What Is Medicare?

Medicare is our country's health insurance program for people age 65 or older. Certain people younger than age 65 can qualify for Medicare, too, including those who have disabilities and those who have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). The program helps with the cost of health care, but it does not cover all medical expenses or the cost of long-term care. Medicare is financed in part by payroll taxes paid by workers and their employers. For every $100 an employee earns, the employer and employee each pay $1.45 in payroll (FICA) taxes to fund the Medicare program.[18] The program is also financed by monthly premiums deducted from Medicare enrollees' Social Security checks.

Today's Medicare Program

Today's Medicare program has four parts:

1. **Part A—Hospital Insurance**—Part A helps pay for inpatient care in a hospital or in a skilled nursing facility (following a hospital stay). It also covers some home health care and hospice care.
2. **Part B—Medical Insurance**—Part B helps pay for doctors' services and many other medical services and supplies that are not covered by Part A.
3. **Part C—Medicare Advantage**—Part C (**Medicare Advantage** or **MA**) is a managed care approach to delivering Medicare-covered services and is available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through a Medicare Advantage provider organization under Part C.
4. **Part D—Prescription Drug Coverage**—Part D is the prescription drug benefit that helps pay for medications that doctors prescribe for treatment.

Medicare recipients (or beneficiaries, as they're often called) can choose the **Original Medicare plan**, which consists of Part A and Part B, or they can opt to enroll in a **Medicare Advantage (MA)** plan, if one is available in their area, for the delivery of their Part A and B services.

The Original Medicare plan is a fee-for-service plan managed by the federal government. **Fee-for-service** means that participants are usually charged a fee for each health care service or supply they receive. In addition, for some services, they pay a deductible before Medicare pays its share of the cost. Then, when a Medicare-covered supply or service is provided, Medicare pays its share, and the participant pays his or her share—the **coinsurance** or **co-payment**. Under the Original Medicare plan, participants may use any doctor, supplier, hospital, or other facility that accepts Medicare.

Medicare Advantage, or MA, is a way in which Medicare-covered services are delivered. These plans combine all of the benefits of Part A and Part B and may, depending on the plan, include the coverage provided by Part D. MA plans are offered and administered by private companies and have been approved by Medicare. Compared to Medicare's traditional fee-for-service approach, MA plans are characterized by greater flexibility and the ability to offer enhanced care management services. Most Medicare Advantage plans take the form of a **health maintenance organization (HMO)** or **preferred provider**

organization (PPO). With HMOs, beneficiaries are required to seek care and services from providers who are part of the HMO network; with PPOs, beneficiaries are also served by a provider network, though they may seek care (at a higher cost) outside the network.

Lastly, as mentioned, **Medicare Part D** provides coverage for prescription drugs. Those enrolled in the Original Medicare plan may choose to enroll in a separate Part D plan; those in a Medicare Advantage plan may have, as part of their plan, coverage for Part D.

With that brief background, let's examine in more detail the specifics of Medicare Parts A, B, C, and D.

Part A—Hospital Insurance

Most people age 65 and older who are citizens or permanent residents of the United States are eligible for free Medicare **Part A Hospital Insurance**.

Part A covers most inpatient hospital care, some inpatient skilled nursing care, some home health care, and hospice care. A monthly Part A premium is not required for people who have 40 or more quarters of Social Security credits, which equates to about ten years of full-time work. Those with 30 to 39 Social Security quarters may buy Part A but will have to pay a monthly premium. People with fewer than 30 Social Security quarters may purchase Part A also but will have to pay a larger monthly premium.

Part A benefits are paid once the beneficiary has met a deductible ($1,288 in 2016). The Part A deductible applies to each **benefit period**. A benefit period starts when an individual enters the hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or SNF care was provided. Hospital stays longer than 60 days require the beneficiary to meet a daily co-payment.

Part B—Medical Insurance

Anyone who is eligible for the free Medicare Part A can enroll in Part B Medical Insurance by paying a monthly premium. Even those who are not eligible for the free Medicare Part A can purchase Part B if they are age 65 or older and are U.S. citizens or lawfully admitted noncitizens who have lived in the U.S. for at least five years.

Part B covers a portion of the Medicare-approved costs for the following:

- doctors' services
- outpatient hospital care
- laboratory tests
- outpatient physical and speech therapy
- some home health care
- ambulance services
- some medical equipment and supplies
- certain preventive care (some of which is covered at 100 percent)

Part B coverage is optional. Some people with other medical coverage do not require this part of Medicare until they are no longer covered under other programs, such as their

employer's health care plan. Part B requires the payment of a monthly premium, which is automatically deducted from a beneficiary's Social Security check.[19] Those who do not receive Social Security will be billed quarterly for their Part B premiums. (High-income wage earners are charged more for their monthly Part B premiums.)

