

SINCE YOU CARE

A Series of Guides from MetLife® in Cooperation with the National Alliance for Caregiving

Medicare and Medicaid Programs - The Basics

About the Subject

MEDICARE AND MEDICAID

America's population is aging. The cost of caring for aging adults is increasing in both time and money. Two programs are in place to assist with the provision of health care for older adults. One is Medicare, which is available to individuals 65 years of age and older as well as to people under 65 with certain disabilities, including those with End-Stage Renal Disease¹.

The other is Medicaid. Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. This program is available to individuals of all ages, but eligibility for Medicaid is based on a person's income and assets. Individuals or families applying for Medicaid coverage must meet the guidelines set forth for acceptance into the program.



MetLife

Caregivers face many challenges as they search for information and make decisions about how best to provide care to their loved ones. To help meet their needs,

MetLife offers SinceYouCare® — a series of guides which provide practical suggestions and useful tools on a variety of specific care-related products.

Although the federal government has established broad guidelines for eligibility standards, each state is responsible for its own rigorous eligibility guidelines.² The Medicaid program pays for over 40% of long-term care services in the United States.³

These two important programs, Medicare and Medicaid, will be discussed in more detail with each having its own section of this guide.

MEDICARE

The Medicare system, with its guidelines, provider networks, rules and regulations, supplemental plans and other details, can be confusing. It is important that Medicare beneficiaries and their families and caregivers understand what benefits and coverage Medicare provides.

Medicare was created in 1965 as a form of health care coverage for qualifying individuals. A qualifying individual:

- Is 65 years of age or older and has worked 40 or more quarters in Medicare-covered employment, or
- Is 65 years of age or older and has a spouse who has worked 40 or more quarters in Medicare-covered employment, or

- Is a person under age 65 with certain disabilities or End-Stage Renal Disease.⁴

Medicare covers some 44 million older adults and disabled Americans.⁵

Medicare is administered by the Centers for Medicare & Medicaid Services (CMS). For many Americans Medicare is their only source of health insurance. It is not, however, all-inclusive in its coverage. It also has premiums, deductibles, and other costs associated with it.

There are several parts of Medicare that are important for individuals and their caregivers to understand. These include the choices an individual makes regarding Medicare coverage. These decisions involve whether to enroll in Original Medicare, which includes two parts, Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), or Medicare Advantage, which includes Medicare's Managed Care Plans. Beginning in 2006, Medicare introduced Medicare Part D, voluntary prescription drug coverage offered through private companies. Each of these Medicare options will be discussed in the next section of the guide: *Things You Need to Know*.

Things You Need to Know

Original Medicare⁶

Original Medicare, as it is now often called, has two distinct parts, Medicare Part A and Medicare Part B. They cover different services, have different deductibles and co-insurance payments, and differ in whether a standard premium is charged for participation.

Medicare Part A

- Medicare Part A is sometimes called "hospital insurance." It is funded by a payroll tax of 1.45% paid by employees and employers.⁷ Most individuals do not pay an annual premium for Part A coverage.

The services covered are:

- Hospitalizations
- Skilled nursing facility stays
- Home health care
- Hospice care
- Blood transfusions during a hospitalization or nursing facility stay.

Service coverage is not all-inclusive, and there are guidelines for reimbursement and deductibles. For example:

- Time spent in a hospital is covered if ordered by the doctor and determined to be appropriate under Medicare guidelines. Lengths of stay in

the hospital are reviewed by Utilization Review Committees. Medicare has a deductible for hospital stays as well as co-payments for days 61-90 and 91-150 during a hospital stay. The payment amounts change from year to year.

- Time spent in a Medicare-certified skilled nursing facility is covered if a three-day related hospital stay preceded the individual's stay and a doctor prescribes skilled care. After day 20 there is a co-payment for each additional Medicare qualifying day up to day 100. A person must meet Medicare skilled criteria to continue receiving benefits up to day 100. During each episode of care, Medicare will no longer reimburse nursing home care after day 100.
- Home health care services are covered if a doctor prescribes skilled care provided by a health care professional such as a nurse or therapist and if it qualifies under Medicare guidelines. The care must come from a Medicare-certified home health care agency and the services must be intermittent in nature. The person receiving the care must be homebound, which means that the person is not normally able to leave the home and leaving the home takes considerable and taxing

effort. A person may leave on occasion such as for doctor visits or to attend religious services. Medicare does not cover 24-hour in-home care or the use of an aide or assistant for personal care services on an on-going long-term basis.

