PacificCPE

COURSE
82255A

Medicare Coverage: Parts, Plans, and Eligibility

Medicare is a cornerstone of retirement planning, yet many clients—and their advisors—don't fully understand how it works. This course provides a comprehensive overview of the Medicare program, including its different parts, what each covers, eligibility requirements, and how costs are structured. Whether you're helping clients prepare for retirement or advising older clients on managing healthcare expenses, a clear understanding of Medicare fundamentals is essential. This course gives you the foundation needed to have informed, confident conversations about one of retirement's biggest financial considerations.

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Assignment

- Study the full course materials included here.
- Complete the review questions after each chapter.
- Answer 10 final exam questions.
- Final exam is scored immediately, 70% or better passes.
- Certificate of completion is available in your account.
- Failed exams can be retaken free of charge.

Course Objectives

- Recognize the characteristics of Medicare.

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Chapter 1: MEDICARE

Chapter Objective

After completing this chapter, you should be able to:

- Recognize the characteristics of Medicare.

Since 1965, the federal Medicare program has been covering a large part of consumers' health care costs. Medicare pays for most of the cost of hospitalization and much other medical care for people age 65 and older and those who are permanently disabled. In all, Medicare now provides coverage for about 70 million people.

Despite its broad reach, however, Medicare doesn't pay for many types of medical services, and it pays only a portion of most services it does cover. Over the decades, Medicare has gradually expanded its coverage. In 2006, it included some of the cost of prescription drugs taken at home, and recently has taken small steps to address the overall skyrocketing costs of those drugs.

And in 2010, the Affordable Care Act expanded Medicare coverage of certain preventive screenings and examinations, along with improved prescription drug coverage. Nonetheless, Medicare still pays for only slightly more than half of all health care costs for those enrolled.

This chapter discusses the Medicare system, what it covers, and how much it pays, including prescription drugs. Chapter 1 of course 82256A shows you how to apply for Medicare and take full advantage of its benefits.

The chapters that follow present detailed information about how to fill some of the gaps in Medicare coverage. Medigap supplemental insurance, offered by private insurance companies but regulated by the federal government, is discussed in Chapter 1 of course 82257A, and the various Medicare Advantage managed care plans, an alternative way to receive your Medicare coverage, are sorted out in Chapter 2 of course 82257A. If you have low income and few assets, Chapter 3 of course 82257A explains the government Medicaid (called Medi-Cal in California) program, which provides free or nearly-free coverage in place of buying private insurance or a managed care plan.

If You'll Turn 65 Soon

If you're turning 65 soon (and aren't already enrolled in Medicare through disability benefits eligibility), there are several things you need to do to prepare for Medicare.

Find out if your current health insurance will continue when you hit 65 and, if so, how it works in conjunction with Medicare.

See what Medicare supplement ("medigap") insurance policies (Chapter 1 of course 82257A) and Medicare Advantage plans (Chapter 2 of course 82257A) are available where you live.

Decide whether to enroll in traditional fee-for-service Medicare and add prescription drug (Medicare Part D) coverage (this chapter), and whether to add a private medigap policy (Chapter 1 of course 82257A) to this, or instead to enroll in a Medicare Advantage managed care plan (Chapter 2 of course 82257A).

Look into whether you might be eligible for Medicaid coverage (Medi-Cal in California) or for state assistance with your Medicare costs (Chapter 3 of course 82257A).

Speak to your physician about scheduling an initial Medicare physical examination (within six months after first enrolling) and about preventive services covered by Medicare that are appropriate to your physical condition and health history.

THE MEDICARE MAZE

There are two different ways that someone eligible for Medicare can receive the program's benefits. The first way is called "traditional Medicare" or "original Medicare," which includes Part A (hospital insurance) and Part B (medical insurance). With this type of Medicare coverage, a beneficiary can receive care from any doctor, hospital, clinic, or other provider who accepts Medicare patients. Medicare pays the provider a fee for each specific service, usually only a portion of the full charges. For the amounts Medicare doesn't fully pay, the patient has several choices. The patient can choose to:

- Pay out of pocket
- Buy a private supplemental insurance policy—commonly known as "medigap" insurance—that pays much of what Medicare doesn't (see Chapter 1 of course 82257A)
- Buy a separate Medicare Part D prescription drug coverage insurance plan (discussed later in this chapter), or
- Apply for Medicaid coverage, which is a federal program for low-income people that pays almost all of the health care costs that Medicare doesn't pay. Even if you don't qualify for

Medicaid, you can apply for subsidized coverage of prescription drugs ("Extra Help") through Medicare Part D.

