730 deductible (in 2005). This high deductible policy covers 100% of covered out-of-pocket expenses once the deductible has been satisfied in a year. It requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount of $1,730 before the policy begins payment of benefits. After 2005, the deductible increases by the percentage increase in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year.

Some choices may not be available in Massachusetts, Wisconsin and Minnesota because these states already required standardized Medigap policies prior to 1992.

**Massachusetts – Chart Of Standardized Medigap Plans**

Basic benefits included in all plans:

- **Inpatient Hospital Care**: Covers the Medicare Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **Medical Costs**: Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood**: Covers the first three pints of blood each year.

<table>
<thead>
<tr>
<th>Medigap Benefits</th>
<th>Core Plan</th>
<th>Core Plan with Rider*</th>
<th>Supplement 1 Plan</th>
<th>Supplement 2 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
### Medicare Part A:
- Inpatient Hospital Deductible: X

### Medicare Part B:
- Deductible: X

### Foreign Travel Emergency
- Emergency: X

### Inpatient Days in Mental Health Hospitals
- 60 days per calendar year: 120 days per benefit year: 120 days per benefit year

### Prescription Drugs
- ($35 deductible each calendar quarter, then 100% coverage for generic drugs and 80% coverage for brand name drugs): X (limited) X (limited)

### State-Mandated Benefits (Annual Pap tests and mammograms. Check your plan for other state-mandated benefits.)
- X

*This plan, offered by Blue Cross and Blue Shield of Massachusetts, also provides coverage for the following services: routine vision services, routine dental services, routine hearing services, fitness programs, and weight loss programs. Contact plan for details. For more information on these policies, call your State Insurance Department or look at [www.medicare.gov](http://www.medicare.gov) on the web. Select “Medicare Personal Plan Finder.”

Note: The crosses in this chart mean the benefit is covered under that plan.

---

**Minnesota – Chart of Standardized Medigap Plans**

Basic benefits included in all plans:

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first three pints of blood each year

<table>
<thead>
<tr>
<th>Medigap Benefits</th>
<th>Basic Plan</th>
<th>Extended Basic Plan</th>
<th>Optional Riders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>X</td>
<td>X</td>
<td>• Medicare Part A: Inpatient Hospital Deductible • Medicare Part B: Deductible</td>
</tr>
</tbody>
</table>
Insurance companies are allowed to offer six additional riders that can be added to a Basic plan. You may choose any one or all of the riders to design a Medigap plan that meets your needs.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A: Inpatient Hospital Deductible</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medicare Part A: Skilled-Nursing Facility Coinsurance</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part B: Deductible</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Foreign Travel Emergency</td>
<td>80%</td>
<td>80%*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usual and Customary Fees</td>
<td></td>
<td></td>
<td>80%*</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>At-home Recovery</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>20%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage while in a Foreign Country</td>
<td></td>
<td></td>
<td>80%*</td>
<td></td>
</tr>
<tr>
<td>State-Mandated Benefits (Diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations.)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The policy pays 100% after you spend $1000 out-of-pocket expenses for a calendar year.

Note: the checkmarks in this chart mean the benefit is covered under that plan.
Wisconsin – Chart of Standardized Medigap Plans

Basic benefits included in all plans:

- **Inpatient Hospital Care**: Covers the Medicare Part A coinsurance
- **Medical Costs**: Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood**: Covers the first three pints of blood each year.

<table>
<thead>
<tr>
<th>Medigap Benefits</th>
<th>Basic Plan</th>
<th>Optional Riders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>X</td>
<td>Medicare Part A Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additional Home Health Care (365 visits including those paid by Medicare)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Part B Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Part B Excess Charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient Prescription Drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Foreign Travel</td>
</tr>
</tbody>
</table>

Insurance companies are allowed to offer additional riders to a Medigap plan.

- Medicare Part A: Skilled-Nursing Facility Coinsurance
  - Inpatient Mental Health Coverage: 175 days per lifetime in addition to Medicare
  - Home Health Care: 40 visits in addition to those paid by Medicare

- Medicare Part B: Coinsurance
  - Outpatient Mental Health
  - Prescription Drugs (after a deductible of $6,250, pays 80%)

Wisconsin also has many other state-mandated benefits under the Medigap Basic Plan. For more information, call your State Insurance Department (see pages 79-80) or look at [www.medicare.gov](http://www.medicare.gov) on the web. Select “Medicare Personal Plan Finder”.

Note: The X's in this chart mean the benefit is covered under that plan.
**Medigap Premiums**

Even though Medigap plans are standardized, premiums can vary from company to company. There can be big differences in the premiums that insurance companies charge for exactly the same coverage. As people shop for a Medigap policy, they should be sure they are comparing the same Medigap policy (Plans A through J). They can get this information by calling insurance companies, or by looking at the “Medicare Personal Plan Finder” at www.medicare.gov on the web.

Some companies base premiums on an individual’s age, while other companies do not. Most charge a premium based on where the policyholder lives. Some charge smokers extra and others offer a variety of discounts. A few companies charge everyone the same price, regardless of their age or marital status. Many companies charge a higher premium for a person with a disability who is younger than 65-years-old, than they do for someone 65-years-old and over with the same policy. Most companies increase the amount of their premiums each year. It is important to compare policies and premiums from different companies before making a decision to buy.

**How Insurance Companies Set Prices**

There are three ways that insurance companies set prices for Medigap policies.

**Attained (Current) Age Rating**

This is the most common way that policies are priced. Attained age rated policies go up in price as insureds age, simply because they get older. Some companies increase the premium each year as they get older; others increase the premium every four years based on their age. An insurance company can base the monthly premium on their current age so the premium goes up each year. Insurance companies call these “attained-age-rated polices.” They may also increase due to inflation.

Premiums for these Medigap policies are usually the lowest at first for younger buyers. However, the premiums go up every year and can eventually become the most expensive.

**Example: Premium based on current age**

Example: An insurer charges each 75-year-old person more than it charges each 70-year-old, instead of spreading the cost between all 70- and 75-year-olds. The Medigap policy will go up in cost due to age, in addition to the increased cost of medical care.

Mrs. Anderson buys a Medigap policy at age 65. She pays a $140 monthly premium. Her premium will go up every year.

- At age 66 her premium will go up to $146.
- At age 67 her premium will go up to $152.

Mr. Dodd buys his Medigap policy at age 72. He pays a $180 monthly premium. His premium is higher than Mrs. Anderson’s because it is based on his current age. Mr. Dodd’s premium will go up every year as he gets older.
- At age 73 his premium will go up to $185.
- At age 74 his premium will go up to $190.

**Issue Age Rating**

These premiums are based mostly on their age when they buy the policy. Unlike Attained Age Rated policies, Issue Age Rated policies do not go up just because you are another year older.

An insurance company can base the monthly premium on the age they are when they buy their Medigap policy. Insurance companies call these “issue-age-rated policies.” Premiums are lower for younger buyers. Premiums for these policies won’t go up each year as they get older except for inflation.

**Example: Premium based on purchaser’s age when they first buy the policy**

Example: If they buy the policy when they are 65, the policy will always cost them the same amount the company is charging other 65-year-olds. If they buy the policy when they are 80, the company will always charge them what it is charging other 80-year-olds.

Mr. Han is 66. He buys a Medigap policy and pays a $160 monthly premium. Mrs. Wright is 73. She buys the same Medigap policy as Mr. Han. Since she is older at the time of purchase, her monthly premium is $175.

**No-Age Rating or Community Rating**

This is the least common way that policies are priced. No matter how old they are, the policy costs the same. With this structure, younger people may pay more than what they would pay for other policies, and older people may pay less.

Some insurance companies charge the same monthly premium for everyone with the same Medigap policy, regardless of age. Insurance companies call these “community-rated (or no-age-rated) policies.”

Premiums for these Medigap policies remain the same except for inflation. Premiums may be higher for younger buyers at first than for policies priced by age. However, if they keep this policy for a while, the premiums will eventually be lower than those policies priced by age.

**Example: Premium based on same premium for everyone**

Mr. Smith is 65. He buys a Medigap policy and pays a $165 monthly premium. Mrs. Perez is 72. She buys the same Medigap policy as Mr. Smith. She also pays a $165 monthly premium because with this type of policy, everyone pays the same price.

No matter which type of pricing the Medigap insurer uses, the price of the policy will probably go up each year because of inflation and rising health care costs. Policies whose prices rise based on both age and increased medical costs usually raise prices faster and at a steeper rate than those that don’t charge separately for age.

Remember that companies do not have to sell anyone a Medigap policy except during open enrollment or during guaranteed issue circumstances. So those who buy an attained age rated
policy whose price goes up faster than another type of pricing may not be able to switch (except in special circumstances) to another company, because of their health history.

Other factors that may affect the cost of a Medigap policy

- **Discounts**: Insurance companies may offer discounts to females, non-smokers, and/or if you are married.

- **Medical Underwriting**: Some insurance companies may use medical underwriting. They must answer medical questions on an application. Fill it out carefully and completely or the Medigap policy could be voided. The insurance company uses this information to decide whether to sell them a Medigap policy, how much they will charge, and whether they will have to wait for coverage to start. Some companies may add a waiting period for pre-existing conditions if State law allows.

  Insurance companies can’t use medical underwriting if they are in their Medigap open enrollment period or if buyers have special rights (called Medigap protections) to buy a Medigap policy.

- **High-deductible Option**: In 1997, Congress added two more high deductible plans to the list of 10 standard plans. Insurance companies may offer a “high-deductible option” on Medigap Plans F and J. Those who choose this option must pay the first $1,730 in Medigap-covered costs (the deductible in 2005) before the Medigap policy pays anything. This amount can change each year.

  Policyholders must pay the deductible first before the Medigap policy pays anything. High-deductible option policies often have lower premiums, but if people need a lot of Medicare covered health care services, supplies, and equipment, their out-of-pocket costs will be higher. They may not be able to change plans.

  **In addition to the $1,730 (in 2005) deductible that they must pay for the high-deductible option for Plans F and J, they must also pay deductibles for:**
  
  - Prescription drugs ($250 per year for Plan J only, because Plan F doesn’t cover prescription drugs), and
  - Foreign travel emergency ($250 per year for Plans F and J).

**Eligibility for a Medigap policy**

**Part B Requirement**

Generally, to buy a Medigap policy people must be enrolled in Medicare Part A and Part B. They will have to pay the monthly Medicare Part B premium of $78.20 (in 2005) to Medicare. In addition, they will have to pay a premium to the Medigap insurance company. As long as they pay their premium, the Medigap policy is guaranteed renewable. This means it is automatically renewed each year. Coverage will continue year after year as long as they pay the premium.

Spouses must buy separate Medigap policies. Each person’s Medigap policy covers health care costs for them and not their spouse.

**Health screening**
Companies selling Medigap plans can refuse to sell a plan because of a past or current health condition. There are certain times however, when by law, companies must sell a Medigap plan regardless of health. These times are called “Open Enrollment” and “Guaranteed Issue” periods, and they occur when people are first eligible for Medicare or following specific events.

**Waiting period**

Some companies impose a waiting period before covering a pre-existing condition. This waiting period cannot last more than six months, and it applies only to those conditions that were treated during the six months prior to purchasing the Medigap policy. For those who had health coverage during the six months prior to purchasing the Medigap plan, there will not be a waiting period.

**Pre-existing conditions**

A pre-existing condition is a health condition or illness for which they sought medical advice or treatment within six months prior to their application for a Medigap policy.

**Medigap & End-stage Renal Disease**

Those who have Medicare solely because they have end-stage renal disease (ESRD), may not be able to buy a Medigap policy until age 65.

**Open enrollment and Guaranteed Issue Periods for Medigap policies**

Insurance companies must sell a Medigap plan during certain periods of time — one period is called “open enrollment period.” The others are called “guaranteed issue periods.” At other times, insurance companies may refuse to sell a policy. If they have or used to have health problems, they may not be able to buy the Medigap plan of their choice.

Open enrollment or guaranteed issue periods are a dependable way to get a Medigap plan when a company would otherwise refuse to sell them one. Those who are relatively healthy, however, may be able to buy any Medigap policy whenever they choose to do so, if they can pass the health screening an insurance company requires.

An open enrollment period for selecting Medigap policies guarantees that for six months immediately following the effective date of enrolling in Medicare Part B, a person age 65 or older cannot be denied Medigap insurance or charged higher premiums because of health problems.

The first six months after someone turns age 65 and are enrolled in Medicare Part B is their Medigap open enrollment period. It doesn’t matter that they have had Medicare Part B before they turned age 65. During this time:

- People can buy any Medigap policy (including those Medigap policies that currently help pay the cost of prescription drugs*), and
- Insurance companies can’t refuse to sell them a Medigap policy due to a disability or other health problem, or charge them a higher premium than they charge other people who are 65 years old.
When a person buys a Medigap policy during the Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of creditable coverage they have. If they had Medicare for more than six months before they turned 65 years old, they won’t have a pre-existing condition waiting period because Medicare counts as creditable coverage.

**Open enrollment period at age 65 or older**

Those who reach age 65 and sign up for Medicare Part B have a one-time six-month period during which they may purchase any Medigap policy at the lowest price available, even if they have or used to have health problems.

