Medicare In a Nutshell

(A Current Overview)

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THE MEDICARE PROGRAM

Insurance Model

Covers *Some* of the Cost of *Some* Health Care

- Reasonable and Necessary
- Illness or Injury
- Diagnosis, Treatment, Rehabilitation
- Limited Preventive Coverage (Expanding)
- Co-Pays, Deductibles, Premiums

THE MEDICARE PROGRAM

- Four Parts
  - Traditional Medicare
    - Part A
    - Part B
  - Part C (Medicare Advantage)
  - Part D (Rx Drug Coverage)

THE MEDICARE PROGRAM

- Traditional Medicare
  - Part A - Hospital Insurance
    - Covers hospital, SNF, Home Health and Hospice Care
  - Part B – Medical Insurance
    - Covers physician services, some outpatient services, some preventive services, ambulance services, durable medical equipment
- Administered by CMS

THE MEDICARE PROGRAM

- Part C – Medicare Advantage
  - Defines alternate delivery systems for Medicare services (e.g. managed care)
  - Managed by private health insurance companies
- Part D – Medicare Prescription Drug Coverage.
  - Might be part of MA plan or a stand alone plan managed by a private health insurance company
- Parts C and D are administered by private insurance companies

THE MEDICARE PROGRAM

- Enrollment in Medicare is handled by the Social Security Administration (SSA)

MEDICARE ELIGIBILITY

3 Categories

1. Age 65 or older;
2. Disability
   - On Social Security disability or RR Retirement disability and collecting benefits for 24 months (waiting period is waived for ALS);
3. ESRD – transplant or 3 months regular dialysis.

MEDICARE PART A

- Premiums
  - Most beneficiaries do not have to pay for Part A (those with a 10 year work history)
  - "Voluntary enrollees" pay monthly premiums
    - 30-39 Quarters: $243/mo (2014)
    - 29 or less Quarters: $426/mo (2014)

PART A COVERAGE

- Hospital Care
- Skilled Nursing Facility Care
- Home Health Care
- Hospice

HOSPITAL COVERAGE

- Coverage
  - Services required can *only* be provided in a hospital
    - 24 hour availability of a physician
    - Special equipment only available in a hospital
  - "Waiting Days" – (After admission) No longer requires hospital level of care but requires SNF level of care and no SNF bed in the geographic area is available.

HOSPITAL COVERAGE

- Days Available per Benefit Period
  - See definition for benefit period after SNF section.
  - 90 days of coverage available
  - Plus 60 lifetime reserve days

- Cost Sharing
  - $1,216 deductible in 2014
  - Co-insurance:
    - $304 per day co-pay days 61-90 (2014)
    - $608 co-pay days 91-150 (2014)

HOSPITAL COVERAGE
Denials

- No notice of non-coverage required
  - *The Important Message from Medicare* (IM) must be given to the beneficiary within two days of a Medicare covered inpatient admission.
    - It includes information about discharge appeal rights.
  - A follow up copy of the IM is given as far as possible in advance of discharge, but no more than two calendar days prior to discharge. Follow up is not required if discharge falls within two days of first IM delivery.

HOSPITAL COVERAGE

Denials

- *If* the beneficiary expresses dissatisfaction with the impending discharge,
- The hospital must provide a Hospital-Issued Notice of Non-coverage (HINN).

HOSPITAL COVERAGE

Observation Status

- Billed to Medicare Part B rather than A.
- Does not count towards three day qualifying hospital stay for purposes of Part A skilled nursing facility coverage.

HOSPITAL COVERAGE

Observation Status

- "Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge…"

HOSPITAL COVERAGE

Observation Status

- "Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours." Medicare Benefits Policy Manual, Pub. 100-02, Chapter 6, § 20.6

SKILLED NURSING FACILITY (SNF) COVERAGE

Threshold Criteria

- Three day qualifying hospital stay
  - 3 day prior inpatient hospital stay that has been Medicare covered (emergency room and observation status do not count)
- 30 day window
  - Transfer to the SNF within 30 days of discharge from the hospital (unless it is not *medically appropriate* to begin a course of treatment until beyond 30 days)
- Physician certification

SNF COVERAGE

- SNF must be Medicare certified
- Requires daily skilled nursing or rehabilitation
  - 7 days per week of skilled nursing; or
  - 5 days per week of PT, OT, or ST; or
  - Combination of therapies for 5 days per week; or
  - Combination of nursing and therapies for 7 days per week

SNF COVERAGE

What's Covered?

