MEDICARE

TALKING ABOUT MEDICARE AND HEALTH COVERAGE

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Welcome

Medicare is a critically important source of health insurance for 43 million Americans. Health insurance coverage matters to people of all ages, but it is especially important for those with permanent disabilities and those with health care diseases and conditions associated with aging. Despite important breakthroughs in medical practice and advances in medical technology, the inescapable truth is that health problems, medical needs, and health care expenses are major concerns -- making health coverage decisions critical for those covered by Medicare. For most of us -- whether we're on Medicare or not -- decisions about health insurance are often difficult because they affect the kind of care we get and our financial security.

About This Guide

Whether you are already on Medicare or the family member or friend of someone on Medicare, this guide will help answer your questions about Medicare, prescription drug coverage, and longterm care, including:

- What does Medicare cover? Do people who have basic protection under Medicare need additional insurance?
- What does the Medicare drug benefit mean for you?
- What about joining a Medicare private plan? How do you choose among plans in your area?
- Should you buy a long-term care policy? How can you tell a good policy from a bad one?

Talking about Medicare is intended to help you think through basic health care issues and provide information that should better equip you and your family to discuss these topics. People on Medicare now face additional choices associated with the Medicare prescription drug benefit. This guide helps you understand how the drug benefit works, how to choose a drug plan that meets your needs, and how to get additional help with drug costs if you are on a limited income.

In addition, a state-by-state list of key agencies that can answer your specific questions about Medicare, Medicaid, supplemental health insurance, the Medicare prescription drug benefit, and long-term care is included under Additional Resources in this guide. We hope this guide will be a useful tool for you.

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Medicare at a Glance

- Know the Basics about Medicare
- Medicare Eligibility
- What Medicare Covers
- Other Upcoming Changes
- What Medicare Does Not Cover
- Plan for Medicare Enrollment

Tip

If you and your spouse are different ages, you won't be able to go on Medicare at the same time. For example, if your husband turns 65 and becomes eligible for Medicare when you are 63, he can be covered by Medicare. You will have to wait two years until you turn 65 before you are eligible for Medicare.

Know the Basics about Medicare

Medicare is the federal health insurance program for almost all Americans age 65 and older and for many adults with permanent disabilities. Knowing the basics about Medicare can help you make good decisions about your health coverage and care.

Medicare Eligibility

You are eligible for Medicare if you are a U.S. citizen or have been a permanent legal resident for five continuous years, and:

- You are 65 years or older and eligible to receive Social Security; or
- You are under 65, permanently disabled, and have received Social Security disability insurance payments for at least 2 years; or
- You get continuing dialysis for permanent kidney failure or need a kidney transplant; or
- You have Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease).

What Medicare Covers

Three parts of Medicare – Part A, Part B, and now Part D – provide coverage for basic medical services and prescription drugs.

Part A: – Hospital Insurance: In addition to hospital inpatient care, Part A covers some skilled nursing facility (SNF), home health, and hospice care. If you are entitled to Part A, there is no monthly or annual premium charge, but there is a charge for most health care services. There are also specific requirements you must meet before you can receive coverage for some services, such as home health care, skilled nursing facility care, and hospice care.

Part A	
BENEFITS	**INDIVIDUAL PAYS (in 2006)**
Inpatient hospital	Deductible of $952 per benefit period*
Days 1-60	No coinsurance**
Days 61-90	$238 a day
Days 90-150	$476 a day
After 150 Days	No benefits
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$119 a day
After 100 days	No benefits
Home health	No deductible or coinsurance
Hospice	Copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
*A benefit period begins when a person is admitted to a hospital and ends 60 days after discharge from a hospital or a skilled nursing facility. **Coinsurance – portion of a health care fee that must be paid by an insured patient	

Part B: – Medical Insurance: Part B pays for doctors' services, outpatient hospital care, and home health visits not covered under Part A. It also covers laboratory tests, such as X-rays and blood work; medical equipment, such as wheelchairs and walkers; preventive services, such as mammograms and prostate cancer screenings; cardiovascular (heart) disease and diabetes screenings; outpatient physical therapy; mental health care; and ambulance services.

Medicare also covers one initial physical exam within six months of when a person first enrolls in Medicare Part B.

