Medicare

Chapter 2

Medicare is a federal health insurance program for people age 65 and over, for some disabled people under age 65, and for people with end stage renal failure. This chapter does not discus Medicaid, a needs based program for low-income persons. See Chapter 3 for information on Medicaid.

In This Chapter

Find definitions for these terms (indicated in bold) in the glossary:

Donut Hole
Premium
Private Contract
Reconsideration

2-1 Medicare Overview

Medicare is a federal health insurance program managed by the Centers for Medicare and Medicaid Services (CMS). It helps pay hospital and medical costs, some or all prescription costs, and care in other health care settings. People who are age 65 or older and some disabled people who are under age 65 are eligible for Medicare.

There are four parts to Medicare:

A. Medicare Hospital Insurance

B. Medicare Medical Insurance

C. Medicare Advantage Plans

D. Prescription Coverage

Medicare Part A is Medicare hospital insurance. It usually covers a necessary stay in the hospital. It may cover inpatient care in a skilled nursing facility or certain health care in your home after you leave the hospital. It will also cover hospice services and inpatient care in a religious nonmedical health care institution. Part A does not cover doctors' services.

Medicare Part B is Medicare medical insurance; it includes doctors' services, outpatient hospital services, diagnostic tests, durable medical equipment, some home health care, and preventative services. There are monthly premiums based on your income. The average premium in 2012 is $99.90.

Medicare Part C or Medicare Advantage is an alternate to the traditional Part A /B combination (**original Medicare**). Under Part C, an enrollee elects to assign Part A and Part B to a private company approved by Medicare. This can be a managed-care or HMO (health maintenance organization), PPO (preferred provider organization), Special Needs Plan (SNP), PFFS (private fee-for-service plan), HMO Point-of-Service (HMOPOS), or a Medical Savings Account Plan (MSA). These plans may include coverage for items that are not covered under original Medicare. They may also have different eligibility requirements and premiums.

Medicare Part D is the general name of the prescription drug plans available for Medicare recipients. Although people must have Medicare Part A, B, or a Medicare Advantage Plan to qualify for a Medicare prescription drug plan, the plans are operated by private insurance companies, not by Medicare.

Medicare does not cover some common health care expenses including dental care, most eyeglasses, hearing aids, and most long term care.

2-2 Medicare Eligibility

You are eligible for Medicare if any of the following situations apply:

- You are age 65 or older and qualify for Social Security or Railroad Retirement benefits, even if you are not collecting them;
- You are a former federal employee who retired in or after 1983;
- You are disabled and have met the Social Security or Railroad Retirement disability requirements for two years; or
- You have end-stage kidney disease and have been treated on dialysis for three months.

If you are age 65 or older but not eligible under the above requirements, you may still choose to enroll in the extended eligibility Medicare program if you live in the United States and have been a citizen or a legal resident for at least five years. If you choose to enroll in this extended eligibility, you must pay higher monthly premiums than eligible beneficiaries.

2-3 Medicare Enrollment

Original Medicare (Part A & B)

The initial enrollment period includes a seven-month period beginning three months prior to your 65th birthday and extending three months past your 65th birthday. If you wait to sign up until your birthday or the three months after, you may experience a delay in coverage for up to three months. **If you don't sign up during the initial enrollment period, you may be penalized up to 10% for each 12 month period you were eligible but not enrolled.**

There is a **special enrollment period** for people who were covered under a group health plan due to employment (COBRA and retiree health plans do not count). You can enroll under the special enrollment period if you or your spouse (or family member if you're disabled) is working, and you're covered by a group health plan through the employer or union based on that work. You may also enroll during the 8-month period that begins the month after the employment ends or the group health plan insurance based on current employment ends, whichever event happens first. There is generally no penalty if you sign up during the special enrollment period.

You can sign up during **open enrollment** between January 1st and March 31st of each year. If you sign up during open enrollment, your coverage will begin January 1st.

