

CHAPTER 2

Medicare and Medicaid

Medicare and Medicaid are two very different programs with names that sound alike. **Medicare** is a federal health insurance program for people aged 65 and over and for people with disabilities. It has premiums, co-payments and deductibles. **Medicaid** is a government assistance program created to pay for health care for low-income families and individuals of any age. You or someone you know may need Medicaid assistance to help pay for long term care in a nursing home or other setting.

This chapter explains the basic eligibility requirements for Medicare and Medicaid. It also discusses which services are covered and which are not. Finally, it provides information on how to appeal if you disagree with a decision about eligibility or coverage.

Medicare

Medicare is a federal health insurance program managed by the Centers for Medicare and Medicaid Services (CMS). It helps pay hospital and medical costs for people who are 65 or older and for some disabled people who are under 65. Beginning in 2006, it pays a part of some prescription costs, too.

Medicare hospital insurance is also called **Part A**. It usually covers a necessary stay in the hospital. Sometimes, it covers skilled care in a nursing facility or certain health care in your home after you leave the hospital. It can cover hospice care, too. Part A does not cover doctors' services.

Medicare medical insurance is also called **Part B**. It covers doctors' services. It also covers outpatient hospital services, diagnostic tests and medical supplies. It can cover home health services prescribed by a doctor even if you have not been in the hospital.

Medicare+Choice or Medicare Advantage is the managed-care or HMO (health maintenance organization) form of Medicare coverage, which offers hospital and medical coverage and limited prescription coverage.

Medicare Part D is the general name of the new prescription drug plans available for Medicare beneficiaries. Although people must have either Medicare Part A or B or Medicare Advantage in order to qualify for a prescription drug plan, the plans are operated by insurance companies, not by Medicare.

Medicare does not cover some common health care expenses, including dental care, eyeglasses, hearing aids and most long term care. It does cover regular gynecological and mammography treatment, smoking cessation counseling, and heart and diabetes screening.

Medicare Eligibility

You are eligible for Part A (hospital insurance) if any of the following situations apply:

1. You are 65 or older and qualify for Social Security or Railroad Retirement benefits, even if you are not actually receiving them;
2. You are a former federal employee who retired in or after 1983;
3. You are disabled and have met the Social Security or Railroad Retirement disability requirements for two years; or
4. You have end-stage kidney disease and have been treated on dialysis for three months.

You are eligible for Part B (medical insurance) if:

1. You meet the requirements for Part A (listed above), although you do not have to have signed up for Part A; and
2. You pay a monthly premium (\$88.50 in 2006), which usually increases annually.

If you are 65 or older but not eligible under the above requirements, you may still choose to enroll in the Medicare program. You must live in the United States and be a citizen or a legal resident for at least five years. If you choose to enroll, you must pay monthly premiums. You can sign up for Part A without having Part B, and for Part B without having Part A. If you have a "Medicare+Choice" medical plan that requires you to use a health maintenance organization (HMO) for all of your care, you may hear that option called Medicare Part C. It goes by other names, too, such as Medicare Advantage, Medicare Health Plan and Medicare Managed Care. These terms can be confusing.

How to Enroll

You should enroll for Medicare benefits shortly before your 65th birthday, even if you are not planning to retire at age 65. If you are going to sign up for Social Security benefits at age 65, you can sign up for Medicare at the same time. You can enroll at your local Social Security office or by mail.

If you don't sign up when you turn 65, remember that the longer you wait, the more the coverage will cost.

If your income and resources are low, Social Security can help you apply for "extra help," a subsidy to help pay the premiums, deductibles and copayments for the drug prescription plan. If Social Security turns you down, and you believe you are eligible, you have the right to appeal the decision.

If you are already receiving reduced Social Security benefits when you reach age 65, you will receive a Medicare card showing your enrollment

CHAPTER 2

Medicare and Medicaid

in Part A (hospital insurance) and Part B (medical insurance). The premium is then deducted from your monthly Social Security check. You can refuse Part B medical benefits by returning the proper form that comes with your original Medicare Card. If you are not receiving Social Security benefits and do not plan to when you reach age 65, but wish to receive Medicare, you should enroll about three months before your 65th birthday. In this case, you will be billed for the premiums.