Part B has an annual $124 deductible (2006) and, for most services, a 20% coinsurance.

If enrolled in Part B, you must pay a monthly premium ($88.50 in 2006), which is typically deducted from your Social Security check. The Part B premium is currently the same for all people on Medicare ($88.50 per month in 2006). Beginning in 2007, it will be higher for people with incomes over $80,000 ($160,000 per couple).

Part B	
BENEFITS	**INDIVIDUAL PAYS (in 2006)**
Premium	$88.50 per month
Deductible	$124 a year
Physician and other medical services MD accepts assignment* MD does not accept assignment	20% coinsurance 20% coinsurance plus up to 15% over Medicare-approved fee[1]
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays; durable medical equipment	20% coinsurance
Physical, speech, and occupational therapy	20% coinsurance[2]
Clinical diagnostic laboratory services	No coinsurance
Home health care	No coinsurance
Outpatient mental health services	50% coinsurance
Preventive services - Flu shots; pneumococcal vaccines; colorectal cancer screenings; prostate cancer screenings; mammograms; Pap smears; pelvic exams - Bone mass measurement; diabetes monitoring; glaucoma screening	Part B deductible and 20% coinsurance waived for certain preventive services 20% coinsurance

[1] Referred to as the Medicare Limiting Charge Law, the limit on the percentage above the Medicare-approved amount that a physician can charge is less than 15% in some states.

[2] There is a coverage limit on Medicare outpatient therapy services. A $1,740 limit per year for occupational therapy services, and a $1,740 limit per year for physical and speech-language therapy services combined.

* Assignment – physicians agree to accept Medicare's predetermined fee as payment-in-full; patients are responsible for 20% copayment but no more.
SOURCE: *Medicare & You 2006* Handbook.

Part C - Medicare Advantage: Medicare Part C offers Parts A and B benefits, and may offer prescription drug coverage (Part D), through private health plans. This part of Medicare does not offer additional Medicare benefits.

Part D – Prescription Drug Insurance: Medicare began covering prescription drugs in 2006 under Medicare Part D. There is a separate monthly premium of about $32 in 2006 for Part D, but the premiums vary greatly among plans. Medicare drug coverage is offered through Medicare-approved private plans. Help for people on Medicare with limited income and resources is available and can reduce or eliminate premiums, deductibles, and co-pays. For more details on Part D, see the Prescription Drug Costs and Medicare.

What Medicare Does *Not* Cover

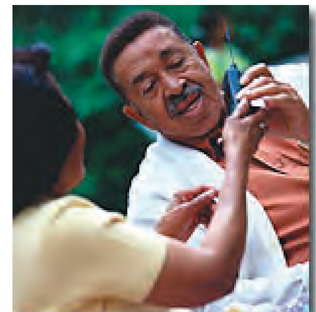
You should be aware that Medicare does not cover all health care expenses -- for example, it does not pay for long-term personal care services at home or in a nursing home but does cover short-term skilled nursing care. Medicare does not cover eye exams, eyeglasses, hearing aids, dental care, or care provided outside the United States.

Medicare private plans -- called Medicare Advantage plans –- often provide coverage of prescription drugs and supplemental benefits, in addition to the benefits covered in the traditional Medicare program. See Talking About Medicare Advantage and Private Plans for additional information.

Plan for Medicare Enrollment

As a senior, eligibility for Medicare begins upon turning 65, even if your eligibility for full Social Security benefits does not begin until later. Choosing to receive Social Security before age 65 does not affect when you become eligible for Medicare, but it may affect the enrollment process.

- **If you are already receiving Social Security benefits when you turn 65,** you will automatically be enrolled in both Parts A and B of Medicare, effective on the first day of the month that you turn 65. A Medicare card will arrive in the mail about three months before your birthday. You can choose to decline Part B coverage, but you should take it if you want to have full Medicare benefits and avoid paying a Part B premium penalty later on (unless you have health care coverage through your or your spouse's current employer).



- **If you are not receiving Social Security benefits when you turn 65,** you must apply for Medicare. You will not be enrolled automatically. You may apply at any Social Security office during the *initial enrollment period*, which begins three months before you turn 65 and ends three months after your birthday. Contact information for making an appointment with your local social security office is available in the Additional Resources section of this guide.

