

## **Question: Who is covered by Medicare?**

**Answer:** All people age 65 and older, regardless of their income or medical history are eligible for Medicare. In 1972 the Medicare program was expanded to include people under age 65 with permanent disabilities and those with end-stage renal disease or Lou Gehrig's disease.

Most people age 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years.

People under age 65 who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those with End Stage Renal Disease and Lou Gehrig's disease become eligible for Medicare when they begin receiving SSDI payments.

## **Question: What are the different parts of Medicare?**

**Answer:** A description of the Medicare parts includes the following:

- **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. Most people do not have to pay a premium for Part A because either they or their spouse already paid for it through their payroll taxes.
- **Part B (Medical Insurance)** - helps cover doctors' services and outpatient care. It also covers some other medical services that Part A does not 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. Most people pay a monthly premium for Part B.
- **Part C (Medicare Advantage program)** - allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. These plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in some cases, prescription drug benefits.

These plans offer combined coverage of Part A, Part B, and in some cases, Part D (prescription drug) benefits.

- **Part D (Prescription Drug Coverage)** - is the new outpatient prescription drug benefit that is delivered through private plans that contract with Medicare. The benefit includes additional assistance with plan premiums and cost-sharing amounts for low-income beneficiaries. People enrolled in Medicare drug plans pay a monthly premium.

### **Question: What services does Medicare cover?**

**Part A** covers some of the following services:

- Inpatient hospital care
- Skilled nursing facility care for 100 days per benefit period following a minimum of a three-day hospital stay
- Intermittent home health care following a minimum of a three-day hospital stay
- Inpatient psychiatric care for up to 190 days during a beneficiary's lifetime
- Hospice care

**Part B** covers some of the following services:

- One-time "Welcome to Medicare" preventive physical exam (within six months of enrollment in Part B)
- Physician services (including office visits)
- Some screening tests, such as mammograms and pap smears; and tests for diabetes, glaucoma, prostate and colorectal cancers; and cardiovascular disease
- Medical equipment
- Outpatient hospital services
- Lab and diagnostic services
- Physical, occupational, and speech therapy
- Some home health care services not preceded by a hospital stay

- Some outpatient mental health care services

**Part D** covers:

- Most outpatient prescription drugs (individual drug plans have formularies)

**Question: How is Medicare financed?**

- **Part A** is primarily financed through payroll taxes; employees and employers each pay 1.45 percent of wage earnings (self-employed individuals pay 2.9 percent). Revenue from the payroll tax is held in the Hospital Insurance Trust Fund and is used to pay Part A benefits.
- **Part B** is financed by beneficiary premiums and by federal general revenues. Premiums collected from beneficiaries cover about 25 percent of total annual costs for Part B services.
- **Part C** is not separately financed; these plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in most cases, prescription drug benefits.
- **Part D** is financed through general revenues, premiums paid by Part D enrollees, and state contributions to Medicare drug costs.

**Question: What are the various Medicare rural provider types?**

**Answer:** Due to the low volume of services provided, many rural providers face special circumstances that would make financial viability under traditional Medicare Prospective Payment Systems (PPS) difficult if not impossible. Many times the existence of those providers are essential for ensuring access to care for rural Medicare beneficiaries. As a solution, several types of special rural designations have been created, which are listed below:

- **Critical Access Hospital (CAH):** Rural hospitals with fewer than 25 acute care beds located at least 35 miles, or 15 by mountainous terrain or secondary roads, from the nearest hospital unless designated as a “Necessary Provider” by a state plan.

- **Sole Community Hospital (SCH):** Rural hospitals with fewer than 50 acute care beds located at least 50 miles from the nearest hospital. Medicare payment to these hospitals is based on either their own historical costs or the PPS.
- **Medicare Dependent Hospital (MDH):** Rural hospitals from whom Medicare represents at least 50% of all inpatient revenue.
- **Rural Referral Center (RRC):** Rural tertiary hospitals who receive referrals from surrounding small primary care hospitals. An acute care hospital can be classified as an RRC if it meets several criteria pertaining to location, bed size, and referral patterns.
- **Rural Health Clinic (RHC):** A clinic located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain non physician services.

For more information about these designations, please see [Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians](#), Centers for Medicare & Medicaid Services, 2007.