- 100 days per benefit period
- No co-payment for days 1-20
- $152/day co-payment days 21-100 (2013)
- No deductible

SKILLED NURSING CARE

42 CFR §409.33(b)

- Specific services include:
  - Intravenous or intramuscular injections
  - Intravenous feeding
  - Insertion and sterile irrigation of supra pubic catheters
  - Application of dressings involving prescription medications and aseptic techniques
  - Treatment of extensive decubitus ulcers and other widespread skin disorders

HOSPITAL/SNF COVERAGE

Benefit Period

(Spell of Illness)

A benefit period begins on the first day a beneficiary is admitted to the hospital and does not end until the beneficiary has not received a hospital or skilled nursing facility level of care for 60 consecutive days.

HOME HEALTH COVERAGE

- Services must be ordered by a physician
- Under a written plan of care
- Beneficiary must be "confined to home"
- Beneficiary must require:
  - Intermittent skilled nursing services; or
  - Skilled PT or ST services (or, in limited circumstances, OT services)

HOME HEALTH COVERAGE

- Face to Face Encounter
  - The physician who initially certifies the beneficiary must document that a face to face encounter related to the primary reason for home health services occurred no more than 90 days prior to the start of home health services or within 30 days of the start of care. 42 C.F.R. § 424.22(a)(1)(v)
  - The certifying physician must document on the certification form why the clinical findings made during the face to face encounter support that the beneficiary is homebound and in need of either skilled nursing services or therapy services. 42 C.F.R. § 424.22(a)(1)(v)(D)

HOME HEALTH COVERAGE

Intermittent Skilled Nursing Services

- Intermittent means:
  - SN less than 7 days per week
  - Daily nursing services may be covered for 21 days or less with extensions if the need for daily care has a finite and predictable end-point.
- No more than 28-35 hours per week combined nursing and aide services

HOSPICE COVERAGE

- Designed to provide palliative care of a terminal illness.
- Terminal illness – reasonable expectation that the beneficiary has less than 6 months to live if the illness runs its normal course.

HOSPICE COVERAGE

- Services covered:
  - Nursing
  - Rehabilitation services (PT,OT,ST)
  - Aide and homemaker services
  - Medical social services
  - Short-term inpatient care
  - Respite care
  - Medical supplies, including prescription drugs
  - Bereavement counseling

HOSPICE

- Four Levels of Care:
  - Routine Home Care
  - Continuous Home Care
  - Respite Care
  - General Inpatient Care

HOSPICE COVERAGE

- Key to obtaining hospice care is the attending physician.
- Hospice Certification
  - Initially, the attending physician and the hospice medical director must certify that the beneficiary has a life-expectancy of six months or less.
  - In later certification periods, only a hospice physician certifies.
  - Face to face certification requirement for third and subsequent election periods. 42 C.F.R. § 418(a)(4)

PART A APPEALS

- Two Kinds
  - Expedited
  - Standard (see Part B)

PART A

Expedited Appeals

- Cessation of care or coverage
  - of SNF, Rehab hospital, home health care, or hospice care
- Does not apply to acute hospital discharges
- Not applicable when level of care is decreased or changed, but Medicare coverage is still available.

PART A
Expedited Appeals

- Notice
  - Generally, notice must be given two days before discharge or complete cessation of Medicare covered care delivered to the beneficiary by the provider.
- Request
  - Beneficiary has the option to request an expedited determination by the Quality Improvement Organization (QIO) by no later than noon of the day following receipt of the notice.
  - QIO must issue a decision within 72 hours.
- Liability
  - Beneficiary not financially liable until the later of 2 days after date of notice or the termination of care/discharge date

MEDICARE PART B

42 C.F.R. § 410.10 (not an exhaustive list)

- Physician services
- Outpatient hospital care
- Diagnostic laboratory and x-ray tests
- X-ray therapy and other radiation therapy services
- Medical supplies, appliances, and devices
- Durable medical equipment
- Ambulance services
- Home dialysis supplies and equipment

PART B

Physician Services

- Most routine care or screening tests are not covered.
- Diagnostic services are covered. Laboratory services are covered 100% and labs must take assignment.
- Services "incidental to physician's services" including drugs and biologicals that cannot be self-administered.