If you do not enroll in Medicare during the initial enrollment period, you must enroll during a general enrollment period, which is January 1st through March 31st of every year. Your coverage will begin on July 1st of the year you sign up. If you wait until after your initial enrollment period, you may have to pay a penalty for each year you delayed enrollment. This penalty will be added permanently to your Part B premium.

If you or your spouse are still working when you turn 65, and you have health coverage through your employer, you may be able to delay enrolling in Part B without paying a late enrollment penalty. This will allow you to avoid duplicating Part B coverage and paying the Part B monthly premium. To avoid a late enrollment penalty you must enroll in Part B within 8 months of the time that you or your spouse stop working or you lose your employer-sponsored health insurance, (called your *Special Enrollment Period*). Your coverage will begin the month after you enroll. You should check with your local Social Security office before declining Part B to be sure you will not have to pay a penalty for late enrollment. Information on contacting your local Social Security office is available in the Additional Resources section of this guide.

If you have continuation health care coverage from a former employer, sometimes called COBRA, you should still enroll in Medicare Parts A and B during your initial enrollment period. Your health insurance under COBRA typically ends as soon as you are eligible for Medicare.

If you are a citizen or permanent resident, but not entitled to Medicare (for example, because you did not work enough years to qualify), you may still voluntarily enroll in Medicare. However, you must pay a monthly premium for Part A benefits (in 2006, $216 if you worked 30 or more quarters; $393 if you worked fewer than 30 quarters).

Prescription Drug Costs and Medicare

1. **Understanding the Basics of the Medicare Prescription Drug Benefit**
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     - Are you currently enrolled in a Medicare Advantage (MA) plan (HMO, PPO, POS, or PFFS plan)?
     - Does Medicaid help pay for your medical care?
     - Do you still have a Medicare-approved drug discount card?
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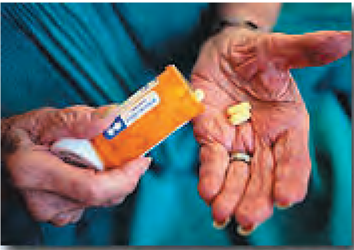
   - Medicare.gov
   - 1-800-MEDICARE
   - Medicare Drug Plan Sponsors
   - State Health Insurance Assistance Programs and Community Organizations

6. **Enrolling in a Plan**

7. **Changing Plans During the Year**

8. **Extra Help for Those with Limited Incomes**
- Important Information for People on Medicare Who Get Help from Medicaid for Medical Care
- Others with Limited Income and Resources
- Who Should Apply for Extra Help?
- Receiving Extra Help
    - Applying for extra help
    - Signing up for a drug plan



Many people on Medicare rely on prescription drugs to manage their health conditions and have been under increasing financial pressure because of the rising cost of their medications. In an effort to help the 43 million people on Medicare with their pharmacy bills, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, which created a new prescription drug benefit for people on Medicare.

This section offers general information about the new Medicare drug benefit, advice for determining if the Medicare drug benefit is right for you, key considerations for selecting a Medicare drug plan that best meets your needs, and information about extra financial assistance with drug costs available for those with limited incomes.

The federal government is helping to cover the cost of the Medicare prescription drug benefit; however, private companies are administering the benefit on behalf of the government. Therefore, to get the Medicare prescription drug benefit, you and others on Medicare need to enroll for coverage under one of these plans.

There are two types of plans you can sign up for to get Medicare drug coverage:

- A Medicare prescription drug plan that just covers prescription drugs (and no other benefits) paired with the original Medicare program (the traditional fee-for-service program); or
- A Medicare Advantage plan, like a Medicare HMO or PPO, which covers all Medicare benefits, including prescription drugs.

The Medicare drug benefit is voluntary. If you currently have a generous source of drug coverage (e.g., from an employer or union, the Veterans Administration, etc.) you may want to keep that coverage rather than sign up for a Medicare prescription drug plan or a Medicare Advantage plan.

You can sign up for either type of Medicare plan between November 15, 2005 and May 15, 2006. For 2007 and future years, you can sign up (or switch plans) between November 15 and December 31 of each year, with drug coverage effective January 1 of the following year.

