What is Medicare?

Medicare is a federally funded program which provides health and hospital insurance benefits. Generally people can receive Medicare if:

- They are 65 years or older.
- They receive Social Security Disability
- They suffer from end stage renal disease.
- They are diagnosed with ALS. ALS is also known as Lou Gehrig ’s disease.
- Recipients of Railroad Retirement benefits.

Unlike Medicaid, receiving Medicare is not based on an individual’s income or assets.

What types of Medicare are there?

There are four types, also called parts, of Medicare. Each part does something different and has been given a letter to separate it from the others. The four parts are Part A, Part B, Part C, and Part D.

Below is an explanation of what each of them does:

Part A provides hospital insurance benefits. This includes inpatient hospital care, inpatient nursing home services, home health services, and hospice care.

Part B provides medical insurance benefits. This includes services from physicians and other medical practitioners, outpatient hospital services, and durable medical equipment. It also includes physical, occupation, and speech therapy services.

Part C is what is known as the Medicare Advantage program. This program allows people that receive Medicare to voluntarily choose to enroll in a private health plan. You do not have to do this but some people may want to in case what they need isn’t covered by **their other insurance.** For those interested, you may be able to get traditional Medicare coverage, managed care plans, private fee-for-service, and medical savings accounts.

Again, just because you receive Medicare doesn’t mean you have to participate in Part C or the Medicare Advantage program. If you are satisfied with the coverage

you already have, you don’t have to get more coverage.

Part D provides Prescription Drug Coverage. People can get this through a stand-alone prescription drug plan or through the Medicare Advantage Plan.

Who is eligible for Medicare?

Generally, Medicare coverage is available to individuals who are 65 or older, as well as certain disabled individuals under 65, including disabled workers, disabled widows and widowers, childhood disability beneficiaries, and individuals suffering from end stage renal disease (terminal kidney disease), and those diagnosed with ALS. Recipients of Social Security Disability or Railroad Retirement Disability benefits qualify for Medicare coverage after they have been entitled to disability benefits for a period of 24 months.

Individuals who attain age 65 without at least 40 quarters of coverage under Social Security are not automatically eligible for Medicare. However, these individuals can voluntarily enroll in Medicare Part A by paying a monthly premium.

Part B coverage is available to beneficiaries who are eligible for Part A. Part B coverage is voluntary and requires the payment of a monthly premium. For people who do not enroll as soon as they are eligible and then later decided to enroll in Part B, there is a premium penalty. The penalty consists of an increase of 10 percent in the premium rate for each full year the beneficiary was out of the program. Waivers of this penalty are available to employees or spouses who continue coverage under an employer health insurance plan.

Part D coverage is available to beneficiaries who are eligible for Part A. If an individual does not enroll into Part D coverage when they are eligible, they will be assessed a penalty for late enrollment. This penalty lasts for the duration of enrollment. However, waivers can be submitted if you can show there was “creditable coverage” for prescription drugs through another provider. Additional, enrollment into Extra Help, or the Medicare Savings Program can eliminate this penalty.

Individuals who are entitled to Part A coverage and are enrolled in Part B coverage are eligible to enroll in a Medicare Advantage Plan.

Does Medicare provide coverage for nursing home care?

Yes, but only in limited situations. Medicare will provide coverage for up to one hundred days of care in a nursing home or a section of a hospital that qualifies as a skilled nursing facility. This coverage will only be provided if the beneficiary was hospitalized for at least three consecutive days prior to entry into the institution, and the beneficiary requires a skilled level of nursing care or skilled rehabilitation services on a daily basis. This coverage is limited to skilled nursing services. There is no Medicare coverage if the beneficiary requires only custodial care.

Are Medicare beneficiaries required to pay deductibles and coinsurance?

Yes. The Medicare deductible and coinsurance amounts are adjusted each year.

If you want to find out the amounts for 2015, click on this link: https://www.medicare.gov/Pubs/pdf/11579.pdf

If a Medicare denies coverage on a claim, can I appeal?

Yes. If Medicare denies coverage, the beneficiary is entitled to receive a letter that says what the decision was and why it was made. Generally you have sixty days from the date of the decision to make an appeal. There's also a regulation that adds another five days to allow for mailing time. So overall, you have 65 days from the date of the decision to appeal. Please note that the date of the decision means from when they made the decision and not the date that you received the decision in the mail.

If I appeal a denial, who does my appeal go to?

Where your appeal goes depends on who made the denial. Medicare Part A, Part B and Part C each have a different process because they are run by different organizations. Below is an explanation of the appeal process for Part A, Part B and Part C denials of coverage.

Medicare Part A claims are reviewed by the Social Security Administration. It goes through their claims process. If a claim is denied, the beneficiary has the right to request reconsideration. A reviewer of the same rank as the initial decision maker does the reconsideration, and the review is conducted with the same information. If the claim is again denied, and the claim involves $100 or more, the beneficiary has the right to request a hearing before an administrative law judge (ALJ). If the ALJ decision is unfavorable, it can be appealed to the Departmental Appeal Board of the Department of Health and Human Services. If that appeal is unsuccessful, and the claim involves $1,000 or more, the beneficiary can seek judicial review in federal district court.

Medicare Part B claims are submitted to private carriers, who determine those claims according to procedures established under the Medicare Act. The carrier then notifies the beneficiary of its determination. If the beneficiary is dissatisfied with the determination, he or she may request a review. A different employee of the carrier then reviews the initial determination on the claim.

If the beneficiary is still dissatisfied, and the claim involves $100 or more, the beneficiary can request a hearing. The hearing is conducted by a hearing officer designated by the carrier. The hearing may be conducted by telephone, in person, or by a simple review of the record. The hearing officer then issues a written decision. If the fair hearing decision is unfavorable, and the issue involves $500 or more, the beneficiary can then request a hearing before an ALJ. From that point on the appeals process follows the same process that is used for Part A claims.

There are two types of **Medicare Advantage** appeals. There are Pre-Service appeals and Post Service appeals. Appeals for Pre-Service are when a Medicare Advantage provider denies services PRIOR to treatment.

Appeals for Post Services are when a Medicare Advantage plan denies coverage AFTER treatment.

Here is a link that explains these processes in more detail:

http://www.medicareinteractive.org/page2.php?topic=counselor&page=section&toc_id=58

Generally it is a good idea to read all of the mail that you get from Medicare, your health care provider, and from your health insurance carrier. It can have important information regarding your appeal rights and the deadlines to make an appeal. If you do not appeal within the deadline, you may not be able to do it later.

Additional Information:

Official U.S. Government Site for Medicare information

AARP - Medicare checklist

National Senior Citizens Law Center

Medicare Rights Center - a national not-for-profit organization

National Counsel for Aging Care

Last Review Date: January 2016

Last updated on September 27, 2017.

Health

Print

Table of Contents

NEWS

News & publications

The news about recent activities for needed peoples.

More News

14 Jan 2025

When a Landlord Won't Make Repairs

Para ver este artículo en español por favor visite aquí. (To view this article…

Continue Reading

20 Dec 2024

Debt Collection Practices and Lawsuits

Para ver este artículo en español por favor visite aquí. (To view this article…

Continue Reading