

Medicare

Description:

Medicare is a national health insurance program for persons age 65 or older and for certain persons with disabilities. Medicare has two parts, A and B. Connecticut beneficiaries have the option of receiving benefits through the original fee-for-service plan or choosing coverage through a Medicare managed care plan. Persons who enroll in Medicare automatically become a part of the fee-for-services program unless they choose to enroll in a Medicare managed care plan. The original fee-for-service program is similar to indemnity insurance in that it helps to cover the medically necessary expenses of acute care, such as illness. Although it provides basic coverage, it does not pay 100 percent of health care costs. Deductibles and co-insurances apply to certain benefits under both Parts A and B. In the fee-for-service program, a beneficiary can receive services from any licensed medical provider anywhere in the country and use any facility that is certified by Medicare. Generally, a fee is paid each time a service is used. Medicare pays a share of the cost; the beneficiary pays whatever Medicare does not.

Both plans provide basic Medicare benefits for hospital and medical services; but there are important differences among these plans in the way services are delivered, how and when payments are made and the amount of out of pocket expenses beneficiaries must pay. Persons are still eligible for Medicare at age 65, however, they must file an application to receive these benefits even if their full retirement age for Social Security benefits is older than 65. Persons already receiving Social Security or Railroad Retirement Board benefits automatically get Part A beginning the first day of the month in which they turn age 65 and the option to have Part B. Persons who are younger than age 65 and have disabilities are eligible for Part A and part B when they have received Social Security disability or Railroad Retirement benefits for 24 months.

Medicare Part A: Hospital

Medicare Part A covers inpatient hospital care, hospice care, some short-term inpatient care in skilled nursing facilities and some home health care services. Part A is largely financed through federal payroll taxes that are paid into the Medicare Trust Fund by employers and employees. Most beneficiaries automatically receive Part A coverage when they reach age 65. Most of the individuals do not have to pay a monthly premium. Persons age 65 or older who did not pay Medicare taxes when they worked and have not accumulated enough Social Security credit may choose to purchase Part A. Persons who are close to age 65 but are not receiving these benefits should apply for them through the Social Security Administration. Persons with Part A coverage have "Hospital Part A" printed on the lower left corner of their red, white and blue Medicare card.

Medicare Part A pays partial costs of certain services from a hospital, skilled nursing facility, hospice and home health agency. There is a substantial deductible for each benefit period (\$1,068 in 2009) and a co-insurance share of daily costs if hospitalized for more than 60 days in a benefit period.

Part B: Medical/Physician:

Medicare Part B is optional; it covers a wide range of services and supplies which includes, services provided by doctors and other medical practitioners, some outpatient care, certain home health care services and some preventative benefits as well as durable medical equipment. This coverage is financed partially by monthly premiums that are paid by all beneficiaries and partially by general revenues from the federal government. There is a monthly premium for Part B, which is \$96.40 (2009). Some people with high incomes pay higher Part B premiums. This amount might also be higher for persons who did not choose Part B when they first became eligible at age 65. Costs may increase by 10 percent for each 12-month period a person could have enrolled in Part B but did not. Individuals who are automatically eligible for Part A are also enrolled in Part B unless they inform Social Security not to do so. New premium rates become effective each January. New rates are sent to beneficiaries in December with their cost of living adjustment notice. Premiums are usually deducted from persons' monthly Social Security, Railroad Retirement or Office of Personnel Management Retirement payments. For those who do not receive such payments, Medicare bills quarterly for coverage.

Part B pays for a wide range of medical services and supplies, including doctor's care, whether such care is received at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. In 2009, there is a \$135 deductible which must be paid each year before Part B begins to pay its share of covered services. After the deductible is met, Part B generally pays 80 percent of the Medicare-approved amount for all covered services received during the rest of the year. The beneficiary is responsible for the remaining 20 percent and any amount in excess of what Medicare has approved. There are no excess charges, however, if the physician or medical supplier agrees to accept the Medicare-approved amount as full payment. This is referred to as "accepting assignment".

Medicare covers certain preventive health care screening tests for which the Part B deductible and co-insurances may be waived for some of these services. These include:

- Annual mammography screening.
- Pap smear and pelvic exam screening.
- Colorectal cancer screening.
- Diabetes screening tests and self-management training.
- Bone mass measurement.
- Prostate cancer screening tests.
- A one time "welcome to Medicare" physical which must be used within the first six months of being enrolled in Medicare Part B.