In addition to the monthly premium, Part B coverage requires the payment of an annual deductible ($166 in 2016). After the deductible is met, Medicare pays for 80 percent of covered and approved charges; the beneficiary is responsible for the balance. In addition, if the charge is greater than the amount allowed by Medicare—referred to as the **excess charge**—the beneficiary is responsible for the difference.

Note

Medicare is not a complete system of health care. Even though it pays for many preventive services and covers most medically necessary services, Medicare pays for less than half of what seniors typically spend for their total health care expenses. Medicare does not pay for routine dental or eye care, or hearing aids. More significantly, it does not pay for long-term care at home or in a nursing home when this care is primarily personal care services or custodial care.

Part C—Medicare Advantage

As noted, an alternative to Original Medicare is a **Medicare Advantage (MA)** plan. MA plans are offered through private health insurance companies and private health care provider organizations and combine into one plan all of the coverages and benefits of Medicare Part A Hospital Insurance and Part B Medical Insurance. Many MA plans offer additional benefits; some may also provide the Part D Prescription Drug coverage. To join an MA plan, participants must have both Medicare Part A and Part B and live in the plan's service area.

The plan may have special rules, such as requiring beneficiaries to see doctors who belong to the plan or requiring them to go to certain hospitals to receive services. While Medicare pays a set amount of money for beneficiaries' care each month to these health plans, beneficiaries may have to pay from their own pockets a monthly premium for extra benefits.

Types of MA plans include the following:

- Medicare preferred provider organization (PPO) plans
- Medicare health maintenance organization (HMO) plans
- Medicare private fee-for-service (PFFS) plans
- Medicare special needs plans
- Medicare medical savings account (MSA) plans

Part D—Medicare Prescription Drug Coverage

Part D Prescription Drug coverage arose from the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, otherwise known as the **Medicare Modernization Act**, or **MMA**. Anyone who has Medicare Part A, Part B, or a Medicare Advantage plan is eligible for prescription drug coverage under Part D. Joining a Medicare Prescription Drug plan is voluntary, and an additional monthly premium is required for the coverage. In 2006, the prescription drug benefit began. Everyone covered by Medicare must make choices with respect to Part D. Beneficiaries are eligible to:

- remain in the traditional Medicare program without participating in the drug benefit
- remain in the traditional Medicare program and enroll in a stand-alone Part D drug plan
- enroll in a private Medicare Advantage plan that offers both Medicare health services and prescription drug coverage

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[18] The Medicare tax on those earning more than $200,000 a year ($250,000 for joint filers) is an additional .9 percent.

[19] For 2016, the monthly premium for the majority of Medicare Part B recipients (about 70 percent) is $104.90. The monthly premium in 2016 for the remaining 30 percent (new enrollees, those not collecting Social Security benefits, dual eligibles, and those who already pay higher income related premiums) is $121.80.

Medigap Insurance

Medigap is the term that applies to private health care insurance policies designed to cover the "gaps," or out-of-pocket expenses, that Original Medicare does not pay for. Also known as **Medicare supplement insurance**, Medigap covers the many deductibles, coinsurance amounts, co-pays, and other limitations and services that Medicare does not pay. For example, a Medigap policy might cover Part B excess charges and emergency health care while the beneficiary is traveling outside the United States.

Clearly, Medigap policies are purchased because Medicare does not pay for total health care. And while a Medigap policy will cover some of these gaps, it doesn't pay for all. A Medigap policy can help lower out-of-pocket costs and expand coverage.

A Medigap policy only works in conjunction with the Original Medicare plan. So, if an individual decides to join a Medicare Advantage plan, Medigap coverage is unnecessary. Those who enroll in Original Medicare may benefit by purchasing a Medigap policy.

Standardized Medigap Policies

A Medigap policy must meet the statutory definition of a Medicare supplement policy as specified in Title XVIII of the Social Security Act. Since 1992, Medigap policies have been standardized. Each plan design provides for a specified set of benefits and is titled simply as a letter of the alphabet. For each plan design, the benefits are the same among all

insurers. Before June 1, 2010, there were 14 standard plan options; as of June 1, 2010, the plans were revamped to reflect changes in the Medicare market. Plans sold after June 1, 2010, must conform to these new changes; plans that were purchased before this date may continue in force.