If you sign up for Social Security benefits at age 65, you can sign up for Medicare at the same time. If you are already receiving reduced Social Security benefits when you reach age 65, you will receive a Medicare card showing your enrollment in Part A (hospital insurance) and Part B (medical insurance). The premium will be deducted from your monthly Social Security payments. If you are not receiving reduced Social Security benefits, you will be billed for the premiums.

You have a 6-month open enrollment from when you sign up for original Medicare to purchase a Medigap policy (*See Medigap section for more information on Medigap policies.)*

Medicare Advantage and Prescription (Part C & D)

See Medigap section for more information on Medigap policies.

You can sign up for Medicare Part C and/or Medicare Part D during specific times of the year, or if there are changes in your circumstances.

Similar to original Medicare, you can sign up for C or D during the **initial enrollment period** beginning three months prior to your 65th birthday through three months after your 65th birthday.

If you enroll in Medicare Part B during the open enrollment from January 1–March 31 you can enroll in C & D Plans from April 1st through June 30th. If you do not have Part A, you can only sign up for a prescriptiondrug Plan (Part D).

You can change plans during the **open enrollment period**, October 15–December 15. From January 1–Feb ry 14 you can drop an Advantage Plan and switch to original Medicare.

There are also **special enrollment periods** if you have a change in circumstance such as moving, a plan changing its relationship with Medicare, or losing your current coverage.

As with traditional insurance the rules and fees can change on an annual basis, as can a company's relationship with Medicare. If the insurance company decides not to work with Medicare you will need to switch coverage to a company that does. You may join Part C with a pre-existing condition (except end-stage renal failure).

Generally, you must stay with the insurance provider for a full calendar year unless you move out of your plan's coverage area or your circumstances change such as moving to a nursing home or qualifying for Medicaid benefits.

You can switch to a five-star Medicare Advantage Plan any time throughout the year. Rating systems are based on member satisfaction surveys, plans, and performance.

There may be a penalty if you don't sign up when you are first eligible for a prescription plan. If your coverage lapses more than 62 days, you may have to pay a penalty equal to 1% of the "national base beneficiary premiums" multiplied by the number of months you were without coverage. This penalty is added to your monthly premium.

2-4 Benefits Covered by Medicare

Part A

Part A covers hospital services, which Medicare considers reasonable and medically necessary. These can include:

Inpatient Care in Hospitals

- Coverage includes semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, including acute care.
- To be medically necessary:
    - A doctor must confirm you need inpatient hospital care for treatment of your illness or injury and the utilization review committee or a quality improvement organization must not disapprove;
    - You require care that can only be administered in a hospital.
    - You must be admitted to a hospital participating in the Medicare program. Staying overnight does not guarantee you are admitted to the hospital. **Always ask if you are receiving inpatient or outpatient services** (or are being held for observation) because it affects your payment and whether you will qualify for skilled nursing care after your stay.

Inpatient Care in a Skilled Nursing Facility

- Coverage includes semi-private rooms, meals, skilled nursing and rehabilitation services, and medically necessary supplies.
- Requires a **medically-necessary inpatient hospital stay** for a related illness or injury. You must have been admitted to the hospital for three days, not including the day you were discharged.
- Requires your doctor to certify you need daily skilled care.
- Does *NOT* include long-term care or custodial care.

Hospice Care Services

- Coverage includes drugs for pain and symptom management, medical and nursing services, durable medical equipment, and spiritual and grief counseling.
- Coverage can also include respite care for up to five days but does not generally include long term care.
- Requires that a doctor certify you are terminally ill with six months or less to live.
- Care must be provided by a Medicare-approved hospice provider.

Home Health Services

- Coverage includes medically necessary part time or intermittent skilled nursing care or therapy (speech, physical, occupational).
- Requires an order by a Medicare enrolled doctor after face-to-face evaluation.
- Care must be provided by a Medicare certified Home Health provider.
- Does NOT include home care or companion care services.

Inpatient care in a Religious Nonmedical Health Care Institution

- Coverage includes inpatient services and home health services, and durable medical equipment.
- Requires nonmedical care to be furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of illnesses.
- Does not include religious services or payment to the religious practitioner.

www.medicare.gov

1-800-MEDICARE

Visit www.medicare.gov or call 1-800-MEDICARE to find out your portion of the costs associated with each of the above. There may be copayments and costs you are responsible for.

