



Understanding Medicare and how it works in Alaska

National Medicare TRAINING PROGRAM

**...helping people with Medicare
make informed health care decisions**



The Alaska SHIP (State Health Insurance Program)



Alaska's Medicare Information Office

1-800-478-6065 or (907) 269-368

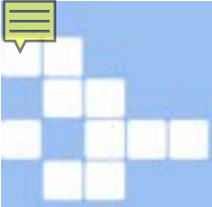
Medicare.alaska.gov

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Session Objectives

- This session will help you to
 - Recognize the parts of Medicare
 - Compare Medicare coverage options
 - Relate Medicare-covered services and supplies
 - Recognize Medicare rights and appeals
 - Explain programs for people with limited income and resources



What is Medicare?

- Health insurance for three groups of people
 - 65 and older
 - Under 65 with certain disabilities
 - Any age with End-Stage Renal Disease (ESRD)
- Administration
 - Centers for Medicare & Medicaid Services

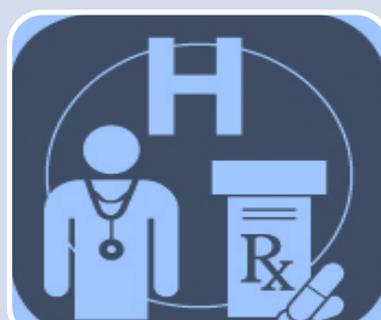
What are the Four Parts of Medicare?



Part A
Hospital
Insurance



Part B
Medical
Insurance



Part C
Medicare
Advantage
Plans , like
HMOs and
PPOs
Includes Part A
& B and usually
Part D
coverage



Part D
Medicare
Prescription
Drug
Coverage

Automatic Enrollment – Part A and B

- Automatic for those receiving
 - Social Security benefits
 - Railroad Retirement Board benefits
- Initial Enrollment Period Package
 - Mailed 3 months before
 - Age 65
 - 25th month of disability benefits
- Others must enroll themselves



Medicare Card

- Keep it and accept Medicare Parts A and B
- Return it to refuse Part B
 - Follow instructions on back of card

Front

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER **000-00-0000-A** SEX **FEMALE**

IS ENTITLED TO **HOSPITAL MEDICAL (PART A)** EFFECTIVE DATE **07-01-1986**
MEDICAL (PART B) **07-01-1986**

SIGN HERE → *Jane Doe*

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical, or health services under Medicare.
3. Your card is good wherever you live in the United States.

WARNING: Issued only for use of the named beneficiary. Intentional misuse of this card is unlawful and will make the offender liable to penalty. If found, drop in nearest U.S. Mail box.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Baltimore, MD 21244-1850
Form CMS-1968 (01/2002)

If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227) or visit us at www.medicare.gov.

I DO NOT WANT MEDICAL INSURANCE Check Here

Written Signature (or Legal Representative)
SIGN HERE

Signature by Mark (X) Must Be Witnessed

Signature of Witness
Address of Witness

If you DO NOT want Medical Insurance

1. Check the box above (top right), sign your name, and return the entire form in the enclosed envelope. Do NOT tear off the Medicare card. It would be improper to use it since you do not want Medical Insurance. You must return the form BEFORE the Medical Insurance effective date shown on the card.
2. Since you are entitled to Hospital Insurance even though you do not want Medical Insurance, we will send you a new card showing that you have Hospital Insurance only.



When Enrolling in Medicare is Not Automatic

- Some people need to sign up
 - Those not automatically enrolled
 - Even if you are eligible to get Part A premium-free
- Enroll through Social Security
 - Railroad Retirement Board for railroad retirees
- Apply 3 months before age 65
 - Don't have to be retired

If Not Automatically Enrolled

Your 7-Month Initial Enrollment Period

No Delay				Delayed Start			
If you enroll in Part B	3 months before the month you turn 65	2 months before the month you turn 65	1 month before the month you turn 65	<i>The month you turn 65</i>	1 month after you turn 65	2 months after you turn 65	3 months after you turn 65

Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.

If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.