The Medigap open enrollment period lasts for six months. It starts on the first day of the month in which they are both:

- Age 65 or older, and
- Enrolled in Medicare Part B.

Once the six-month Medigap open enrollment period starts, it can't be changed. During this period, an insurance company can't:

- Deny them insurance coverage,
- Place conditions on a policy (like making them wait for coverage to start), or
- Charge them more for a policy because of past or present health problems.

For those who buy a Medigap policy during their Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage they have. This is called “creditable coverage.”

**Example: Medigap Open Enrollment Period**

It is October 1, 2005, and Mr. Rodriguez wants to buy a Medigap policy. He needs to know if he is in his Medigap open enrollment period. He looks at his Medicare card. His Medicare Part B coverage started August 1, 2005. To figure out if he is in his open enrollment period, he must add six months to his Medicare Part B start date and see if it is before or after the current date.

August 1, 2005 + six months = January 31, 2006

Since it is October 1, 2005, he is still in his open enrollment period. Mr. Rodriguez has until January 31, 2006, to buy a Medigap policy during his Medigap open enrollment period.

**Open enrollment period at ages younger than 65**

In the case of individuals enrolled in Medicare Part B prior to age 65, Medigap insurers are required to offer coverage, regardless of medical history, for a six-month period when the individual reaches age 65. Insurers are prohibited from discriminating in the price of policies for such an individual, based upon the medical or health status of the policyholder. If they already have a Medigap plan, they can keep it and get a lower premium, or they can choose a new Medigap plan. However, this right does NOT apply to people who have permanent kidney failure known as End Stage Renal Disease or ESRD.
If they are in a situation that gives them the right to:

- Return to a Medigap policy they previously had but dropped, or
- Buy Medigap Plans A, B, C, or F,

they must be allowed to return to the same Medigap policy they dropped, if it is still available from their old insurance company, or to buy a Medigap Plan A, B, C, or F that is sold by any insurance company in the State to people under age 65. They can buy the Medigap policy at the best premium price available, with no review of their medical records. However, there is no Federal law that says insurance companies must sell Medigap policies to people under age 65. If an insurance company does sell these Medigap policies to anyone under age 65, they must sell one to them if they are in one of these situations.

During the Open Enrollment period, people have the right to purchase Medigap plans A, B, C, F. It is a good idea to apply for a Medigap policy early so it will take effect on the same day as the Part B benefits. Because there are no limits on the premiums a company can charge, they may pay a higher premium than someone who is 65 or older.

**After the Medigap open enrollment period**

Once the Medigap open enrollment period ends, a person may not be able to buy the policy of his choice, or any Medigap policy at all, because of pre-existing health conditions.

Those who don’t buy a Medigap policy during their open enrollment period may not be able to buy the one they want later, or they may be charged more for the policy. In addition, if they drop their Medigap policy, they may not be able to get it back. (However, special rules may apply if they have been in a Medicare Advantage Plan, or have employer sponsored insurance.)

If they take out Medicare Part B when older, their six-month period starts when their Medicare Part B benefits begin. Because most companies charge premiums based on age, people are likely to pay more when they are older than 65 and not in the open enrollment period, when they have to be given the lowest available price for their age. If an insurance company turns them down because of a previous health condition, try another company. They do not all have the same rules.

If they apply for a Medigap policy after the open enrollment period has ended, the Medigap insurance company is allowed to use medical underwriting to decide whether to accept their application, and how much to charge them for the policy. If they are in good health, the insurance company is likely to accept their application, but there is no guarantee that they will get the Medigap policy.

**Medicare Part B and Medigap open enrollment period if still working or covered under my spouse’s plan**

Those who are age 65 or older, and they or their spouse are working, and have health coverage through an employer or union based on current employment may want to wait to enroll in Medicare Part B to delay the Medigap open enrollment period.

The Medigap open enrollment period won’t start until they sign up for Medicare Part B. Remember, once they’re age 65 or older and enrolled in Medicare Part B, their Medigap open enrollment period starts and can’t be changed. However, if the employer group health plan pays
after (or “secondary to”) Medicare, it may require them to enroll in Medicare Part B in order to get benefits under that plan.

**Medigap Rights and Protections**

**Rights to buy a Medigap policy**

In some situations, people have the right to buy a Medigap policy outside of the Medigap open enrollment period. These rights are called “Medigap protections.” They are also called guaranteed issue rights because the law says that insurance companies must sell (“issue”) them a Medigap policy. In these situations, an insurance company:

- Can’t deny Medigap coverage or place conditions on a policy (like making them wait for coverage to start),
- Must cover all pre-existing conditions, and
- Can’t charge more for a Medigap policy because of past or present health problems.

In many cases, the guaranteed issue rights apply when the health coverage changes. Remember, it is best to apply for a Medigap policy before the current health coverage has ended. They can apply for a Medigap policy while they are still in your health plan and choose to start their Medigap coverage the day after their health plan coverage ends. This will prevent gaps in their health coverage. Those who drop their Medigap policy may not be able to get it back except in very limited cases.

In some situations, people have a guaranteed issue right to buy a Medigap policy because they lost certain kinds of health coverage. They should keep a copy of any letters, notices, and claim denials received. They should be sure to keep anything that has their name on it. They should also keep the postmarked envelope these papers come in as proof of when it was mailed. They may need to send a copy of some or all of these papers with their application for a Medigap policy to prove they lost coverage and have the right to these Medigap protections.

The Medigap protections in this section are from Federal law. Many States provide more Medigap protections than Federal law. Call the State Health Insurance Assistance Program or State Insurance Department for more information. Those who live in Massachusetts, Minnesota, or Wisconsin have the same guaranteed issue rights to buy a Medigap policy.

**Federal guaranteed-issue rights with a 63-day period**

Regardless of their age, for a period of 63 days following the four events described below, people are guaranteed the right to buy Medigap plans A, B, C, F.

They must apply for one of these “guaranteed-issue” Medigap plans no later than 63 days after one of these four events. They usually need to provide evidence of the date their other coverage ends with their application. The events include:

1. **Their employer-sponsored health plan supplementing Medicare reduces benefits, or they lose their eligibility for continued coverage.** This applies when their employer-sponsored retiree plan stops providing supplemental benefits and coverage for the 20% coinsurance under Medicare, or they lose your eligibility to continue benefits due to the death or divorce of a spouse or other family member.
2. **Their Medicare HMO increases costs, reduces benefits, or terminates a contract with a medical professional who is treating them.** In this situation, they only have the right to buy a Medigap from the Medicare HMO they are enrolled in, if it sells one.

They can only make this choice of buying a Medigap from their Medicare HMO once every two years. They have 63 days from the time they are notified of any increase in premium, reduction of benefits, or increases in co-payments, or that a medical provider treating them will no longer be eligible to treat the members of the Medicare HMO.

3. **They move out of the service area of their Medicare HMO:** They have the right to buy a Medigap even if their current HMO or another Medicare HMO is available where they are moving and they choose not to enroll.

4. **They are 65 or older and give up a Medigap plan to enroll in a Medicare HMO for the first time, and disenroll from the Medicare HMO within the first 12 months.** They have the option of returning to their previous Medigap plan if it is still available, or they can buy A, B, C, F or one with prescription drug benefits.*

**Other federal guaranteed issue events**

- **Their Medicare HMO leaves their geographic area.** This guaranteed issue event applies when their Medicare HMO leaves, or reduces the boundaries of the plan. Their choice of Medigap plans is limited to policies A, B, C, F or one with prescription drug benefits. They must apply for a Medigap policy within 123 days after their benefits in the Medicare HMO end.

- **They are age 65 or older and enroll in a Medicare HMO when they are first eligible for Medicare, and then disenroll from that plan within the first 12 months.** They have 63 days after their Medicare HMO benefits end in which they can choose any of the 10 Medigap plans.

- **30-day guaranteed issue period following their birthday each year.** Regardless of their age, for 30 days following their birthday, they have the right to buy any Medigap that has the same or fewer benefits than one they already have. (This does not include buying a Medicare Select plan.)

For example, those who already have Plan C may switch to any other Plan C, from the same or a different company.

If they already have a Medicare Select plan, they can switch to any other company with a Medigap policy that has the same or fewer benefits.

Those who are enrolled in a Program for All-Inclusive Care for the Elderly (PACE) when any of the following events occur can buy A, B, C, F, or a policy with a prescription drug benefit if the company sells one.

- The PACE program leaves the Medicare program or their geographic care area.
- They move out of the service area of the PACE program.
- They joined the PACE program when they were first eligible for Medicare at age 65 and left within the first year.
There may be times when more than one of these situations applies. When this happens, people can choose the Medigap protection that provides the best choice of Medigap policies.

**SITUATION #1: Their Medicare Advantage Plan or PACE* program coverage ends because the plan is leaving the Medicare program or stops giving care in their area.**

In this situation, the Medicare Advantage (formerly Medicare + Choice) Plan or PACE program sends them a letter telling them that they will no longer be covered by the plan. People have the right to buy a Medigap Plan A, B, C, or F that is sold in their State by any insurance company. They can buy the Medigap policy at the best premium price available (based on health status), with no review of their medical records even if they have health problems.

*The Programs of All-inclusive Care for the Elderly (PACE) combines medical, social, and long-term care services for frail people. PACE is available only in States that choose to offer it under Medicaid.*

Consumers can apply for a Medigap policy as soon as they get the final notification letter from their plan. When they get this letter telling them that their plan is leaving the Medicare program or will no longer give care in their area, they may:

- Switch to another Medicare Advantage Plan in their area. The final notification letter will tell them if there are other plans available in their area. In some cases, they may have to wait until the plan they want to join is accepting new members.

**If someone joins a new Medicare Advantage Plan when their current plan coverage ends, they won’t need (or be able to use) a Medigap policy, or**

- Leave their Medicare Advantage Plan or PACE program (disenroll) any time between the date they get their final notification letter and when their health coverage ends.

  Unless they join another Medicare Advantage Plan, consumers will automatically return to the Original Medicare Plan when they leave (disenroll from) their plan or PACE program. **They have 63 calendar days from the day they leave their plan or PACE program to apply for a Medigap policy, or**

- Stay in their plan or PACE program until the date their coverage ends. Unless they join another Medicare Advantage Plan, they will automatically return to the Original Medicare Plan when their coverage ends. **They have 63 calendar days after their health coverage ends to apply for a Medigap policy.**

**Important: Consumers will have additional rights under Situation #4 or Situation #5 if:**

- This was the first time they were in a Medicare Advantage Plan,
- They were in the plan less than one year before the plan left the Medicare program or stopped giving care in their area, and
- They choose to return to the Original Medicare Plan and apply for a Medigap policy.

If, instead, consumers immediately join another Medicare Advantage Plan, they can stay in that plan for up to one year and still have the rights described in Situations #4 and #5.
**SITUATION #2:** Their employer group health plan coverage ends.

They have the right to buy a Medigap policy if they are in an employer group health plan that pays after (or “secondary to”) Medicare, but their plan coverage ends because of the following:

- The employer goes out of business,
- The employer stops offering a plan, or
- They are no longer eligible for coverage under the plan.

For example, someone may lose eligibility for coverage in the plan when they retire (or their spouse retires, if their coverage is through his or her plan) because the plan only covers current employees (and their dependents) and doesn't provide retiree coverage.

In this situation, consumers have the right to buy a Medigap Plan A, B, C, or F that is sold in their State by any insurance company. They can buy the Medigap policy at the best premium price available (based on health status) with no review of their medical records even if they have health problems.

A person may get a letter or a notice from their employer, the health plan, or the insurance company telling them that their coverage is or will be cancelled. They have 63 calendar days from the date their coverage ends or from the date on the letter or notice (whichever is later) to apply for a Medigap policy. In some cases, they won't get a notice, but they may get a claim denial. If this happens, this claim denial is the same as a letter telling them that their coverage has ended.

People should remember to keep a copy of the letter, notice, or claim denial, and the postmarked envelope. They may need these papers to prove they lost coverage. They will need to send a copy of the letter, notice, or claim denial with their application to prove that they have a right to this Medigap protection.

State law may also give them the right to buy a Medigap policy when they lose coverage under an employer plan that paid before (or “primary to”) Medicare. If they are offered COBRA when their employer plan ends, and decide to take it instead of getting a Medigap policy, they will again have guaranteed issue rights when their COBRA coverage ends.

*COBRA is a law that lets some people keep their group health plan coverage for a limited period of time after they leave their employment.*

**SITUATION #3:** A person has to end their health coverage because they move out of the plan’s service area.

If someone has health coverage from a Medicare Advantage (formerly Medicare + Choice) Plan or they are in a PACE program, and they move out of the plan’s service area, they will have to end their coverage.

If they have a Medicare SELECT policy, they can keep their policy because it is guaranteed renewable. However, because they have moved, they can’t use hospitals or other health care providers that are on the policy’s list of approved providers. This is called the policy’s “network.” Consumers might want to switch to another Medigap policy that is sold in their State.
People have the right to buy a Medigap Plan A, B, C, or F that is sold by any insurance company in their State (if they move within the same State but outside of the plan’s service area), or the State they are moving to (if they move out of State). They can buy the Medigap policy at the best premium price available, with no review of their medical records even if they have health problems.

