MEDICARE: PART A, PART B, & PART C

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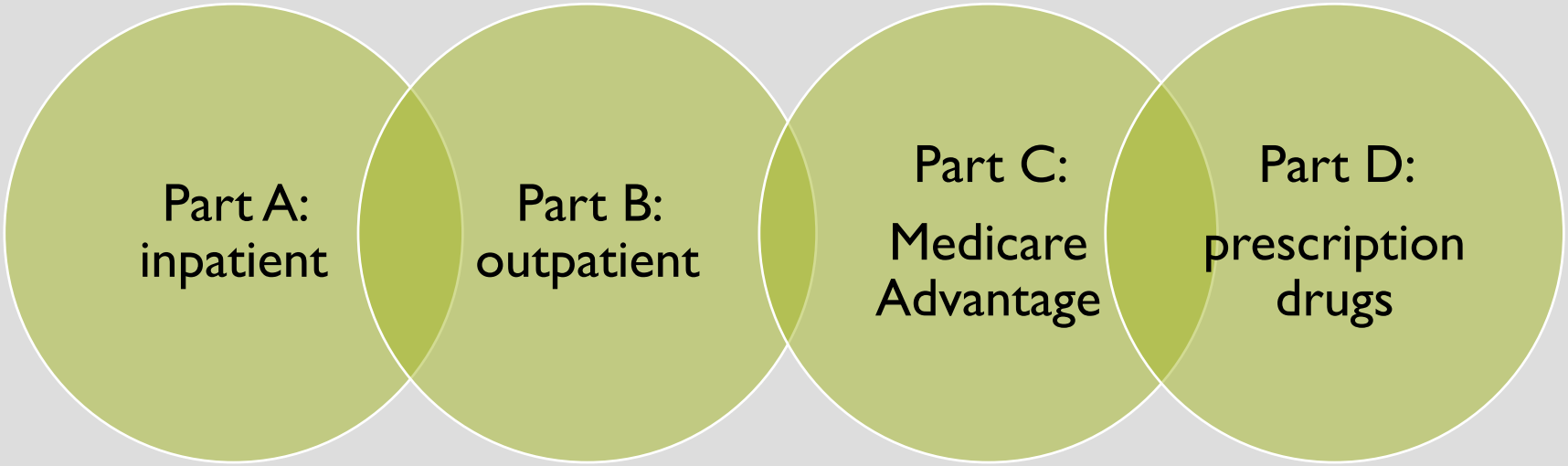
WHAT IS MEDICARE?

- A federal health insurance program established in 1965 that is administered by the Center for Medicare and Medicaid Services (CMS), under the Secretary of Health and Human Services (HHS).
- It resembles private insurance, including co-payments, co-insurance, deductibles, and premiums.
- It differs from MassHealth (Medicaid) in a number ways, including that it is not needs-based.
- Coverage Rules: Medicare covers a share of the cost of a medical service or equipment if it is "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed member."
    - A limited number of preventive services (screening for diabetes, cardiovascular disease, and depression) are also covered.

PARTS

- There are 4 "parts" to Medicare and it is helpful to think of each part as addressing a different aspect of someone's health care:



PARTS A & B

- **Part A** – inpatient (hospital, skilled nursing facility, home health, hospice)
- **Part B** – outpatient (physician visits, medical equipment, clinical lab tests, ambulance, screenings, preventative treatment)*

*Parts A and B are often referred to as "traditional, fee for service" Medicare. These services are paid on a "fee for service" basis, where providers are paid per service and beneficiaries can choose providers throughout the country.

PARTS C & D

- **Part C** – Medicare Advantage (coverage provided by private health plans through managed care models, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs))*
  - Part C plans are limited to certain service areas and networks except for emergency/urgently needed services.
- **Part D** – prescription drugs (similar to Medicare Advantage plans in the way that part D is provided by private sponsors approved by Medicare. A part D plan can be included in a Medicare Advantage plan or be free-standing)

*Part C is an alternative to traditional, "fee-for-service" Medicare, which is comprised of parts A and B.

