Getting Started with Medicare
Advanced Medicare Training
Talking Points:

n4a is working with UnitedHealthcare to provide educational tools that Aging Network staff and volunteers can utilize to prepare for Medicare Open Enrollment.

A study of Medicare counselors was conducted by n4a and UnitedHealthcare to help identify information gaps in understanding Medicare and to help trainers identify which educational tools and resources are available, training session dynamics and unmet needs. As a result, this training was developed to help assist Medicare counselor staff and volunteers.
Talking Points:

At the end of this presentation, you’ll know how to:

1. Determine a person’s current Medicare coverage
2. Learn about Medicaid and the qualifications to get assistance
3. Educate about additional benefits that Medicare covers
4. Answer common Medicare Part D questions
5. Understand the filing, appeal and grievance process
Talking Points:

Now that we’ve gone through module 1 of the training to learn the basics of Medicare, we’re going to dig a little deeper.

Today we’ll talk about:
1. How an individual can determine what type of Medicare coverage they have
2. How does age and retirement affect a person’s Medicare choices?
3. What is the difference between Medicare and Medicaid?
4. How do I know if a consumer qualifies for assistance?
5. What are some additional benefits Medicare covers?
6. What are common Medicare Part D questions?
7. What is the process if someone needs to file an appeal and grievance?

Then we’ll open things up to go over any questions you may have.
QUESTION 1
How can an individual determine what type of Medicare coverage they have?

Talking Points:
How can an individual determine their Medicare coverage?
### How can an individual determine what type of Medicare coverage they have?

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<thead>
<tr>
<th>Original Medicare (Parts A &amp; B)</th>
<th>Original Medicare + Part D Plan</th>
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<tbody>
<tr>
<td>If an individual only uses their Medicare card issued by the federal government.</td>
<td>If an individual has a Medicare card plus a separate drug plan card. A discount card for drugs does not mean they have a Part D plan.</td>
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<td>If an individual uses their Medicare card along with a card for Medicare supplement insurance that helps pay some of the expenses that Medicare doesn’t.</td>
<td>If an individual has three cards that include a Medicare card, a Part D drug plan card as well as a Medicare Supplement card that covers expenses Medicare doesn’t cover.</td>
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**Talking Points:**

By reviewing a consumers cards you can help determine what type of coverage they have.

- First there’s Original Medicare, which is made up of Parts A & B. For this plan, an individual only uses their Medicare card issued by the federal government.

- Then there’s Original Medicare plus a Part D plan. For this kind of coverage, an individual has a Medicare card plus a separate drug plan card. A discount card for drugs does not mean they have a Part D plan.

- If an individual uses their Medicare card along with a card for Medicare supplement insurance that helps pay some of the expenses that Medicare doesn’t.

- If an individual uses their Medicare card along with a card for Medicare supplement insurance that helps pay some of the expenses that Medicare doesn’t. As well as a separate Part D drug plan card.
Talking Points:

There are two options for a Medicare Advantage (Part C) plan that has medical and Part D plans included. The first is when a member only uses a health plan card instead of their Medicare card from the federal government for medical and drug coverage.

The second option for a Medicare Advantage (Part C) plan that has medical and Part D plan coverage is when a member uses a health plan card for their medical coverage and a second health plan card for their drug coverage expenses.

It’s good to remind people to keep their Original Medicare cards in a safe place to prove coverage — even if they do not need them regularly.
Talking Points:

**True or False:** Once you enroll in Medicare, you must give up any other health care coverage you have.

**The correct answer is false. Here’s why:**

If you have employee, retiree or union health care coverage, check with your plan administrator to discuss the best arrangement for your situation. You may want to sign up for Medicare Part A regardless of having other coverage, since it’s usually premium free.

You can choose not to enroll in Medicare Part B when you’re first eligible to delay having to pay the Part B premium. If this is the case, you can sign up for Part B during the Special Enrollment Period (SEP) after your employer coverage ends. Your SEP is 63 days from the day you retire or lose your employer health insurance, whichever comes first.

