THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE

TALKING ABOUT MEDICARE AND HEALTH COVERAGE

APRIL 2006

The Henry J. Kaiser Family Foundation, 2400 Sand Hill Road, Menlo Park, CA 94025 (650) 854-9400 Facsimile: (650) 854-4800

Washington, D.C. Office: 1330 G Street, N.W., Washington, DC 20005
(202) 347-5270 Facsimile: (202) 347-5274

Website: www.kff.org

Table of Contents

Welcome

Medicare is a critically important source of health insurance for 43 million Americans. Health insurance coverage matters to people of all ages, but it is especially important for those with permanent disabilities and those with health care diseases and conditions associated with aging. Despite important breakthroughs in medical practice and advances in medical technology, the inescapable truth is that health problems, medical needs, and health care expenses are major concerns -- making health coverage decisions critical for those covered by Medicare. For most of us -- whether we're on Medicare or not -- decisions about health insurance are often difficult because they affect the kind of care we get and our financial security.

About This Guide

Whether you are already on Medicare or the family member or friend of someone on Medicare, this guide will help answer your questions about Medicare, prescription drug coverage, and longterm care, including:

- What does Medicare cover? Do people who have basic protection under Medicare need additional insurance?
- What does the Medicare drug benefit mean for you?
- What about joining a Medicare private plan? How do you choose among plans in your area?
- Should you buy a long-term care policy? How can you tell a good policy from a bad one?

Talking about Medicare is intended to help you think through basic health care issues and provide information that should better equip you and your family to discuss these topics. People on Medicare now face additional choices associated with the Medicare prescription drug benefit. This guide helps you understand how the drug benefit works, how to choose a drug plan that meets your needs, and how to get additional help with drug costs if you are on a limited income.

In addition, a state-by-state list of key agencies that can answer your specific questions about Medicare, Medicaid, supplemental health insurance, the Medicare prescription drug benefit, and long-term care is included under Additional Resources in this guide. We hope this guide will be a useful tool for you.

Acknowledgements: This guide was developed by Michelle Kitchman Strollo, Molly Voris, and Tricia Neuman of the Kaiser Family Foundation, in conjunction with Ruth Brown, Kaiser Family Foundation Summer Intern.

Medicare at a Glance

Tip

If you and your spouse are different ages, you won't be able to go on Medicare at the same time. For example, if your husband turns 65 and becomes eligible for Medicare when you are 63, he can be covered by Medicare. You will have to wait two years until you turn 65 before you are eligible for Medicare.

Know the Basics about Medicare

Medicare is the federal health insurance program for almost all Americans age 65 and older and for many adults with permanent disabilities. Knowing the basics about Medicare can help you make good decisions about your health coverage and care.

Medicare Eligibility

You are eligible for Medicare if you are a U.S. citizen or have been a permanent legal resident for five continuous years, and:

- You are 65 years or older and eligible to receive Social Security; or
- You are under 65, permanently disabled, and have received Social Security disability insurance payments for at least 2 years; or
- You get continuing dialysis for permanent kidney failure or need a kidney transplant; or
- You have Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease).

What Medicare Covers

Three parts of Medicare – Part A, Part B, and now Part D – provide coverage for basic medical services and prescription drugs.

Part A: – Hospital Insurance: In addition to hospital inpatient care, Part A covers some skilled nursing facility (SNF), home health, and hospice care. If you are entitled to Part A, there is no monthly or annual premium charge, but there is a charge for most health care services. There are also specific requirements you must meet before you can receive coverage for some services, such as home health care, skilled nursing facility care, and hospice care.

Part A	
BENEFITS	**INDIVIDUAL PAYS (in 2006)**
Inpatient hospital Days 1-60 Days 61-90 Days 90-150 After 150 Days	Deductible of $952 per benefit period* No coinsurance** $238 a day $476 a day No benefits
Skilled nursing facility Days 1-20 Days 21-100 After 100 days	 No coinsurance $119 a day No benefits
Home health	No deductible or coinsurance
Hospice	Copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
*A benefit period begins when a person is admitted to a hospital and ends 60 days after discharge from a hospital or a skilled nursing facility. **Coinsurance – portion of a health care fee that must be paid by an insured patient	

Part B: – Medical Insurance: Part B pays for doctors' services, outpatient hospital care, and home health visits not covered under Part A. It also covers laboratory tests, such as X-rays and blood work; medical equipment, such as wheelchairs and walkers; preventive services, such as mammograms and prostate cancer screenings; cardiovascular (heart) disease and diabetes screenings; outpatient physical therapy; mental health care; and ambulance services.

