



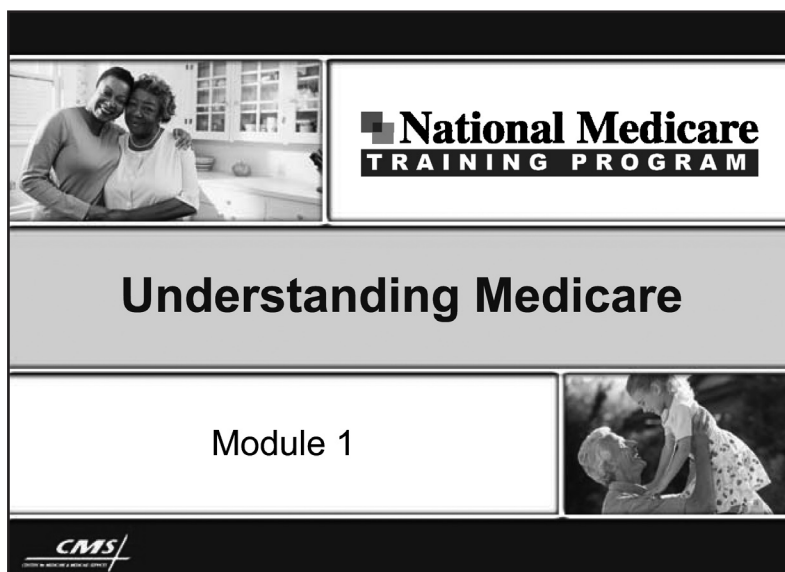
 **National Medicare**
TRAINING PROGRAM

Module 1
**Understanding
Medicare**

Training Workbook



Module 1: Understanding Medicare



This module, Understanding Medicare, contains basic information about the Medicare program. It is divided into four lessons.

[NOTE TO INSTRUCTORS: This module is suitable for presenting to groups of people with Medicare, as well as partners, trainers, and other information intermediaries. The various lessons can be included and/or adapted based on the audience and time limits for the presentation.]

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare and Medicaid. This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings. The information in this module was correct as of April 2008. To check for an updated version of this training module, visit www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp on the web.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Lessons

1. Program Basics
2. Original Medicare (Part A and Part B)
3. Medicare Advantage Plans (Part C) and other Medicare plans
4. Medicare prescription drug coverage (Part D)
5. Programs for people with limited income and resources

4/22/2008

2

Let's look at the five lessons we'll cover in this training session.

In Lesson 1 we'll provide a brief overview of the Medicare program including eligibility and enrollment. In Lesson 2 we'll review the benefits provided under Part A and Part B, and discuss the different ways people can get Medicare. Lesson 3 will explore Medicare Advantage Plans and other Medicare plans. Lesson 4 is an overview of Medicare prescription drug coverage, and in Lesson 5 we'll take a brief look at some programs that are available to help you pay your health care expenses if you have limited income and resources.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Program Basics Lesson 1 Topics

- What is Medicare
- Options
- Who is eligible
- How to apply

4/22/2008

4

Let's look at the topics we'll cover in Lesson 1.

We will start with a brief overview of the Medicare program, what is Medicare, the options people with Medicare have on how they receive their health care services, who is eligible, and how to apply for Medicare.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare

- Health insurance for people
 - Age 65 and older
 - Under age 65 with certain disabilities
 - Any age with End-Stage Renal Disease (ESRD)
- Administered by
 - Centers for Medicare & Medicaid Services (CMS)
- Enroll through
 - Social Security or
 - Railroad Retirement Board (RRB)

4/22/2008

5

Medicare is health insurance for people:

- Age 65 and older
- Under age 65 with certain disabilities (who have been receiving Social Security disability benefits for a certain amount of time—24 months in most cases). The 24-month Medicare waiting period does not apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, known as Lou Gehrig’s Disease). People with ALS get Medicare the first month they are entitled to disability benefits. This provision became effective on July 1, 2001.
- Of any age who have End-Stage Renal Disease (ESRD; permanent kidney failure requiring dialysis or a transplant).

President Lyndon Johnson signed the Medicare and Medicaid programs into law July 30, 1965. Medicaid became effective January 1, 1966, and Medicare became effective July 1, 1966. Medicare is the nation’s largest health insurance program, currently covering about 44 million Americans.

While Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), Social Security is responsible for enrolling most people in Medicare. The Railroad Retirement Board (RRB) is responsible for enrolling railroad retirees.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare

- Medicare has
 - Part A – Hospital insurance
 - Part B – Medical insurance
 - Part C – Medicare Advantage Plans
 - Part D – Prescription drug coverage
- You have choices in how you get your Medicare health and drug coverage

4/22/2008

6

Medicare covers many types of services, and people have options for how they can get their Medicare coverage. Medicare has Part A, which is hospital coverage; Part B, which is medical coverage; Part C, private insurance plans that provide Medicare coverage, such as Health Maintenance Organizations (HMO) and Preferred Provider Organization (PPO); and Part D, which covers outpatient prescription drugs. Medicare gives you choices in how you get your health and prescription drug coverage. We'll discuss your Medicare plan options in more detail during Lesson 2.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Original Medicare

- Red, white, and blue Medicare card
- Part A and/or Part B
- Go to any provider that accepts Medicare
- You pay
 - Part B premium
 - Part A free for most people
 - Deductibles
 - Coinsurance or copayments

4/22/2008

7

Original Medicare is one of the choices in the Medicare program. You will be in Original Medicare unless you choose to join a Medicare Advantage Plan or other Medicare plan. Original Medicare is a fee-for-service program that is managed by the Federal Government.

When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care. If you have Medicare Part A, you get all the Part A-covered services, and if you have Medicare Part B, you get all the Part B-covered services. As we mentioned earlier, Part A (hospital insurance) is premium-free for most people. For Medicare Part B (medical insurance) you pay a monthly premium (\$96.40 in 2008 for most people). With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.

In Original Medicare, you also pay deductibles and coinsurance or copayments. After you receive health care services, you get a letter in the mail showing what was covered, called a Medicare

Summary Notice (MSN). This notice lists the services you received, what was charged, what Medicare paid, and how much you may be billed. If you disagree with the information on the MSN or with any bill you receive, you can file an appeal. There is information on the MSN about how to ask for an appeal.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Card (front)

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER SEX
000-00-0000-A FEMALE

IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986

SIGN HERE → Jane Doe

4/22/2008

8

This slide shows a sample of a red, white, and blue Medicare card. The Medicare card shows the Medicare coverage (Part A hospital coverage and/or Part B medical coverage) and the date the coverage starts. Note: Your card may look slightly different from this one; it's still valid.

The Medicare card also shows your Medicare claim number. For most people, the claim number has 9 numerals and 1 letter. There also may be a number or another letter after the first letter. The 9 numerals show which Social Security record your Medicare is based on. The letter or letters and numbers tell how you are related to the person with that record. For example, if you get Medicare on your own Social Security record, you might have the letter "A," "T," or "M" depending on whether you get both Medicare and Social Security benefits or Medicare only. If you get Medicare on your spouse's record, the letter might be a B or a D. For railroad retirees, there are numbers and letters in front of the Social Security number. These letters and numbers have

nothing to do with having Medicare Part A or Part B.

Your use of the Medicare card will differ depending on the type of Medicare health plan option you choose. If you choose Original Medicare, you will use the red, white, and blue Medicare card when obtaining health care. If you choose another Medicare health plan, your plan may give you a card to use when you get health care services and supplies. If any information on the card is incorrect, you should contact the Social Security Administration, or the Railroad Retirement Board if you receive railroad retirement benefits.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Applying for Medicare

- Apply 3 months before age 65
 - Need not be retired
- Automatically enrolled if receiving Social Security or Railroad Retirement benefits
 - If not receiving benefits, apply 3 months before age 65
 - Call SSA at 1-800-772-1213
 - TTY users call 1-800-325-0778

4/22/2008

9

SSA advises people to apply for Medicare benefits 3 months before age 65. If you meet all the requirements, SSA will enroll you in Medicare starting the first day of the month you become age 65. You don't have to be retired to enroll in Medicare. Except for people with certain disabilities or ESRD, Medicare benefits can begin no earlier than the month you turn 65.*

If you are already receiving Social Security benefits, you will be automatically enrolled in Medicare without an additional application. You will receive a welcome to Medicare package, which includes your Medicare card and other information about 3 months before age 65 or your 25th month of disability benefits.

(NOTE: People with ALS—Amyotrophic Lateral Sclerosis, or Lou Gehrig's disease—automatically get Part A the month their disability benefits begin.)