It’s possible that your current plan complements what you’ll get with Medicare. In any case, you don’t need to give up your outside coverage once you enroll in Medicare.
**True or False:** Consumers can have a Medicare Advantage plan and a Medicare Supplement insurance plan.

**The correct answer is false.**
Consumers are not allowed to have both and cannot be sold a Medicare Advantage (Part C) plan along with a Medicare Supplement insurance plan. Although they are both offered by private insurance companies, a Medicare Advantage plan allows for consumers to have their care coordinated by the insurance company. A Medicare Supplement insurance plan works with Original Medicare (Parts A and B) and supplements the coverage that the consumer receives from the federal government.
Talking Points:

**True or False:** You can change your Medicare Advantage or prescription drug plan once a year during Medicare Open Enrollment, October 15 through December 7.

The correct answer is true. Here’s why:
You can change your plan without penalty during Medicare Open Enrollment each year, so it’s a good idea to review your coverage annually. In addition, you may switch from a Medicare Advantage plan back to Original Medicare during the Medicare Advantage Disenrollment Period from January 1 through February 14. You can change your Medicare supplement insurance plan at any time, if you qualify.
Talking Points:

How does age and retirement affect a person’s Medicare choices?

QUESTION 2

How does age and retirement affect a person’s Medicare choices?
Talking Points:

Medicare coverage options vary depending on whether people have reached 65 and whether they have retired or are still working.

**Retiring before 65:**
- Medicare: Persons younger than 65 are not eligible for Medicare unless they have a qualifying disability. Employees who retire before 65 will need to find other health care insurance.
- Retiree coverage: Some employers or unions may provide supplemental health care coverage as part of their retiree benefits.
- Individual health insurance: This is designed for individuals and families with members under 65. A variety of plans are available with different levels of coverage. Professional or alumni associations the retiree belongs to are often good sources for health insurance plans.
- COBRA: The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides workers with group health coverage for limited periods of time under certain circumstances, including job loss, a reduction in work hours and other life events.
- Health insurance exchanges are online marketplaces for individuals to shop for and compare health insurance options. These options might be available and may be less expensive than COBRA.

**Retiring at 65:**
- Medicare: Employees turning 65 can enroll in a Medicare plan.
- If a company offers health insurance to retirees, a Medicare plan may work with the employer-sponsored coverage. Make sure to review the company’s health plan to see if it requires retirees to enroll in Original Medicare (Parts A and B).
- If a company doesn’t offer health insurance to retirees, the consumer should consider enrolling in Medicare during their initial enrollment period.
- If someone does not sign up for Medicare during their initial enrollment period, they will have to pay a Late Enrollment Penalty.
- Once retirees enroll in Original Medicare, they may also want to see what plans are available to help cover
Talking Points:

**True or False:** When a person first enrolls in Medicare, it’s a good idea for them to speak with their current health plan benefits administrator to see how their coverage may work with Medicare.

The correct answer is true. Here’s why:
If the person has an employee, retiree or union health insurance plan, it may provide everything they’ll need for the long term, or it may help to pay for some of the things Medicare doesn’t cover. Have them talk to their plan administrator about their choices. They may still want to enroll in Original Medicare (Parts A and B) because they’ll need it if they want a Medicare Part D prescription drug plan or a Medicare Advantage (Part C) plan, and they may pay a penalty if they delay signing up.
Talking Points:

Medicare coverage options vary depending on whether people have reached 65 and whether they have retired or are still working.