MEDICARE PART B

Usually does not pay for:

- Most prescription drugs
- Eyeglasses
  - Except one pair after each cataract surgery during which an intraocular lens is inserted
- Hearing aids
- Most dental care

MEDICARE PART B

Mental Health Care

- In the past, for outpatient mental health care, Medicare discounted the approved amount by 1/3rd and then paid 80% of that amount. The co-insurance amount usually was about 50% of the approved amount.
- Beginning in 2010, Medicare began to increase the percentage that it covered.
- Medicare now pays 80% of the approved amount;
- And it will cover 80% all subsequent calendar years.

MEDICARE PART B
Outpatient Therapy Caps

- On 1/1/06, physical, speech and occupational therapy performed in an outpatient setting became subject to financial caps imposed by The Balanced Budget Act of 1997.
- Caps (do not apply to care rendered in a hospital outpatient department)
  - $1920 for physical and speech therapy combined (2014)
  - $1920 for occupational therapy(2014)
- Exceptions process.
  - Beginning October 1, 2012, mandatory medical review of all therapy services furnished when the beneficiary reaches a dollar aggregate threshold amount of $3,700. This includes care received in a hospital outpatient department.

PART B

Durable Medical Equipment

- Durable – can withstand repeated use. Medicare expects a piece of equipment to last 5 years and will not usually pay for like or similar equipment within that time frame.
- Medical – Primarily and customarily used for a medical purpose and is generally not useful to a person in the absence of the illness or injury.

PART B
Durable Medical Equipment

- For use in the home (SNF is not considered home)
- Must be reasonable and necessary; most items require a Certificate of Medical Necessity (CMN) filled out by a doctor

PART B

Durable Medical Equipment

Payment Policy

- For inexpensive or customized items, Medicare pays 80% of its approved charge
- For items such as wheelchairs, hospital beds, etc. there is a capped rental policy for 13 continuous months, then title to the equipment passes to the beneficiary.

PART B
Ambulance Services

- Must be only safe means of transportation available
  - Show jeopardy to health if transported any other way
- Transportation is to the closest institution with appropriate facilities

PART B
Ambulance Services

- Must be between certain destinations:
  - Home to/from hospital
  - SNF to/from hospital
  - SNF to SNF
  - SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip
  - Hospital to Hospital
  - For a beneficiary who is receiving renal dialysis for ESRD, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.
- Problem with Volunteer Ambulance Companies/Paramedic Intercept Services

PART B

Ambulance Services

Non-Emergency Transportation

- Physician's written order required
- Orders are valid for 60 days
- Orders must certify that either the beneficiary is bed confined or that his medical condition is such that transportation by ambulance is medically required.

PART B

Preventive Services

- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement
- Cardiovascular Screenings
- Colorectal Cancer Screenings
- Diabetes Screenings
- Diabetes Self-management Training
- Flu Shots
- Glaucoma Tests
- Hepatitis B Shots

PART B
Preventive Services

- HIV Screening
- Mammogram (screening)
- Medical Nutrition Therapy Services
- Pap Test and Pelvic Exam
- Physical Exams
  - One-time "Welcome to Medicare"
  - Yearly "Wellness" exam
- Pneumococcal Shot
- Prostate Cancer Screenings
- Smoking Cessation

MEDICARE PART B

Beneficiary Costs

- Deductible
  - $147 in 2014
- Co-insurance- generally 20% of Medicare's approved charge

MEDICARE PART B

Beneficiary Costs

- Standard monthly premium
  - $109.40 (income <$85,001)

MEDICARE PART B

Beneficiary Costs

Part B Income-Related Premium (2014)

- Income greater than $85,000 $146.90
- Income greater than $107,000 $209.80
- Income greater than $160,000 $272.70
- Income greater than $214,000 $335.70

MEDICARE ENROLLMENT

Three Enrollment Periods

- Initial Enrollment Period (IEP)
- Special Enrollment Period (SEP)
- General Enrollment Period (GEP)

MEDICARE ENROLLMENT

1. Initial Enrollment Period (IEP)- 7 months, beginning 3 months before month of 65th birthday.
2. Beneficiaries can opt out of Part B.

