FROM THE DESK OF

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## Medicare for Railroad Families

The Federal Medicare program provides hospital and medical insurance protection for railroad retirement annuitants and their families, just as it does for social security beneficiaries. Part A (hospital insurance) is financed through payroll taxes paid by employees and employers, while Part B (medical insurance) is financed by premiums paid by participants and by Federal general revenue funds.

The following questions and answers provide basic information on Medicare eligibility and coverage.

**1. Full retirement age for unreduced social security benefits and some unreduced railroad retirement benefits is gradually increasing. Is Medicare eligibility based on age also changing?**

No. Medicare eligibility based on age has not changed. Although the age requirements for some unreduced railroad retirement benefits are rising just like the social security requirements, **beneficiaries are still eligible for Medicare at age 65.** 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.

**2. Who is eligible for Medicare coverage before age 65?**

In general, coverage before age 65 is available for disabled employee annuitants who have been entitled to monthly benefits based on total disability (i.e., the employee must have met the Social Security Act's requirements for a disability benefit) for at least 24 months. Disabled widow(er)s under 65, disabled surviving divorced spouses under 65, and disabled children may also be eligible.

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. (Special rules also apply for individuals diagnosed with Amyotrophic Lateral Sclerosis.)

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### 3. How do persons enroll in Medicare?

If a retired employee or a family member is receiving a railroad retirement annuity, enrollment for both Part A (hospital insurance) and Part B (medical insurance) is generally automatic and coverage begins when the person reaches age 65. An individual may decline Part B if so desired, and this does not preclude him or her from applying for medical insurance at a later date. Premiums may be higher, however, 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 in order to apply for Medicare.** (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 does not enroll for Part B in the three months before attaining age 65, he or she can enroll in the month age 65 is reached or during the next three months, but there will be a delay of one to three months before medical insurance is 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.

### 4. How much can Medicare Part B premiums increase for delayed enrollment?

Premiums for Part B are increased 10 percent for each 12-month period the individual could have been, but was not, enrolled. However, individuals who wait to enroll in Part B because they have group health plan coverage based on their own or their spouse's current employment may not have to pay higher premiums because they are eligible for special enrollment periods.

### 5. What should be considered by a person who can delay Part B enrollment because he or she is covered by an employer group health plan?

Individuals deciding when to enroll in Medicare Part B should consider how this will affect eligibility for health insurance policies, known as "Medigap" insurance, which supplement Medicare coverage.

Individuals can get more detailed information about Medigap policies from the publications *Medigap Policies* or *Guide to Health Insurance for People with Medicare*. To get a copy, they can 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."

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**6. What is covered by Part A (hospital insurance) of the Original Medicare Plan?**

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.

**7. What are the Medicare Part A deductible and coinsurance charges in 2003?**

For the first 60 days in a benefit period, a Medicare patient is responsible for paying a deductible which for 2003 is the first $840 of all covered inpatient hospital services. The daily coinsurance charge that a Medicare beneficiary is responsible for paying for hospital care for the 61st through the 90th day is $210 in 2003. If a beneficiary uses "lifetime reserve" days, he or she will be responsible for paying $420 a day for each reserve day used in 2003. Lifetime reserve days are an extra 60 hospital days a beneficiary can use if illness keeps him or her in the hospital for more than 90 days; a beneficiary has only 60 reserve days during his or her lifetime and the beneficiary decides when to use them.

In addition, the daily coinsurance charge a beneficiary is responsible for paying for care in a skilled nursing facility for the 21st through the 100th day is $105 in 2003.

**8. What are some of the services Part B (medical insurance) of the Original Medicare Plan covers?**

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 certain ambulance services, outpatient hospital care, X-rays, laboratory tests, physical and speech therapy, blood, mammograms, Pap smears, and colorectal cancer screening.

**9. What are the basic Medicare Part B premium and medical insurance deductible in 2003?**

The basic Medicare medical insurance premium deducted from railroad retirement or social security payments is $58.70 a month in 2003. Also, the annual medical insurance deductible for doctor bills a beneficiary must pay is $100 in 2003. After the deductible is paid, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year; the beneficiary is responsible for paying the remaining 20 percent of the cost.

**10. What does Medicare not cover?**

Medicare provides basic protection against the high cost of illness, but it will not pay all health care 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.

**11. Besides the Original Medicare Plan, what other Medicare health care options are available?**

The Medicare + Choice program was created to provide more health care options under the Medicare laws. To be eligible for these other options, the beneficiary must have Medicare Part A and Part B, must not have permanent kidney failure requiring hemodialysis 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 the Original Medicare Plan and the Original Medicare Plan with a Medigap policy, Medicare Managed Care Plans and Medicare Private Fee-for-Service Plans are available.

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).

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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 Plans are also 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.

In any case, while more options are available, beneficiaries can remain with the Original Medicare Plan if they are satisfied with it.

**12. Are there other sources that will provide additional information on Medicare?**

A handbook, *Medicare & You,* is mailed to Medicare beneficiary households each fall by the Centers For Medicare & Medicaid Services. It describes the benefits, costs and health service options available. To get a copy, beneficiaries can call the Medicare toll-free number 1-800-MEDICARE (1-800-633-4227) or go to www.medicare.gov.

*Medicare for Railroad Workers and Their Families* (Form RB-20) provides general information on Medicare and is available at any Board field office. It is also available on the Board's Web site at www.rrb.gov.

Also, for information on enrollment before age 65 on the basis of disability, potential applicants should contact the nearest Board office. However, the Social Security Administration, rather than the Railroad Retirement Board, has jurisdiction of Medicare for those eligible on the basis of permanent kidney failure. For information on coverage for kidney disease, a social security office must be contacted.

Beneficiaries can find the address and phone number of the Board office serving their area by calling the automated toll-free RRB Help Line at 1-800-808-0772 or by checking the Board's Web site. Most Board field offices are open to the public from 9:00 a.m. to 3:30 p.m., Monday through Friday, except on Federal holidays.

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