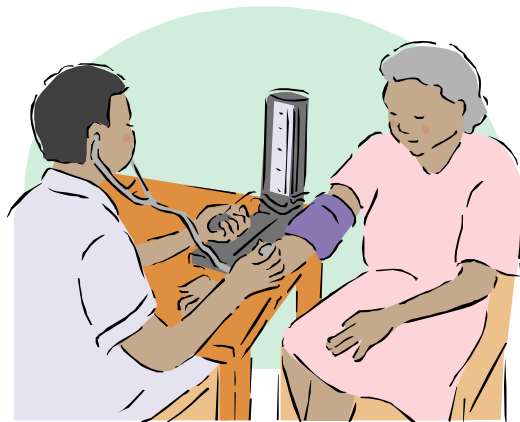


Medicare & Medicaid Fundamentals



Course Manual

Important Information

Course Intent

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Acknowledgements

The information in this course was obtained from the following government resources:

- <http://www.medicare.gov>
- **Medicare & You 2005**
<http://www.medicare.gov/publications/pubs/pdf/10050.pdf>
- **Medicaid: A Brief Summary**
<http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp%0c>

Table of Contents

1—Medicare History & Purpose.....	1
History of Medicare.....	1
Medicare Basics.....	6
2—Medicare Parts A & B.....	7
Part A—Covered Expenses.....	7
Part A—Enrollment & Cost.....	7
Part B—Covered Expenses.....	8
Part B—Enrollment & Cost.....	10
Part B and COBRA Coverage.....	11
Part B and Group Health Plan Coverage.....	12
Using Doctors Who Don't Accept Medicare.....	12
3—Original Medicare Plan.....	14
Original Medicare Plan Basics.....	14
Assignment.....	14
Out-of-Pocket Expenses.....	15
Original Plan Part A—Patient Responsibility (2005).....	16
Original Plan Part B—Patient Responsibility (2005).....	17
Original Medicare Plan—Things Not Covered.....	19
4—Medicare Advantage Plans.....	21
Medicare Advantage Plans.....	21
Medicare Managed Care Plans.....	22
Medicare Preferred Provider Organization (PPO) Plans.....	23
Medicare Private Fee-for-Service Plans.....	23
Medicare Specialty Plans.....	24
Medicare Advantage Plans—Enrollment & Cost.....	24
5—Drug Cards & Drug Plans.....	27
Approved Drug Discount Cards.....	27
Prescription Drug Plans.....	27
6—Medicaid Fundamentals.....	29
Overview.....	29
Eligibility.....	29
Medically Needy Option.....	31
Welfare Reform Bill Changes.....	31

State Children's Health Insurance Program (SCHIP)..... 32
Coverage Duration..... 32
Scope of Services 32
Programs of All-inclusive Care for the Elderly (PACE) 34
Amount and Duration of Medicaid Services 34
Payment for Medicaid Services 34
Medicaid Summary and Trends..... 36
Relationship between Medicaid & Medicare 38

1—Medicare History & Purpose

History of Medicare

On July 30, 1965 President Lyndon B. Johnson signed into law the Social Security Amendments of 1965 which established Medicare. The signing ceremony occurred in Independence, Missouri at the Truman Library with former President Harry Truman seated beside President Johnson. The ceremony was held at the Truman Library to honor President Truman's leadership on health insurance, which he first proposed in 1945.

President Johnson's speech that day summarized the original purpose and scope of Medicare. Here is an excerpt from that speech:

"There are more than 18 million Americans over the age of 65. Most of them have low incomes. Most of them are threatened by illness and medical expenses that they cannot afford.

And through this new law, Mr. President (Truman), every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age.

This insurance will help pay for care in hospitals, in skilled nursing homes, or in the home. And under a separate plan it will help meet the fees of the doctors.

Now here is how the plan will affect you.

During your working years, the people of America--you--will contribute through the social security program a small amount each payday for hospital insurance protection. For example, the average worker in 1966 will contribute about \$1.50 per month. The employer will contribute a similar amount. And this will provide the funds to pay up to 90 days of hospital care for each illness, plus diagnostic care, and up to 100 home health visits after you are 65. And beginning in 1967, you will also be covered for up to 100 days of care in a skilled nursing home after a period of hospital care.

And under a separate plan, when you are 65--that the Congress originated itself, in its own good judgment--you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay \$3 per month after you are 65 and your Government will contribute an equal amount.

The benefits under the law are as varied and broad as the marvelous modern medicine itself. If it has a few defects--such as the method of payment of certain specialists - then I am confident those can be quickly remedied and I hope they will be.

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away

over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.”

Since 1965, a number of changes have been made to Medicare. Below are some of the key legislative milestones that have shaped Medicare and other related programs.

- **1965**—Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act, extending health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board), and providing health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Seniors were the population group most likely to be living in poverty; about half had insurance coverage.
- **1966**—Medicare was implemented and more than 19 million individuals enrolled on July 1.
- **1967**—An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 was established.
- **1972**—Medicare eligibility was extended to individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD). Medicare was given the authority to conduct demonstration programs. Medicaid eligibility for elderly, blind and disabled residents of a state could be linked to eligibility for the newly enacted Federal Supplemental Security Income program (SSI).
- **1973**—The HMO Act provided for start-up grants and loans for the development of health maintenance organizations (HMOs); HMOs meeting Federal standards relating to comprehensive benefits and quality were given preferential treatment in the marketplace.
- **1977**—The Health Care Financing Administration (HCFA) was established to administer the Medicare and Medicaid programs.
- **1980**—Coverage of Medicare home health services was broadened. Medicare supplemental insurance, also called "Medigap," was brought under Federal oversight.
- **1981**—Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were established in Medicaid; states were required to provide

additional payments to hospitals treating a disproportionate share of low-income patients (i.e., DSH hospitals).