**Continuing to work after 65:**
- Medicare: Many people who choose to work past 65 enroll in only Medicare Part A because there is no monthly premium.
- Others choose to enroll in both Medicare Parts A and B (Original Medicare). However, Medicare Part B comes with a monthly premium based on a person’s income; for that reason, many don’t enroll in Part B until they lose their employer sponsored coverage.
- If a company offers health insurance, a Medicare plan may work with their employer sponsored coverage. People can review their company’s health plan to see if it makes sense to enroll in Original Medicare (Parts A and B) in addition to what their employer sponsored coverage provides.
- Employees 65 and older should be sure to keep their health insurance coverage records so they can prove they had creditable coverage past their initial enrollment period for Medicare.

**Retiring after 65:**
- Medicare: When employees have worked past 65 and then choose to retire, they are eligible for a Special Enrollment Period (SEP).
- The SEP gives individuals 8 months after their employer sponsored coverage ends to enroll in Original Medicare (Parts A and/or B) without penalty.
- It is best to sign up before they retire to avoid a lapse in coverage. During the SEP, individuals can enroll in a Medicare Advantage plan (Part C), or a prescription drug plan (Part D) or a Medicare supplement insurance plan as long as they have already enrolled in Original Medicare (Parts A and B) first.
Talking Points:

Now, we’re going to talk about the differences between Medicare and Medicaid.
Talking Points:

The words “Medicare” and “Medicaid” are so much alike that it’s easy to get them confused. To add to the confusion, both are government programs and both help people pay for health care. But that’s where the similarities end.

Medicare and Medicaid are two completely different programs. The main difference is that Medicare is generally for people who are older or disabled, and Medicaid is for people with limited income and resources.

Medicaid is the most talked-about assistance program, but there are others. Medicaid helps pay costs not covered by Medicare, like premiums and cost sharing, and it may include some additional benefits that Medicare doesn’t cover, such as prescription drugs, eye care or long-term care. Medicaid is jointly funded by the federal and state governments and managed by the states.

It’s possible for a person to be eligible for both Medicare and Medicaid.
Talking Points:

A person is eligible for a Dual Special Needs Plan (DSNP) if they are enrolled in Original Medicare Parts A and B and receive state Medicaid benefits.

- 65 or older
- DSNP enrollment is not limited to a specific time; consumer can enroll year-round
- Based on the individual’s needs, he/she may qualify for Low Income Subsidy (LIS) assistance
Talking Points:

There are many assistance programs available for those who need help. Let’s go over how to know if a consumer qualifies for assistance.
Talking Points:

Help is available for people with low incomes and few assets. If they qualify, they can get help with the costs that Medicare doesn’t cover. If a consumer thinks they might qualify, they should apply.

Based on their income and resource levels, consumers can get financial assistance through programs like the Medicare Savings Program. This program helps people pay their Part A and/or Part B premiums, deductibles and co-insurance amounts.

The Program of All-Inclusive Care for the Elderly (PACE) combines medical, social and long-term care services for the frail elderly who live in and get their health care services in the community, not in a nursing home. This joint Medicare and Medicaid program is not yet available in all states.

There are prescription drug premium assistance programs that help people pay some or all of their Medicare Part D premiums and cost sharing. Programs may include the Extra Help or low-income subsidy program offered by the federal government.

There may be additional programs available in each state.
Talking Points:

Consumers can get help from their state for paying their Medicare premiums. In some cases, Medicare Savings Programs may help pay Medicare Part A and Part B deductibles, co-insurance and co-payments if they meet certain criteria.

Who’s eligible? Eligibility for all of these programs depends on a person’s income. The government also looks at people’s assets. States set their own income eligibility levels, but the average is close to $17,820 per year for an individual, or $24,030 for a married couple. Limits are slightly higher in Alaska and Hawaii.

To be eligible, consumers must have low assets, which include resources and income available to them.

Resources that count toward assets:
- Funds in a checking or savings account
- Stocks
- Bonds

Resources that do NOT count toward assets:
- Their home
- A car
- Furniture and other household and personal items
- Burial plot
- Up to $1,500 in burial expenses
- Collectibles

Note: All numbers are from 2016.
*https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html
Talking Points:

Most states offer Medicare Savings Programs that help pay Parts A and B premiums, deductibles, co-pays and co-insurance. There are four different kinds of programs:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualified Individual (QI)
- Qualified Disabled and Working Individual (QDWI)

Disclaimer: These numbers are from 2016.
How do I know if a consumer qualifies for assistance programs?

