



Medicare

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Overview

Medicare is the federal health insurance program that covers:

- People age 65 or older,
- People under age 65 with certain disabilities, and
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare is divided into four parts: A, B, C, and D.

Part A: Hospital Insurance

Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Medicare Part A coverage is tied to a benefit period of 60 days for a spell of illness. A spell of illness benefit period commences on the first day of your stay in a hospital or in a skilled nursing facility and continues until 60 consecutive days have lapsed and you have received no skilled care. Medicare does not cover

care that is or becomes primarily custodial, such as assistance with bathing and eating.

Your benefit period with Medicare, the spell of illness, does not end until 60 days after discharge from the hospital or the skilled nursing facility. Therefore, if you are readmitted within those 60 days, you are considered to be in the same benefit period. On the other hand, Medicare considers it a new spell of illness if you are readmitted more than 60 days after discharge. The good news is that this means that if you are readmitted within 60 days, you are not charged another deductible; the bad news is that your previous admission is tacked on to the second one in calculating the percentage amount Medicare will cover, since Medicare full coverage is only for 60 days. There is no limit on the number of spells of illness Medicare will cover in your lifetime.

For inpatient hospital stays, Medicare will pay:

-100 percent of costs for up to 60 days of inpatient care, after you pay the deductible.

-After 60 days, beneficiaries are responsible for coinsurance costs. In 2006, beneficiaries must pay \$238/day (up from \$228/day in 2005).

-Beneficiaries are also entitled to a lifetime reserve of 60 additional days. If those reserve days are also used, beneficiaries must pay



\$476/day in 2006 (up from \$456/day in 2005) for days 91 to 150.

-If you choose not to use your lifetime reserve, all Medicare coverage stops after 90 days of inpatient care or after 60 days without any skilled care for this spell of illness.

Part B: Medical Insurance

Most people pay a monthly premium for Part B. 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 when they are medically necessary.

Under the 2003 Medicare Act, for enrollees whose coverage began on or after January 1, 2005, Part B covers an initial preventive physical examination. The physical must be performed within six months of initial coverage under Part B. Additionally, as of January 1, 2005 under the 2003 Medicare Act, Part B also covers cardiovascular and

diabetes screening tests, and certain mammography services.

In 2005, the premium for Medicare Part B is \$78.20. The premium is indexed for inflation, and typically increases each year. Beginning in 2007, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (2003 Medicare Act), beneficiaries with higher incomes (\$80,000 and over for individuals, \$160,000 and over for married couples) will pay a higher premium based on a sliding scale that will be phased in over five years.

Deductibles

The Medicare Part B deductible is \$110 in 2005 (up from \$100 in previous years). Beginning in 2006, it will be increased by the same percentage as the premium.

Part C: Medicare Advantage

When Medicare was created in 1965 (original Medicare), it provided only two parts; Part A and Part B. Generally speaking, Part A is free to eligible recipients and helps pay for in-hospital care. Part B is optional and helps pay for regular medical care (e.g., doctor's bills, X-rays, lab tests). Individuals who choose to enroll in Part B must pay a premium, a deductible, and co-payments.

In 1997, Medicare Part C (originally called Medicare + Choice) became available to persons who are eligible for Part A and enrolled in Part B. Under Part C, private health insurance companies can contract with the federal government to offer Medicare benefits through their own policies.

Insurance companies that do so are able to offer Medicare beneficiaries health coverage not only through PFFSs, but also through managed care plans (such as HMOs) and

preferred provider organizations (PPOs).

Choosing the right Medicare Advantage plan

There's a lot to consider when deciding which Medicare option is right for you. Here are some questions to ask during the decision-making process:

- How much is the premium?
- Will you need to satisfy a deductible or pay copayment or coinsurance costs?
- Does the plan cover the extra benefits or services you need?
- Do the health care providers you normally see participate in the plan?

Part D: Prescription Drug Coverage

Most people will pay a monthly premium for this coverage. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

Other Medicare Health Plans Programs of All-Inclusive Care for the Elderly (PACE)

PACE combines medical, social, and long-term care services, and prescription drug coverage for frail elderly and disabled people. This program provides community-based

care and services to people who otherwise need nursing home-level of care.

To qualify for PACE, you must meet the following conditions:

You are age 55 or older.

You live in the service area of a PACE organization.

You are certified by your state as meeting the need for nursing home-level care.

At the time you join, you are able to live safely in the community with the help of PACE services.

PACE is only available in states that have chosen it as an optional Medicaid benefit. Call your State Medical Assistance (Medicaid) office to find out if you are eligible and if there is a PACE site near you.

For more information:

The Senior Resource Center
http://www.medicare.org/index.php?option=com_frontpage&Itemid=1

Centers for Medicare and Medicaid
http://www.cms.hhs.gov/MedicareGenInfo/01_Overview.asp#TopOfPage

Medicare and You 2009
<http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

Medicare 101 Video:
<http://www.cms.hhs.gov/apps/training/videotutorials/content/Medicare101/player.html?slide=>