- Hospice benefits are available for those covered under Medicare Part A. Individuals choosing Medicare hospice benefits would be selecting them instead of their regular Medicare benefits for care of their terminal illness. The hospice benefit covers an array of services to support individuals who are terminally ill and their families. The Centers for Medicare & Medicaid Services (CMS) produces a booklet that describes how the hospice benefit works. It can be printed from the web site at www.medicare.gov.

Medicare Part B

Medicare Part B, sometimes called "medical insurance," is available to individuals when they become eligible for Part A. It covers some medical and other services such as outpatient hospital services, certain outpatient therapies, doctor services, preventive health screens, durable medical equipment, laboratory services, and some home health care benefits.

Again, certain requirements may have to be met for Medicare Part B to cover these costs. Once an annual deductible is met, Part B pays 80% of the covered cost for most services. Some outpatient services may be fully covered, while others may be reimbursed by Medicare at less than 80%.

Enrolling in Medicare⁸

In general, if individuals already receive Social Security benefits, they are automatically enrolled in Medicare Part A, effective the month they turn 65. Enrollment in Part B, which is offered at that time, is voluntary. However, if an individual elects not to enroll in Medicare Part B when first eligible and decides to enroll later, the cost of Part B will go up 10% for each 12-month period that the individual could have had Part B but chose not to enroll, except in special circumstances outlined in the *Medicare and You 2007* guide. Approximately 95% of beneficiaries with Part A enroll in Part B.⁹ A Medicare card is sent out about three months prior to the date that people become eligible for coverage if they are already receiving Social Security benefits.

The initial enrollment period for Medicare Part B begins three months prior to the 65th birthday, includes the month the individual turns 65, and then

concludes with the third month following. Delaying enrollment until one's 65th birthday will delay the effective date of Medicare Part B coverage. If individuals are not yet receiving Social Security benefits, when they are about to turn 65, they should call or visit their local Social Security office about three months prior to their 65th birthday to inquire as to whether they should enroll in Medicare at that time.

Cost

An individual who has worked ten or more years for an employer who paid into the Medicare system incurs no cost for Medicare Part A. However, Medicare Part B has a monthly premium which is adjusted each fall and becomes effective January of the following year. The premium is deducted each month from an individual's Social Security, Railroad Retirement, or Civil Service Retirement. If the individual receives none of these, Medicare will send a bill every three months.

If a person has not worked at all in Medicare-covered employment or not long enough to have earned enough quarters, he or she may still be able to pay premiums for Medicare.¹⁰

Information may be obtained by calling the Social Security Administration at 1-800-772-1213.

Medicare premiums for Part B coverage usually increase each year. For the first time in 2007, individuals and couples with annual incomes over a certain amount (\$80,000 for individuals and \$160,000 for couples) will pay a premium higher than the standard premium based on their income.

The standard premium for 2007 is \$93.50 per month, while the premiums for those with higher incomes will range from \$105.80 to \$161.40 monthly, based on income.¹⁰

There are instances in which state and government funding are available for assistance to cover some Medicare costs. The

program is called the "Medicare Savings Program."¹¹ Program eligibility for individuals and couples is based on income and resource guidelines. Information on the program can be obtained by calling Medicare at 1-800-633-4227 or at any office handling Medicaid applications, such as your local state Department of Human Services or Social Services office. The number is usually in the blue pages of your phone book. Information on your state can be found by going to www.medicare.gov. Scroll down the page and click on "Find Helpful Phone Numbers and Websites." Select "State Medical Assistance Office" and identify your state.

Most providers of health care services, products and durable medical equipment contract with Original Medicare Parts A & B, but it is always good to verify coverage before receiving care or ordering services to ensure payment.

Medigap¹²

Medigap, also known as Medicare Supplement Insurance, is not a government-sponsored program. Rather, it is a series of products offered by private insurance carriers providing

supplemental insurance to the Medicare program. As the name implies, it covers the “gaps” for deductibles, co-insurance, and other charges not covered by Medicare. To be eligible to elect a Medigap policy, an individual must be enrolled in Medicare Parts A & B.

