

MEDICARE

What is it?

Medicare is a federal health insurance program that pays some of the costs of medical care, including hospital and doctors' charges, skilled nursing, home health, hospice, and outpatient care.

Who is it for?

People age 65 and older, certain people with disabilities, and people with end-stage renal disease.

Where are applications taken?

Applications are taken at the district offices of the Social Security Administration. These offices are listed in Appendix B. An applicant may call 800-772-1213 to begin the application process and arrange an appointment at the Social Security office.

INTRODUCTION

Medicare is a two-part federal program designed to provide health insurance for people 65 years of age and older, for people with certain disabilities, and for people with end-stage renal disease.

Medicare Part A provides some coverage of hospital and long-term care services; it is financed through Medicare payroll tax deductions. Almost everyone age 65 and older and certain people with disabilities are eligible for Part A without the payment of any additional premium.

Medicare Part B is a voluntary program that pays for the costs of professional medical services, outpatient care, and some medical equipment. It is financed by a combination of federal contributions and premiums paid by the individual. Anyone who is eligible for Medicare Part A is eligible for Medicare Part B, but some people do not purchase it.

Medicare is administered by the Social Security Administration. Payment problems with Part A coverage are handled by:

Medicare Part A Beneficiary Services
Palmetto GBA
Durham, NC
(800) 685-1512

<http://www.palmettogba.com>

Payment problems with Part B coverage are handled by:

CIGNA
High Point, NC
(800) 672-3071
(336) 882-4562 (Outside of North Carolina)

Unlike Medicaid, Medicare eligibility is not based on need. There are no income or resource (assets) limits.

BENEFITS

Medicare is not full health care coverage. Because of cost-sharing (deductibles, copayments, and coinsurance) and gaps in coverage, Medicare has been estimated to cover only about half of an enrollee's health care costs. Every year, Medicare cost-sharing increases.

People on Medicare have several ways of supplementing their Medicare coverage. Some low-income Medicare beneficiaries may be eligible for Medicaid. Depending on their income, low-income Medicare beneficiaries may be eligible for full Medicaid coverage (Medicaid for the Aged, Blind, or Disabled), or may be eligible for more limited Medicaid coverage (Medicare Savings programs). Medicare Savings programs pay some or all of the out-of-pocket costs (premiums, copayments, and deductibles) of Medicare. For information on the different Medicaid options, please see the section on Medicaid, Chapter 12.

Many insurance companies offer Medicare supplement (commonly called "Medigap") policies that are designed to cover medical costs not covered by Medicare. For information on "Medigap" policies, please see Chapter 6 of this book. In addition, some retirees are eligible for employer sponsored retirement benefits that supplement Medicare coverage.

Benefits under Part A

Medicare Part A covers inpatient hospital services. After a hospital stay, Part A will cover skilled nursing home care, and, if ordered by a doctor, home health services or hospice care. It does not cover custodial nursing care, private duty nurses, or personal convenience items that you request (for instance, television or telephone while in the hospital).

Note: The cost-sharing amounts listed in this chapter are for the 2003 calendar year. They are revised annually, effective January 1st.

Part A has an \$840 deductible per benefit period for inpatient hospital services. That is, a person on Medicare who is hospitalized must pay the first \$840 in hospital charges before Medicare will begin to pay benefits. A benefit period starts on the day of the hospital admission and ends 60 days after the date of discharge from the hospital or nursing home.

After the deductible is met, Medicare will pay 100% of the hospital charges for days 1 through 60 of a person's hospital stay. For days 61 through 90, the patient is responsible for paying a \$210 per day copayment.

People on Medicare also have what is called "lifetime reserve days" to cover extended hospital stays. A Medicare beneficiary has 60 "lifetime reserve days" during which Medicare will cover a portion of hospital care. For instance, if you are hospitalized for 91 days, Medicare pays 100% of the charges for days 1 through 60. You pay a \$210 per day copayment for days 61–90. Day 91 is charged against your 60 lifetime reserve days, and you have 59 lifetime reserve days left. For day 91 (and all lifetime reserve days), you pay a \$420 per day copayment.

Once your "lifetime reserve days" are exhausted, Medicare coverage for that benefit period ends. However, when a new benefit period begins, you are once again eligible for Medicare coverage of a hospital stay of up to 90 days. Once you exhaust your lifetime reserve days, you are no longer eligible for additional hospital coverage past 90 days each benefit period.