General Enrollment Period (GEP)

- January 1 through March 31 each year
- Coverage effective July 1
- Premium penalty
 - 10% for each 12-months eligible but not enrolled
 - Must pay as long as you have Part B
 - Limited exceptions



Enrolling in Part B While You or Spouse Have Employer or Union Coverage

- May affect your Part B enrollment rights
 - You may want to delay enrolling in Part B if
 - You have employer or union coverage and
 - You or your spouse, or family member if you are disabled, is still working
- See how your insurance works with Medicare
 - Contact your employer/union benefits administrator



Working beyond 65? - Special Enrollment Period (SEP)

- When your employment ends
 - You may get a chance to elect COBRA
 - You may get a Special Enrollment Period
 - Sign up for Part B without a penalty
- Medigap Open Enrollment Period
 - Starts when you are both 65 and sign up for Part B
 - Once started cannot be delayed or repeated



Enrollment in Medicare if You Have TRICARE Coverage

- Medicare Part A and TRICARE For Life
 - If retired you must have Part B to keep TRICARE
- Active-duty member, spouse or dependent child
 - You don't have to have Part B to keep TRICARE
- You get a Part B Special Enrollment Period
 - If you have Medicare because you are age 65 or
 - Because you are disabled

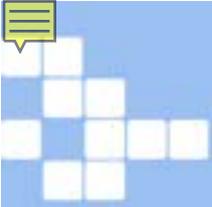


Exercise

Social Security is responsible for enrolling most people in Medicare.

1. True
2. False





What Does Medicare Cover?

- What is covered in
 - Medicare Part A (Hospital Insurance)
 - Medicare Part B (Medical Insurance)

Medicare Part A Covered Services

Inpatient Hospital Stays

Semi-private room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in psychiatric hospital (lifetime 190-day limit). Generally covers all drugs provided during an inpatient stay received as part of your treatment.

Skilled Nursing Facility Care

Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.

Home Health Care Services

Can include part-time or intermittent skilled care, and physical therapy, speech-language pathology, a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies.

Hospice Care

For terminally ill and includes drugs, medical care, and support services from a Medicare-approved hospice.

Blood

In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.



Paying for Medicare Part A

- Most people receive Part A premium free
 - If you paid FICA taxes at least 10 years
- If you paid FICA less than 10 years
 - Can pay a premium to get Part A
 - May have penalty if not bought when first eligible



Benefit Periods

- Measures use of inpatient hospital and skilled nursing facility (SNF) services
- Begins the day you first receive inpatient care
 - In hospital or skilled nursing facility
- Ends when not in hospital/SNF 60 days in a row
- Pay Part A deductible for each benefit period
 - \$1,184 in 2013
- No limit to number of benefit periods

Paying for Inpatient Hospital Stays

For each benefit period in 2013	You Pay
Days 1-60	\$1,184 deductible
Days 61-90	\$296 per day
Days 91-150	\$592 per day (60 lifetime reserve days)
All days after 150	All Costs



Skilled Nursing Facility Care

- Must meet all conditions
 - Require daily skilled services
 - Not just long-term or custodial care
 - Hospital inpatient 3 consecutive days or longer
 - Admitted to SNF within specific timeframe
 - Generally 30 days after leaving hospital
 - SNF care must be for a hospital-treated condition
 - Or condition that arose while receiving care in the SNF for hospital-treated condition
 - **MUST** be a Medicare-participating SNF



Skilled Nursing Facility Care

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation (limited)
- Dietary counseling

Paying for Skilled Nursing Facility Care

For each benefit period in 2012	You Pay
Days 1-20	\$0
Days 21-100	\$148 per day
All days after 100	All Costs



Five Conditions for Home Health Care

1. Must be homebound
2. Must need skilled care on intermittent basis
3. Must be under care of a doctor
 - Receiving services under a plan of care
4. Have face-to-face encounter with doctor
 - Prior to start of care
5. Home health agency must be Medicare-approved



Paying for Home Health Care

- Fully covered by Medicare
- Plan of care reviewed every 60 days
 - Called episode of care
- In Original Medicare you pay
 - Nothing for covered home health care services
 - 20% of Medicare-approved amount
 - For durable medical equipment (covered by Part B)



Hospice Care

- Special care for the terminally ill and family
 - Expected to live 6 months or less
- Focus on comfort and pain relief, not cure
- Doctor must certify each “benefit period”
 - Two 90-day periods
 - Then unlimited 60-day periods
 - Face-to-face encounter
- Hospice provider must be Medicare-approved