Services Covered

PART A

Services covered under Part A are:

1. **Hospital services**, which are covered if Medicare finds that they are **reasonable and necessary**:
 - Bed and board;
 - Routine nursing services;
 - Inpatient drugs;
 - Supplies;
 - Equipment normally furnished by the hospital;
 - Operating and recovery room costs; and
 - Diagnostic, therapeutic or rehabilitative services and items the hospital normally furnishes.
2. Some **skilled nursing home services**, which are covered for a limited period of time after you have been in the hospital for at least three days:
 - Bed and board;
 - Skilled nursing care;
 - Inpatient drugs;
 - Physical, occupational and speech therapy; and
 - Medical social services.

A nursing facility may also provide intermediate or custodial care, which is *not* covered by Medicare. **Medicare pays only if you receive skilled services and under very specific circumstances.**
3. Certain **home health care services**, when ordered by a doctor and given by a Medicare-certified home health care agency:
 - Part-time skilled nursing care;
 - Physical therapy;
 - Part-time services of home health aides;
 - Medical social services;
 - Medical supplies;

CHAPTER 2

Medicare and Medicaid

You should enroll for **MEDICARE** benefits shortly before your 65th birthday, even if you are not planning to retire at age 65.

- Equipment provided by the agency; and
- Some speech and physical therapy.

Medicare pays for home health care only if you need occasional skilled nursing care or rehabilitative services.

4. **Hospice services** to provide supportive care for terminally ill patients and their families, at home or in a facility:

- Skilled nursing care;
- Physical and speech therapy;
- Medical social services;
- Home health aid and homemaker services;
- Medical supplies and appliances;
- Prescription drugs;
- Physician services;
- Counseling; and
- Short-term inpatient care.

To get Medicare coverage for hospice services, you must sign a request choosing hospice **instead** of other Medicare-covered services. If you choose hospice, you can change your mind later.

PART B

Services covered under Part B include:

- A “Welcome to Medicare” physical examination;
- Periodic diabetes, cardiovascular and gynecological examinations;
- Smoking cessation services;
- Physicians’ services;
- Some hospital outpatient services and supplies (such as diagnostic tests, x-rays and radiation treatment);
- Ambulance services;
- Rental or purchase of durable medical equipment (such as wheelchairs and walkers);
- Outpatient physical therapy and speech pathology;
- Surgical dressings, splints and casts;
- Prosthetic devices; and
- Certain home health services.

PART C (MEDICARE ADVANTAGE)

Services covered under Medicare Advantage include:

- HMO and preferred provider organization services, covering both Part A and Part B; and
- Some kinds of medicines.

Services and Supplies *Not* Covered by Medicare

Though Medicare has broad coverage, it does not pay for many services and supplies. These uncovered services and supplies include:

- Medicine you buy without a doctor's prescription, or with a doctor's prescription if you have no prescription drug plan or your plan does not cover the specific medication;
- Care in a nursing facility (unless it meets the Medicare requirements for skilled care and it follows a hospital stay of at least three days);
- Care in an adult foster home, residential care facility or assisted living facility;
- Most in-home services;
- Services not reasonable or necessary as defined by Medicare;
- Routine check-ups;
- Hearing aids/examinations;
- Eyeglasses/examinations;
- Chiropractic services;
- Cosmetic surgery;
- Dental care;
- Services the patient has no legal duty to pay for;
- Services paid by a government agency;
- Personal comfort items;
- Optional private hospital rooms; and
- Orthopedic shoes.

Medicare's Basic Payment Policies

Like private insurance policies, Parts A and B have **deductibles** you must pay before Medicare pays anything. Parts A and B also have **co-insurance payments** for most services. You are responsible for paying the deductible and making the co-payments to the health care provider unless you have a Medicare supplemental insurance policy ("**Medigap**" coverage) that covers these costs or you belong to a health maintenance organization (HMO).

