Medicare 101

Medicare Overview

Most Americans have heard of Medicare, approximately 45 million people were receiving Medicare benefits in 2008. The Centers for Medicare and Medicaid Services (CMS) has predicted that there will be 78 million people eligible for the program by the year 2030.

It might be expected that Medicare is very well understood, but the reality is that there are many pieces and parts that can be very confusing to the average person. A recent search on the internet for the term ?Medicare? returned more than 16 million results in less than 1/10th of a second. It would take a person a really long time to read through all of those references. We hope to remove some of the mystery surrounding Medicare.

The program was designed to be available to anyone who was born in the US, a permanent and legal resident for 5 years, or the spouse of an individual who paid Medicare taxes for at least 10 years. Additional eligibility criteria include:

- Those under 65 who were disabled and receiving disability benefits for at least two years from Social Security or the Railroad Retirement board
- People with end stage renal disease (ESRD) or those who needed a kidney transplant regardless of age (as long as they met the residency requirements)
- The program also includes those afflicted with amyotrophic lateral scleroses (better known as Lou Gehrig?s disease) that are eligible for disability

In 2011 those with Medicare Part B will have an annual deductible of $162/year. This is generally considered an out of pocket cost but may be covered by special programs for those with low income or other special circumstances. When a person elects Medicare coverage they will receive a special red, white and blue Medicare card. This is their insurance card and it will show if they have parts A and/or B.

To order a free booklet from Medicare you can **click here** [1] or call 1-800-633-4227. Hearing impaired can call TTY 1-877-486-2048

Click here [2]to learn more about the different parts of Medicare

Click here [3]to learn about programs for low income people

To learn about Medicare/Medicaid coordination **click here** [4]

References

Medicare http://www.medicare.gov/ [2]

Social Security Administration Online http://www.ssa.gov/history/lbjsm.html [5]

SSA Medicare Booklet http://www.socialsecurity.gov/pubs/10043.html#part5 [1]

Medicare Premium Rules for Higher Income Beneficiaries: http://www.socialsecurity.gov/pubs/10536.html#rules [6]

Medicare Premium Information https://www.ssa.gov/pubs/EN-05-10003.pdf [7]

Medicare by the Letter

Part A

Medicare part A is designed to help cover expenses for institutional care. These mean hospitals, skilled nursing facilities after a hospital stay, hospice and home health care. For people who paid Medicare taxes (or their spouse did) while working this coverage does not cost any money. A person might also be able to buy this coverage if they are disabled and meet residency requirements.

- People who are receiving disability from Social Security or the Railroad Retirement Board will automatically receive information near the time they will become eligible for Medicare. Those who are not receiving retirement benefits should contact Medicare 3 months before they turn 65. Even if a person does not retire at 65 they can still get Medicare coverage.
- Besides the eligibility criteria mentioned above, there are a few other special circumstances that would make a person eligible for Medicare.
- A disabled person between the ages for 50 to 65 who has not applied for disability because they are receiving money from another Social Security program.
- Government employees who become disabled before they turn 65
- A person that did not sign up or dropped their Medicare coverage they may be able to sign up again.
- Permanent kidney failure at any age.

Part B

Part B is designed to cover healthcare services that are provided to people who live at home, often referred to as outpatient services. Part B pays for home health care, durable medical equipment, flu shots and doctor office visits. These are medical services that are not covered by Part A. Everyone who is eligible for free Part A can sign up for Part B, but there is a monthly premium for this coverage. The cost may be higher for those who have a very high income. If a person is not eligible for free Part A they may be able to purchase Part B alone if they are 65 or older and meet residency requirements.

When a person is turning 65 and becomes eligible for Medicare Part A they have a 7 month window to sign up for Part B. This window starts 3 months before a person turns 65 and runs through the birthday month and the 3 months after the birthday.

If a person is disabled or has permanent kidney damage their eligibility will depend on the date that the disability or treatment began.

The Centers for Medicare and Medicare created a chart showing when Part B coverage will start based on when you sign up for coverage.

If you enroll in this month of your Initial enrollment period:	**Then your Part B Medicare coverage starts:**
1 (3 months before your 65th birthday)	The month you become eligible for Medicare
2 (2 months before your 65th birthday)	The month you become eligible for Medicare
3 (1 month before your 65th birthday)	The month you become eligible for Medicare
4 (your birthday month)	One month after enrollment
5 (1 month after)	Two months after enrollment
6	Three months after enrollment
7	Three months after enrollment

If a person does not sign up when they first become eligible they have another opportunity each year during general enrollment which runs January 1 through March 31. If they sign up during this period their coverage will not become effective until July of that year. The catch here is that for each year they wait to sign up, the premium goes up by 10%.

If a person is 65 or older and still covered by a group health plan either from their own or their spouse's current employment, they have a "special enrollment period". This means they may delay enrolling in Medicare Part B without having to wait for a general enrollment period and paying the 10% surcharge for late enrollment. This exception allows a person to enroll in Medicare Part B at any time while they are covered under a group plan based on current employment. Eligibility to sign up for Part B begins the month after employment ends or the 8 months after group coverage ends, whichever comes first. A person receiving disability payments but still covered by a group plan based on their own or their spouses employment, have a similar "special enrollment period".