ELIGIBILITY

- Age 65 and above: Must be U.S. citizen or Legal Permanent Resident (resided in U.S. for 5 continuous years*) before filing application.
- Under age 65 with disabilities: Must be U.S. citizen or Legal Permanent Resident (resided in U.S. for 5 continuous years) before filing application.
  - Coverage begins the 25th month of receiving Social Security Disability (SSDI) benefits, following 5 month waiting period.
  - Exception: Individuals with Amyotrophic lateral sclerosis (ALS)
- End Stage Renal Disease (ESRD): Permanent kidney failure requiring kidney dialysis or replacement.
  - No waiting period, but start date depends on treatment.
- Certain public employees

*There is no length residency requirement for lawfully present non-citizens who qualify for premium-free Part A.

HOW TO ENROLL

- Online
- Telephone
- In person at local SSA office

ENROLLMENT PERIODS

Initial Enrollment Period "IEP"

- When turning 65, 3 months before, month of, and 3 months after 65th birthday, OR 25th month of disability

General Enrollment Period "GEP"

- Annually from January 1-March 31

Special Enrollment Period "SEP"

- Some people are allowed to delay enrollment because they or their spouse are actively employed and covered by employer group health insurance. There are also other special enrollment periods available.

Open Enrollment for Parts C & D

- Annually from October 15-December 7

AUTOMATIC ENROLLMENT

- Automatic enrollment in part A happens when an individual is 65 and receiving Social Security Benefits or Railroad Retirement Benefits, an individual is under 65 but is eligible based on disability status or ALS diagnosis.
- Automatic enrollment in part A creates a deemed enrollment in part B. You may decline part B, but can run the risk of incurring a late enrollment penalty if you do not have a special enrollment period.

WHEN DOES COVERAGE START?

- Initial Enrollment Period (IEP):
  - 3 months *before* 65th birthday, then coverage is effective the first day of birthday month.
  - Birthday month, then coverage is effective first day of month following month of enrollment.
  - 3 months *after* 65th birthday, then coverage is effective first day of month following month of enrollment.

WHEN DOES COVERAGE START?

- General Enrollment Period (GEP) – January 1-March 31st of each year:
  - Coverage is effective the first day of the month following the month of enrollment.

SPECIAL ENROLLMENT PERIOD (SEP)

- People covered under an Employer Group Health Plan based on the ***active*** employment of either themselves or their spouse have the option to enroll in Medicare later than 65 without having to pay a late enrollment penalty or experience a delay in coverage.
  - Can enroll outside of the Initial and General Enrollment Periods during employment or for 8 months after you or your spouse stop working.
  - You or your spouse must be actively employed. COBRA and retirement insurance do not create a SEP.

SPECIAL ENROLLMENT PERIOD (SEP)

- Medicare also provides SEPs to people who miss an enrollment period due to an exceptional condition:
  - People impacted by emergency or disaster;
  - Formerly incarcerated people transitioning to the community;
  - People who delay enrollment due to reliance or error from a government employee, health plan, or employer;
  - People who are terminated from Medicaid due to non-eligibility; and
  - People who miss enrollment periods due to circumstances beyond their control preventing them from enrolling (evaluated on a case-by-case basis).

LATE ENROLLMENT PENALTY (LEP)

- If you are not eligible for a special enrollment period and they fail to enroll in part B during the initial enrollment period, you will be subject to a 10% premium surcharge (or penalty) for each 12-month period you've delayed enrollment.
  - If you are 65 years or older, this is a lifetime penalty. However, if you are under 65, the penalty is waived once you turn 65.
  - If you do not enroll during your initial enrollment period or a special enrollment period, you must wait for the general enrollment period (Jan 1-March 31) to enroll.