Part A

Medicare measures your use of Part A hospital insurance with benefit periods called **spells of illness**. Your first benefit period begins the first

CHAPTER 2

Medicare and Medicaid

day you enter the hospital after your insurance goes into effect. A new benefit period begins after you have not been in the hospital (or skilled nursing facility) for 60 days in a row. There is no limit to the number of spells of illness (benefit periods) you can have.

HOSPITAL CARE: With Part A, you receive up to 90 days of hospital care for each spell of illness. The following is what **you** must pay:

- The first 60 days: You pay the deductible of \$952 in 2006. Medicare pays the remaining covered expenses.
- The next 30 days: You pay a co-payment of \$238 in 2006. Medicare pays the remaining covered expenses.
- After 90 days: You may use some of your 60 **lifetime reserve days**. For each used lifetime reserve day, you pay \$476 per day (in 2006) of the initial cost. Medicare pays the remaining covered expenses for each day up to a 60 lifetime-day maximum. However, people rarely stay in the hospital for more than a few days at a time. If you need to stay longer and your doctor agrees, Medicare must continue to pay, so long as you still have lifetime reserve days. Hospitals have a financial incentive to discharge Medicare patients as soon as possible. Medicare has developed a system of diagnosis related groups (DRGs) that determines how much the hospital is paid. Medicare bases its payment on the average length of stay for a patient with your diagnosis and not on the actual number of days you spend in the hospital.

SKILLED NURSING CARE: Medicare pays for the first 20 days of **covered** skilled nursing care in a Medicare facility **after you pay the Part A deductible** and after a minimum three-day hospital stay. For days 21 to 100, Medicare will pay a certain amount, while you pay the remaining balance (\$119 per day in 2006). After 100 days, you pay the full amount, and Medicare pays nothing. People rarely spend as long as three months in this kind of facility.

HOME HEALTH VISITS: Part A pays for the full approved cost of home health visits by a licensed home health agency that follows a treatment plan prepared by a physician. However, strict requirements limit the coverage of home health services. You must be homebound **and** you must need the skilled services only periodically (not every day). If you meet the Medicare requirements, there is no deductible, no co-payment and no limit on the number of visits.

HOSPICE CARE: Medicare covers hospice care for two periods of 90 days each and one following period of 30 days. The usual deductible and co-payments do not apply to hospice care. You must pay 5 percent of the cost for prescription drugs, or up to \$5 per prescription. You also must pay 5 percent of the cost of respite care, up to a maximum equal to the inpatient hospital deductible.

Part B

Under Part B, Medicare pays 80 percent of the **approved charge** for covered services after you pay the annual deductible (\$124 in 2006) and the monthly premium (\$88.50 in 2006). The approved charge is the value that Medicare has set for the service you received. It often is lower than the amount the provider bills you. You pay 20 percent of the Medicare

approved charge, plus the difference between the approved charge and the actual bill. The provider cannot charge a difference that is more than 15 percent of the approved charge. For example:

The doctor bills you:	\$100
The Medicare approved charge is:	\$90
The difference is:	\$10
Medicare pays 80 percent of \$90:	\$72
You pay 20 percent of \$90:	\$18
Plus the difference between \$90 and the actual bill:	\$10
For a total of:	\$28

If the doctor accepts **assignment**, he or she has agreed to accept the amount of the Medicare approved charge as full payment. This often decreases the total you have to pay. For example:

A doctor who accepts assignment bills you:	\$100
The Medicare approved charge is:	\$90
Medicare pays 80 percent of \$90:	\$72
You pay 20 percent of \$90:	\$18
You do not pay the \$10 difference between \$90 and the actual bill:	\$0
So your total payment is:	\$18

The Social Security office and CMS have lists of doctors who have agreed to accept assignment.

Oregon helps pay the monthly Part B premium for some lower-income people, known as "Qualifying Individuals." To get this help, a person must have Part A coverage and have monthly income below 135 percent of the federal poverty level. In 2006, that amount equals \$1,123 for one person and \$1,505 for a couple. Oregon's Area Agency on Aging and Seniors and People with Disabilities offices have information on this program. (See General Resource List.)