Qualified Medicare Beneficiary (QMB)

QMB Only Requirements:
• Income and resources are within limits listed in chart
• Does not qualify for any additional Medicaid benefits

QMB Plus Requirements:
• Income and resources are within limits listed in chart
• Qualifies for additional Medicaid benefits

QMB Only pays for: Medicare premiums, deductibles, co-pays and co-insurance (not including Part D)

QMB Plus pays for: Medicare premiums, deductibles, co-pays and co-insurance as well as benefits under the State Medicaid plan (not including Part D)

Talking Points:

Qualified Medicare Beneficiary (QMB)

QMB Only Requirements:
• Income and resources are within limits
• Does not qualify for any additional Medicaid benefits

QMB Plus Requirements:
• Income and resources are within limits
• Qualifies for additional Medicaid benefits

QMB Only: Pays for Medicare premiums, deductibles, co-pays and co-insurance (not including Part D).
QMB Plus: Pays for Medicare premiums, deductibles, co-pays and co-insurance as well as benefits under the State Medicaid plan (not including Part D).

Income limits
$1,010/$1,355

Resources
$7,280/$10,930

Note: All numbers are from 2016.
Talking Points:

**Specified Low-Income Medicare Beneficiary (SLMB)**

**SLMB Only Requirements:**
- Income and resources are within limits listed in chart
- Does not qualify for any additional Medicaid benefits

**SLMB Plus Requirements:**
- Income and resources are within limits listed in chart
- Qualifies for full Medicaid benefits

**SLMB Only pays for:** Medicare Part B premium

**SLMB Plus pays for:** Medicare Part B premium and qualifies for full Medicaid benefits

Income limits
$1,208/$1,622

Resources
$7,280/$10,930

Note: All numbers are from 2016.
How do I know if a consumer qualifies for assistance programs?

Qualified Individual (QI)

Requirements:
• Income and resources are within limits listed in chart

QI Pays for: Medicare Part B premium.

Talking Points:

Qualified Individual (QI) Requirements:
• Income and resources are within limits

QI: Pays for Medicare Part B premium.

income limits
$1,357/$1,823

resources
$7,280/$10,930

Note: All numbers are from 2016.
How do I know if a consumer qualifies for assistance programs?

Qualified Disabled and Working Individual (QDWI)

Requirements:
- Income and resources are within limits listed in chart

QI Helps pay for: Medicare Part A premium for certain working disabled Medicare beneficiaries who have exhausted their entitlement to a premium-free Part A benefit.

Talking Points:

Qualified Disabled and Working Individual (QDWI)

Requirements:
- Income and resources are within limits

QDWI: Helps pay Medicare Part A premium for certain working disabled Medicare beneficiaries who have exhausted their entitlement to a premium-free Part A benefit.

- Income limits: $4,045/$5,425
- Resources: $4,000/$6,000

Note: All numbers are from 2016.
Talking Points:
Extra Help or Low Income Subsidy (LIS)
Helps pay for some or all of a person’s Medicare Part D premiums, deductibles and co-pays or co-insurance.

**Full Subsidy Requirements:**
- Individual / couple monthly income $1,357/$1,823
- Individual / couple resources $8,780/$13,930

**Partial Subsidy Requirements:**
- Individual / couple monthly income $1,505/$2,023
- Individual / couple resources $13,640/$27,250

*Note: All numbers are from 2016.*
Talking Points:

**True or False:** Extra Help or Low Income Subsidy (LIS) helps pay for some or all of a person’s Medicare Part B premiums, deductibles and co-pays or co-insurance.