APPEALING THE LEP – "SEEKING EQUITABLE RELIEF"

- Part B penalties may be waived and a special enrollment period date allowed if the beneficiary is able to prove that the late enrollment was inadvertent and beyond their control (i.e. due to misinformation from a federal employee)
- Social Security Act as Amended in 1972, §1837(h)
  - Regulations 42 CFR 406.26 and 407.32
- SSA Program Operations Manual System (POMS) HI 00805.170 "Conditions for Providing Equitable Relief"
  - SSA - POMS: HI 00805.170 - Conditions for Providing Equitable Relief - 12/05/2022

PART A: COSTS (2025)

Premium-Free Part A:

- At 65:
  - You or your current or former spouse worked for at least 10 years during which they paid Medicare taxes.
  - If eligible for Social Security Retirement Benefits or Railroad Retirement Benefits.
  - If you/spouse have Medicare-covered government employment.
  - Under 65: You are eligible based on disability, ALS, or ESRD diagnosis.

PART A: COSTS (2025)

- If not eligible for premium free part A, you may voluntarily enroll in part A by paying premiums:
  - $518 per month in 2025 if you have less than 30 quarters
  - $285 per month in 2025 if you have 30-39 quarters
- Part A cost-sharing: Part A will pay a portion of the Medicare approved cost for limited stays in a hospital or skilled nursing facility.
  - When a patient reaches the covered limit and they have gone 60 days without hospital or skilled care, a new benefits period is established.

PART A: HOSPITAL COSTS (2025)

DAYS	MEDICARE PAYS	PATIENT PAYS
1-60:	All except annual deductible	Annual deductible of $1,676
61-90:	All except daily coinsurance	Daily coinsurance of $419
91-150:	All except daily coinsurance	Daily coinsurance of $838 “lifetime reserve” (60 days)
Beyond 150:	None	All costs

PART A: SKILLED NURSING FACILITY COSTS (2025)

DAYS	MEDICARE PAYS	PATIENT PAYS
1-20:	Everything	$0
21-100:	All except daily co-insurance	Daily co-insurance of $209.50
Beyond 100:	None	All costs for each day

PART A: HOSPICE & HOME HEALTH COSTS (2025)

SERVICE	MEDICARE PAYS	PATIENT PAYS
Hospice Care	Everything	$0 – may be responsible for miscellaneous costs (i.e. room & board)
Home Health Care	Everything	$0 – 20% of Medicare approved amount goes to durable medical equipment

PART B: COSTS (2025)

- Annual deductible in 2025: $257
- Standard monthly premium in 2025: $ 185.00
- Medicare pays 80% and beneficiary pays 20%
- Part B pays 80% of the Medicare approved rate for:
  - Physician services, tests, ambulance, most home health aides
  - Durable Medical Equipment for use in the home: oxygen, wheelchairs, scooters, walkers, hospital beds, prosthetic and orthotic equipment

PART B IRMAA (2025)

- If an individual reports a Modified Adjusted Gross Income (MAGI) to the IRS 2 years prior to enrollment that is above a certain amount, an Income-Related Monthly Adjusted Income Amount (IRMAA) increase is added to their monthly premiums.
  - The higher someone's income is, the higher the premium they'll have to pay.
- Life changing event: if an individual experiences a life changing event (i.e. marriage, divorce/annulment, spouse's death, work stoppage, or reduction, etc.), which reduces income on which IRMAA was based, beneficiary may apply for and secure premiums based on lower income.

PART B: PREVENTATIVE SERVICES

- Bone mass measurement
- Chemotherapy
- Clinical Research Studies
- Screenings: cardiovascular, colorectal cancer, depression, diabetes, mammograms and prostate cancer, pap smears and pelvic exams
- Injections: flu, pneumonia, and hepatitis b
- Initial preventative physical exam
- Medical nutrition therapy

PART B-ID: IMMUNOSUPPRESSIVE DRUG BENEFIT

Patients who meet specific criteria are now able to qualify for continuous Medicare-covered immunosuppressive drugs, known as part B-ID.