If you are not already getting benefits, you should call SSA at 1-800-772-1213 3

months before your 65th birthday, even if you plan to continue working. (TTY users should call 1-800-325-0778.)

***(NOTE:** If your birthday falls on the first day of a month, you are eligible for Medicare beginning the first day of the previous month.)

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Part A & B

Lesson 2 Topics

- Applying for Medicare Part A and Part B
- Paying Part A & B premiums
- Coverage services and cost
- Assignment and private contract
- Medigap (Medicare Supplement Insurance)

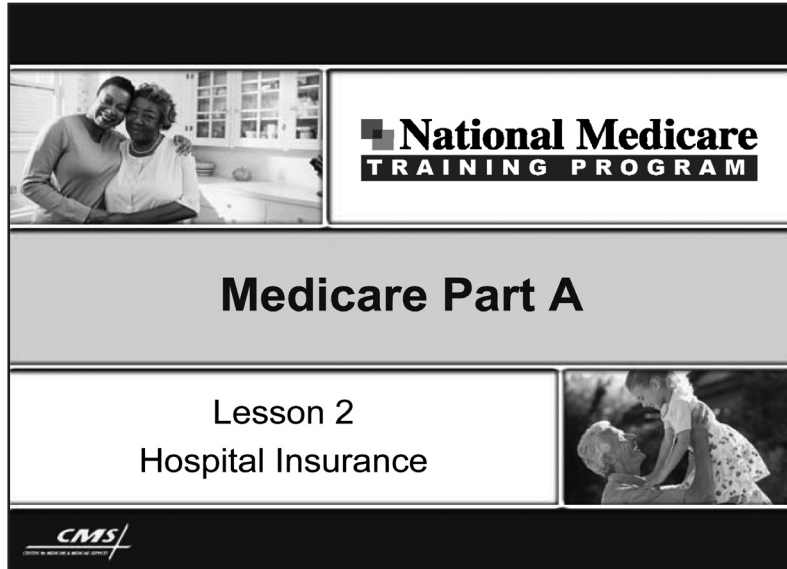
4/22/2008

10

Let's look at the topics we'll cover in Lesson 2. During this lesson we will learn about applying for Medicare Part A and B and associated premiums. We will go over the benefits covered under Part A and Part B and your cost for the actual services. Then we'll cover, what it means when a doctor accepts "assignment," private contracts, and what Medigap, or Medicare Supplement Insurance, is and how it works.

*My Health.
My Medicare.*

Module 1: Understanding Medicare



Lets begin lesson 2 by learning everything about Medicare Part A, hospital insurance.

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Part A

- Most people receive Part A premium free
- People with less than 10 years of Medicare-covered employment
 - Can pay a premium to get Part A
- For information, call SSA
 - 1-800-772-1213
 - TTY users call 1-800-325-0778

4/22/2008

12

Most people don't have to pay a monthly payment (premium) for Medicare Part A because they or their spouse paid Medicare or FICA taxes while they were working. (FICA stands for Federal Insurance Contributions Act. It's the tax withheld from your paycheck, or that you pay based on your self-employment income, that funds the Social Security and Medicare programs.)

If you or your spouse did not pay Medicare taxes while you were working, or if you or your spouse did not work long enough (10 years in most cases) in Medicare-covered employment to qualify for premium-free Medicare Part A, you may still be able to get Medicare Part A. However, you will have to pay a monthly premium. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.

If you worked for less than 7½ years in Medicare-covered employment, you will pay a higher premium than if you worked between 7½ years and 10 years in Medicare-covered employment. SSA will

determine if you have to pay a premium for Part A.

For **2008**, the premium amounts are **\$423 per month** for those who have not worked at least 7½ years, and \$233 per month for those who have worked at least 7½ years but not as long as 10 years.

For information on Medicare Part A entitlement, enrollment, or premiums, call SSA at 1-800-772-1213. TTY users should call 1-800-325-0778.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Part A Helps Pay for

- Hospital inpatient care
- Skilled nursing facility (SNF) care
- Home health care
- Hospice care
- Blood

4/22/2008

13

Medicare Part A, hospital insurance, helps pay for

- Hospital inpatient care
- Skilled nursing facility (SNF) care (not custodial or long-term care)
- Some home health care
- Hospice care
- Blood

For more information about Part A coverage and services, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

(NOTE: Part A may also help cover inpatient care in a Religious Non-medical Health Care Institution (RNHCI), which is a facility that provides non-medical health care to people for whom the acceptance of medical services would be inconsistent with their religious beliefs.)

Section 1821 of the Social Security Act provides for coverage of services furnished in a Medicare qualified RNHCI, when the beneficiary meets specific coverage conditions. The beneficiary

must have a valid election for RNHCI services and would otherwise qualify for care in a conventional hospital or post hospital extended care facility that was not an RNHCI.

The RNHCI benefit provides only for Part A inpatient services. The program does not pay for supporting religious services or payment for the religious practitioner. The cost of religious items/services and the cost of using a religious practitioner is a personal financial responsibility and not covered by Medicare.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Part A

- Charges based on “benefit period”
 - Inpatient hospital care and SNF services
 - Begins day admitted to hospital
 - Ends when no care received in a hospital or SNF for 60 days in a row
 - You pay deductible for each benefit period
 - No limit to number of benefit periods

4/22/2008

14

Let’s look at what you will pay for hospital stays.

First, we need to understand what a benefit period is. A benefit period refers to the way Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you are admitted to a hospital as an inpatient. The benefit period ends when you have not received Medicare-reimbursed hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins.

You must pay the inpatient hospital deductible (\$1,024 in 2008) for each benefit period.

There is no limit to the number of benefit periods you can have.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Inpatient Hospital Stays

- Covered services
 - Semi-private room
 - Meals
 - General nursing
 - Other hospital services and supplies
- Includes care in critical access hospitals
- 190-day limit for inpatient mental health care in a lifetime

4/22/2008

15

Covered services for hospital inpatients include the following:

- Semi-private room
- Meals
- General nursing
- Other hospital services and supplies

This includes inpatient care you get in acute care hospitals; in critical access hospitals (small facilities that give limited services to people in rural areas); as part of a clinical research study; and mental health care.

- Inpatient mental health care coverage in an independent psychiatric hospital is limited to 190 days in a lifetime

Coverage does not include:

- Private duty nursing
- Television or telephone in your room if there are separate charges for these items
- Private room unless medically necessary

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Paying for Hospital Stays

- For inpatient stays in 2008 you pay
 - \$1,024 total deductible for days 1 – 60
 - \$256 co-payment per day for days 61 – 90
 - \$512 co-payment per day for days 91 – 150 (60 lifetime reserve days)
 - All costs for each day beyond 150 days

4/22/2008

16

For inpatient hospital stays in 2008 you pay

- A total of \$1,024 for days 1 – 60 each benefit period (the hospital deductible)
- \$256 co-payment per day for days 61 – 90 each benefit period
- \$512 co-payment per day for days 91 – 150 of a hospital stay. Original Medicare will pay for a total of 60 extra days—called “lifetime reserve days”—when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don’t get any more extra days during your lifetime.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Skilled Nursing Facility Coverage

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation
- Dietary counseling

4/22/2008

18

If you qualify, Medicare will cover the following SNF services:

- Semi-private room (a room you share with one other person)
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy (if needed to meet your health goal)
- Medical social services
- Medications, and medical supplies/equipment used in the facility
- Ambulance transportation, when other transportation endangers health, to the nearest supplier of needed services that are not available at the SNF
- Dietary counseling

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Paying for Skilled Nursing Facility Care

- For each benefit period in 2008 you pay
 - \$0 for days 1 – 20:
 - \$128 per day for days 21 – 100
 - All costs after 100 days
- Must meet requirements for Medicare-covered stay
 - Does NOT include custodial care

4/22/2008

19

Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay. Under Original Medicare, for days 21 – 100, SNF care is covered except for coinsurance of up to \$128 per day in 2008. After 100 days, Medicare Part A no longer covers SNF care.

You can qualify for skilled nursing care again every time you have a new benefit period.

Keep in mind that skilled nursing care is different from nursing home care. Most nursing home care is custodial or non-skilled care, such as help with dressing, bathing, eating, or other activities of daily living, which are not covered by Medicare.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Home Health Care

- For as long as you are eligible
 - Limited hours per day
 - Limited days per week
- Four conditions
 - Doctor must make a plan for your care at home
 - Must need specific skilled services
 - Must be homebound
 - Home health agency must be Medicare-approved

4/22/2008

20

Medicare Part A pays for your home health services for as long as you are eligible and your doctor says you need these services. (Part B also may pay for home health care under certain conditions.) However, there are limits on the number of hours per day and days per week that you can get skilled nursing or home health aide services.