The correct answer is false. Here's why:
Based on their income and resource levels, consumers can get financial assistance through programs like the Medicare Savings Program, which helps people pay their Part A and Part B premiums, deductibles and co-insurance amounts.

Extra Help or Low Income Subsidy (LIS) helps pay for some or all of a person’s Medicare Part D (prescription drug) premiums, deductibles and co-pays or co-insurance. Help is available for people with low incomes and few assets. If they qualify, they can get help with most of the costs that Medicare doesn't cover. If a consumer thinks they might qualify, they should apply.
How do I know if a consumer qualifies for assistance programs?

Other Full Benefit Dual Eligible (FBDE):

Requirements:
- Meet State Medicaid/MSP financial eligibility
- Eligible for Medicaid either categorically or through optional coverage groups based on medically needy status, special income levels for institutionalized individuals or home and community-based waiver.

States set their own income eligibility levels.

FBDE may cover: The Part B premium, deductibles, co-pays and co-insurance (varies by state) and qualifies for full Medicaid benefits.

Talking Points:

Requirements:
- Eligible for Medicaid either categorically or through optional coverage groups based on medically needy status, special income levels for institutionalized individuals or home and community-based waiver.
- States set their own income eligibility levels. Consumers must meet their State Medicaid/MSP financial eligibility.

FBDE: May cover the Part B premium, deductibles, co-pays and co-insurance (varies by state) and qualifies for full Medicaid benefits.

Note: All numbers are from 2016.
How do I know if a consumer qualifies for assistance programs?

Program of All-Inclusive Care for the Elderly (PACE)

PACE combines: Medical, social and long-term care services for frail elderly people who live in the community, not a nursing home.

States set their own income eligibility levels.

Talking Points:

PACE: Combines medical, social and long-term care services for frail elderly people who live in the community, not a nursing home.

Program of All-Inclusive Care for the Elderly (PACE)

Note: Not available in all states.

All numbers are from 2016.
QUESTION 5
What are some additional benefits that Medicare covers?

Talking Points:
What are some of the other benefits that Medicare covers?
Talking Points:

**Durable Medical Equipment**
Medicare Part B covers doctor prescribed durable medical equipment for use at home, including:
- Braces (arm, leg, back and neck)
- Crutches
- Oxygen supplies and therapy
- Some diabetic supplies
- Therapeutic shoes or inserts
- Walkers
- Wheelchairs
- And more

*Note:* Consumers will be responsible for the 20% co-insurance of the Medicare-approved amount.

In order to qualify, medical equipment must be:
- Used for a medical reason
- Used in their home
- Durable (or long-lasting)
- Not useful for someone who isn’t sick or injured

The doctor or supplier needs to be enrolled in Medicare and accept the assignment.

For example, oxygen is covered by Medicare. Your doctor or supplier must be enrolled in Medicare and accept the assignment in order for you to qualify for using oxygen. Most consumers rent their equipment from the supplier and Medicare pays the supplier a monthly fee for the oxygen and equipment. Consumers are still responsible for the 20% co-insurance.

Some Diabetic Testing Supplies are covered under Medicare Part B, including blood sugar test strips and monitor. Diabetic Testing Supplies can be purchased through Medicare’s National Mail-Order Program. Testing supplies are sent right to the consumer’s home or they can go to a local pharmacy and purchase them directly. Consumers are just responsible for 20% of the Medicare-approved amount.
Talking Points:

**Ambulance**
Ambulance costs are covered under Part B when emergency transportation is needed to a hospital, critical access hospital or skilled nursing facility.

Consumers are responsible for paying the 20% co-insurance.

**Dental, Optical and Hearing** is not covered under Original Medicare (Parts A and B).
- In Part A and Part B, skilled nursing care and therapy, such as speech therapy or physical therapy is provided to the homebound on a part-time or intermittent basis.
- For services that aren’t covered, consumers need to seek separate insurance from an insurance company.
QUESTION 6
What are common questions about Medicare Part D?

