

Understanding Medicare

Module 1C



Lessons

1. Program Basics
2. Your Medicare Coverage Choices
 - A. Original Medicare (Part A and Part B)
 - B. Medicare Advantage (Part C) and Other Medicare Plans
 - C. Medicare Prescription Drug Coverage (Part D)
3. Appeals
4. Programs for People with Limited Income and Resources



Lesson 1 Program Basics

- **What is Medicare**
- **Who is Eligible**
- **Enrollment**
- **How to Apply**
- **The Four Parts of Medicare**
- **What is not Covered**

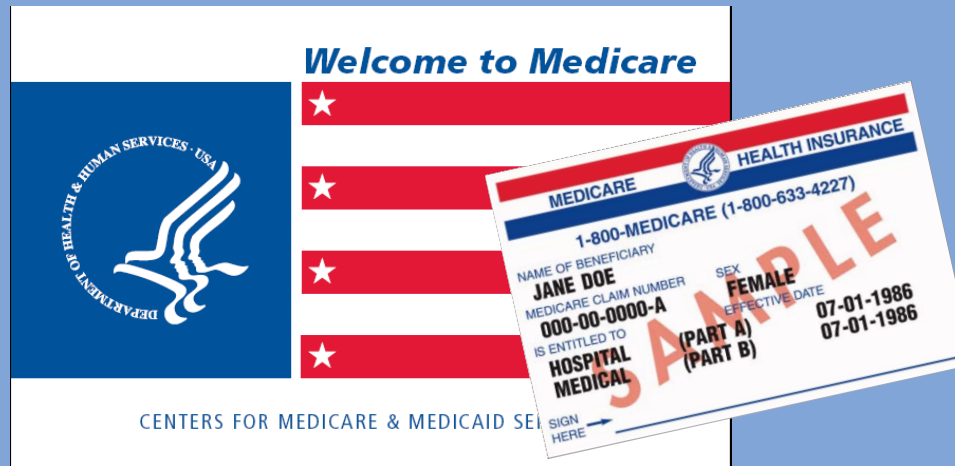


What is Medicare?

- 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
- Enrollment
 - Social Security Administration for most
 - Railroad Retirement Board (RRB)

Automatic Enrollment

- Automatically enrolled if you already get Social Security
 - 3 months before age 65
 - 3 months before your 25th month of disability benefits
- Receive Initial Enrollment Package (IEP) in mail
 - Includes your Medicare card
 - If you don't want Part B, follow directions in IEP





Enrolling in Medicare

- Some people need to sign up
 - Not getting Social Security or Railroad benefits
 - Enroll through Social Security (SSA) or
 - Railroad Retirement Board for railroad retirees
- Apply 3 months before age 65
 - Don't have to be retired



Medicare has Four Parts

Part A – Hospital Insurance	Helps cover inpatient care in hospitals and skilled nursing facilities, hospice and home health care.
Part B – Medical Insurance	Helps cover doctors' services, outpatient care, home health care and some preventive services.
Part C – Medicare Advantage Plans	Another way to get Medicare benefits. Combines Parts A and B. Usually includes Part D coverage. Run by private insurance companies approved by and under contract with Medicare.
Part D – Medicare Prescription Drug Coverage	Helps cover the cost of prescription drugs. Run by private insurance companies approved by and under contract with Medicare.



Lesson 2 – Your Medicare Coverage Choices

- A. Original Medicare (Part A and Part B)**
- B. Medicare Advantage (Part C) and Other Medicare Plans**
- C. Medicare Prescription Drug Coverage (Part D)**



Medicare Part A Hospital Insurance

- **Costs**
- **Coverage**
 - Inpatient Hospital Stays
 - Skilled Nursing Facility Care
 - Home Health Care
 - Hospice Care
 - Blood



Medicare Part A (Hospital Insurance)

- Most people receive Part A premium free
- Less than 10 years of Medicare-covered employment
 - Can pay a premium to get Part A
- For information, call SSA at 1-800-772-1213
 - TTY users call 1-800-325-0778



Medicare Part A Helps Pay For

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).
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, and occupational therapy.
Hospice Care	Includes drugs and medical, 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.