### **Coordination of Federal Health Insurance and Medicare**

#### **Q. Does My FEHB Plan or Medicare Pay Benefits First?**

**A.** Medicare law and regulations determine whether Medicare or FEHB is primary (that is, pays benefits first). Medicare automatically transfers claims information to your FEHB plan once your claim is processed, so you generally don't need to file a claim with both. You will receive an Explanation of Benefits (EOB) from your FEHB plan and an EOB or Medicare Summary Notice (MSN) from Medicare.

#### **Q. When is My FEHB Plan the Primary Payer?**

**A.** Your FEHB Plan must pay benefits first when you are an active Federal employee or reemployed annuitant and either you or your covered spouse has Medicare. (There is an exception if your reemployment position is excluded from FEHB coverage or you are enrolled in Medicare Part B only.)

Your FEHB Plan must also pay benefits first for you or a covered family member during the first 30 months of eligibility or entitlement to Part A benefits because of End Stage Renal Disease (ESRD), regardless of your

employment status, unless Medicare (based on age or disability) was your primary payer on the day before you became eligible for Medicare Part A due to ESRD.

Your FEHB Plan must also pay benefits first when you are under age 65, entitled to Medicare on the basis of disability, and covered under FEHB based on you or your spouse's employment status.

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**Q. When is Medicare the Primary Payer?**

**A.** Medicare must pay benefits first when you are an annuitant, (unless you are a reemployed annuitant, see above), and either you or your covered spouse has Medicare. (This includes Federal judges who retired under title 28, U.S.C., and Tax Court judges who retired under Section 7447 of title 26, U.S.C.)

Medicare must pay benefits first when you are a former Federal employee receiving Workers' Compensation and the Office of Workers'

Compensation has determined that you're unable to return to Duty, except for claims related to the Workers' Compensation injury or illness.

If Medicare was the primary payer prior to the onset of End Stage Renal Disease, Medicare will continue to be primary during the 30-month coordination period. However, if Medicare was secondary prior to the onset of End Stage Renal Disease, it will continue to be secondary until the 30-month coordination period has expired. After the 30-month coordination period has expired, Medicare will be primary regardless of your employment status.

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**Q. If I Continue to Work Past Age 65, is My FEHB Coverage Still Primary?**

**A.** Your FEHB coverage will be your primary coverage until you retire.

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**Q. I am Retired With FEHB and Medicare Coverage. I am Also Covered Under My Spouse's Insurance Policy Through Work. Which Plan is Primary?**

**A.** Since you are retired but covered under your working spouse's policy, your spouse's policy is your primary coverage. Medicare will pay secondary benefits and your FEHB plan will pay third.



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**Q. Will My FEHB Fee-For-Service Plan Cover All My Out-Of Pocket Costs Not Covered by Medicare?**

**A.** Not always. A fee-for-service plan's payment is typically based on allowable charges, not billed charges. In some cases, Medicare's payment and the plan's payment combined will not cover the full cost.

Your out-of-pocket costs for Part B services will depend on whether your doctor accepts Medicare assignment. When your doctor accepts assignment, you can be billed only for the difference between the Medicare-approved amount and the combined payments made by Medicare and your FEHB plan.

When your doctor doesn't accept assignment, you can be billed up to the difference between 115 percent of the Medicare approved amount (limiting charge) and the combined payments made by Medicare and your FEHB plan.

Medicare will pay its share of the bill and your FEHB plan will pay its share. Some services, such as medical supplies and some durable medical equipment, do not have limiting charges.

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**Q. Must I Use My FEHB HMO's Participating Providers When Medicare is Primary?**

**A.** If you want your FEHB HMO to cover your Medicare deductibles, coinsurance, and other services it covers that are not covered by Medicare, you must use your HMO's participating provider network to receive services and get the required referrals for specialty care.

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**Q. If I Go to My FEHB HMO's Providers, Do I Have to File a Claim With Medicare**

**A.** No. If needed, your HMO will file for you and then pay its portion after Medicare has paid.

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**Q. Do I Have to Pay Medicare's Deductibles and Coinsurance When I Use My FEHB HMO's Doctors?**

**A.** Your HMO will pay the portion not paid by Medicare for covered services.

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**Q. Do I Have to Pay My FEHB HMO's Copays" Do I Have to Pay My FEHB HMO's Copays?**

**A.** Usually, you will still have to pay your FEHB HMO's required copays. Some HMOs waive payment of their copays and deductibles when Medicare is primary. Check your FEHB plan's brochure for details. For additional information about Coordination of Benefits please visit Medicare's website at [www.cms.hhs.gov/COBGeneralInformation/](http://www.cms.hhs.gov/COBGeneralInformation/)

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**New-to-Medicare Frequently Asked Questions (FAQs)**

If you are new to Medicare or about to become eligible, the Frequently Asked Questions below may provide you with the information you may need.