MEDICARE ENROLLMENT

2. Special Enrollment Periods (SEP)
   - Those eligible may delay their enrollment in Medicare Part B without incurring a penalty.

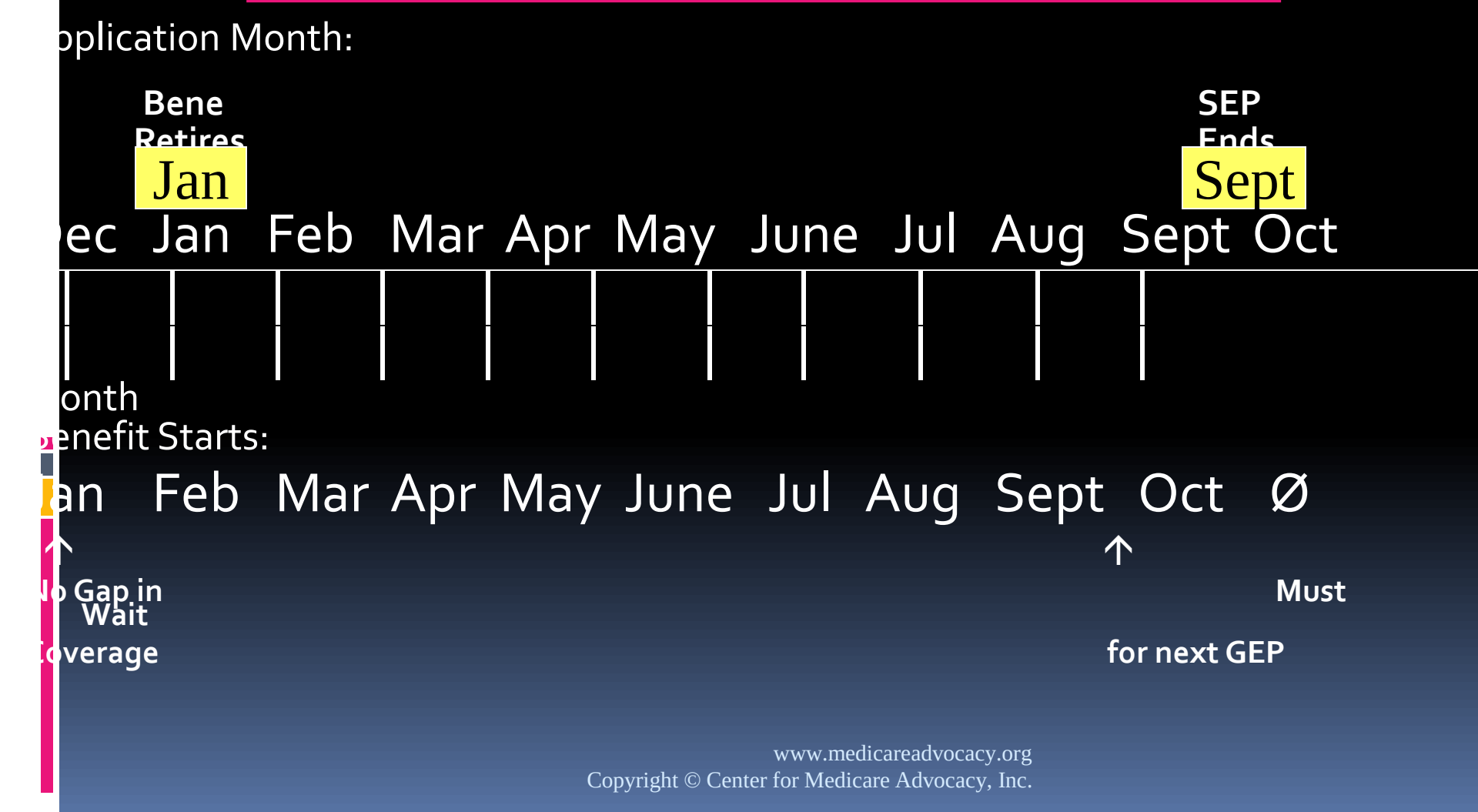
MEDICARE ENROLLMENT

- Special Enrollment Period for those over 65
  - Beneficiaries who are covered by an employee group health plan through
    - their own *active employment* or
    - the *active employment* of their spouse
  - The SEP lasts for eight months, beginning the month *after* the employment or employee group health coverage ends (whichever comes first).

MEDICARE ENROLLMENT

- Special Enrollment Period
  - For disabled individuals (except ESRD)
    - If they were covered by a large group health plan (greater than 100 employees)
    - Through their own employment or the employment of a family member.
  - The SEP lasts for eight months, beginning the month *after* the employment or employee group health coverage ends (whichever comes first).

SPECIAL ENROLLMENT PERIOD