Benefit Period

- Charges based on “benefit period”
 - Inpatient hospital care and skilled nursing facility (SNF) services
 - Begins day admitted to hospital
 - Ends when out of a hospital or SNF for 60 days in a row
 - You pay deductible for each benefit period
 - No limit to number of benefit periods



Paying for Hospital Stays

- For each benefit period in 2010 you pay
 - \$1,100 total deductible for days 1 – 60
 - \$275 co-payment per day for days 61 – 90
 - \$550 co-payment per day for days 91 – 150
(60 lifetime reserve days)
 - All costs for each day beyond 150 days



Skilled Nursing Facility Care

- Must meet all conditions
 - Require daily skilled services
 - Not just long-term or custodial care
 - Inpatient in a hospital 3 consecutive days or longer
 - Admitted to the SNF within 30 days after leaving hospital
 - Care is for a condition that was treated in the hospital
 - Facility **MUST** be a Medicare participating SNF



Skilled Nursing Facility Coverage

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, & 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 2010 you pay
 - \$0 for days 1 – 20
 - \$137.50 per day for days 21-100
 - All costs after 100 days



Home Health Care

- Four conditions for home health coverage
 - Doctor must make a plan for your care at home
 - Must need specific skilled services
 - Must be homebound
 - Home health agency must be Medicare-approved



Home Health Care Coverage

- Part-time/intermittent skilled nursing care
- Physical, occupational & speech-language therapy
- Medical social services
- Some home health aide services
- Durable medical equipment, supplies



Paying for Home Health Care

- In Original Medicare you pay
 - Nothing for covered home health care services
 - 20% of Medicare-approved amount for durable medical equipment



Hospice Care

- Special care for terminally ill and family
 - Expected to live 6 months or less
- Focuses on comfort, not on curing the illness
- Doctor must certify for each “period of care”
 - Two 90-day periods, then unlimited 60-day periods
- Hospice provider must be Medicare-approved



Covered Hospice Services

- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care (limited)
- Respite care in a Medicare-certified facility
 - Up to 5 days each time with no limit to number of times
- Home health aide and homemaker services
- Social worker services
- Dietary counseling
- Grief counseling



Paying for Hospice Care

- In Original Medicare you pay
 - Nothing for hospice care
 - Up to \$5 for prescription drugs for pain and symptom mgmt
 - 5% for inpatient respite care
 - Amount can change each year
- You generally pay 100% for room and board in a facility



Blood (Inpatient)

- If the hospital gets blood free from a blood bank
 - You won't have to pay for it or replace it
- If the hospital has to buy blood for you, you either
 - Pay the hospital costs for the first 3 units of blood you get in a calendar year **or**
 - Have the blood donated by you or someone else



Medicare Part B Medical Insurance

- Enrolling
- Keeping Part B
- Medicare and other coverage
- Premium
- Coverage
- Part B costs
- Assignment



Enrolling in Medicare Part B

Automatic Enrollment	<ul style="list-style-type: none">▪ If you already get Social Security, Railroad Retirement, or disability benefits▪ Must opt out if you don't want to be enrolled
Initial Enrollment Period (IEP)	<ul style="list-style-type: none">▪ 7 month period. Starts 3 months before month of eligibility, and includes the month you turn 65 and 3 months after the month you turn 65
General Enrollment Period (GEP)	<ul style="list-style-type: none">▪ January 1 through March 31 each year▪ Coverage effective July 1▪ Premium penalty<ul style="list-style-type: none">– 10% for each 12-month period eligible but not enrolled– Paid for as long as the person has Part B– Limited exceptions



Part B and Employer or Union Coverage

- Find out how your insurance works with Medicare
 - Contact your employer/union benefits administrator
- You may want to delay enrolling in Part B if
 - You have employer or union coverage and
 - You or your spouse is still working