Consumers must tell their current plan that they are moving and give them a date when they will end their coverage. They can apply for a Medigap policy as early as 60 calendar days before the date their health coverage ends. They must apply for a Medigap policy no later than 63 calendar days after their health coverage ends to get this protection.

**SITUATION #4:** A person joined a Medicare Advantage Plan or PACE program when they were first eligible for Medicare at age 65 and within the first year of joining, they decide they want to leave.

People have the right to buy any Medigap policy that is sold in their State by any insurance company. They can buy the Medigap policy at the best premium price available, with no review of their medical records even if they have health problems. They must tell the plan that they want to leave (disenroll) and give them a date to end coverage. This date must be before they have been in the plan for a year. They will have from 60 calendar days before their coverage ends until 63 calendar days after their coverage ends to apply for a new Medigap policy.

Consumer rights under this situation may last for an extra 12 months if the plan they first joined leaves the Medicare program or stops giving care in their area before they have been in the plan for one year, AND they immediately join another Medicare Advantage Plan or PACE program.

**SITUATION #5:** Someone dropped a Medigap policy to join a Medicare Advantage Plan, Medicare SELECT policy, or PACE program for the first time and now they want to leave and they have been in the plan less than a year.

Consumers have the right to go back to the Medigap policy they had, if the same insurance company still sells it. They need to tell the Medicare Advantage (formerly Medicare + Choice) Plan, Medicare SELECT, or PACE program or policy that they want to leave (disenroll) and give them a date to end coverage. This date must be before they have been in the plan for a year.

If their former Medigap policy isn’t available, they have the right to buy a Medigap Plan A, B, C, or F that is sold in their State by any insurance company. They can buy the Medigap policy at the best premium price available, with no review of their medical records even if they have health problems. They will have from 60 calendar days before their coverage ends until 63 calendar days after their coverage ends to apply for a new Medigap policy.

Consumer rights under this situation may last for an extra 12 months if the plan they first joined leaves the Medicare program or stops giving care in their area before they have been in the plan for one year, AND they immediately join another Medicare Advantage Plan or PACE program.

**SITUATION #6:** Their Medigap insurance company goes bankrupt and they lose their coverage, or their Medigap policy coverage ends through no fault of their own.
They have the right to buy a Medigap Plan A, B, C, or F that is sold in their State by any insurance company. They can buy the Medigap policy at the best premium price available, with no review of their medical records even if they have health problems. They will have 63 calendar days from the date their coverage ends to apply for a new Medigap policy. Because Medigap policies are guaranteed renewable, the only way they would lose coverage under a Medigap policy would generally be if the insurance company goes bankrupt.

Remember, some States provide more Medigap protections. Their State might let them choose from more Medigap policies or give them a longer time to apply for a Medigap policy when they lose coverage. Consumers should call the State Health Insurance Assistance Program for more information.

SITUATION #7: Consumers leave their plan because their Medicare Advantage Plan, Medicare SELECT, or Medigap insurance company hasn’t followed the rules, or misled them.

In this situation, they leave the health plan because it failed to meet its contract obligations to them. This could include things such as quality standards weren’t met, the company misled them, or it used untrue statements in its marketing materials.

Generally, to have this right, they must have filed a grievance with the health plan, Medicare, or the State Insurance Department and received a decision that the plan was at fault.

Consumers have the right to buy a Medigap Plan A, B, C, or F that is sold in their State by any insurance company. They can buy the Medigap policy at the best premium price available, with no review of their medical records even if they have health problems. They must tell the plan that they want to leave (disenroll) and give them a date to end coverage. They will have 63 calendar days from the date their coverage ends to apply for a new Medigap policy.

Creditable Coverage

Creditable coverage is generally any other health coverage a person had before they applied for the Medigap policy. If they buy a Medigap policy during their Medigap open enrollment period, creditable coverage can reduce the time they have to wait before their pre-existing health problems will be covered by the Medigap policy.

Even when a person buys a Medigap policy in this open enrollment period, the policy may still exclude coverage for "pre-existing conditions" during the first six months the policy is in effect. Pre-existing conditions are conditions that were either diagnosed or treated during the six-month period before the Medigap policy became effective.

For those who buy a Medigap policy during the Medigap open enrollment period, and had at least six months of previous health coverage that qualifies as “creditable coverage”, the company can’t give them a pre-existing condition waiting period. If they had less than six months of creditable coverage, this waiting period will be reduced by the number of months of creditable coverage they had.

These types of coverage count as creditable coverage:

- A group health plan (like an employer or union plan)
- A health insurance policy
- Medicare Part A or Medicare Part B
- Medicaid
- A medical program of the Indian Health Service or tribal organization
- A state health benefits risk pool (sometimes called a state high risk pool)
- TRICARE (the health care program for military dependents and retirees [see page 71])
- A Federal Employees Health Benefit Plan
- A public health plan
- A health plan under the Peace Corps Act

Hospital indemnity insurance, specified disease insurance, vision or dental policies, and long-term care policies aren’t considered creditable coverage.

Whether someone had creditable coverage depends on whether there were any “breaks in coverage” when they were without health coverage of any kind for more than 63 days in a row. They can only count creditable coverage that they had after that break in coverage. If they have had one or more breaks in coverage, but each break was shorter than 63 days, then they can add the periods of coverage together to count towards their creditable coverage.

**Example: Creditable Coverage**

Mr. Smith is 65 and is being treated for heart disease. His Medicare Part A and Part B started November 1, 2004. Before this date, he had no health insurance coverage. On March 1, 2005, Mr. Smith buys a Medigap policy. His Medigap insurance company refuses to cover his heart disease condition for six months (the pre-existing condition waiting period). However, since Mr. Smith had Medicare Part A and Part B from November 1 to March 1, the insurance company must use his four months of Medicare coverage as creditable coverage to shorten this six-month waiting period. Now his waiting period will only be two months instead of six months.

During these two months, after Medicare pays its share, Mr. Smith will have to pay the rest of the costs for the care of his heart disease. He will also have to pay his Medigap premiums. The Medigap policy will pay for other covered care.

**Replacing Medigap policies**

During the first six months that someone has Medicare Part B insurance companies must agree to sell them a Medigap policy, regardless of their medical condition. When they switch Medigap policies or insurers after this six-month period, however, they are no longer guaranteed that insurers will sell them a policy. If an insurer agrees to sell them one, however, they cannot refuse to pay for any pre-existing health conditions.

Those who decide to switch shouldn’t cancel the first Medigap policy until the second Medigap policy is in force, and they have decided to keep it. Once they have the second Medigap policy, they have 30 days to decide if they want to keep the new Medigap policy. This is called the “free look” period. If they decide not to keep it for any reason whatsoever, they can return it to the insurance company for a full refund within this 30-day period.

The length of time they had their policy will affect how their new policy covers them for pre-existing conditions. Their new Medigap policy generally must cover all pre-existing conditions if they have had the previous policy at least six months.
Their new Medigap policy might not cover all pre-existing conditions if they’ve had their current Medigap policy for less than six months. However, the amount of time they’ve had their current Medigap policy must count towards the amount of time they must wait before the new policy covers their pre-existing condition (creditable coverage).

If there is a benefit in the new Medigap policy that wasn’t in their old policy, the company can make them wait up to six months before covering that benefit.

**Older Medigap policies**

Those who have an older Medigap policy bought before 1992 when standardized policies were first sold can keep it. They don’t have to switch to one of the newer standardized Medigap plans. But, if they decide to switch their Medigap policy, they won’t be able to go back to their older Medigap policy.

Before switching policies, agents and consumers must compare benefits and premiums carefully. Some of the older Medigap policies may offer better coverage, especially for prescription drugs and long-term care. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies.

**Renewability**

All Medigap policies purchased after 1990 are guaranteed renewable. This means that they continue in force as long as the premium is paid. The law says that the insurance company must automatically renew their Medigap policy as long as they pay their premium.

The insurance company can drop them if they lie (for example, they commit fraud under the policy). Other than that, there is only one situation where they may lose a Medigap guaranteed renewable policy: if the insurance company goes bankrupt. If this happens, and State law doesn’t make some other coverage available, they have the right to buy a Medigap Plan A, B, C, or F that is sold in their state.

Insurance companies in some states may refuse to renew Medigap policies that were purchased before 1990 because these old Medigap policies may not have been required to be guaranteed renewable. In order for an insurance company to refuse to renew one of these older Medigap policies, the company must get the State’s approval and cancel all Medigap policies of this type that they sold in the State. If this happens, policyholders have the right to buy a Medigap Plan A, B, C, or F that is sold in the State.

**Example: Guaranteed renewable**

In 1987, Mr. Jones bought a Medigap policy. The Medigap policy Mr. Jones bought isn’t guaranteed renewable because he bought it before 1990, and it didn’t say it was guaranteed renewable. The insurance company won’t renew Mr. Jones’s policy because it has decided (and got the State’s approval) to cancel all Medigap policies of this type in the State.

Therefore, Mr. Jones has the right to buy Medigap Plan A, B, C, or F that is sold in his State from any insurance company that offers them.

**How Medigap bills get paid**
In most cases, Medigap claims are sent directly to the insurance company because most Medigap insurance companies arrange to get claims information directly from Medicare carriers. A Medicare carrier is a private company that has a contract with Medicare to pay Part B bills.

However, if the Medigap insurance company doesn’t have this automatic claims service, they can arrange to have their claims sent directly to the Medigap insurance company so their doctor or provider is paid directly.

- First, the doctor or provider has to sign an agreement with Medicare to accept assignment of all Medicare claims for all their Medicare patients.
- Then, the doctor’s office has to put on the Medicare claim form that they want Medigap insurance benefits paid to the doctor or supplier. The doctor should put their Medigap policy number and the company name on the Medicare claim form.

They will need to sign the claim form or have the doctor keep the insured’s signature on record.

When these conditions are met, the Medicare carrier will process the claim and send it to the Medigap insurance company. The Medicare carrier will send the insured a Medicare Summary Notice. Their Medigap insurance company will pay the doctor or provider directly and then send them a notice. Those who don’t receive this notice may ask for it from their Medigap insurance company.

If the Medigap insurance company doesn’t pay the doctor directly when the above two conditions are met, insureds should report this to the State Insurance Department. For more information on Medigap claim filing by the Medicare carrier, call the Medicare carrier.

**Private contracts**

Some doctors don’t accept Medicare payments. Those who want to get care from a doctor who doesn’t accept Medicare payment may be asked to sign a private contract. A private contract is a written agreement between them and a doctor (like a physician, podiatrist, dentist, or optometrist) who has decided not to provide services through the Medicare program.

The private contract only applies to the services consumers receive from the specific doctor who asked them to sign it. They still have the right to see other Medicare doctors for services. No one can be asked to sign a private contract in an emergency situation or when they receive urgently needed care.

**If someone signs a private contract with their doctor:**

- They will have to pay whatever this doctor or provider charges them for the services they get. Medicare’s limiting charge won’t apply.
- No claim will be sent to Medicare, and Medicare won’t pay if one is submitted.
- Their Medigap policy, if they have one, won’t pay anything for this service.
- Medicare health plans won’t pay any amount for the services they get from this doctor.
- Many other insurance plans won’t pay for the services either.
- Consumers should call the insurance company before they get the service if they have any questions.
- The doctor must tell them whether Medicare would pay for the service if they get it from another doctor who participates in Medicare.
The doctor must tell them if he or she has opted out of or been excluded from the Medicare program.

Patients can always choose to get services not covered under Medicare and pay for these services themselves. In this case, they don’t have to sign a private contract, and the doctor doesn’t have to stop giving services through Medicare.

It is important for people to talk to someone in the State Health Insurance Assistance Program before signing a private contract.

**Rules for Selling Medigap Insurance**

Both state and federal laws govern sales of Medigap insurance. Companies or agents selling Medigap insurance must avoid certain illegal practices.

It is unlawful to sell or issue to an individual entitled to benefits under Hospital Insurance (Part A) or enrolled under Medical Insurance (Part B):

- a health insurance policy with knowledge that the policy duplicates health benefits the individual is otherwise entitled to under Medicare or Medicaid,
- a Medigap policy with knowledge that the individual is entitled to benefits under another Medigap policy, or
- a health insurance policy, other than a Medigap policy, with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled.

Penalties do not apply, however, to the sale or issuance of a policy or plan that duplicates health benefits to which the individual is otherwise entitled if, under the policy or plan, all benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual. In addition, for the penalty to be waived in the case of the sale or issuance of a policy or plan that duplicates benefits under Medicare or Medicaid, the application for the policy must include a statement, prominently displayed, disclosing the extent to which benefits payable under the policy or plan duplicate Medicare benefits.

The National Association of Insurance Commissioners (NAIC) has identified 10 separate types of health insurance policies that must provide an individualized statement of the extent to which the policy duplicates Medicare. These types of policies are:

- Policies that provide benefits for expenses incurred for an accidental injury only.
- Policies that provide benefits for specified limited services.
- Policies that reimburse expenses incurred for specified disease or other specific impairments (including cancer policies, specified disease policies and other policies that limit reimbursement to named medical conditions).
- Policies that pay fixed dollar amounts for specified disease or other specified impairments (including cancer, specified disease policies and other policies that pay a scheduled benefit or specified payment based on diagnosis of the conditions named in the policy).
- Indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.
- Policies that provide benefits for both expenses incurred and fixed indemnity.
- Long-term care policies providing both nursing home and non-institutional coverage.
• Long-term care policies primarily providing nursing home benefits only.
• Home care policies.
• Other health insurance policies not specifically identified above.