The second way that people can receive Medicare benefits is through a "Part C" Medicare Advantage plan, offered by private insurance companies. These managed care plans cover everything that traditional Medicare does, plus some services Medicare doesn't cover at all.

Many Medicare Advantage plans also include outpatient prescription drug coverage. And, they eliminate some of the copayments and deductibles required by traditional Medicare.

Medicare Advantage plans are managed care plans similar to HMOs. They're generally less expensive than a combination of traditional Medicare with a medigap supplemental insurance policy. However, Medicare Advantage plans place greater limits on which specific doctors and other health care providers a patient can use, control referrals to specialists, and otherwise sometimes place restrictions on care.

Medicare Advantage plans also make annual changes: Sometimes they increase the copayment amounts they charge enrollees, sometimes they limit or eliminate specific coverage, and sometimes they eliminate coverage entirely in a particular geographic area. (For more information, see Chapter 2 of course 82257A.)

Because of their lower cost, about half of Medicare beneficiaries are now enrolled in Medicare Advantage plans, though those numbers include some people who are required to enroll in Medicare Advantage due to their dual status as enrollees in both Medicare and Medicaid (see Chapter 3 of course 82257A).

Medicare Prescription Drug Coverage

Medicare Part D provides some coverage for outpatient prescription drug costs. Unfortunately, Medicare Part D prescription drug coverage leaves some drug costs uncovered. Medicare handed Part D over to private insurance companies—whose inefficient overhead and enormous profits have added to the cost of prescription drugs under the program. Historically, the law specifically barred the Medicare program from negotiating with drug and insurance companies for lower prices on behalf of Medicare patients.

This restriction has helped drug prices increase at rates far above the cost of living, which, in turn, has placed enormous economic pressure on seniors and others enrolled in Medicare.

The Inflation Reduction Act now allows Medicare to negotiate prices on a limited number of drugs. How much of the savings will be passed on to beneficiaries remains to be seen.

(Medicare Part D's coverage is explained at the end of this chapter.)

Medicare and Medicaid: A Comparison

People are sometimes confused about the differences between Medicare and Medicaid. Medicare was created to deal with the high medical costs that older citizens face relative to the rest of the population— especially troublesome given their reduced earning power. However, eligibility for Medicare isn't tied to individual financial need. Rather, it's an entitlement program; you're entitled to it because you or your spouse paid for it through Social Security and Medicare taxes.

Medicaid, on the other hand, is for low-income, financially needy people, set up by the federal government, and administered differently in each state.

Although you might qualify for and receive coverage from both Medicare and Medicaid, you must meet separate eligibility requirements for each program; being eligible for one program doesn't necessarily mean you're eligible for the other. If you qualify for both, Medicaid will pay for most Medicare Part A and B premiums, deductibles, and copayments or will offer you enrollment in a managed care plan that provides a combination of Medicare and Medicaid coverage.

Chapter 3 of course 82257A explains Medicaid and the chart below describes the basic differences between the two programs.

A Comparison of Medicare and Medicaid

Medicare	Medicaid
Who Is Eligible	
Medicare is for almost everyone 65 or older, rich or poor; for people on Social Security disability after a waiting period; and for some people with permanent kidney failure. Medicare is an entitlement program; people are entitled to Medicare based on their own or their spouse's Social Security tax contributions, and on payment of premiums.	Medicaid is for low-income and financially needy people, including those 65 and older who are also on Medicare. Medicaid is an assistance program only for the needy.
Who Administers the Program	
Medicare is a federal program. Medicare rules are the same all over the country. Medicare information is available at your Social Security office or through the Centers for Medicare & Medicaid Services.	Medicaid rules differ in each state. Medicaid information is available at your local county social services, welfare, or department of health and human services office.
Coverage Provided	
Medicare hospital insurance (Part A) provides basic coverage for hospital stays, post-hospital skilled nursing facilities and home health care. Medicare medical insurance (Part B) pays most of basic doctor and laboratory costs, and some other outpatient medical services, including medical equipment and supplies, home health care, and physical therapy. Part D covers some of the cost of outpatient prescription drugs.	Medicaid provides comprehensive inpatient and outpatient health care coverage, including many services and costs Medicare doesn't cover, most notably, prescription drugs, and sometimes eyeglasses, hearing aids, and some dental care. The amount of coverage, however, varies from state to state. Medicaid can pay Medicare deductibles and the 20% portion of covered charges not paid by Medicare. Medicaid can also pay the Medicare premium.
Costs to Consumer	