To be eligible, you must meet four conditions:

1. Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
2. You must need at least one of the following services: intermittent (not full-time) skilled nursing care, physical therapy, speech language pathology services, or continue to need occupational therapy.
3. You must be homebound, which means that you are normally unable to leave home or that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care (may include adult day care) or attend a religious service.

4. The home health agency caring for you must be approved by Medicare.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Home Health Care

- Covered services
 - Part-time/intermittent skilled nursing care
 - Therapy
 - Physical
 - Occupational
 - Speech-language
 - Medical social services
 - Some home health aide services
 - Durable medical equipment, supplies

4/22/2008

21

Home health care is limited to reasonable and necessary part-time or intermittent skilled care or continuing need for physical therapy, occupational therapy, or speech-language pathology ordered by the doctor and provided by a Medicare-certified home health agency. Home health services may also include medical social services, home health aide services or other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), and medical supplies for use at home.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Paying for Home Health Care

- In Original Medicare you pay
 - Nothing for covered home health care services
 - 20% of the Medicare-approved amount for covered durable medical equipment

4/22/2008

22

If you qualify, home health care is fully covered by Medicare for each 60-day period that you need care (called an episode of care). Your doctor and home health agency staff review your plan of care at least once every 60 days. You will continue to get home health care for as long as you are eligible.

486-2048. To find a home health agency in your area, call 1-800-MEDICARE or visit www.medicare.gov and use the Home Health Compare tool.

In Original Medicare, you pay:

- Nothing for covered home health care services provided by a Medicare-approved home health agency
- 20% of the Medicare-approved amount for an assigned durable medical equipment claim. If the claim is non-assigned, the person with Medicare is responsible for whatever the durable medical equipment supplier charges over and above the Medicare-approved amount. (We will discuss **assignment** in just a few minutes.)

If you have questions about home health care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Hospice

- Special care for terminally ill and family
 - Expected to live 6 months or less
- Focuses on comfort, not on curing the illness
- Doctor must certify for each “period of care”
 - Two 90-day periods
 - Unlimited 60-day periods
- Hospice provider must be Medicare-approved

4/22/2008

23

Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.

You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than 6 months to live if the disease runs its normal course. Care is given in “periods of care”—two 90-day periods followed by unlimited 60-day periods.

At the start of each period of care, your doctor must certify that you are terminally ill for you to continue getting hospice care. Medicare must approve the hospice care provider.

Hospice care is usually given in your home (or a

facility you live in). However, Medicare also covers short-term hospital care as well as inpatient respite care when needed, which we will discuss on the next slide.

The Medicare Modernization Act authorizes CMS to conduct a Hospice Demonstration project, to test the benefits of providing hospice services **in a hospice facility** to people in rural areas who are unable to receive hospice care at home for lack of an appropriate caregiver.

You must sign a statement choosing hospice care instead of routine Medicare covered benefits to treat your terminal illness. However, medical services not related to the hospice condition would still be covered by Medicare.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Covered Hospice Services

- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care
- Respite care in a Medicare-certified facility
 - Up to 5 days each time
 - No limit to number of times
- Home health aide and homemaker services
- Social worker services
- Dietary counseling
- Grief counseling

4/22/2008

24


The hospice benefit covers many services that are out of the ordinary. In addition to the regular Medicare-covered services such as doctor and nursing care, physical and occupational therapy, and speech therapy, the hospice benefit also covers:

- Medical equipment
(such as wheelchairs or walkers)
- Medical supplies
(such as bandages and catheters)
- Drugs for symptom control and pain relief
- Short-term care in the hospital when needed for pain and symptom management
- Inpatient respite care, which is care given to a hospice patient by another caregiver, so the usual caregiver can rest. You will be cared for in a Medicare-approved facility, such as a hospice residential facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there is no limit to the number of times you can get respite care.
- Home health aide and homemaker services

- Social worker services
- Dietary counseling
- Counseling to help you and your family with grief and loss

*My Health.
My Medicare.*


Module 1: Understanding Medicare



**National Medicare
TRAINING PROGRAM**

Medicare Part B

Lesson 2
Medical Insurance



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Now that we know all about Medicare Part A,
lets look at Medicare Part B, medical insurance.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Enrolling in Medicare Part B

- General Enrollment Period (GEP)
 - January 1 through March 31 each year
 - Coverage effective July 1
 - Premium increases 10% for each 12-month period you were eligible but did not enroll
 - Pay this penalty as long as you have Part B
 - Limited exceptions
- Special Enrollment Period
 - Sign up within 8 months of the end of employer or union health plan coverage
 - No increased premium

4/22/2008

28

If you do not choose Part B when you are first eligible at age 65, you may sign up during a General Enrollment Period (GEP). This period runs from January 1 through March 31 of each year, with coverage effective July 1 of that year. However, the cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases. In most cases, you will have to pay this penalty for as long as you have Part B.

If you didn't take Part B when you were first eligible because you or your spouse was working and you had group health coverage through your or your spouse's employer or union, you can wait to sign up for Part B during a Special Enrollment Period. People who sign up for Part B during a Special Enrollment Period do not pay higher premiums. You can sign up:

- Any time you are still covered by the employer or union group health plan through your or your spouse's current or active employment

OR

- During the 8 months following the month when the employer or union group health plan coverage ends, or when the employment ends (whichever is first)

Call SSA at 1-800-772-1213 if you have questions about the date to enroll or the amount of your premiums. TTY users should call 1-800-325-0778. If you will be getting benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

(NOTE: People who have to pay a premium for Part A can also sign up for Part A during their Initial Enrollment Period, the General Enrollment Period, or a Special Enrollment Period.)

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Paying the Part B Premium

- Most people pay \$96.40 monthly in 2008

If Your Yearly Income is		You pay
File Individual Tax Return	File Joint Tax Return	
\$82,000 or less	\$164,000 or less	\$96.40
\$82,001-\$102,000	\$164,001-\$204,000	\$122.20
\$102,001-\$153,000	\$204,001-\$306,000	\$160.90
\$153,001-\$205,000	\$306,001-\$410,000	\$199.70
Above \$205,000	Above \$410,000	\$238.40

4/22/2008

29

People generally pay a monthly premium for Medicare Part B. For most people, the Part B premium is \$96.40 in 2008. If you can't afford to pay the Part B premium, there are programs that may help, which will be discussed later in this module.

Some people with higher annual incomes pay a higher Part B premium. These amounts can change each year. In 2008, if the modified adjusted gross income for an individual is:

- \$82,001 - \$102,000, the Part B premium is \$122.20 per month
- \$102,001 - \$153,000, the Part B premium is \$160.90 per month
- \$153,001 - \$205,000, the Part B premium is \$199.70 per month
- Greater than \$205,000, the Part B premium is \$238.40 per month

The income ranges for joint returns are double that of individual returns. Social Security uses

the income reported on your most recent tax return to determine the Part B premium. For example, the income reported on a 2006 tax return filed in 2007 is used to determine the monthly Part B premium in 2008. Contact Social Security if you filed an amended return or your income has gone down. For more information about premiums based on income, call Social Security at 1-800-772-1213.

Remember that this premium may be higher if you did not choose Part B when you first became eligible. The cost of Medicare Part B may go up 10% for each 12-month period that you could have had Part B but did not take it. An exception would be if you or your spouse is still employed and you are covered by a group health plan through that employment. In that case, you could delay enrolling in Part B without a penalty.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Paying the Medicare Part B Premium

- Taken out of your monthly payment
 - Social Security
 - Railroad Retirement
 - Federal Government retirement
- For information about premiums
 - Call SSA or RRB
 - OPM if a retired Federal employee
- May be billed every 3 months
- Medicare Easy Pay
- Programs available to help

4/22/2008

30

If you choose to have Medicare Part B, the premium is automatically taken out of your monthly Social Security or Railroad Retirement payment. If you are a Federal Government retiree, you may be able to have the premium deducted from your retirement check.

For information about your Medicare Part B premiums, call the agency that enrolled you in Medicare, or call the Office of Personnel Management if you are a retired Federal employee.