Certain policies are not required to carry a disclosure statement. These are:

• policies that do not duplicate Medicare benefits, even incidentally,
• life insurance policies that contain long term care riders or accelerated death benefits,
• disability insurance policies,
• property and casualty policies,
• employer and union group health plans,
• managed care organizations with Medicare contracts, and
• health care prepayment plans (HCPPs) that provide some or all Medicare Part B benefits under an agreement with the Centers for Medicare & Medicaid Services.
• Policies offering only long-term care nursing home care, home health care, or community based care, or any combination of the three, are allowed to coordinate benefits with Medicare and are not considered duplicative, provided the coordination is disclosed.

Illegal Insurance Practices

An insurer is subject to civil money and criminal penalties for failing to provide the appropriate disclosure statement. Federal criminal and civil penalties (fines) may also be imposed against any insurance company or agent that knowingly:

• Sells a health insurance policy that duplicates a person’s Medicare or Medicaid coverage, or any private health insurance coverage the person may have.
• Tells a person that they are employees or agents of the Medicare program or of any government agency.
• Makes a false statement that a policy meets legal standards for certification when it does not.
• Sells a person a Medigap policy that is not one of the 10 approved standard policies (after the new standards have been put in place in the person’s state).
• Denies a person his Medigap open enrollment period by refusing to issue the person a policy, placing conditions on the policy, or discriminating in the price of a policy because of the person’s health status, claims experience, receipt of health care, or the person’s medical condition.
• Uses the United States mail in a state for advertising or delivering health insurance policies to supplement Medicare if the policies have not been approved for sale in that state.

The sale of a Medigap policy to a Medicaid beneficiary is prohibited, except for policies containing prescription drug coverage to Qualified Medicare Beneficiaries. There is no prohibition on sale of policies to low-income Medicare beneficiaries for whom Medicaid pays only the Medical Insurance (Part B) premiums.

It is illegal for anyone to do the following:

• Pressure someone into buying a Medigap policy, or lie or mislead them to switch from one company or policy to another.
• Sell someone a second Medigap policy when they know that person already has one, unless they tell the insurance company in writing that they plan to cancel their existing Medigap policy.
• Sell someone a Medigap policy if they know a person has Medicaid, except in certain situations.
• Sell a Medigap policy if they know a person is in a Medicare Advantage (formerly Medicare + Choice) Plan.
• Claim that a Medigap policy is part of the Medicare program or any other Federal program. Remember, Medigap is private health insurance.
• Sell someone a Medigap policy that can’t legally be sold in that person’s State. Check with the State Insurance Department to make sure that the Medigap plan they are selling can be sold in that State.
• Misuse the names, letters, symbols, or emblems of the U. S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Centers for Medicare & Medicaid Services (CMS), or any of their various programs like Medicare.

If a consumer believes that a Federal law has been broken, they should call the Inspector General’s hotline at 1-800-HHS-TIPS (1-800-447-8477). In most cases, however, their State Insurance Department can help them with insurance-related problems.

**Helping Clients Choose a Medigap Plan**

Before selling a Medigap plan, get as much information about your clients as you can. If they are considering a Medigap plan, here are some questions you should ask them:

• Do they need a Medigap plan, or are they eligible for a program for low-income people?
• Do they have Medicare HMO coverage? If so, it's likely that they already have many of the benefits of a Medigap policy — and it would be illegal for an agent to sell them one unless they plan to leave the HMO.
• Do they want to be able to see any doctor or specialist who accepts Medicare, or are they willing to be restricted to a limited ‘network’ of doctors, hospitals and other providers in a HMO or a Medicare Select Plan?
• How much can they afford to spend on monthly premiums for Medigap?
• How might their costs change in the future?
• What is the premium? Remember, all policies with the same letter—for example A or E or J policies — cover identical benefits, no matter which insurance company is offering them. This makes it easy for them to compare premiums for the same lettered policy, quickly and easily.
• What benefits do they need? Remember, if they can pay some predictable costs themselves — such as the Part B deductible — it may save them premium dollars to buy a plan that doesn't include that benefit. Also, they should determine their current prescription drug costs and how much they would spend with and without a prescription drug benefit. This information will help determine whether the higher premium for drug coverage is worth paying.*
• Does the insurer file claims electronically? Insurers that accept electronic claims directly from Medicare make it easier for them and their doctors to receive payment. Note, however, that doctors who do not accept assignment are not required to file Medigap claims.
• Is there a waiting period to cover pre-existing conditions? If so, how long is it? And do they have any previous coverage that applies toward the waiting period?
* In looking ahead to 2006, they can approximate the total out-of-pocket costs with a Medigap plan and a Medicare Part D prescription drug plan, which will be offered by private companies starting in January 2006. More information on Part D prescription drug plans will be available closer to 2006. Prescription drug plans can also charge a monthly premium in addition to Part D’s estimated $35 monthly premium. Note: when the new Medicare Part D drug benefit begins in January 2006, Medigap polices with drug coverage can no longer be sold. If they would like a Medigap with drug coverage, they must purchase policy H, I or J before January 1, 2006.

**Steps to Buying a Medigap Policy**

Buying a Medigap policy is an important decision. Each individual must decide if a Medigap policy is the right kind of Medicare supplement health insurance coverage for them. Those who decide to buy a Medigap policy should shop carefully. Look for a Medigap policy that they can afford and that provides the coverage they need most. Keep in mind that different insurance companies may charge different amounts for the same type of Medigap policy, and not all insurance companies offer all of the Medigap policies.

**Look at Which Benefits Best Meet Their Needs**

They should think about their current and future health care needs. As they get older, their health care needs might increase.

A person must determine which benefits he is likely to need before purchasing a Medigap policy. Often, a person does not need the most comprehensive policy. For example, Policy A is the least expensive policy and offers the basic core package of benefits. Policy H is the least expensive package that includes prescription drug coverage. Policies F and G might be considered if a person uses nonparticipating doctors—those who charge more than the amount approved by Medicare; however, excess charges are limited to 115% of what Medicare pays. If the doctors charge no more than the amount approved by Medicare, less expensive policies such as Policy C or Policy D may be appropriate. Policy D also includes important benefits not covered by Policy A, such as coverage of custodial care at home following an illness or injury and the cost of coinsurance for skilled nursing home care.

Those who want to buy a Medicare supplement insurance policy must decide which benefit package to buy and which insurer to use. Before making a decision, they should clearly understand what benefits are covered and how to compare plans. Not all plans are available in all areas. Each Medigap plan pays for a particular set of benefits. Plan A offers the fewest benefits and is usually the least expensive. Plans H, I, and J are typically the most expensive, but include some prescription drug coverage (H, I and J will no longer be sold after 2006 when Medicare prescription drug coverage begins). The most popular Medigap plans are C and F, because they cover major benefits and are less expensive than other plans. No Medigap plan covers unlimited prescription drugs, long-term custodial care at home or in a nursing facility, vision and dental care, hearing aids, or private duty nursing.

The cost of their Medigap policy depends on the type of Medigap plan they choose and the company from which they buy it. Plans with the same letter name offer the same benefits, but the premiums vary from company to company. If they buy their Medigap policy during their open enrollment period or other federally mandated times, their premium cannot vary based on their health status.
No insurance policy fills gaps in coverage for Medicare HMOs or any of the Medicare private plan. Should they select an HMO, PPO, or other type of plan, they should budget for any costs that the plan doesn’t cover.

**Evaluate the Insurance Company**

Buying a Medigap policy is an important decision. Clients want to make sure that they are buying from a reliable insurance company. To help them find out if an insurance company is reliable, they can take the following actions:

- Call the State Insurance Department in the State. Ask about a record of complaints against insurance companies and selling Medigap policies in their state.
- Call the State Health Insurance Assistance Program in the State for free help with choosing a Medigap policy.
- Get information on an insurance company’s financial strength by independent rating services such as, Weiss Rating, Inc., A.M. Best, and Standard & Poor’s, and
- Look at information on the web.

Talk to someone they trust, like a family member, or a friend who has a Medigap policy.

To find out which insurance companies sell Medigap policies in the State, consumers can:

- Call the State Health Insurance Assistance. Ask if they have a Medigap rate comparison shopping guide for their State. These types of guides usually list the insurance companies that sell Medigap policies in their State and compare the costs of policies from each insurance company.
- Call the State Insurance Department.

This website will help them find information on all the health plan options, including the Medigap policies in their area. They can also get information on the following:

- Insurance companies that sell Medigap policies in their State,
- How to contact these insurance companies,
- What the policies must cover, and
- How insurance companies decide what to charge for a Medigap policy premium.

Call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative will provide information on all health plan options, including the Medigap policies in their area. They will get their Medicare Personal Plan Finder results in the mail within three weeks. TTY users should call 1-877-486-2048.

**Buy the Medigap policy**

Once they have decided on the insurance company and the Medigap policy they want, they can buy their policy. The insurance company must give a clearly worded summary of their Medigap policy. They should read it carefully, and if they don’t understand it, ask questions. Remember the following when buying the Medigap policy:
- Always stress the importance of filling out the application carefully and completely and answering all of the medical questions. If the insurance agent fills out the application, clients should review it to make sure it’s correct.
- People should never buy more than one Medigap policy. If they already have a Medigap policy, it is illegal for an insurance company to sell them a second policy unless they put in writing that they are going to cancel the first Medigap policy. However, consumers should not cancel the first Medigap policy until the second one is in place, and they have decided to keep the second Medigap policy. Once they have received the second Medigap policy, they have 30 days to decide if they want to keep the new Medigap policy. This is called the “free look” period. The 30-day free look period starts when their Medigap policy is issued.

**Medigap and Disability or ESRD**

If they have ESRD and are in a Medicare Advantage (formerly Medicare + Choice) Plan, and the plan leaves Medicare or no longer provides coverage in their area, they have a one-time right to join another Medicare Advantage Plan. They don’t have to use their one-time right to join a new Medicare Advantage Plan immediately.

Those who change directly to the Original Medicare Plan after their plan leaves or stops providing coverage will still have a one-time right to join a Medicare Advantage Plan at a later date during a time that people can enroll in a Medicare health plan.

**Medigap policies for people under age 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD)**

They may have Medicare before age 65 due to:

- A disability, or
- ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

If they are a person with Medicare under age 65 and are disabled or have ESRD, they might not be able to buy the Medigap policy wanted until they turn 65. Federal law doesn’t require insurance companies to sell Medigap policies to people under age 65. However, some States require Medigap insurance companies to sell them a Medigap policy, at certain times (during a limited Medigap open enrollment period), even if they are under age 65.

These States are listed below. For questions, call the State Health Insurance Assistance Program. At the time of this printing, the following States require insurance companies to offer at least one kind of Medigap policy to people with Medicare under age 65.

- California
- Colorado
- Connecticut
- Kansas
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Mississippi
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
Medigap insurance protections for those enrolled in the Medicare Advantage program

For many years Medicare law has allowed for Medicare covered services to be furnished to individuals through HMOs that contracted with Medicare. The Medicare Advantage program was created by Congress in 1997. Medicare Advantage expands the types of health plans that can contract with Medicare to enroll beneficiaries.

A person who currently has a Medigap policy may enroll in a Medicare Advantage plan and can keep the Medigap policy after enrollment. Keeping the Medigap policy may give a person time to determine whether to stay in the Medicare Advantage plan or return to the original Medicare plan with Medigap insurance. However, expenses paid for by the Medicare Advantage plan will not be reimbursed by the Medigap insurer. Eventually the person should drop Medigap coverage if satisfied with the Medicare Advantage plan.

A person already enrolled in a Medicare Advantage plan cannot buy Medigap insurance but may have the right to purchase a Medigap policy by returning to the original fee-for-service Medicare plan. To be guaranteed the right to buy Medigap insurance the person must have enrolled in the Medicare Advantage plan at age 65, must terminate enrollment in the Medicare Advantage plan within 12 months of entry into that plan, and must not have had any previous enrollment in a Medicare managed care plan.

If a Medicare Advantage plan terminates coverage because it leaves the Medicare program, plan enrollees have certain rights to new coverage, but these are time limited. The Medicare Advantage plan is required to provide information to assist making a decision about enrolling in another Medicare Advantage plan or switching to the original Medicare plan with a Medigap policy to supplement the coverage. In general, most individuals with Medicare have the right to guaranteed issue of any Medigap policies designated A, B, C, or F that are offered to new enrollees by issuers in the state.

This right applies to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in terminating Medicare Advantage plans may have another basis for entitlement to guaranteed issue of a Medigap policy. If a person had been enrolled in the Medicare Advantage plan for fewer than 12 months, was never enrolled in any other Medicare HMO, and had a previous Medigap policy, that person may return to the former Medigap policy if the previous Medigap insurance company still sells the policy in the state.