- Eligibility:
  - Person who currently or previously had Medicare because of ESRD that ends 36 months after a kidney transplant
  - Attest that they are not currently enrolled in other health coverage that covers immunosuppressive drugs and don't expect to enroll in other coverage that would make them ineligible for part B-ID.
- Coverage:
  - Can enroll and dis-enroll at any time without penalty
  - Continuous immunosuppressive drugs that are medically necessary for preventing or treating the rejection of a transplanted organ or tissue.

★ Note: this is a standalone benefit, meaning it does not cover anything except for the immunosuppressive drugs.

HELP WITH MEDICARE COSTS

Medicare is expensive. It includes premiums, co-payments, co-insurance, deductibles, and services that are not covered. Some of the out of pocket costs under part A and B can be covered by:

- Medigap (Medicare Supplement) plan
- Medicare Savings Program (MSPs)
- Employment-based coverage: either through retiree or active employment
- Health Safety Net
- Medicaid (MassHealth)

MEDICARE SAVINGS PROGRAM (MSP)

- Three tiers based on income: QMB, SLMB, QI
  - Covers part B premiums
  - QMB covers cost-sharing including deductibles and coinsurance too
- Sometimes in Massachusetts it is referred to as the MassHealth Buy-In or Senior Buy-In
- Eligibility: Must meet income limits
  - 225% FPL (income limit is higher than MassHealth Standard)
- Automatic waiver of late enrollment penalties
- Eligibility for Extra Help (which caps cost sharing on generic and brand drugs)
- No estate recovery

MEDIGAP "MEDICARE SUPPLEMENT" PLANS

- Medigap is a supplemental insurance offered by private insurance plans that helps pay for part A and B out of pocket costs.
- Medigap plans do not pay for gaps in services, but are intended to "bridge the gap" between what Medicare pays and the leftover patient responsibility.
- There are many Medigap plans offered in Massachusetts, but there are two basic kinds: Core Plan and Supplement 1A Plan.
  - Supplement 1A plan covers a wider range of costs compared to Core plan, such as co-insurance for skilled nursing facilities, deductibles for inpatient hospital stays, and costs incurred in case of a foreign travel emergency.

MEDICARE AS A SECONDARY PAYER

- Medicare Secondary Payer: used when another entity has the responsibility for paying before Medicare.
- Primary payer: those who have the primary responsibility for paying a claim.

PRIMARY VS. SECONDARY SITUATIONS

- Individual is 65 or older, covered by GHP through current employer/spouse's current employer AND employer has less than 20 employees: ***Medicare pays primary, GHP pays secondary.***
- Same facts but employer has 20 or more employees: ***GHP pays primary, Medicare pays secondary.***
- Individual is disabled, covered by GHP and employer has 100 or more employees: ***GHP pays primary, Medicare pays secondary.***

PART C PLANS AKA "MEDICARE ADVANTAGE"

- Private health plans that contract with Medicare for a certain plan type and service area/provider network
  - Unlike Original Medicare, where services can be provided throughout the country
- Primarily managed care that could require:
  - Staying in network
  - Getting referrals for specialists
  - Prior authorizations
- Individuals must be enrolled in part A and part B.

MEDICARE ADVANTAGE PLANS CONT.

- Requirements:
  - Plans must:
    - Provide all Medicare rights and protections
    - Cover at least all Original part A and B services, but may also offer additional benefits – dental, vision, hearing aids – at additional costs.
      - As previously mentioned, many plans also include prescription drug coverage (part D)
- Costs:
  - Additional charges to part A and B premiums
  - Out of pocket costs vary by plan, but must be within Medicare approved limits
  - Annual spending cap

MEDICARE ADVANTAGE ENROLLMENT

- Initial and special enrollment periods – same as Original Medicare
- Annual election periods:
  - Coverage effective January 1
- Annual disenrollment period: January 1-February 14
  - Disenrollment effective 1st of month following receipt of disenrollment request
  - Coordinate Special Enrollment Period to enroll in prescription drug plan

ONECARE/SENIOR CARE OPTION (SCO)

- One Care: option for adults with disabilities age 21-64 at the time of enrollment who are eligible for both MassHealth and Medicare
- Senior Care Option (SCO): fully integrated Dual Eligible Special Needs Plan that provide integrated Medicare and Medicaid services to MassHealth Standard eligible members aged 65 and older
- Enrollees in both plans are provided with the full range of Medicare and MassHealth services, as well as some additional services, such as dental and vision, Behavioral health, diversionary services, and community-based support services.