If you do not get any of the above payments, Medicare sends you a bill for your Medicare Part B premium every 3 months. You may pay your bill by credit card, check, or money order. You may also elect to have your Part B premium automatically deducted from your bank account using the Easy Pay option. (You may also use Easy Pay if you pay a premium for Part A.) You can contact 1-800-MEDICARE (1-800-633-4227) and request a Medicare Easy Pay Authorization Form. TTY users should call 1-877-486-2048.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Part B Coverage

- Doctors' services
- Outpatient medical and surgical services and supplies
- Diagnostic tests
- Outpatient therapy
- Outpatient mental health services
- Some preventive health care services
- Other medical services

4/22/2008

31

We have just reviewed the services covered by Medicare Part A. Now let's talk about Part B.

Medicare Part B helps pay for doctors' services, outpatient hospital care, medical supplies, and some other medical services that Medicare Part A does not cover, such as the services of physical, occupational, and speech therapists in an outpatient setting, and some home health care. Part B also covers outpatient mental health care.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Part B Coverage

- Clinical laboratory tests
- Home health services
- Durable medical equipment
- Outpatient hospital services
- Blood
- Ambulance service
 - If other transportation would endanger your health

4/22/2008

32

Other services covered by Medicare Part B include, but are not limited to, the following:

- Clinical laboratory services (blood tests, urinalysis, and more)
- Home health services (part-time skilled care, home health aide services)
- Durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services
- Outpatient hospital services for the diagnosis or treatment of an illness or injury
- Blood (pints of blood needed as an outpatient or as part of a medical service covered by Medicare Part B, after the first 3 pints)
- Ambulance service, when other transportation would endanger your health. (For more information on coverage, payment, and rights and protection issues related to ambulance services, get a copy of Medicare Coverage of Ambulance Services, CMS Pub. No. 11021, by visiting www.medicare.gov on the web.)

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

- Acupuncture
- Dental care and dentures (with only a few exceptions)
- Cosmetic surgery
- Health care while traveling outside the U.S. (except in limited cases)
- Hearing aids
- Eye care (routine exam), eye refractions, and most eyeglasses
- Long-term care, such as custodial care in a nursing home

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Covered Preventive Services

- “Welcome to Medicare” physical exam
- Abdominal aortic aneurysm screening
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- Glaucoma tests
- Mammograms (screening)
- Pap test/pelvic exam/clinical breast exam
- Prostate cancer screening
- Flu shots
- Pneumococcal shots
- Hepatitis B shots
- Smoking cessation

4/22/2008

33

Medicare Part B also covers preventive services like exams, lab tests, and screening shots to help prevent, find, or manage a medical problem. Preventive services may find health problems early when treatment works best. Talk to your doctor about which preventive services you need and if you meet the criteria for coverage. The *Medicare & You* handbook includes guidelines for who is covered and how often Medicare will pay for these services.

Currently Medicare helps pay for:

- “Welcome to Medicare” physical exam (one-time review of your health, as well as education and counseling about the preventive services you need. To be covered, you must have the physical exam within the first 6 months you have Medicare Part B.)
- Abdominal aortic aneurysm screening (new in 2007)
- Bone mass measurement
- Cardiovascular disease screenings

- Colorectal cancer screenings
- Diabetes screenings
- Glaucoma tests
- Screening mammograms
- Pap test and pelvic exam (includes clinical breast examination)
- Prostate cancer screening
- Three kinds of vaccinations (shots)—for influenza, pneumococcal pneumonia, and Hepatitis B
- Smoking cessation (counseling to stop smoking)

These services are discussed in depth in Module 7.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Paying for Part B Services

- In Original Medicare you pay
 - Yearly deductible
 - \$135 in 2008
 - 20% coinsurance for most services
 - Some copayments
- Some programs may help

4/22/2008

34

If you are in Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. For 2008, the amount is \$135. This means that you must pay the first \$135 of your Medicare-approved medical bills in 2008 before Medicare Part B starts to pay for your care. In addition, a person who needs blood must pay for the first three pints.

You also pay some copayments or coinsurance for Part B services. The amount depends upon the service, but is 20% in most cases.

If you can't afford to pay these costs, there are programs that may help, which will be discussed later in this module.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Assignment

- Agreement between
 - People with Medicare
 - Doctors and other health care suppliers and
 - Medicare
- Applies to Original Medicare Part B Claims

4/22/2008

35

To understand Original Medicare, it is important to define the term “assignment.” Assignment is an agreement between people with Medicare, doctors and other health care suppliers or providers, and Medicare. It is important to know that the assignment provision only applies to Medicare Part B claims.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Accepts Assignment

- Providers agree to
 - Be paid by Medicare
 - Get only the amount Medicare approves for their services
 - Only charge the Medicare deductible and/or coinsurance amount

4/22/2008

36

Doctors or providers who accept assignment from Medicare agree to be paid by Medicare and agree to get only the amount Medicare approves for their services. Providers who accept assignment can only charge people with Medicare, or any other insurance they have, the Medicare deductible and/or coinsurance amount.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Does NOT Accept Assignment

- May charge more than Medicare-approved amount
 - Limit of 15% more for most services
 - Called “the limiting charge”
- May ask you to pay entire charge at time of service
- In some cases, providers must accept assignment
 - Some examples
 - Medicare Part B-covered prescription drugs
 - Ambulance providers

4/22/2008

37

If a doctor, other health care supplier, or provider doesn't agree to accept assignment, he or she may charge you more than the Medicare-approved amount. For most services, there is a limit to how much over the Medicare-approved amount your doctors and providers can bill you. The highest amount of money you can be charged for a Medicare-covered service by doctors and other providers who don't accept assignment is called the limiting charge. The limiting charge is 15% over the Medicare-approved amount.

The limiting charge applies only to certain services and doesn't apply to medical supplies and durable medical equipment.

In addition, you may have to pay the entire charge at the time of service. Medicare will send you its share of the charge when the claim is processed.

In some cases, your health care providers and suppliers must accept assignment. For example,

if you get Medicare Part B-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare program, the pharmacy or supplier must accept assignment. Medicare-covered ambulance services must also be assigned claims.

Caution: If you get your Medicare Part B-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, you may have to file your own claim for Medicare to pay. Doctors and other providers generally have to submit your claim to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can't charge you for this service.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Private Contracts

- Individual agreement between you and your doctor
 - Original Medicare will not pay
 - Medigap will not pay
 - Other Medicare plans will not pay
 - You will pay charges
 - No claim should be submitted
 - Cannot be asked to sign in an emergency

4/22/2008

38

A private contract is an agreement between you and a doctor who has decided **not** to give services through the Medicare program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medigap (Medicare Supplement Insurance) will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.

If you sign a contract with your doctor:

- No Medicare payment will be made for the services you get from this doctor.
- Your Medigap policy, if you have one, will not pay anything for this service. (Call your insurance company before you get the service.)
- You will have to pay whatever this doctor or provider charges you. (The Medicare limiting charge will not apply.)

- Other Medicare plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- Many other insurance plans will not pay for the service either.
- The doctor cannot bill Medicare for any services for people with Medicare for 2 years.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

What Is Medigap?

- Health insurance policies
 - Sold by private insurance companies
 - Follow Federal and state laws that protect you
 - Must say “Medicare Supplement Insurance”
 - Cover “gaps” in Original Medicare
 - Sold as standardized policies, plans A – L
 - Except in Minnesota, Massachusetts, Wisconsin
 - Costs may vary by
 - Plan, company, where you live

4/22/2008

39

What is a Medigap policy? Original Medicare pays for many health care services and supplies, but it doesn't pay all of your health care costs. There are costs that you must pay, like coinsurance, copayments, and deductibles. These costs are sometimes called “gaps” in Medicare coverage. A Medigap policy is a health insurance policy sold by a private insurance company to fill the “gaps” in Original Medicare coverage. The companies must follow Federal and state laws that protect people with Medicare.

The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.” In all states except Minnesota, Massachusetts, and Wisconsin, any new Medigap policy sold must be one of 12 standardized plans, A through L. The **benefits** in any Medigap Plan A through L are the same for any insurance company. For example, the benefits in one insurance company's Medigap Plan C are the same as any other insurance company's Medigap Plan C. **However, there can be big differences in the premiums**

different insurance companies charge for exactly the same coverage. Insurance companies are not required to sell Medigap policies for all 12 plans.

(**NOTE:** Some people may still have a Medigap policy they bought before Medigap policies were standardized.)

