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ELDER CARE

A Resource for Interprofessional Providers

The ABCDs of Medicare

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Medicare is a US government-sponsored program that provides health insurance coverage for adults over 65 and qualified individuals with disabilities. This issue of *Elder Care* will focus on Medicare for older adults.

The Medicare program has evolved since the first enrollees began receiving coverage in 1966. Part of that evolution has been the introduction of different categories of coverage, known as Parts A, B, C, and D (Table 1).

There are now two types of Medicare programs: "original Medicare," which is the standard program that has existed since the program began, and "Medicare Advantage Plans." Advantage Plans are governed by Part C.

ORIGINAL MEDICARE - PART A

Part A covers hospital care, skilled nursing facility care, hospice care, home health services, and non-custodial nursing home care. Part A is an automatic benefit of Medicare enrollment (i.e., there is no fee or premium).

Hospital care is covered in hospitals that accept Medicare. Coverage includes a semi-private hospital room, meals, nursing care, drugs and other treatments administered in the hospital, including rehabilitation. Private rooms are covered only if medically necessary (e.g., isolation for infection control).

Patients on original Medicare must pay a portion of the costs of hospital care (Table 2) unless they have purchased supplemental Medigap insurance that may cover all or some of those costs.

Skilled nursing is covered in facilities that accept Medicare payments, assuming the patient was admitted and hospitalized for at least 3 full days prior to transfer to the skilled nursing facility (SNF); observation status in the hospital does not count.

As with hospital care, patients pay a portion of the cost of skilled nursing facility (SNF) care unless they have supplemental Medigap insurance. Without Medigap insurance, there is no cost to patients for the first 20 days in a SNF. But, the cost is $170.50/day for days 21-100 and after day 100, the patient is responsible for all costs.

Table 1. Parts A, B, C, and D of Medicare

Part	Services Covered
A	Hospital care, skilled nursing facility care, hospice, home health services, nursing home care (as long as custodial care is not the only care required)
B	Doctor visits, lab tests, medical supplies and equipment, certain preventive services, ambulance transport, inpatient and outpatient mental health care, second opinions before surgery
C	Medicare Advantage Plans
D	Prescription drugs

Hospice Care is also covered at no charge, including physician care if the physician is employed by the hospice. If not, Part B applies to physician care. But, there is a small copayment ($5) for prescription drugs used for pain relief and symptom control, and the patients may need to pay 5% of the actual cost of inpatient respite care (costs vary).

Table 2. Patient Costs for Hospital Care on Original Medicare (2019)

Length of Hospital Stay	Patient Out-of-Pocket Costs
Days 1-60	$1,364 deductible
Days 61-90	$341/day
Days 91 and beyond (lifetime reserve days)	$682/day up to a lifetime maximum of 60 days
Beyond the 60 lifetime reserve days	Patient pays all costs
www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance	

ORIGINAL MEDICARE - PART B

The essence of Part B is coverage for physicians' fees and other aspects of outpatient care such as lab tests, imaging, and other services (Table 1). However, patients are responsible for a $185 deductible, and after reaching their deductible they are responsible for 20% of all costs (unless they have a Medigap policy that covers those costs).

TIPS ABOUT MEDICARE

- Be aware of your patients' Medicare coverage. Are they in a Medicare Advantage Plan in which they must see providers with a defined network, or can they see any provider who accepts Medicare?
- Be aware that for Medicare Part D, which provides drug coverage, the copay for medication can vary considerably depending on whether the medication is classified as Tier 1, 2, 3, 4 or 5. Tier-1 and Tier-2 medications are much less costly, sometimes only a few dollars per prescription. Tier-4 and Tier-5 medications can cost hundreds of dollars.

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Medicare Part B also covers a variety of preventive services without copayments (Table 3), as long as the service providers accept Medicare. Several other services are not covered at all under original Medicare Part B, including routine dental and vision care, dentures, cosmetic surgery, acupuncture, hearing aids, and routine foot care.

In contrast to Part A, Part B is not an automatic benefit of Medicare. Rather, enrollees must pay a monthly premium that can be deducted from their monthly Social Security check. The 2019 standard Part B monthly premium is $135, but can be up to $460 based on income and other factors.

Table 3. Preventive Services Covered by Medicare Part B (2019)

• Abdominal aortic aneurysm screening	• Immunizations (influenza, hepatitis B, pneumococcal)
• Alcohol misuse screenings and counseling	• Lipid screening (every 5 years)
• Bone density measurements	• Lung cancer screening for selected patients
• Cardiovascular disease risk reduction counseling	• Mammograms (screening)
• Cervical, vaginal, and colorectal cancer screening	• Nutrition services for patients with diabetes or renal disease
• Depression screening	• Obesity screening/counseling
• Diabetes screening and self-management training	• One-time "Welcome to Medicare" preventive visit
• Glaucoma tests for high risk patients	• Prostate cancer screening
• HIV and hepatitis C screening	• Sexually transmitted infection screening and counseling
	• Tobacco cessation counseling
	• Yearly "Wellness" visit

Source: https://www.medicare.gov/coverage/preventive-screening-services

ADVANTAGE PLANS - PART C

Medicare Advantage Plans are health insurance plans offered by private companies that contract with Medicare. They provide all Part A and B services except hospice care, which is still covered by Medicare at no cost to the patient. Monthly premiums, which vary by plan and coverage, are less costly than for original Medicare and are typically deducted from the enrollee's monthly Social Security check.

A key difference between original Medicare and Advantage plans is where and from whom services can be obtained. With original Medicare, enrollees can receive services nationwide from any provider or institution that accepts Medicare payment. With Advantage Plans, care must be obtained through designated insurance plan networks such as preferred provider organizations (PPOs), health maintenance organizations (HMOs), or others.

Depending on the specific Advantage plan, in-network care may be free or require a modest copay. Some plans require referrals from a primary care clinician before specialist services will be covered. Out-of-network care, other than emergency care, is typically not covered.

Another difference between original Medicare and Medicare Advantage plans is that some Advantage plans cover hearing aids, dental care, and vision care (refraction and eyeglasses), even though these services are not covered by original Medicare.

DRUG COVERAGE PLANS - PART D

Medicare Part D covers prescription drugs, for which individuals enrolled in original Medicare pay a monthly premium that varies by state and plan, plus an additional income-dependent fee that can range from $0-77 per month. With Medicare Advantage plans, drug coverage is often included as part of the plan (with or without an extra monthly premium), in which case Part D is not needed.

Available drugs are determined by a formulary that can vary between plans. The zoster vaccine, in contrast to other immunizations, is covered under Part D.

A copay is required when obtaining medications through Part D. It varies depending on the medication's tier rating. Copays for Tier-1 (basic) drugs can be as low as a few dollars per prescription, while copays for Tier 4-5 (specialty) drugs can be hundreds or thousands of dollars.

Part D currently has a coverage gap, referred to as the "donut hole." In 2019 enrollees have a copay until the total actual cost of medications exceeds $3,820. Then the gap begins and enrollees pay much of the real cost of the drug. When this out-of-pocket spending exceeds $5,100, Medicare resumes payment with patients responsible only for a small copay. The donut hole concept will be phased out by 2020, but patients will still be responsible for paying up to 25% of the retail price of their medications.

References and Resources

What Does Medicare Part A Cover? http://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html

What Does Medicare Part B Cover? https://www.medicare.gov/what-medicare-covers/what-part-b-covers

Medicare Advantage Plans : https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans

Medicare Part D: Costs in the Coverage Gap https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap

Medicare Hospice and Respite Care: https://www.medicare.gov/coverage/hospice-and-respite-care.html

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