Understanding the Basics of the Medicare Prescription Drug Benefit

As of January 1, 2006, Medicare helps pay for prescription drugs. All people with Medicare are eligible for this coverage, regardless of their medical history or income.

The Medicare drug benefit is expected to reduce drug costs for most enrollees and protect against catastrophic drug expenses, but it is not free. When you get Medicare prescription drug coverage, you pay a share of the costs and Medicare pays part of the costs. Your costs will vary depending on which plan you choose, but all plans must, at a minimum, provide you with a standard level of coverage.

Standard Coverage (the minimum coverage all drug plans must provide)

If you join a drug plan in 2006 that offers the standard benefit, you will pay:

- A monthly premium which varies greatly depending on the plan you choose, but the average is $32 a month in 2006)
- The first $250 of your prescription drug costs each year, called the 'deductible'

After you pay the yearly deductible, you will pay the following for the remainder of 2006:

- 25% of the cost of covered drugs from $250 to $2,250, (your plan pays the other 75% of these costs); then
- 100% of your next $2,850 in total drug costs (called the "doughnut hole," you are responsible for all drug costs out of your own pocket); then
- 5% of your drug costs (or a small copayments for the rest of the calendar year (known as catastrophic coverage) after you have spent a total of $3,600 out of pocket.

Although this is the standard plan, many Medicare prescription drug plans offer a benefit package that differs from the standard. Most plans do not have a $250 deductible and do not use a 25% coinsurance for each prescription filled. Alternatively, most plans impose different drug copayment amounts, depending on the medication. Typically, they charge substantially less for generic drugs than brand-name drugs.

Most of the Medicare drug plans *do* have a doughnut hole. If you enroll in a plan with a doughnut hole, you will pay the entire cost of your prescription drugs until you have spent $3,600 for your prescriptions (in addition to any amount you have spent on premiums). Keep in mind that you will continue to pay the monthly premiums for your drug plan during the months that you have expenses in the doughnut hole when the plan is not helping to pay for your medications. For tips on how to manage your spending in the doughnut hole, see the "How much will I have to pay for each of my prescriptions?" section.

Determining if the Medicare Drug Benefit is Right for You

Now that you've learned a little bit about the Medicare drug benefit, it's time to decide whether the coverage is right for you.

The first thing to consider is whether you currently have drug coverage. If you do not have coverage, the Medicare drug benefit is worth your consideration. It is expected to reduce drug costs for most enrollees and protect against catastrophic drug expenses. For many people, the coverage could be a good deal, because Medicare is subsidizing the cost. However, if you decide not to sign up, it is also important to be aware of the consequences of doing so.

What to Consider When Deciding to Sign Up

- Do you currently have drug coverage? Will it be available next year?
- Do you spend a lot on drugs?
- Are you likely to spend more than $3,600/year on prescription drugs?

Assessing Your Current Source of Drug Coverage (if you have one)

Many people on Medicare have supplemental drug coverage, and if this is true for you, you should consider your current coverage and what that means for you in deciding whether to sign up for the Medicare drug benefit.

The following is a list of scenarios that may fit your current supplemental coverage situation and help you decide whether to sign up for a Medicare drug plan.

Do you get your drug coverage from a former or current employer or union?

In general, benefits offered by employers are more generous than the standard Medicare drug benefit. You should have received a letter from your former or current employer letting you know whether your coverage is "creditable," which means as generous as the standard Medicare prescription drug benefit. If you did not receive this information, contact your employer.

If your employer says your drug plan meets this test, you can either keep your employer health plan or enroll in a Medicare prescription drug plan. Compare the benefits offered under your employer plan with the benefits offered by Medicare drug plans in your area so you can be sure which plan is best for you.

If your employer plan does not meet the "creditable coverage" test, you may want to consider a Medicare plan for your drug coverage so you don't face a late enrollment penalty down the road.

If your "creditable" retiree coverage ends or you retire and are not offered retiree health benefits, you can then enroll in a Medicare prescription drug plan. You will not have to pay a late enrollment penalty as long as you join a Medicare plan within 63 days after your employer coverage ends.

Tip

You cannot receive the extra help available to people with low incomes for the Medicare drug benefit if you are in an employer plan, even if you qualify based on income and resources. People with low incomes should consider all of the options carefully before making a decision. Individualized help is available through your state SHIP program.

