Chapter 4

HEALTH INSURANCE FOR THE AGED AND DISABLED

Amendments to the Social Security Act enacted in 1965 established a broad program of health insurance, known popularly as "Medicare," for people age 65 or older, including railroad workers and members of their families. The program has two main parts. Part A provides hospital insurance and related benefits financed through payroll taxes. Part B provides medical insurance benefits on a voluntary basis, with the cost shared by the participants and the Federal Government.

Persons covered by the railroad retirement system participate in the health insurance program on the same basis as those under the social security system.

ELIGIBILITY

All railroad retirement beneficiaries age 65 or over and other persons who are directly or potentially eligible for railroad retirement benefits are covered by the program. Coverage before age 65 is available for disabled employee annuitants who have been entitled to monthly benefits based on total disability for at least 24 months. Special rules apply for disabled individuals diagnosed with amyotrophic lateral sclerosis. Disabled widow(er)s under 65, disabled surviving divorced spouses under 65, and disabled children may also be eligible.

Full Medicare coverage before age 65 on the basis of permanent kidney failure is also available to employee annuitants, employees

who have not retired but meet certain minimum service requirements, spouses, and dependent children who suffer from permanent kidney failure requiring hemodialysis or a kidney transplant.

The Ticket to Work and Work Incentives Improvement Act of 1999 expanded Medicare coverage for disability beneficiaries who return to work. Effective October 1, 2000, the law extended Part A premium-free coverage for four and a half years beyond the prior limit of 39 months for railroad retirement or social security disability beneficiaries who work.

ENROLLMENT

If a retired employee or a family member is receiving a railroad retirement annuity, enrollment for both hospital and medical insurance is generally automatic and coverage begins when the person reaches age 65. Even though enrollment is automatic, an individual may decline medical insurance, if so desired; this does not preclude him or her from applying for medical insurance at a later date. Premiums may be higher if enrollment is delayed.

If an individual is eligible for but not receiving an annuity, he or she should contact the nearest Board office approximately three months before attaining age 65. (This does not mean that the individual must retire if presently working.) The best time to apply is during the three months before the month in which the individual reaches age 65. He or she will then have both hospital and medical protection beginning with the month age 65 is reached. If the individual is not enrolled for medical insurance in the three months before attaining age 65, he or she can be enrolled in the month age 65 is reached or during the next three months, but there would be a delay of one to three months before medical insurance becomes effective. Individuals who do not enroll during their initial enrollment period may sign up in any General Enrollment Period (January 1 - March 31 each year). Coverage for such individuals begins July 1 of the year of enrollment.

Premiums for medical insurance are increased 10 percent for each year the individual could have been, but was not, enrolled.

However, when individuals are covered by an employer health plan based on their or their spouse's current employment, they may delay their enrollment in Medicare Part B without penalty. Special enrollment periods apply.

Individuals deciding when to enroll in Medicare Part B must consider how this will affect eligibility for health insurance policies which supplement Medicare coverage. These policies are known as "Medigap" insurance and are explained later in this chapter.

When an individual enrolls in Medicare Part B at or after age 65, a one-time "Medigap open enrollment period" is triggered. If the individual enrolls in Part B while covered under an employer-provided group health plan, a Medigap policy may not be needed. The employer will be the primary payer and Medicare Part B will be the secondary payer. Later, however, when no longer covered by an employer-provided group health plan, the individual may need a Medigap policy, but may be unable to purchase one because the Medigap open enrollment period will have expired.

If, on the other hand, Part B enrollment is delayed until the employer-provided group health plan coverage is about to stop, an individual may purchase any Medigap plan from any company at its most favorable price for the individual's age group during open enrollment.

For information on enrollment before age 65 on the basis of disability, potential applicants should contact the nearest Board office. For information on coverage for kidney disease, a social security office should be contacted.

EXPLANATION OF HOSPITAL INSURANCE BENEFITS

(Part A of Medicare)

The hospital insurance program is designed to help pay the bills when an insured person is hospitalized. The program also provides payments for required professional services in a skilled

nursing facility (but not for custodial care) following a hospital stay, home health services, and hospice care.

There is a limit on how many days of hospital or skilled nursing care Medicare helps pay for in each "benefit period." A benefit period begins the first day a patient receives services in a hospital. It ends after a person has been out of a hospital or other facility primarily providing skilled care for 60 days in a row.

Benefits are ordinarily paid only for services received in the United States or Canada. Hospital insurance also covers hospital stays in Mexico under very limited conditions.

Inpatient Hospital Care

For the first 60 days in a benefit period, hospital insurance pays the cost of all covered inpatient hospital services except for a deductible. From the 61st through the 90th day, it pays for all covered services except for a daily coinsurance amount. Hospital insurance helps pay for up to 90 days in a participating hospital in a benefit period. Additional days are available, up to a lifetime total of 60, after exhaustion of the 90 days in a benefit period; the patient pays a daily coinsurance amount for these additional days. Covered hospital services include almost all those ordinarily furnished by a hospital to its patients. However, payments will not be made for private-duty nursing or personal comfort items.