If that coverage is not available under the previous Medigap policy, the individual may purchase Medigap policies A, B, C, or F from any insurer who sells these policies in the state.

The insurance company selling the policy may not: (1) deny or condition the sale of the policy, (2) discriminate in the pricing of the policy because of health status, prior history of claims experience, receipt of health care for a medical condition, or (3) impose an exclusion for any pre-existing condition.
However, the individual has only 63 days after coverage ends to select a Medigap insurer. Also, if the individual moves outside the Medicare Advantage plan’s service area, he has 63 days to select a Medigap insurer.

An individual is guaranteed issuance of any Medigap policy if: (1) at least 65 years old, (2) eligible for Medicare, (3) enrolled in a Medicare Advantage plan, and (4) disenrolled from that plan within 12 months of the effective date of enrollment.

Even if the State doesn’t require insurance companies to sell Medigap policies to people with Medicare under age 65, some insurance companies may voluntarily sell Medigap policies to some people under age 65. Whether or not the State requires insurance companies to sell to them, Medigap policies sold to people under age 65 may cost more.

Remember, those who live in a State that has a Medigap open enrollment period for people under age 65 will still get another Medigap open enrollment period when they turn age 65. They may have other choices of Medigap policies or be able to get a better rate on their Medigap policy at that time.

Those who join a Medicare Advantage (formerly Medicare + Choice) Plan and their coverage ends may have the right to buy a Medigap policy. If they have questions, call the State Health Insurance Assistance Program.

**Right to suspend a Medigap policy for disabled people with Medicare**

Those who are under 65, who have Medicare, have a Medigap policy, and have employer group health plan coverage have a right to suspend (put on hold) their Medigap policy. Their Medigap coverage will stop, and they don’t have to pay the monthly premium while they are enrolled in an employer group health plan. They won’t have to pay more when they start the Medigap policy again than they would otherwise have to pay if they had not suspended the policy.

If, for any reason, they lose their employer group health plan coverage, they can get their Medigap policy back. Within 90 days of losing employer group health plan coverage, they must notify their Medigap insurance company that they want their Medigap policy back.

Their Medigap benefits and premiums will start again on the day their employer group health plan coverage stops. The Medigap policy must have the same benefits and premiums it would have had if they had never suspended their coverage. Their Medigap insurance company can’t refuse to cover care for any pre-existing conditions (health problems) they have. So, if they are disabled and working, they can enjoy the benefits of their employer’s insurance while knowing that they will be able to get their Medigap policy back when they need it.

**COBRA and Medicare Supplements**

“Continuation Coverage” under the Consolidated Omnibus Budget Reconciliation Act may provide them and their dependents with rights to keep their health care coverage temporarily if:

- They lose their job,
- They working hours are reduced,
- They leave their job voluntarily,
- They employer goes bankrupt.
It may also help the spouse keep health care coverage if the person dies, or they get divorced.

COBRA allows employees to keep their employer group health plan coverage for 18 months (or up to 36 months or sometimes even for a lifetime if they are a retiree and their former employer goes bankrupt) if they lose the coverage for one of the reasons listed. There are important timeframes that employees must know about COBRA and Medigap policies if they lose their employer coverage.

Those who lose their employer coverage might have to make a decision to either elect COBRA coverage or enroll in Medicare Part B. If they choose to enroll in Medicare Part B, their Medigap Open Enrollment Period will start. Once their Medigap Open Enrollment Period starts, it can’t be changed. If their Open Enrollment Period has already passed, they might be protected by the Medigap protections.

Whether they choose to elect COBRA coverage, enroll in Medicare Part B, or have Medigap protections, they must follow the important timeframes below. In most cases these timeframes overlap.

COBRA gives them a 60-day timeframe to elect COBRA coverage. This timeframe begins either the day they lose their employer coverage or the date when they get a notice from their employer letting them know they have COBRA rights, whichever occurs later.

Medigap Protections are available only if they apply within 63 calendar days after consumers get a notice from their employer letting them know that their coverage is ending. In some cases, they won’t get a notice, but may get a claim denial. If this happens, they may have the right to buy a Medigap policy within 63 calendar days after they get a notice that a claim has been denied. Remember, this timeframe ends 63 calendar days after this notice or claim denial. The Medigap guaranteed issue timeframe might be different depending on the law in their State.

In most cases, the COBRA timeframe and the Medigap guaranteed issue timeframe will overlap. To learn how these timeframes will affect them, call their State Health Insurance Assistance Program.

Other Ways To Pay Health Care Costs

There are other kinds of health care coverage, besides a Medigap policy, that may pay for some health care costs not covered by Medicare. The following provides a brief description. For more detailed information, get a free copy of the Health Care Coverage Directory for People with Medicare (CMS Pub. No. 02231) at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Some of the types of insurance and other ways to pay health care costs are:

Employee or Retiree Coverage from an Employer or Union

Employees or spouses who had health care coverage from a current or previous employer or union may change the benefits or premiums, and may also cancel the coverage if they choose.

There are some important timeframes for persons who are working and have group health coverage based on current or active employment, see “Medigap Open Enrollment Period.”
Retiree Health Coverage

As a rule of thumb, if people can get supplemental retiree coverage from a former employer or union, they should. Retiree policies are often more generous than Medigap and may also be cheaper than Medigap policies, since employers tend to pay at least part of the cost. Those who are not yet on Medicare should find out what benefits they may be eligible for from their employer when they go on Medicare and how these benefits coordinate with Medicare.

If their employee or retiree coverage ends, they may have the right to buy a Medigap policy. They may get a notice or claim denial letting them know that their health care coverage is ending. If this happens, they have the right to apply for a Medigap policy (see Medigap Protections, Situation #2) within 63 calendar days from the date your coverage ends or from the notice or claim denial.

Federally Qualified Health Centers (FQHCs)

FQHCs are special health centers, usually located in urban or rural areas, that can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.

Home and Community-Based Service/Waiver Programs (HCBS)

HCBS programs are available to some people with Medicaid. They offer services and programs that help them get care in their home and community. This program allows them to stay more independent. Some examples are: homemaker services, personal care, adult day care, meals, and transportation.

Hospital Indemnity Insurance

This kind of insurance pays a set amount of money for each day of a hospital stay. People won’t need this kind of insurance if their health insurance coverage or Medigap policy already pays for this type of care. This insurance doesn’t fill gaps in their Medicare coverage. It usually pays in addition to their health insurance.

Long-term Care Insurance

Long-term care insurance may help pay for persons health or personal care needs and activities of daily living, such as bathing, dressing, using the bathroom, and eating, at home as well as in assisted living facilities, community services (adult day care and meal programs), and nursing homes. Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care which might help people remain independent.


Programs for People with Low Incomes
Millions of seniors who are living on a limited income and unable to afford supplemental insurance may be able to get assistance from Medicaid or a Medicare Savings Program. Those who qualify could save hundreds of dollars on their monthly Medicare Part B premiums. They might be able to save even more if they qualify for additional Medicaid benefits such as long-term care and prescription drugs (note: prescription drug coverage only available under Medicaid through 2005.)

Many low-income people on Medicare are eligible for financial assistance under Medicaid, but they do not apply. Below are some of the basic rules for programs that exist for people on Medicare with low incomes. To get additional information about whether they may qualify for full Medicaid benefits or one of the Medicare Savings Programs in their state, they should contact their state Medicaid program. Another option is to use the online tool provided by the National Council on Aging (www.benefitscheckup.org).

**Medicaid Benefits to Supplement Medicare**

Those who receive cash assistance under the Supplemental Security Income (SSI) program are eligible for full Medicaid benefits. To receive SSI, their income cannot exceed $579 a month in 2004 ($869 per couple), and their assets must be less than $2,000 ($3,000 per couple). Some states allow people with Medicare to have higher monthly incomes to be eligible for Medicaid (up to $797.50/individual and $1,069.17/couple in 2005).

Those who have a higher income, but fairly high medical or long-term care expenses may qualify for Medicaid if their state has a “spend-down” program. For more information, they should contact the state Medicaid program.

People with limited incomes and resources pay their medical costs. Since this is a joint Federal and State program, coverage varies from State to State. People with Medicaid may get coverage for things like nursing home care, home care, and outpatient prescription drugs that aren’t covered by Medicare.
Medicaid and Medigap insurance

Low-income people who are eligible for Medicaid usually do not need additional insurance. Medicaid pays for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care. A person who purchases Medigap insurance and later becomes eligible for Medicaid can ask that the Medigap insurance benefits and premiums be suspended for up to two years while he is covered by Medicaid. If the person becomes ineligible for Medicaid benefits during the two years, the Medigap policy is automatically reinstated provided the person gives proper notice and begins paying premiums again.

Those who have a Medigap policy and then get Medicaid should know:

- They can suspend (put on hold) their Medigap policy within 90 days of getting Medicaid.
- They won’t have to pay their Medigap policy premiums while it is suspended.
- They Medigap policy won’t pay benefits while the Medigap policy is suspended.
- They can suspend a Medigap policy for up to two years.
- At the end of the suspension, they can reinstate the Medigap policy without new medical underwriting or pre-existing condition waiting periods.

To help them with the suspension decision, call the State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). For questions about suspending a Medigap policy, call their insurance company.

If they already have health insurance coverage through their State Medicaid program, an insurance company can sell them a Medigap policy only in certain situations:

- The insurance company can legally sell any Medigap policy if Medicaid pays their Medigap policy premium or if Medicaid only pays their Medicare Part B premium.
- The insurance company can legally sell Medigap Plans H, I, or J if Medicaid only pays their Medicare premiums, deductibles, or coinsurance. (This only applies to Medigap policies sold between now and January 1, 2006.)

In any other situation, it is illegal for an insurance company to sell a Medigap policy if they are getting any Medicaid benefits.

Medicare Savings Programs (help from the State as part of the State Medical Assistance Program)

For people with limited income and resources these programs can help pay Medicare premiums and, in some cases may also pay Medicare deductibles and coinsurance.

To be eligible for this program, people must meet certain requirements. These programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

To find out if these programs are available in your area or for more information, people should call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). Since the names of these programs may vary by State, ask for information on Medicare Savings Programs.
Qualified Medicare Beneficiary Program

Called QMB for short, this program is for people whose income is at or below 100% of poverty (up to $797.50 a month for singles, and $1,069.17 a month for couples in 2005) and whose savings are limited (up to $4,000 for singles, $6,000 for couples). For those who qualify, the state will pay Medicare premiums and may pay some or all of the deductibles and coinsurance.

Specified Low-Income Medicare Beneficiary Program

The Specified Low-Income Medicare Beneficiary (SLMB) program pays Medicare's Part B premiums for people whose income is between 100% and 120% of poverty (up to $957 a month for singles, $1,283 a month for couples in 2005) and whose savings are limited.

Qualifying Individual Program (QI-1)

The QI-1 program pays Medicare's Part B premiums for people whose income is between 120% and 135% of poverty (up to $1,076.63 a month for singles, $1,443.38 a month for couples in 2004) and whose assets are limited (some states do not have an asset test for QI-1).

Military Retiree Benefits (TRICARE)

TRICARE is a health care program that offers medical coverage to active duty and retired uniformed services members and their families. The TRICARE program includes TRICARE Prime, TRICARE Extra, TRICARE Standard, and TRICARE for Life (TFL).

Those who are eligible will get all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits. For more information about the TRICARE programs, people should call 1-800-538-9552 or look at www.tricare.osd.mil on the web.

Prescription Drug and Other Assistance Programs

People get discounted or free prescription drugs that help pay for their health care.

Medicare-approved Drug Discount Cards


Drug Discount Cards and Medigap Policies

Some people might already have a drug discount card with their Medigap policy which isn't a Medicare-approved drug discount card, and they can also get a Medicare-approved drug discount card.
Prescription Drugs and Medigap

Those who are thinking about signing up for the State’s Prescription Drug Assistance Program and they haven’t yet bought a Medigap policy, should get the Medigap policy **before** applying for prescription drug assistance. After they get the prescription drug assistance they might not be able to buy a Medigap policy.

Some States offer programs that either offer discounted or free prescription drugs. They also may offer other assistance programs to help pay for their other health care costs. To be eligible for these programs, people must meet certain requirements. For more information, they can look at www.medicare.gov on the web. Select “Prescription Drug and Other Assistance Programs.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Specified Disease Insurance

This kind of insurance pays benefits for a single disease, such as cancer, or for a group of diseases. They usually have to buy this insurance before they are diagnosed or treated for the specified disease.

People won’t need this insurance if their health insurance coverage or Medigap policy already pays for this type of care. This insurance doesn’t fill gaps in Medicare coverage. It usually pays in addition to health insurance.

State Children’s Health Insurance Program (SCHIP)

Some States offer free or low-cost health insurance to uninsured children under age 19 whose families don’t qualify for Medicaid. For more information about the State’s program, look at www.cms.hhs.gov/sCHIP/ on the web.

The PACE program (Programs of All-inclusive Care for the Elderly)

PACE combines medical, social, and long-term care services for frail people. PACE might be a better choice for them instead of getting care through a nursing home. PACE is available only in States that have chosen to offer it under Medicaid. Those who live in a State that offers PACE, and have Medicare and are eligible for PACE can choose to get their Medicare benefits through this program.

