Del Mar Caregiver Resource Center
A program of Health Projects Center

Fact Sheet

Medicare: What Caregivers Need to Know

Medicare is the main health insurance program for the elderly and for permanently disabled younger Americans. Established by Congress in 1965 and changed many times, the program is not free healthcare. Instead, it is health *insurance* with important enrollment and benefit rules and many out-of-pocket costs for recipients. Even with its limitations and expenses, however, Medicare protects most elderly and persons with permanent disabilities from the high costs that can result from illness or failing health.

About 40 million Americans are enrolled in Medicare. It is managed by The Centers for Medicare & Medicaid. The program is funded through deductions from workers' paychecks, federal revenues, and premiums paid by Medicare enrollees. Healthcare and other service providers approved by Medicare are paid when their claims are submitted to claims processors. Enrollees, also called beneficiaries or recipients, receive payment summaries and are billed for any costs that are not paid by Medicare.

Why Caregivers Need to Know about Medicare

Medicare is a vast program with complicated rules. Whether an individual or family becomes a caregiver because of a sudden, acute illness or as a result of a gradually worsening illness, knowledge of Medicare is important. If the beneficiary becomes incapacitated and unable to handle his or her own affairs, the caregiver will likely have to monitor claims, keep up supplemental coverage, pay out-of-pocket costs and, when necessary, appeal decisions about care or benefits.

This fact sheet summarizes basic information about Medicare for families and caregivers. The sections on Additional Reading and Resources provide more in-depth information.

Caregivers and care receivers need to understand what Medicare is *not* and what it does *not* do:

- Medicare is NOT "free" healthcare.
- Medicare does NOT cover prescription medicines outside a hospital except in very limited cases.
- Medicare does NOT cover extended, long-term care at home or in a nursing home beyond certain specified periods or purposes.
- Medicare does NOT cover services deemed to be medically unnecessary (that is, so-called "custodial care") if they are the only services needed. (Examples: bathing,

dressing, eating, shopping, cleaning and 24-hour supervision at home.)

- Medicare does NOT cover all preventive care; it excludes routine annual physical exams, and routine dental, foot and eye care.
- Medicare does NOT pay for most healthcare while traveling outside the U.S.

Eligibility and Enrollment

Medicare offers two plans, *Original Medicare* and *Medicare + Choice*. All Americans who are qualified to receive Social Security or Railroad Retirement benefits, and their spouses, can enroll in Original Medicare (Parts A and B). For those already receiving Social Security, enrollment in Original Medicare is automatic on the first day of the month they turn 65. Otherwise, individuals can apply for Medicare when they apply for Social Security at age 65.

A permanently disabled younger person is automatically enrolled in Medicare two years after Social Security Disability benefits begin. Persons with End-Stage Renal Disease or Amyotrophic Lateral Sclerosis (ALS)—regardless of age—are also eligible for Medicare.

At the time they are first enrolled, new Medicare recipients receive instructions for selecting a program under the Medicare + Choice plan option. (See plan descriptions below under Medicare Benefits.)

Individuals who are ineligible for Social Security, such as retired government workers who paid into Medicare-only plans, can also enroll in Medicare during the initial enrollment period. Certain people, including those who did not work enough quarters to earn Social Security benefits, may apply for Medicare but must pay an additional monthly premium.

Opting out of Part B (Medical Insurance): A person may decline to participate in Part B ("opt out") for various reasons: he or she may still be employed and covered by a plan at work, or may be retired and covered by a retiree plan and feel that Part B coverage is not needed. Those who opt out of Part B can enroll at a later date but, depending on the reason for declining Part B in the first place, may face penalties and higher premiums. It is important to discuss all options with Medicare and employee-benefits counselors before turning 65 or becoming eligible for Medicare.

Medicare + Choice, (M+C) is provided through private companies or other sources as a managed care or private fee-for-service plan. M+C requires a participant to enroll separately in the M+C plan, although they still pay Medicare Parts A and B premiums when applicable. A recipient may enroll in M+C at any time, according to the provider's rules and enrollment periods. In fact, Medicare beneficiaries may switch back and forth between Original Medicare and Medicare + Choice at any time, so long as the M+C plan is accepting new members. But beneficiaries should seek advice from Medicare and the plan provider before making such decisions.