- **1982**—The Tax Equity and Fiscal Responsibility Act made it easier and more attractive for health maintenance organizations to contract with the Medicare program. In addition, the Act expanded the Agency's quality oversight efforts through Peer Review Organizations (PROs).
- **1983**—An inpatient acute hospital prospective payment system for the Medicare program, based on patients' diagnoses, was adopted to replace cost-based payments.
- **1985**—The Emergency Medical Treatment and Labor Act (EMTALA) required hospitals participating in Medicare that operated active emergency rooms to provide appropriate medical screenings and stabilizing treatments.
- **1986**—Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of the Federal Poverty Level (FPL) was established as a state option.
- **1987**—The Omnibus Budget Reconciliation Act of 1987 (OBRA87) strengthened the protections for residents of nursing homes.
- **1988**—The Medicare Catastrophic Coverage Act, which included the most significant changes since enactment of the Medicare program, improved hospital and skilled nursing facility benefits, covered mammography, and included an outpatient prescription drug benefit and a cap on patient liability; Medicaid coverage for pregnant women and infants to 100 percent FPL was mandated; special eligibility rules were established for institutionalized persons whose spouses remained in the community to prevent "spousal impoverishment"; Qualified Medicare Beneficiary (QMBs) program was established to pay Medicare premiums and cost sharing charges for beneficiaries with incomes and resources below established thresholds; the Clinical Laboratory Improvement Amendments (CLIA) strengthened quality performance requirements for clinical laboratories in order to assure accurate and reliable laboratory tests and procedures.
- **1989**—The Medicare Catastrophic Coverage Act of 1988 was repealed after higher-income elderly protested new premiums. A new Medicare fee schedule for physician and other professional services, a resource-based relative value scale, replaced charge-based payments. Limits were placed on physician balance billing above the new fee schedule. Physicians were prohibited from referring Medicare patients to clinical laboratories in which their physicians, or physicians' family members, have a financial interest.
- Medicaid coverage of pregnant women and children under age 6 to 133 percent FPL was mandated; expanded EPSDT requirements were established.

- **1990**—Phased in Medicaid coverage of children ages 6 through 18 under 100 percent FPL was established; Medicaid prescription drug rebate program was established; Specified Low-Income Medicare beneficiary eligibility group was established (SLMBs) for Medicaid programs to pay Medicare premiums for beneficiaries with incomes at least 100 percent but not more than 120 percent of the FPL and limited financial resources; additional federal standards for Medicare supplemental insurance were enacted.
- **1991**—Medicaid Disproportionate Share Hospital (DSH) spending controls were established and provider-specific taxes and donations to states were capped.
- **1996**—Welfare Reform - The Aid to Families with Dependent Children (AFDC) entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant; the welfare link to Medicaid was severed; a new mandatory low income group not linked to welfare was added; and enrollment/termination of Medicaid was no longer automatic with receipt/loss of welfare cash assistance. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) had several provisions. First, it amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to provide for new Federal rules improving continuity or "portability" of coverage in the large group, small group and individual health insurance markets. CMS implements HIPAA provisions affecting the small group and individual markets. Second, it created the Medicare Integrity Program which dedicated funding to program integrity activities and allowed CMS to competitively contract for program integrity work. Third, it created national administrative simplification standards for electronic health care transactions. Fourth, it required HHS to issue privacy regulations if Congress failed to enact substantive privacy legislation.
- **1997**—Balanced Budget Act of 1997 (BBA) - State Children's Health Insurance Program (SCHIP) was created; limits on Medicaid payments to disproportionate share hospitals were revised; new Medicaid managed care options and requirements for states were established. Medicare changes include: establishing an array of new Medicare managed care and other private health plan choices for beneficiaries, offered through a coordinated open enrollment process; expanding education and information to help beneficiaries make informed choices about their health care; requiring CMS to develop and implement five new prospective payment systems for Medicare services (for inpatient rehabilitation hospital or unit services, skilled nursing facility services, home health services, hospital outpatient department services, and outpatient rehabilitation services); slowing the rate of growth in Medicare spending and extending the life of the trust fund for 10 years; providing a broad range of beneficiary protections; expanding preventive benefits; and testing other innovative approaches to payment and service delivery through research and demonstrations.

- **1998**—The internet site www.medicare.gov was launched to provide updated information about Medicare.
- **1999**—The toll-free number, 1-800-MEDICARE (1-800-633-4227), was available nationwide. The first annual Medicare & You handbook was mailed to all Medicare beneficiary households. The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work. Established optional Medicaid eligibility groups and allowed states to offer a buy-in to Medicaid for working-age individuals with disabilities. The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and increased the amount of Medicaid DSH funds available to hospitals in certain States and the District of Columbia. Other related legislation improved Medicaid coverage of certain women's health services.
- **2000**—The Benefits Improvement and Protection Act (BIPA) further increased Medicare payments to providers and managed health care organizations, reduced certain Medicare beneficiary copayments, and improved Medicare's coverage of preventive services; BIPA created a new Medicaid prospective payment system for Federally Qualified Health Centers and Rural Health Clinics and it modified the amount of Medicaid DSH funds available to hospitals, while it provided a one year extension on the sunset of transitional medical assistance provided to families eligible for welfare.
- **2003**—The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made the most significant changes to Medicare since the program began. MMA creates a prescription drug discount card until 2006, allows for competition among health plans to foster innovation and flexibility in coverage, covers new preventive benefits, and makes numerous other changes. In 2006, the new voluntary Part D outpatient prescription drug benefit will be available to beneficiaries from private drug plans as well as Medicare Advantage plans. Employers who provide retiree drug coverage comparable to Medicare's will be eligible for a federal subsidy. Medicare will consider beneficiary income for the first time: beneficiaries with incomes less than 150% of the federal poverty limit will be eligible for subsidies for the new Part D prescription drug program; beneficiaries with higher incomes will pay a greater share of the Part B premium starting in 2007.

Originally, Medicare was a responsibility of the Social Security Administration (SSA), which was an agency in the Department of Health, Education, and Welfare (HEW). In 1977, the Health Care Financing Administration (HCFA) was created under HEW to effectively coordinate Medicare. In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

Medicare Basics

Medicare is administered by CMS which is a Federal agency within HHS. Currently, Medicare provides coverage to approximately 40 million Americans. Medicare is the national health insurance program for:

- People age 65 or older
- Some people under age 65 with disabilities
- People with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant

Medicare has two parts:

- **Part A—Hospital Insurance.** Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.
- **Part B—Medical Insurance.** Most people pay a monthly premium for Part B.

Medicare health plan choices include:

- **Original Medicare Plan.** This plan is available nationwide.
- **Medicare Advantage Plans.** These plans are available in many areas and include the following:
 - Medicare **Managed Care** Plans
 - Medicare **Preferred Provider Organization** Plans
 - Medicare **Private Fee-for-Service** Plans
 - Medicare **Specialty** Plans

2—Medicare Parts A & B

Part A—Covered Expenses

Medicare Part A helps pay for the following medically necessary expenses:

- **Hospital Stays:** Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care someone gets in critical access hospitals and mental health care. This doesn't include private duty nursing or a television or telephone in their room. It also doesn't include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.
- **Skilled Nursing Facility Care:** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related three-day inpatient hospital stay). Medicare does not cover custodial or long-term care.
- **Home Health Care:** Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language therapy which are ordered by a doctor. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
- **Hospice Care:** For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in the home (which may include a nursing facility if this is a home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).
- **Blood:** Pints of blood someone gets at a hospital or skilled nursing facility during a covered stay.