Employer or Union Coverage Ends

- 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
- Important -- Medigap open enrollment period
 - Starts when you are both 65 and sign up for Part B
 - Once started cannot be delayed or repeated



Medicare and TRICARE Coverage

- Medicare Part A and TRICARE For Life (TFL)
 - If retired you must have Part B to keep TFL
- Active-duty member, spouse or dependent child
 - You don't have to have Part B to keep TRICARE
- Part B Special Enrollment Period
 - Age 65 or older or you are disabled

Monthly Part B Premium

If your Yearly Income in 2008 was		You Pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or below	\$170,000 or below	\$96.40* or \$110.50
\$85,001–\$107,000	\$170,001–\$214,000	\$154.70
\$107,001–\$160,000	\$214,001–\$320,000	\$221.00
\$160,001–\$214,000	\$320,001–\$428,000	\$287.30
above \$214,000	above \$428,000	\$353.60

*Most people pay \$96.40 if their premiums were being deducted from Social Security.



Paying the Part B Premium

- Deducted monthly
 - Social Security
 - Railroad retirement
 - Federal retirement payments
- If not deducted
 - Billed every 3 months, or
 - Use Medicare Easy Pay
- Contact SSA, RRB or OPM about paying 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
- Usually no penalty if you sign up during a SEP



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 (\$110.50 in 2010). So for 2010, her premium will be as follows.

$$\begin{array}{r} \$110.50 \text{ (2010 Part B standard premium)} \\ + \$22.10 \text{ (20\% [of \$110.50] (2 X 10\%))} \\ \hline \$132.60 \text{ (Mary's Part B monthly premium for 2010)} \end{array}$$



Part B Coverage

- Doctors' services
- Outpatient medical/surgical services and supplies
- Diagnostic tests
- Outpatient therapy
- Outpatient mental health services
- Some preventive health care services
- Other medical services



Covered Preventive Services

Health
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Section
4103

- One time “Welcome to Medicare” physical exam
- Physical Exam (yearly “Wellness Exam”) Starts 2011
- Abdominal aortic aneurysm screening*
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- EKG Screening*
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV Screening
- Mammograms (screening)
- Pap test/pelvic exam/clinical breast exam
- Prostate cancer screening
- Pneumococcal shots
- Smoking cessation

*When referred during Welcome to Medicare physical exam



Paying for Part B Services

- In Original Medicare you pay
 - Yearly deductible of \$155 in 2010
 - 20% coinsurance for most services
 - Some copayments
- Some programs may help pay these costs



Assignment

- Medicare doctors/providers/ suppliers
 - Accept the Medicare-approved amount
 - As full payment for covered services
 - Only charge Medicare deductible/coinsurance amount
 - They submit your claim to Medicare directly
- Applies to Original Medicare Part B claims
- We say “accepts assignment”



Providers who do NOT Accept Assignment

- May charge more than Medicare-approved amount
 - Limit of 15% more for most services
 - “The limiting charge”
- May ask you to pay entire charge at time of service
- Providers sometimes must accept assignment
 - Medicare Part B-covered Rx drugs
 - Ambulance providers



Private Contracts

- Agreement between you and your doctor
 - 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



What is not covered by Medicare Part A or Part B



What's NOT Covered by Part A and Part B?

- Items and services Medicare doesn't cover include, but aren't limited to:
 - Long-term care
 - Routine dental care
 - Dentures
 - Cosmetic surgery
 - Acupuncture
 - Hearing aids and exams for fitting hearing aids



Exercise

A. The Centers for Medicare & Medicaid Services is responsible for enrolling most people in Medicare.

1. True
2. False



Exercise

B. The Part B premium for most people is \$96.40 in 2010.

1. True
2. False



Original Medicare

- What it is
- Medicare Card
- Medigap (Medicare Supplement Insurance) policies
- Private contracts