Medicare also covers one initial physical exam within six months of when a person first enrolls in Medicare Part B.

Part B has an annual $124 deductible (2006) and, for most services, a 20% coinsurance.

If enrolled in Part B, you must pay a monthly premium ($88.50 in 2006), which is typically deducted from your Social Security check. The Part B premium is currently the same for all people on Medicare ($88.50 per month in 2006). Beginning in 2007, it will be higher for people with incomes over $80,000 ($160,000 per couple).

Part B	
BENEFITS	**INDIVIDUAL PAYS (in 2006)**
Premium	$88.50 per month
Deductible	$124 a year
Physician and other medical services MD accepts assignment* MD does not accept assignment	20% coinsurance 20% coinsurance plus up to 15% over Medicare-approved fee[1]
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays; durable medical equipment	20% coinsurance
Physical, speech, and occupational therapy	20% coinsurance[2]
Clinical diagnostic laboratory services	No coinsurance
Home health care	No coinsurance
Outpatient mental health services	50% coinsurance
Preventive services - Flu shots; pneumococcal vaccines; colorectal cancer screenings; prostate cancer screenings; mammograms; Pap smears; pelvic exams - Bone mass measurement; diabetes monitoring; glaucoma screening	 Part B deductible and 20% coinsurance waived for certain preventive services 20% coinsurance

[1] Referred to as the Medicare Limiting Charge Law, the limit on the percentage above the Medicare-approved amount that a physician can charge is less than 15% in some states.

[2] There is a coverage limit on Medicare outpatient therapy services. A $1,740 limit per year for occupational therapy services, and a $1,740 limit per year for physical and speech-language therapy services combined.

* Assignment – physicians agree to accept Medicare's predetermined fee as payment-in-full; patients are responsible for 20% copayment but no more.
SOURCE: *Medicare & You 2006* Handbook.

Part C - Medicare Advantage: Medicare Part C offers Parts A and B benefits, and may offer prescription drug coverage (Part D), through private health plans. This part of Medicare does not offer additional Medicare benefits.

Part D – Prescription Drug Insurance: Medicare began covering prescription drugs in 2006 under Medicare Part D. There is a separate monthly premium of about $32 in 2006 for Part D, but the premiums vary greatly among plans. Medicare drug coverage is offered through Medicare-approved private plans. Help for people on Medicare with limited income and resources is available and can reduce or eliminate premiums, deductibles, and co-pays. For more details on Part D, see the Prescription Drug Costs and Medicare.

What Medicare Does *Not* Cover

You should be aware that Medicare does not cover all health care expenses -- for example, it does not pay for long-term personal care services at home or in a nursing home but does cover short-term skilled nursing care. Medicare does not cover eye exams, eyeglasses, hearing aids, dental care, or care provided outside the United States.

Medicare private plans -- called Medicare Advantage plans –- often provide coverage of prescription drugs and supplemental benefits, in addition to the benefits covered in the traditional Medicare program. See Talking About Medicare Advantage and Private Plans for additional information.

Plan for Medicare Enrollment

As a senior, eligibility for Medicare begins upon turning 65, even if your eligibility for full Social Security benefits does not begin until later. Choosing to receive Social Security before age 65 does not affect when you become eligible for Medicare, but it may affect the enrollment process.

- **If you are already receiving Social Security benefits when you turn 65,** you will automatically be enrolled in both Parts A and B of Medicare, effective on the first day of the month that you turn 65. A Medicare card will arrive in the mail about three months before your birthday. You can choose to decline Part B coverage, but you should take it if you want to have full Medicare benefits and avoid paying a Part B premium penalty later on (unless you have health care coverage through your or your spouse's current employer).
- **If you are not receiving Social Security benefits when you turn 65,** you must apply for Medicare. You will not be enrolled automatically. You may apply at any Social Security office during the *initial enrollment period*, which begins three months before you turn 65 and ends three months after your birthday. Contact information for making an appointment with your local social security office is available in the Additional Resources section of this guide.