RIGHTS & PROTECTIONS - APPEALS

- Beneficiaries may appeal if they disagree with a coverage or payment decision by Medicare or their Medicare plan.
- If Medicare denies:
  - Request for health care service, item, or drug,
  - Request for payment of a health care service, item, or drug already paid for,
  - Request to change the amount a beneficiary must pay for service, item, drug, OR
  - Stops providing or paying for all or part of service, item, drug.
- Specific time frames apply for filing and responses. Expedited or standard time frames are also offered.

MEDICARE SUMMARY NOTICE

- Not a bill
- https://www.medicare.gov/Pubs/pdf/summarynoticeb.pdf
- https://www.cms.gov/medicare/medicare-general-information/msn/downloads/sample-part-a-medicare-summary-notice.pdf

★ Pay attention to appeal deadlines!

Medicare Summary Notice
for Part A (Hospital Insurance)

Page 1 of 4

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	1A23BC4DE56
Date of This Notice	September 15, 2020
Claims Processed Between	June 15 – September 15, 2020

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met your **$1,184.00** deductible for **inpatient hospital** services for the benefit period that began May 27, 2020

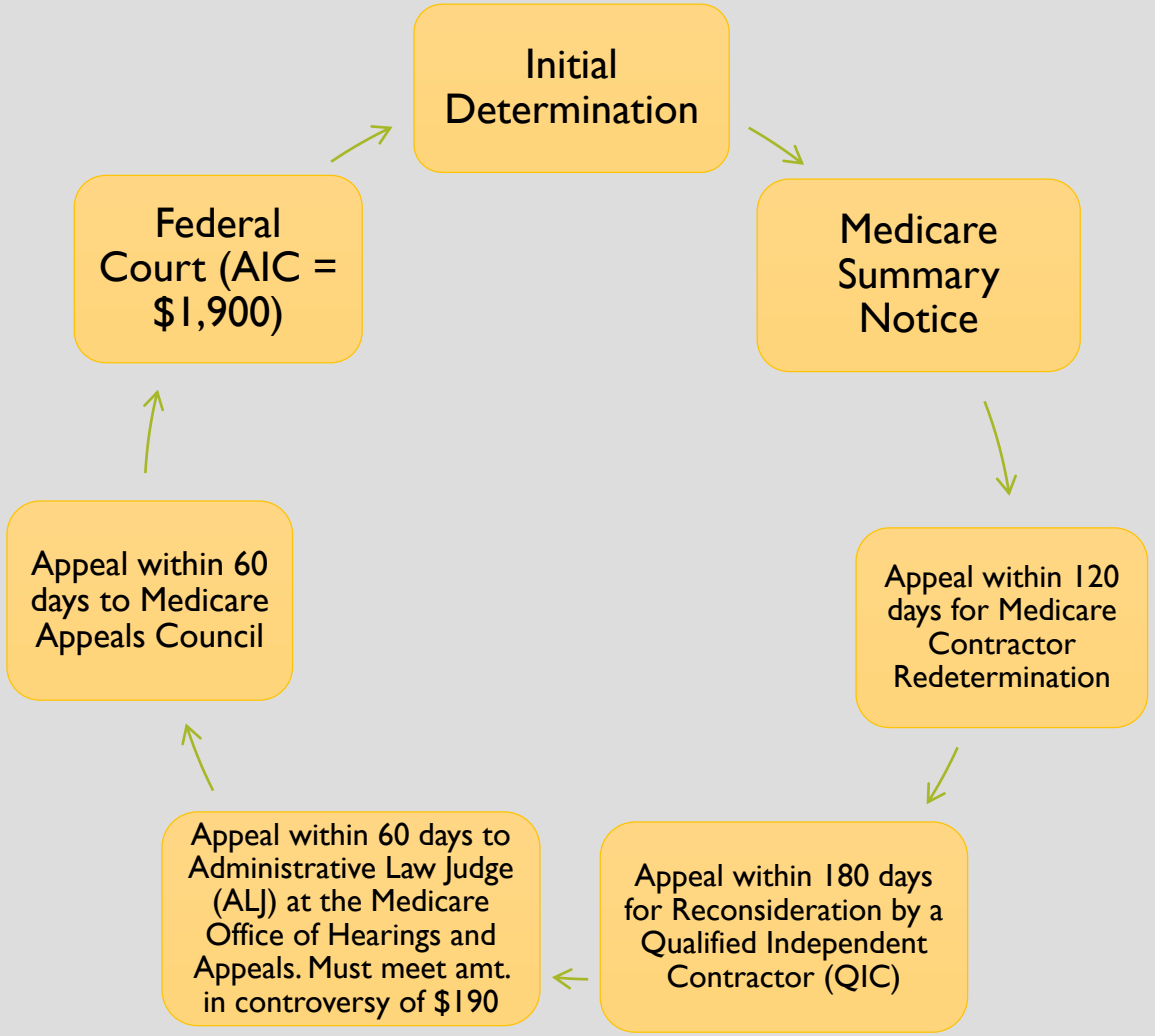
Your Claims & Costs This Period

Did Medicare Approve All Claims?	**YES**
See page 2 for how to double-check this notice.	
Total You May Be Billed	**$2,062.50**