Medicare Benefits

Original Medicare: Also called "Fee-for-Service Medicare," Original Medicare consists of Part A (Hospital Insurance) and Part B (Medical Insurance).

Under Part A, those who receive Social Security and Railroad Retirement benefits pay no monthly premium. Others who do not have enough quarters of Medicare-covered employment may be charged a monthly premium that ranges in 2003 from $174 to $316. All recipients will have additional ("out-of-pocket") expenses for some services.

Part A covers:

- **Stays in a hospital, "critical access hospitals" and mental health facilities.** Medicare pays for medically necessary services and supplies during the stay (e.g., surgery, intensive care, diagnostic tests, *inpatient* prescription drugs but *not outpatient* drugs, meals, and inpatient rehabilitation). The recipient pays a *deductible* ($840 in 2003) for each *benefit period.* (A benefit period begins the day someone starts receiving care in a hospital or nursing facility and ends when that person has been out of the hospital or nursing facility for 60 days.) Recipients begin paying *coinsurance* on day 61 ($210 per day in 2003, increasing to $420 per day after 90 days). There are no limits to the number of times one can be hospitalized—but each new stay starts a *benefit period* during which continuing treatment or care must occur, and another deductible must be paid.
- **Stays in a skilled nursing facility (SNF) up to 100 days** if they occur within 30 days of a minimum three-day stay in a hospital

and are related to the reason for the hospital stay. (Most people receive much less though.) The care must be certified by a physician as *medically necessary* and includes the need for either *daily skilled nursing care* or *rehabilitation services.* Beneficiaries begin paying *coinsurance* on the 21st day ($105 per day in 2003.)

- **Home health care**, if a person meets the following conditions:
    - is homebound (it is very difficult to leave home alone without assistance)
    - needs skilled nursing care (care given or supervised by a registered nurse) or skilled therapy services
    - is certified by a physician as needing skilled home health care.

  Medicare pays for part-time (up to 35 hours per week) skilled nursing care, assistance from a home health aide if it supports the skilled care, physical, occupational and speech therapy, medical social services, and medical supplies. Durable medical equipment such as hospital beds, wheelchairs, oxygen or walkers are covered but the recipient must pay 20 percent of the cost.

- **Hospice care**, including pain relief, physician and nursing services, home and health aide and homemaker services, supportive medical and social services, physical therapy, medical equipment and symptom management, is provided free under Medicare to those terminally ill persons with life expectancies of six months or less or who waive standard Medicare benefits for treatment. A 5 percent (up to $5) coinsurance is charged for drugs. Inpatient care will be provided with a 5 percent copayment if the family caregiver needs respite.

Part B (Medical Insurance) covers approximately 80 percent of the approved cost of outpatient medical care if it is *medically necessary* or an *approved preventive benefit*. Recipients pay a *monthly premium* ($58.70 in 2003), which is usually deducted from their Social Security or other government retirement check, and an *annual deductible* of $100. Recipients pay *coinsurance* for many services, usually 20 percent of the Medicare-approved costs with some exceptions, including mental health care for which the coinsurance is 50 percent. Some services have additional copayment requirements.

Part B covers medical and related services, including visits to physicians and surgeons, outpatient medical and surgical services and supplies, diagnostic tests, ambulance services, durable medical equipment, outpatient mental healthcare, limited home health care, and physical, occupational and speech rehabilitation services not covered under Part A. The services provided must be covered by Medicare, and practitioners must accept Medicare patients if a doctor "*accepts assignment*," which means he or she cannot charge more than Medicare-approved amount for a service.

Routine annual exams are not covered but several preventive benefits, such as colorectal cancer screening, mammograms, and flu or pneumonia shots, are covered.

Medicare + Choice: A recent option under Medicare, called "Medicare plus Choice," offers several advantages and disadvantages. A person can choose a program from a company or provider that is under contract with Medicare for a *Medicare Managed Care Plan*, such as a health maintenance organization (HMO), or *Medicare Private Fee-for-Service Plan*. Under "Medicare + Choice," Medicare pays a set amount to the plan provider each month and the provider must offer the standard Medicare benefits.