To find out if they are eligible and if there is a PACE site near them, or for more information, people should call the State Medical Assistance Office. To get their telephone number call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, look at www.medicare.gov/Nursing/Alternatives/pace.asp on the web.

Veterans’ Benefits

The U.S. Department of Veterans Affairs offers health care benefits and other types of benefits and services to eligible members. For more information about VA benefits and services, call the U.S. Department of Veterans Affairs at 1-800-827-1000.
Long-Term Care

Long-term care is not covered adequately by any government program, other than Medicaid for those with low income and assets. Neither is it covered by any private insurance policy, other than long-term care insurance.

This section provides a brief overview of the subject of long-term care. For a more in-depth treatment of this complex subject, please refer to one of our courses specifically on Long-term care insurance.

Women are more likely than men to use long-term care services. Nearly three out of four nursing home residents age 65 and older are women. – Centers for Disease Control/National Center for Health Statistics, National Nursing Home Survey, 1999

Those who think that they may need to move into a facility of some type, consider the following tips for choosing among facilities:

- Visit the facility unannounced at various times, including at mealtime and on the weekends to see how the residents are treated. Is the staff respectful of the residents' wishes and privacy? Are the residents properly dressed and assisted with activities? Is the environment pleasant for residents? Is it somewhere they could picture themselves living?
- Talk to residents and their family members. Most facilities have both a residents' council and a family council that may be helpful.
- Ask to see the most recent survey of the facility made by the state licensing and regulatory agency. The survey spells out the facility's deficiencies.
- Contact a long-term care ombudsman to discuss any concerns he or she may have about the long-term care facility. Every facility must post the ombudsman program's phone number in a visible place. Required by law, an ombudsman acts as an advocate for residents and helps resolve complaints.

Assess Long-Term Care Needs and Options

The idea of shouldering the cost of nursing home care and seeing their savings consumed by long-term care costs is daunting. The very possibility may already have prompted some people to consider how they would like to receive and pay for long-term care should they need it in the future.

Long-term care may include care in a nursing home and medical and personal care at home. Medicare covers only a fraction of long-term care costs and, even then, only under certain circumstances. As a result, they must understand Medicare's limitations and plan ahead for whatever expenses they may incur. They also need to consider who will care for them when they need help, what kind of care they want, and where they will live as they age.

Determine the Level of Care Needed

When they are no longer able to live independently and appear to need some help taking care of themselves, the first step is to determine the type of care they need. Evaluating care options is easier once they know the range and extent of services required. Often, the client and their family members are best equipped to make this assessment, since they know the situation and
how much day-to-day help they really need. If they prefer, they can hire a geriatric care manager, nurse, or social worker for a professional evaluation. If they are eligible for Medicaid, a state social worker sometimes will do this assessment without charge.

**Explore Long-Term Care Options**

There are a number of different ways to meet their long-term care needs, ranging from a few hours of personal assistance in the home to skilled, round-the-clock care in a nursing home. Depending on their needs and preferences, there are several home-, community-, and institutionally-based services available. They may especially want to discuss with family members whether they want to stay in their own home or whether they would feel comfortable in an outside facility.

**Home-based Care**

Many older people prefer to remain in their own homes rather than move into a supervised facility when they need long-term care. If they elect to stay at home, they may need to consider how much care they will require. For example, will they need help in the middle of the night, or a few hours of personal assistance several days each week? They may be best suited by a "patchwork" of formal and informal caregivers and services.

Formal services include visiting nursing services, home health aides, and such social service programs as "Meals on Wheels." Services in the community may be found by calling the local Area Agency on Aging or the Eldercare Locator at 1-800-677-1116.

Quite often informal caregivers -- family members and friends -- end up providing a large share of assistance. To supplement care giving in the home, some families use community-based services such as adult daycare and senior centers. Call the local Area Agency on Aging to find out about available services in their neighborhood.

If home-based care is the most appropriate solution to their long-term care needs, they may need help making simple adaptations to their home to make it a safe and comfortable environment. Improvements may include appropriate lighting, railings, well-secured carpeting, and quick access to emergency response, if needed.

If it becomes too difficult or too expensive to receive long-term care at home, a supervised living facility, such as an assisted living facility or nursing home, may be an option.

**Continuing Care Retirement Communities**

These facilities offer long-term contracts that usually provide lifelong shelter and access to specified health care services. To be admitted, large advance payments often are required. Eligibility for new residents is generally based on age, financial assets, income level, and physical health and mobility.

Residents usually are expected to move into a continuing care community while they are still independent and able to care for themselves. Find out what happens when people become sick or frail and can no longer live independently. Does the retirement community have a nursing facility on the premises? What if the nursing facility is full when they require that level of care? What happens if a person runs out of money?
Assisted Living Facilities

These facilities (also called "board and care" or "adult care") are usually in a residential or home-like setting. Most provide meals, housekeeping, and some assistance with activities of daily living such as dressing and bathing. Some of these facilities care for people who require skilled nursing and 24-hour attentive supervision. Find out where they would get their health care, whether they will continue to see their own doctors, and how they will get to medical appointments. Health care services may be delivered at the facility itself or elsewhere, through an arrangement with another provider such as a hospital. Ask what happens (both in terms of services and price) if their condition declines after they enter an assisted living facility. Ask if the facility takes responsibility for making sure residents take their medicines properly.

Some facilities may discharge persons who health care needs increase considerably.

Nursing Homes

These facilities provide custodial and skilled care prescribed by doctors and delivered by registered nurses, licensed practical nurses, and certified nurse assistants. Find out whether they can get physical, occupational, and other therapy, and whether Medicare or Medicaid will pick up the cost. Costs and quality of care can vary considerably. Be sure to ask if the nursing home meets Medicare and Medicaid quality standards. Information on every Medicare- and Medicaid-certified nursing home in the U.S. is available on the Centers for Medicare and Medicaid Services’ Nursing Home Database website (www.medicare.gov/nhcompare/home.asp).

Consider Ways to Pay for Long-Term Care

The price tag for long-term care can be astronomical, beyond the resources of most families. At best, Medicare pays only a fraction of these costs. Extended nursing home stays for an individual can easily cost in excess of $5,000 a month, although fees vary widely. Although home care is generally far cheaper (in part because it does not include housing and food costs, which are factored into nursing homes' rates), it too can be very expensive to patients and their families. Costs may depend on the level of care needed, the number of hours of care per week, and where you live.

Before the need for long-term care becomes a reality, you should consider very carefully how to pay for it: through Medicaid, if they qualify, with private long-term care insurance, or out-of-pocket. Often, the decision is about money. Here are some fundamentals to help guide this tough decision.

Medicare Coverage of Long-Term Care

While Medicare covers some home health, skilled nursing, and hospice care, it is not a long-term care program. For example, although Medicare covers relatively short-term, medically necessary home health care, it does not pay for custodial care services such as cleaning or cooking at home. Nor does the program pay for prolonged care in a nursing home.
Home Health Care

Home health care is covered for homebound people who need the services of a skilled nurse or a skilled physical, speech, or occupational therapist. In these cases, Medicare will also cover home health aide services to help with bathing, toileting, feeding, other personal care, and medical social services.

Home health benefits are only covered if people meet certain requirements: the visits must be prescribed by a doctor, and they must need intermittent or part-time skilled nursing care or therapy services and generally must be homebound. There is no co-payment for home health services under Medicare, and no limit to the number of covered visits, as long as they continue to meet these criteria.

Skilled Nursing Facility Care

Medicare covers up to 100 days of nursing home care, but only in limited situations. To qualify for this benefit, they must need daily skilled care (seven days a week of nursing care or five days a week of rehabilitative care).

Also, for Medicare to cover the SNF stay, people must have been hospitalized for at least three days within the 30 days preceding admission to a Medicare-certified skilled nursing facility. In addition, they will have to pay a daily co-payment ($114 in 2005) for the 21st through the 100th day of their care.

Medical Equipment

Medicare also helps cover some durable medical equipment for use at home, whether it is rented or purchased. These items include walkers, canes, wheelchairs, and commodes that could assist with long-term care needs.

Hospice Care

Hospice care is available under Medicare for people with advanced illness and who are expected to live six months or less. It concentrates on improving quality of life, not on curing the condition. Medicare's hospice benefit covers a range of services, including care from doctors, nurses, therapists, and home health aides. It also covers services that Medicare usually does not, including some prescription drugs, respite care, and continuous nursing services for medical emergencies.

Hospice care is designed to help with pain management and other symptoms, so that patients can make the most of the time that remains. In addition, it can provide emotional and spiritual support to individuals and their family members.

Medicaid Coverage of Long-Term Care

Medicaid is the country's largest public payer for long-term care. For people who qualify for Medicaid, it will pay for nursing home care, and other LTC costs that Medicare does not cover, including some long-term care services provided at home.
Those who have SSI, or have extremely limited income and assets may be able to qualify for Medicaid. Medicaid also looks at assets such as savings accounts when determining eligibility. The exact income and assets eligibility levels for Medicaid vary by state.

Those who have income higher than the state's Medicaid eligibility level may still be eligible for Medicaid coverage. In several states, people can qualify for Medicaid after spending their income and assets on nursing home and other health care expenses. This is called Medicaid "spend down."

Some people enter a nursing home as private-pay patients but become eligible for Medicaid over time because of the high cost of such care. Generally, states let nursing home residents covered by Medicaid keep $2,000 in assets and an income of about $30 per month.

Medicaid rules vary by state. Persons or family members who have questions about Medicaid should contact the state Medicaid office or long-term care ombudsman in the area.

**Long-Term Care Insurance**

Long-term care insurance covers some of the costs of long-term care and may help people preserve a portion of their assets. Today, more than 100 insurance companies sell private long-term care insurance that covers nursing home and home care, but only a small share of people on Medicare have a long-term care policy. This section contains a brief look at long-term care insurance and its role in supplementing Medicare. For more detailed information about long-term care insurance please refer to one of our courses specifically covering LTC.

While long-term care insurance can limit costs for some people, it is not a good option for everyone. Such insurance is expensive, and the older people are when they buy it, the higher the cost of the monthly premiums. Policies purchased at age 65 average $1,800 a year for four years of comprehensive coverage; at 79, they average $5,900 a year. And people with Alzheimer's or other serious health problems may not even be able to buy a policy at any price.

A major reason for purchasing long-term care insurance is to avoid depleting life savings with a prolonged nursing home stay and to preserve savings and other assets for children and grandchildren. Another is to help offset the cost of long-term care for couples whose assets are limited, but whose income is fairly high (over $35,000 a year). But, if people already qualify for Medicaid or would quickly spend down their assets to qualify, long-term care insurance might not be sensible. Nor is it a prudent investment if they can't afford to pay the premium for the rest of their life. Even if they can, long-term care insurance may not be a wise choice if they can pay for their care out-of-pocket.

No two long-term care insurance policies are alike. Before deciding which policy consumers should buy, consider these issues:

**Benefits Covered**

Does it provide for care in a nursing home, in their own home, or in a community setting? Some policies will pay cash once people meet eligibility requirements and will allow them to spend the money for care in the location of their choice. Others will pay for care only in a specifically defined location. Be sure the policy covers the type of care they want.
Affordability of Premiums

Will the premiums will rise over time, and by how much, and will they be able to afford premium hikes in the future? Premiums are also affected by the number of years covered under the policy. Four years of coverage is a good compromise between lifetime coverage (which can be quite expensive) and the risk of less coverage. Consider this: people between age 65 and 94 who enter a nursing home stay, on average, two and a half years, while 90% stay less than four years.

Elimination Periods

Long-term care insurance policies have elimination periods, which are waiting periods that act as deductibles. Individuals must pay for their own care during that time. The longer the elimination period, the lower the premium. However, clients should be sure they can afford the out-of-pocket costs they will incur before the policy begins paying.

The level of Benefits

People should choose a policy with a benefit that will cover a good portion of the daily cost of services they may need. For some people having a small LTC benefit may be worse than no LTC insurance at all, especially if the coverage does not include protection against inflation.

Individuals need coverage that keeps up with the rising cost of long-term care. Otherwise, a policy they buy today to cover 80% of these costs may cover only 40% later on, when they need such care. Inflation protection is often sold as a "rider" to long-term care products.

Benefit Eligibility Triggers

Long-term care policies have different ways of determining if and when someone is eligible for benefits. For example, under some plans, policyholders qualify for coverage when they cannot perform activities of daily living on their own. These may include eating, walking, moving from a bed to a chair, dressing, bathing, and using the toilet. Make sure bathing is mentioned specifically, since people with long-term care needs are likelier to require help with this task sooner than with any other activity. This is one of the most important provisions in LTC policies.

Paying for Long-Term Care Out-of-Pocket

Because Medicare's coverage is limited, and many don't qualify for Medicaid or are unable to afford or qualify for a long-term care policy, elderly people and their families often must tap into savings to pay for care. They need to think about how much care may cost over an extended period of time.

The cost of institutional care depends heavily on the amount of time it is used. Find out about nursing home care costs in your client's area. Then, calculate how much money they would need for a four-year stay. If they can set aside enough to cover four years of residential care, they might consider simply paying for it themselves. But realize that actual costs can't be predicted. Individuals who suffer from Alzheimer's or other forms of dementia may need care for ten or more years.