Standardized Plan Benefits

Every Medigap policy must provide for a minimum level of "basic" or "core" benefits. These are represented by Plan A. Every other plan must provide these basic benefits, but they also have additional benefits. The following charts summarize the benefits that the current series of Medigap policies provide:

	Medigap Plan									
Benefit	**A**	**B**	**C**	**D**	**F***	**G**	**K****	**L****	**M**	**N**
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used (core benefit)	•	•	•	•	•	•	•	•	•	•
Part B coinsurance or co-payment (core benefit)	•	•	•	•	•	•	50%	75%	•	•***
First 3 pints of blood (core benefit)	•	•	•	•	•	•	50%	75%	•	•
Part A hospice care coinsurance or co-payment (core benefit)	•	•	•	•	•	•	50%	75%	•	•
Skilled nursing facility care coinsurance			•	•	•	•	50%	75%	•	•
Part A deductible		•	•	•	•	•	50%	75%	50%	•
Part B deductible			•		•					
Part B excess charges					•	•				
Foreign travel emergency care (at 80%)			•	•	•	•			•	•
Out-of-pocket limit	NA	NA	NA	NA	NA	NA	$4,960 in 2016	$2,480 in 2016	NA	NA

* *Plan F also offers a high-deductible option. The high-deductible option pays the same benefits as the other Plan F but only after the payment of an annual deductible ($2,180 in 2016).*

** *Plans K and L pay 100 percent after the annual out-of-pocket limit is reached.*

*** *Plan N pays 100 percent of the part B coinsurance except for a co-payment of up to $20*

Medicare and Long-Term Care

Many people mistakenly believe that Medicare pays for long-term care. The truth is that Medicare does *not* pay for long-term care. Medicare is designed to cover medical expenses

for acute conditions. For example, if a person suffers a stroke or cancer, Medicare will pay for hospitalization and treatment. However, as soon as the beneficiary no longer requires a bed in an acute care facility, Medicare benefits cease, and the beneficiary is on his or her own.

Medicare does pay for medically necessary skilled nursing facility care for very short periods; however, beneficiaries must meet certain criteria. To qualify for this type of Medicare coverage, the following is required:

- The individual must have had a prior hospital stay of at least three full days.
- The individual must be admitted to the skilled care facility within 30 days of discharge from the hospital.
- A doctor must certify that skilled care is required.
- The services or care must be delivered by a Medicare-certified facility.

Medicare will not pay for personal care services or custodial care outside a nursing facility. However, if an individual qualifies for coverage based on the need for skilled nursing or rehabilitation as described, Medicare will cover all of his or her needs in the facility, including assistance with ADLs.

SNF Coverage Restrictions

Even when an individual meets the requirements of having spent at least three full days in the hospital, needs skilled nursing care, and a physician has ordered the care, Medicare limits the number of days it will pay for care in a skilled nursing facility. Medicare covers SNF care as follows:

- **days 1 through 20**—Medicare pays 100 percent of the approved cost.
- **days 21 through 100**—The beneficiary is responsible for a daily co-payment ($161 in 2016); Medicare pays the balance.
- **days 101 and beyond**—Medicare pays nothing.

The supplemental coverage provided through a Medicare Advantage plan or a Medigap plan may cover part or all of the beneficiary's share of the SNF cost for days 21 through 100 when Medicare coverage requires a daily co-payment. However, when the underlying Medicare benefit ceases, the supplemental coverage also stops.

After 100 days, Medicare pays nothing for skilled nursing facility care. Once these limited Medicare benefits are exhausted, other options for payment are personal funds, a long-term care insurance policy (if the beneficiary had the forethought to pre-plan), or Medicaid, the subject of our next chapter.

Medicare's Home Health Care Coverage

Medicare covers the costs of having an agency provide part-time or intermittent health care services in the patient's home, but again, this coverage is limited, and the patient must need skilled care. To qualify for Medicare's home health care benefit, the following conditions must be met:

- The care must be certified as medically necessary.
- The care must be ordered by a physician.
- The level of intermittent care needed and provided must be skilled care.
- The care must be provided by a Medicare-certified home health agency.
- The patient must be homebound, meaning that leaving the home requires a great deal of effort and is done only infrequently.

In addition, for qualifying patients, Medicare will pay for medical social services, home health aide services, medical supplies, and durable medical equipment used in the home. However, Medicare does *not* cover custodial home health care.

Medigap and Long-Term Care

Just as Medicare provides only limited coverage for long-term care services, so, too, do Medigap policies. Medigap policies are designed to cover the "gaps" in Medicare associated with the program's many deductibles, coinsurance, co-payments, and other similar limits. These policies pick up where Medicare leaves off. They are not intended to provide coverage or benefits for conditions that Medicare itself does not cover. Consequently, because Medicare does not cover long-term custodial care and does not cover long-term stays in skilled nursing facilities, Medigap does not cover these needs either. Other than coverage for the daily coinsurance amount for post-hospital care in a skilled nursing facility—a benefit that ends after 100 days—Medigap policies provide no benefits or payments for long-term care.

Summary

- The Original Medicare plan is a fee-for-service plan managed by the federal government and includes Part A Hospital Insurance and Part B Medical Insurance.
- Part C Medicare Advantage comprises plans obtained through private health insurance companies to expand benefits.
- Medicare Part D Prescription Drug coverage was added as a benefit as of 2006.
- Neither Medigap, a system of standardized private insurance policies designed to provide additional coverage and benefits where Medicare leaves off, nor the very comprehensive Medicare health insurance program provides LTC benefits as many people believe.