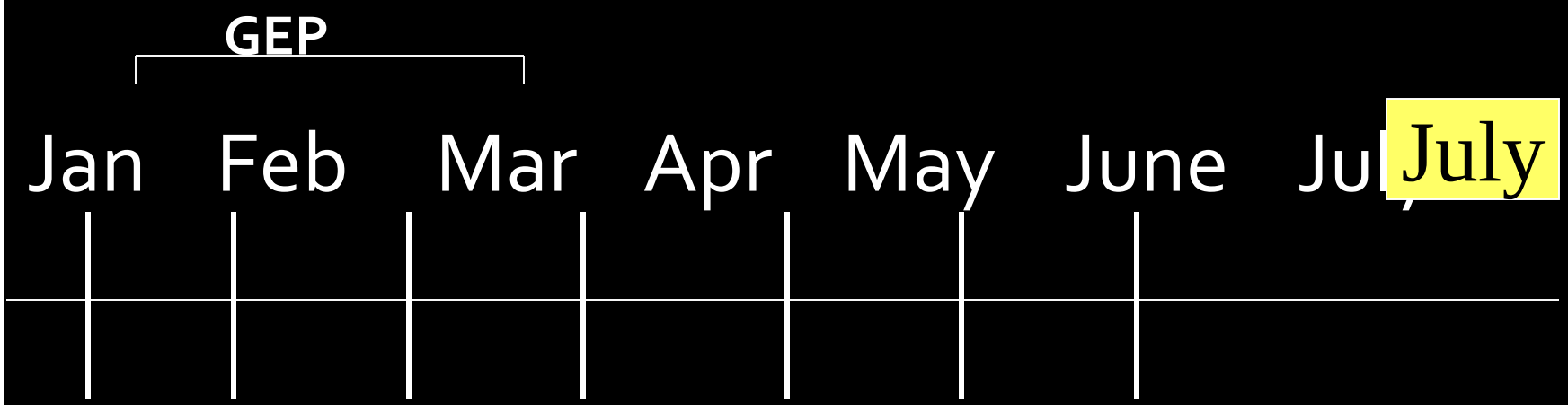


MEDICARE ENROLLMENT

3. General Enrollment Period (GEP)
   - First 3months of every year (Jan. Feb. March).
   - Part B benefits do not begin until 7/1 of that year.
   - There will be a penalty.

GENERAL ENROLLMENT PERIOD

Application Month:



Month Benefit Starts: **July 1st**

LATE ENROLLMENT PENALTIES

- Waiver
  - Penalties may be waived if late enrollment was due to misinformation from federal employee or its agents.
  - For disabled beneficiaries, the SSA Program Operations Manual provides for equitable relief when the delay in enrollment was caused by incorrect information provided by their employer or group health plan.

LATE ENROLLMENT PENALTIES

- Penalties:
  - Part A – 10% penalty, based on the monthly Part A premium price, for every month of late enrollment up to twice the number of months for which the beneficiary failed to enroll.
  - Part B – 10% for each full twelve month periods the enrollment is late. No durational limit.