Part D

Medicare's new drug benefit has these general features:

- This plan is optional. You do not have to sign up for the drug benefit when you first become eligible for it. But if you decide to sign up later, it will cost more.
- There is a monthly premium for the drug benefit, costing between \$8 and \$90 per month, depending on the plan.
- Because private companies offer the plans, they vary in what medications they cover (their "formulary").
- You have to pay a \$250 deductible every year.
- After the deductible, Medicare covers approximately 75 percent of your drug costs, up to a total cost of \$2,250. You are responsible for approximately 25 percent of the cost. The percentage varies from plan to plan.

CHAPTER 2

Medicare and Medicaid

- If your drug costs reach \$2,250, Medicare will stop paying until you have paid all of the next \$2,850 for drugs on the plan formulary. (Payment for other drugs doesn't count toward this amount.)
- After you have spent that amount, Medicare will cover approximately 95 percent of your further medication costs. You will be responsible for the larger of 5 percent or \$2 (generic) or \$5 (brand name) of the prescription costs.
- Expect the costs to rise every year, although not necessarily in the same amounts as your Parts A and B coverage.
- If you have drug coverage through your insurance from an employer or former employer, you may not need a Medicare drug prescription plan. If your employer has sent you a letter saying your current coverage is "creditable," you should probably not get a Medicare plan. Be sure to save this letter if you get one. If you change to a Medicare drug plan later, the letter will be needed to avoid a late enrollment penalty.
- Enrolling in the right prescription plan can be quite complicated. Get help from a Senior Health Insurance Benefits Assistance (SHIBA) volunteer in your community before deciding on a plan.

People who are "Qualifying Individuals" for Medicare Part B also get help with their prescription costs under Part D, paying \$2 or \$5 per prescription. Information about this program is available from Area Agencies on Aging and Senior and People with Disabilities offices. (See General Resource List.)

Medicare Claims and Payments

Under Medicare, you do not have to file claims or send in any bills you receive from hospitals, skilled nursing facilities or home health agencies. These providers bill Medicare directly for services under Part A. In Oregon, most Part A claims are processed by Noridian Administrative Services. (See Resources at end of chapter.) Noridian will send you a notice showing what benefits you used, the amount that Medicare has paid, and any deductible or co-payment amounts. It is a very good idea to ask your hospital for an itemized bill for its services so that you can make sure all of the charges are proper.

Providers also bill Medicare directly for services under Part B. If the provider accepted assignment, he or she will receive payment directly from Medicare. If the provider did not accept assignment, you will receive the payment from Medicare and be responsible for paying the provider's bill. In Oregon, most Part B claims are processed by Noridian Administrative Services. (See Resources at end of chapter.) Noridian will send you an Explanation of Medicare Benefits form or Medicare Summary Notice form showing whether the claim was approved or denied, whether the provider accepted assignment, the Medicare approved charge, the amount Medicare has paid, and the deductible and co-payment amounts, if there are any.

Unless you have a Medicare supplement insurance policy or belong to a health maintenance organization (HMO), you pay the Medicare

deductible amounts, plus any co-payments, directly to the provider. For more information about Medicare supplement (also called "Medigap") insurance and HMOs, see Chapter 12.

Medicare Denials and Appeals

Parts A and B

If you are in a hospital or a skilled nursing facility, your doctor or someone from the facility may tell you that Medicare will not pay for you to stay there any longer. If you disagree, you can appeal, but you must do so right away. The facility should give you written notice of noncoverage, which explains how to appeal the decision. Whether you get a written notice or not, the first step in the appeal process is to call the Oregon Medical Professional Review Organization (OMPRO) at 503-279-0100 or 800-785-0411 and ask for an immediate review.

If **MEDICARE** denies your claim, you have the right to appeal.

If Medicare denies a claim for payment under Part A or Part B, the Medicare notice will include your appeal rights. You have 120 days from the date you get the notice to ask for an informal review, called "redetermination." Your request must be in writing. If you disagree with the redetermination decision, you have 180 days from the date you get the decision to ask for a "reconsideration." If you disagree with the result at this level, and if your claim involves at least \$100, you can ask for a hearing in front of a CMS administrative law judge. You can get the form used to request a hearing from a Social Security office. It also is available on the Internet from the Centers for Medicare and Medicaid Services. (See Resources at end of chapter.)