Original Medicare

- Run by the Federal government
- Provides your Part A and/or Part B coverage
- Go to any doctor or hospital that accepts Medicare
- You pay
 - Part B premium (Part A free for most people)
 - Deductibles, coinsurance or copayments
 - Can buy a Medigap policy to help pay some of these costs
- Get Medicare Summary Notice (MSN)
- Can join a Medicare Rx Plan to add drug coverage

Medicare Card (front)

The image shows a sample Medicare card for Jane Doe. The card features a red and blue header with the text 'MEDICARE HEALTH INSURANCE' and the Department of Health & Human Services seal. Below the header, the phone number '1-800-MEDICARE (1-800-633-4227)' is displayed. The beneficiary's name is 'JANE DOE'. The Medicare claim number is '000-00-0000-A' and the sex is 'FEMALE'. The card is entitled to Hospital (Part A) and Medical (Part B) coverage, both effective as of 07-01-1986. A signature line at the bottom is signed 'Jane Doe'.

NAME OF BENEFICIARY	MEDICARE CLAIM NUMBER	SEX
JANE DOE	000-00-0000-A	FEMALE
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL (PART A)	07-01-1986	
MEDICAL (PART B)	07-01-1986	

SIGN HERE → Jane Doe



Medigap

- Medigap (Medicare Supplement Insurance) policies
 - Private health insurance for individuals
 - Sold by private insurance companies
 - Supplements Original Medicare coverage
 - Follow Federal/state laws that protect you
 - Must state “Medicare Supplement Insurance”



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 Plans Effective on or after June 1, 2010

How to read the chart:

If a checkmark appears in a column of this chart, the Medigap policy covers 100% of the described benefit. If a column lists a percentage, the policy covers that percentage of the described benefit. If a column is blank, the policy doesn't cover that benefit. **Note:** The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible).

You may buy the following Medigap Plans which become effective June 1, 2010:

Medigap Benefits	Medigap Plans Effective June 1, 2010									
	A	B	C	D	F	G	K	L	M	N
Medicare Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood (First 3 Pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)			✓	✓	✓	✓			✓	✓
Medicare Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
							Out-of-Pocket Limit**			
							\$4,620	\$2,310		



Medicare Advantage & Other Medicare Plans



Medicare Advantage (MA) Plans (Part C)

- What they are
- Who can join
- How the plans work
- When to join and switch plans
- MA Plan costs
- Other Medicare plans



What Are Medicare Advantage (MA) Plans?

- Health plan options approved by Medicare
- Run by private companies
- Part of the Medicare program
 - Sometimes called “Part C”
 - Available in many areas of the country
- Medicare pays a set amount to plan for your care



If you join a Medicare Advantage Plan

- You are still in Medicare the program
- You still have Medicare rights and protections
- You still get regular Medicare-covered services
- You may get extra benefits
 - Such as vision, hearing, or dental care
- You may be able to get prescription drug coverage



Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- Medicare Medical Savings Account (MSA)



Medicare Advantage Eligibility Requirements

- You must live in plan's service area
- You must have Medicare Part A **and** Part B
- You must not have ESRD at time of enrollment
 - Some exceptions



How Medicare Advantage Plans Work

- You get Medicare-covered services through the plan
 - All Part A and Part B covered services
 - Some plan may provide additional benefits
- Most plans include prescription drug coverage
- May have to go to network doctors or hospitals
- Benefits and cost-sharing may be different than in Original Medicare

When You Can Join or Switch MA Plans*

Initial Coverage Election Period	<ul style="list-style-type: none"> ▪ 7 month period begins 3 months before the month you turn 65 –Includes the month you turn 65 –Ends 3 months after month you turn 65
Annual Election Period for 2010	<ul style="list-style-type: none"> ▪ November 15 – December 31 ▪ Coverage begins January 1, 2011
Annual Election Period for 2011 and After	<p>October 15 – December 7 each year</p> <p>Coverage begins January 1 of following year</p>

Health Reform Section 3204

*Plan must be allowing new members to join.