When you buy a Medigap policy, you pay a **premium** to the Medigap insurance company. As long as you pay your Medigap premium, a policy bought after 1990 is automatically renewed each year. This means that your coverage continues year after year as long as you pay your premium; we say your policy is **guaranteed renewable**. You still must pay your monthly Medicare Part B premium. In some states, insurance companies may legally refuse to renew Medigap policies that were bought before 1990.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

How Medigap Works

- Only works with Original Medicare
 - Don't need Medigap if in MA Plan or other Medicare plans
- Can go to any doctor, hospital, or provider that accepts Medicare
 - Except with a Medicare SELECT policy
- You pay a monthly premium

4/22/2008

40

A Medigap policy only works with Original Medicare. If you are in a Medicare Advantage Plan or other Medicare plan, you may not want a Medigap policy. Medigap policies won't work with Medicare Advantage Plans or other Medicare plans. In fact, it is illegal for anyone to sell you a Medigap policy if you:

- Are in a Medicare Advantage Plan (unless your enrollment is ending),
- Have Medicaid (unless Medicaid pays for your Medigap policy or only pays your Medicare Part B premium), or
- Already have a Medigap policy (unless you are canceling your old Medigap policy).

If you have a Medigap policy and you join a Medicare Advantage Plan or other Medicare plan, you may want to drop your Medigap policy. Even though you are entitled to keep it, it can't pay for benefits that you get under your Medicare Advantage Plan or other Medicare plan and can't pay any cost-sharing under these plans.

If you are in Original Medicare and you have a Medigap policy, you can go to any doctor, hospital, or other health care provider that accepts Medicare. However, if you have a type of Medigap policy called **Medicare SELECT**, you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits.

*My Health.
My Medicare.*

Exercise

Exercise

1. The Centers for Medicaid & Medicaid Services is responsible for enrolling most people in Medicare.
A. True
B. False

4/22/2008

41

1. The Centers for Medicaid & Medicaid Services is responsible for enrolling most people in Medicare.
A. True
B. False

NOTES:

ANSWER: B. False - Social Security is responsible for enrolling most people in Medicare.

*My Health.
My Medicare.*

Exercise

Exercise

2. Most people receive Part A premium free.
- A. True
 - B. False

4/22/2008

42

2. Most people receive Part A premium free.
- A. True
 - B. False

NOTES:

Answer: A. True

*My Health.
My Medicare.*

Exercise

Exercise

3. The Part B premium for most people is \$96.40 in 2008.

- A. True
- B. False

4/22/2008

43

3. The Part B premium for most people is \$96.40 in 2008.

- A. True
- B. False

NOTES:

ANSWER: A. True

*My Health.
My Medicare.*

Exercise

Exercise

4. "Assignment" is an agreement between people with Medicare, doctors and other health care suppliers or providers, and Medicare.
- A. True
 - B. False

4/22/2008

44

4. "Assignment" is an agreement between people with Medicare, doctors and other health care suppliers or providers, and Medicare.
- A. True
 - B. False

NOTES:

Answer: A. True

*My Health.
My Medicare.*

Exercise

Exercise

5. Providers who don't accept "assignment" may charge as much as they wish.
- A. True
 - B. False

4/22/2008

45

5. Providers who don't accept "assignment" may charge as much as they wish.
- A. True
 - B. False

NOTES:

ANSWER: B. False - The highest amount of money you can be charged for a Medicare-covered service by providers who don't accept assignment is 15% over the Medicare-approved amount, called the limiting charge. The limiting charge doesn't apply to medical supplies and durable medical equipment.

*My Health.
My Medicare.*

Exercise

You're the counselor...



Eric and Sandy are in your office. Their mother is about to turn 65 and she is planning to retire when she turns 67. She is working full-time and has health insurance through her current employer. They want to find out if she needs to enroll in Medicare now, and what are her options. Discuss the Medicare eligibility requirements and the enrollment periods.

4/22/2008

46

Discussion should include the following points:

Even though she is still working, Sandy and Eric's mother should enroll in Part A when she is first eligible, 3 months prior to turning 65. Remember most people don't have to pay a monthly payment (premium) for Medicare Part A because they or their spouse paid Medicare or FICA taxes while they were working.

Enrollment in Medicare Part B is optional. Since Sandy and Eric's mother is currently working and has a group health coverage through her employer, she can wait to sign up for Part B during a Special Enrollment Period. People who sign up for Part B during a Special Enrollment Period do not pay higher premiums. She can sign up:

- Any time she is still covered by the employer or union group health plan through her current or active employment OR
- During the 8 months following the month when the employer or union group health plan coverage ends, or when the employment ends (whichever is first)

*My Health.
My Medicare.*

Exercise

You're the counselor...



David has called you to see if you can help him understand some information he received in the mail about a Medigap policy. He will be eligible for Medicare next month. Discuss what Medigap is and how it works.

4/22/2008

47

Discussion should include the following points:

- Medigap is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare, like coinsurance, copayments, and deductibles.
- Medigap policies are sold as standardized plans A through L in all states except Minnesota, Massachusetts, and Wisconsin. The standardized Medigap policies must provide the same benefits, e.g., a Medigap Plan A policy always provides the same benefits.
- When you buy a Medigap policy, you pay a premium to the Medigap insurance company, and you still must pay your monthly Medicare Part B premium. As long as you pay your Medigap premium, a policy bought after 1990 is automatically renewed each year.
- A Medigap policy only works with Original Medicare, not with a Medicare Advantage Plan or other Medicare plan.
- If you have Original Medicare and a Medigap policy, you can go to any doctor, hospital, or other health care provider that accepts Medicare. (This is true unless you have a Medicare SELECT policy, in which case you must use specific hospitals or doctors to get full benefits.)

*My Health.
My Medicare.*

Module 1: Understanding Medicare



Lesson 3, *Understanding Medicare*, provides more information on Medicare Advantage Plans and other Medicare plans.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Advantage Plans *Lesson 3 Topics*

- What are Medicare Advantage Plans and other Medicare plans
- Who can join
- How to join and switch
- How plans work
- Your out-of-pocket costs

4/22/2008

49

During this lesson we will cover:

- What are Medicare Advantage Plans and other Medicare plans
- Who can join these plans
- Opportunities to join and switch plans
- How the plans work
- Your out-of-pocket costs

NOTE: In this lesson, when we use the term “Medicare Advantage Plans,” we mean those with and without prescription drug coverage. Unless we state otherwise, we also intend the term to include other Medicare plans. (We will not include Original Medicare or stand-alone Medicare Prescription Drug Plans.)

*My Health.
My Medicare.*

Module 1: Understanding Medicare

What Are Medicare Advantage Plans?

- Health plan options approved by Medicare
- Run by private companies
- Part of the Medicare program
 - Sometimes called “Part C”

4/22/2008

50

Medicare Advantage Plans are health plan options that are approved by Medicare and run by private companies. They are part of the Medicare program, and are sometimes called “Part C.”

Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays a set amount of money to these private health plans for their members’ health care.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- Medicare Medical Savings Account (MSA)

4/22/2008

51

There are five main types of Medicare Advantage Plans:

- **Medicare Health Maintenance Organizations (HMO) Plans**—managed care plans that cover all Part A and B services and may provide extra services. You can generally only go to doctors, specialists, or hospitals that are part of the plan’s network, except in an emergency.
- **Medicare Preferred Provider Organization (PPO) Plans**—similar to an HMO plan, but members can see any doctor or provider that accepts Medicare, and they don’t need a referral to see a specialist. Going to a provider that isn’t part of the plan’s network will usually cost more.
- **Medicare Special Needs Plans (SNP)**—membership is limited to certain groups of people, such as those in certain institutions (like a nursing home), those eligible for both Medicare and Medicaid, or those with certain chronic or disabling conditions.

- **Medicare Private Fee-for-Service (PFFS) Plans**—members can go to any provider that accepts the plan’s terms, and may get extra benefits. The private company decides how much it will pay and how much members pay for services.
- **Medicare Medical Savings Account (MSA) Plans**—similar to Health Savings Account plans available outside of Medicare, and they have two parts.

The first part is a Medicare Advantage Health Plan with a high deductible. This health plan won’t begin to pay covered costs until you have met the annual deductible, which varies by plan.

The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Other Medicare Plans

- Medicare Cost Plans
- Demonstrations/Pilot Programs
- Programs of All-inclusive Care for the Elderly (PACE)

4/22/2008

52

There are three other types of other Medicare health plans:

- Medicare Cost Plans—similar to an HMO, but services received outside the plan are covered under Original Medicare
- Demonstrations and pilot programs—special projects that test possible future improvements in Medicare coverage, costs, and quality of care, and
- PACE (Programs of All-inclusive Care for the Elderly)—combine medical, social, and long-term care services for frail elderly people, those who are eligible for both Medicare and Medicaid.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

When Can You Switch?