The government has defined twelve standardized plans to simplify Medigap coverage. These plans are lettered A through L. With the exception of Massachusetts, Minnesota, and Wisconsin, which have made some modifications to the Medicare defined plans, all other states offer Medigap plans A through L as defined by Medicare. However, as in any privately marketed product, the number of plans offered in a state, as well as the premiums for them, can vary.

Every Medigap plan A through J must include the following basics:

- The Medicare Part A co-insurance for days 61-90 and days 91-150 of a hospital stay
- Coverage of up to 365 additional days of a hospital stay during your lifetime after you use up all Medicare hospital benefits
- Co-insurance or co-payment amount for Medicare Part B services after you meet the yearly deductible

- The first three pints of blood or equal amounts of packed red cells per calendar year

In addition to the basic benefits, Plans A-J offer some additional benefits depending on the plan selected. These may include skilled nursing facility co-payments, Medicare Part A and Part B deductibles, foreign travel emergencies, some preventive care, and some additional, at-home recovery.

With the addition of the Medicare Prescription Drug Program in 2006, Medigap plans that had previously offered

some prescription drug benefits are no longer allowed to offer them to new enrollees. In addition, Plans K and L have been added to the Medicare defined standard Medigap plans. These plans differ somewhat from the original 10 plans in their basic benefits. Plans K and L have lower premiums but higher out-of-pocket annual limits before paying 100% of co-insurance and co-payments. (In 2007, Plan K has a \$4,000 annual out-of-pocket limit, while Plan L has a \$2,000 limit.) As part of the basic benefits, they pay a percentage rather than the full Medicare Part B co-insur-



ance and co-payments for most services until the annual out-of-pocket limits are met. They do, however, provide 100% of the co-insurance for Medicare preventive services and a percentage of the hospice cost sharing for all Medicare Part A covered expenses and respite care. It is important to note that “excess charges,” which are charges above what Medicare approves, are not covered and do not count toward the out-of-pocket-limit.

An individual may enroll in any Medigap plan during his or her open enrollment period. The open enrollment period begins the first day of the month in which a person is 65 and is enrolled in Medicare Part B. During this open enrollment, an insurer cannot deny an individual a policy based on pre-existing conditions or charge more because of them.

If an individual has a Medigap plan and decides to drop it, it is likely that he or she will not be able to re-enroll at a later date. However, if the person moves out of the service area or the company selling the Medigap plan doesn't renew its contract with Medicare, the person would have the right to re-enroll.

If a person is enrolled in a Medicare Advantage Plan (see next section), he or she does not need a Medigap plan and can generally not use one.

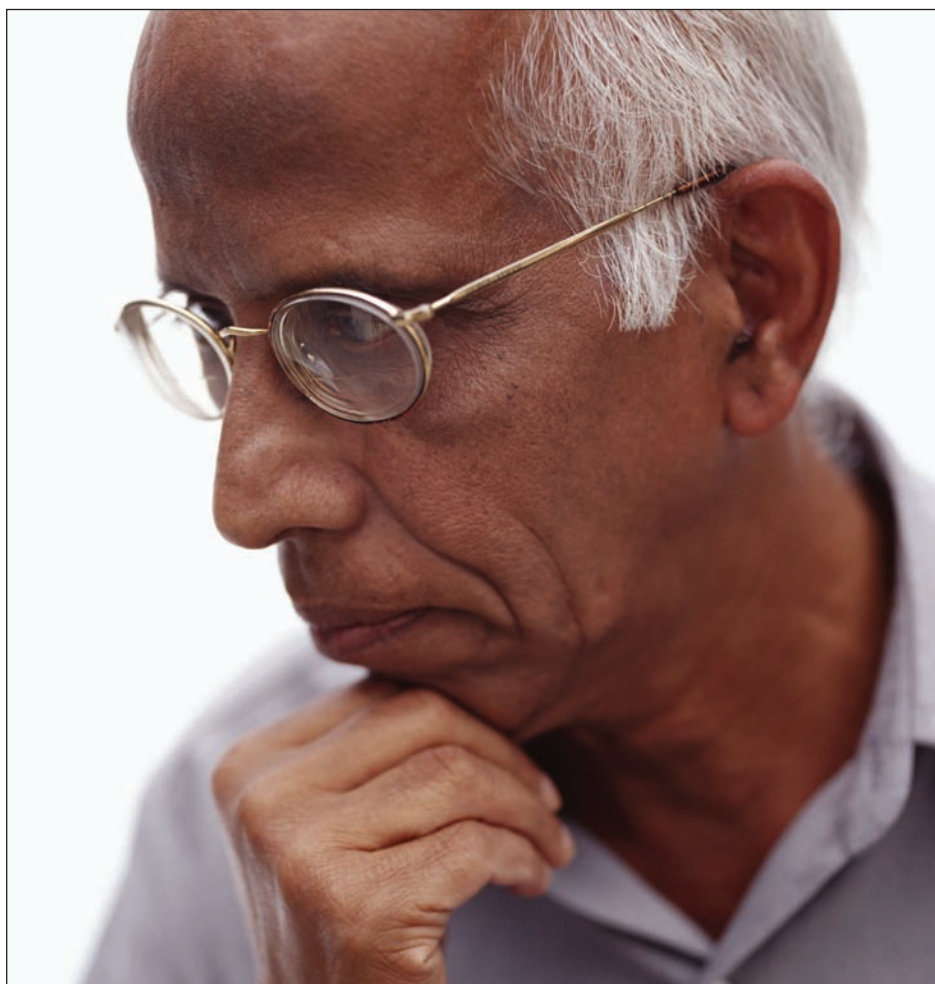
A Medigap policy is not required if someone is in a Medicare Advantage Plan.