LATE ENROLLMENT PENALTIES

- Example:
  - Medicare eligible May 2013 (turned 65)
    - IEP ends August 2013
  - Enrolls in Medicare Part B during 2014 GEP
    - GEP ends March 31, 2013
    - 7 months between end of IEP and end of GEP (only one full 12 month period)
  - Part B effective July 1st 2014
  - Part B premium penalty is 10%
    - 1 x 10% per full 12 month period not enrolled but was eligible
    - $109.40 + (10% of 109.40)= $120.34
  - No durational limit

RELATED INSURANCES

- Beneficiaries deal with Medicare cost-sharing in a number of ways:
  - self-insure
  - EGHP
  - Medicaid
  - Medicare Savings Programs
  - Medigap policy

MEDIGAP

- Medigap insurance is meant to work in tandem with the original Medicare program by paying for beneficiary cost-sharing and some other services not usually covered by Medicare.
- Must have Parts A and B to buy a Medigap plan.
- Connecticut Medigap insurance is community rated.
  - Everyone is the community pays the same amount for a particular Medigap policy.
  - Premiums may go up due to inflation or other factors but not due to the beneficiary's age or health status.

MEDIGAP

- In Connecticut
  - Insurance companies that sell plans A, B, and C must sell these plans to disabled Medicare beneficiaries. (Any time!)
  - Insurance companies that sell plans A-N to beneficiaries over age 65 must sell these plans at *all* times to Medicare beneficiaries who are over age 65.

MEDIGAP

- **Remember:** In CT beneficiaries over 65 have the right to purchase, at any time, from any company selling policies in CT.

MEDIGAP
Federal Consumer Protections

- Pre-existing Conditions
  - Insurance companies sometimes have clauses prohibiting coverage for conditions that pre-date the insurance.

MEDIGAP
Federal Consumer Protections

- Pre-existing Conditions
  - Under HIPAA, if an individual had *credible* health insurance coverage for a period of at least 6 months prior to their initial enrollment period for Medicare, no pre-existing exclusions may be imposed.
    - Most insurance is considered credible: employee or union group health insurance; retiree health insurance; Medicare Parts A and B; Medicaid

MEDIGAP
Federal Consumer Protections

- Pre-existing Conditions
  - If an individual was previously in another Medigap plan or Medicare Advantage plan for at least 6 months, no previous existing condition limit can be imposed by a new Medigap plan.

RELATED INSURANCES

Who Pays First?

- Medicare is **primary** to Medigap policies and to retirement plans.

WHO PAYS FIRST?

Medicare is secondary to EGHP for:

1. Employed beneficiaries over age 65 or beneficiaries over age 65 with *employed* spouses who have group health plan coverage through an employer with 20 or more employees.

WHO PAYS FIRST?

Medicare is secondary to EGHP for:

2. Certain disabled beneficiaries with EGHP through active employment. Medicare is the secondary payer for Medicare eligible disabled people who are also covered by a large group health plan of an employer with over 100 employees.

WHO PAYS FIRST?

Medicare is secondary to EGHP for:

3. Beneficiaries with permanent kidney failure. Medicare is the secondary payer for 30 months (coordination period).

WHO PAYS FIRST?

- For problems or questions, call the Medicare Coordination of Benefits Contractor: 1-800-318-3782.
- Also see "Medicare and Other Health Benefits: Your Guide to Who Pays First" http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf

To understand Medicare Part D, must have basic information about these two programs that work closely with Part D:

- Medicaid
- Medicare Savings Program ("MSP")

Both are administered by the CT State Department of Social Services thru a central office in Hartford and/or regional (district) offices throughout the state.

Medicaid (MAABD now HUSKY C)
Medicaid vs. Medicare
Medicaid Services
Medicaid Asset Limits
Medicaid Income Limits
“Spenddown”
Calculating Spenddown
Dual Eligibles, Part D and the LIS
The Low Income Subsidy (LIS)
The Effect of the Part D LIS on Spenddown

MEDICAID – Title 19
for Adults in the Community

Formerly called "MAABD", now called "HUSKY C"
Provides medical assistance to adults in the community who meet "financial" and "categorical" eligibility requirements:

- Financial: income and assets must be within certain limits
- Categorical: adults must be 65 +, or between 18-65 and "totally and permanently" disabled or legally blind

50% state funded with 50% federal match (Therefore, states must follow federal rules for the program.)
Also known as "Title XIX " or "Title 19"

MEDICAID – Title 19

<u>Medicaid is NOT the same thing as Medicare</u>!