Coverage of skilled nursing home care is limited to 100 days per spell of illness. Skilled nursing home care is covered only if the following conditions are met:

- ◆ You must have been hospitalized for at least three days before entering a skilled nursing care facility
- ◆ You must be admitted to the skilled nursing care facility within 30 days of the hospitalization
- ◆ The care required must be rehabilitative in nature
- ◆ The condition that requires skilled nursing home care must be the same condition that required the hospitalization

If a doctor certifies that a patient needs skilled rehabilitative care, then Medicare will pay 100% of the first 20 days of nursing home care. The patient is responsible for a \$105 per day copayment for days 21 through 100.

Part A coverage of home health care is broader than that of nursing home services. (Note: Part B also covers home health services.) You can qualify for an unlimited number of home health visits if:

- ◆ You receive part-time or intermittent skilled nursing or physical, speech, or occupational therapy
- ◆ You are at least temporarily unable to leave your home
- ◆ The care is medically reasonable and necessary

In order for these services to be covered by Medicare, your physician needs to prescribe a home health treatment plan for you, and the home health agency that provides the services must be certified by Medicare. There are no copayments or deductibles for these services.

Medicare also covers hospice services. To qualify for hospice services, a patient must be terminally ill, with a prognosis of less than six months to live, and must have completed aggressive therapies. Agreeing to hospice services entitles a patient to medical and supportive services offered by an interdisciplinary team that includes the patient's physician and hospice personnel. Hospice services also cover durable medical equipment and drugs related to the terminal illness. Small copayments for inpatient respite care and outpatient drugs may be required.

When a patient signs on to hospice benefits, Medicare Part A coverage for the terminal illness is waived. However, Medicare Part A coverage remains in effect for other illnesses unrelated to the terminal illness. The patient may revoke the hospice benefit at any time.

Benefits under Part B

Medicare Part B covers:

- ◆ The medical services of doctors, nurse practitioners, and physician assistants
- ◆ Supplies and drugs that cannot be self-administered and are incidental to doctor care
- ◆ Outpatient services and diagnostic tests
- ◆ Rental or purchase of durable medical equipment (for instance, wheelchairs, prostheses, or braces)
- ◆ Prosthetic devices, including breast prosthesis after a mastectomy
- ◆ Ambulance services, when medically necessary
- ◆ Services provided in rural health clinics
- ◆ Outpatient physical, occupational, and speech therapy
- ◆ Outpatient dialysis for people with end-stage renal disease
- ◆ Outpatient mental health treatment (there is a 50% copayment for these services)
- ◆ The services of psychologists and mental health social workers
- ◆ Limited psychiatric hospitalization
- ◆ Immunosuppressive drugs
- ◆ Vaccines for pneumococcal pneumonia, hepatitis B, and flu
- ◆ Certain preventive screenings, such as: Pap smears, mammograms, colorectal cancer screening, glaucoma screenings, and prostate cancer screenings
- ◆ Diabetes glucose monitoring and diabetes education (for those with diabetes)

Medicare Part B does *not* cover such medical care as routine physicals, dental care (except dental surgery or emergency dental care), intermediate nursing home care, eyeglasses or vision care (except after cataract surgery or treatment for macular degeneration), hearing aids and hearing examinations, routine foot care and

orthopedic shoes (except where foot care is necessitated by diabetes), custodial care, homemaker services, private duty nurses, acupuncture, medical transportation (except for medically necessary ambulance services), immunizations (except as noted above), the first three pints of a blood transfusion, or most outpatient prescription drugs.

There is a \$100 Part B deductible each year. That is, for services covered by Part B, the patient must pay \$100 out of pocket, and Part B then pays 80% of the Medicare-approved payment level. Medicare sets pre-determined payment levels for medical procedures and services.

Some physicians accept Medicare “assignment” and some do not. It is important to find out if your doctor accepts Medicare assignment. If not, you may be required to pay more out of pocket for his or her medical services. Here is an example of the difference in what you might pay out of pocket, depending on whether your physician accepts Medicare assignment:

Assume that your physician recommends a certain minor surgical procedure for you. For that procedure, Medicare’s approved payment amount is \$100. If your doctor accepts Medicare assignment, Medicare will pay 80% of that amount (\$80) to the doctor, and the doctor is permitted to bill you only \$20 — the difference between the Medicare approved charge (\$100) and the Medicare payment (\$80). The doctor is paid a total of \$100 for procedure X, no matter what the “going rate” for that procedure is, and your out-of-pocket cost will be \$20.

If your doctor does not accept Medicare assignment, you may be responsible for paying up to 115% of the Medicare- approved charge—here, \$115. In this case, Medicare would pay \$80 (80% of its approved charge amount). Medicare’s payment is sent to you, and the doctor can bill you \$115. Your total out-of-pocket cost would be \$35.