- Annual Election Period
- Medicare Advantage Open Enrollment Period
- Special Enrollment Periods
 - Move from the plan service area and cannot stay in the plan
 - Plan leaves Medicare program
 - Other special situations

4/22/2008

55

A person can switch to another Medicare Advantage Plan or to Original Medicare:

- During the Annual Election Period
- During the Medicare Advantage Open Enrollment Period
- Under special circumstances that grant a Special Enrollment Period. For example, if a person moves out of the plan's service area, or if the plan decides to leave the Medicare program or reduce its service area at the end of the year, there are special rules that allow for enrollment in a different Medicare Advantage Plan, or Original Medicare and a Medigap policy.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

How MA Plans Work

- Get Medicare-covered services through the plan
- Can include prescription drug coverage
- May have to see certain doctors or go to certain hospitals to get care
- Benefits and cost-sharing may be different than in Original Medicare

4/22/2008

56

Let's talk more about how Medicare Advantage Plans work.

In most Medicare Advantage Plans, you generally get all your Medicare-covered health care through that plan. Some plans also include Medicare prescription drug coverage. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. In some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals. Benefits and costsharing in a Medicare Advantage Plan may be different than in Original Medicare.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Out-of-Pocket Costs

- Generally must still pay Part B premium
 - Some plans may pay all or part
- May pay additional monthly premium
- Pay other out-of-pocket costs
 - Different from Original Medicare
 - Vary from plan to plan

4/22/2008

57

If you join a Medicare Advantage Plan, it's important to know:

- You must continue to pay the monthly Medicare Part B premium (\$96.40 in 2008 for most people). However, some Medicare Advantage Plans may offer an additional benefit by reducing the amount members pay for their Medicare Part B premiums.
- You may pay an additional monthly premium to the plan.
- You will have to pay other costs (such as copayments or coinsurance) for the services you get.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

In a Medicare Advantage Plan

- Still in Medicare program
- Still have Medicare rights and protections
- Still get regular Medicare-covered services
- May get extra benefits
 - Such as vision, hearing, or dental care
- May be able to get prescription drug coverage

4/22/2008

58

It's also important to note that if you join a Medicare Advantage Plan, you:

- Are still in the Medicare program
- Still have Medicare rights and protections
- Still get all your regular Medicare-covered services offered under Part A and Part B
- May get additional benefits offered through the plan, including Medicare prescription drug coverage. Other extra benefits could include coverage for vision, hearing, or dental care, and/or health and wellness programs.

*My Health.
My Medicare.*

Exercise

Exercise

1. Medicare Advantage plans are sometimes called Medicare Part D.
 - A. True
 - B. False

4/22/2008

59

1. Medicare Advantage Plans are sometimes called Part D.
 - A. True
 - B. False

NOTES:

ANSWER: B. False - Medicare Advantage Plans are sometimes called Part C.

*My Health.
My Medicare.*

Exercise

Exercise

2. PACE stands for Programs of All-Inclusive Care for the Elderly.

- A. True
- B. False

4/22/2008

60

2. PACE stands for Programs of All-inclusive Care for the Elderly.

- A. True
- B. False

NOTES:

Answer: A. True

*My Health.
My Medicare.*

Exercise

Exercise

3. The Medicare Advantage Open Enrollment Period is from November 1 through January 15 each year.

- A. True
- B. False

4/22/2008

61

3. The Medicare Advantage Open Enrollment Period is from November 1 through January 15 each year.

- A. True
- B. False

NOTES:

ANSWER: B. False - The Medicare Advantage Open Enrollment Period is from January 1 through March 31 each year.

*My Health.
My Medicare.*

Exercise

Exercise

4. Special Needs Plans may limit enrollment to certain groups of people with Medicare.

- A. True
- B. False

4/22/2008

62

4. Special Needs Plans may limit enrollment to certain groups of people with Medicare.

- A. True
- B. False

NOTES:

Answer: A. True

*My Health.
My Medicare.*

Exercise

Exercise

5. You can join a Medicare Advantage Plan at any time during the year.

- A. True
- B. False

4/22/2008

63

5. You can join a Medicare Advantage Plan at any time during the year.

- A. True
- B. False

NOTES:

ANSWER: B. False - People can join a Medicare Advantage Plan during their Initial Coverage Election Period, the Annual Election Period, the annual Medicare Advantage Open Enrollment Period, and in special situations that provide a Special Enrollment Period.

*My Health.
My Medicare.*

Exercise

You're the counselor...



You are meeting with Margaret and Elizabeth, two sisters who are in a Medicare HMO. They have decided to sell their home and move to a warmer climate. Their HMO does not offer service where they will be living. Discuss some of their options.

4/22/2008

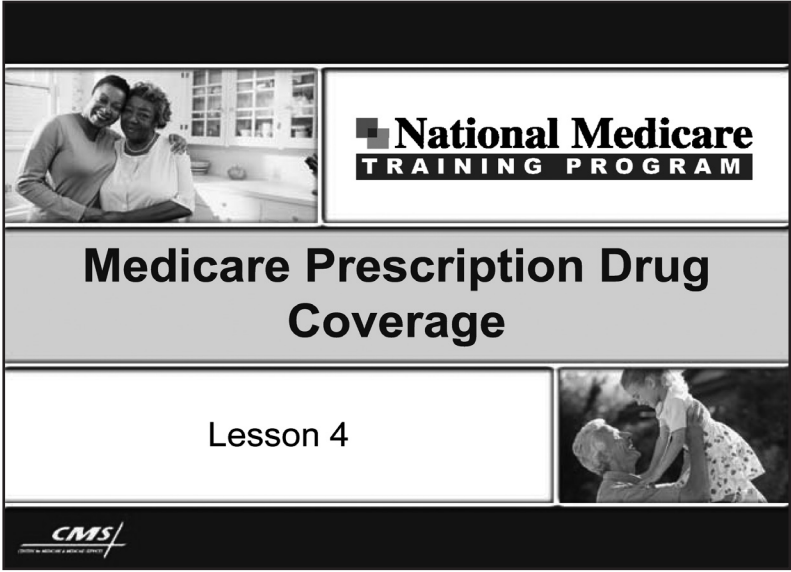
64

Discussion should include the fact that Margaret and Elizabeth get a Special Enrollment Period that allows them to join a different Medicare Advantage Plan or switch to Original Medicare. If they switch to Original Medicare, they can also choose to get Medigap policies.

NOTES:

*My Health.
My Medicare.*

Module 1: Understanding Medicare



Lesson 4, Understanding Medicare, addresses Medicare prescription drug coverage.

For more information on Medicare Prescription Drug Coverage, including classroom training modules that review the topic in more detail, visit [www.cms.hhs.gov/NationalMedicare TrainingProgram](http://www.cms.hhs.gov/NationalMedicareTrainingProgram) on the web.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Prescription Drug Coverage *Lesson 4 Topics*

- What is Medicare Prescription Drug Plan
- Who can join
- How to join and switch
- How plans work
- Your out-of-pocket cost
- Extra help

4/22/2008

66

The topics we'll discuss in this lesson include:

- What is a Medicare Prescription Drug Plan
- Who can join
- How to join and switch
- How plans work
- Your out-of-pocket cost
- Extra help

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Prescription Drug Coverage

- Coverage began January 1, 2006
- Available for all people with Medicare
- Provided through
 - Medicare Prescription Drug Plans
 - Medicare Advantage Plans
 - Other Medicare plans

4/22/2008

67

As of January 1, 2006, everyone with Medicare became eligible to join a Medicare prescription drug plan to help lower prescription drug costs and help protect against higher costs in the future.

CMS contracts with private companies offering prescription drug plans to negotiate discounted prices on behalf of their enrollees. People with Medicare can also receive drug benefits through a Medicare Advantage Plan or other Medicare plan if they are enrolled in one. (Some employers and unions may also provide Medicare drug coverage to people with Medicare.)

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Who Can Join

■ You must

- Have Medicare Part A, Part B, or both
- Live in plan service area
- Enroll in a Medicare prescription drug plan

4/22/2008

68

Anyone who has Medicare Part A (hospital insurance) and/or Part B (medical insurance) is eligible to join a Medicare prescription drug plan. You must live in the service area of a plan to enroll in it.

In most cases, you must enroll in a Medicare drug plan to get Medicare prescription drug coverage.

Individuals who live outside of the U.S. or who are incarcerated cannot enroll in a Medicare drug plan.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

When Can You Join?

- When first eligible for Medicare
 - 7 months beginning 3 months before first month of Medicare eligibility
- During specific enrollment periods
 - Annual Coordinated Election Period
 - November 15 – December 31 each year
 - Special Enrollment Periods
- Some people are enrolled automatically

4/22/2008

69

People can join a Medicare Prescription Drug Plan when they first become eligible for Medicare, i.e., during their Initial Coverage Election Period, which begins 3 months immediately before their first entitlement to both Medicare Part A and Part B.