**1. What is Medicare?**

Medicare is the federal health insurance program for:

- Most people age 65 and over;
- Certain people younger than 65 who qualify for Social Security disability benefits;
- People with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease;and
- People with end-stage renal disease, also known as permanent kidney failure.

**2. If I am eligible for Medicare, how do I enroll?**

If you are receiving Social Security or Railroad Retirement benefits, you may be automatically enrolled. If you are automatically enrolled, you don't need to pay a premium for Part A. For more information about automatic enrollment

or if you are not automatically enrolled call Social Security at 1-800-772-1213.

### **3. What does Medicare cover?**

Medicare covers health care services and items that are medically necessary and reasonable as follows:

- Medicare Part A covers inpatient hospital stays, inpatient skilled nursing facility stays, home health care, and hospice care.
- Medicare Part B covers outpatient medical services such as doctor visits, diagnostic lab tests and preventive care.
- Medicare Part D covers most prescription drugs.

**Note:** Medicare Part C refers to Medicare Advantage which is an alternative way to receive your Medicare benefits. You receive them through a private insurance plan instead of original fee for service Medicare. Contact the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222

California Health Advocates: [cahealthadvocates.org](http://cahealthadvocates.org)

### **5. Why do some people delay enrollment in Medicare Part B?**

If you are covered by an employer group health plan due to active employment (i.e. not a retiree plan), you may delay enrolling in Part B.

### **6. Why do some people delay enrollment in a Medicare Part D plan?**

If you have creditable prescription drug coverage (meaning it is as good as or better than the standard Medicare Part D drug benefit), you may decide not to enroll in a Medicare Part D plan or to enroll later. For example, if you have the Veterans Affairs (VA) health care benefits or TriCare for Life, you have creditable prescription drug coverage.

### **7. Medicare doesn't cover all my health care costs. What are some ways to supplement it?**

Most people supplement Medicare with some other form of coverage, such as a Medigap plan, retiree plan, Medicaid through Hawaii's Department of Human Services (if they have low-income and assets), or Veterans benefits (if they qualify). Others receive their Medicare through private health plans called Medicare Advantage (MA) plans.

- What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities under age 65.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).
- People with Amyotrophic Lateral Sclerosis (ALS) -also known as Lou Gehrig's Disease

Medicare has four Parts:

- Part A (hospital insurance) - Most people do not have to pay for Part A.
- Part B (medical insurance) - Most people pay monthly for Part B.
- Part C (managed care) - this is optional, but beneficiaries must have both Parts A and B coverage to enroll.
- Part D (drug coverage) - new in 2007. Most people pay for Part D coverage.

For more information about Medicare Part A & B covered services, review the publication "Medicare & You".

### **What is the Coverage and amounts out of my pocket for Part A - Hospital Insurance (HI)**

Part A helps beneficiaries pay for inpatient hospital care, care in critical access hospitals (small facilities that give limited outpatient and inpatient services to people in rural areas), short-term care in skilled nursing facilities, hospice care and some home health care.

Most people get Part A automatically when they turn age 65. They do not have to pay a monthly payment called a premium for Part A because they, or a spouse, paid Medicare taxes while they worked for 40 or more quarters in their lifetime. Persons age 65 and older that did not pay Medicare taxes while they worked may be able to buy Part A coverage.

Medicare beneficiaries are responsible for deductibles and co-insurance for Part A covered services:

- Hospital Deductible: One deductible is charged per hospital admission (\$1,068 in 2009). Hospital readmission within a 60-day period does not trigger another deductible.
- Hospital Coinsurance: From the 61st day to the 90th day of hospitalization, beneficiaries are responsible for (\$267 per day in 2009);
- from the 91st through the 150th day of hospitalization, the coinsurance is (\$534 per day in 2009).
- The beneficiary is responsible for all hospital costs each day beyond 150 days.
- Skilled Nursing Facility (SNF) coinsurance: Day one through twenty is covered 100% by Medicare if the individual is at a skilled level.
- The daily coinsurance for the twenty-first through one-hundredth day of SNF care is \$133.50 per day in 2009. Medicare does not pay for SNF care beyond 100 days.
- Home Health Care: Beneficiaries who need skilled care on a part-time or intermittent basis and are largely confined to their homes are eligible for certain services at home under Medicare. Home health services are covered in 60-day units of care called *episodes* of care. Medicare pays for home health care services out of both Part A and Part B funds. No beneficiary copayment is required for these services. Other beneficiaries who are not confined to their homes may be eligible for Medicare-covered home care services under certain circumstances.
- Durable Medical Equipment: Beneficiaries are responsible for a 20% co-payment for durable medical equipment.
- Hospice coinsurance: There is a copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (not to exceed the inpatient Part A deductible amount of \$1,068 in 2009).
- Inpatient Psychiatric Care: Medicare pays for up to 90 days of inpatient psychiatric care per episode of illness. The beneficiary is responsible for an inpatient deductible (\$1,068 in 2009) and a per day