Part-time home care often costs much less than residential care. Since people with long-term care needs often wish to continue living in their own homes, they may want to research the
costs of home and community-based services in their area. Such services, along with home adaptations, can help people stay in their own home.

People should not wait until they need long-term care to begin discussing it with their family members. Talking about their preferences and needs now can help them plan how to pay for care. Depending on the decisions they make together with their family, they can purchase a long-term care insurance policy, rely on savings, or use Medicaid to cover their needs.

Women are more likely than men to use long-term care services. Nearly three out of four nursing home residents age 65 and older are women. – *Centers for Disease Control/National Center for Health Statistics, National Nursing Home Survey, 1999*

**Advance Directives**

As people live longer, the chance that they may not be able to make their own health care decisions increases. To let people know what kind of treatment they want if they are unable to make health care decisions, they should fill out a “health care advance directive.” This is a written document in which they give directions about who they want to speak for you and what kind of health care they want or don’t want if they can’t speak for themselves. They might be able to get more information by calling the Area Agency on Aging. To get the telephone number for the Area Agency on Aging, call the Eldercare Locator at 1-800-677-1116, or look at www.aoa.gov on the web.

The importance of this section has been crystallized by recent national news where the parents of a woman in a persistent vegetative state battled for some years with her husband to determine whether or not to disconnect life support systems. Her husband stated that she had expressed to him that she would not want to remain alive under those circumstances; however, she never put her wishes in writing. Her parents held out hope that she would recover and used all legal methods to artificially keep her alive.

It's important for people to think about their wishes concerning medical care and to put them in writing in the event that they become too ill to communicate. Such instructions, called advance directives, will comfort them and save family members from having to make difficult decisions without knowing what they want. It is important to make sure family members know where they keep important documents, such as wills and advance directives. Keep in mind that, since advance directives are legal documents, they must be written while individuals are still mentally competent.

Thirty percent of adults say they do not know where their parent keeps important papers, such as their health insurance card, financial statements, or will. – *Family Circle and Kaiser Family Foundation, 2000*

Although laws vary from state to state, there are basically two types of advance directives:

**Health Care Proxies**

A health care proxy is a legal document that allows them to appoint an agent to make medical decisions for them when they are unable to do so. They can select anyone they trust, such as a friend or family member. Generally, their agent may make health care decisions whenever they cannot speak for yourself.
Living Wills

A living will is a legal document that allows people to state their wishes about which medical treatments they do and don’t want in the event that they are unable to communicate for themselves at the end of life.

Typically, living wills direct health care personnel whether or not to prolong life if the patient is suffering from an incurable or irreversible condition. For example, their living will can have a "Do Not Resuscitate" order, which means that they will not be revived if their heartbeat and breathing stop. It can also state whether they want their organs donated.

People should be sure their advance directives comply with laws of the state in which they live and that their doctors, lawyers, and other trusted persons have copies. Health personnel can follow the directions of the living will only if they have a copy of it. To obtain forms that are valid in their state, contact the state ombudsman program or a hospital or medical society in the area.
Glossary

**Appeal**—An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn’t pay for or provide an item or service you think you should be able to get. There is a specific process that your Medicare Advantage Plan or the Original Medicare Plan must use when you ask for an appeal.

**Assignment:** In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor’s visit.

**Benefit Period**—The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven’t received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

**Carrier**—A private company that contracts with Medicare to pay Part B bills.

**Coinsurance**—The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

**Comprehensive Outpatient Rehabilitation Facility (CORF)**—A facility that provides a variety of services including physicians’ services, physical therapy, social or psychological services, and outpatient rehabilitation.

**Co-payment**—In some Medicare health plans, the amount that you pay for each medical service, like a doctor’s visit. A co-payment is usually a set amount you pay for a service. For example, this could be $10 or $20 for a doctor’s visit. Co-payments are also used for some hospital outpatient services in the Original Medicare Plan.

**Creditable Coverage:** Any previous health insurance coverage that can be used to shorten a pre-existing condition waiting period. (See pre-existing conditions.)

**Critical Access Hospital**—A hospital facility to which Medicare has given specific status to provide outpatient and certain inpatient services to people in rural areas.

**Custodial Care**—Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn’t pay for custodial care.

**Deductible**—The amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.
**Durable Medical Equipment (DME):** Medical equipment that is ordered by a doctor for use in the home. These items must be durable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

**Durable Medical Equipment Regional Carrier**—A private company that contracts with Medicare to pay bills for durable medical equipment.

**End-Stage Renal Disease (ESRD):** Permanent kidney failure that requires dialysis or a kidney transplant.

**Excess Charges:** If you are in the Original Medicare Plan, this is the difference between a doctor’s or other health care provider’s actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

**Fiscal Intermediary**—A private company that contracts with Medicare to pay Part A and some Part B bills. (Also called “Intermediary.”)

**Guaranteed Issue Rights (also called “Medigap Protections”):** Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can’t deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can’t charge you more for a policy because of past or present health problems.

**Guaranteed Renewable:** A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you make untrue statements to the insurance company, commit fraud or don’t pay your premiums.

**Home Health Care:** Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

**Hospice Care:** A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

**Inpatient Care**—Health care that you get when you are admitted to a hospital.

**Lifetime Reserve Days**—In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($456 in 2005).

**Limiting Charge**—In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don’t accept assignment. The limiting charge is 15% over Medicare’s approved amount. The limiting charge only applies to certain services and doesn’t apply to supplies or equipment.

**Long-term Care**—A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Most long-term care is custodial care. Medicare doesn’t pay for this type of care if this is the only kind of care you need.

**Managed Care Plan**—In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan’s list except in an emergency. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extra benefits, like extra days in the hospital. In most cases, a type of Medicare Advantage Plan that is available in some areas of the country. Your costs may be lower than in the Original Medicare Plan.

**Medicaid**—A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medically Necessary**—Services or supplies that

- are proper and needed for the diagnosis or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- aren’t mainly for the convenience of you or your doctor.

**Medical Underwriting:** The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your State law allows it), and how much to charge you for that insurance.

**Medicare Advantage Plan**—A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

**Medicare-approved Amount**—In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the “Approved Charge.”

**Medicare Carrier:** A private company that contracts with Medicare to pay Part B bills.

**Medicare Managed Care Plan:** A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan’s list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

**Medicare Preferred Provider Organization (PPO) Plan:** A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

**Medicare Private Fee-for-Service Plan:** A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan’s payment.
The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits.

You may have extra benefits the Original Medicare Plan doesn’t cover.

**Medicare SELECT**: A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

**Medicare Specialty Plan**: A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.

**Medigap Policy**: A Medicare supplement insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

**Open Enrollment Period**: A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can’t be denied coverage or charged more due to past or present health problems.

**Original Medicare Plan**: A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

**Outpatient Care**: Medical or surgical care that doesn’t include an overnight hospital stay.

**Point-of-Service (POS)**: A Medicare Managed Care Plan option that lets you use doctors and hospitals outside the plan for an additional cost.

**Pre-existing Condition**: A health problem you had before the date that a new insurance policy starts.

**Preferred Provider Organization (PPO) Plan**: A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

**Premium**: The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

**Preventive Services**: Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).

**Primary Care Doctor**: A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Managed Care
Plans, you must see your primary care doctor before you can see any other health care provider.

**Private Fee-for-Service Plan**—A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan’s payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare covered benefits. You may have extra benefits the Original Medicare Plan doesn’t cover.

**Programs of All-inclusive Care for the Elderly (PACE):** PACE combines medical, social, and long-term care services for frail people. PACE is available only in States that have chosen to offer it under Medicaid. To be eligible, you must:

- be 55 years old or older,
- live in the service area of the PACE program,
- be certified as eligible for nursing home care by the appropriate state agency, and
- be able to live safely in the community.

The goal of PACE is to help people stay independent and living in their community as long as possible, while getting the high-quality care they need.

**Quality**—Quality of care is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person—and getting the best possible results.

**Quality Improvement Organization**—Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service Plans, and ambulatory surgical centers.

**Referral**—A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you don’t get a referral first, the plan may not pay for your care.

**Regional Home Health Intermediary**—A private company that contracts with Medicare to pay home health and hospice bills and check on the quality of home health care.

**Skilled Nursing Facility:** A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

**Skilled Nursing Facility Care**—A level of care that requires daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can’t be provided on an outpatient basis. Examples of skilled nursing facility care include intravenous injections and physical therapy. Needing custodial care, such as help with bathing and dressing, can’t, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for skilled nursing or rehabilitation care, Medicare covers all of your care needs in the facility.

**Specialty Plan**—A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care.
to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.

**State Health Insurance Assistance Program**—A State program that gets money from the Federal Government to give free local health insurance counseling to people with Medicare.

**State Insurance Department**: A State agency that regulates insurance and can provide information about Medigap policies and any insurance-related problem.

**State Medical Assistance Office**: A State agency that is in charge of the State’s Medicaid program and can give information about programs to help pay medical bills for people with low incomes. Also provides help with prescription drug coverage.

**Telemedicine**—Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site.

**TTY**—A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don’t have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
Additional Resources

There are a number of places to turn for information about Medicare and health care coverage. Since different agencies supply different types of information, they might have to contact several before finding one that can help.

Places to Start

Get basic Medicare information by calling the National Medicare Hotline at 1-800-MEDICARE; TTY/TTD 1-877-486-2048 or visiting www.medicare.gov on the Internet.

They can also order Medicare & You, an overview of Medicare, by calling the hotline or by writing to Medicare Publications, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244-1850.

Get information on Medicare enrollment and eligibility by calling the National Social Security Hotline at 1-800-772-1213. Also call this number to report lost Medicare cards and a change of address.

Find out about Medicaid eligibility requirements and enrollment procedures at their state or local welfare office, social service, or Medicaid agency.

Get referrals for local agencies that can help them obtain information and services in their community on issues including home health care, nursing home care, and long-term care insurance by calling the Eldercare Locator at 1-800-677-1116.

Request detailed information in English or Spanish about the Medicare Advantage (MA) plans available in their area by calling the automated Medicare Special Information number at 1-800-MEDICARE (1-800-633-4227) or by visiting www.medicare.gov.

Additional Resources by State

A variety of state and local agencies can provide more specific information about Medicare, Medigap, and long-term care. The following state-by-state lists include some of these sources.

State Health Insurance Assistance Programs (SHIPs)

For information and free counseling related to Medicare, Medigap, MA plans, and long-term care, call your State Health Insurance Assistance Program. These are federally funded programs established to help beneficiaries with their health insurance choices.

State Medicaid Agencies

To answer questions about eligibility and enrollment in Medicaid, call your state Medicaid agency. It administers Medicaid benefits, including QMB, SLMB, and QI-1 programs.

Long-Term Care Ombudsmen
For questions about nursing homes and other long-term care facilities in their area, call this number. Their state long-term care ombudsman protects the rights of nursing home residents and responds to questions about facilities.

**Social Security Offices**

To find the local Social Security office, call 1-800-772-1213 or enter your zip code at this website: http://s00dace.ssa.gov/pro/fol/fol-home.html. State Social Security office websites are listed in the state-by-state table below.

**State Pharmacy Assistance Programs**

Many states have programs that help low-income Medicare beneficiaries who are not eligible for Medicaid pay for their prescription medications. To find out if there is a program in their state, see www.medicare.gov and follow the link for prescription drug assistance programs. See the table below for state websites and phone numbers.