Medicare Part D: Prescription Drug

Medicare prescription drug coverage, also known as Medicare Rx, pays for prescription drugs, insulin and insulin supplies and smoking cessation drugs for Medicare beneficiaries. Medicare contracts with private companies to provide this drug coverage. In 2009 there are 47 Prescription Drug Plans (PDPs) and 32 Medicare Advantage Plans (HMO, PPO and PFFSs) that offer prescription drug coverage in Connecticut. Most companies offer several plans with different levels of coverage and costs. Some employers may “wrap-around” the program to offer coverage through their retirement health plans, meaning that whatever costs part D does not cover, the employer offered plan would.

Medicare beneficiaries must enroll in a PDP to have Medicare provide prescription drug coverage. There are guidelines concerning when a beneficiary can enroll in a Medicare prescription drug plan as well as when and how often an individual can change plans.

Beneficiaries are penalized one percent per month for each month that they could have enrolled in a Medicare prescription drug plan but did not. Plans issue ID cards to enrollees that are used at the pharmacy; some cards allow members to receive prescriptions by the mail.

Medicare Part D covers most outpatient prescription drugs, insulin and insulin supplies and smoking cessation drugs. Medicare approved plans offer their own selection of covered drugs, which is called a “formulary”. Formularies vary from plan to plan. These plans offer a choice of at least two drugs in each of the 146 categories of drugs. Plans also include their own formulary for drugs in the following six categories of drugs: anti-depressants, anti-psychotics, anti-convulsants, anti-cancer, immuno-suppressants and HIV/AIDS. Medicare Part D does not cover some drugs. Some plans may cover certain excluded drugs as an enhanced benefit for an additional charge. Medicaid and ConnPACE also cover some of these drugs for their consumers.

The Medicare Part D “standard benefit” includes an annual deductible. In 2009 this deductible cannot exceed \$295 per year. Beneficiaries must meet their plans specific annual deductible before Part D coverage begins. When the deductible is met, the “initial benefit period” begins at which time Medicare pays 75 percent of each prescription drug; the beneficiary pays 25 percent for the next \$2,405 in drug costs. Then a coverage gap or “donut hole” in which the beneficiary pays 100 percent of all prescription costs until another \$3,453.75 out of pocket has been spent. Some plans may pay for prescription costs during the coverage gap. Once the beneficiary has spent a total of \$4,350 in allowable “true-out-of-pocket costs” (TrOOP), “Catastrophic Coverage” begins and for the remainder of the year Medicare pays 95 percent of prescription drug costs and the beneficiary pays 5 percent of each prescription, \$2.40 or \$6 co-pay, whichever is greater.

Individuals who receive benefits from ConnPACE, Medicaid, a Medicare Savings Program (QMB, SLMB, ALMB/QI) or Supplemental Security Income (SSI) are automatically enrolled in a Medicare prescription drug plan if they do not select a plan

on their own. Dual eligible individuals may switch plans one time per month; the change is effective the first day of the following month.

All plans have co-pays or co-insurances that beneficiaries are responsible to pay for each prescription. Beneficiaries with limited income and assets may qualify for Extra Help to assist them in paying the premiums, deductibles, co-pays and co-insurance. Persons can apply for Extra Help at their local Social Security office.

Medigap:

Many other medical expenses, such as self-administered prescription drugs, dental care, and routine physicals are not covered either through Part A or Part B. To help pay for these out of pocket expenses, beneficiaries often buy supplemental private insurance policies, called Medigap. For more information about Medigap insurance, please refer to the section of this Manual called “Medigap Insurance Policies.”

Medicare Managed Care Plans:

Connecticut beneficiaries have the option of receiving Medicare services through one of several federally approved Medicare managed care plans. Unlike fee-for-service, these plans are “preventive” in nature and attempt to coordinate all health care services an individual receives to maximize benefits and minimize costs. To achieve these goals, plans use a limited network of health care providers and facilities and a system of “prior approval” from a primary care physician, sometimes referred to as a “gatekeeper”. Primary care physicians authorize, arrange for, and coordinate care that they decide is reasonable and necessary.