Medicare Health Maintenance Organizations (HMOs)

If you belong to an HMO, you have the right to appeal decisions that deny coverage or access to services. You have 60 days from the date you get a written notice from the HMO to ask the HMO to reconsider its decision. If you do not get a written notice, you can still ask for reconsideration. Your request must be in writing. If the HMO continues to deny the coverage or deny your access to services, the HMO will send the information from your file to the Center for Health Dispute Resolution. The Center for Health Dispute Resolution has a contract with Medicare to review HMO cases that are appealed. If you disagree with its decision and there is at least \$110 at stake (for services under Part A, Part B, Part D or any combination of those programs), you have 60 days to ask for a formal hearing in front of a CMS administrative law judge. (Note: The minimum amount of money that must be at stake in order to request a hearing is adjusted each year; \$110 is the threshold for 2006.)

Further Appeals

The administrative law judge's decision regarding services under Part A, under Part B or from an HMO can be appealed to the Medicare Appeals Council of the Center for Medicare and Medicaid Services. You have 60 days to request an Appeals Council review. If you disagree with the review decision and there is at least \$1,090 at stake, you have 60 days to file a civil complaint in the U.S. District Court. (Note: The minimum

amount of money that must be at stake in order to file a complaint in district court is adjusted each year; \$1,090 is the threshold for 2006.)

Social Security publishes a free detailed Medicare Handbook each year. Listen to the following Tel-Law topics for more information: 1097 and 1107, "Medicare Eligibility and Benefits, Parts 1 and 2;" and 1106, "Medicare Claims and Appeals."

CHAPTER 2

Medicare and Medicaid

Supplemental Health Insurance: "Medigap"

Since Medicare does not pay all of your health care expenses, private insurance companies sell insurance to supplement Medicare. This is known as Medicare Supplement insurance or Medigap. Before buying such insurance, make sure it does not duplicate your Medicare coverage. (See Chapter 12 for information on health insurance.) If you have Medicaid, you do not need Medigap coverage.

The Medicare prescription plan may affect your Medigap policy if that policy provides drug coverage. You will not be able to have both the Medicare drug benefit and the Medigap drug benefit beginning in 2006. You must choose between them if you want to have a drug benefit. You will no longer be able to purchase Medigap drug benefits if you do not then already have that coverage. If you decide to change from Medigap drug coverage to Medicare drug coverage after the time you first become eligible for the Medicare coverage, you will have to pay a penalty. The penalty amount rises each month that you delay.

Help in Making Medicare Health Plan Decisions

Oregon's Senior Health Insurance Benefits Assistance program (SHIBA) can provide you with information and counseling by trained volunteers to help you come to an informed decision about your choices for health insurance generally and Medicare in particular. Seniors find the SHIBA program helpful and knowledgeable about the Medicare prescription drug program.

Medicaid

Medicaid helps pay for health care for people who have low incomes and limited assets. The Oregon Health Plan is a Medicaid program. Medicaid covers many items and services, including the full range of long term care. People who have Medicare coverage may also qualify for Medicaid. When they do, Medicaid may pay for the Medicare premiums, as well as the deductibles, co-payments and health care not covered by Medicare.

Medicaid Eligibility

People who receive certain government benefits are automatically entitled to Medicaid. These include recipients of Supplemental Security Income (SSI) who are over the age of 65 or disabled. In 2006, the income standard for SSI is \$603 per month for one person and \$904 per month for a couple.

The asset limit is \$2,000 for one person and \$3,000 for a couple. Certain assets are exempt and are not counted in determining eligibility for SSI or Medicaid. These include the person's home (regardless of its value), one vehicle (regardless of its value if it is needed for work or medical purposes), clothing and household items up to a value of \$2,000, and a burial fund of up to \$1,500.