- Eligibility for Medicare is based on Social Security *work history / work quarters* (regardless of income or assets). It is administered by the *federal* government.
- Eligibility for Medicaid is based on *income and assets*. It is administered by the *state* government (DSS)

People who have both Medicare and Medicaid are called "Dual Eligibles"

Dual eligibles are the focus of this discussion.

MEDICAID SERVICES

Medicaid covers:

- doctor and clinic visits
- hospital (inpatient and outpatient care)
- lab and x-ray
- home health care
- durable medical equipment
- nursing home care
- some medical transportation
- limited dental and eye care, etc.

Prescription drugs also covered if the person is on Medicaid only.

BUT, dual eligibles must be enrolled in a Part D prescription drug plan to get prescription drug coverage!

Eligibility is first determined by comparing applicant's assets to Medicaid asset limits
Counted assets include (but not limited to) bank accounts, CDs, stocks and bonds, cash surrender value of life insurance, and non-home property
Some assets are not counted, e.g., personal residence, car, funds set aside for burial
Person simply NOT Eligible if countable assets exceed $1,600 (single) or $2,400 (couple) I.e., no "spenddown" of assets!

State compares adjusted gross income to the "Medically Needy Income Limit" (**MNIL**), which varies by state region (Regions A,B and C)
Some income is not counted, e.g., $302/ person = basic "unearned income disregard" (There are other disregards and exclusions of income.)

MNIL **Region A Limit**	**MNIL** **Regions B and C Limits**
$912.00 (sgl) $1381.00 (cpl)	$808.00 (sgl) $1276.00 (cpl)

Person may still qualify if adjusted income exceeds MNIL if medical bills are very high in relation to income
Eligibility begins once the person has INCURRED (not necessarily paid) medical bills equal to the amount of "excess" income
Process of calculating eligibility for people with excess income is called "spenddown"
NOTE #1: spenddown applies to income only, not assets!
NOTE #2: spenddown only applies to people living in community. People living in institutions, like LTC facilities, are not subject to spenddown – but most of their income must be applied to cost of care.

Formula

1. Start with monthly gross income.
2. Deduct unearned income disregard (and any other exclusions or deductions that apply)
3. Compare result with MNIL (Person is eligible for Medicaid if adjusted income is within MNIL amount)
4. Multiply any excess amount by 6 (months)
5. Result is the person's spenddown amount
6. Person must submit copies of medical bills to DSS worker so they can be applied against spenddown amount.
7. Person is eligible for Medicaid benefits once paid *or* incurred medical bills equal spenddown amount.
8. Spenddown is recalculated every six months.

Dual eligibles must be enrolled in a Medicare Part D insurance plan to get coverage of most prescription drugs.
Duals who do not enroll in a Part D plan are auto-enrolled into a plan by CMS.
BUT, there are costs associated with Part D: premiums, co-pays, deductibles, etc.

THEREFORE, duals automatically qualify for the Part D Low Income Subsidy ("LIS"), which helps them pay Part D costs, such as premiums and co-pays. LIS also covers during the deductible and Donut Hole periods.

Once granted, the LIS continues for a year.

"EXTRA HELP" (LIS)

LIS is administered by SSA

LIS also called "Extra Help"

The LIS helps pay for Part D costs:

- LIS pays or contributes to Part D monthly premium
- Generic co-pays = $0 to $2.55 max. (2014)
- Brand name co-pays = $0 to $6.35 max. (2014)
- No Part D deductible
- No Part D "donut hole" (gap in coverage)

Before Part D, people on a Medicaid spenddown had to pay for their prescription drugs out-of-pocket

They could apply the cost of their drugs (and other medical expenses) against their spenddown amounts.