Covered Hospice Services

- Physician and nursing services
- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care
- Respite care in a Medicare-certified facility
 - Up to 5 days each time, no limit to times
- Hospice aide and homemaker services
- Social worker services
- Grief, dietary and other counseling
- Physical, occupational, or speech therapy



Paying for Hospice Care

- In Original Medicare you pay
 - Nothing for hospice care
 - Up to \$5 per Rx to manage pain and symptoms
 - While at home
 - 5% for inpatient respite care
- Room and board may be covered
 - Short term respite care or for pain/symptom management
 - If you have Medicaid and live in nursing facility



Blood (Inpatient)

- If hospital gets blood free from blood bank
 - You won't have to pay for it or replace it
- If hospital has to buy blood for you
 - You pay for first 3 units per a calendar year, or
 - You or someone else donates to replace blood



Medicare Part B Coverage

Doctors' Services

Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services.

Except for certain preventive services, you pay 20% of the Medicare-approved amount (if the doctor accepts assignment), and the Part B deductible applies.

Outpatient Medical and Surgical Services and Supplies

For approved procedures (like X-rays, a cast, or stitches).

You pay the doctor 20% of the Medicare-approved amount for the doctor's services if the doctor accepts assignment. You also pay the hospital a copayment for each service. The Part B deductible applies.



Medicare Part B Coverage

Home Health Care Services

Medically necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, occupational therapy, part-time or intermittent home health aide services, medical social services, and medical supplies. Durable medical equipment and an osteoporosis drug are also covered under Part B.

You pay nothing for covered services.

Medicare Part B Coverage

Durable Medical Equipment

Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented.

You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Other (including but not limited to)

Medically necessary medical services and supplies, such as clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited outpatient prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services are covered.

Costs vary.



Part B Covered Preventive Services

- “Welcome to Medicare” visit
- Annual “Wellness” visit
- Abdominal aortic aneurysm screening*
- Alcohol misuse screening and counseling
- Behavioral therapy for cardiovascular disease
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Mammograms (screening)
- Obesity screening and counseling
- Pap test/pelvic exam/clinical breast exam
- Pneumococcal pneumonia shot
- Prostate cancer screening
- Sexually transmitted infection screening (STIs) and high-intensity behavioral counseling to prevent STIs
- Smoking cessation

*When referred during Welcome to Medicare physical exam



NOT Covered by Part A and Part B

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting hearing aids
- Other – check on www.medicare.gov



Paying for Part B Services

- In Original Medicare you pay
 - Yearly deductible of \$147 in 2012
 - 20% coinsurance for most services
- Some programs may help pay these costs

Monthly Part B Premium

If your Yearly Income in 2011 was		You Pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or less	\$170,000 or less	\$104.90
\$85,001–\$107,000	\$170,001–\$214,000	\$146.90
\$107,001–\$160,000	\$214,001–\$320,000	\$209.80
\$160,001–\$214,000	\$320,001–\$428,000	\$272.70
above \$214,000	above \$428,000	\$335.70



Paying the Part B Premium

- Deducted monthly from
 - Social Security payments
 - Railroad retirement payments
 - Federal retirement payments
- If not deducted
 - Billed every 3 months
 - Medicare Easy Pay to deduct from bank account
- Contact SSA, RRB or OPM about premiums



Part B Late Enrollment Penalty

- Penalty for not signing up when first eligible
 - 10% more for each full 12-month period
 - May have penalty as long as you have Part B
- Sign up during a Special Enrollment Period
 - Usually no penalty



Part B Late Enrollment Penalty Example

Mary delayed signing up for Part B two full years after she was eligible. She will pay a 10% penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium (\$99.90 in 2012). So for 2012, her premium will be as follows:

	\$104.90 (2013 Part B standard premium)
+	\$20.98 (20% [of \$104.90] (2 X 10%))
	\$125.88 (Round up) (For this example only)
<hr/>	
	\$125.88 (Mary's Part B monthly premium for 2013)



Exercise

The Part B premium most people with Medicare will pay in 2012 is \$99.90.

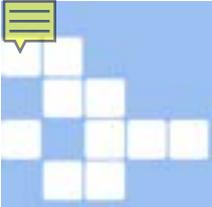
1. True
2. False





What is Original Medicare?