Skilled Nursing Facility Care

If an individual needs inpatient skilled nursing or rehabilitation services after a hospital stay and certain other conditions are met, hospital insurance helps pay for up to 100 days in a Medicare-participating skilled nursing facility in each benefit period.

Hospital insurance pays for all covered services for the first 20 days. For the next 80 days, it pays for all covered services except a daily coinsurance amount.

Home Health Care

If an individual is confined at home and meets certain other conditions, Medicare can pay the full approved cost of home health visits from a Medicare-participating home health agency. There is no limit to the number of covered visits.

A 20-percent copayment applies to covered durable medical equipment (e.g., wheelchairs and hospital beds).

Hospice Care

A hospice program provides pain relief and other support services for terminally-ill people. Medicare hospital insurance can help pay for hospice care for terminally-ill beneficiaries if the care is provided by a Medicare-certified hospice and certain other conditions are met.

Financing

Railroad employers and employees each pay hospital insurance taxes with their railroad retirement taxes. These taxes are collected together with the regular retirement taxes and initially go into the railroad retirement trust funds. They are subsequently transferred to the Federal Hospital Insurance Trust Fund. The cost of hospital insurance benefits for social security and railroad retirement beneficiaries (other than the cost of benefits for the latter with respect to services received in Canada) is borne by that fund. The railroad retirement trust funds bear the costs for compensable benefits paid to railroad retirement beneficiaries for services received in Canada.

EXPLANATION OF MEDICAL INSURANCE BENEFITS

(Part B of Medicare)

The medical insurance program is designed to help pay the bills for doctors' services and for a number of other medical costs not

covered by the hospital insurance program. The medical insurance program is voluntary, but eligible persons who wish to participate pay a monthly premium. For persons who are receiving railroad retirement benefits (including those also in receipt of social security benefits), the monthly premium is deducted from their railroad retirement checks; others make payments or, in some cases, have their premiums paid under a State assistance program.

Benefits Provided

Medicare medical insurance helps pay for doctors' services and many medical services and supplies that are not covered by the hospital insurance part of Medicare, such as ambulance services, outpatient hospital care, X-rays, laboratory tests, physical and speech therapy, blood, mammograms, Pap smears, and colorectal cancer screening.

Each year, before Medicare medical insurance begins paying for covered services, the annual medical insurance "deductible" must be met. After the deductible is met, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year.

Medicare provides basic health care coverage, but it will not pay all medical expenses. Some of the services and supplies Medicare cannot pay for are custodial care, such as help with bathing, eating, and taking medicine; dentures and routine dental care; most eyeglasses, hearing aids, and examinations to prescribe or fit them; long-term care (nursing homes); personal comfort items, such as a phone or TV in a hospital room; most prescription drugs; and routine physical checkups and most related tests.

Medical insurance generally does not pay for services outside the United States. There are rare emergency cases where medical insurance can pay for care in Canada or Mexico. Medical insurance can sometimes also pay if a Canadian or Mexican hospital is closer to a beneficiary's home than the nearest U.S. hospital that

can provide the care needed. If emergency treatment is received in a Canadian or Mexican hospital or if a beneficiary lives near a Canadian or Mexican hospital, he or she should ask the Board's carrier about coverage.

Financing

Part B medical insurance is paid for in part by premiums from persons who enroll in the program.

MEDICARE PLAN CHOICES

The Balanced Budget Act of 1997 provided more health care options, beginning in 1999. While more options are available, beneficiaries can remain with the plan they already have if they are satisfied with it.

To be eligible for the additional plans, the beneficiary must have Medicare Part A and Part B, must not have permanent kidney failure requiring dialysis or a kidney transplant and must live in the service area of a health plan.

The plans must provide basic Medicare Part A and Part B services (except hospice services). They may charge additional amounts to provide extra services. In addition to traditional fee-for-service plans (now called the Original Medicare Plan) and plans with a supplemental insurance policy, managed care plans such as health maintenance organizations (HMOs) are available.

Original Medicare Plan

Under the Original Medicare Plan, patients visit the hospital, doctor, or health care provider of their choice who accepts Medicare patients. Medicare pays a set percentage of the expenses, and patients are responsible for certain deductibles and coinsurance payments, the portion of the bill Medicare does not pay.

Many private insurance companies sell insurance to help pay for services not covered by Medicare. This kind of insurance is called "Medigap" for short. There are 10 standard Medigap poli-

cies in most States, and each offers a different combination of benefits.

Medigap policies pay most, if not all, Medicare coinsurance amounts and may provide for Medicare deductibles. Some of the 10 standard policies pay for services not covered by Medicare, such as outpatient prescription drugs and preventive screening.

Any of the standardized policies can be sold as a Medicare SELECT policy. This type of policy requires patients to use certain hospitals and doctors and generally has lower premiums than other Medigap policies.

When someone first enrolls in Medicare Part B at age 65 or older, he or she has a 6-month "Medigap open enrollment period." During that time, the individual has a right to buy the Medigap policy of his or her choice regardless of any health problems. The company cannot refuse a policy or charge the individual more than all other open enrollment applicants.