Part A—Enrollment & Cost

People who are already getting benefits from Social Security or the Railroad Retirement Board automatically get Medicare Part A starting the first day of the month they turn age 65. People who are under age 65 and disabled, will automatically get Medicare Part A after they get disability benefits from Social Security or the Railroad Retirement Board (RRB) for 24 months. There is no 24-month waiting period for those who have ALS (Amyotrophic Lateral Sclerosis). People who are close to age 65 and aren't yet getting Social Security or Railroad Retirement benefits must apply for Medicare Part A.

Even if a person's full retirement age for Social Security or Railroad Retirement benefits

is older than age 65, he/she is still eligible for Medicare at age 65.

Most people don't have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse paid Medicare taxes while working.

Persons who aren't eligible for premium-free Part A may be able to buy it if they or their spouse aren't entitled to Social Security because: they didn't work or didn't pay Medicare taxes while they worked and are age 65 or older; or they are disabled but no longer get free Part A because they have been working for a long time.

Part B—Covered Expenses

Medicare Part B helps pay for the following medically necessary expenses:

- **Medical and Other Services:** Doctors' services (not routine physical exams; however, if Part B coverage begins on or after January 1, 2005, Medicare will cover a "Welcome to Medicare" one-time physical examination within the first six months of having Part B), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). It also covers a second, and sometimes a third, surgical opinion for surgery that isn't an emergency (in some cases), outpatient mental health care, and outpatient occupational and physical therapy, including speech-language therapy. (These services are also covered for long-term nursing home residents.)
- **Clinical Laboratory Services:** Blood tests, urinalysis, some screening tests, and more.
- **Home Health Care:** Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language therapy which are ordered by a doctor. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
- **Outpatient Hospital Services:** Hospital services and supplies received as an outpatient as part of a doctor's care.
- **Blood:** Pints of blood received as an outpatient or as part of a Part B-covered service.

Medicare Part B helps pay for the following preventive services:

- **Bone Mass Measurements:** Once every 24 months for qualified individuals and more frequently if medically necessary.
- **Cardiovascular Screening Blood Tests:** Starting January 1, 2005, includes blood tests to check cholesterol, lipid or triglyceride levels, and other tests for early detection of, or to identify a high risk for developing, cardiovascular

disease.

- **Colorectal Cancer Screening:** Only covered for people with Medicare age 50 and older; however, there is no minimum age for having a colonoscopy.
 - Fecal Occult Blood Test (FOBT)—Once every 12 months.
 - Flexible Sigmoidoscopy—Once every 48 months.
 - Colonoscopy—Once every 24 months if a person is at high risk for colorectal cancer. If he/she isn't at high risk for colorectal cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.
 - Barium Enema—Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy. It's covered every 24 months if someone is at high risk for colorectal cancer and every 48 months if they aren't at high risk.
- **Diabetes Services:**
 - Diabetes Screening Tests—Includes fasting plasma glucose test. (Covered for certain people with Medicare who are at risk for diabetes, starting January 1, 2005.)
 - Diabetes Self-Management Training. (Covered for certain people with Medicare who are at risk for complications from diabetes.)
- **Glaucoma Testing:** Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service. Covered for people with Medicare who are in one of the following groups at high risk for glaucoma: people with diabetes, a family history of glaucoma, or African Americans age 50 and older.
- **Pap Test and Pelvic Examination:** Includes a clinical breast exam. Covered once every 24 months, or once every 12 months if person is high risk for cervical or vaginal cancer or of childbearing age and have had an abnormal Pap test in the past 36 months. Covered for all women with Medicare.
- **Prostate Cancer Screening:** Covered for all men with Medicare age 50 and older.
 - Digital Rectal Examination—Once every 12 months.
 - Prostate Specific Antigen (PSA) Test—Once every 12 months.
- **Screening Mammograms:** Covered once every 12 months. Medicare also covers digital technologies for mammogram screening. Covered for all women with Medicare age 40 and older. One baseline mammogram between ages 35 and 39 is also covered.

- **Vaccination Shots:**
 - Flu Shot—Coverage for all people with Medicare once a flu season in the fall or winter. (The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 65 and older and people of any age with certain chronic medical conditions. A flu shot is needed each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect people from the flu for about one year.)
 - Pneumococcal Shot—Coverage for all people with Medicare. One shot is usually all a person ever needs.
 - Hepatitis B Shots—Coverage for certain people with Medicare at medium to high risk for Hepatitis B.
- **“Welcome to Medicare” Physical Examination:** One time only, within the first six months a person starts Part B. Includes measurement of height, weight and blood pressure, an EKG, education, and counseling. Covered for people whose Part B coverage begins on or after January 1, 2005.

Part B—Enrollment & Cost

There are three times when a person can sign up for Medicare Part B:

- 1. Initial Enrollment Period.** If a person is turning age 65 in the next three months and hasn't applied for Social Security or Railroad Retirement benefits, or Medicare Part A, he/she can sign up for Medicare Part B when applying for retirement benefits or Medicare Part A. He/she can sign up for Part B during the Initial Enrollment Period. The Initial Enrollment Period begins three months before the month a person turns age 65, and ends three months after the month he/she turns age 65. Note: The start date for Medicare Part B will be delayed if signing up the month turning age 65 or signing up the last three months of the Initial Enrollment Period.
- 2. General Enrollment Period.** If a person didn't sign up for Medicare Part B when he/she first became eligible, they may sign up during the General Enrollment Period. The General Enrollment Period runs from January 1 through March 31 of each year. If a person signs up during the General Enrollment Period, Medicare Part B coverage will start on July 1 of the year he/she signs up. The cost of Medicare Part B will go up 10% for each full 12-month period that a person could have had Medicare Part B but didn't take it, except in special cases. This extra amount will have to be paid as long as the person has Medicare Part B.
- 3. Special Enrollment Period.** This period is available if a person is eligible for Medicare and waited to enroll in Medicare Part B because he/she or his/her spouse were working and had group health plan coverage through an employer

or union based on this current employment. If this applies, a person can sign up for Medicare Part B anytime he/she is still covered by an employer or union group health plan, through current employment, or during the eight months following the month that the employer or union group health plan coverage ends, or when the employment ends (whichever is first). If a person is still working and plans to keep his/her employer's group health plan coverage, he/she should talk to their benefits administrator or the State Health Insurance Assistance Program to help them decide the best time to enroll in Medicare Part B. When he/she signs up for Medicare Part B, the six-month Medigap (Medicare Supplement Insurance) open enrollment period automatically begins. Once the Medigap open enrollment period begins, it can't be changed or restarted. Most people who sign up for Medicare Part B during a Special Enrollment Period don't pay higher premiums. However, if a person who is eligible but doesn't sign up for Medicare Part B during the Special Enrollment Period, he/she will only be able to sign up during the General Enrollment Period, and the cost of Medicare Part B may go up.