- Health care option run by the Federal government
- Provides your Part A and/or Part B coverage
- See any doctor or hospital that accepts Medicare
- You pay
 - Part B premium (Part A free for most people)
 - Deductibles, coinsurance or copayments
- Get Medicare Summary Notice (MSN)
- Can join a Part D plan to add drug coverage



3 types of providers

- Those that accept Assignment
- Those that do not accept assignment
- Those that opted out - Private Contracts



Providers that accept Assignment

- Doctor, provider, supplier ***accepts assignment***
 - Signed an agreement with Medicare
 - Or is required by law
 - Accept the Medicare-approved amount
 - As full payment for covered services
 - Only charge Medicare deductible/coinsurance amount



Providers that do not accept Assignment

- Suppliers that don't accept assignment
 - May charge you more
 - The limiting charge is 15% more
 - May have to pay entire charge at time of service
- Providers sometimes must accept assignment
 - Medicare Part B-covered prescription drugs
 - Ambulance suppliers



Providers that “opt out” - Private Contracts

- Agreement between you and your doctor
 - Doctor doesn't furnish services through Medicare
 - Original Medicare and Medigap will not pay
 - Other Medicare plans will not pay
 - You will pay full amount for the services you get
 - No claim should be submitted
 - Cannot be asked to sign in an emergency



Medigap Policies

- Medigap (Medicare Supplement Insurance) policies
 - Private health insurance for individuals
 - Sold by private insurance companies
 - Supplement Original Medicare coverage
 - Follow Federal/state laws that protect you
- Medigap Open Enrollment Period
 - Starts when you are both 65 and sign up for Part B
 - Once started cannot be delayed or repeated



Medigap

- Costs vary by plan, company, and location
- Medigap insurance companies can only sell a “standardized” Medigap policy
 - Identified in most states by letters
 - MA, MN, and WI standardize their plans differently
- Does not work with Medicare Advantage
- No networks except with a Medicare SELECT policy
- You pay a monthly premium



Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K**	L**	M	N
Part A Coinsurance up to an addition 365 days	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Care Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)			✓	✓	✓	✓			✓	✓
*Plan F has a high-deductible plan							Out-of-Pocket Limit**			
*** Plan N pays 100% Part B coinsurance with copay up to \$20/\$50 for emergency room visits not resulting in inpatient							\$4,660	\$2,330		



Medicare Advantage (MA) Plans

- Health plan options approved by Medicare
- Also called Medicare Part C
- Run by private companies
- Medicare pays amount for each member's care
- Another way to get Medicare coverage
- Part of the Medicare program
- May have to use network doctors or hospitals



5-Star Special Enrollment Period (SEP)

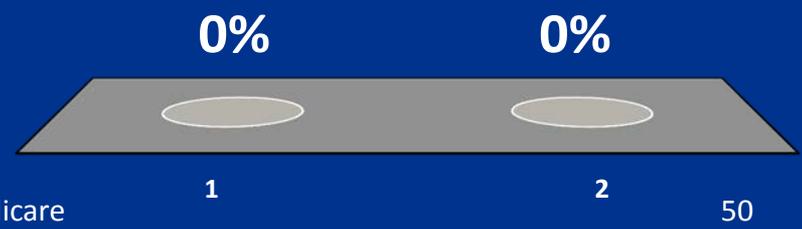
- Can enroll in 5-Star MA, MA-PD, or PDP
- Enroll at any point during the year
 - Once per year
- New plan starts first of month after enrolled
- Plan ratings granted on calendar basis
 - Ratings assigned in October of the preceding year
 - Use Medicare Plan Finder to view plan ratings
 - Look at Overall Plan Rating to identify eligible plans



Exercise

Cost Plans are a type of Medicare Advantage Plan.

- 1. True
- 2. False



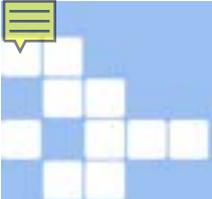


Exercise

The 5- Star Special Enrollment Period is from January 1 through February 14.

