Medicare and FEHB

Before we start…..

Let's see how much you know!

Do you know…….?

Q: When was Medicare created? Who was the President of the United States at that time?

Do you know……?

A: Medicare started in 1966.

Effective 1/1/83, Federal employees were required to pay Medicare taxes as part of the move to get all Federal employees under social security.

The president was Lyndon Baines Johnson (1963-1969)

Do you know……?

True or False: Medicare covers long term care in a nursing home?

Do you know…….?

False - Medicare does not pay for long term care in a nursing home. Medicare covers your care in a *skilled nursing facility* for the first 20 days. From the 21st through the 100th day you pay up to $101.50 per day. You're responsible for the cost beyond the 100th day. Medicare does not cover custodial care in a nursing home.

Do you know…….?

Medicare Part B pays:

A. 100% of all services

B. 80% of all services

C. 100% of the Medicare-approved amount after a one time deductible

D. 100% of the Medicare-approved amount after an annual deductible

E. 80% of the Medicare-approved amount after an annual deductible

Do you know…..?

E You pay a deductible ($100 in 2001) once per calendar year. After that Medicare pays 80% of the Medicare-approved amount. You pay the 20% balance.

Do you know……..?

Q: What is Medicare + Choice?

Do you know…….?

A: Congress passed a law in 1997 which made many changes in the Medicare program. The law includes a section called Medicare + Choice which, starting in 1999,lets more private insurance companies offer coverage to people with Medicare.

What is Medicare?

A health insurance program for:

- people 65 years old and older
- certain younger people with disabilities
- people with End-Stage Renal Disease

Medicare is available to any one who is age 65 and

- is a US citizen living in the United States, or
- is a legally-admitted alien who has continuously resided in the United States for 5 years prior to filing an application.

The original Medicare plan is a traditional pay-per-visit arrangement. You can go to any doctor, hospital or other health care provider who accepts Medicare.

There are two parts to Medicare:

- Part A - Hospital Insurance
- Part B - Medical Insurance

Medicare Part A
Hospital Insurance

- Helps pay for :
  - care in hospitals
  - care in skilled nursing facilities
  - home health and hospice care
- Cost of Part A is free if you are receiving or are eligible to receive benefits from Social Security

Medicare - Part A

Federal employees are covered by premium-free Medicare Part A at age 65, if they:

- were employed on January 1, 1983 (P.L. 97-248), or
- have 10 years of Medicare-covered employment, or
- have a spouse who is eligible for Medicare Part A.

Medicare Part B Medical Insurance

Helps pay for

- doctors
- outpatient hospital care
- physical and occupational therapists
- lab tests

Medicare Part B Medical Insurance

- Is voluntary--you must choose to enroll

  You can sign up anytime during a 7-month period that begins 3 months before you turn 65

- Monthly premium - currently $54.00

  The premium can be higher if you do not enroll when it is first available to you

Medicare Part B Medical Insurance

- If you do not enroll during the 7-month period, you must wait until the next general enrollment period (1/1 to 3/31 each year)
- If you wait 12 or more months, premiums go up 10% for each 12 months you could have enrolled but did not
- $5.40/month penalty in 2001.

Part B Penalty
Example

John belonged to an HMO (not FEHB) when he became age 65. He declined Part B. Three years later, he moved and joined a FFS plan and enrolled in Part B during the 2001 general enrollment period. In 2001, he will pay a $15 per month penalty. $70.20 vs $54.00 per month.

Part B Penalty (continued)

Although he pays a $16.20/month penalty, John saved several hundred dollars over the 3-year period he was not enrolled in Part B.

The savings will pay the penalty for almost 10 years.

Remember, enrollment in Medicare is "elective," not mandatory.

Part B Premiums

Part B premiums can be withheld from social security payments (if eligible) or from civil service annuity benefits,

Or

Payments may be made quarterly to the Heath Care Financing Administration (HCFA).

What Does Medicare Cover?

Skilled Nursing Facility

Care in a skilled nursing facility (SNF) is covered if:

- You have Medicare Part A
- Qualifying hospital stay (at least 3 days)
- Doctor says you need skilled care
- You get services at a SNF approved by the Health Care Financing Administration (HCFA)
- You need skilled service for condition treated during qualifying hospital stay.

Most FEHB plans will not pay for care in a SNF. However, if you also have Blue Cross and Blue Shield under FEHB...

- Medicare pays for SNF - 20 days.
- Medicare & BCBS pay for SNF - days 21-30. Medicare pays days 31-100, but you pay $101.50 per day co-payment.
- If you have 60 days of SNF care, you pay $3,045.

Remember!