copayment for days 61-90 of their stay (\$267 per day in 2009). There is a lifetime coverage limit of 190 days.

### **What is the Coverage and amounts out of my pocket for Part B - Medical Insurance (SMI)**

Part B covers Medicare-eligible physician, outpatient hospital and certain home health services; ambulance, lab and certain chiropractic services; durable medical equipment, bone mass measurements and screening mammograms.

- For 2009 the Part B deductible is \$135.00 (the beneficiary also pays 20% of Medicare-approved service amounts after they meet the deductible).
- There is a monthly premium for Part B enrollment (\$96.40 in 2009). A small percent of beneficiaries with higher incomes pay a higher monthly premium for Part B coverage.
- Preventive Care Services that are not related to an underlying condition (such as diabetes) are generally not covered (i.e. routine physical exams, routine foot care, and most immunizations are not covered). Flu shots are covered.

Routine eye care, most eyeglasses and the cost of hearing aids are not covered. One pair of eyeglasses following cataract surgery is covered (the beneficiary pays the coinsurance and Part B deductible).

Cosmetic Surgery is generally not covered.

Complete coverage information can be found in the "Medicare and You" handbook.

### **Part D- Outpatient Drug Benefit**

In January 2006, Medicare began offering a voluntary outpatient drug benefit known as "Part D". The standard benefit for 2009 includes a

- \$295 deductible,
- partial coverage (75%) of outpatient drug expenses from \$296 - \$2,700,
- no coverage (beneficiary pays 100% of drug costs) from \$2,701 - \$6,153.75, and an
- approximately 5% copayment (95% covered) for drug spending over \$6,153. 76

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What is a benefit period?

Coverage for care in hospitals and skilled nursing facilities is measured in "benefit periods." In each benefit period, there are limits to the number of days Medicare will help pay for inpatient hospital, skilled nursing facility or hospice care. Once the limit is exceeded, the beneficiary is responsible for all charges for each additional day of care.

A benefit period begins the day of admission to a hospital. It ends when the beneficiary has been out of a hospital or skilled nursing facility for 60 straight days, including the day of discharge. A beneficiary must pay the inpatient hospital deductible for each benefit period. The benefit period also ends for those in a skilled nursing facility who have not received skilled nursing care for 60 straight days.

Once a benefit period has ended, a new benefit period begins and hospital and skilled nursing facility benefits are renewed. There is no limit to the total number of benefit periods.

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What are lifetime reserve days?

60 non-renewable days that can be used over and above the 90 covered days of hospitalization during a benefit period. For instance, a beneficiary who stays in the hospital 95 days during a benefit period may elect to use 5 of his/her 60 lifetime reserve days, permanently reducing the total reserve days to 55.

Who is eligible for Medicare?

To be eligible for Medicare, one must be a U.S. citizen living in the U.S. or a foreign national who has applied for legal residency and has lived in the U.S. for a minimum of five years.

There are four categories of Medicare eligibility:

- **Social Security/Railroad Retiree:** Persons aged 65 or older who are eligible for Social Security or Railroad Retirement benefits. Medicare Part A is automatic and Part B is optional. Medicare Part A becomes

available at age 65. For Medicare Part B enrollment can occur three months before, during the month of, and up to three months after a qualified individual's 65<sup>th</sup> birthday.

- Social Security Disability/ESRD Recipients: People under age 65 who meet the eligibility criteria for Social Security Disability can qualify for Medicare. However, individuals must first be entitled to Social Security benefits for 24 successive months in order to get Medicare. Thereafter, Medicare Part A is automatic and Part B is optional. In addition, individuals with End Stage Renal Disease (ESRD) are also eligible for Medicare.
- Voluntary Enrollee: Persons age 65 or older who are not qualified for Social Security can purchase Medicare coverage. A person who buys Medicare has the option of purchasing both Medicare Part A and Part B, or only Part B.
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