Since Medicare’s approved charges are often lower than a physician’s usual fees, some physicians may limit the number of Medicare beneficiaries that they will take as patients, or may not accept Medicare assignment. It is therefore very important to find out whether your doctor accepts assignment.

Benefits under Medicare + Choice

In some areas of North Carolina, benefits may also be available through managed care plans. There are three Medicare Managed Care Plans operating in North Carolina:

Partners Medicare Choice

P. O. Box 24907
Winston-Salem, NC 27114-4907
800-668-8037
<http://www.partnershealth.com>

Counties served: Alamance, Alexander, Alleghany, Ashe, Cabarrus, Davidson, Davie, Forsyth, Gaston, Guilford, Iredell, Mecklenburg, Orange, Rockingham, Rowan, Stokes, Surry, Wake, Wilkes, and Yadkin

QualChoice Medicare Gold

100 Kimel Forest Drive
P. O. Box 340
Winston-Salem, NC 27102-0340
800-273-4115
<http://www.qualchoicenc.com>

Counties served: Alexander, Alleghany, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Rowan, Stokes, Surry, Wilkes and Yadkin

United HealthCare of NC Medicare Complete

P. O. Box 26403
Greensboro, NC 27404
888-264-8761
(336) 851-8740

Counties served: Alamance, Chatham, Durham, Forsyth, Guilford, Mecklenburg, Orange, Randolph, Rockingham and Wake.

Enrollment into these plans is voluntary. Enrollees will receive all benefits available under Part A and Part B. They may also receive benefits not included under the original Medicare program, such as prescription drugs or preventive care. Enrollees must pay the Medicare Part B premium (\$54/month), although some plans may require additional premiums. There may also be copayments for certain services.

Members of managed care plans may have less choice of providers and less freedom to see specialists without prior approval from their plan. However, they may have less out-of-pocket payments and may be eligible for additional services.

Beginning in 2003, some insurers around the country will begin offering a Preferred Provider Organization (PPO) product to Medicare recipients. In North Carolina, only one company will offer a PPO product:

the patient may not be required to pay for the service. Medicare may agree to pay for the service if the patient follows a special waiver process. This procedure can be used for any claims denied under Part A. Under Part B, the waiver process is available only if the claim is denied for a service provided by a physician who accepts Medicare assignment.

Liability will be waived if it can be shown that the patient could not have been expected to know that the service would not be covered. Generally, it is presumed that a patient would not be able to know that a service would not be covered, unless the patient received advance written notice of noncoverage. When liability is waived, Medicare pays for the service even though the claim was denied.

PERSONAL ELIGIBILITY

Part A

Eligibility without a premium

The following people are eligible for Medicare Part A without the payment of any premium:

- ◆ Recipients of Social Security or Railroad Retirement benefits who are age 65 and older.
- ◆ Federal civil service employees age 65 and older who became eligible for federal retirement benefits after January 1, 1983.
- ◆ State and local government employees age 65 and older who were hired after April 1, 1986.
- ◆ People with disabilities under age 65 who have been entitled to Social Security disability or Railroad Retirement disability benefits for 24 months or more. (Note: there is a five-month waiting period before anyone can qualify for Social Security disability, so you would have to be disabled for at least 29 months before you could qualify for Medicare under this category.)
- ◆ Certain people who receive a kidney transplant or undergo hemodialysis. This is called end-stage renal disease, or ESRD. To qualify for Medicare under this

category, you must be under age 65 and fully or currently insured for Social Security, or you must be an employee covered by the Railroad Retirement Act. This type of Medicare coverage begins with the kidney transplant or three months after the hemodialysis begins, and ends 36 months after the transplant or 12 months after hemodialysis ends.

Eligibility with a premium

Certain older individuals who are not receiving Social Security or Railroad retirement payments may still be eligible to buy into Medicare Part A. To qualify for Part A with a premium, a person must be a resident of the U.S. (a citizen or a lawfully admitted alien who has resided in the United States for five consecutive years) who is age 65 or older and enrolled in Medicare Part B. Anyone who meets the following criteria may choose to enroll in Medicare Part A by paying the policy's premium. The 2003 premium is \$316 per month, but it may be reduced based on a person's past contributions to the Social Security system. Medicaid will pay this premium for some low-income individuals (see page 109).

Part B

Anyone entitled to participate in Medicare Part A may choose to participate in Part B upon the payment of a monthly premium. Effective January 1, 2003, the monthly premium is \$58.70. The premium amount is adjusted yearly. The monthly premium is usually deducted from a person's Social Security check. Medicaid will pay this premium for some low-income individuals (see page 109).