When you can Join or Switch MA Plans*

MA Open Enrollment Period	<ul style="list-style-type: none">▪ Was January 1 – March 31 each year▪ Eliminated in 2011	Health Reform Section 3204
Special Election Period	<ul style="list-style-type: none">▪ Move from the plan service area –And cannot stay in the plan▪ Plan leaves Medicare program▪ Other special situations	

*Plan must be allowing new members to join.

When you can Join or Switch MA Plans

New in 2011 Annual Disenrollment Period

- Can leave an MA plan and switch to Original Medicare
- Between January 1–February 14
 - Coverage begins the first of the month after you switch
- If you make this change you also may join a Medicare Prescription Drug Plan to add drug coverage
 - Between January 1-February 14
 - Drug coverage begins the first of the month after the plan gets enrollment form

Health
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Section
3204



Medicare Advantage Plan Costs

- Must still pay Part B premium
 - Some plans may pay all or part for you
 - Some people may be eligible for state assistance
- You may pay additional monthly premium to plan
- You pay deductibles, coinsurance, and copayments
 - Different from Original Medicare
 - Varies from plan to plan



Other Medicare Plans

- Other types of Medicare plans that aren't MA plans
 - Medicare Cost Plans
 - Demonstrations/Pilot Programs
 - Programs of All-inclusive Care for the Elderly (PACE)
- Only available in certain areas



Exercise

A. Medicare Advantage plans are sometimes called Medicare Part D.

1. True
2. False



Exercise

B. In 2011, the Medicare Advantage Open Enrollment Period is from January 1 through February 14.

1. True
2. False



Medicare Prescription Drug Coverage (Part D)

- What it is
- Who can join
- When you can join and switch
- Part D plan costs
- Extra Help
- What is covered
- How plans work



Medicare Prescription Drug Coverage

- Available for all people with Medicare
- Provided through
 - Medicare Prescription Drug Plans
 - Medicare Advantage Plans
 - Other Medicare plans



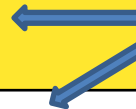
Who Can Join

- You must have Medicare Part A and/or Part B
- You must live in plan service area
- You must enroll in a Medicare Rx plan
- You can't live outside the U.S. or be incarcerated

When you can Join or Switch Medicare Prescription Drug Plans

Initial Coverage Election Period (IEP)	<ul style="list-style-type: none">▪ 7 month period▪ Starts 3 months before month of eligibility
Annual Coordinated Election Period (AEP)	November 15 – December 31 each year <i>(Time period will change in 2011 to October 15 – December 7)</i>
New in 2011 Annual Disenrollment Period	<ul style="list-style-type: none">▪ Starting in 2011, between January 1–February 14, you can leave an MA plan and switch to Original Medicare. If you make this change, you may also join a Medicare Prescription Drug Plan to add drug coverage. Coverage begins the first of the month after the plan gets enrollment form.

Health Reform Section 3204





When you can Join or Switch Medicare Prescription Drug Plans (continued)

Special Enrollment Periods (SEP)

- You permanently move out of your plan's service area
- You lose other creditable Rx 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
- Or in exceptional circumstances



Late Enrollment Penalty

- People who wait to enroll after their IEP
 - Pay additional 1% of base beneficiary premium
 - For every month eligible and not enrolled
 - For as long as they have Medicare drug coverage
 - Except those with other creditable drug coverage
 - At least as good as Medicare prescription drug coverage



Prescription Drug Costs

- Costs vary by plan
- Most people will pay
 - Monthly premium
 - Deductible
 - Copayments or coinsurance
 - Very little after \$4,550 out-of-pocket in 2010
- Extra Help if you have limited income/resources
- One-time \$250 rebate
 - During coverage gap in 2010

**Health
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3315**



Extra Help with Drug Plan Costs

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

Income and Resource Limits

■ Income

- Below 150% Federal poverty level

*2010
amounts*

- \$1,353.75 per month for an individual* or
- \$1,821.25 per month for a married couple*
- Based on family size

■ Resources

*2010
amounts*

- Up to \$12,510 (individual)
- Up to \$25,010 (married couple)
 - Includes \$1,500/person funeral or burial expenses
 - Counts savings and stocks
 - Does not count home you live in