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<tr>
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<th>State Health Insurance Assistance Programs</th>
<th>State Medicaid Agencies</th>
<th>Long-Term Care Ombudsman</th>
<th>Social Security Office</th>
<th>State Pharmacy Assistance Programs</th>
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<tbody>
<tr>
<td>Colorado</td>
<td>888-696-7213 or 303-894-7552</td>
<td>800-221-3943 or 203-866-2993</td>
<td>800-288-1376 or 303-722-0720</td>
<td><a href="http://www.ssa.gov/denver/colorado.htm">http://www.ssa.gov/denver/colorado.htm</a></td>
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<td>Iowa</td>
<td>800-351-4664 or 515-281-6867</td>
<td><a href="http://www.ship.state.ia.us/">www.ship.state.ia.us</a></td>
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<td>800-338-8366 or 515-327-5121</td>
<td><a href="http://www.ssa.gov/kc/fos-ia.htm">www.ssa.gov/kc/fos-ia.htm</a></td>
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<td>800-532-3213 or 515-242-3327</td>
<td><a href="http://www.in.gov/fssa/hoosierrx/">www.in.gov/fssa/hoosierrx/</a></td>
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<td>Kansas</td>
<td>800-860-5260 or 316-337-6010</td>
<td><a href="http://www.agingkansas.org/shick/">www.agingkansas.org/shick/</a></td>
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<td>800-792-4884 or 785-274-4200</td>
<td><a href="http://www.ssa.gov/kc/fos-ks.htm">www.ssa.gov/kc/fos-ks.htm</a></td>
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<td>877-662-8362 or 785-296-3017</td>
<td><a href="http://www.aginkingkansas.org/kdoa/programs/pharmassitprog.htm">www.aginkingkansas.org/kdoa/programs/pharmassitprog.htm</a></td>
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<td>Kentucky</td>
<td>877-293-7447</td>
<td><a href="http://www.chs.ky.gov/aging/programs/state%20health%20insurance%20assistance.htm">www.chs.ky.gov/aging/programs/state%20health%20insurance%20assistance.htm</a></td>
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<td>800-327-2991 or 502-564-5497</td>
<td><a href="http://www.ssa.gov/atlanta/southeast/k/y/kentucky.htm">www.ssa.gov/atlanta/southeast/k/y/kentucky.htm</a></td>
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<td>Louisiana</td>
<td>800-259-5301 or 225-342-5301</td>
<td><a href="http://www.idi.state.la.us/office_index/office_of_health.htm">www.idi.state.la.us/office_index/office_of_health.htm</a></td>
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<td>255-342-9500</td>
<td><a href="http://www.ssa.gov/dallas/state_la.html">www.ssa.gov/dallas/state_la.html</a></td>
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<td>Maine</td>
<td>800-750-5353 or 207-623-1797</td>
<td><a href="http://www.state.me.us/dhs/beas/hiap/welcome.htm">www.state.me.us/dhs/beas/hiap/welcome.htm</a></td>
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<td>800-321-5557 or 207-287-3094</td>
<td><a href="http://www.ssa.gov/boston/ME.htm">www.ssa.gov/boston/ME.htm</a></td>
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<td>Maryland</td>
<td>800-243-3425 or 410-767-1100</td>
<td><a href="http://www.mdoa.state.md.us/services/ship.html">www.mdoa.state.md.us/services/ship.html</a></td>
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<td>800-492-5231 or 410-767-5800</td>
<td><a href="http://www.ssa.gov/phila/states/maryland.htm">www.ssa.gov/phila/states/maryland.htm</a></td>
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<td></td>
<td>800-243-3425 or 410-767-1100</td>
<td><a href="http://www.dhmh.state.md.us/mma/mpap/">www.dhmh.state.md.us/mma/mpap/</a></td>
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<td>Massachusetts</td>
<td>800-243-4636 or 617-727-7750</td>
<td><a href="http://www.800ageinfo.com/programs/shine.cfm">www.800ageinfo.com/programs/shine.cfm</a></td>
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<td></td>
<td>800-325-5231 or 617-628-4141</td>
<td><a href="http://www.ssa.gov/boston/ma.htm">www.ssa.gov/boston/ma.htm</a></td>
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<td>Michigan</td>
<td>800-803-7174 or 517-717-7174</td>
<td><a href="http://www.ssa.gov/chicago/mich">www.ssa.gov/chicago/mich</a></td>
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<td>800-642-3195 or 517-335-5001</td>
<td><a href="http://www.ssa.gov/chicago/mich">www.ssa.gov/chicago/mich</a></td>
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<td>866-485-9393 or 517-335-1560</td>
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<td>866-747-5844 or 517-241-2412</td>
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<td>Mississippi</td>
<td>800-948-3090 or 601-359-4929</td>
<td><a href="http://www.mdhs.state.ms.us/aas_info.html">http://www.mdhs.state.ms.us/aas_info.html</a></td>
<td><a href="http://www.dhs.s.mo.gov/moseniorx">http://www.dhs.s.mo.gov/moseniorx</a></td>
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<td>Montana</td>
<td>800-332-2272 or 406-444-4077</td>
<td><a href="http://www.dphhs.state.mt.us/site/protective_legal/07.02_ship.cms.htm">http://www.dphhs.state.mt.us/site/protective_legal/07.02_ship.cms.htm</a></td>
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<td>Nebraska</td>
<td>800-234-7119 or 402-471-2201</td>
<td><a href="http://www.state.ne.us/home/ndoi/nica/nica.htm">http://www.state.ne.us/home/ndoi/nica/nica.htm</a></td>
<td><a href="http://www.dhs.s.mo.gov/moseniorx">http://www.dhs.s.mo.gov/moseniorx</a></td>
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<td>New Jersey</td>
<td>800-792-8820 or 609-943-3437</td>
<td><a href="http://www.state.nj.us/health/senior/ship.shtml">http://www.state.nj.us/health/senior/ship.shtml</a></td>
<td><a href="http://www.dhs.s.mo.gov/moseniorx">http://www.dhs.s.mo.gov/moseniorx</a></td>
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<td>New Mexico</td>
<td>800-432-2080 or 505-889-2583 or 505-827-3100</td>
<td><a href="http://www.ssa.gov/dallas/state_rn.html">http://www.ssa.gov/dallas/state_rn.html</a></td>
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<td>New York</td>
<td>800-333-4114</td>
<td><a href="http://www.nmaging.state.nm.us/benes.htm">Website</a></td>
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<td>800-541-2831 or 518-747-8887</td>
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<td>800-342-9871 or 518-474-7329</td>
<td><a href="http://www.ssa.gov/ny/services-fo.htm">Website</a></td>
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<td>North Carolina</td>
<td>800-443-9354 or 919-733-0111</td>
<td><a href="http://www.ncship.com/consumer/ship/ship.asp">Website</a></td>
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<td>800-662-7030 or 919-857-4011</td>
<td><a href="http://www.ssa.gov/atlanta/southeast/nc/north-carolina.htm">Website</a></td>
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<td>North Dakota</td>
<td>800-247-0560 or 701-328-2440</td>
<td><a href="http://www.state.nd.us/ndins/consumer/details.asp?id=58">Website</a></td>
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<td>800-755-2604 or 701-328-2332</td>
<td><a href="http://www.ssa.gov/denver/northdakota.htm">Website</a></td>
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<td>Ohio</td>
<td>800-686-1578 or 614-644-3999</td>
<td><a href="http://www.ohioinsurance.gov/consumerservice/ship/whatisship.htm">Website</a></td>
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<td>800-324-8680 or 614-728-3288</td>
<td><a href="http://www.ssa.gov/chicago/ohio.htm">Website</a></td>
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<td>Oklahoma</td>
<td>800-763-2828 or 405-521-6628</td>
<td>[Website](<a href="http://www">http://www</a> oid.state.ok.us/ndins/consumer/ship.html)</td>
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<td>800-522-0114 or 405-522-7300</td>
<td><a href="http://www.ssa.gov/dallas/state_ok.html">Website</a></td>
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<td>Oregon</td>
<td>503-947-7984 or 800-722-4134</td>
<td><a href="http://oregonshiba.org">Website</a></td>
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<td>800-527-5772 or 503-945-5772</td>
<td><a href="http://www.ssa.gov/seattle/index.htm">Website</a></td>
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<td>Pennsylvania</td>
<td>800-783-7067</td>
<td><a href="http://www.aging.state.pa.us/aging/cwp/view.asp?qa=282&amp;question_id=173806">Website</a></td>
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<td>800-692-7462</td>
<td><a href="http://www.ssa.gov/philadelphia/pennsylvania.htm">Website</a></td>
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<td>717-783-7247</td>
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<td>Rhode Island</td>
<td>401-464-4000 or 401-462-0508</td>
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<td>401-462-5300</td>
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<td>401-785-3340</td>
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<td>South Carolina</td>
<td>800-868-9095 or 803-898-2850</td>
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<td>800-868-9095 or 803-898-2850</td>
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<td>South Dakota</td>
<td>800-536-8197 or 605-773-3656</td>
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<td>605-773-3495 or 800-452-7691</td>
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<td>Utah</td>
<td>800-541-7735 or 801-538-3910</td>
<td><a href="http://www.ssa.gov/denver/utah.htm">http://www.ssa.gov/denver/utah.htm</a></td>
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<td>800-662-9651 or 801-538-6155</td>
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<td>Vermont</td>
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<td><a href="http://www.medicarehelpvt.net/">http://www.medicarehelpvt.net/</a></td>
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<td>Virginia</td>
<td>800-552-3402 or 804-662-9333</td>
<td><a href="http://www.ssa.gov/boston/vt.htm">http://www.ssa.gov/boston/vt.htm</a></td>
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<td>800-250-8427 or 802-241-2800</td>
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<td>800-562-3022</td>
<td><a href="http://www.ssa.gov/seattle/index.htm">http://www.ssa.gov/seattle/index.htm</a></td>
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<td>West Virginia</td>
<td>877-987-4463 or 304-558-2241</td>
<td><a href="http://www.ssa.gov/philadelphia/westvirginia.htm">http://www.ssa.gov/philadelphia/westvirginia.htm</a></td>
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<td>304-558-1700</td>
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<td>Wisconsin</td>
<td>800-242-1060 or 608-267-3201</td>
<td><a href="http://www.ssa.gov/chicago/wisconsin.htm">http://www.ssa.gov/chicago/wisconsin.htm</a></td>
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<td>800-362-3002 or 608-221-5720</td>
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<td><a href="http://www.dhfs.state.wi.us/aging/genage/benspecs.htm">http://www.dhfs.state.wi.us/aging/genage/benspecs.htm</a></td>
<td><a href="http://dhfs.wisconsin.gov/seniorcare/">http://dhfs.wisconsin.gov/seniorcare/</a></td>
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<td>Wyoming</td>
<td>800-856-4398 or 307-856-6880</td>
<td><a href="http://www.ssa.gov/denver/wyoming.htm">http://www.ssa.gov/denver/wyoming.htm</a></td>
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For More Information

You can learn more about Medicare’s preventive services by looking at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244-1850
Publication No. CMS-02110
Revised April 2004

How people with disabilities obtain these services if Medicare does not cover them

Assistance may be available under Medicaid for people with disabilities if their income is low enough. Persons who receive both Medicare and Medicaid are known as “dual eligibles.” For many people with disabilities, Medicaid provides a critical supplement to Medicare, filling in Medicare’s gaps in coverage.

Supplemental insurance is sometimes available, and some Medicare beneficiaries also have access to retiree health benefits provided by their previous employer that supplements Medicare’s benefits package. Medigap, or Medicare supplemental insurance, may also be available to provide supplemental benefits to some people with disabilities who are receiving Medicare. Under federal law, Medicare beneficiaries age 65 and over have a right to obtain Medigap coverage, but the law denies this protection to Medicare beneficiaries under age 65 with disabilities.

Only a small number of states require insurers that provide Medigap coverage in their state to offer it to nonelderly people with disabilities.

To learn if Medigap coverage is available to people with disabilities under age 65 in your state, you can contact your State Health Insurance Assistance Program. For contact information, go to www.healthassistancepartnership.org.

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*For many states, toll-free numbers work in-state only.

For help with Medicare questions, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week.

Tommy G. Thompson
Secretary
Department of Health and Human Services
Mark McClellan, M.D., Ph.D.

Administrator Centers for Medicare & Medicaid Services

- Visit www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227)

**Use This Three Step Approach if Suspect Fraud**

- Call your health care provider.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call the Inspector General's hotline 1-800-HHS-TIPS (1-800-447-8477).
Contacting Medicare

Medicare is administered by a federal agency, the Centers for Medicare and Medicaid Services (CMS), which is part of the U.S. Department of Health and Human Services. To get answers to questions about Medicare or to order official government publications, you can contact Medicare by telephone or online.

*Telephone (toll free): 1-800-Medicare (1-800-633-4227) 1-877-486-2048 TTY*

*Website: www.medicare.gov*

Finding the Local Social Security Office

To find the local Social Security office or to get answers to questions, there are three easy options for contacting the Social Security Administration (SSA):

- **Online:** Go to http://s3abaca.ssa.gov/pro/fol/fol-home.html. Enter their zip code and they will be able to obtain office location, phone number, office hours, and other useful information.

- **By toll-free telephone call:** Call 1-800-772-1213. Social Security operates this number from 7 a.m. to 7 p.m., Monday through Friday. If they have a touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays.

- **By toll-free TTY telephone call:** Call 1-800-325-0778. This number, for people who are deaf or hard of hearing, is available between 7 a.m. and 7 p.m., Monday through Friday.

- Callers should have their Social Security number available when calling Social Security.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

For help with your Medicare questions

- visit www.medicare.gov
- call 1-800-MEDICARE (1-800-633-4227)
- call 1-877-486-2048 (TTY users)

Who do I call with questions about Medicare?

For questions about Medicare, call 1-800-MEDICARE (1-800-633-4227). Customer Service Representatives are available 24 hours a day, everyday. TTY users should call 1-877-486-2048.

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<td>&quot;Health Spending Rebound&quot;</td>
<td><a href="http://www.healthaffairs.org">www.healthaffairs.org</a></td>
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<td>&quot;Continues in 2002,&quot; by Katharine Levit et al., Health Affairs, January/February 2004, Volume 23, Number 1, pages 147-159.</td>
<td>content.healthaffairs.org/cgi/content/full/hlthaff.w4.79v1/DC1</td>
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<td>&quot;Health Spending Projections through 2013,&quot; by Stephen Heffler et al., Health Affairs, Web Exclusive, February 11, 2004, pages W4-79 - W4-93.</td>
<td>content.healthaffairs.org/cgi/content/full/hlthaff.w4.79v1/DC1</td>
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<td>&quot;Health Accounts&quot;</td>
<td><a href="http://www.cms.hhs.gov/statistics/nhe/">www.cms.hhs.gov/statistics/nhe/</a></td>
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