1. True
2. False





Medicare Prescription Drug Coverage

- What is Part D?
- Part D benefits and costs
- Who can join
- When to join and switch plans
- Part D covered drugs
 - Drugs Not Covered
- Access to Covered Drugs (Plan Utilization Rules)



Medicare Prescription Drug Coverage

- Also called Medicare Part D
- Prescription drug plans approved by Medicare
- Run by private companies
- Available to everyone with Medicare
- Must be enrolled in a plan to get coverage
- Two sources of coverage
 - Medicare Prescription Drug Plans (PDPs)
 - Medicare Advantage Plans with Rx coverage (MA-PDs)
 - And other Medicare health plans with Rx coverage



Medicare Drug Plan Costs

- Costs vary by plan
- In 2013, most people will pay
 - A monthly premium
 - A yearly deductible
 - Copayments or coinsurance
 - 50% for covered brand name drugs in coverage gap
 - 86% for generic drugs in coverage gap
 - Very little after spending \$4,750 out-of-pocket

Standard Structure in 2013

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2013. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly Premium – Ms. Smith pays a monthly premium throughout the year.

1. Yearly Deductible	2. Copayment or Coinsurance	3. Coverage Gap	4. Catastrophic Coverage
<p>Ms. Smith pays the first \$325 of her drug costs before her plan starts to pay its share.</p>	<p>Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus deductible) reaches \$2,970.</p>	<p>Once Ms. Smith and her plan have spent \$2,970 for covered drugs, she is in the coverage gap. In 2013, she gets a 50% discount on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2013, she also gets a 14% discount on covered generic drugs while in the coverage gap.</p>	<p>Once Ms. Smith has spent \$4,750 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each drug until the end of the year.</p>

Improved Coverage in the Coverage Gap

Year	What You Pay for Brand Name Drugs in the Coverage Gap	What You Pay for Generic Drugs in the Coverage Gap
2012	50%	86%
2013	47.5%	79%
2014	47.5%	72%
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Note: Dispensing fees are not discounted.



Part D Eligibility Requirements

- To be eligible to join a Prescription Drug Plan
 - You must have Medicare Part A **or** Part B
- To be eligible to join a Medicare Advantage plan with drug coverage
 - You must have Part A **and** Part B
- You must live in plan's service area
 - You cannot be incarcerated
 - You cannot live outside the United States
- You **must** be enrolled in a plan to get drug coverage



When you can Join or Switch Medicare Prescription Drug Plans

Initial Enrollment Period (IEP)	<ul style="list-style-type: none">▪ 7 month period▪ Starts 3 months before month of eligibility
Medicare's Open Enrollment Period	October 15 – December 7 each year <ul style="list-style-type: none">▪ Coverage begins January 1
January 1 – February 14	During this period, you can leave an MA plan and switch to Original Medicare. If you make this change, you may also join a Part D plan to add drug coverage. Coverage begins the first of the month after the plan gets the enrollment form.

When You Can Join or Switch Plans

Special Enrollment Periods (SEP)

- You permanently move out of your plan's service area
- You lose other creditable prescription coverage
- You weren't adequately informed your other coverage was not creditable or was reduced and is no longer creditable
- You enter, live in or leave a long-term care facility
- You have a continuous SEP if you qualify for Extra Help
- You belong to a State Pharmaceutical Assistance Program (SPAP)
- Or in other exceptional circumstances



Late Enrollment Penalty

- Higher premium if you wait to enroll
 - Additional 1% of base beneficiary premium
 - For each month eligible and not enrolled
 - For as long as you have Medicare drug coverage
 - Except if you had creditable drug coverage
 - National base beneficiary premium
 - \$31.17 in 2013
 - Can change each year



Part D-Covered Drugs

- Prescription brand-name and generic drugs
 - Approved by Food and Drug Administration (FDA)
 - Used and sold in United States
 - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
 - Supplies associated with injection or inhalation



Required Coverage

- “All or substantially all” drugs in 6 categories
 - Cancer medications
 - HIV/AIDS treatments
 - Antidepressants
 - Antipsychotic medications
 - Anticonvulsive treatments
 - Immunosuppressants
- All commercially-available vaccines
 - Except those covered under Part B (e.g., flu shot)



Drugs Excluded By Law Under Part D

- Anorexia, weight loss or weight gain drugs
- Barbiturates and benzodiazepines* covered in 2013
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes (e.g., hair growth)
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs



Access to Covered Drugs

- Plans must cover range of drugs in each category
- Coverage and rules vary by plan
- Plans can manage access to drug coverage through
 - Formularies (list of covered drugs)
 - Prior authorization (doctor requests before service)
 - Step therapy (type of prior authorization)
 - Quantity limits (limits quantity over period of time)

Formulary

- A list of prescription drugs covered by the plan
- May have “tiers” that cost different amounts

Tier Structure Example		
Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand-name
3	Highest copayment	Non-preferred, brand-name
Specialty	Highest copayment or coinsurance	Unique, very high-cost

Rules Plans Use to Manage Access to Drugs

Prior Authorization

- Doctor must contact plan for prior approval
 - Before prescription will be covered
 - Must show medical necessity for drug
- Process for requests may vary by plan

Step Therapy

- Type of prior authorization
- You must first try similar, less expensive drug
- Doctor may request an exception if
 - Similar, less expensive drug didn't work, or
 - Step therapy drug is medically necessary

Quantity Limits

- Plan may limit drug quantities over a period of time for safety and/or cost
- Doctor may request an exception if additional amount is medically necessary



Exercise

All Medicare drug plans use the same tiers in their formulary.

1. True
2. False

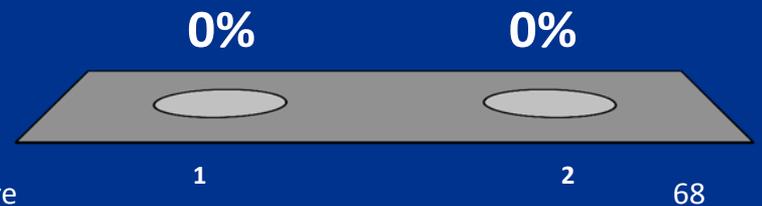




Exercise

Step Therapy is a type of prior authorization.

1. True
2. False





Guaranteed Rights Under Medicare

- You have guaranteed rights in
 - Original Medicare
 - Medicare Advantage and Other Medicare Health Plans
 - Medicare Prescription Drug Plans



Medicare Rights

- Protect you when you get health care
- Ensure you get medically necessary, Medicare-covered health care services
- Protect you against unethical practices
- Protect your privacy



You Have the Right to

- Be treated with dignity and respect
- Be protected from discrimination
- Get information you can understand
- Get culturally-competent services
- Get emergency care where and when you need it
- Get urgently needed care
- Get answers to your Medicare questions



You Have the Right to

- Learn about your treatment choices
 - In clear understandable language
- File a complaint
- Appeal a denial of a treatment or payment
- Have personal information kept private
- Know your privacy rights



Right to File a Complaint or Appeal

- Complaint (sometimes called a grievance)
 - Quality of services
 - Care that is received
- Appeal a coverage or payment decision
- For information contact
 - Your plan
 - Your State Health Insurance Assistance Program
 - 1-800-MEDICARE (1-800-633-4227)



Appeals in Original Medicare

- Ask provider for information to help your case
- Medicare Summary Notice explains
 - Why Medicare didn't pay
 - How to appeal
 - Where to file your appeal
 - How long you have to appeal
- Keep copies of appeal documents



Medigap Rights in Original Medicare

- To buy a Medigap policy
 - Also called Medicare Supplemental Insurance
 - Guaranteed issue rights
 - In your Medigap Open Enrollment Period companies
 - Can't deny you Medigap coverage
 - Can't place conditions on coverage
 - Can't charge more because of past or present health problems
 - Must cover pre-existing conditions
 - May have up to six-month waiting period
 - Some states give additional rights



Rights in Medicare Health Plans

- Choice of plan's health care providers
- Access to plan's specialists (treatment plan)
- Know how your doctors are paid
- Fair, efficient, and timely appeals process
 - Fast appeals in certain health care settings