Medicare + Choice

All individuals who are eligible for Part A and Part B, except those eligibles with end stage renal disease, may enroll in a Medicare + Choice plan, provided that they live in an area where a plan is offered.

FINANCIAL ELIGIBILITY

Unlike Medicaid, eligibility for Medicare does not depend on financial need. Anyone who meets the personal eligibility requirements outlined above is eligible for Medicare, regardless of that person's income or resources.

APPLICATIONS

Applications are taken at district offices of the Social Security Administration, which are listed in Appendix B. Call 800-772-1213 for information about setting up an appointment.

Automatic enrollment for Part A and Part B

People who are entitled to Social Security or Railroad Retirement benefits will be automatically enrolled in Medicare when they turn 65. People who begin collecting Social Security disability benefits prior to age 65 are automatically enrolled once

turning 65. People who have received Social Security disability benefits for 24 months are also automatically enrolled. No separate application is required.

Applying for Part A and Part B

People who are eligible for but not receiving Social Security benefits must apply for Medicare benefits. In addition, people with end-stage renal disease and voluntary enrollees (those who are eligible for Medicare by paying a premium) do not receive Medicare automatically. They must file an application to become eligible for Medicare. Contact the Social Security Office to apply for Medicare.

Part B enrollment

People who are enrolled in Medicare Part A are automatically enrolled in Part B. However, you may “opt out” of Part B coverage.

If you are not automatically enrolled in Part A, you may enroll in Part B at certain times without any penalty. If you enroll late — that is, after the set enrollment periods — you may be charged as much as 10% more for your Part B premium than if you enrolled during the prescribed enrollment periods.

The “initial enrollment period” begins three months before a person becomes eligible for Medicare Part A and continues for seven months. If you are not automatically eligible for Medicare and wish to enroll, you should apply during this initial enrollment period.

There is also a “general enrollment period” for people who did not enroll during the initial enrollment period. The general enrollment period runs from January 1 to March 31 of each year. Coverage becomes effective July 1st.

“Special enrollment periods” are also available under certain circumstances. A person 65 or older who had health insurance from another source (for instance, through an employer’s health plan) and later loses that coverage may enroll during a special enrollment period. In this case, the special enrollment period is an eight-month period beginning when employment terminates or after the employer’s group plan ends. You are not charged a penalty if you enroll during a special enrollment period.

Medicare + Choice Enrollment

All Part C plans must participate in an “open enrollment” period during the month of November. Some plans may also accept members at other times during the year. In order to join one of the plans, you must contact the plan and obtain an enrollment form. Once you have completed the form and returned it to a plan representative, the plan will provide you with a letter stating the date that coverage will begin.

The plans may place restrictions on when members can disenroll in the + Choice plan. Beginning in 2002, beneficiaries may change plans only once during the first six months of the year.

APPEALS

If you are a Medicare beneficiary (or applying for Medicare), you may sometimes disagree with a Medicare decision — for example—about whether you are required to pay a Part A premium, the appropriate length of a hospital stay, or if Medicare denies payment for a medical procedure. The Medicare program has systems to appeal such decisions. The appeal process you need to use will depend on the type of Medicare decision you wish to appeal. If you do appeal a Medicare decision, you have a right to be represented by a lawyer. Legal Services offices may be able to assist some low-income people who need an attorney's assistance with a Medicare appeal. Legal Services offices are listed in Appendix B.

Appealing a decision about eligibility

Decisions about whether someone is eligible for Medicare (Parts A and B) are appealed to the Social Security Administration. If you receive notice that you are ineligible for Medicare and you want to appeal that decision, you have 60 days from the time you receive notice to file a written request for reconsideration.

The Medicare program may end, reduce, or suspend a person's Medicare benefits for a variety of reasons. If you wish to appeal a Medicare decision about termination, reduction, or suspension of benefits, you should file a request for reconsideration within 60 days of receiving notice of the decision. If you file your request for reconsideration within 10 days of receiving your notice, your Medicare benefits will continue while you are making your appeal. Unlike the Medicaid program, the Social Security Administration is not required to issue a decision on an appeal within a certain length of time.

If you disagree with the Social Security Administration's decision on your written request for reconsideration, you may continue your appeal. You have 60 days after receiving notice of SSA's decision to request a face-to-face hearing before an Administrative Law Judge (ALJ). The ALJ will issue a written decision and will mail it to you and your legal representative. The ALJ is not required to issue a decision within a certain length of time.

If you disagree with the ALJ's decision, you may request a review of your case by the Appeals Council. The request for review must be made within 60 days of receiving the ALJ's decision. The Appeals Council's written decision will be mailed to you and your legal representative. As with previous steps in the appeals process, the Appeals Council is not required to issue its decision within a certain length of time.