A major reason for selecting M+C is that some providers also offer additional services such as prescription drugs or more preventive and wellness care. Beneficiaries continue to pay the Part B monthly premium, and may pay an additional premium to the M+C provider, as well as any other deductibles or copayments that the plan requires.

Other advantages of M+C include receiving all care in one location or through one group of professionals, less paperwork, and lower costs than some other Medicare plans. Drawbacks may include being required to see only doctors within the plan and limits on the number of enrollees. A growing problem is that some M+C providers are reducing services or leaving the Medicare system. Because M+C providers sign one-year contracts with Medicare, such changes can occur frequently. If a provider leaves Medicare, enrollees return to Original Medicare or can select another provider, if one is available in their area. One should seek

advice from Medicare immediately either through (800) MEDICARE or a state health insurance counseling program (SHIP).

Medicare Costs

The Henry J. Kaiser Family Foundation reports that Medicare pays just 56 percent of beneficiaries' total healthcare costs with the balance paid out of the individual's own pocket or by other insurers.[1] These costs increase annually and include the premiums, deductibles and other out-of-pocket costs detailed above under descriptions for Part A and Part B. In fact, Medicare Part B works much like traditional health insurance by requiring deductibles and coinsurance. Several programs attempt to help beneficiaries pay for these out-of-pocket expenses.

Paying for Unfunded Costs

Insurance: Private insurance companies and other public programs continue to play a role in healthcare for seniors and younger persons with disabilities. Options for funding enrollees' out-of-pocket expenses include:

- **Medigap and Other Supplemental Insurance** – Ten standardized insurance plans (called "Medigap") have been approved by Congress to supplement Medicare. They are offered by private insurance companies or organizations, although not all companies provide all ten plans. Purchasers of Medigap policies must pay a monthly premium *in addition to* the premiums paid for Medicare Part B. Lower cost Medicare SELECT policies are offered but may require use of specific hospitals or doctors. Medicare + Choice participants cannot purchase Medigap policies. All Medigap plans are designed to pay for various Part A and Part B expenses, such as the $100 annual deductible under Part B, additional hospital days, a portion of doctors' services not paid by Medicare, and so on. A few of the plans provide additional home health or limited prescription drug coverage. See "Resources" for programs that can help with Medigap policy selection. Medicare beneficiaries under age 65 are currently able to purchase Medigap insurance only in those states that require coverage of the younger age group.

- **Employer or Union Insurance:** Many Medicare recipients receive some form of health insurance from their employer or union even after retirement. Before making any decisions about coverage, recipients should talk to a Medicare or employee benefits counselor to learn the limitations of employer-sponsored insurance and the rules for enrolling in Medicare Part B. For more information, consult The Medicare Rights Center's brochure, "Medicare and Employer Insurance: How They Work Together" (see Resources).

- **Long-Term Care and Other Specialized Insurance:** Little is standardized in long-term care insurance policies. Caregivers can refer to several publications available from AARP or *Consumer Reports* or request a copy of "Understanding Long Term Care Insurance" from the American Healthcare Association and National Center for Assisted Living at (800) 321-0343 or *www.ahcabookstore.org*. Other specialized private insurance policies are available including disability, home health or cancer-only plans.

Veterans and Military Service: Eligible veterans and military retirees can receive health benefits through the Veterans' Administration and TRICARE for Life, respectively.

Low-Income Assistance: The incomes of one-half of Medicare beneficiaries fall below $25,000 per year, and income levels fall lower for older population groups.[2] To help low-income participants, other publicly-funded assistance is available, including Medicaid, qualified assistance programs offered to Medicare beneficiaries, Medicare Savings Programs for those with limited income or savings, and state assistance programs. The Program for All-Inclusive Care for the Elderly (PACE) is also an option in some communities for people who would otherwise require nursing home placement.