The premium for Medicare Part B is \$78.20 each month in 2005. In some cases, this amount may be higher if the person didn't sign up for Part B when he/she first became eligible. The cost of Part B may go up 10% for each full 12-month period that a person could have had Part B but didn't sign up for it, except in special cases. A person will have to pay this extra amount as long as he/she has Part B. In 2005 the Part B deductible is \$110 each year before Medicare starts to pay its share. Medicare deductible and premium rates may change every year in January. If a person gets Social Security or Railroad Retirement Board benefits, the new premium and deductible rates are sent to him/her each December with the cost of living adjustment notice. The premium and deductible rates can also be obtained at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Part B and COBRA Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that may let someone keep their employer group health plan coverage for a limited period of time after their employment ends or after someone loses coverage as a dependent of the covered employee. Even if someone elects to get COBRA coverage when their employer coverage ends, they should still consider enrolling in Medicare Part B at the same time, because they won't get another Special Enrollment Period (SEP). The SEP means they will have to sign up for Medicare Part B within eight months after their group health plan coverage ends or when they lose coverage.

If someone is age 65 or older and he/she is covered under COBRA, their employer group health plan may require him/her to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is before their employment ends or they will lose their employer's coverage. If someone waits to sign up for Medicare Part B during the eight months after their employment or coverage ends, their employer could make them pay for services that Medicare would have paid for if they had signed up earlier. If

someone doesn't sign up for Medicare Part B during the eight-month period (SEP) after their employment ends or when they lose coverage, whichever comes first, they will only be able to sign up during the General Enrollment Period and the cost of Medicare Part B may go up.

Once someone is age 65 or older and they enroll in Medicare Part B, their Medigap open enrollment period starts and it can't be changed. Before someone elects COBRA coverage, it may be helpful for them to talk with their State Health Insurance Assistance Program about whether buying a Medigap policy would be better for them than electing COBRA coverage.

If someone has COBRA coverage when they first enroll in Medicare, their COBRA coverage may end. Their employer has the option of canceling their COBRA coverage if their first Medicare enrollment is after the date they elected COBRA coverage.

Part B and Group Health Plan Coverage

If someone has Part B and then drop it because they, their spouse, or a family member is working and have group health plan coverage through the employer or union, they can sign up for Part B again during a Special Enrollment Period. It's important to make sure that the group health plan coverage is in effect before dropping Part B. In this case, the cost of Part B won't go up when they get it again. When someone drops Part B, their coverage ends the last day of the next month. Also, if someone drops Part B after age 65, they won't get another Medigap open enrollment period when they restart Part B.

Using Doctors Who Don't Accept Medicare

Some doctors don't accept Medicare payments. If someone wants to get care from a doctor who doesn't accept Medicare payment, they may be asked to sign a private contract. A private contract is a written agreement between a patient and a doctor who has decided not to participate in the Medicare program. The private contract only applies to the services they get from the doctor (such as a physician, dentist, podiatrist, or optometrist) who asked them to sign it. Someone can't be asked to sign a private contract in an emergency situation or when they get urgently needed care.

If someone signs a private contract with their doctor:

- They will have to pay whatever this doctor or provider charges them for the services they get. Medicare's limiting charge won't apply.
- No claim should be submitted to Medicare, and Medicare won't pay if one is submitted.
- Their Medigap policy, if they have one, won't pay for this service.
- Medicare health plans won't pay for the services they get from this doctor.
- A doctor must tell the patient whether Medicare would pay for the service if they

get it from another doctor who participates in Medicare.

- A doctor must tell the patient if he or she has opted out of, or been excluded from, the Medicare program. A patient may want to talk with someone in their State Health Insurance Assistance Program before signing a private contract.

3—Original Medicare Plan

Original Medicare Plan Basics

The Original Medicare Plan is a “fee-for-service” plan. This means a fee is usually charged for each health care service or supply. This plan, managed by the Federal Government, is available nationwide. A person stays in the Original Medicare Plan unless he/she chooses to join another type of Medicare health plan.

The **Original Medicare Plan** works like this:

- A person may go to any doctor or specialist who accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. Generally, a fee is charged each time they get a health care service.
- If a person has Medicare Part A, they get all the Part A—Covered Expenses listed previously in this manual.
- If a person has Medicare Part B, which has a monthly premium of \$78.20 in 2005, they get all the Part B—Covered Expenses listed previously in this manual.
- A person pays a set amount for their health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and the patient pays their share (coinsurance or copayment).
- After someone gets a health care service, each month they get a Medicare Summary Notice in the mail.
- This notice is sent by companies that handle bills for Medicare. The notice lists the amount the patient owes.

Assignment

Assignment is an agreement between people with Medicare, their doctors and suppliers, and Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment from Medicare for covered Part B services, equipment, and supplies. Doctors or suppliers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the proper Medicare deductible and coinsurance amounts from the person with Medicare, their other insurance, or anyone else. If assignment isn't accepted, doctors and providers may charge more than the Medicare-approved amount. For most services, there is a limit on the amount over the Medicare-approved amount doctors and providers can bill a patient. The highest amount of money someone can be charged for a Medicare covered service by doctors and other health care providers who don't accept assignment is called the limiting charge. The limiting charge is 15% over Medicare's approved amount. The limiting charge applies only to certain services and doesn't apply to supplies and equipment. In addition, a patient may have to

pay the entire charge at the time of service. Medicare will send the patient his/her share of the charge when the claim is processed.

In some cases, health care providers and suppliers must accept assignment. For example, if someone gets Medicare-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare program, the pharmacy or supplier must accept assignment. If someone gets Medicare-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, Medicare won't pay.

Doctors and suppliers must submit claims to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can't charge for this service. A patient can't send in the claim.

Out-of-Pocket Expenses

Patient out-of-pocket expenses for the Original Medicare Plan depend on:

- Whether someone has Part A and/or Part B (most people on Medicare have both).
- Whether the doctor or supplier accepts "assignment" as explained previously.
- How often someone needs health care.
- The type of health care is needed.
- Whether someone chooses to get services or supplies not covered by Medicare. In this case, he/she would pay for these services.
- Whether someone has other health insurance coverage.

In most cases, Medicare doesn't pay for health care a person gets while traveling outside of the United States.

The following charts show the patient responsibility for expenses in 2005 under the **Original Medicare Plan**. The chart refers to "each benefit period" for Part A, which begins the day a patient goes to the hospital or skilled nursing facility—and ends when the patient hasn't received any care for 60 days in a row.