If you disagree with the Appeals Council's decision, you have 60 days to file an appeal in Federal District Court. The case is reviewed by a judge or a federal magistrate, who considers the evidence already submitted in the prior proceedings. This decision may be appealed to the U.S. Court of Appeals.

Appealing a decision about Part A hospital services

Decisions about Medicare's hospital services (such as preadmission certification, length of stay, and hospital procedures and care) are made by a group of doctors working for a Quality Improvement Organization (QIO, formerly called Peer Review Organization or PRO). In North Carolina, the QIO is Medical Review of North Carolina. If you disagree with the QIO decision, you may request a reconsideration within 60 days of the action or decision you wish to challenge. Your request is made to the QIO and is given an initial review by them. This is a "paper review" — that is, not a face-to-face hearing.

An expedited reconsideration process is available when time is of the essence. This is especially important if you are hospitalized and have been notified by Medicare that a continued stay or an anticipated procedure will not be covered. You must request the review within three days of getting the notice, and the QIO must respond within three days.

If the amount in question is at least \$200, a Medicare beneficiary has a right to appeal the QIO decision to an Administrative Law Judge (ALJ). If the amount in controversy is at least \$2,000, the ALJ's decision can be appealed to Federal District Court.

If you are a Medicare beneficiary and you are admitted to a hospital, you must be given a brochure called "An Important Message from Medicare." This brochure explains how to appeal a Medicare decision about Part A hospital services.

Appealing a decision about other Part A services

Appeals about other Part A services such as home health or hospice care are heard first by Palmetto-GBA. If you do not agree with their decision and the amount in dispute is at least \$100, you may appeal the decision to an Administrative Law Judge (ALJ). The ALJ's decision can be appealed to Federal District Court if the amount in controversy is at least \$1,000.

Appealing a decision about Part B services

If Medicare Part B denies payment for services, you will get a "Medicare Summary Notice" (MSN) which explains Medicare's decisions about Part B services and tells you how to appeal a decision. You have six months from the date of the MSN to request a review.

If Part B benefits are denied and the amount in question is at least \$100, you can request reconsideration of the denial and a hearing before CIGNA. You must make the request for reconsideration within six months of the denial. (The amount in dispute can be accumulated over the six-month period.) If the amount in controversy is at least \$500, you can appeal the reconsideration decision to an Administrative Law Judge (ALJ). If the amount in controversy is at least \$1,000, the ALJ's decision can be appealed to Federal District Court. You may also request a hearing if Medicare fails to respond to a request for payment.

Appeals process for members of Part C plans

The appeals process for Part C claims is divided into two categories: non-urgent and urgent.

Non-urgent

If a plan member files an appeal for a denied service that is not needed immediately, the plan has 30 days to respond. If the plan does not reverse its denial, it must send the member's appeal to the Center for Health Disputes and Resolution (CHDR). The CHDR has 30 days to review the appeal. If the CHDR agrees with the denial and the denied service costs more than \$100, the member can request that the appeal be heard by an administrative law judge. If the member does not agree with the ALJ's decision, the member can appeal the decision to a Federal District Court if the amount in controversy is at least \$1,000.

Urgent

If a denied service is needed immediately, a member can request an expedited decision from the plan. If the plan denies the request for an expedited decision, the member's doctor can request the expedited decision requiring the plan to consider the request within 72 hours.

If the member's doctor does not support the request for an expedited appeal, the plan will review the appeal according to the non-urgent appeals process. However, the member may also file a grievance with the plan if the member believes that the appeal was urgent. All grievances filed with the plan should also be sent to CMS and to the member's congressional representative.

SOURCES OF LAW

Federal statute(s):	42 U.S.C. §1395 <i>et seq.</i>
Federal regulations:	42 C.F.R. §§400-424, 460-498 C.F.R. §405 <i>et seq.</i>
Federal policy:	CMS Medicare Manuals

FOR MORE INFORMATION

Social Security Administration

800-772-1213

<http://www.ssa.gov>

The Social Security Administration publishes The Medicare Handbook each year. It is available free from SSA.

Medicare-Consumer Information

1-800-MEDICARE

<http://www.medicare.gov>

For Part A:

Medicare Part A Beneficiary Services

Palmetto GBA

Durham, NC

800-685-1512

Medical Review of North Carolina

(For appeals of hospital stays)

Raleigh, NC

800-722-0468

For Part B:

CIGNA

High Point, NC

(800) 672-3071

(336) 882-4562 (Outside of North Carolina)