According to the state office for Seniors and People with Disabilities, the average cost for long term care is over \$4,000 per month. Few people can afford to continue paying that much for very long. People with higher incomes (up to three times the SSI standard, or \$1,812 for one person in 2006) may qualify for Medicaid assistance if they need long term care in a nursing home, adult foster home, residential care facility, assisted living facility, adult day services program or their own homes. A person whose income is over the Medicaid limit may still be able to qualify for assistance by creating a special type of trust, called a Medicaid income cap trust. The asset limit for someone who needs Medicaid for long term care is \$2,000, the same as for SSI. The same assets are exempt as for Medicaid purposes.

If you are facing long term care bills and think that you have too many assets to qualify for Medicaid, do not give your assets away. If you or your spouse gives assets away within the five years before you apply for Medicaid, you will not be eligible for assistance for up to five years after you apply, based on the value of what was given away. Certain transfers are permitted. Talk to an elder law attorney or another lawyer who has experience in this area. You may be able to keep some of the assets, or use them in a way that will benefit you and your spouse.

If you are married, the Medicaid rules allow the spouse who does not need care to keep a share of the couple's income. Generally, this is one-half of the total assets belonging to either spouse or both the husband and the wife, up to \$99,540 in 2006. The well spouse may also get a monthly allowance from the ill spouse's income. The standard allowance is the amount needed to bring the well spouse's gross income up to at least \$1,604 per month (in 2006), and possibly higher. If these amounts are not sufficient to cover the well spouse's expenses, an attorney can explain the options that are available to increase the amount of assets or income or both.

How to Apply

You can apply for Medicaid through a local Area Agency on Aging or Seniors and People with Disabilities office. (See the General Resource List for locations and telephone numbers.) The eligibility worker at these locations can help you complete the application, but is not able to advise you on what steps you (or your spouse) can take to avoid having the well spouse become impoverished.

Services Covered

Medicaid covers a broad range of services, including:

- Hospital services;
- Doctors' services;
- Prescription drugs;

CHAPTER 2

Medicare and Medicaid

- Medical equipment and supplies;
- Eyeglasses;
- Hearing aids;
- Some dental care;
- Mental health services;
- Diagnostic tests;
- Ambulance services and medical transportation; and
- The full range of long term care services.

Medicaid does have limitations. First, most people who get Medicaid assistance have to join a Health Maintenance Organization (HMO) or other managed care plan. The primary physician is responsible for deciding when his or her patients should get medical items or services. Second, the state has a list of treatment priorities. Treatment for certain medical conditions—those that are least likely to be helped by treatment—is not covered if the conditions are not within the current priorities.

Payment for Services

Medicaid pays the health care provider or managed care plan directly. There are no claim forms to complete. If you have Medicaid, you should tell the doctor or other health care provider before you receive treatment or other items or services. You may need to get a referral from your primary physician or prior authorization from your managed care plan. Health care providers are not allowed to charge you additional amounts for services covered by Medicaid.

People who are not eligible for SSI and who are not receiving long term care may be able to get coverage under the Oregon Health Plan by paying monthly premiums and modest co-payments. The availability of this program changes with changes in the state budget for health care.

People who are getting long term care services will have to pay some or most of their income toward the cost of their care. The amount that each person pays depends on the setting in which the care is being provided, whether the person is single or married, and a number of other factors.

Estate Recovery

The state wants to be reimbursed for what it spends on care for Medicaid recipients. But there are limits on what the state can do and when it can do it. For example, the state cannot collect its Medicaid claim while the Medicaid recipient is alive or has a surviving spouse or a minor or disabled child living in the family home. After the spouse passes away, the state can make a claim against the spouse's estate to collect whatever it could have collected from the estate of the Medicaid recipient. Oregon does not place a lien on the person's home or on another piece of property. If you have questions about how estate recovery will affect your property, or if you have received a Medicaid claim from the state, contact a lawyer for advice.

Medicaid Denials and Appeals

You will receive a written notice from the Area Agency on Aging or the Seniors and People with Disabilities office if your application for Medicaid assistance is denied or if your benefits are being reduced or terminated. The notice will give the reason for the action, tell you which administrative rules are involved, and explain how to request a hearing. The hearings are held by administrative law judges who work for the state. The hearing may be in person at the local office or by telephone. You may want to have an attorney represent you at the hearing. You may be able to get representation through a legal aid office near you. (See the General Resource List for locations and telephone numbers.)