Original Plan Part A—Patient Responsibility (2005)

Part A—Hospital Stays	<p>For each benefit period, the patient pays:</p> <ul style="list-style-type: none"> • A total of \$912 for a hospital stay of 1–60 days. • \$228 per day for days 61–90 of a hospital stay. • \$456 per day for days 91–150 of a hospital stay. (These 60 days of coverage are known as Lifetime Reserve Days and can only be used once during a person’s lifetime.) • All costs for each day beyond 150 days.
Part A—Skilled Nursing Facility Care	<p>For each benefit period, the patient pays:</p> <ul style="list-style-type: none"> • Nothing for the first 20 days. • \$114 per day for days 21–100. • All costs beyond the 100th day in the benefit period.
Part A—Home Health Care	<p>The patient pays:</p> <ul style="list-style-type: none"> • Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment.
Part A—Hospice Care	<p>The patient pays a copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (short-term care given to a hospice patient so that the usual caregiver can rest). The amount the patient pays for respite care can change each year. Medicare generally doesn’t pay for room and board except in certain cases. For example, room and board aren’t covered if the patient gets general hospice services while a resident of a nursing home or a hospice’s residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays.</p>
Part A—Blood	<p>The patient pays for the first three pints of blood, unless he/she or someone else donates blood to replace what is used.</p>

Original Plan Part B—Patient Responsibility (2005)

Part B—Medical and Other Services	<p>Each year the patient pays</p> <ul style="list-style-type: none"> • \$110 (in 2005) deductible (once per calendar year). This amount can change each year. • 20% of the Medicare-approved amount after the deductible (if the doctor, provider, or supplier accepts “assignment”). • 20% for all outpatient physical, occupational, and speech-language therapy services. • 50% for most outpatient mental health care.
Part B—Clinical Laboratory Services	<p>The patient pays nothing for Medicare-approved services.</p>
Part B—Home Health Care	<p>The patient pays</p> <ul style="list-style-type: none"> • Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment.
Part B—Outpatient Hospital Services	<p>The patient pays a coinsurance or copayment amount, which may vary according to the service.</p>
Part B—Blood	<p>The patient pays for the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible)— unless the patient or someone else donates blood to replace what is used.</p>
Part B—Bone Mass Measurements	<p>The patient pays 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.</p>
Part B—Cardiovascular Screening Blood Tests	<p>There is no coinsurance or Part B deductible for lab tests. For all other tests, the patient pays 20% of the Medicare-approved amount after the yearly Part B deductible.</p>

Part B— Colorectal Cancer Screening	The patient pays nothing for the fecal occult blood test (FOBT). For all other tests, the patient pays 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, the patient pays 25% of the Medicare-approved amount after the yearly Part B deductible if the test is done in a hospital outpatient department.
Part B— Diabetes Services	There is no coinsurance or Part B deductible for diabetes screening lab tests. For all other tests and services, the patient pays 20% of the Medicare-approved amount after the yearly Part B deductible.
Part B— Glaucoma Testing	The patient pays 20% of the Medicare-approved amount after the yearly Part B deductible.
Part B—Pap Test and Pelvic Examination (includes a clinical breast exam)	The patient pays nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, the patient pays 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.
Part B— Prostate Cancer Screening	Generally, the patient pays 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA (Prostate Specific Antigen) test.
Part B— Screening Mammograms	The patient pays 20% of the Medicare-approved amount with no Part B deductible.
Part B—Shots (vaccinations)	The patient pays nothing for flu and pneumococcal shots if the health care provider accepts assignment. For Hepatitis B shots, the patient pays 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Part B— “Welcome to Medicare” Physical Examination	The patient pays 20% of the Medicare-approved amount after the yearly Part B deductible.

Original Medicare Plan—Things Not Covered

The Original Medicare Plan does not cover the following items and services:

- Acupuncture.
- Deductibles, coinsurance, or copayments when someone gets health care services (as shown in the chart previously).
- Dental care and dentures (with only a few exceptions).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Health care while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams for the purpose of fitting a hearing aid.
- Hearing exams (screening) unless ordered by a doctor.
- Long-term care, such as custodial care in a nursing home.
- Orthopedic shoes (with only a few exceptions).
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care. (Foot exams are covered if patient has diabetes-related nerve damage and meet certain conditions.)
- Routine eye care and most eyeglasses. (However, after cataract surgery one pair of eyeglasses is covered with standard frames that include an intraocular lens.)
- Routine or yearly physical exams. (If Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time physical examination within the first six months of having Part B.)
- Screening tests and labs except those listed previously under Part B—Covered Expenses.
- Shots (vaccinations) except those listed previously under Part B—Covered Expenses.
- Some diabetic supplies (like syringes or insulin unless it is used with an insulin pump).

If a person with Medicare also has other health insurance, sometimes the other insurance pays the health care bills first and the Original Medicare Plan pays second. Other insurance that may pay first includes: employer group health plan coverage under certain conditions, no-fault insurance, liability insurance, black lung benefits, and

workers' compensation. In most cases, these types of insurance must pay first. In some cases, if the insurance that is supposed to pay first doesn't pay promptly (that is, within 120 days), the Original Medicare Plan may make a "conditional" payment. The Medicare payment is "conditional" because it must be repaid to Medicare when the insurance that is supposed to pay first makes a payment. It's important that a patient tells his/her doctor and hospital that they have other insurance, so the provider will know how to handle the bills correctly.

4—Medicare Advantage Plans

Medicare Advantage Plans

The **Medicare Advantage Plans** are alternatives to the Original Medicare Plan. They provide more health care coverage choices and better health care benefits than the Original Medicare Plan. Starting in 2005, Advantage is the new name for Medicare + Choice. Medicare Advantage Plans are sold by private insurance companies, although they are government-subsidized.

Medicare Advantage provides the following choices:

- **Medicare Managed Care Plans:** In most of these plans, a patient can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. This is called the plan's "network." A patient may also have to choose a primary care doctor and get referrals to see a specialist. Patients may pay lower copayments and get extra benefits, such as coverage for extra days in the hospital.
- **Medicare Preferred Provider Organization Plans (PPOs):** In most of these plans, patients can use doctors, specialists, and hospitals on the plan's list (network). They can go to doctors, specialists, or hospitals not on the plan's list, but it may cost extra. They don't need referrals to see doctors, specialists, or go to hospitals that aren't part of the plan's network. Patients may pay lower copayments and get extra benefits, such as coverage for extra days in the hospital.
- **Medicare Private Fee-for-Service Plans:** If someone joins one of these plans, they can go to any doctor or hospital that accepts the terms of the plan's payment. The private company, rather than the Medicare program, decides how much it will pay and how much the patient pays for the services they get. A patient may get extra benefits, like coverage for extra days in the hospital.
- **Medicare Specialty Plans:** These plans, if available, provide more focused health care for specific people. If a person joins one of these plans, he/she gets all Medicare health care as well as more focused care to manage a specific disease or condition.