It is also important to point out a couple of things about employer coverage that are important to consider when making your choice about the Medicare drug benefit:

- Employer plans usually include other benefits besides drug coverage, so you should consider not only the drug coverage but all health care benefits offered by the employer plan.

- If you decide to drop your employer coverage, you will probably not be able to rejoin the plan in the future, so make sure you think through your decision.

- A final concern is whether you may qualify for additional help that is available to people with limited incomes and resources. This help can be quite valuable but is not available to you if you keep your employer coverage.

Do you currently have a Medigap supplemental policy and does it pay for prescription drugs?

If you are currently covered by a Medigap policy with no drug coverage (Plans A-G), you may want to keep your current Medigap policy and sign up for a Medicare drug plan. You would then have original fee-for-service Medicare for basic benefits, a Medicare prescription drug plan, and a Medigap policy to fill the gaps, all of which require a monthly premium. Another option would be to switch to a Medicare HMO or PPO, which would cover all Medicare benefits, including prescription drugs.

If you are currently covered by a Medigap policy with prescription drug coverage (Plans H, I or J), these policies are generally not considered "creditable," which means the drug coverage is typically not as generous as the standard Medicare drug benefit. You should have received a letter from your Medigap insurer describing your options for 2006. Assuming the letter indicates that your Medigap drug coverage is not as generous as the standard Medicare drug benefit, and you don't sign up for a Medicare drug plan in 2006, you will face a late enrollment penalty if you decide to sign up for Medicare drug coverage in the future.

Rather than keep what you have, you could switch to a Medigap policy without prescription drug coverage (Plans A-G, or H, I, and J without drug coverage) *and* enroll in a Medicare drug plan. If you make this switch, you would probably reduce your Medigap premium since policies without drug coverage are typically less expensive. Of course, you would also pay a premium for your new Medicare drug plan.

Another option would be to switch from traditional Medicare to a Medicare Advantage plan, like a Medicare HMO or PPO, which would cover all Medicare benefits, including prescription drugs. With this option, you could save money by dropping Medigap altogether but could face restrictions on the doctors, specialists, and hospitals you can use under the plan.

There are two new Medigap plans (K and L). These plans do not offer prescription drug coverage but are plans with high deductibles meant to cover catastrophic costs. Like Medigap plans A through G, you may still join one of these plans, keep original Medicare, and join a Medicare drug plan to receive traditional Medicare benefits, catastrophic coverage protection, and prescription drug coverage.

Are you currently enrolled in a Medicare Advantage (MA) plan (HMO, PPO, POS or PFFS plan)?

If so, you should have received information from your plan explaining what your options are for prescription drug coverage. If your plan covers prescription drugs, you can stay with your current Medicare Advantage plan and continue to receive all Medicare benefits through your plan, including drug coverage.

If your Medicare Advantage plan does *not* cover prescription drugs, you can keep your current coverage, but you will face a late enrollment penalty if you decide to switch to a Medicare stand-alone drug plan or Medicare Advantage plan that covers prescription drugs (called a Medicare Advantage prescription drug (MA-PD) plan) in the future. If you choose an MA-PD plan, you would continue to pay the monthly Part B Medicare premium and may pay another premium for additional benefits, such as the new prescription drug benefit.

If you are dissatisfied with your MA-PD plan and want to switch to another Medicare Advantage plan with prescription drug coverage, you can do so once through June 30, 2006. In 2007 and each year thereafter, you will be allowed to switch to another Medicare Advantage plan with drug coverage through March 30.

If you decide to disenroll from your Medicare Advantage plan and opt for health coverage through traditional Medicare, you will need to decide whether to sign up for a stand-alone plan that provides the Medicare prescription drug benefit. If you choose traditional Medicare with a prescription drug plan, you will pay a monthly premium for each.

Does Medicaid help pay for your medical care?

As of January 1, 2006, Medicaid no longer provides basic prescription drug coverage to people who are covered under both Medicare and Medicaid. Your drug coverage is now provided by a Medicare prescription drug plan, but Medicaid continues to pay for other benefits.