- SNF care is NOT custodial care.
- Medicare and BCBS pay for some, but not all SNF care.
- BCBS benefits end on the 30th day in the SNF.
- You are responsible for co-payment of $101.50 per day after the 30th day.

Medicare Home Health Care
What is it?

"Skilled nursing care and certain other health care services you get in your home for treatment of an illness or injury".

It can:

- be part-time or intermittent care
- include home health aids who support treatment/work by licensed nurses

Home Health Care

Also provides for:

- physical therapy
- speech language pathology services, and occupational therapy as long as a doctor requires them
- counseling for social or emotional concerns over illness or injury
- some medical supplies

Home Health Care

Occupational therapy helps a person become able to perform usual daily activities by him/herself. New ways to feed, clean, groom, and do other usual daily activities. OT can continue even when other skilled care is no longer needed.

Medical equipment is available, too.

How do I qualify for Home Health Care?

1. Your doctor decides you need home health care and designs a specific home health care plan for you.
2. You must need at least 1 of these intermittent services:
   - skilled nursing care,
   - PT,
   - speech pathology, or
   - occupational therapy

How do I qualify?

3. You must be "home bound," i.e., unable to leave due to illness of injury,
4. The home health care agency must be an agency approved by the HCFA

All four of these conditions must be met.

Home Heath Care No Way, Man!!!

The following are NOT covered services:

- 24-hour per day home care;
- prescription drugs;
- meals delivered to the home;
- homemaker services, e.g., shopping;
- personal care by home health aids when this is the only care needed.

Medicare and Diabetes

Medicare now provides coverage under Part B for diabetic supplies:

- glucose monitors,
- test strips,
- lancets,

IF you have diabetes (insulin treated and non-insulin treated), you (or FEHB) pay 20% co-payment.

How?

1. Need doctor's prescription.
2. Go to pharmacy,clinic pharmacy, or medical equipment supplier.
3. Do not accept supplies that you have not ordered - Medicare will only pay if you ordered the diabetic supplies. Also, you should never pay for supplies you did not order.

How Does Medicare Work?

What do you pay in the original Medicare Plan?

First,

you pay an amount for your health care each year (deductible) before Medicare pays its part.

Then,

Medicare pays its share and you pay your share (coinsurance)

What are Medicare Participants?

Doctors and suppliers who agree to accept Medicare "assignment" in all cases. This means that they accept Medicare's "approved" amount for the service or product provided. Payment of the amount due is shared by Medicare and FEHB.

Who is a Medicare Participant?

- Ask your doctor/supplier.
- Ask you Medicare carrier.
- Ask your Medicare carrier to send the *Medicare-Participating Directory*. There is also a directory for suppliers. *The Medicare-Participating Supplier Directory*.

What if my Doctor doesn't Participate?

- Some doctors don't accept assignment 100% of the time; they may except on case-by-case basis.
- If a doctor does not accept assignment, **you** are responsible for the bill. However the charges are limited for most covered services.

The Legal Limit

- Doctors can charge up to 115% of the Medicare-approved amount.
- This limit applies to certain services of suppliers, but not most.
- Doctors can be fined if they charge more.
- Medicare and FEHB FFS cover everything up to the 115% limit.

Assignment - how does it work?

Your charge:	$	300
Medicare-approved amount	-	250
Medicare deductible	+	100
Balance	$	150
Medicare pays (80%)	-	120
Balance		30
You owe ($100 + 20%)	$	130
FEHBB FFS pays up to	$	130

What if Assignment is not accepted

Amount charged	$	300
Medicare approved amount		250
115% limiting charge		288
Medicare annual deductible	-	100
Balance	$	188
Medicare pays (75%)		112
Balance		76
You owe ($100 + up to limiting charge)	$	176
FEHB pays (Ded. + up to limiting charge)	$	176

Private Contracts

- If your doctor asks you to sign a "private contract," you agree to be responsible for the total charge.
- Medicare will not pay anything.
- FEHB plan will not pay anymore than they would have paid if Medicare had made payment.
- You pay the rest.

Example: Private Contract

Private contract charge	$ 1000
Medicare-approved amount	475
Annual Medicare deductible	100
Balance	$ 375
Medicare pays	0
You owe	$ 1000
FEHB pays (20% + $100)	175
Balance	825
You pay	$ 825

Medicare Suppliers

Generally, no limiting charge.

Supplier charges	$ 600
Medicare-approved amount	425
Medicare pays (80%)	340
You pay	$ 260

FEHB plan will pay up to its allowance based on status of supplier. (E.g., PPO, non-PPO, etc.)