To find out what policies are available and who the providers are in your state, contact your state's Insurance Department. For information to assist you in determining which Medigap plan might be right for you, con-

tact your State Health Insurance Assistance Program (SHIP). These numbers can be found by going to www.medicare.gov. Scroll down the page and click “Find Helpful Phone Numbers and Websites.” Then click on “Related Websites” to reach SHIP. Search by organization and state to obtain contact information.

Medicare Advantage¹³

Congress passed a law in 1997 that implemented new Medicare health plans, called Medicare Advantage, also



known as Medicare Part C. Under the Medicare Advantage option, private companies contract with Medicare to provide health care services to Medicare recipients. Currently, with nearly 44 million Americans in the Medicare program, over 8 million have chosen Medicare Advantage Options.¹⁴

In these plans, individuals are enrolled in the Medicare system, but their health care benefits are administered by Medicare Managed Care Plans such as:

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

Medicare pays a set amount to the Medicare Advantage Plan and, in turn, the plan determines the cost reimbursement to the provider, as well as to the insured individual. All Medicare Advantage plans must offer at least the same services as Original Medicare. Many offer more, such as eye exams and routine physicals, but sometimes with added costs and restrictions. Not all areas of the country will offer the

same number or type of plans. Benefits, premiums, and co-payments may all change from one year to the next. You would need to check with the Medicare provider as to the specifics of coverage.

Enrollment

Any individual who opts for a Medicare Advantage plan must have both Medicare Parts A and B prior to enrollment and continue paying the Part B premium while in the Medicare Advantage Plan. Individuals can generally join a Medicare Advantage Plan that is available in their area when they are first eligible for Medicare or during open enrollment periods between November 15 and December 31 of each year. They can generally also join or switch Medicare Advantage Plans or switch to Original Medicare between January 1 and March 31 of any year as long as they maintain their Medicare Prescription Drug coverage. Also, under certain circumstances, individuals may join Medicare Advantage at any time, such as when they move out of the service area that their current plan covers.

Leaving the Plan

Medicare Advantage Plans may discontinue their Medicare contract at the end of each year,

should they choose to do so. They must notify their members if they are going to leave the program. If an individual's plan stops providing services in his or her area or leaves altogether, the individual has the right to join another Medicare Advantage Plan in the area or return to Original Medicare.

