MEDICARE:
its "A," "B," "C" [and "D"s]....

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HOW-TO and QUESTIONS

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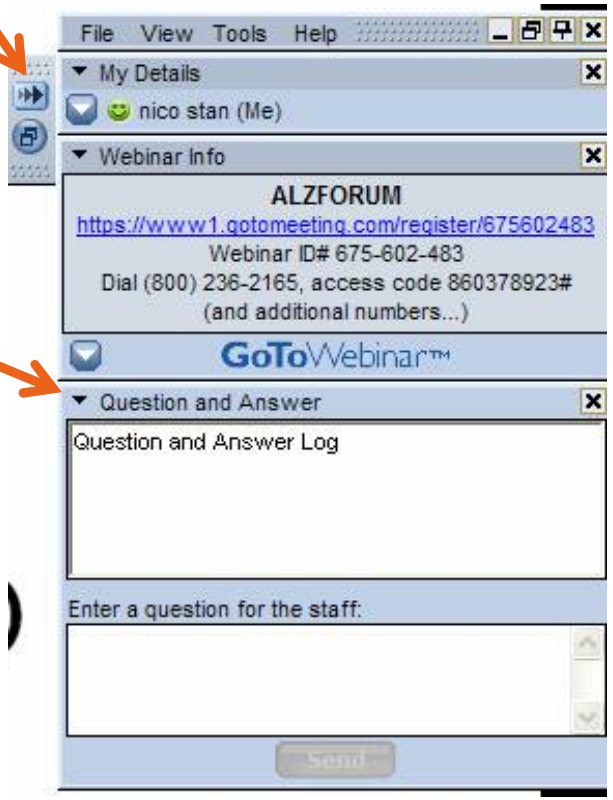


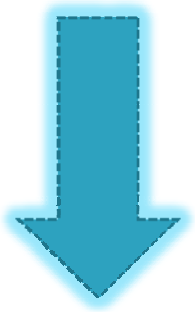
MEDICARE - ATTRIBUTES

- USA's **only national health insurance program**.
- Requires deductibles and copayments by the insured
- Pays only a portion of the cost of certain services for certain patients.
- Claims must be submitted to an insurance company or other entity acting as an agent for the government, for approval prior to payment, and payments are usually made directly to the health care provider.
- Medicare eligibility/program payment are NOT predicated upon the income or assets of the beneficiary (as opposed to Medicaid).
- Individuals entitled to Social Security Retirement Insurance who are 65 years or older and individuals entitled to Social Security Disability Benefits for not less than 24 months are eligible to participate in Medicare.

MEDICAID - MEDICARE

Medicaid is a shared state-federal program, paid in part by both entities, and administered by state agencies with federal oversight.

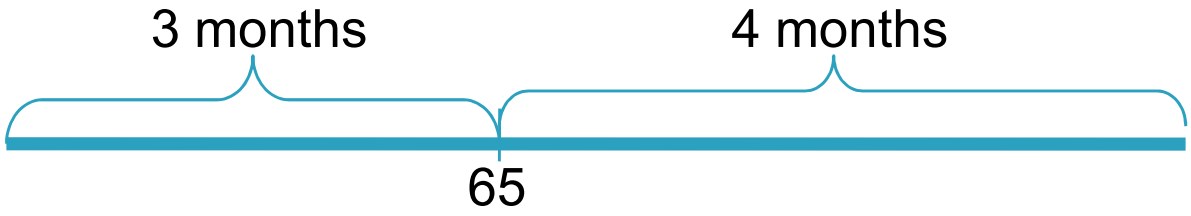
Medicare is entirely a federal program, and benefits are paid entirely from federal sources.



Both programs are overseen by the Centers for Medicare & Medicaid Services (CMS).

ENROLLMENT and ELIGIBILITY

- Individuals who are 65 and are entitled to Social Security Retirement, are automatically entitled to and enrolled in Medicare Part A and will be deemed to have also enrolled in Part B.



- People who are not receiving Social Security must enroll in Part A during an initial enrollment period, which begins in the third month before the person reaches 65.

- The initial enrollment period extends for the next seven months.

- Generally, there are two sets of individuals who are eligible for Medicare:
  - those obtaining the age of 65 and entering the retirement system and
  - those receiving disability benefits *(these can enroll, but must file an application, for benefits 24 months after they receive disability benefits or 29 months after they apply).*

ENROLLMENT and ELIGIBILITY

- Individuals who miss the initial enrollment period must wait for a general enrollment period to enter Medicare Part B *(first three months of each calendar year and the benefits do not begin until July of that year).*
- Medicare Part D, the prescription drug benefit, requires individuals who want drug coverage to enroll in a prescription drug plan (PDP) or a Part C plan with prescription drug coverage.
- Penalties apply for late enrollment under Part A, Part B, and Part D.
- Medicare has established a special enrollment period (SEP) for persons who do not purchase Medicare Part B at age 65 because they (or their spouse) are covered under an employer's large group plan. The SEP is also available to eligible Medicare beneficiaries who are members of a qualified HMO.