Part B

Services covered under Medicare Part B include:

- A "Welcome to Medicare" physical examination (in the first 12 months) and yearly wellness visits.
- Periodic screening for diabetes, cardiovascular, colorectal, prostate cancer, breast and gynecological, glaucoma, and requested HIV.
- Flu and pneumococcal vaccines.
- Hepatitis B vaccine for people at high risk.
- Diabetes supplies, self-management training and foot care for people with diabetes. Supplies, education, and screening for people with diabetes risk factors.
- Outpatient mental health care.
- Prescription drugs are limited to injections in a doctor's office and some oral cancer drugs.
- Physicians' services.

- Some hospital outpatient services and supplies (such as diagnostic tests, x-rays, and radiation treatment).
- Ambulance ride to hospital or skilled nursing facility when transportation in another type of vehicle would endanger your health.
- Emergency department services and urgent care.
- Outpatient chemotherapy.
- Rental or purchase of durable medical equipment (such as oxygen supplies, wheelchairs, and walkers) if purchased or rented from a Medicare approved supplier.
- Outpatient physical therapy, occupational therapy, and speech pathology.
- Surgical dressings, splints, and casts.
- Transplants and immunosuppressive drugs.
- Limited chiropractic adjustments.
- Smoking cessation services for people with an illness from smoking.
- Prosthetic devices.
- Certain home health services.

For the services listed above, Medicare pays all or some of the costs depending on the type of service. Generally you have to pay deductibles, coinsurance, and copayments. You can go to www.medicare.gov/coverage for more details about each of the above items or call 1-800-MEDICARE.

Part A and Part B *DO NOT* cover routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, private hospital rooms, most in-home care, personal comfort items, most long term care, and health care received outside of the United States.

Part C—Medicare Advantage

Part C is a combination of Part A and Part B (original Medicare) that is offered by private companies approved by Medicare. They cover all the services of original Medicare, other than hospice care, which is covered by original Medicare even if you have Part C.

Private companies may offer additional services not covered by original Medicare and may have different deductibles and copayments. They also have different service eligibility guidelines. Generally, you pay monthly premiums.

Part D—Medicare Prescription Drug Coverage

Prescription plans are available to anyone who has original Medicare (A and B) or an Advantage Plan (C). The cost for the plan and the plan's coverage vary. They must cover all commercially-available vaccines not covered under Part B. Also included is a Medication Therapy Management program for those with complex health needs to help ensure medications are working and used safely.

There is a monthly **premium** (fee), the cost of which varies depending on the policy and your income. In addition, there may be copayments and an annual deductible (amount you must pay out of pocket before insurance begins to pay).

Most plans have a gap in coverage once you have spent a certain amount on prescription drugs; this is often referred to as the **donut hole**. While you are in the donut hole, you are responsible for the cost of your prescription drugs until you hit catastrophic coverage (up to $4,700 in 2012). Once you hit catastrophic coverage, Medicare will begin covering your covered prescriptions again.

The donut hole is expected to close by 2020. Currently all brand name drugs covered by Medicare will receive a 50% discount from the drug companies while a person is in the donut hole. Generic drugs have historically not been covered. Starting in 2012, Medicare will pay for 14% of the price and dispensing fee for generic drugs while you are in the donut hole. The table below outlines the current plan to close this coverage gap by 2020.

TABLE 2.1

Year	% you are responsible for. Brand Name Drugs in Gap	% you are responsible for. Generic Drugs in Gap
2012	50%	86%
2013	47.5%	79%
2014	47.5%	72%
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Your deductibles, coinsurance, and copayments or the discounts paid by drug companies on name brand drugs, dispensing fees, and your out of pocket cost for covered generic and name brand drugs all go toward this gap. Additional "gap" insurance is available. Generally the gap insurance has a higher monthly premium.