If you do not enroll in Medicare during the initial enrollment period, you must enroll during a general enrollment period, which is January 1st through March 31st of every year. Your coverage will begin on July 1st of the year you sign up. If you wait until after your initial enrollment period, you may have to pay a penalty for each year you delayed enrollment. This penalty will be added permanently to your Part B premium.

If you or your spouse are still working when you turn 65, and you have health coverage through your employer, you may be able to delay enrolling in Part B without paying a late enrollment penalty. This will allow you to avoid duplicating Part B coverage and paying the Part B monthly premium. To avoid a late enrollment penalty you must enroll in Part B within 8 months of the time that you or your spouse stop working or you lose your employer-sponsored health insurance, (called your *Special Enrollment Period*). Your coverage will begin the month after you enroll. You should check with your local Social Security office before declining Part B to be sure you will not have to pay a penalty for late enrollment. Information on contacting your local Social Security office is available in the Additional Resources section of this guide.

If you have continuation health care coverage from a former employer, sometimes called COBRA, you should still enroll in Medicare Parts A and B during your initial enrollment period. Your health insurance under COBRA typically ends as soon as you are eligible for Medicare.

If you are a citizen or permanent resident, but not entitled to Medicare (for example, because you did not work enough years to qualify), you may still voluntarily enroll in Medicare. However, you must pay a monthly premium for Part A benefits (in 2006, $216 if you worked 30 or more quarters; $393 if you worked fewer than 30 quarters).

Prescription Drug Costs and Medicare

1. **Understanding the Basics of the Medicare Prescription Drug Benefit**
   - Standard Coverage

2. **Determining if the Medicare Drug Benefit is Right for You**
   - Assessing Your Current Source of Drug Coverage
     - Do you get your drug coverage from a former or current employer or union?
     - Do you currently have a Medigap supplemental policy and does it pay for prescription drugs?
     - Are you currently enrolled in a Medicare Advantage (MA) plan (HMO, PPO, POS, or PFFS plan)?
     - Does Medicaid help pay for your medical care?
     - Do you still have a Medicare-approved drug discount card?
   - Understanding the Late Enrollment Penalty

3. **Assessing What Type of Plan Is Best for You**
   - Medicare Prescription Drug Plan (PDP)
   - Medicare Advantage (MA) Plan

4. **Choosing a Medicare Drug Plan: Consider the Following Questions**
   - Are My Prescription Medications on the Plan's List of Covered Drugs?
   - How Much Will I Have to Pay for Each of My Prescriptions?
   - Is My Regular Pharmacy in the Plan's Network?

5. **Using Information Sources to Select a Plan**
   - The Medicare & You 2006 Handbook
   - Medicare.gov
   - 1-800-MEDICARE
   - Medicare Drug Plan Sponsors
   - State Health Insurance Assistance Programs and Community Organizations

6. **Enrolling in a Plan**

7. **Changing Plans During the Year**

8. Extra Help for Those with Limited Incomes

- Important Information for People on Medicare Who Get Help from Medicaid for Medical Care
- Others with Limited Income and Resources
- Who Should Apply for Extra Help?
- Receiving Extra Help
  - Applying for extra help
  - Signing up for a drug plan

Many people on Medicare rely on prescription drugs to manage their health conditions and have been under increasing financial pressure because of the rising cost of their medications. In an effort to help the 43 million people on Medicare with their pharmacy bills, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, which created a new prescription drug benefit for people on Medicare.

This section offers general information about the new Medicare drug benefit, advice for determining if the Medicare drug benefit is right for you, key considerations for selecting a Medicare drug plan that best meets your needs, and information about extra financial assistance with drug costs available for those with limited incomes.

The federal government is helping to cover the cost of the Medicare prescription drug benefit; however, private companies are administering the benefit on behalf of the government. Therefore, to get the Medicare prescription drug benefit, you and others on Medicare need to enroll for coverage under one of these plans.

