

Medicare 2004

This module is designed to provide a basic understanding of the current federal Medicare Program, to assist you in the marketing of Long-Term Care Insurance. This is intended for informational purposes only. It provides a very general and brief overview of Medicare, and is largely based on information from “All About Medicare”, 2004, a publication of National Underwriter ” and “Medicare & You 2004”, a publication of The Department of Health & Human Services. Additional information can be obtained from the “2003/2004 Guide to Medicare.

Medicare is the federal Health Insurance Program for people age 65 or older, and disabled persons of any age receiving Social Security disability benefits for not less than 24 months. It was designed to pay some of the costs of some health care services in order to provide recipients access to a basic level of health care. As a governmental program, it is subject to legislative change and administrative interpretation.

Medicare has deductibles, requires co-payments in some cases, and has maximums, after which it pays nothing. Generally, Medicare does not cover preventive care—it provides coverage only when services are medically reasonable and necessary for the diagnosis or treatment of illness or injury, and the care must be “skilled” care, not custodial care. *

In order to understand what Medicare benefits are available for long-term care, you must first understand the types of long-term care services a person may need.

- Skilled Care – care provided by a health care professional, RN, LPN, Physical or Speech Therapist.
- Personal/Custodial Care – care provided to assist with daily activities of living or to meet personal needs by a non-health care professional. For example, help in walking, getting in or out of bed, with bathing, dressing, eating, and taking medicine.

The majority of care provided in the U.S. today in connection with chronic long-term illnesses or conditions is Personal/Custodial Care. ** Medicare **will generally not pay for personal or custodial care**. Rather, it is designed to provide benefits for Skilled Care.

There are two parts to Medicare:

Part A – Hospital Insurance Program provides coverage for inpatient acute hospital care and limited coverage for inpatient care in a skilled nursing facility or hospice, and home health care services.

Part B – Medical Insurance Program provides limited coverage for medical care and services provided by doctors and other medical practitioners, certain outpatient care services, diagnostic tests and durable medical equipment and some home health care services, not covered by Part A.

* Medicare does provide for coverage for certain services that fall into the category of preventive care, e.g. certain cancer screening diabetes monitoring, glaucoma screening, influenza vaccinations, etc.

**Source: Centers for Medicaid & Medicare Services, Department of Health and Human Services, 2004. www.medicare.gov

**TABLE OF MEDICRE – PART A (HOSPITAL INSURANCE BENEFITS)
Effective after January 1, 2004**

Service	Benefit	Medicare Pays	A Person Pays
HOSPITALIZATION Semiprivate room and board ¹ , general nursing, and other hospital services and supplies	First 60 days	All but \$876	\$876
	61 st to 90 th day	All but \$219 a day	\$219 a day
	91 st to 150 th day ²	All but \$438 a day	\$438 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies, following a stay in a hospital ³ .	First 20 days	100% of approved amount	Nothing
	21 st to 100 th days	All but \$109.50 a day	\$109.50 a day
	Beyond 100 days	Nothing	All costs
POST-HOSPITAL HOME HEALTH CARE Part-time or intermittent skilled care, home health aid services, following an institutionalization. Durable medical equipment and supplies and other services.	First 100 visits ⁴	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for home health services; 20% of approved amount for durable medical equipment
HOSPICE CARE (generally excluding room and board in a nursing home or hospice residential facility) Pain relief, symptom management and support services for the terminally ill.	For as long as the doctor certifies need	All but a co payment of up to \$5.00 for outpatient drugs and 5% of the approved amount for inpatient respite care	\$5.00 for outpatient drugs and 5% of approved amount for inpatient respite care
BLOOD When furnished by a hospital or skilled nursing facility during covered stay.	Blood	All but first 3 pints per calendar year	For first 3 pints ⁵

1. The individual is entitled to hospital coverage of up to 90 days per any one “spell of illness”. A new “spell of illness” would begin when the individual has gone for at least 60 consecutive days without being an inpatient in a hospital or skilled nursing home.
2. 60 Reserve Days benefit may be used only once in a lifetime. These days can be used for hospital stays from day 91 to 150.
3. The individual is entitled to skilled nursing facility coverage of up to 100 days per any one “spell of illness”, as post-hospital care. However, neither Medicare nor private Medigap (Medicare Supplement)) insurance will pay for most nursing home care.
4. The individual is entitled to coverage for 100 visits providing skilled home health care, if confined to his or her home, for any one spell of illness.
5. Blood paid for or replaced under Part B of Medicare during the calendar year does not have to be paid for or replaced under Part A.

AGENT USE ONLY

TABLE OF MEDICARE – PART B (MEDICAL INSURANCE BENEFITS)
Effective after January 1, 2004
Monthly Premium \$66.60

Services*	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and other services.	Unlimited, if medically necessary	80% of approved amount (after \$100 annual deductible). Reduced to 50% for most outpatient mental health services.	\$100 deductible, ¹ plus 20% of approved amount and limited charges above approved amount. ² 50% for most outpatient mental health services.
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more	Unlimited, if medically necessary	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE Part-time or intermittent skilled care, home health aid services. Durable medical equipment and supplies and other services.	Unlimited, if Medicare conditions are met	100% of approved amount; 80% of amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited, if medically necessary.	80% of billed amount (after \$100 annual deductible). Medicare payment to hospital based on hospital cost.	20% of billed amount (after \$100 deductible) ¹
BLOOD	Unlimited, if medically necessary.	80% of approved amount (starting with 4 th pint).	For first 3 pints plus 20% of approved amount for additional pints.
AMBULATORY SURGICAL SERVICES	Unlimited, if medically necessary	80% of pre-determined amount	20% of pre-determined amount ¹ .

1. This is a one-time annual deductible applicable to services covered under Part B. Once a person has paid \$100 of expenses for covered services in any one year, the Part B deductible does not apply to other Part B covered services received for the rest of that year.
2. A person pays for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. When a physician accepts "assignments," he or she has accepted the approved amount as full payment. But the insured will still pay the co insurance amount (usually 20%).

3. Blood paid for or replaced under Part A of Medicare during the calendar year does not have to be paid for or replaced under Part B.

*Other services may be available under Part B

Key Points

An individual may qualify for Medicare-covered skilled nursing facility (SNF) benefits if a physician certifies that he or she needs skilled nursing facility care and the individual:

- Requires daily skilled care which can only be provided in a skilled nursing facility on an inpatient basis;
- Was in the hospital for at least three (3) consecutive days (not counting the day of discharge) before entering a skilled nursing facility that is certified by Medicare;
- Is admitted to the skilled nursing facility for the same condition for which he or she was treated in the hospital; and
- Is admitted to the facility within 30 days of his/her discharge from the hospital;

However, only 100 days per spell of illness are covered.

The individual may qualify for Medicare-covered home health care benefits if:

- Care is medically necessary and reasonable;
- The individual needs skilled nursing care on an intermittent basis or physical or speech therapy;
- The physician has signed a “plan of care”;
- The individual is confined to his/her home(a condition that will be met if the individual requires personal assistance, crutches or a wheelchair in order to leave the home); and
- A Medicare-certified provider provides care.

However, this coverage is limited to 100 visits.