*Higher amounts for Alaska and Hawaii



How to Apply for Extra Help

- Multiple ways to apply
 - Paper application
 - www.socialsecurity.gov
 - State Medical Assistance office
 - Local organization
- You or someone on your behalf can apply



Medicare Prescription Drug Coverage

- Must include a range of drugs in each Rx category
 - Generic and brand-name prescription drugs
- Must cover all drugs in 6 classes
 - Anti-psychotics, anti-depressants, anti-convulsants, immunosuppressants, cancer, and HIV/AIDS drugs
- Don't have to cover certain drugs
 - Benzodiazepines, barbiturates, drugs for weight loss or gain, and drugs for erectile dysfunction



Access to Covered Drugs

- 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 for period of time)

Formulary

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

Example of Tiers (Plans can form tiers in different ways)

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



Prior Authorization

- Doctor must contact plan for prior authorization
 - Before prescription will be covered
 - Must show medical necessity for that particular drug
- Ask plan for prior authorization requirements
 - Process for requests may vary by plan



Drugs Not Covered by Part D

- Excluded by law from Medicare coverage
 - Anorexia, weight loss or weight gain drugs
 - Barbiturates and benzodiazepines*
 - 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

*To be covered in 2014



Drugs Not Covered by Part D

- Medicare Part A or Part B covered drugs
 - Unless you don't meet Part A or B coverage requirements
- Plan may choose to cover excluded drugs
 - At their own cost, or
 - Share the cost with members



Step Therapy

- Type of prior authorization
- Person must try a similar, less-expensive drug that has been proven effective
- Doctor can request an exception if
 - Tried similar, less expensive drug and it didn't work, or
 - Step-therapy drug is medically necessary

Example of Step Therapy

Step 1

Mr. Todd is prescribed an ACE inhibitor to treat his heart failure. Some of the drugs Dr. Smith considers prescribing are brand-name drugs covered by Mr. Todd's Medicare drug plan. The plan rules require him to use the generic drug lisinopril first. For most people, lisinopril works as well as brand-name drugs.



Step 2

If Mr. Todd has side effects or has little improvement using lisinopril, Dr. Smith can provide information to the plan to get approval to prescribe a brand-name drug. If approved, his Medicare drug plan will then cover the brand-name drug.



Quantity Limits

- Plans may limit quantity of drugs they cover
 - Over a certain period of time
 - For reasons of safety and/or cost
- Doctor may need to request an exception
 - Additional amount is medically necessary



Exercise

- A. People who wait to enroll in a Part D plan after their Initial Enrollment Period may pay an additional 1% of the base beneficiary premium for every month they were eligible but not enrolled.
1. True
 2. False