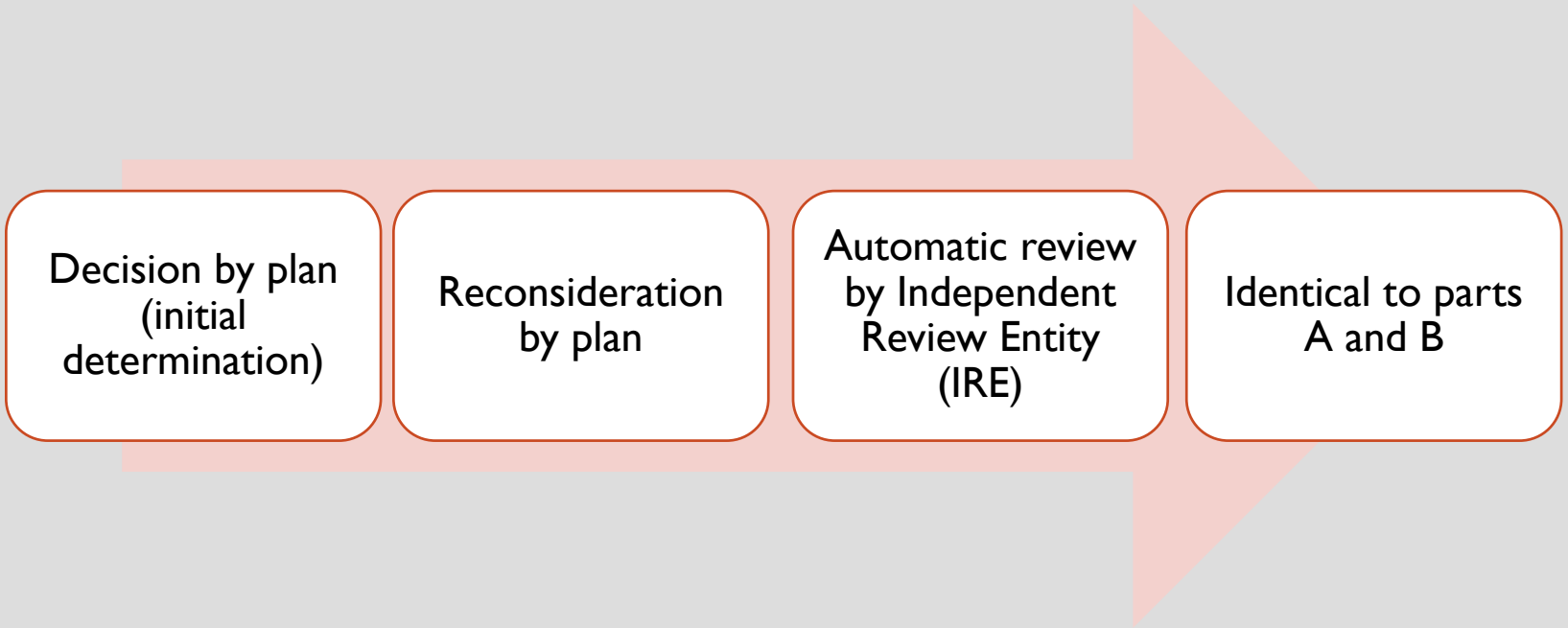
Facilities with Claims This Period

June 18 – June 21, 2020
Otero Hospital

APPEALS UNDER PARTS A & B



APPEALS UNDER PART C



Medicare Advantage plans are required to provide members with information regarding appeals process as part of the materials; there must be written Notice for denials. You have 60 days to appeal the initial determination.

RIGHTS & PROTECTIONS - GRIEVANCES

- Beneficiaries may file a grievance, also known as a complaint, to express dissatisfaction or concerns about the quality of care they're receiving or received.
  - Grievances can be filed regarding any operation, activity, or behavior of a member of the plan except when it comes to organization determinations.
- Examples:
  - Beneficiary is unhappy with the way they were treated by the staff personnel (doctor, nurse, etc.)
  - Problems with getting an appointment or had to wait too long to get an appointment.
- Must file grievance within 60 days of incident; Plan must respond within 30 days.

SKILLED NURSING FACILITY DISCHARGES

- Center for Medicare Advocacy - Improvement Standard and Jimmo News - Center for Medicare Advocacy
- ***Jimmo v. Sebelius*** and the "improvement standard."
  - Buzz phrases to look out for are " they've plateaued, not making meaningful progress,"
  - *Jimmo* clarifies existing law that one does not need to improve in order to justify the need for skilled care. They must need skilled care to improve or maintain current condition OR prevent further decline.
- Patients rights with SNF discharges:
  - Notice

TELEHEALTH COVERAGE (2025)

Effective April 1st, 2025, individuals must be in an office or medical facility located in a rural area (within the U.S.) for many telehealth services.

If an individual is not in a rural health care setting, they can still get certain Medicare telehealth services on or after April 1, including:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis;
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit; and
- Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder (including a substance use disorder) in your home

MEDICARE LAW

- Social Security Act XVIII §801 et seq.
- 42 USC §1395 et seq.
- 42 CFR §400 et seq.
- Local Coverage Determinations "LCDs"
- National Coverage Determinations "NCDs"
- Internet – Only Manuals

MEDICARE ADVOCACY PROJECT

- At the Medicare Advocacy Project (MAP), we provide free legal assistance ranging from advice to full representation for Massachusetts Medicare beneficiaries who are dealing with Medicare related issues.
- Offices are located at Greater Boston Legal Services (GBLS), Community Legal Aid (CLA), and South Coastal Counties Legal Services (SCCLS).

LEARN MORE

- Center for Medicare Advocacy: www.medicareadvocacy.org
- Center for Medicaid and Medicare Services: www.medicare.gov
- Justice in Aging: www.justiceinaging.org
- Kaiser Family Foundation: www.kff.org
- Resources:
  - SHINE: 800-243-4626, press 2
  - CMS: 1-800-MEDICARE

QUESTIONS AND COMMENTS?

CONTACT INFORMATION:

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