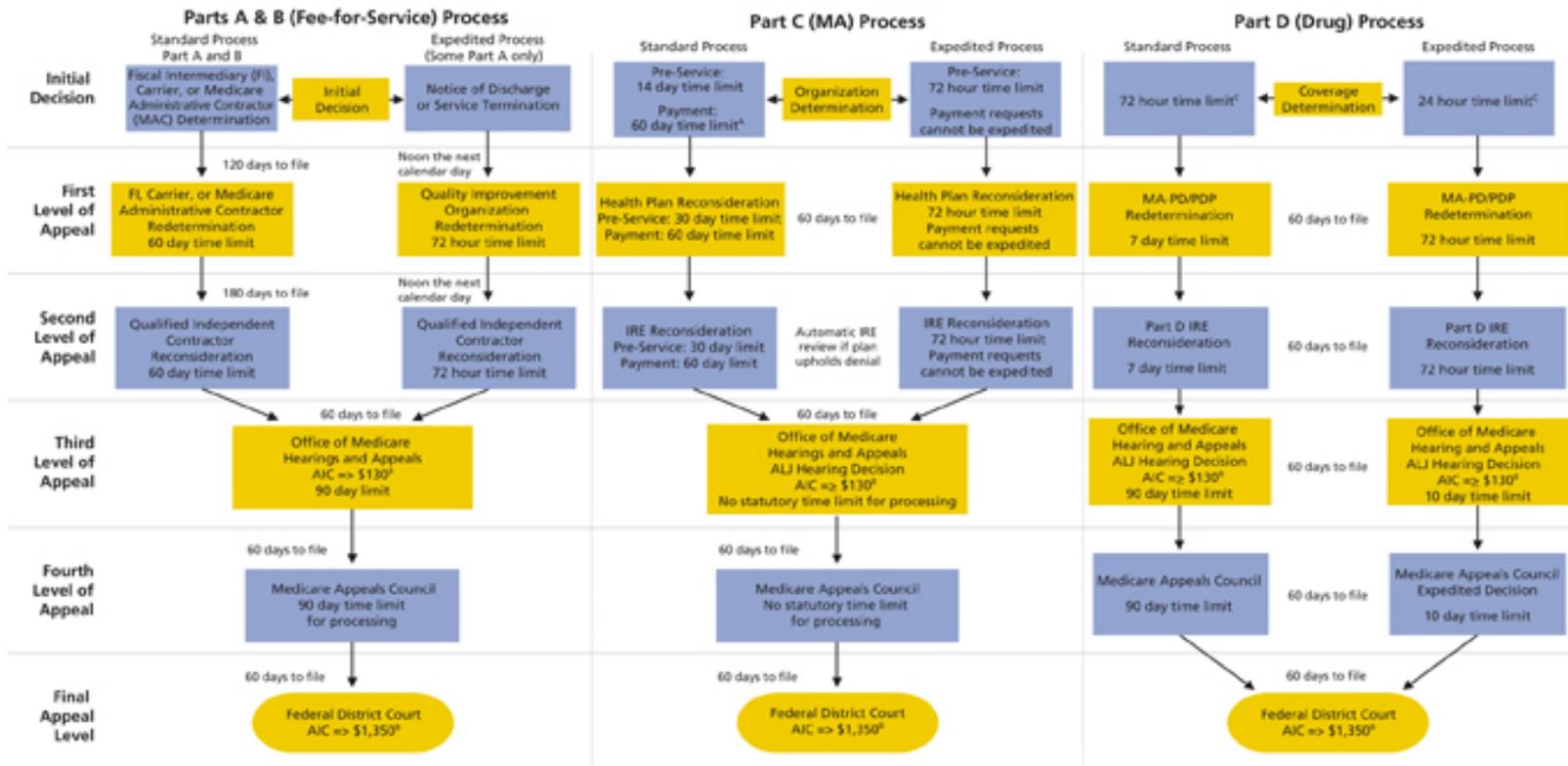


Rights in Medicare Health Plans

- Grievance process
- Coverage/payment information before service
- Privacy of personal health information
- Urgently needed care
- Contact your plan for more information

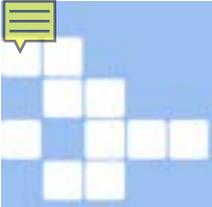
Parts A, B, C, and D Appeal Processes

Comparison of the Parts A, B, C, and D Appeal Processes



AIC = Amount in Controversy
 ALJ = Administrative Law Judge
 Contractor = Fiscal Intermediary, Carrier or Medicare Administrative Contractor (MAC)
 IRE = Independent Review Entity
 MA-PD = Medicare Advantage Prescription Drug
 MMA = Medicare Prescription Drug, Improvement & Modernization Act of 2003
 PDP = Prescription Drug Plan
 QIC = Qualified Independent Contractor

¹ Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.
² The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2011 AIC amounts.
³ A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, or the enrollee's physician. The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication time frame begins when the plan sponsor receives the physician's supporting statement.