Talking Points:

What are common questions about Medicare Part D?
Talking Points:

What vaccines does Medicare cover?

- Flu: Part B covers a shot once per flu season in the fall and winter.
- Shingles: Not covered under Parts A or B, but generally covered under Part D.
- Pneumonia: Part B covers a shot once.
- Hepatitis B: Covered by Part B.
- Diphtheria, tetanus and whooping cough: Covered by Part B.

What drugs are covered under Part B versus Part D?

- Part B covers some prescription drugs.
- Examples include:
  - Infused drugs
  - Antigens
  - Osteoporosis drugs
  - Erythropoisis stimulating agents
  - Blood clotting factors
  - Injectable drugs
  - Oral ESRD
  - Immunosuppressive drugs
  - Oral anti-cancer and anti-nausea drugs
  - Self-administered drugs in outpatient settings.

How is the coverage gap changing?

- Patient Protection and Affordable Care Act (PPACA) is gradually reducing the coverage gap.
- More than 1 million seniors and people with disabilities saved $887 million on prescription drugs in the donut hole.
- It is expected that discounts will increase each year until the coverage gap closes (Projected for 2020).
Talking Points:

**True or False:** Medicare Part B covers flu, diphtheria, tetanus and whooping cough vaccines.

**The correct answer is true. Here's why:**
Medicare Part B covers a flu shot once per flu season in the fall and winter, one pneumonia shot, and vaccines for hepatitis B diphtheria, tetanus and whooping cough. The shingles vaccine is not covered under Parts A or B, but is generally covered under Part D.
Talking Points:

Once a person is on a Part D plan, but one of their drugs isn’t covered, the member has options:

**Change to another drug** – Member should talk to their doctor and/or pharmacist to see if another drug on the formulary will work.

**Transition Supply** – Member may be able to request a temporary supply of the drug. Under certain circumstances if, for instance, the plan can offer a temporary supply if the drug is no longer on the formulary or when it is restricted in some way.

**Step Therapy** – Requirement to try one or more similar drugs before the plan covers a medication. If one of the alternatives doesn’t work, member may request an exception.

**Prior Authorization** – Approval from the health plan before the specific drug will be covered. Member must call the health plan to obtain prior authorization and provide a statement from the doctor to support request.

**Exception** – Member and doctor can ask the plan for an exception. Plan could cover drug not on a formulary or a drug without restrictions.
Talking Points:

Now we'll go over the appeal and grievance process.
Talking Points:

**What’s an appeal?**
An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan.

It is important for Medicare beneficiaries to understand their formal right to complain, or appeal, about their treatment in certain situations. For example, they have the right to appeal when their prescription drug plan doesn’t cover a drug that they and their doctor think they should have. As another example, they have the right to question the amount that Medicare paid for a service they received.

Appeal forms can be on Medicare.gov as well as the Five Tips from Medicare on filing an Appeal.

1. If a person decides to file an appeal, they must ask their doctor, health care provider, or supplier for any information that may help their case.
2. If the person thinks their health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. If the plan or doctor agrees, the plan must make a decision within 72 hours.
3. The plan must tell the person, in writing, how to appeal. After the appeal is filed, the plan will review its decision. If the plan doesn’t decide in the beneficiary’s favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan.
4. If the person believes they’re being discharged from a hospital too soon, they have a right to immediate review by the Quality Improvement Organization in their area. They’ll be able to stay in the hospital at no charge while their case is reviewed. The hospital can’t force them to leave before the Quality Improvement Organization reaches a decision.
5. A person has the right to a fast-track appeals process when they disagree with a decision that they no longer need services they’re getting from a skilled nursing facility, home health agency, or a comprehensive outpatient rehabilitation facility.

What is the difference between hospital inpatient status and observation status?