To help cover the costs Medicare does not cover, you can:

- keep or get employer health coverage
- check to see if you qualify for State assistance
- buy a Medigap Policy

Medigap Policies

What is a Medicare "Gap"?

Services or items that are not covered and thus not paid for by Medicare. For example,

- $812 for any hospitalization from 1 to 60 days;
- $203 per day for any hospitalization of 61-90 days.
- $406 per day for hospitalizations of 91-150 days;

"Medicare Gaps"

- $101.50 per day for skilled nursing facility care after 20 days and up to 100 days;
- the cost of the first 3 pints of blood you use;
- Part B annual deductible = $100;
- all prescription drug costs because Medicare generally does not cover prescription drugs.

"Medicare Gaps"

Medicare Part B gaps are -

- the 20% coinsurance on the Medicare-approved amount;
- up to the 115% limiting charge;
- outpatient mental health treatment; you pay coinsurance of 50%

FEHB Fills Most of the Gaps!!!!

FEHB fee-for-service plans fill the gaps in Medicare for services covered by the FEHB plans, with the exception of Skilled Nursing Facility care. BC/BS pays for SNF care from day 21 to day 30. Most plans do not pay SNF benefits.

Gaps Closed + Waivers

In addition to filling most of the gaps, FEHB FFS plans waive most of their deductibles, coinsurance and co-payments for their Medicare-eligible enrollees with one exception -

PRESCRIPTION DRUGS

Some plans reduce the co-payments.

$ $ $ $ $

You may also save money by joining one of the other Medicare health plans

- managed care plans
- private fee-for-service plan

This is known as Medicare + Choice

Medicare + Choice

Medicare + Choice

Medicare also provides services through Medicare Managed Care Plans (MMCP), or a Private Fee-for-Service plan.

Also known as:

- Medicare Coordinated Care Plans (MCCP), or
- Medicare Part C

Sometimes, coverage is offered in conjunction with FEHB HMO plans.

Medicare Managed Care Plan
What is it?

- A health plan offered by private insurance companies; sometimes called an HMO
- You still get regular Medicare-covered services; you often get extra benefits, such as prescription drugs
- You pay the monthly Medicare Part B premium; you may also pay an additional premium.

Private Fee-for-Service Plan
What is it?

- Provides health care coverage to people with Medicare Parts A & B
- Offered by a private insurance company rather than the Federal government
- You can go to any doctor or hospital that accepts the plan's payment
- You may be able to get extra benefits

How do I join a Medicare + Choice Plan?

- Medicare health plans must accept new members in November. Coverage begins January 1 of following year
- Most plans also accept new members at other times of year.

What if I want to leave the plan?

You may leave at any time for any reason

Medicare + Choice FEHB Enrollees

- FEHB enrollees can cancel FEHB coverage to enroll in MMCPs.
- If lose coverage under Medicare MMCP *involuntarily*, can reenroll immediately
- If lose coverage under Medicare MMCP *voluntarily*, must wait until next open season to reenroll

Medicare + Choice

If you re-enroll in an FEHB FFS plan, you also return to Original Medicare.

Medicare + Choice

IMPORTANT

When you re-enroll in FEHB, you must also affirmatively dis-enroll from the MMCP (either through the MMCP or social security).

If you do not, you will NOT return to Original Medicare.

Medicare + Choice

- If you do not return to Original Medicare because you fail to timely dis-enroll from MMCP, you can only get Medicare coverage from the MMCP.
- FEHB FFS plans will only pay their supplemental amounts since Medicare is primary.

Medicare + Choice

If you move from the MMCP service area and do not affirmatively dis-enroll, you will pay for the lion's share of your medical services, until the Original Medicare coverage "kicks back in."

FEHB enroll PLUS MMCP dis-enroll

Medicare + Choice

- As of June 1, 2001, MMCP dis-enrollments are effective at the end of the month in which the MMCP or Social Security receives the dis-enrollment document.
- Under the old "10th of the month rule," dis-enrollments received after the 10th were effective the end of the following month.

Medicare + Choice

Delayed dis-enrollment dates proved to be costly to many former MMCP enrollees who did not get their dis-enrollment requests in by the 10th, or did not file dis-enrollments because they thought FEHB re-enrollment took care of everything. $$$ in the drain!

Medicare and FEHB

Everyone who is eligible for premium-free Medicare Part A should take it.

But...

what about Part B?

Do you need Part B if you are enrolled in an FEHB fee-for-service plan or an HMO plan ?

FEHB Fee-for-Service Plans

If you belong to a FFS plan, Medicare Part B is a good choice.

- Medicare Part B and FFS plans combine to provide almost complete coverage for all medical expenses.
- FFS plans also may pay for expenses not covered by Medicare.