Prescription Drugs: Spending in the U.S. on prescription medications increased more than 17 percent in 2001, the fourth year in a row that costs increased.[3] But Medicare does not pay for outpatient prescription drugs except in specific instances. Few Medigap supplemental insurance policies cover prescriptions; and those have deductibles and other costs. Medicare recipients who have other health coverage, such as employer sponsored insurance, or even the managed care plans of Medicare + Choice, often must pay part of their prescription expenses. Several programs aim to assist with drug costs, including State Pharmacy

Assistance Programs in many states; mail order and internet-based pharmacies, discount pharmacies in the community, membership programs (e.g., AARP), and discount cards; and discount programs directly from pharmaceutical companies. Information about discount programs can be found through Needy Meds (*www.needymeds.com*) and The Medicine Program (*www.themedicineprogram.com*), as well as several Resources listed below.

Medicare's Limitations

Limits on what Medicare does and does not cover cause confusion and frustration for beneficiaries and their caregivers. In addition to the costs of healthcare, the major problems include lack of long-term care coverage, benefit periods, requirements for approved rates, and "acceptance of assignment."

There may be service limitations within geographic areas as well, especially in rural areas.

Long-Term Care and Rehabilitation: According to a survey by CareQuest National Work & Family LTC Solutions, 63 percent of those aged 65 and over do not know or have incorrect information about Medicare coverage for long-term care.[4] Two-thirds of all Medicare beneficiaries live with multiple chronic health conditions, and nearly one-fourth have cognitive limitations, (that is, problems with mental processes) according to the Henry J. Kaiser Family Foundation.[5] Yet the services needed by these individuals are largely not covered by Medicare because *Medicare does not cover long-term care*.

The U. S. Senate Committee on Aging defines "long-term care" as healthcare that does not have as a goal the cure of an illness but "to allow an individual to attain and maintain an optimal level of functioning. Long-term care encompasses a wide array of…services needed by individuals who have lost some capacity for self-care because of a chronic illness or disabling condition."[6]

In a **skilled nursing facility**, Medicare will cover care only if it occurs within 30 days of a minimum three days' stay in a hospital. The care required must be for the same condition for which one was hospitalized. Example: a Medicare beneficiary falls and breaks her hip. After receiving care for the fracture in a hospital, she is sent to a skilled nursing or inpatient rehabilitation center for further healing and therapy. While in the skilled facility she can receive skilled nursing services, aide services that support the skilled care, and physical or occupational therapy for the hip fracture. Medicare coverage will end if her doctor and care team decide that her hip has improved as much as possible while in the facility and she is sent home.

In-home care is also limited to authorized skilled care and services that support the skilled care. The care must be certified as medically necessary by a physician. Again, Medicare coverage may end when professional assessments determine that no further improvement will occur for the condition being treated.

Medicare does not cover other types of care and services needed by a person who is homebound or unable to handle his or her own daily activities such as bathing, dressing, meal preparation and eating, shopping, house cleaning and so on, if that is the only help that that person needs. Medicare also does not pay for 24-hour care. The hospice benefit is more comprehensive but requires that a person have a terminal diagnosis.

Other obstacles: Medicare recipients may run into other obstacles in obtaining healthcare services. They can: reach coverage limits for different services (such as skilled nursing facility stays or home health care); have to find service providers that are approved by Medicare and accept Medicare-approved payment rates; be asked to sign a "private contract" to pay higher rates; or experience service cut-backs because of changes in Medicare programs or policies.

Rights and Appeals

All Medicare recipients have rights and can appeal decisions regarding the services they receive, coverage limits or payment decisions. See Resources for Medicare contacts and organizations that help with issues related to protecting these rights, filing claims and obtaining assistance.

Additional Reading

"Medicare & You," the federal government's comprehensive booklet that is revised and mailed annually to all Medicare recipients, is available in English and Spanish by calling (800) MEDICARE or from www.medicare.gov.

"Medicare Health Plan Choices: 2002 Consumer Update," United Seniors Health Council, 409 Third St., S.W., Washington, D. C., 20024-3604; telephone (800) 637-2604 or Fax (202) 479-6660.

"Talking to Your Parents about Medicare and Health Coverage," published by the Henry J. Kaiser Family Foundation (see Resources) helps

families think through the decisions they must make about healthcare coverage.