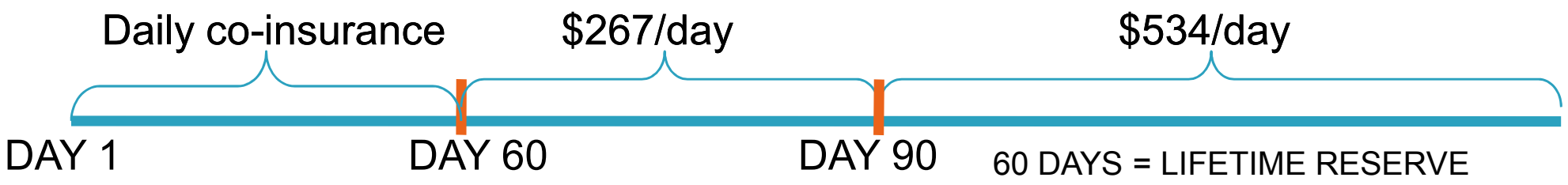
PART A

Part A is an absolute right if you qualify for Social Security Retirement.

- Hospital Coverage
- Skilled Nursing Facility Care
- Home Health Care and
- Hospice Care.

PART A: HOSPITAL CARE COVERAGE

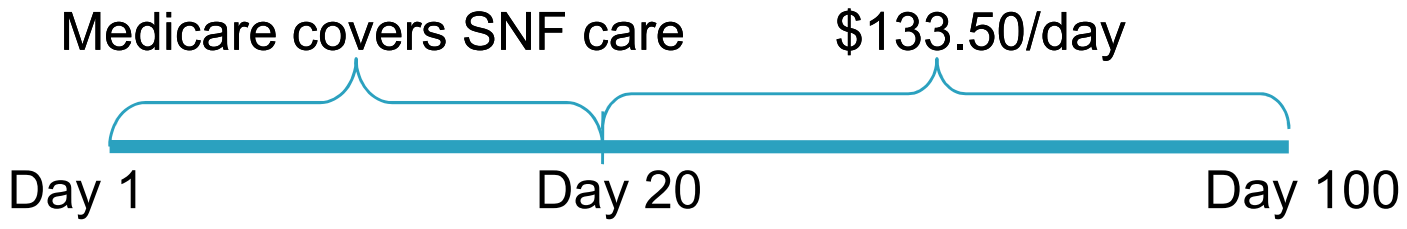
- Hospital Care Coverage provides for a beneficiary to receive 90 days of Medicare coverage for hospital care during each benefit period, or “spell of illness.”
- Deductible: $1,068.00 in 2009.
- Part A is not a free ride!



3-DAY RULE; SKILLED NURSING FACILITY CARE

Medicare offers services in a Skilled Nursing Facility (SNF).

- **An individual must be admitted to a hospital for three (3) consecutive calendar days in order to move to a Skilled Nursing Facility.**
- **Patient must require Skilled Nursing Services** (*nursing care provided by a registered professional nurse, physical therapy, occupational therapy, speech therapy and other necessary services for the patient "to attain or maintain the highest practical level of functioning")*
- **A physician must certify that the patient needs SNF care**
- The individual must be admitted to an SNF within thirty (30) days of the three day qualifying hospital stay. (*Individual can actually go home from the hospital and then enter an SNF but it must be within thirty (30) days of their discharge.)*



PART A: HOME HEALTH CARE

Medicare covers home health care services in full with no required deductible or copayments from the beneficiary.

Services must be medically necessary and reasonable, and:

- A physician signs or must sign a plan of care.
- The patient is confined to home.
- The patient needs or will need physical or speech therapy, or intermittent skilled nursing services.
- The home health care is provided under the arrangement with a Medicare-certified provider.

If above are met, the beneficiary is entitled to Medicare coverage for home health services, including:

- Part-time or intermittent nursing care under the supervision of a RN;
- Physical or occupational speech therapy;
- Medical social services under the direction of a physician; and
- Intermittent services of a home health aide.

PART A: HOSPICE CARE

Hospice care: to provide "palliative and supportive care for terminally ill people and their families rather than treatment for the underlying condition."

- Medicare covers two 90-day periods of hospice care and unlimited number of additional periods of 60 days each.
- For Medicare hospice coverage, a patient must decide to enter hospice and as such, terminate most other Medicare coverage for treatment of the underlying terminal condition.
- Care be provided by/under arrangement with a Medicare certified hospice program.
- Patient must be certified by the patient's physician and the hospice care must be part of a written plan of treatment.

PART B: GENERAL ATTRIBUTES

PART B:

- Provides services for beneficiaries in non-institutionalized settings.
- Is optional.
- Is financed by premiums paid by individuals enrolled in the program and by general revenues from the federal government.

