

Medicare

Editors' Note: It is important to remember that purely custodial care (the type of care that most persons at home or in nursing homes require) is not covered by Medicare or Medigap policies. The only home-care or nursing-home services that Medicare covers are for skilled nursing or rehabilitation. Long-term-care insurance and Medicaid are the major alternative sources for paying for custodial-care services.

Introduction

The Medicare program is a system of health insurance for the aged and disabled. It is administered by the Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration. It consists of two basic units: Part A provides coverage for the costs incurred by eligible beneficiaries for inpatient hospital care, inpatient care in a skilled-nursing facility following a hospital stay, home-health-care and hospice services; Part B is a voluntary program in which eligible beneficiaries who pay a monthly premium are entitled to reimbursement for physician and other medical services and supplies. Parts C and D are reviewed below.

Eligibility

Primary Medicare eligibility is linked to Social Security retirement and disability benefits. Disabled persons and disabled widows/widowers under age 65 may also be eligible for Medicare. Some persons who are 65 years of age or older, but not otherwise eligible, may purchase this insurance by applying to Social Security.

Enrollment

The initial enrollment period begins 3 months prior to the month of the 65th birthday and continues 3 months after that. (There are substantial penalties for late enrollment.) A special enrollment period is available to the working aged and their spouses who delay enrollment because of primary, employer-based insurance.

Medicare Part A - Hospital Insurance

Inpatient Hospital Coverage

Medicare Hospital Insurance (Part A) will pay for all medically necessary inpatient hospital care for the first sixty days minus a deductible of \$1,132 for each benefit period. For the remaining days a beneficiary must pay substantial co-payments, which may be covered under a Medigap policy (see discussion below). Major in-hospital services covered by Medicare Part A include a

semi-private room, all meals, special-care units including the intensive-care and coronary-care units, regular nursing services and drugs furnished by the hospital during the patient's stay.

Skilled Nursing Facility Care

Medicare will also pay for up to 100 days in a skilled-nursing facility. The first 20 days are covered, but for days 21 through 100 a \$141.50 daily co-payment is required. The patient must have been hospitalized for at least 3 days and be admitted to the facility generally within 30 days after leaving the hospital.

Home Health Care

Medicare also provides home-health-care services for a beneficiary who is under a physician's plan of care, requires skilled-nursing care and is essentially confined to home. Physical, occupational and speech therapy and the services of a home-health aide are available. A prior hospital stay is not required.

Hospice Care

Medicare's hospice program includes both home care and inpatient care, when needed, and a variety of services not otherwise provided by Medicare. To be eligible, a Medicare beneficiary must be certified by a physician as terminally ill with a life expectancy of approximately 6 months or less. Those who choose hospice care receive non-curative medical and support services for their terminal illness. Regular Medicare continues to pay for medical treatments not related to the terminal illness.

Part B - Medical Insurance

Medicare Medical Insurance (Part B) covers a variety of medical services of particular importance to Medicare beneficiaries, including physician services in and out of the hospital, durable medical equipment, outpatient hospital services, physical, occupational and speech therapy and ambulance transportation. Part B coverage is voluntary. Most Medicare beneficiaries decide to enroll in the program with their monthly premiums deducted from their Social Security checks. There is a monthly Part B standard premium of \$115.40. (Most people will pay \$96.40, as in 2010, because there is no Social Security COLA increase.) Persons who file an individual tax return with annual income above \$85,000 (or \$107,000 for a married couple filing a joint tax return) will pay a Part B premium ranging from \$161.50 to \$369.10. There is an annual deductible of \$162 which must be paid before Medicare benefits are reimbursed. Medicare pays 80% of the approved charges for services and the beneficiary is responsible for the 20% co-payment. Some Medicare supplemental insurance policies cover these charges. See Medigap Insurance below.

Limiting Charge

There is a cap imposed on the amount doctors may charge their Medicare patients for each service. In New York, doctors may not charge more than 5% above the Medicare-approved rate

for most services.

Excluded Services under Part A and Part B

Some services not covered by Medicare Part A are private-duty nursing and, generally, a private room. Other services excluded under Medicare Part B are routine physical checkups, immunizations with some exceptions, eyeglasses or contact lenses, most dental care and hearing aids. Generally, Medicare will not pay for hospital or medical services abroad or for physician services on ship cruises beyond the territorial waters of the United States.

Medigap Insurance

Medicare beneficiaries generally decide to buy supplemental insurance (Medigap). At present,

there are ten standard Medigap policies that may be offered by insurance companies. Plan A is a policy with core benefits that are included in the nine other plans. For further information, request a copy of the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare by calling Medicare (800) 633-4227 or Social Security (800) 772-1213 or visit the Medicare website at www.medicare.gov/publications/search/view/viewpublist.asp.

Part C - Medicare Advantage Plans

Medicare Advantage plans are managed-care programs that are sometimes called coordinated care or prepaid plans or health maintenance organizations (HMOs). They might be thought of as a combination of insurance company and doctor/hospital. Like insurance companies, they cover health-care costs in return for a monthly premium which may be waived. Generally, the plans have 'lock-in' requirements. This means that an enrolled member is locked into receiving all covered care from the doctors, hospitals and other care providers who are affiliated with the plan. In most cases, if the enrollee goes outside the plan for services, neither the plan nor Medicare will pay. The enrollee will be responsible for the entire bill.

Part D - Medicare Prescription Drug Plans

Medicare pays, in part, for out-patient prescription drugs. All Medicare beneficiaries have the opportunity to enroll in a Medicare prescription drug plan sponsored by a private-sector company. New York has more than 30 different plans available to beneficiaries from the companies.

Part D plans charge a monthly premium, and many have a deductible to meet and co-payments or coinsurance requirements as well. Overall, there should be savings of 25-50% depending on the person's drugs and the plan's price and co-pays. After a period of shared drug costs are met, where the plan pays 75% of the costs, an enrollee goes into a period of non-coverage (nicknamed the "donut hole") where he is responsible for 100% of the cost of the drugs until he pays a total of \$4,550 out-of-pocket. At that point, he pays 5% of his drug costs or a small co-payment for the rest of the calendar year and the monthly premium.

If the individual's annual income is less than \$16,245 and resources less than \$12,510 (for couples income less than \$21,855 and resources less than \$25,010) he may qualify for Extra Help, a program that reduces the Medicare Part D out-of-pocket costs. If the individual qualifies for Extra Help, the drug-plan premium could be free and the co-payments low for each prescription. Persons who qualify for Extra Help do not have the coverage gap, what is otherwise known as "the donut hole." With so many plans to choose from and the list of covered medications different from one plan to another, help is needed. The NYC Department for the Aging through its HIICAP unit has trained counselors at 2 Lafayette Street in Manhattan and at numerous sites across the City to provide assistance. Staff members are prepared to assist beneficiaries with their specific needs and choices, including Extra Help for low-income beneficiaries. Please call 311 for locations.