Federal Resources for Caregivers

(800) MEDICARE (800) 633-4227
www.medicare.gov

The Federal government's comprehensive resource for and about Medicare, from making address changes to learning about coverage basics. The "Medicare Personal Plan Finder" helps in selecting an appropriate Medicare plan and supplemental insurance. The Prescription Drug Assistance Program links caregivers to low-cost prescription programs (www.medicare.gov/Prescription). Also includes the booklet "Medicare & You" and other publications; and links to individual State Health Insurance Programs (SHIPs).

CarePlanner
www2.careplanner.org

Sponsored by The Centers for Medicare and Medicaid Services, this site offers an interactive "decision support tool" to help seniors, caregivers and others plan for long-term care and assistance.

"FirstGov" for Seniors
www.seniors.gov

A portal site to federal and other resources for seniors.

National Family Caregiver Support Program
www.aoa.dhhs.gov/carenetwork

For local information about the NFCSP, caregivers can contact their Area Agency on Aging.

Other Resources

MONTEREY COUNTY
Health Projects Center's
Del Mar Caregiver Resource Center
(831) 424-4359
Web site: http://www.delmarcaregiver.org

SANTA CRUZ COUNTY
Health Projects Center's
Del Mar Caregiver Resource Center
(831) 459-6639
Web site: http://www.delmarcaregiver.org

SAN BENITO COUNTY
Health Projects Center's
Del Mar Caregiver Resource Center
(831) 459-6639
Web site: http://www.delmarcaregiver.org

Del Mar Caregiver Resource Center supports and assists caregivers of brain-impaired adults through education, research, services and advocacy.

For residents of Central California, Monterey, Santa Cruz and San Benito Counties, Del Mar CRC provides direct family support services for caregivers of those with Alzheimer's disease, stroke, head injury, Parkinson's and other debilitating brain disorders that strike adults.

AARP
601 E Street NW
Washington, D.C. 20049
(800) 424-3410
www.aarp.org

Information booklets and research on Medicare basics and related topics. Also offers supplemental health insurance and information about insurance. Discounted prescription medicines are available through AARP Pharmacy (*www.aarppharmacy.com* or (800) 456-2277).

Benefits CheckUp
www.benefitscheckup.org

Sponsored by the National Council on Aging and several public and private partners, helps find programs for seniors that may pay some of the costs of prescription drugs, healthcare, utilities and other services.

Center for Medicare Advocacy, Inc.
P. O. Box 350
Willimantic, CT 06226
(860) 456-7790
(800) 262-4414
www.medicareadvocacy.org

A nonprofit organization that provides education, advocacy and legal assistance to elderly and persons with disabilities to help them obtain healthcare.

Center for Medicare Education
www.MedicareEd.org

The Center for Medicare Education (CME) is a resource for public agencies and private organizations that provides consumer education about the Medicare program and its health plan options.

The Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
(800) 656-4533
www.kff.org

Publishes "Talking With Your Parents About Medicare and Health Coverage," "Medicare Chart Book," and other information and research through "The Medicare Policy Project."

Medicare Rights Center
1460 Broadway, 11th Floor
New York, NY 10036
(212) 869-3850(888) 466-9050 (HMO appeals hotline)
www.medicarerights.org

Information and assistance about rights and appeals dealing with Medicare and related insurance issues; low-cost prescription drug information; glossary of Medicare terms.

[1]"Medicare Chart Book," Second Edition, Fall 2001, The Henry J. Kaiser Foundation (see Resources).
[2]"Medicare Chart Book," ibid.[3]*Wall Street Journal*, March 29, 2002.
[4] "Perception of Medicare Long-Term Care Coverage Among Those Aged 65 and Over in the United States," June 2001, CareQuest National Work & Family LTC Solutions, Madison, WI.
[5]"Medicare Chart Book," ibid.
[6] "Developments in Aging: 1997 and 1998", Volume 1, Report 106-229, February 2000, Special Committee on Aging, United States Senate, Washington, D. C.

Prepared by the National Center on Caregiving at Family Caregiver Alliance. Reviewed by Marisa A. Scala, Executive Director, Center for Medicare Education. Funded by the Archstone Foundation. Printed June 2003.