WHO IS ELIGIBLE FOR PART B:

- individuals receiving Social Security Retirement Benefits;
- individuals receiving Social Security Disability Benefits for 24 months;
- individuals otherwise entitled to Medicare Part A.

Above groups are automatically enrolled in Part B unless they decline coverage.

- Part B requires a monthly premium ($96.40 in 2009) which is income related.
- Premium payment is automatically deducted from Social Security checks.
- Part B has an annual deductible of $135.00 (2009).
- After deductible is met, Part B pays 80% of the **REASONABLE CHARGES**
- Part B only pays 50% of the reasonable charges for outpatient mental health treatment (actually 62.5% of the approved amount times 80%).

PART B: BENEFITS

INCLUDED:

- Payment for physician services.
- Laboratory costs covered
- Diagnostic x-ray
- Prosthetic devices
- Ambulance services
- Institutional and home dialysis
- Mammography screenings
- Some preventative services, including screening for prostate cancer, glaucoma and diabetic tests.

NOT INCLUDED:

- Custodial care
- Routine physical checkups
- Eyeglasses or contact lenses
- Hearing aids
- Cosmetic surgery
- Dental services, and services that are not medically reasonably or necessary.

PART B: ASSIGNMENT - EXAMPLE

Assume a patient goes to a doctor who does not accept assignment.

- The doctor's actual charge is $600.
- Medicare approved charge allows only $349.37.
- The doctor's total bill may not exceed $401.78 (115% x $349.37).
- This is the **LIMITING CHARGE**.
- Medicare will pay $279.50 (80% of the $349.37, which is the approved charge).
- The physician cannot charge the patient more than $122.28 ($401.78 – $279.50).
- If the doctor bills above $401.78, he is billing above the limiting charge and is violating federal law.

PART C:

Medicare provides some options for the delivery of care for Medicare covered services, including managed care. It is called Medicare Advantage—Part C—or MA.

The MA plan must accept eligible beneficiaries who select that plan during an open enrollment period, without restrictions.

The Medicare Advantage Option Plans include:

- Coordinated Care Plans, i.e., (HMOs) provider sponsored organization, PSOs, preferred provider organizations (PPOs);
- Medicare Medical Savings Accounts;
- Health Savings Accounts;
- Private Fee for Service Plans;
- Religious Fraternal Benefit Society Plans; and
- Specialized MA Plans for Special Needs Individuals

PART D:

- Medicare provides limited assistance in paying for prescript. drugs through Part D.
- The statute creates three categories of drug plans:

  A. Standard Plans that offer only prescription drug coverage;
  B. Medicare Advantage Plans with a drug benefit; and
  C. Fallback Plans.

- In addition, the legislation authorizing Part D established a Low Income Subsidy (LIS) for beneficiaries with income having a maximum of 150 percent of the federal poverty level and with limited resources.
- Private companies offer a wide array of Part D Plans throughout the country.
- Eligibility for Part D is voluntary. A beneficiary may enroll and purchase Part D coverage if they have Part A or Part B. They must enroll in a program that serves the geographic region where they reside.

PART D:

- There are two groups of plans:
  - The Standard Prescription Drug Plans offered to individuals who remain in the traditional Medicare program, and
  - For individuals who are enrolled in the Medicare Advantage under Part C, the Medicare Advantage Program would offer prescription drug coverage known as MA-PD Plan.
- Enrollment is voluntary.
- The initial enrollment period is the same for Part B.
- There are penalties assessed for late enrollment and there are special enrollment periods for certain groups of individuals.

PART D: DRUG BENEFITS

- Part D plans are not required to pay for all covered Part D drugs.
- A Part D drug is a drug that is approved by the Food and Drug Administration for which a prescription is required, and for which payment is required under Medicaid.
- Certain drugs are excluded: *Viagra and Cialis, barbiturates, benzodiazepines*.

DONUT HOLE

For 2009:

1. The standard benefit requires a payment of a **$295 deductible**;
2. The beneficiary then pays 25% of the cost of a covered Part D prescription drug up to the initial coverage limit of $2,700. The initial coverage limit is calculated based on the total cost of the drugs used by the beneficiary. So, the beneficiary would have paid $295, plus $675 for a total of $970 through the first step.
3. Once the individual covered limit is reached, the beneficiary enters a second deductible period known as the “donut hole” in which he or she pays the full cost of his or her medicine.
4. When the beneficiaries total out-of-pocket expenses for the year, including the deductible, an initial co-insurance reaches $4,350, he or she then pays $2.40 for a generic or preferred drug and $6.00 for other drugs or 5 percent co-insurance, whichever is greater.
5. Note that the $4,350 is calculated on a calendar year basis.

MEDICARE HANDBOOK

An annual publication put out by the Center for Medicare Advocacy.

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Q&A

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