If a plan leaves the service area, individuals have a legal right to purchase Medigap policies A, B, C, F, K, or L regardless of their health status unless they are under age 65 and have End-Stage Renal Disease. The individual must apply within 63 days from when the Medicare Advantage coverage ends. If the individual is eligible for one of these guaranteed issue Medigap Plans, companies cannot require a waiting period before covering health conditions the person already has or charge more premium than another person of the same age would pay.¹⁵

Types of Medicare Advantage Plans¹⁶

Medicare HMO

- In most instances, individuals must use network providers. They will need a primary care doctor to provide referrals for specialists when necessary. Services may be more

expensive or not covered if they are out of the service area and network providers are not used. Up to a limit, the plan can charge a premium above the monthly Part B premium. Providers must accept HMO payment as payment in full.

Medicare PPO

- Individuals may use network providers, but they may also go out of the network and pay more. Primary care doctors or referrals for specialists are not generally required. The plan can charge a premium above the monthly Part B premium, within certain limits.

Private Fee for Service

- Individuals may usually go to any physician or hospital willing to provide care and accept the plan's payment. There is often a co-payment. Depending on the plan, the provider may be able to charge more than the plan's reimbursement amount for services, which means you will incur higher costs. The plan can charge a premium above the monthly Part B premium. It is important to check with the company offering the plan about service payments and premiums.

Medicare Special Needs Plans

- These plans are specially designed for individuals with certain chronic conditions or other special health care needs. They provide all Part A and B services, as well as Medicare Prescription Drug coverage (Medicare Part D). They often provide additional services and have lower co-payments than Original Medicare. They often have a care coordinator to develop a care plan for the individual and coordinate all of the services involved in the care.

Medicare Medical Savings Account Plans

- Introduced in 2007, these plans are similar to Health Savings Account Plans that are available outside of Medicare. They include two parts. The first is a Medicare Advantage Plan with a high deductible which must be met before the plan will pay for services, and the second is a Medicare Savings Account into that Medicare deposits money which may be used to pay for health care costs.

Medicare Advantage Plans vary widely in services offered, provider requirements, and premium costs. It is important to look closely at the details of any

plan you are considering, paying close attention to what it covers and its costs. Note that many of Medicare Advantage Programs include prescription drug coverage as part of the premium. If it is included in a Medicare Advantage Plan, in most circumstances, individuals must obtain their Medicare Prescription Drug coverage through the Medicare Advantage Plan. If they purchase stand alone Medicare Part D coverage, their enrollment in the Medicare Advantage Plan will be discontinued. For any plans that do not include prescription drug coverage, individuals may purchase a stand-alone Medicare Part D Plan. The new prescription drug coverage is discussed in the next section of this guide.

It is often helpful to consult with an expert when making these decisions. For information about which Medicare Advantage Plans may be available in your loved one's area or to compare plans, you can call Medicare at 1-800- 633-4227 or visit www.medicare.gov.

Medicare Prescription Drug Coverage¹⁷

Effective January 1, 2006, Medicare introduced a voluntary Prescription Drug Program. This program was established under



the Medicare Modernization Act of 2003 with the intent of lessening the financial burden of prescription drug costs for beneficiaries, especially for those with low incomes and with extremely high out-of-pocket expenses.

Under the law, Medicare Part D will pay for outpatient drug coverage through Medicare-approved private drug plans, giving beneficiaries access to a standard drug benefit or its equivalent. Medicare has defined the minimum requirements for standard coverage. While plans may vary, in general they will have a monthly premium based on the plan that an individual chooses and include deductibles and co-pays. Under the standard plan, once an individual meets the annual deductible (\$265 in 2007), Medicare will pay 75% of the drug costs. The individual will be responsible for 25% up to a certain limit in total drug costs, which in 2007

is \$2,400. Once this limit in total drug costs is met, there is a gap in coverage, often referred to as the donut hole, in which Medicare does not pay any of the costs until the individual reaches a certain total out-of-pocket expenditure (\$3,850 in 2007), which includes his or her deductible and earlier 25% co-payments. Once the individual reaches the annual out-of-pocket limit, the coverage gap ends and what is called catastrophic coverage comes into play. For the remainder of the year, the individual will pay a small co-insurance (e.g., 5% of the drug cost) or small co-payment (\$2.15 or \$5.35 in 2007) for each prescription for the remainder of the year. The above costs do not include the monthly premium for the coverage. Assistance with the costs of the Medicare Prescription Drug Program is available to certain individuals with limited income

and assets. For those who qualify, assistance can be provided for covering the monthly premium, yearly deductible, and prescription co-payments. Related information can be found on the Medicare website or obtained by calling Medicare (See *Resources to Get You Started*.)