Most managed care plans in Connecticut require an additional monthly premium, especially if there is a prescription drug benefit included in the plan. Plans require co-payments for physician visits or for the use of other services. Individuals must continue to pay the Medicare Part B premiums; but they do not have to pay the deductible and co-insurance under Medicare’s original fee-for-service. Benefits vary from plan to plan, however, each plan is required by Medicare law to provide all of the Medicare benefits that are generally available in the plan’s service area.

All plans have a “lock-in” requirement, which means that individuals generally must receive all covered care from doctors, hospitals, and other health care providers that are affiliated with the plan. Exceptions include emergency care, urgent care and certain care provided under an additional “point of service” (POS) option.

If individuals enroll in a Medicare managed care plan and later decide to return to Medicare’s original fee-for-service, they may disenroll at any time. Certain time restrictions on this policy will be phased out. Persons who do this may be limited in the available Medigap policies from which they can choose. Persons who want to change from one Medicare managed care plan to another may do so by enrolling in the other plan; this action automatically disenrolls them from the first plan. Persons whose Medicare managed care plan no longer provides coverage in their region also have

options available to them. Contact the CHIOCES program at 800-994-9422 for more information on these situations.

To enroll in a Medicare managed care plan individuals must be enrolled in Medicare Parts A and B, continue to pay Part B premiums and not be medically determined to have end-stage renal disease prohibition. Persons may not be denied membership because of otherwise poor health, a disability or other pre-existing conditions.

Choosing the Best Medical Plan:

Both the original fee-for-service Medicare and Medicare managed care plans have advantages and disadvantages depending upon individual's personal circumstances. Information detailing each program option, including plan comparison guides and other considerations as well as general assistance can be obtained through the CHOICES programs.

Beneficiaries should read program materials, ask questions and consider the important personal aspects of each option to make sure the best medical program is chosen.

Eligibility Requirements, Service Areas and Program Year:

Eligibility Requirements:

- Must be age 65 or older or have certain disabilities.

Service Areas:

Statewide

Program Year:

N/A

Contact Information:

Call 1800-medicare or go to www.Medicare.gov

For Social Security offices and information regarding Medicare, contact the Social Security offices below:

District and Branch Offices in Connecticut:

Ansonia:
307 Main Street
Ansonia, CT 06401
Telephone: 203-735-6201

Bridgeport:
3885 Main Street, 3rd Floor
Bridgeport, CT 06606
Telephone: 203-365-8452

Bristol:
225 North Main Street, Room 400
Bristol, CT 06010
Telephone: 860-584-2716

Danbury:
131 West Street
Danbury, CT 06810
Telephone: 203-748-3569

East Hartford:
478 Burnside Avenue
East Hartford, CT 06108
Telephone: 860-290-5420

Hartford:
One Corporate Center
20 Church Street, Suite 900
Hartford, CT 06103
Telephone: 860-493-1857

Meriden:
One West Main Street, 4th Floor
Meriden, CT 06451
Telephone: 203-238-0346

Middletown:
425 Main Street, 3rd floor
Middletown, CT 06457
Telephone: 860-347-8562

New Britain:
100 Arch Street
New Britain, CT 06050
Telephone: 860-229-4844

New Haven:
150 Court Street, Room 325A
New Haven, CT 06510
Telephone: 203-773-5201

New London:
2 Shaw's Cove, Room 203
New London, CT 06320
Telephone: 860-443-8455

Norwich:
Thames Plaza
101 Water Street, 3rd floor
Norwich, CT 06360
Telephone: 860-886-7118

Norwalk:
24 Belden Avenue, 5th floor
Norwalk, CT 06850
Telephone: 203-849-1911

Stamford:
2 Landmark Square, Suite 105
Stamford, CT 06901
Telephone: 203-359-0030

Torrington:
147 Litchfield Street
Torrington, CT 06790
Telephone: 860-489-1633

Waterbury:
14 Cottage Place
Federal Building, Room 255
Waterbury, CT 06702
Telephone: 203-756-7476

Willimantic:
54 North Street
Willimantic, CT 06226
Telephone: 860-423-6386

Contact Information:

For information regarding the CHOICES program and general questions about Medicare refer to [CHOICES](#) on page XIII – 5 in this manual.

For further information on accepting assignment refer to [ConnMAP](#) on page VIII 8 of this manual.

For an explanation of supplemental private insurance policies refer to [Medigap Insurance Policies](#) on page IX – 16 of this manual.

Related Information:

[Center for Medicare Advocacy, refer to page I – 3.](#)