Exercise

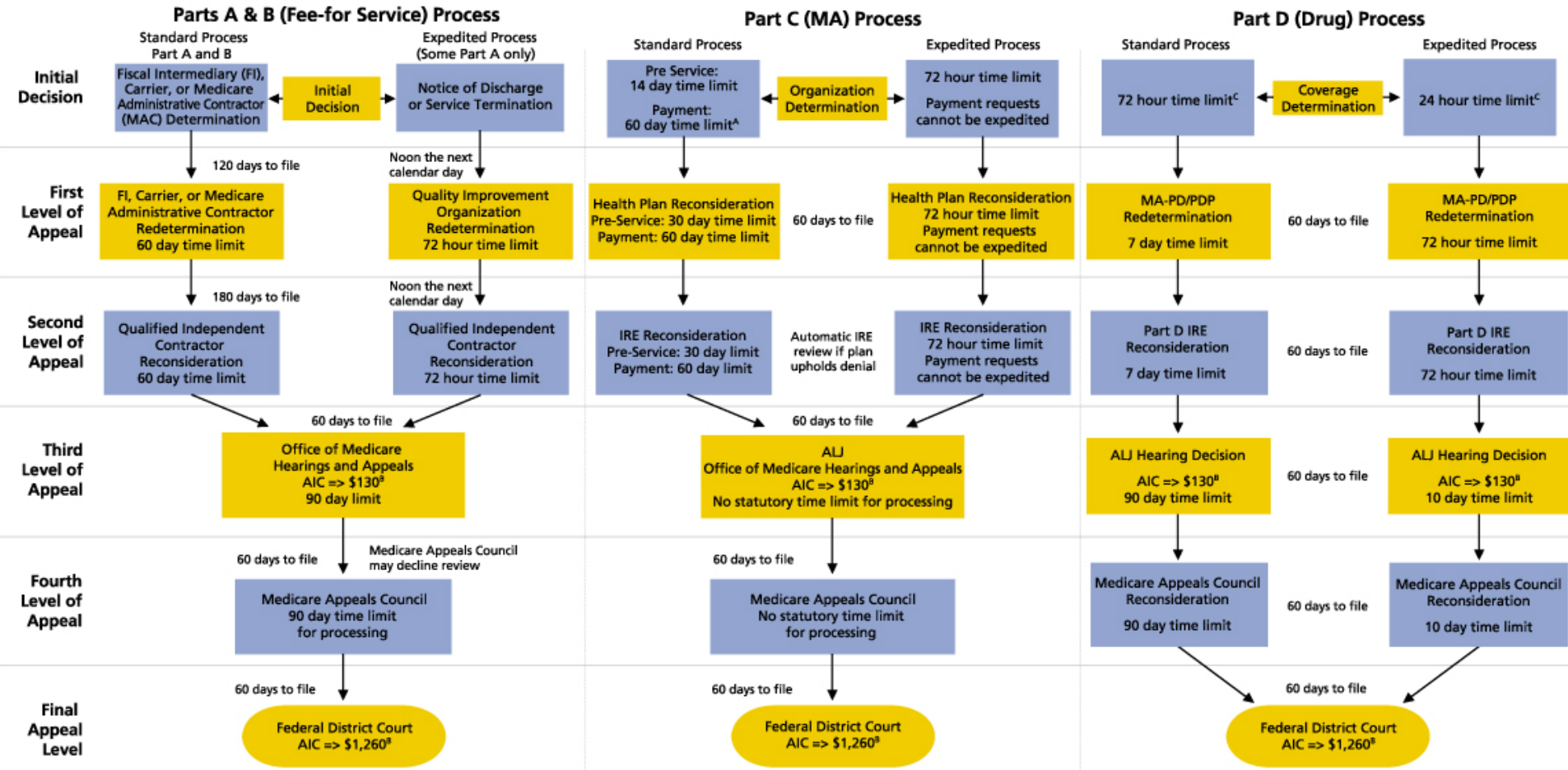
- B. You must have Medicare Part A and Part B to enroll in a Medicare prescription drug plan.
1. True
 2. False



Lesson 3 – Appeals

- Part A and B appeals process
- Part C appeals process
- Part D appeals process

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

^a 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.

^b 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 2010 AIC amounts.

^c 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 as 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

- Medicaid
- Medicare Savings Programs
- Help for People Who Live in the U.S. Territories



Medicaid

- Federal-state health insurance program
 - People with limited income and resources
 - Certain people with disabilities
- If eligible, most health care costs covered
- Eligibility determined by state
- Application processes and benefits vary
- Office names vary



Medicare Savings Programs

- Help from Medicaid paying Medicare premiums
 - For people with limited income and resources
 - May also pay Medicare deductibles and coinsurance
 - Programs include
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individual (QI)



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



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



Exercise

A. Medicaid eligibility requirements are set by each CMS Regional Office.

1. True
2. False



For More Information

- 1-800-MEDICARE (1-800-633-4227)
 - TTY users should call 1-877-486-2048
- *Medicare & You* handbook, CMS Pub. #10050
 - Other Medicare publications on www.medicare.gov
- www.medicare.gov
- www.cms.gov
- Your State Health Insurance Assistance Program (SHIP)



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