People in Medicare can also enroll in a Medicare Prescription Drug Plan during the Annual Coordinated Election Period, which runs from November 15 — December 31 each year, and during a Special Enrollment Period, which we will discuss on the next slide.

In most cases, you must fill out an application and enroll with a plan to get coverage. However, if people who are found eligible for the extra help do not choose a plan on their own, CMS will usually enroll them in one.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

When Can You Switch?

- Annual Election Period
- Special Enrollment Periods
 - Permanently move out of plan service area
 - Lose creditable prescription drug coverage
 - Enter, reside in, or leave a long-term care facility
 - Like a nursing home
 - Qualify for the extra help
 - Have other exceptional circumstances

4/22/2008

70

After you enroll in a Medicare Prescription Drug Plan you must remain with that plan for the rest of the calendar year.

You can change Medicare Prescription Drug Plans during your Annual Coordinated Election Period, or you must be eligible for a Special Enrollment Period.

In certain situations, you may get a Special Enrollment Period. These include:

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage
- If you were not adequately informed that your other coverage was not creditable or that the coverage was reduced so that it is no longer creditable
- When you enter, reside in, or leave a long-term care facility like a nursing home

- If you qualify for the extra help, you have a continuous Special Enrollment Period and can change your Medicare prescription drug plan at any time.

(NOTE: Before June 2007, only some people with the extra help had a continuous Special Enrollment Period.)

- Or in exceptional circumstances, such as if you no longer qualify for the extra help

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Late Enrollment Penalty

- People who wait to enroll after their IEP
 - Pay additional 1% of base beneficiary premium
 - For every month eligible and not enrolled
 - For as long as they have Medicare drug coverage
 - Except those with other creditable drug coverage
 - Coverage at least as good as Medicare prescription drug coverage

4/22/2008

71

You can choose whether or not to enroll. However, if you don't join a Medicare prescription drug plan at your first opportunity, you may have to pay a higher monthly premium if you decide to enroll later. The premium is 1% higher for each month you waited to join and did not have other coverage at least as good as Medicare prescription drug coverage. You will have to pay this penalty as long as you have Medicare prescription drug coverage.

People who have another source of drug coverage —through a former employer, for example— may choose to stay in that plan and not enroll in a Medicare prescription drug plan. If your other coverage is **at least as good as Medicare prescription drug coverage**, called “creditable” coverage, you will not have to pay a higher premium if you later join a Medicare prescription drug plan. Your other plan will notify you about whether or not your coverage is at least as good as Medicare's. This notice will explain your options. You can contact your plan's benefits

administrator for more information.

Some examples of coverage that may be considered creditable include:

- Group Health Plans (GHP)
- State Pharmaceutical Assistance Programs (SPAP)
- VA coverage
- Military coverage including TRICARE
- Medigap (Medicare Supplement Insurance)

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Prescription Drug Costs

- Costs vary by plan
- Most people will pay
 - Monthly premium
 - Deductible
 - Copayments or coinsurance
 - Very little after \$4,050 out-of-pocket in 2008
- Extra help available for people with limited income and resources

4/22/2008

72

Costs vary depending on the plan. Most people will pay a monthly premium for Medicare prescription drug coverage. You will also pay a share of the cost of your prescriptions, including a deductible, copayments, and/or coinsurance. All Medicare drug plans have to provide at least a standard level of coverage, which Medicare has set. However, some plans might offer more coverage and additional drugs, generally for a higher monthly premium. With every plan, once you have paid \$4,050 out of pocket for drugs costs in 2008, you will pay about 5% for the cost of your covered prescriptions for the rest of the year.

People with limited income and resources may be able to get extra help paying for their Medicare drug plan costs.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Extra Help

- Help with drug plan costs for people with limited income and resources
- Social Security or state makes determination
- Both income and resources are counted
- Some groups are automatically eligible
 - People with Medicare and
 - Medicaid
 - Supplemental Security Income (SSI) only
 - Medicare Savings Programs
 - Everyone else must apply

4/22/2008

73

As we mentioned earlier, people with Medicare who have limited incomes and resources may be able to get extra help with the costs of Medicare prescription drug coverage. You must be enrolled in a Medicare prescription drug plan to get the extra help.

You can apply with either Social Security or your state's Medicaid program office. When you apply, you will be asked for information about your income and resources and you will be asked to sign a statement that your answers are true. Social Security will check your information from computer records at the Internal Revenue Service and other sources. You may be contacted if more information is needed.

When your application has been processed, you will get a letter telling you if you qualify for the extra help.

Certain groups of people automatically qualify for the extra help and do not have to apply.

These include:

- People with Medicare and full Medicaid benefits (including prescription drug coverage)
- People with Medicare who get Supplemental Security Income only (SSI)
- People who get help from Medicaid paying their Medicare premiums (Medicare Savings Programs)

All other people with Medicare must file an application to get the extra help.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Income and Resource Limits

■ Income

- Below 150% Federal poverty level
- 2008 amounts {
- \$1,300 per month for an individual* or
 - \$1,750 per month for a married couple*
 - Based on family size

■ Resources

- 2008 amounts {
- Up to \$11,990 (individual)
 - Up to \$23,970 (married couple)
 - Includes \$1,500/person funeral or burial expenses
 - Counts savings and stocks
 - Does not count home you live in

4/22/2008

*Higher amounts for Alaska and Hawaii

74

The extra help is available to people with Medicare with income below 150% of the Federal poverty level and limited resources. (The poverty guidelines are generally published in late January or February for the current year.)

Let's talk about how income and resources are counted.

Medicare counts the income of you and your spouse living in the same household, regardless of whether or not your spouse is applying for the extra help. The income is compared to the Federal poverty level for a single person or a married person, as appropriate. This takes into consideration whether you and/or your spouse has dependent relatives who live with you and who rely on you for at least half of their support. A grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Resources also are counted for you and a spouse

*My Health.
My Medicare.*

living with you. Only two types of resources are considered:

- Liquid resources (i.e., savings accounts, stocks, bonds, and other assets that could be cashed in within 20 days) and
- Real estate that does not include your home or the land on which your home is located.

Items such as wedding rings and family heirlooms are not considered resources for the purposes of qualifying for the extra help.

Contact the Social Security Administration at 1-800-772-1213 or your state Medical Assistance office for more information on the requirements and how to apply. To get the telephone number for your state Medical Assistance office, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Module 1: Understanding Medicare

How to Apply for Extra Help

- Multiple ways to apply
 - Paper application
 - www.socialsecurity.gov
 - State Medical Assistance office
 - Local organization
- You or someone on your behalf can apply

4/22/2008 75

Eligibility for the extra help may be determined by either Social Security or your state Medicaid office.

You can apply for the extra help by:

- Completing a paper application that you can get by calling Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778)
- Applying with Social Security at www.socialsecurity.gov on the web
- Applying through your state Medical Assistance office
- Working with a local organization, such as your State Health Insurance Assistance Program (SHIP)

You can apply on your own behalf, or your application can be filed by a personal representative with the authority to act on your behalf, such as Power of Attorney, or you can ask someone else to help you apply.

*My Health.
My Medicare.*

Exercise

Exercise

1. People who wait to enroll in a Part D plan after their Initial Enrollment Period may pay an additional 1% of the base beneficiary premium for every month they were eligible but not enrolled.
A. True
B. False

4/22/2008

76

1. People who wait to enroll in a Part D plan after their Initial Enrollment Period may pay an additional 1% of the base beneficiary premium for every month they were eligible but not enrolled.
A. True
B. False

NOTES:

Answer: A. True

*My Health.
My Medicare.*

Exercise

Exercise

2. If you change to another Part D plan during the Annual Coordinated Election Period, the change will be effective on January 15 of the following year.
- A. True
 - B. False

4/22/2008

77

2. If you change to another Part D plan during the Annual Coordinated Election Period, the change will be effective on January 15 of the following year.
- A. True
 - B. False

NOTES:

ANSWER: B. False - Effective January 1 of the following year.

*My Health.
My Medicare.*

Exercise

Exercise

3. You must have Medicare Part A and Part B to enroll in a Medicare prescription drug plan.
- A. True
 - B. False

4/22/2008

78

3. You must have Medicare Part A and Part B to enroll in a Medicare prescription drug plan.
- A. True
 - B. False

NOTES:

Answer: B. False - You must have Part A, Part B, or both.