Enrolling in the right prescription plan can be quite complicated. Get help from a Senior Health Insurance Benefits Assistance (SHIBA) volunteer in your community before deciding on a plan. *(See Chapter 14, Resources for contact information.)*

See Chapter 14, Resources, for SHIBA contact information.

2-5 Medicare's Basic Payment Policies

Like private insurance policies, Parts A and B have deductibles you must pay before Medicare pays. Parts A and B also have co-insurance payments for most services. You are responsible for paying the deductible and making the co-payments to the health care provider unless you have a Medicare supplemental insurance policy ("Medigap" coverage) that covers these costs or you belong to a health maintenance organization (HMO).

Part A

Hospital Coverage

Your benefit period begins the day you are admitted to the hospital and ends 60 days after your treatment in the hospital or skilled nursing facility ends. A new benefit period will begin if you enter the hospital after the 60 day period.

You are responsible for payments throughout the benefit period but the amount you are responsible for varies depending on the number of days you are in the hospital. You are responsible for the deductible and daily expenses as follows:

- In the first 60 days, you are responsible for the deductible (in 2012 this amount is $1,156) and Medicare pays the remaining covered expenses.
- Days 61–90, you are responsible for a daily amount (in 2012 this is equal to $289 each day) and Medicare pays the remaining covered expenses.
- Days 91–150*, you are responsible for a daily amount (in 2012 this is equal to $578 each day) and Medicare pays the remaining covered expenses.
- After 150, you are responsible for all expenses.

** You have limited lifetime reserve days that give you an extra 60 days of inpatient coverage when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime.*

Medicare has developed a system of diagnosis related groups (DRGs) that determine how much the hospital is paid. Medicare bases its payment to the hospital on the average length of stay for a patient with your diagnosis, not the actual number of days you spend in the hospital.

Skilled Nursing Care

Medicare pays for the first 20 days of covered skilled nursing care under certain circumstances. To be covered, you must meet the following:

- Have qualified days left in your benefit;
- Been admitted as an inpatient to a hospital for three consecutive days, not including the day you leave the hospital; and
- Go to a Medicare certified nursing home within 30 days of your hospital discharge and your doctor certifies you require skilled services.

Day 21 to 100, Medicare will pay a certain amount, while you pay the remaining balance ($144.50 per day in 2012). After 100 days, you pay the full amount for services.

Hospice Care

Medicare covers most of the costs for hospice care. It also covers respite care for up to five days each time you receive respite care. You must pay up to $5 per prescription for drugs and all of the costs associated with room and board other than respite care.

Home Health Visits

Part A pays for the full approved cost of home health visits by a licensed home health agency that follows a treatment plan prepared by a physician. It covers skilled nursing care and certain other health care services only; companion, housekeeping and other in home services are not included.

To qualify, you must:

- Be homebound; and
- Must need the skilled services only periodically (not every day).

If you meet the Medicare requirements, there is no deductible, no co-payment, and no limit on the number of visits.

Part B

You are responsible for your monthly premiums (between $99.90 and $319.70, depending on your income level) and the annual deductible ($140 in 2012) before Medicare begins to pay. Medicare then pays 80 percent of the approved charge for covered services from a medical provider that has agreed to accept Medicare amounts as full payment for services rendered (known as assignment). If you receive service from a medical provider that is non-participating, you pay 20 percent of the Medicare approved charge, plus the difference between the approved charge and the actual bill, up to 15 percent of the approved charge.

For example (non-participating):

Provider's charge	**$100**
Medicare approved charge	$ 90
Medicare pays 80% of the approved charge	$ 72
You are responsible for:	
The remainder of approved charge	$ 18
Plus the difference between the approved charge and provider charge:	$ 10
Your total responsibility:	**$ 28**

If the doctor accepts assignment, he or she has agreed to accept the amount of the Medicare approved charge as full payment. This often decreases the total you have to pay.