Medicare Managed Care Plans

The most common Managed Care Plans are health maintenance organizations (HMOs). Managed Care Plans that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, usually services must be obtained from the Managed Care Plan's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases, neither the Managed Care Plan nor Medicare will pay for services not authorized by the Managed Care Plan (except emergency services or services urgently required while the patient is out of the Managed Care Plan service area).

Many Managed Care Plans that have contracts with Medicare also provide benefits beyond those Medicare pays for. These include preventive care, prescription drugs, dental care, hearing aids and eyeglasses. The benefits may vary by Managed Care Plan.

Private Fee-for-Service Plan

This is a health care choice in some areas of the country. A Private Fee-for-Service plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the Federal Government. In a Private Fee-for-Service Plan, Medicare pays a set amount of money every month to the private company. The private company provides health care coverage to people with Medicare on a pay-per-visit arrangement. The insurance company, rather than the Medicare program, decides how much the patient pays for the services received.

More Information About Other Plans

More information about health care options is available from the following publications:

Medicare and You.--This general guide is mailed to Medicare beneficiary households each fall and to new Medicare beneficiaries when they become eligible for the coverage. It describes the benefits, costs and health service options available.

Guide to Health Insurance for People with Medicare.--A guide to how other health insurance plans supplement Medicare and some shopping hints for people looking at those plans.

Understanding Your Medicare Choices.--A summary of health care options and what each one offers.

Worksheet for Comparing Medicare Health Plans.--This worksheet helps individuals to compare plans and to decide which one is right for them.

To get a copy of any of these publications, call the Medicare toll-free number, 1-800-MEDICARE (1-800-633-4227) or go to www.medicare.gov on the Internet and click on "Publications."

HEALTH INSURANCE THROUGH AN EMPLOYER PLAN

Persons ages 65 and over who are working for an employer with 20 or more employees and workers' spouses ages 65 and over must, by law, be offered the same health benefits that are offered to younger workers. If an employee continues working after age 65, he or she has the option to reject the employer's health plan. If it is rejected, Medicare remains the primary health insurance payer and the employer plan cannot offer coverage supplementing Medicare. If the plan is accepted, Medicare is the secondary payer.

Medicare is the secondary payer for certain disabled people who are covered under a large group health plan through their current employment or a health plan based on current employment of a family member. This secondary payer provision applies to group health plans of employers that employ 100 or more people.

CLAIMING MEDICARE BENEFITS

When a patient receives hospital insurance benefits, he or she is billed by the hospital only for the deductible amount, any coinsurance amount and any noncovered services. The remainder of the bill from the hospital, as well as bills for services in skilled nursing facilities or home health visits, is sent to the intermediary selected to serve the area. However, the patient is given a record of what services were utilized for each claim.

Claims for medical insurance benefits filed on behalf of railroad retirement beneficiaries are generally handled by the Board's carrier on a nationwide basis.

Under the assignment method, the doctor or supplier agrees that his or her total charge for the covered service will be the amount approved by the Medicare carrier. Medicare pays the doctor or supplier 80 percent of the approved amount, after subtracting any part of the $100 annual deductible the patient has not

met. The doctor or supplier can charge the patient only for the part of the $100 annual deductible not met and for the coinsurance, which is the remaining 20 percent of the approved amount. The doctor or supplier also can charge for any services that Medicare does not cover.

If the doctor does not accept assignment, the patient must pay directly and is responsible for any part of the bill that is more than the Medicare-approved amount. Medicare pays the patient 80 percent of the approved amount, after subtracting any part of the annual deductible not met. Even if a doctor does not accept assignment, there are limits in the amount he or she can charge. All doctors and suppliers must fill out claim forms for patients and send them to Medicare whether or not they take assignment.

Doctors and suppliers can sign agreements to become Medicare-participating. This means that they have agreed in advance to accept assignment on all Medicare claims. The names and addresses of Medicare-participating doctors and suppliers are listed (by geographic area) in the "Medicare-Participating Physician/Supplier Directory." This directory is available for review in all Railroad Retirement Board and Social Security Administration offices, State and area offices of the Administration on Aging and most hospitals.

APPEALS

If a patient disagrees with a decision on the amount Medicare will pay on a claim or whether services received are covered by Medicare, he or she has the right to appeal the decision. The notice received from Medicare stating the decision made on a claim also tells a patient exactly what appeal steps can be taken. More information about appeal rights can be obtained from any Railroad Retirement Board office.

ADMINISTRATION OF MEDICARE

The Secretary of Health and Human Services, operating through the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration) is responsible for administering both parts of Medicare. Assistance in the administration is supplied by various public and private organizations.

The Railroad Retirement Board has the same authority to determine the rights of persons coming under its jurisdiction as the Social Security Administration has with respect to its own beneficiaries. The Board establishes the eligibility for hospital insurance benefits of actual or potential railroad retirement beneficiaries and certifies the records of such individuals to the Secretary of Health and Human Services. It enrolls qualified railroad retirement beneficiaries in the medical insurance plan and collects Part B premiums. In addition, the Board has sole authority to select a carrier to handle medical insurance claims of all railroad beneficiaries. The current carrier is Palmetto GBA.