Part C

Medicare Part C coverage is more commonly known as Medicare Advantage. These plans are available in many areas through different provider organizations. A person who has Part A and B can elect to receive their care through one of these organizations through Part C. There

are different types of Medicare Advantage Plans which include:

- Medicare managed care plans
- Medicare preferred provider (PPO) plans
- Medicare private fee for service plans
- Medicare specialty plans

If a person chooses to join one of the Medicare Advantage plans you may have to pay a monthly premium for any extra benefits that might be offered. They will also receive a different type of health card. A person can choose to sign up for one of these plans when they first become eligible for Medicare or during the annual enrollment period from November 15 through December 31 each year. Special circumstances may allow for special enrollment periods.

Part D

Medicare Part D helps to cover prescription medicines. Anyone with Part A, B, or C is eligible for Part D. Joining Part D is optional and voluntary. There is an extra cost associated with this additional coverage. Again the cost is higher for those with very high incomes. If a person has different prescription coverage they may wait to sign up for Part D. In general, if this coverage is at least as good as Part D, there will be a penalty in cost for waiting. A person can sign up for Part D when they first sign up for Medic are or during the annual enrollment period from November 15 through December 31 each year. Special circumstances may allow for special enrollment periods.

Drugs that are not approved by the Food and Drug Administration (FDA)This is the newest part of Medicare; Part D was signed into law in 2003 and went into effect January 1, 2006. Just like most health plans Part D will not help to cover:

- Those prescribed for off label use
- Drugs not available in the United States
- Drugs that would be covered under Medicare Part A or B
- Drugs that are excluded by Medicaid

There is a gap in coverage that is referred to as "the donut hole". The gap begins when the total retail drug costs reach a certain amount. This gap remains in effect until a person's out of pocket costs reach another set amount. Once past this gap a person is responsible for set amount per month for generic medications and a higher amount per month for name brand medications.

Click here [8] to learn more about "the donut hole"

References

Medicare http://www.medicare.gov/ [2]

Social Security Administration Online http://www.ssa.gov/history/lbjsm.html [5]

SSA Medicare Booklet http://www.socialsecurity.gov/pubs/10043.html#part5 [1]

Medicare Premium Rules for Higher Income Beneficiaries: http://www.socialsecurity.gov/pubs/10536.html#rules [6]

Medicare Prescription Drug Coverage: http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx [9]

Medicare and ESRD

Medicare helps to pay for kidney dialysis as well as kidney transplants.

Eligibility

- A person whose kidneys no longer work can get Medicare no matter what their age as long as they meet other criteria.
- You have worked long enough to qualify for retirement benefits from Social Security, the Railroad Retirement Board, or as a government employee
- You are already receiving retirement benefits
- You are the spouse or child or a person who meets either of the above criteria

In order to receive full benefits you must apply for both Medicare Part A and B and wait the required amount of time. If you don't qualify for Medicare, you may be able to get help from your state to pay for your dialysis treatments.

A person with ESRD who is new to Medicare will most likely be covered under ?original Medicare? rather than a Medicare Advantage Plan. A Medicare Part D plan may also be selected to help cover prescription costs. Some people may be able to enroll in a Medicare Special Needs Plan if there is one in their state.

Children and Medicare
A child with permanent kidney failure is eligible for Medicare as long as one with their parents has worked long enough to qualify for retirement benefits through Social Security, the Railroad Retirement Board, or as a government employee. A child can also be eligible if they are already receiving benefits from Social Security or Railroad Retirement.

When does Coverage Start?

When enrolling in Medicare because of ESRD and on dialysis, Medicare coverage usually starts the first day of the fourth month of dialysis treatments.

May	June	July	August
First month of dialysis treatments	Second month of dialysis treatments	Third month of dialysis treatments	Fourth month of dialysis treatments ? **Medicare coverage begins**

If a person is covered by a group health plan related to employment, this plan will pay first for 30 months of dialysis treatments and Medicare pays second. If there is no group health plan there are other programs that can bridge the gap and help pay expenses not covered by Medicare.

This 30 month window is called the coordination period, and it starts whether or not a person has applied for Medicare coverage. When an approved Medicare home training program is

completed or a transplant is done during the initial 3 month waiting period, the coordination period will start earlier.

If the group health plan has deductibles or co-insurance, Medicare A and B may help to pay for these expenses. Since Part B has a premium some people may find it better to wait to enroll until the 30 month coordination period is over to avoid paying premiums that may not be needed. If the group coverage ends before the coordination period has passed it will be important to sign up for Medicare Part A and B right away.

What happens after the coordination period?

At the end of the 30 month coordination period, Medicare begins to pay first for all covered services. Usually the group health plan coverage pays for services not covered by Medicare. Plans can vary so it is wise to check with the benefit coordinator for the group health plan to verify coverage.