Since Part D, the federal government pays for a large portion of these prescriptions through the Part D Low Income Subsidy (LIS).

The LIS = federal $$$
Federal LIS $$$ cannot be applied against spenddown.
Therefore:

People can now get their prescription drugs while on spend down; BUT:
Because they have LIS, and are paying very little for prescription drugs, it takes longer to meet spend down.
Some people now remain in "perpetual spend down

RELATED INSURANCES

Medicare Savings Programs

- Qualified Medicare Beneficiary Program (QMB)
- Specified Low Income Medicare Beneficiary Program (SLMB)
- Qualified Individual Program (QI) or ALMB

MEDICARE SAVINGS PROGRAMS

QMB

- Benefits:
  - Payment of Part A monthly premiums (volunteer enrollees).
  - Payment of Part B monthly premiums and annual deductibles.
  - Payment of co-insurance and deductible amounts for Part A and B.
    - *Co-insurance will only be covered if provider is certified as a Medicaid provider.*
    - Providers can become certified by simply calling the State Medicaid contractor, EDS, which will send an enrollment package.
    - If provider does not accept Medicaid, the provider is barred from billing the beneficiary for Part A and B cost sharing.

MEDICARE SAVINGS PROGRAMS

QMB

- Eligibility Criteria:
  - Must be eligible for Medicare Part A (even if not enrolled).
  - Income Limits (April 1, 2014)
    - $2,053.03 (single) or $2,76.21 (couple)
  - No asset test
  - Estate recovery eliminated in 2010. If benefits received prior to January 1, 2010, the State can recover money equal to the amount of benefits received.

MEDICARE SAVINGS PROGRAMS

QMB

- Eligibility is effective the first day of the month following the month that DSS has all the information and verification necessary to determine eligibility. This should not take more than 45 days.

MEDICARE SAVINGS PROGRAMS

QMB

- Conditional Enrollment
  - Connecticut has a Part A "buy in agreement"
    - DSS can simultaneously enroll QMB applicants in both Parts A and B.
    - If SSA has not yet determined that the applicant is eligible for Medicare, she will be enrolled in Part B and "conditionally" enrolled in Part A.
    - No need for a Special Enrollment Period.

MEDICARE SAVINGS PROGRAMS

Specified Low-Income Medicare Beneficiary Program (SLMB)

- Pays Part B monthly premium only
- Eligibility
  - Eligible for Part A insurance (need not be currently enrolled).
  - Income Limits (April 1, 2014)
    - $2,247.63 (single) or $3,028.41 (couple)
  - No asset test
  - Estate recovery eliminated in 2010. If benefits received prior to January 1, 2010, the State can recover money equal to the amount of benefits received.

MEDICARE SAVINGS PROGRAMS

SLMB

- Eligibility may be retroactive up to 3 months prior to the date of the application.

MEDICARE SAVINGS PROGRAMS

Qualified Individual Program (QI)
Additional Low Income Medicare Beneficiaries (ALMB)

- Block grants to the States for limited expansion of ALMB. Not an entitlement, first come, first served. No asset limit.
- Must apply every year. Best to apply early. Priority given to those who received benefit the previous year.
- Not available to those receiving any other kind of Medicaid.
- Eligibility may be retroactive up to 3 months prior to the date of the application.

MEDICARE SAVINGS PROGRAMS

Additional Low-Income Medicare Beneficiary Program (ALMB)

- Pays Part B monthly premium only
- Eligibility
  - Eligible for Part A insurance (need not be currently enrolled).
  - Income Limits (April 1, 2014)
    - $2,393.58 (single) or $3,225.06 (couple)
  - No asset test
  - Estate recovery eliminated in 2010. If benefits received prior to January 1, 2010, the State can recover money equal to the amount of benefits received.

THE MEDICARE PROGRAM
Review

- Four Parts
  - Traditional Medicare
    - Part A
    - Part B
    - Additional Insurance
  - Part C (Medicare Advantage)
  - Part D (Rx Drug Coverage)

RESOURCES

- www.medicareadvocacy.org
- www.nsclc.org
- www.cms.hhs.gov
- www.medicare.gov
- www.shiptalk.org