*My Health.
My Medicare.*

Exercise

Exercise

4. Certain groups of people automatically qualify for the extra help with Medicare prescription drug costs and do not have to apply.
- A. True
 - B. False

4/22/2008

79

4. Certain groups of people automatically qualify for the extra help with Medicare prescription drug costs and do not have to apply:
- A. True
 - B. False

NOTES:

ANSWER: A. True - These groups include people with Medicare and full Medicaid benefits (including prescription drug coverage); people with Medicare who get Supplemental Security Income (SSI) only; and people who get help from Medicaid paying their Medicare premiums (Medicare Savings Programs).

*My Health.
My Medicare.*

Exercise

You're the counselor...



Maria thinks she might qualify for extra help with Medicare prescription drug costs. She has called you to ask what she needs to do. Discuss how she should proceed.

4/22/2008

80

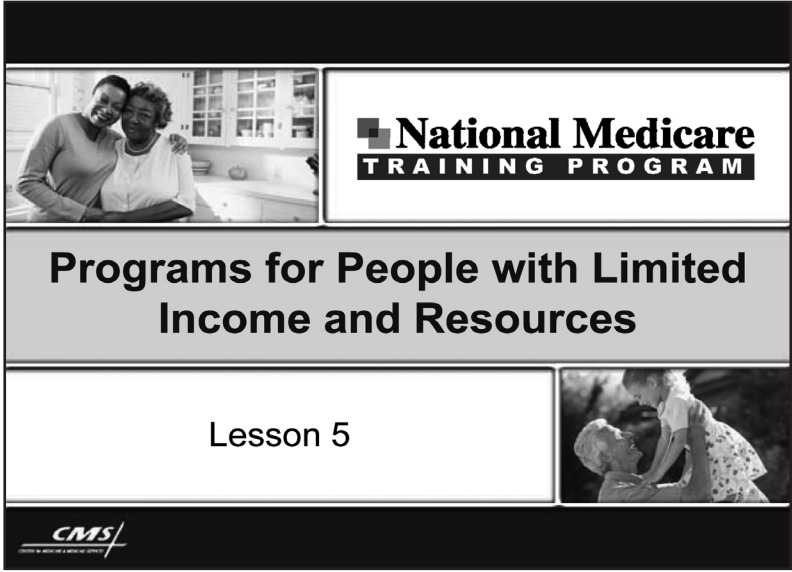
Discussion should include the following:

- Is Maria in one of the groups that automatically qualify for the extra help?
- Is she married and living with her husband? Does she have any dependents living with her?
- Does Maria (and her husband, if applicable) have limited income and resources? If yes, is her/their income below 150% of the Federal poverty level? Do her/their resources meet the limits?
- Does she have Medicare drug coverage now? Does she have any other drug coverage?
- If she could be eligible for the extra help and does not automatically qualify, Maria should contact Social Security or her state Medicaid office to apply. If she needs assistance, she can ask someone else to apply on her behalf.

NOTES:

*My Health.
My Medicare.*

Module 1: Understanding Medicare



Lesson 5, addresses other programs, in addition to the extra help with drug plan costs, available to help people with limited income and resources.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Programs for People with Limited Income and Resources *Lesson 5 Topics*

- Medicaid
- Medicare Savings Programs (MSP)
- Help for people living in U.S. territories

4/22/2008

82

In this lesson, we will cover

- Medicaid
- Medicare Savings Programs, and
- Help available for people who live in the U.S. territories

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicaid

- Federal-state health insurance program
 - People with limited income and resources
 - Certain people with disabilities
- If eligible, most health care costs covered
- Eligibility determined by state
- Application processes and benefits vary
- Office names vary
 - Social Services
 - Public Assistance
 - Human Services

4/22/2008

83

Medicaid is a program that helps pay medical costs for some people with limited income and resources. Medicaid is jointly funded by the Federal and state government and is administered by each state. It can cover children; aged, blind, and disabled people; and some other groups, depending on the state. If you are eligible for both Medicare and Medicaid, most of your health care costs are covered. People with both Medicare and Medicaid get drug coverage from Medicare, not Medicaid. People with Medicaid may get coverage for services that aren't fully covered by Medicare, such as nursing home care and home health care.

Medicaid eligibility is determined by each state, and Medicaid application processes and benefits vary from state to state. You need to contact your state Medical Assistance office to see if you qualify. For instance, a person in Name of State, would apply for Medicaid at Name of Agency. **[Instructor: insert information specific to Medicaid in your state.]**

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Medicare Savings Programs

- Help from Medicaid paying Medicare premiums
 - For people with limited income and resources
 - May also pay Medicare deductibles and coinsurance
 - Programs include
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individual (QI)

4/22/2008

84

States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than Medicaid. These programs are collectively called Medicare Savings Programs, and include the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs.

Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the Federal poverty level.

Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs.

Contact the State Health Insurance Assistance

*My Health.
My Medicare.*

Program (SHIP) in your state to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Module 1: Understanding Medicare

Programs in U.S. Territories

- Help people pay their Medicare costs
- U.S. territories
 - Puerto Rico
 - Virgin Islands
 - Guam
 - Northern Mariana Islands
 - American Samoa
- Programs vary
 - Contact Medical Assistance office

4/22/2008 85

There are also programs available to help people with limited income and resources who live in the U.S. territories—Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa—pay their Medicare costs. Programs vary in these areas. Contact the Medical Assistance office in the territory for more information.

*My Health.
My Medicare.*

Module 1: Understanding Medicare

Steps to Take

- If you think you might qualify
 1. Review guidelines
 2. Collect your personal documents
 3. Get more information
 - Call your state Medical Assistance office
 - Call your local SHIP
 - Call your local Area Agency on Aging
 4. Complete application with state Medical Assistance office

4/22/2008

86

Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses.

First, review the income and resource (or asset) guidelines for your area.

If you think you may qualify, collect the personal documents the agency requires for the application process. You will need:

- Medicare card
- Proof of identity
- Proof of residence
- Proof of any income, including pension checks, Social Security payments, etc.
- Recent bank statements
- Property deeds
- Insurance policies
- Financial statements for bonds or stocks
- Proof of funeral or burial policies

You can get more information by contacting your state Medical Assistance office, your local SHIP program, or your local Area Agency on Aging.

Finally, complete an application with your state Medical Assistance office.

*My Health.
My Medicare.*

Exercise

Exercise

1. Medicaid is a program that fills in the gaps in Original Medicare.
 - A. True
 - B. False

4/22/2008

87

1. Medicaid is a program that fills in the gaps in Original Medicare.
 - A. True
 - B. False

NOTES:

ANSWER: B. False - Medicaid is a program that helps pay medical costs for some people with limited income and resources.

*My Health.
My Medicare.*

Exercise

Exercise

2. Medicaid eligibility requirements are set by each CMS Regional Office.

- A. True
- B. False

4/22/2008

88

2. Medicaid eligibility requirements are set by each CMS Regional Office.

- A. True
- B. False

NOTES:

Answer: B. False - Medicaid eligibility requirements are set by each state.

*My Health.
My Medicare.*

Exercise

Exercise

3. The Medicaid application process is the same in every state.

- A. True
- B. False

4/22/2008

89

3. The Medicaid application process is the same in every state.

- A. True
- B. False

NOTES:

ANSWER: B. False

*My Health.
My Medicare.*

Exercise

Exercise

4. The medical assistance program is the same for all U.S. territories.

- A. True
- B. False

4/22/2008

90

4. The medical assistance program is the same for all U.S. territories.

- A. True
- B. False

NOTES:

Answer: B. False

*My Health.
My Medicare.*

Exercise

You're the counselor...



John's son has called you to find out what help is available for his father. His father's medical costs have been high, and he is finding it hard to pay his bills. You schedule a meeting with the two of them. Discuss what you would ask them to bring and how you might be able to help them.

4/22/2008

91

Discussion should cover:

- John and his son should bring John's Medicare card, address, income amounts, including pension checks, Social Security payments, etc., recent bank statements, property deeds, insurance policies, financial statements for bonds or stocks, proof of funeral or burial policies.
- When they come in to see you, describe the available programs, including the extra help with Medicare prescription drug costs (assuming John is entitled to Medicare).
- You could check the requirements for assistance in their state to see if John appears to qualify for any assistance with his medical bills.
- You could fill out the application(s) with them (if appropriate) or set up an appointment with the state Medical Assistance office, or refer them to the correct office, to apply for assistance.
- If John appears to qualify for the extra help, you could help him apply with Social Security using the online application.

NOTES:

*My Health.
My Medicare.*