Medicare Advantage Plans are available in many areas of the country. They manage the Medicare coverage for their members. Medicare pays a set amount of money for care every month to these private health plans. If Medicare Advantage Plans are available in someone's area, and they have Medicare Part A and Part B, that person can join one and get Medicare-covered benefits through the plan.

Someone who joins a Medicare Advantage Plan:

- Is still in the Medicare program.

- Can still have Medicare rights and protections.
- Receives all regular Medicare-covered services.
- May be able to get extra benefits, such as coverage for extra days in the hospital.

Medicare Managed Care Plans

Some of the rules for Medicare Managed Care Plans differ slightly from plan to plan. Here are the general rules for how Medicare Managed Care Plans work:

- In most Medicare Managed Care Plans, there are doctors and hospitals that join the plan (called the plan's "network"). Patients may need to get most of their care and services from the plan's network. Persons should call or get a list from the plan to see which doctors and hospitals are in the plan. If someone wants to see a doctor or use a hospital out-of-network, they should ask their plan and the doctor or hospital what the costs will be.
- If someone joins a plan, they may be asked to choose a primary care doctor. If he/she wants to keep seeing their current doctor, the patient should call and ask if the health care provider is in the Medicare Managed Care Plan and can continue to see the patient if they join the plan. If not, the patient may want to ask them for a recommendation.
- If someone wants to change their primary care doctor, they can ask their plan for the names of other plan doctors in the area.
- Doctors can join or leave Medicare Managed Care Plans at any time. If the primary care doctor should leave the patient's plan, their plan will notify them in advance and give them a chance to pick a new doctor.
- If a patient gets health care outside the plan's service area, they may pay more, or it may not be covered. The service area is where the plan accepts members and where plan services are provided.
- Special rules might apply if someone needs emergency or urgently needed care and he/she isn't in his/her managed care plan's service area.
- A patient usually needs a referral to see a specialist (such as a cardiologist). A referral is a written OK from the primary care doctor for the patient to see a specialist or get certain services.
- There are special rules for certain services. Women can go once a year, without a referral, to a specialist in the network for Medicare-covered routine and preventive women's care services. If the type of specialist needed isn't available, the plan will arrange for care outside the network.
- Medicare Managed Care Plans may leave the Medicare program or change their benefits and premiums.

- Some Medicare Managed Care Plans offer a Point-of-Service option. This allows someone to go to other doctors and hospitals who aren't a part of the plan ("out-of-network"), but he/she may pay more.
- A few Medicare Managed Care Plans aren't Medicare Advantage Plans. Generally, these plans still work as described above, but some rules may be different. For instance, a patient may be able to get non-emergency covered services from doctors and other health care providers that aren't in the plan's network. A person needs to look at their plan materials for the rules that apply to them.

Medicare Preferred Provider Organization (PPO) Plans

Preferred Provider Organization Plans (PPOs) are among the most common and popular health plans right now for working Americans. Medicare PPOs use many of the same rules as Medicare Managed Care Plans listed above.

However, in a PPO, patients:

- Don't need referrals to see a specialist provider out-of-network. Approval may be needed before certain services can be performed.
- Can see any doctor or provider that accepts Medicare (in most cases). However, if someone goes to doctors, hospitals, or other providers who aren't part of the plan ("out-of-network" or "non-preferred"), he/she may pay more.

Every PPO plan is different in terms of what is covered out-of-network and how much the patient will have to pay. In 2006, the Medicare Modernization Act allows regional PPOs to give all people with Medicare choices for Medicare health care coverage. In a regional PPO, members will have an added protection. PPOs will limit the maximum amount that members pay for care outside the network.

Medicare Private Fee-for-Service Plans

Medicare Private Fee-for-Service Plans are fee-for-service plans offered by private companies. Here are the general rules for how Medicare Private Fee-for-Service Plans work:

- Patients can go to any Medicare-approved doctor or hospital that is willing to give them care and accepts the terms of their plan's payment.
- Patients may get extra benefits not covered under the Original Medicare Plan, such as extra days in the hospital.
- The private company, rather than the Medicare program, negotiates with providers to decide how much it will pay and what the patient will pay for the services received.
- Patients may have to pay a premium to join a Medicare Private Fee-for-Service Plan. Patients may also have to pay other costs (such as a copayment or

coinsurance) for the services they get. These costs may be different from those in the Original Medicare Plan.

- At the end of each year, the companies offering Medicare Private Fee-for-Service Plans may decide to join, stay with, or leave Medicare, or change their benefits or premiums.

Medicare Specialty Plans

Medicare is working to create specialty plans, which are new ways to provide more focused health care for specific people. For example, these plans may be for people in certain long-term care facilities or people eligible for both Medicare and Medicaid. These Medicare specialty plans are designed to provide Medicare health care, as well as more focused care that is specially designed to treat specific groups of people or people with certain medical conditions. The goal is to provide health care in an efficient, effective, high quality manner to treat the special needs of the specific covered group.

Medicare Advantage Plans—Enrollment & Cost

The amount of patient out-of-pocket expenses for the Medicare Advantage Plans depends on:

- Whether the plan charges a monthly premium in addition to the monthly Part B premium (\$78.20 in 2005).
- Whether the plan reduces the monthly Part B premium.
- The amount the patient must pay for each visit or service.
- The type of health care needed and how it is provided.
- The types of extra benefits needed, and whether the plan covers them.

Medicare Advantage Plans may pay all or part of the Medicare Part B premium. If someone joins a plan that offers this benefit, it may save them money. They would still get all Medicare Part A and Part B-covered services. A person should read the plan materials carefully before joining to see if the Medicare Advantage Plan offers lower premiums. Plans decide each year if they will reduce part or the entire Medicare Part B premium.

Sometimes a patient's other insurance pays their health care bills first and Medicare Advantage Plan pays second. Other insurance that may have to pay first includes: employer group health plan coverage (under certain conditions), no-fault insurance, liability insurance, black lung benefits, and workers' compensation. It's important that the patient tells the doctor and hospital that he/she has other insurance so the provider knows how to handle the bills correctly.

A person can join a Medicare Advantage Plan if:

- They have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) and continue to pay the monthly Medicare Part B premium (\$78.20 in 2005).
- They live in the service area of the plan. The service area is where the person must live for the plan to accept him/her as its member. In the case of a Medicare Managed Care Plan, it's also usually where the person gets services from the plan. The plan can provide more information about its service areas.
- They don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)—although there are some exceptions.