Managed Care Issues

Each HMO or managed care organization that serves people who receive Medicaid assistance has an Exceptional Needs Care Coordinator (ENCC). The role of the ENCC is to help people who are having difficulty getting the care they need through the managed care system. If you are having problems, ask your primary physician to help. If your primary physician is the problem, ask to change to another primary physician or contact the ENCC. If the problems continue, you may want to change to a different HMO. You may also be able to get information and advice from a legal aid office. (See the General Resource List for locations and telephone numbers.)

Resources

See **General Resource List** for AAA/SPD offices, legal aid offices, OSB Tel-Law service and more. Also, see Resources at end of Chapter 12 for more information about insurance.

For more information about Medicare and Medicaid, call your nearest senior center. Some centers have SHIBA (Senior Health Insurance Benefits Assistance) volunteers. These volunteers are trained to help you. For more information, call your local AAA/SPD office.

Centers for Medicare and Medicaid Services (CMS)

www.cms.hhs.gov

Noridian Administrative Services

Medicare Parts A and B information
901 40th Street South, Suite 1
Fargo, ND 58103
877-908-8431
www.noridianmedicare.com

Oregon Insurance Division

350 Winter Street, Room 440
PO Box 14480
Salem, OR 97309
503-947-7984 or 888-877-4894
www.insurance.oregon.gov

Oregon State Bar Tel-Law Topics

1097 - Medicare Eligibility and Benefits, Part 1
1107 - Medicare Eligibility and Benefits, Part 2
1106 - Medicare Claims and Appeals
1108 - Medicare Prescription Drug Program
503-620-3000 or 800-452-4776
www.osbar.org

Senior Health Insurance Benefits Assistance (SHIBA)

250 Church Street SE, Suite 200
Salem, OR 97301
800-722-4134 or 503-378-2051
www.oregonshiba.org

Also, call or write for the booklet *“Oregon Consumer Guide to Medicare Supplemental Insurance and HMOs.”*

Glossary of Terms

Approved Charge: *The value that Medicare has set for the service received. It is often lower than the amount the provider bills.*

Assignment: *A method of payment under Medicare Part B. The doctor agrees to accept the amount of the Medicare approved charge as full payment.*

Co-insurance Payments: *Payments you make to share costs with Medicare.*

Deductible: *Amount of medical bill you must pay annually before Medicare pays anything.*

Hospice: *Supportive care provided for terminally ill patients and their families at home or in a facility.*

Lifetime Reserve Days: *Sixty extra days you may use for hospitalization. You share daily costs with Medicare. These days can be used only after you have stayed more than 90 days in a hospital and can be used only one time.*

Medicaid: *A program that helps pay some health care costs for qualifying individuals with low incomes and limited assets. It will cover some expenses that Medicare does not.*

Medicare: *A federal health insurance program for people aged 65 and over and for certain people with disabilities.*

Medicare Advantage: *See Medicare+Choice.*

Medicare Hospital Insurance: *Also called Medicare Part A. Health insurance that usually covers a necessary hospital stay and sometimes covers skilled care in a nursing facility or certain health care in your home after you leave the hospital.*

Medicare Medical Insurance: *Also called Medicare Part B. Insurance that covers doctors' services, outpatient hospital services, diagnostic tests and medical supplies. It can cover home health services prescribed by a doctor even if you have not been in the hospital.*

Medicare Part D: *The general name of the new prescription drug plans available for Medicare beneficiaries. Although people must have either Medicare Part A or B or Medicare Advantage in order to qualify for a prescription drug plan, the plans are operated by insurance companies, not by Medicare.*

Medicare+Choice: *Also called Medicare Advantage. The managed-care or HMO (health maintenance organization) form of Medicare coverage, which offers hospital and medical coverage and limited prescription coverage.*

Medigap: *See Chapter 12.*

Spells of Illness: *Benefit periods beginning with the first day you enter the hospital after your Medicare goes into effect. A new benefit period begins after you have not been in the hospital (or skilled nursing facility) for 60 days in a row. There is no limit to the number of spells of illness that qualify for Medicare.*