Like Medicare Part B, the Medicare Prescription Drug Program is voluntary. However, there may be penalties for delayed enrollment, unless an individual has coverage under another prescription drug plan, such as retiree prescription drug benefits through an employer, that is at least comparable to the Medicare Standard Prescription Drug Plan.

There are multiple prescription drug plans available to Medicare beneficiaries. If your loved one is considering a plan, check to see that his or her current medications are covered under any plan you are considering. The Medicare plans will cover both generic and brand-name drugs, but plans may have different rules about which drugs are covered in different categories. Most plans will have a formulary that lists the drugs covered under the plan. The list must meet Medicare's requirements,

but it can change over time. A company is required to inform the beneficiary at least 60 days before discontinuing or changing its costs on any drug the person may be using. If a beneficiary's doctor feels that a drug not included in the list is needed, or if a drug an individual is taking

is being removed from the list and is needed, the beneficiary or doctor can apply for an exception or appeal the decision.

The Medicare website contains local and state specific information on available Medicare Prescription Drug Plans, a plan

comparison capability based on an individual's Medicare number and demographic information, a formulary finder to allow individuals to search formularies in their state in relation to medications they are currently taking, and a section related to how to lower costs during the coverage gap. Utilize the Medicare website; call Medicare if you have questions; and consider speaking with your loved one's pharmacist, who will likely be familiar with the available plans. There are multiple options from which to choose, and it may seem overwhelming at first, but there are resources that can help through Medicare and at the state and local level. See *Resources to Get You Started*.

These are general guidelines. For Medicare Advantage plan specifics and payment amounts, you should call the plan you are interested in and ask that an information packet be sent to you.



MEDICAID¹⁸

(Sometimes called Title 19)

Medicaid became law in 1965 and was started as a cooperative venture, jointly funded by federal and state governments, to assist in furnishing medical assistance to eligible needy persons. It is, at present, the largest source of funding for medical and health-related services for America's poor. In 2003, over 55 million people were covered under Medicaid at an average annual cost of \$4,072 per enrollee.¹⁹ Unlike Medicare, individual states control much of their Medicaid coverage and eligibility.

The federal government established broad national guidelines under which each state can:

- Establish its own eligibility standards
- Determine the type, amount, duration, and scope of services
- Set the rate of payment for services
- Administer the program

Because each state can set its own standards, Medicaid services vary greatly from state to state. Even those in close geographic proximity to one another can significantly differ in the amount, duration, or scope of services.

Basic Services

The federal government allows for a certain degree of flexibility in how the states administer Medicaid funding, but it also imposes several mandatory requirements for services for a state to receive matching federal funds. A state's Medicaid program must provide certain basic services, including:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Nursing home services for those 21 years or older
- Home health care services for those persons eligible for skilled nursing care

A state may also offer a variety of optional services, such as:

- Diagnostic services
- Clinic services
- Prescription drugs and prosthetic devices
- Transportation services
- Rehabilitation and therapy services
- Home and Community Based Care (HCBS) to certain persons with chronic impairments

In addition to the federally funded and matched funds of Medicaid, many states also have state-funded assistance programs that are not federally matched.

Medicare and Medicaid — Dual Eligibility

Some individuals enrolled in the Medicare program also qualify for Medicaid assistance. When an individual meets full eligibility for a state's Medicaid program and is enrolled in Medicare, Medicaid supplements the Medicare health care coverage. Individuals eligible and covered by Medicare are first covered under the Medicare program. Medicaid pays for the remainder of services, as it is always the last payor.

Some Medicare participants, depending on their state's requirements, may be able to receive assistance with paying Medicare premiums and co-payments through Medicaid programs. It is best to speak with your local Medicaid office or Department of Human Services to discuss these programs.

The Medicaid program utilizes HMO provider networks and allows individuals some

choices in the care they receive. Depending on the situation, states may require minimal co-pays and deductibles on some services. Many providers accept Medicaid payment as payment in full.

Helpful Hints

- You can reach Medicare customer assistance 24 hours a day, 7 days a week at 1-800-633-4227. TTY users should call 877-486-2048.
- The Medicare program adjusts coinsurance amounts, deductibles, benefits, and premium rates in the autumn of each year. This is a good time to review your Medicare plan for any changes that you might like to make. Any changes made go into effect in January of the following year.