Note: If someone is already in a Medicare Managed Care Plan and have only Part B, they may stay in their plan.

When someone first joins Medicare, that person can join a Medicare Advantage Plan if one is available in their area and is accepting new members. If they have been in Medicare (the Original Medicare Plan) and later choose to join a Medicare Advantage Plan, they can join:

- Generally, at any time in 2005. Usually, coverage begins the first day of the month after the plan gets the enrollment form.
- Between November 15 and December 31, if the Medicare Advantage Plan only accepts new members during this election period.

Some Medicare Advantage Plans stop accepting new members when they reach their membership limit. Beginning January 1, 2006, a person will only be able to join or leave a Medicare Advantage Plan at certain times.

The steps for joining a Medicare Advantage Plan are:

1. Call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, or
2. Get an enrollment form from a plan representative. Fill out the form and mail it to the plan, or give it to the plan representative. The plan representative can help fill out the form.

The person enrolling will get a letter from the plan stating when coverage begins. A person can't join more than one Medicare Advantage Plan at the same time. Someone trying to join more than one Medicare Advantage Plan with the same starting dates may not be enrolled in either plan—and may remain in the Original Medicare Plan.

If someone has End-Stage Renal Disease (ESRD), they usually can't join a Medicare Advantage Plan. However, if they are already in a plan, they can stay in the plan or join another plan offered by the same company in the same state. If the person has had a successful kidney transplant, they may be able to join a plan.

If someone has ESRD and in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in that area, the person has a one-time right to join another Medicare Advantage Plan. He/she doesn't have to use the one-time right to join a new Medicare Advantage Plan immediately. If they change directly to the Original Medicare Plan after their plan leaves or stops providing coverage, they will still have a one-time right to join a Medicare Advantage Plan at a later date as long as the plan is accepting new members.

A person can keep their Medigap (Medicare Supplement Insurance) policy if they join a Medicare Advantage Plan. However, it may be expensive and the person may get little or no benefit from a Medigap policy while enrolled in a Medicare Advantage Plan. A person's State Health Insurance Assistance Program can help someone decide whether to keep a Medigap policy.

If someone drops their Medigap policy, they may not be able to get it back, except in certain situations. If someone joins a Medicare Advantage Plan when he/she first becomes eligible for Medicare at age 65, or if this is the first time they've enrolled in a Medicare Advantage Plan, he/she may have special Medigap protections that provide a right to buy a Medigap policy later.

An individual may, in some cases, join a Medicare Advantage Plan if he/she has employer or union coverage—and still be able to use this coverage along with their Medicare Advantage Plan coverage.

5—Drug Cards & Drug Plans

Approved Drug Discount Cards

Medicare has contracted with private companies to offer Medicare-approved drug discount cards. These companies negotiate drug prices. Anyone with Medicare can get one of the drug discount cards except those who have outpatient prescription drug coverage from Medicaid when they apply. Enrolling in a Medicare-approved drug discount card is optional. If someone is paying for the full cost of prescription drugs, a Medicare-approved drug discount card can help save on outpatient prescription drug costs. This is a temporary program to help with prescription costs until Medicare prescription drug plans start in 2006.

Enrollment in Medicare-approved drug discount cards started May 3, 2004. If someone is eligible and hasn't enrolled yet, they can enroll anytime until December 31, 2005. The drugs that are discounted and the amount of the discount offered vary among different cards and can change.

Each drug discount card has a list of pharmacies where the discount card can be used. A person must go to a pharmacy that accepts Medicare-approved drug discount cards to get the discounted price.

Companies offering the discount cards can charge an enrollment fee of no more than \$30 each year. Money can be saved on covered brand name drugs and even more on generic drugs. If someone is enrolled in a Medicare Advantage Plan or a state program that helps pay for prescriptions, different rules might apply.

Prescription Drug Plans

On January 1, 2006, Medicare-approved drug discount cards will begin to phase out, and the new Medicare prescription drug plans will begin. Medicare will contract with private companies to offer this drug coverage. These companies will most likely offer a variety of options, with different covered prescriptions, and different costs. Medicare prescription drug plans are voluntary. If someone wants to participate, he/she must choose a plan offering the coverage that best meets their needs and then enroll. In most cases, there is no automatic enrollment to get a Medicare prescription drug plan.

To enroll in a Medicare Prescription Drug Plan, someone must have Medicare Part A or Part B. They can first enroll from November 15, 2005 through May 15, 2006. This is called the "initial open enrollment period." Enrolling is optional. After this initial open enrollment period, someone can change plans during the open enrollment period, which will be from November 15 through December 31 each year. Medicare prescription drug plan will begin January 1 of the following year. To join, a person will need to decide among the following ways to get prescriptions:

- Get all health care benefits and prescriptions through a Medicare Advantage Managed Care Plan that offers optional coverage for prescription drugs,
- Get health care benefits through the Original Medicare Plan and choose a Medicare prescription drug plan, or
- Get health care benefits through another type of Medicare Advantage health plan or a Medicare Managed Care Plan that isn't a Medicare Advantage Plan. In these kinds of plans, a person may be able to choose a Medicare prescription drug plan.

Medicare prescription drug plans might vary, but in general, this is how they will work. When someone joins, they will pay a monthly premium (varies depending on the plan chosen, but estimated at about \$35) in addition to any premiums for Medicare Part A and Part B. A person will pay the first \$250 per year for prescriptions. This is called a "deductible."

After the patient pays the \$250 yearly deductible, here's how the costs work:

- Patient pays 25% of yearly drug costs from \$250 to \$2,250, and the plan pays the other 75% of these costs, then
- Patient pays 100% of drug costs from \$2,251 until out-of-pocket costs reach \$3,600, then
- Patient pays 5% of drug costs (or a small copayment) for the rest of the calendar year after spending \$3,600 out-of-pocket and the plan pays the rest.

Medicare prescription drug plans can offer coverage like this or more generous coverage for higher premiums. Joining is a choice. However, if a person doesn't join when first eligible, he/she may have to pay a higher premium if they choose to join later. They will have to pay this higher premium for as long as they have a Medicare prescription drug plan.

Important Points about Medicare Prescription Drug Plans:

- They start January 1, 2006.
- If someone wants coverage, they must enroll in a plan. Enrollment isn't automatic.
- Once enrolled, a person will pay a monthly premium.
- If someone has a low income and limited assets, there will be extra help with the costs.
- If someone has a low income, they can start enrolling early (summer 2005).

6—Medicaid Fundamentals

Overview

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.