You must pay a yearly deductible for both Medicare Part A and Part B. You must also pay hefty copayments for extended hospital and rehabilitation stays. Under Part B, you must also pay the 20% of doctors' bills Medicare doesn't pay. Part B also charges a monthly premium. Under Part D, you must pay a monthly premium, a deductible, and copayments, unless you qualify for a low-income subsidy. If you opt for a Medicare Advantage plan, you still have to pay the Part B premium, but your other costs, such as deductibles and copays, will be much lower.	In some states, Medicaid charges consumers small amounts for certain services.

MEDICARE: THE BASICS

Medicare is a federal government program that assists older and some disabled people with paying their medical costs. Part A is called "hospital insurance" and covers most of the costs of a stay in the hospital, as well as some follow-up recovery costs afterward. Part B, "medical insurance," pays some of the costs of doctors and outpatient medical care. And Part D pays some prescription drug costs.

Medicare Part C refers to separate Medicare Advantage managed care plans, run by private insurance companies, which can replace Parts A, B, and D (see Chapter 2 of course 82257A).

Medicare is operated by the Centers for Medicare & Medicaid Services (CMS), part of the Department of Health and Human Services, in cooperation with the Social Security Administration. The Medicare program's daily business, however, is run by private companies, called carriers or intermediaries, operating under contract with the federal government.

Most of a patient's direct contact with Medicare happens with the company—Blue Cross, Blue Shield, or another large insurance company—that administers Medicare or that runs the patient's Medicare Advantage or Part D prescription drug plan in that patient's geographic area.

One of the flaws of the current Medicare system is that giving Medicare administrative monopolies to these private insurance companies drives up costs to the public.

Special Medicare Eligibility for End-Stage Renal Disease (ESRD)

While Medicare coverage is generally reserved for people age 65 or older and people with long-term disabilities, a special Medicare provision provides full Medicare coverage to most people suffering from permanent kidney failure, known as "end-stage renal disease" (ESRD), regardless of their age. The rules regarding eligibility for this coverage and the extent of this coverage are discussed fully later in this chapter.

Health Coverage If You Stop Working Before Age 65

Medicare, medigap supplemental insurance, and Medicare Advantage plans are available to most people age 65 and older. But what if you stop working before age 65—either because you choose to retire, are laid off, or lose your business? Chances are you'll lose your health insurance at the same time. Then the issue becomes finding affordable medical coverage, and a plan that will cover preexisting conditions, to fill the gap until you turn 65.

Here are some ways to try to stretch your medical coverage without turning to the open market for an individual health insurance policy:

- **Take advantage of continued health insurance from your employer.** If you're entitled to retirement benefits from your employer, these might include continued health care coverage. Be aware, however, that your employer is permitted to drop that retiree health coverage once you turn 65 and are eligible for Medicare. Many retiree health plans at least continue what's called "secondary coverage" for costs above what Medicare pays. If you aren't automatically eligible for retiree health coverage, you might be able to negotiate continued health coverage with your employer as part of your severance package, or with the purchaser of your business as part of its sale price.
- **Convert to individual coverage under an employer-sponsored plan.** Some employer-sponsored insurance plans permit employees to convert their group coverage to individual coverage upon leaving their employment. If your plan allows this, you'll probably have to pay all the premiums—and they're likely to be quite a bit higher than when you were part of a group policy. Even if such individual coverage is available to you through your employer, you might want to compare its coverage and cost with individual insurance available through the federal or state health insurance exchanges (see below).
- **Continue coverage under COBRA.** The federal Consolidated Budget Reconciliation Act (COBRA) mandates a period of continued health care coverage for people who lose or leave their jobs (unless they're fired for gross misconduct) and their spouses and children. It also applies to employees whose hours are reduced below the number that qualifies them for health benefits. If you qualify for COBRA, you're entitled to buy 18 months of