For example (participating):

Provider's charge	**$100**
Medicare approved charge	$90
Medicare pays 80%	$72
You are responsible for:	
The remainder of approved charge	$18
Your total responsibility	$18
You do not pay the $10 difference between $90 and the actual bill	$0
Your total payment	**$18**

Medicare will not pay for services performed by a health care provider who does not accept Medicare. If you sign a **private contract** with your health care provider you will be responsible for the full amount charged. You don't have to sign these contracts and can opt for health care by a Medicare certified health care provider. Visit www.medicare.gov to search for Medicare approved health care providers.


www.medicare.gov

1-800-MEDICARE

Oregon helps pay the monthly Part B premium for some lower-income people, known as "Qualifying Medicare Beneficiaries." To qualify, a person must have Part A coverage and monthly income at 100 percent of the federal poverty level. In 2012 that amount equals $907.50 per month for one person and $1,225.83 per month for a couple. For anyone at 120 percent of the federal poverty level and a specified number of people between 120 and 135 percent, the state will pay for Medicare Part B Premiums. Oregon's Area Agency on Aging and Seniors and People with Disabilities offices have information on this program. *(See Chapter 14, Resources.)* Your assets must not exceed $4000 per individual or $6000 per couple, not including your home, car, and burial plan (up to $1,500).


See Chapter 14, Resources, for AAA contact information.

2-6 Medicare Claims

Under Medicare Part A, you do not have to file claims or submit bills from hospitals, skilled nursing facilities, or home health agencies. These providers bill Medicare directly for services. You will receive statements detailing the benefits used, amount Medicare has paid, deductible, and co-payments. Request an itemized bill of services from your provider to ensure all charges are correct.

Providers also bill Medicare directly for services under Part B. If the provider accepted assignment, they will receive payment directly from Medicare. If the provider did not accept assignment, you will receive the payment from Medicare and be responsible for paying the provider's bill. You will receive an Explanation of Medicare Benefits form or Medicare Summary Notice form

showing whether the claim was approved or denied, whether the provider accepted assignment, the Medicare approved charge, the amount of Medicare payments, and any deductible and co-payment amounts.

Unless you have a Medicare supplement insurance policy or belong to a health maintenance organization (HMO), you pay deductible amounts, plus any co-payments, directly to the provider. If Medicare denies your claim, you have the right to appeal.

2-7 Medicare Denials & Appeals

You can appeal any Medicare denial of service, supply, or prescription; a denial of payment for services received; a notice of discharge from the hospital or skilled nursing facility; and amount you pay for a prescription.

Part A & B

There are five levels of appeals: redetermination; reconsideration; review by Administrative Law Judge; Medicare Appeals Council; and judicial review in U.S. District Court. Always keep copies of anything you send to Medicare in addition to all the statements, letters, and decisions from Medicare.

If Medicare denies a claim for payment under Part A or Part B, the Medicare Summary Notice will include your appeal rights.

Redetermination: You have 120 days from the date you receive the denial notice to ask for an informal review of the decision. Medicare then has 60 days to provide a decision. Request must be in writing, following the instructions on the back of your Medicare Summary Notice. You may also file a Redetermination Request Form.

Reconsideration: You have 180 days from the date you receive the redetermination decision to ask for a "reconsideration." If you disagree with the result at this level, and if your claim involves at least $120, you can

seek a hearing in front of a Center for Medicare & Medicaid Services (CMS) Administrative Law Judge within 60 days from the decision. You can obtain the form used to request a hearing from your local Social Security office or the CMS Internet site. *(See Chapter 14, Resources.)* You have 60 days to appeal the judicial decision; it is recommended that you obtain legal counsel at this point. One final appeal is available to the U.S. District Court.

See Chapter 14, Resources, for local social security office locations and contact information.

The hospital or skilled nursing facility should provide written notice of noncoverage, which explains how to appeal the decision. If you do not receive written notice, ask for it or call Acumentra Health (Oregon's Medical Professional Review Organization) at 503-279-0100 and ask for an immediate review. You are entitled to an expedited review.

Part C—Medicare Advantage Plans

If you are enrolled in a Medicare Advantage Plan, you have the right to appeal decisions that deny coverage or access to services. Each plan has specific rules for appealing decisions. They must meet minimum federal requirements including allowing you 60 days from the date you get a written notice from the plan to file an appeal. If you do not get a written notice, you can still ask for reconsideration. If they continue to deny coverage or deny your access to services, the denial will automatically forward to an independent review entity.