Lesson 4 – Programs for People with Limited Income and Resources

- Extra Help
- Medicaid
- Medicare Savings Programs
- Help available for people in the U.S. territories



Extra Help with Drug Plan Costs

- Help for people with limited income and resources
- Social Security or state makes determination
- Some groups automatically qualify
 - People with Medicare and Medicaid
 - Those who get Supplemental Security Income (SSI) only
 - Those in Medicare Savings Programs
- Everyone else must apply



2013 Extra Help Income/Resource Limits (AK)

■ Income

- Below 150% of the Federal poverty level (FPL)
 - \$1,746.25 per month for a single person
 - \$2,365.00 per month for a married couple

■ Resources

- Up to \$13,300 for a single person
- Up to \$26,580 for a married couple
 - Includes \$1,500/person for funeral or burial expenses
 - Counts savings and investments
 - Does not count home you live in or car you drive



Applying for Extra Help is easy

- Multiple ways to apply
 - On the web at benefitscheckup.org/alaska
 - Fill out a paper application
 - Through ssa.gov

- You or someone on your behalf can apply



Medicaid

- Federal-state health insurance program
 - For people with limited income and resources
 - Certain people with disabilities
- Most costs covered for Medicare/Medicaid
 - Sometimes called “dually eligible”
- Eligibility determined by state
- Application processes and benefits vary
- Office names vary



Medicare Savings Programs

- Help from Medicaid paying Medicare costs
 - For people with limited income and resources
 - Programs include
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individual (QI)
 - Qualified Disabled & Working Individuals (QDWI)
- See Appendix D



Steps to Take

- If you think you might qualify
 1. Review guidelines
 2. Collect your personal documents
 3. Get more information
 - Call your state Medical Assistance office
 - Call your local SHIP
 - Call your local Area Agency on Aging
 4. Complete application with state Medical Assistance office



Programs in U.S. Territories

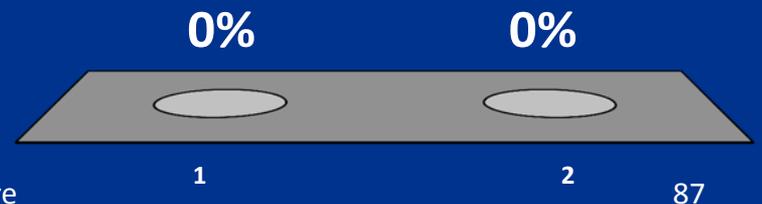
- Help people pay their Medicare costs
- U.S. territories
 - Puerto Rico
 - Virgin Islands
 - Guam
 - Northern Mariana Islands
 - American Samoa
- Programs vary
 - Contact Medical Assistance office



Exercise

Medicare Savings Programs frequently have higher income and resource limits than Medicaid.

1. True
2. False



Introduction to Medicare Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)

1-800-MEDICARE
(1-800-633-4227)
(TTY 1-877-486-2048)
www.medicare.gov

www.CMS.gov

Social Security

1-800-772-1213
TTY 1-800-325-0778
<http://www.socialsecurity.gov/>

Railroad Retirement Board

1-877-772-5772
<http://www.rrb.gov/>

State Health Insurance Assistance Programs (SHIPs)*

*For telephone numbers call CMS
1-800-MEDICARE (1-800-633-4227)
1-877-486-2048 for TTY users

<http://www.medicare.gov/caregivers/>

<http://www.HealthCare.gov>

<http://www.Benefits.gov>

<http://www.Insurekidsnow.gov>

Affordable Care Act

www.healthcare.gov/law/full/index.html

Medicare Products

Medicare & You Handbook

CMS Product No. 10050

Your Medicare Benefits

CMS Product No. 10116

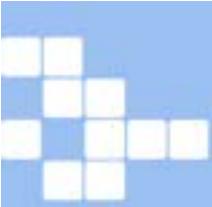
Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare

CMS Product No. 02110

To access these products

View and order single copies at
www.medicare.gov

Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.



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