EXCEPTION: prescription drugs.

Prescription Drugs

- Medicare generally does not cover prescription drugs.
- Before 2000, FEHB FFS plans waived prescription drug deductibles and co-payments for Medicare eligible enrollees.
- Due to high costs of drugs, FFS plans stopped waivers in 2000-2001.

Medicare & FEHB

- Even with co-payments, FEHB provides cost-effective prescription coverage for Medicare-eligible enrollees.
- Drugs prolong life and enhance the quality of life for older people.
- Technology makes more drugs and more costly drugs available.

HMO Plans

HMO enrollees may not need Medicare Part B.

- HMOs provide most medical services for small co-payments.
- HMO enrollees may not recover the cost of Part B expenses in terms of benefits received.

HMOs

However, if you belong to an HMO, Part B would pay for:

- costs involved with seeing outside doctors.
- Costs in the U.S. if you travel a lot. Your HMO will not pay for non-emergency medical services (except where it has reciprocity). Medicare pays everywhere in the U.S.

Primary Payer
FEHB or Medicare?

- Insurance benefits payments are coordinated among insurance carriers, including Medicare.
- Medicare laws and regulations determine who pays primary and who pays secondary in any particular case.
- In no case do Medicare and FEHB BOTH pay their maximums.

Medicare & FEHB Primary Payer Chart

You or spouse has Medicare and FEHB and you are:	The Primary Payer is:
An active employee	FEHB
An annuitant	Medicare
A reemployed annuitant	FEHB
Enrolled in Part B only	Medicare, for Part B services; FEHB for other services
Receiving Workers' Compensation	Medicare

Medicare-FEHB-TRICARE

- October 1, 2001 - effective date for "TRICARE for Life".
- Covers retired military and retired reserves.
- TRICARE for Life - free except for small co-payments for prescription drugs.

Medicare-TRICARE Who is pays first?

To join TRICARE, you must enroll in Medicare Part B.

- Medicare will be the primary payer for TRICARE for Life enrollees.
- TRICARE is secondary

Medicare-FEHB-TRICARE

If a military retiree has TRICARE for Life and is enrolled in FEHB, the FEHB is the secondary payer after Medicare and TRICARE for Life is the tertiary payer.

Both FEHB and TRICARE for Life supplement Medicare, but FEHB requires premiums.

Should you cancel FEHB for TRICARE for Life?

Medicare-FEHB-TRICARE for Life

- It is expected that most military retirees will want to cancel FEHB in favor of TRICARE for Life.
- Spouse/dependent issues are a factor.
- Concerns about TRICARE for Life funding.
- Many "don't trust the Government."

Cancel FEHB?

- Usually, FEHB cancellation is forever.
  - Exception: cancellation to join MMCPs.
- On 9/26/2001, OPM published a new regulation to allow FEHB cancellation to join TRICARE for Life & later re-enrollment in FEHB.

What if???

Q: What if the military retiree's spouse is not age 65?

Should you continue FEHB coverage for the spouse until she is 65?

A: You can cancel FEHB (after OPM issues the regs); sign spouse up for TRICARE Prime, TRICARE Standard, etc. Choose whatever works best for you.

Premium Conversion

- Premium conversion became an option for Federal employees on 10/1/2000.
- Retirees are excluded from by the Internal Revenue Code.
- Some Medicare-eligible retirees have employee spouses, with each carrying their own self-only FEHB enrollment.

Premium Conversion

- The savings in PC participation was estimated at over $400 per year.
- The employee/annuitant couples went to family FEHB in the employee's name to maximize the benefit of PC.
- What happened next?

FEHB = Primary Insurer

Since enrollment is in the employee's name, FEHB became primary payer for the retired Medicare-eligible spouse.

FEHB FFS plans stopped waivers of deductibles, coinsurance, and co-payments.

Some enrollees complained they lost **$$$** due to the change.

What to do??!!??

- IRS rules on pulling out of PC are very strict.
- Enrollees cannot change from family to self-only at any time.
- Enrollees must wait until:
  - FEHB Open Season
  - Life Event (60-day time limit)

Resources

- OPM's FEHB web site www.opm.gov/insure/health
- Medicare web site www.medicare.gov
- FEHB plan brochure

Resources

- Medicare publications are available in English and Spanish. Some are available in Chinese.
- Call 1-800-MEDICARE for copies.
- Available on-line at www.medicare.gov.

Resources

Medicare publications:

- cover a variety of issues.
- provide phone numbers in each state where people can call for help in getting or understanding information.

Summary listing of some but not all of the Medicare publications that are available.