Part D—Medicare Prescription Drug Coverage

You can petition for a non-covered prescription drug or to have a denial of prescriptions reviewed. This can be done by phone or in writing. If you are requesting an exception to the standard drug coverage, your doctor or prescriber must include a written statement as to the medical reason it should be approved. Your plan must notify you of its decision within 24 hours for expedited appeals and 72 hours for standard appeals. If you disagree with your plan's decision, request an independent review of your case. The process is similar to Part A and B appeals.

2-8 Supplemental Health Insurance "Medigap"

Since Medicare does not pay all of your health care expenses, private insurance companies sell insurance to supplement or fill in the Medicare gap. These policies are known as Medicare Supplement Insurance or **Medigap Insurance**. Medigap helps pay for copayments, coinsurance, and deductibles. Medicare will pay its share of the Medicare-approved amounts for covered health care costs before the Medigap policy pays its share.

A Medigap policy should be purchased within six months of your 65th birthday and your enrollment in Part B. Insurance companies cannot refuse an applicant for Medigap policies provided the person applies for coverage within six months of enrolling in Medicare Part B.

Oregon law does have certain minimum requirements for Medigap insurance. For example, with minor exceptions, Medigap policies cannot exclude coverage by type of illness, accident, treatment, or medical condition. These policies cannot limit or reduce coverage for pre-existing diseases or physical conditions. If you have a claim for losses caused by an existing medical condition prior to purchasing your policy, Medigap cannot deny a covered claim that you make six or more months after you purchased the policy. The Medigap provider cannot end your coverage because of deteriorating health. It will end for a lapse in payment. Medigap policies cannot duplicate Medicare coverage.

Note: neither Medicare nor the government sells or endorses any particular Medigap insurance.

Purchasing Medigap Insurance or Joining an HMO:

There are a number of plans offered. These plans are typically expensive. Shop carefully before you buy. Policies and plans differ in coverage and cost, and companies differ in service.

When shopping:

- Learn what Medicare does and does not cover.
- Know your insurance needs before you talk to an agent.
- Contact your local Social Security office for information.
- Compare policies and plans. Decide whether you want to buy an insurance policy or join an HMO.
- Do not duplicate coverage; one good Medigap insurance policy or HMO plan is enough. It is illegal for anyone to sell you a Medigap plan if you are enrolled in an Advantage Plan.
- Talk to your friends and peers about their policies and plans before you buy. They can give you excellent information.
- Take someone with you when you meet your agent.
- Make sure you understand any limits or restrictions.
- Review written materials about the policy or plan.
- Don't pick an insurance company based solely on a spokesperson.
- Doubt an agent who says you must "buy today or risk penalty."
- Be careful when replacing existing policies or switch plans, as the new plan may have a waiting period before you can use it for existing health problems.
- You may not save much by buying insurance from unknown or distant companies and agents. You will usually have to deal with more inconvenience when correcting problems and misunderstandings.
- A 30-day "free look" period allows you to cancel the policy for a full refund.
- Medigap will not pay deductibles, premiums, or coinsurance for Medicare Advantage Plans.

Find more info on Medicgap at: www.medicare.gov/Medigap

For more information visit: www.medicare.gov/Medigap.

The Oregon Health Plan / Medicaid

People with limited income and assets may qualify for the Oregon Health Plan (the state's **Medicaid** program) whether they have Medicare coverage or not. Medicaid can pay for prescription drugs, limited dental care, and other services in addition to doctor and hospital services. *(See Chapter 3 for more information on the Oregon Health Plan.)*

See Chapter 3 for more information on the Oregon Health Plan.

Help in Making Medicare Health Plan Decisions

Oregon's Senior Health Insurance Benefits Assistance program (SHIBA) can provide you with information and counseling by trained volunteers to help you come to an informed decision about your choices for health insurance in general and Medicare in particular. *(See Chapter 14, Resources, for contact information.)*

See Chapter 14 Resources, for contact information.