Eligibility

Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the Federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. Low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels (as determined by each State within Federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for State-only programs. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect

in their State on July 16, 1996.

- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL).
- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).
- Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which States will receive Federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each State).
- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their State on July 16, 1996.
- Institutionalized individuals eligible under a "special income level" (the amount is set by each State--up to 300 percent of the SSI Federal benefit rate).
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Recipients of State supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.

- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs).
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid.
- "Optional targeted low-income children" included within the State Children's Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33).
- "Medically needy" persons (described below).

Medically Needy Option

The medically needy (MN) option allows States to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately or may "spend down" by incurring medical expenses that reduce their income to or below their State's MN income level.

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a State elects to have a MN program, there are Federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A State may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program.

Welfare Reform Bill Changes

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)--known as the "welfare reform" bill--made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are State options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of the new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled

children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstated by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides States with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits States to impose a wide range of other requirements as well--in particular, those related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

State Children's Health Insurance Program (SCHIP)

Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a new program initiated by the BBA. In addition to allowing States to craft or expand an existing State insurance program, SCHIP provides more Federal funds for States to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which States may select to provide health care coverage for more children, as prescribed within the BBA's Title XXI program.

Coverage Duration

Medicaid coverage may begin as early as the third month prior to application--if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows States to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Those with higher incomes may pay a sliding scale premium based on income.

Scope of Services

Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program must offer medical assistance for

certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal matching funds to provide certain optional services. Following are the most common of the thirty-four currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facilities for the mentally retarded (ICFs/MR).
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Home and community-based care to certain persons with chronic impairments.

Programs of All-inclusive Care for the Elderly (PACE)

The Balanced Budget Act (BBA) included a State option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 or older who require a nursing facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

Amount and Duration of Medicaid Services

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) Medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan; and (2) States may request "waivers" to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, States have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, States may not provide room and board for the beneficiaries). With certain exceptions, a State's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs).

Within federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. During 1988-1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. Under legislation passed in 1991, 1993, and again within the BBA of 1997, the Federal share of payments to DSH hospitals was somewhat limited. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554) increased DSH allotments for 2001 and 2002 and made other changes to DSH provisions that resulted in increased costs to the Medicaid program.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services.

The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In fiscal year (FY) 2004, the FMAPs varied from 50 percent in twelve States to 77.08 percent in Mississippi, and averaged 60.2 percent overall. The BBA also permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent and raised the FMAP for Alaska from 50 percent to 59.8 percent through 2000. The BIPA of 2000 further adjusted Alaska's FMAP to a higher level for FY 2001-2005. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108-27), in order to bring about State fiscal relief in the current troubled economy, has made three temporary modifications to the States' FMAP calculation: (1) the FMAP for the last two quarters of 2003 will equal the greater of the current law FMAPs for 2002 or 2003; (2) the FMAP for the first three quarters of 2004 will equal the greater of the current law FMAPs for 2003 or 2004; and (3) for the last two quarters of 2003 and first three quarters of 2004, the newly calculated (under 1 and 2 above) FMAP will increase by 2.95 percentage points. The Federal Government pays States a higher share for children covered through the SCHIP program. This "enhanced" FMAP averages about 70 percent for all States, compared to the general Medicaid average of 60.2 percent.

The Federal Government also reimburses States for 100 percent of the cost of services provided through facilities of the Indian Health Service, provides financial help to the twelve States that furnish the highest number of emergency services to undocumented aliens, and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the SCHIP program, the Qualifying Individuals (QI) program (described later), and DSH payments, Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal Government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into Public Law 106-113, the appropriations bill for the District of Columbia for FY 2000) increased the amount that certain States and the territories can spend on DSH and SCHIP payments, respectively. The BIPA set upper payment limits for inpatient and outpatient services provided by certain types of facilities.

Medicaid Summary and Trends

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and economic recessions.
- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase Federal payments to States.
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low-birth-weight babies and other critically ill or severely injured persons alive and in need

of continued extensive and very costly care.

- The increase in drug costs and the availability of new expensive drugs.
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 2001, for example, indicate that Medicaid payments for services for 23.3 million children, who constitute 50 percent of all Medicaid beneficiaries, average about \$1,305 per child (a relatively small average expenditure per person). Similarly, for 11.6 million adults, who comprise 25 percent of beneficiaries, payments average about \$1,725 per person. However, certain other specific groups have much larger per-person expenditures. Medicaid payments for services for 4.4 million aged, constituting 9 percent of all Medicaid beneficiaries, average about \$10,965 per person; for 7.7 million disabled, who comprise 16 percent of beneficiaries, payments average about \$10,455 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2001 payments to health care vendors for 47.0 million Medicaid beneficiaries average \$3,965 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41 percent of the total cost of care for persons using nursing facility or home health services in 2001. National data for 2001 show that Medicaid payments for nursing facility services (excluding ICFs/MR) totaled \$37.2 billion for more than 1.7 million beneficiaries of these services--an average expenditure of \$21,890 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled \$3.5 billion for more than 1.0 million beneficiaries--an average expenditure of \$3,475 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without

increasing costs. Finally, the BBA provided States a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 59 percent in 2003.

More than 46.0 million persons received health care services through the Medicaid program in FY 2001 (the last year for which beneficiary data are available). In FY 2003, total outlays for the Medicaid program (Federal and State) were \$278.3 billion, including direct payment to providers of \$197.3 billion, payments for various premiums (for HMOs, Medicare, etc.) of \$52.1 billion, payments to disproportionate share hospitals of \$12.9 billion, and administrative costs of \$16.0 billion. Outlays under the SCHIP program in FY 2003 were \$6.1 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach \$445 billion and \$7.5 billion, respectively, by FY 2009.

Relationship between Medicaid & Medicare

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their State's Medicaid program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort."

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to the Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes that are above 120 percent and less than 175

percent of the FPL, the BBA establishes a capped allocation to States, for each of the 5 years beginning January 1998, for payment of all or some of the Medicare Part B premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The payment of this QI benefit is 100 percent federally funded, up to the State's allocation.

The Centers for Medicare & Medicaid Services (CMS) estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million Medicare beneficiaries.

Starting January 2006, the new Medicare prescription drug benefit will provide drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, individuals eligible for both Medicare and Medicaid will also receive the low-income subsidy for both the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid will no longer provide drug benefits for Medicare beneficiaries.

Since the Medicare drug benefit and low-income subsidy will replace a portion of State Medicaid expenditures for drugs, States would see a reduction in Medicaid expenditures. To offset this reduction, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) requires each State to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006 this payment is 90 percent of the projected 2006 reduction in State spending. After 2006 the percentage decreases by 1-2/3 percent per year to 75 percent for 2014 and later.