Resources to Get You Started

Books and Publications

All About Medicare - 2007

This book provides information about Medicare, Medigap Insurance, and Medicaid in a question and answer format. It discusses covered services and state specific information on filing claims. It also contains

contact information for insurance counseling and Medicare Quality Improvement Organizations that can answer questions about quality of care and access to care in Medicare-certified facilities.

Fenton, John H.ed.(2007), National Underwriter Company, \$21.95, ISBN: 0872189074

The American Bar Association Legal Guide for Americans Over 50

This guide provides information for older Americans and their caregivers on a variety of issues that impact them. It includes sections on Medicare and Medicaid and applying for health care benefits, as well as a discussion of recent changes to the laws surrounding Social Security and healthcare.

American Bar Association (2006), Random House Reference, \$16.95, ISBN: 0375721398

Centers for Medicare & Medicaid Services (CMS) Publications

The Centers for Medicare & Medicaid Services produce a number of guides about Medicare and related insurance. These guides can be ordered by calling Medicare at 1-800-MEDICARE (1-800-633-4227) or can be downloaded at www.medicare.gov/publications.

TTY users should call 1-877-486-2048. To order publications you should know the title and the publication number. Individuals can also be put on a mailing list to receive an e-mail whenever a new Medicare publication is available by going to www.medicare.gov and selecting "Mail List." The guides include:

- **Medicare Publications Catalog** This booklet provides a listing and overview of available Medicare publications including booklets, brochures, and fact sheets. It also lists whether they are available in Spanish, in Braille, audio, or large print. **CMS Pub. No.02240 Revised July 2006.**
- **Medicare & You 2007** (Annual editions of *Medicare and You* are available.) This publication provides an overview of all aspects of Medicare including Original Medicare, Medicare Advantage, and the new Medicare Prescription Drug Program. It also gives an overview of the rights covered individuals have under Medicare. **CMS Pub. No. 10050. September 2006.**

- **2007 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.** This guide was jointly developed by the Centers for Medicare & Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC). It provides an overview of Medigap insurance and the differences among the 12 standard plans. It also includes information on finding the policy that best meets one's needs and guidance on where individuals can go for help if they have questions. **CMS Pub. No. 02110. Revised March 2007.**

- **Your Guide to Medicare Prescription Drug Coverage.** This guide describes:
 - How the Medicare Prescription Drug Program works
 - Steps to making a decision about which plan to choose
 - How it may affect current drug coverage an individual already has
 - How people with limited incomes may qualify for assistance in covering costs associated with the prescription drug program**CMS Pub. No. 11109. Revised December 2006.**

Internet Sites

AARP

AARP is a nonprofit organization serving members age 50 and over. Its website provides information related to Medicaid and Medicare, including Medigap, Medicare Advantage, and the Medicare Prescription Drug Program. It offers a tool for individuals to compare plans in their state that offer stand-alone prescription drug coverage. AARP also produces publications that can be ordered from the website at www.aarp.org or by calling 1-888-OUR-AARP (1-888-687-2277), Monday - Friday, 7am - 12 midnight ET.



Benefits CheckUp

This site is maintained by the National Council on Aging and helps individuals 55 years and older determine their eligibility for programs that may help cover the cost of medications (including assistance with costs associated with the Medicare Prescription Drug Program), health care, and other necessary services. All information is completed on-line with a confidential and straightforward questionnaire. Access the site at www.benefitscheckup.org.

Centers for Medicare & Medicaid Services (CMS)

This is the main Medicare and Medicaid site maintained by the federal government. It provides information on benefits, on-line publications, prescription drug assistance, and telephone contacts for information and assistance. To find information specific to either Medicare or Medicaid, click on the program you are interested in under the heading “CMS Programs & Information” on the home page at www.cms.gov.

Medicare

The Medicare website at www.medicare.gov provides detailed information about all aspects of Medicare, including useful tools and calculators related to

selecting a prescription drug plan or making decisions about Medicare Advantage. It lets individuals look at what is available in their state and local area and provides information on how individuals can obtain information about whether they are entitled to assistance with the Medicare Prescription Drug Program.