**Hospital Inpatient Status:**
When a patient is formally admitted to a hospital with a doctor’s order
- Covered under Medicare Part A and B

**Hospital Observation Status:**
When doctors don’t know what care a patient may need but the patient is too sick to get care in the doctor’s office
- Covered under Medicare Part B
- Viewed as outpatient care

Talking Points:

Hospitals assign patients to either inpatient status or observation status.

**Inpatient Status:**
Physicians and hospitals follow a specific set of clinical criteria (severity of illness and intensity of service needed to diagnose and treat) that assists in determining whether a patient meets medical necessity for an “inpatient” status in the hospital.

Medicare Part A (hospital insurance) covers inpatient hospital services. Generally, this means you pay a one-time deductible for all of your hospital services for the first 60 days you’re in the hospital. If you are hospitalized again after 60 days Medicare may apply another deductible. Medicare Part B (medical insurance) covers most of your physician services when you’re an “inpatient.” You pay 20% of the Medicare-approved amount for physician services after paying the annual Part B deductible.

**Observation Status:**
Patients may be assigned observation status when doctors aren’t sure how sick they are or what care they may need—but they are too sick to get care in the doctor’s office.

As an example, let’s say a patient is having chest pain and goes to the hospital emergency room. Doctors there aren’t sure whether the patient is having a heart attack or not. They decide to keep the patient in the hospital on observation status for monitoring. The patient stays in a hospital room for two nights, is attached to a heart monitor and has blood drawn for tests every few hours. The chest pain subsides and the patient’s condition stabilizes. Tests reveal that he or she is not having a heart attack, and the patient is discharged from the hospital and sent home.

In this example, the patient was on observation status for the entire stay.

When patients are in the hospital on observation status, they may pay more than they would as an inpatient for the same care. In addition, any necessary follow-up care in a skilled nursing facility may not be covered by Medicare at all.

Care received while on observation status in the hospital is covered under Medicare Part B (medical insurance).
Talking Points:

Medicare or any other health plan is called a “payer.” A payer is the party responsible for paying health care bills. When consumers are covered by more than one payer, there are rules that direct which payer pays first. The one that pays first is the primary payer. Consumers’ primary payer pays their medical bills up to the amount allowed by their coverage. If more is still owed, then the remaining amounts go to their secondary payer for payment. It’s important to know the difference because it can impact how much is paid out of pocket for benefits and services.

Medicare is the primary payer if:

• The consumer is at least 65 years old, is still working, and is covered by a group health plan through an employer with less than 20 employees.
• The consumer is at least 65 and covered by a retiree health plan through a former employer (of any size).

As the primary payer, Medicare will pay for any Medicare-covered benefits before the employer sponsored coverage contributes. It’s important to understand that even after the primary and secondary payer make payment on your bill, there may still be an outstanding balance due. How much they will pay depends on what’s covered by the plan and what costs Medicare is responsible for covering.
Talking Points:

The federal government has 10 different Medicare supplement plans, named with letters from “A” to “N.” (These letters have no relationship to the Medicare Part A, B, C and D designations.) The different types vary in which gaps in coverage they fill.

To keep it simple, all policies with the same letter offer the same benefits. This chart shows standard benefits for each plan type. Not all plans are available in all states. The plans in Massachusetts, Minnesota and Wisconsin differ from those shown.
Talking Points:

The federal government has 10 different Medicare supplement plans, named with letters from “A” to “N.” (These letters have no relationship to the Medicare Part A, B, C and D designations.) The different types vary in which gaps in coverage they fill.

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Talking Points:

Now we can take time to go over any questions you have.
Thank You

This Medicare Counselor Training program was developed under a grant from UnitedHealthcare through a joint project with the National Association of Area Agencies on Aging (n4a). However, nothing in these educational materials shall imply an n4a endorsement of any kind regarding UnitedHealthcare or its products and services or those of any Medicare Advantage, Medicare Prescription Drug or Medicare Supplement insurance plan. As a matter of practice, n4a does not endorse any insurance products or services.

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