As someone with Medicare and Medicaid, you have been automatically enrolled into one of the new Medicare prescription drug plans to prevent any possible gaps in your drug coverage. You should have received a letter from Medicare with the name of the Medicare drug plan that you were assigned to for 2006. If you need to fill a prescription and are not sure which plan you are in, bring along your Medicare and Medicaid cards to the pharmacy and the pharmacist should be able to tell you which plan you've been assigned to and which of your drugs are covered by the plan.

If the Medicare drug plan to which you were assigned does not cover some of your medications, you can switch to another Medicare drug plan offered in your area that is better suited to your medication needs. However, before switching plans, check to see if the plan that you prefer would require you to pay an additional premium. In general, Medicare pays the full monthly premium for people with Medicare and Medicaid but only up to a certain amount. If you were to enroll in a higher premium plan, you would have to pay a share of the monthly premium for the more expensive plan.

For more information on extra help paying for a prescription drug plan, see Extra Help for Those with Low Incomes.

Do you still have a Medicare-approved drug discount card?

You can continue to use it but only until May 15, 2006. However, once you sign up for a Medicare prescription drug plan, you can no longer use your Medicare-approved discount drug card – even to help pay for prescriptions that are not covered by your new plan. However, the Medicare prescription drug benefit is expected to do a better job than discount cards in cutting drug costs for enrollees. Medicare drug plans offer insurance coverage and protection from catastrophic expenses, unlike discount cards which simply provide discounts off retail prices.

During 2004 and 2005, some people with modest incomes who signed up for a Medicare-approved drug discount card received up to a $600 credit to help pay for their prescriptions. If you received the credit but have not spent it, you can use the amount that is left over before May 15, 2006. However, if you enroll in a Medicare drug plan, the credit is not available to you once your coverage in a drug plan begins.

Medicare provides significant financial help to people with limited incomes and resources enrolled in Medicare drug plans. So, if you received the $600 credit with the discount card, you should apply for the extra help through the drug benefit, which will offer far more help than the discount card.

For more information on receiving extra help paying for a prescription drug plan, see Extra Help for Those with Low Incomes.

Understanding the Late Enrollment Penalty

After the initial enrollment period from November 15, 2005 to May 15, 2006, you are no longer able to sign up for Medicare drug coverage for 2006. You will have to wait until November 2006 to sign up for coverage for 2007. If you decide to wait to join a Medicare drug plan for a few years or you maintain drug coverage that is not "creditable," you will face a late enrollment penalty. The late enrollment penalty is based on the amount of time that you delay enrollment. Medicare will charge a one percent premium penalty for every month you wait to sign up. This premium penalty would increase the cost of your Medicare prescription drug coverage permanently.

Here is how it is expected to work:

- If you don't sign up for 2006, but enroll in 2007, you delayed enrollment for 7 months after the enrollment period ends on May 15, 2006. If the average premium for 2007 is $41/month, you would pay your plan's premium plus 7% (1% x 7 months) of $41, or an additional $2.87 per month. In all future years, you will pay a monthly premium that is increased by 7% of the average monthly premium for a given year.

- If you don't sign up until 2008, you would face a 19% premium penalty (a 7-month delay in 2006 and a 12-month delay in 2007). If the average premium in 2008 is $44/month, then the premium penalty would be 19% of $44 or another $8.36 per month added onto your premium, which is an additional $100 more that year.

As you can see, the premiums for Medicare prescription drug plans can rise pretty quickly if you delay enrollment, so it is important to make the decision of whether and when to sign up for the Medicare drug benefit with care.

Assessing What Type of Plan Is Best for You

There are two general types of Medicare drug plans being offered, and you may want to consider which type of plan is best for you before making a decision.

Medicare Prescription Drug Plan (PDP)

The first type of plan, called a Medicare prescription drug plan (PDP), covers prescription drugs and no other benefits. These plans, offered by Medicare-approved private companies, are generally best for people who need drug coverage but prefer to get their other benefits, such as doctor's visits, from the traditional fee-for-service Medicare program. There are at least 40 prescription drug plans offered in most states, so there are several choices for you to consider.

With a PDP, you receive prescription drug insurance directly from the Medicare-approved private plan, but you continue to use the doctors and hospitals that you have been using under traditional Medicare. While prescription drug plans generally have a similar structure to the standard Medicare drug benefit, the plans vary in their premiums, deductibles, formularies, and cost-sharing arrangements.