The “Search Tools” section provides the ability to go to specific sections of the site to obtain other useful web links and telephone numbers including Medical Assistance Offices for state specific Medicaid information. You can search for other sites or resources by either the topic or name of the organization. Another Medicare tool is www.mymedicare.gov which allows individuals to view their health care claims, track the preventive services they may need, and get up-to-date details as to how to best use their Medicare benefits.

Each state offers a State Health Insurance Assistance Program (SHIP) with counselors available to provide free one-on-one help for individuals with Medicare questions or problems. The Medicare website includes state-specific contact numbers for this

program at: www.medicare.gov/contacts/static/allStateContacts.asp.

USA.Gov for Seniors

USA.gov has a section specific to the needs of older Americans. It contains links to government sponsored sites related to health care, prescription drug coverage, consumer protection, and retirement. It provides a central point to access government agencies, including Social Security, the Centers for Disease Control and Prevention, the Administration on Aging, and the Centers for Medicare & Medicaid Services (CMS), and information related to many important topics including Medicare and Medicaid. Information is divided into broad topic areas with many sub-headings so individuals can narrow their search to more specific information. The site can be accessed at www.usa.gov/Topics/Seniors.shtml.

Useful Tools

- Enclosed is an Original Medicare and Medicare Advantage comparison chart.

Medicare Plan Chart

Questions To Consider When Making Medicare Decisions

Medicare Advantage Plan

Original Medicare

Provider Access

Can I see MDs both in/out of network, even if I have to pay more?

Yes No

Yes No

Can I receive care in any hospital?

Yes No

Yes No

Do I need a primary MD?

Yes No

Yes No

Will the plan cover out-of-network services?

Yes No

Yes No

Do I need referrals for specialists?

Yes No

Yes No

Will the plan cover services if I am out of the area and need care?

Yes No

Yes No

Is my current physician covered in the plan?

Yes No

Yes No

Additional information: (Include restrictions, special circumstances, etc.)

Benefits

Is there dental coverage?

Yes No

Yes No

Is there vision coverage?

Yes No

Yes No

Is there foreign travel coverage?

Yes No

Yes No

Is there prescription drug coverage included?

Yes No

Yes No

Additional benefit: (Specify) _____

Additional information: (Include restrictions, special circumstances, etc.)

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Questions To Consider When Making Medicare Decisions

Medicare Advantage Plan

Original Medicare

Out-of-Pocket Costs

Monthly premium: _____

Deductibles if not covered by Medigap or retiree insurance:

• Hospital Care: _____

• Outpatient Services: _____

Co-payments/Co-insurance if not covered by Medigap or retiree health insurance:

• Hospital Services: _____

• Nursing Home: _____

• MD Visits: _____

• Other: (Specify) _____

Medigap monthly premium: _____

Retiree Health Insurance Monthly Premium: _____

Monthly Premiums and other Costs – Prescription Drug Coverage

(Describe Premium and how co-payments/co-insurance works and list anticipated monthly cost in addition to premium)

Medicare Advantage: _____

Medicare Part D: (with Original Medicare) _____

Retiree Drug Coverage: (Specify use with Medicare Advantage or Original Medicare)



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Endnotes

- ¹ *Medicare & You - 2007*, via the Internet at www.medicare.gov/Publications/.
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About the Authors of Since You Care®

Since You Care guides are prepared by the MetLife Mature Market Institute in cooperation with the National Alliance for Caregiving and MetLife's Nurse Care Managers.

MetLife Mature Market Institute® is the the company's information and policy center on issues related to aging, retirement, long-term care, and the mature market. The Institute, staffed by gerontologists, provides research, training and education, consultation, and information to support Metropolitan Life Insurance Company, its corporate customers and business partners. MetLife, a subsidiary of MetLife, Inc. (NYSE: MET), is a leading provider of insurance and other financial services to individual and institutional customers.

MetLife Nurse Care Managers are available to MetLife's long-term care customers and their caregivers to help identify and resolve caregiving questions and concerns through counseling and referral.

National Alliance for Caregiving

Established in 1996, the National Alliance for Caregiving is a nonprofit coalition of national organizations that focuses on issues of family caregiving across the life span. The Alliance was created to conduct research, do policy analysis, develop national programs and increase public awareness of family caregiving issues.

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