Special Circumstances

There is a separate 30-month coordination period each time a person enrolls in Medicare because of permanent kidney failure. When a kidney transplant continues to work for 36 months, Medicare coverage ends unless a person is over 65 or disabled for another reason. If the transplant then fails a person will need to re-enroll in Medicare but coverage will begin right away, without the 3 month waiting period. There will be a new 30 month coordination period if there is a group health plan providing coverage.

Coverage Exceptions

- Medicare can become effective sooner if a person meets both of these criteria
- When a person takes part in a Medicare approved home dialysis training program
- Your doctor expects the person to finish training and be able to do their own dialysis treatments at home

Medicare coverage can begin the month a person is admitted to a Medicare-approved hospital for a kidney transplant (or services that are needed before a transplant) as long as the transplant takes place in that same month or within the following 2 months.

Medicare does not pay for care that is needed in order to prepare for dialysis such as fistula placement unless the person has completed an approved home training program and starting regular dialysis all in the same month.

When does coverage end?

If eligibility for Medicare is only because of permanent kidney failure, coverage ends when:

- It has been 12 months since dialysis was stopped
- 36 months after a kidney transplant

Medicare coverage may be extended if one of the following criteria is met:

- Dialysis is restarted or a transplant is done within the 12 months after dialysis was stopped
- If dialysis is restarted or another kidney transplant is performed within 36 months after the first transplant

References

Q1 Medicare.com: http://www.q1medicare.com/PartD-MoreOnTheDonutHolesOrCoverageGap.php [10]

Medicare website: https://secure.ssa.gov/apps6z/i1020/main.html [11]

Medicare Basics: https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf [12]

Dual Eligibility Medicare/Medicaid

Dual Eligibility refers to a person being eligible in some way for both Medicare and Medicaid. Medicare is a federal program while Medicaid is a state program that is available to those with low income and/or resources.

Medicare and Medicaid
Medicare covers acute care services and Medicaid covers Medicare premiums and cost sharing expenses. Medicaid may also cover expenses for long term care.

There are different types of eligibility and this link goes to a report with a table that outlines the differences

http://www.medpac.gov/publications%5Ccongressional_reports%5CJune04_ch3.pdf [13]

Medicare is considered the primary insurer and covers medically necessary acute care services, including physician, hospital, hospice, SNF, home health services as well as durable medical equipment (DME).

Medicaid is the secondary payer and covers services that are not covered by Medicare. Examples include transportation, dental and vision. There may be coverage for services not covered by Medicare as well as care after the Medicare benefit is exhausted or if certain Medicare criteria are not met. Types of services may include hospital, nursing home or home health care.

Medicare-Medicaid Coordination Office
The Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, serves people who receive benefits from both Medicaid and Medicare. A person covered by both has dual eligibility. The goal for this office is to make sure that people with limited income and resources have full access to seamless, high quality health care while making the system as cost-effective as possible.

The Medicare-Medicaid Coordination Office works with each state?s Medicaid program and all federal agencies to help coordinate benefits between the two programs effectively and efficiently. Work is being done to create new care models and to improve the way those who are dual eligible receive health care.

The Medicare-Medicaid Coordination Office was created as part of the Affordable Care Act. The goals include the following for those who are dual eligible:

- Assure full access to available benefits
- Simplify processes to access items and services
- Improve health care quality and services
- Increase understanding of programs and improve satisfaction with coverage
- Solve rule conflicts between state and federal programs
- Improved continuity of care and safe care transitions among health care providers
- Improved provider performance and care quality

Special Programs

The Program of All-Inclusive Care for the Elderly (PACE) serves frail elderly beneficiaries, age 55 and older, who meet states? standards for nursing home placement and live in areas served by the PACE organizations.

State Demonstration Waivers have been created and operate under the Medicare demonstration authority. Typically these programs use a model based on a different type of fee schedule to improve coordination of services. Examples include the Minnesota Senior Health Options and the Wisconsin Partnership Program.

Evercare is a demonstration project that provides case management for those living in nursing homes. The goal is to reduce the need for hospital and emergency room care. Nurse practitioners work closely with primary care physicians and the project has shown that hospitalizations decreased when compared with control groups and that care is at least comparable to what is available to those not in the demonstration project. It currently operates in 11 states with 24,000 enrolled.

References

About the Medicare-Medicaid Coordination Office: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html [14]

Understanding the Affordable Care Act http://www.healthcare.gov/law/introduction/index.html [15]

Dual Beneficiaries Overview: http://www.medpac.gov/publications%5Ccongressional_reports%5CJune04_ch3.pdf [13]

The Kaiser Foundation on Medicaid Facts: http://www.kff.org/medicaid/upload/4091-04%20Final(v2).pdf [16]

Links

[1] http://www.socialsecurity.gov/pubs/10043.html#part5
[2] http://www.medicare.gov/
[3] https://www.medicaid.gov/medicaid/index.html
[4] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-MedicaidCoordination.html
[5] http://www.ssa.gov/history/lbjsm.html
[6] http://www.socialsecurity.gov/pubs/10536.html#rules
[7] https://www.ssa.gov/pubs/EN-05-10003.pdf
[8] http://blog.medicare.gov/2010/08/09/what-is-the-donut%C2%A0hole/
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