Be Prepared

Do you know the details of Medicare coverage?

Presented by

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of the

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Who/when is an individual eligible for Medicare?

Adults 65+ years of age who have been legal residents for at least 5 years. Those under 65 who are disabled, have renal failure or ALS (Lou Gehrig's disease).

Enrollment Period

- 7 month period; 3months prior to 65th birthday + month of birthday + 3 months post 65th birthday.
- Open General Enrollment – January 1 through March 31
- Medicare Advantage Plans (Plan C) – October 15 through December 7

If you sign up for Part A/ B in this month:	**Your coverage starts:**
The month you turn 65	1 month after you sign up
1 month after you turn 65	2 months after you sign up
2 months after you turn 65	3 months after you sign up
3 months after you turn 65	3 months after you sign up
During the January 1– March 31 General Enrollment Period	July 1

*MediCAL (California state program for Medicaid) is provided to those individuals who meet the low income requirement. Please note benefits paid under this program can be deducted from an estate after the individual's death.

There are 4 Medicare categories…

Part A - Hospital Insurance

Covers 90 days (doesn't cover anything less than two midnights.) ***Care provided prior to a formal admission is not counted in the two midnights. It's important to ask if the patient has been formally admitted. First 60 days covered in full by Medicare with the exception of a copay of $1216 at the beginning of the stay. The last 30 days requires a copay of $304/day (2014 figure).

FYI, readmissions with 30 days are subject to applicable penalties. End result...adequate post hospital care; in home caregivers, more referrals to hospice, etc.

SNF (skilled nursing facility)/rehab communities are also covered with a 3 day qualifying hospital stay (3 midnights) not counting the discharge date. Maximum length of stay is 100 days; first 20 paid in full, balance of 80 days requiring a copay of $152/day.

SNF (skilled nursing facility) stay must be for a condition diagnosed during the hospital stay or for the main cause of the hospital stay. In other words, stay must be medically necessary and care must be skilled.

If an individual only requires assistance with activities of daily living (meal prep, bathing, dressing assistance) they are not eligible to stay in skilled nursing.

The 90 day hospital stay and 100 day SNF (skilled nursing facility) stay clock resets if benefits are not drawn for 60 consecutive days.

Hospice care is fully covered by Part A. Order written by a physician who has determined the individual has 6 months or less to live. Respite (custodial care) is not covered.

Examples to further explain the provisions of Part A…

Scenario 1

65+ year old patient goes to the ER with a minor hip fracture that doesn't require surgery. Stays in ER from 4:00 pm Tuesday until 1:00 am Wednesday without being admitted. Officially admitted at 1:30 am on Wednesday and discharged at 10:00 am on Thursday. Patient did NOT stay over 2 midnights; therefore, Medicare may not cover hospital stay! However, discharge can be appealed by patient, family or responsible party.

Scenario 2

Same situation as above; however, patient stays over two midnights. He/she is discharged on Friday midday with precaution instructions; no weight bearing activity on injured side, no bending, crossing legs, etc. Patient doesn't follow instructions and readmits to ER on Saturday due to extreme pain possibly caused by further damage to fractured area. There is a strong possibility the second ER visit will NOT be covered by Medicare (30 day rule).

Scenario 3

Same situation as 1 and 2; however, fracture requires surgery. Patient is officially admitted, undergoes surgery, post op stay of 7 days. Transferred to skilled nursing community for physical and occupational therapy. Patient requires a stay exceeding 20 days. Out of pocket expense could be approximately $144.50/day for days 21 through 100. Days spent beyond 100 are NOT covered (completely out of pocket).

Supplemental insurance could pay all or part of "out of pocket" expense depending on plan purchased.

Part B – Medical Insurance

Covers 80% of approved services. Balance of 20% is paid by the patient or private insurance.

Part C – Medicare Advantage Plans (OPTIONAL)

A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits. The most commonly used is Kaiser. The premium is slightly less than original Medicare + supplemental. Obviously, the patient only has access to Kaiser physicians, hospitals, etc.

Part D – Prescription Drugs

These are stand alone programs administered by private health insurance companies and pharmacy benefit managers; i.e., Medco. However, they are highly regulated by Center for Medicare Services (CMS).

Cost

Cost varies based on…

- Monthly income. The higher the income, the higher the monthly premium.
- Whether or not the individual selects a Medicare Advantage Program; i.e., Kaiser, Brown & Toland, etc.
- Whether or not an individual purchases supplemental insurance to cover the 20% not covered by Medicare for medical insurance (Part B).

As an example, an individual's annual healthcare cost in our area could run approximately $14,400 annually for a PPO policy. After turning 65 and converting to Medicare, the annual cost could drop to $4800 including supplemental insurance.

Helpful information & tips…

- Review your current coverage before a medical crisis occurs.
- Prepare a "To Go" envelope that contains…
  - Copy of your Medicare card
  - Copy of supplemental insurance card
  - Copy of prescription drug card
  - Copy of DNR and health care directives

  Keep this envelope in an accessible location; i.e., kitchen, desk or nightstand drawer. Advise location of envelope to adult children or emergency contact person. These documents will be needed in the event of a medical emergency and should be brought to the hospital.

- Give copies of the items in the "To Go" envelope to your adult children or emergency contact person.

For more information about Medicare or MediCAL benefits, please contact your county's HICAP (Health Insurance Counseling and Advocacy Program) office at the numbers listed below. Their services are free of charge.

Alameda County – 510 839-0393

Contra Costa County - 1-800 510-2020

San Francisco County – 415 677-7520

San Mateo County - 650 627-9350

Santa Clara County – 408 350-3200