There are two types of plans you can sign up for to get Medicare drug coverage:

- A Medicare prescription drug plan that just covers prescription drugs (and no other benefits) paired with the original Medicare program (the traditional fee-for-service program); or
- A Medicare Advantage plan, like a Medicare HMO or PPO, which covers all Medicare benefits, including prescription drugs.

The Medicare drug benefit is voluntary. If you currently have a generous source of drug coverage (e.g., from an employer or union, the Veterans Administration, etc.) you may want to keep that coverage rather than sign up for a Medicare prescription drug plan or a Medicare Advantage plan.

You can sign up for either type of Medicare plan between November 15, 2005 and May 15, 2006. For 2007 and future years, you can sign up (or switch plans) between November 15 and December 31 of each year, with drug coverage effective January 1 of the following year.

Understanding the Basics of the Medicare Prescription Drug Benefit

As of January 1, 2006, Medicare helps pay for prescription drugs. All people with Medicare are eligible for this coverage, regardless of their medical history or income.

The Medicare drug benefit is expected to reduce drug costs for most enrollees and protect against catastrophic drug expenses, but it is not free. When you get Medicare prescription drug coverage, you pay a share of the costs and Medicare pays part of the costs. Your costs will vary depending on which plan you choose, but all plans must, at a minimum, provide you with a standard level of coverage.

Standard Coverage (the minimum coverage all drug plans must provide)

If you join a drug plan in 2006 that offers the standard benefit, you will pay:

- A monthly premium which varies greatly depending on the plan you choose, but the average is $32 a month in 2006)
- The first $250 of your prescription drug costs each year, called the 'deductible'

After you pay the yearly deductible, you will pay the following for the remainder of 2006:

- 25% of the cost of covered drugs from $250 to $2,250, (your plan pays the other 75% of these costs); then
- 100% of your next $2,850 in total drug costs (called the "doughnut hole," you are responsible for all drug costs out of your own pocket); then
- 5% of your drug costs (or a small copayments for the rest of the calendar year (known as catastrophic coverage) after you have spent a total of $3,600 out of pocket.

Although this is the standard plan, many Medicare prescription drug plans offer a benefit package that differs from the standard. Most plans do not have a $250 deductible and do not use a 25% coinsurance for each prescription filled. Alternatively, most plans impose different drug copayment amounts, depending on the medication. Typically, they charge substantially less for generic drugs than brand-name drugs.

Most of the Medicare drug plans *do* have a doughnut hole. If you enroll in a plan with a doughnut hole, you will pay the entire cost of your prescription drugs until you have spent $3,600 for your prescriptions (in addition to any amount you have spent on premiums). Keep in mind that you will continue to pay the monthly premiums for your drug plan during the months that you have expenses in the doughnut hole when the plan is not helping to pay for your medications. For tips on how to manage your spending in the doughnut hole, see the "How much will I have to pay for each of my prescriptions?" section.

Determining if the Medicare Drug Benefit is Right for You

Now that you've learned a little bit about the Medicare drug benefit, it's time to decide whether the coverage is right for you.

The first thing to consider is whether you currently have drug coverage. If you do not have coverage, the Medicare drug benefit is worth your consideration. It is expected to reduce drug costs for most enrollees and protect against catastrophic drug expenses. For many people, the coverage could be a good deal, because Medicare is subsidizing the cost. However, if you decide not to sign up, it is also important to be aware of the consequences of doing so.

What to Consider When Deciding to Sign Up

- Do you currently have drug coverage? Will it be available next year?
- Do you spend a lot on drugs?
- Are you likely to spend more than $3,600/year on prescription drugs?

Assessing Your Current Source of Drug Coverage (if you have one)

Many people on Medicare have supplemental drug coverage, and if this is true for you, you should consider your current coverage and what that means for you in deciding whether to sign up for the Medicare drug benefit.

The following is a list of scenarios that may fit your current supplemental coverage situation and help you decide whether to sign up for a Medicare drug plan.

Do you get your drug coverage from a former or current employer or union?

In general, benefits offered by employers are more generous than the standard Medicare drug benefit. You should have received a letter from your former or current employer letting you know whether your coverage is "creditable," which means as generous as the standard Medicare prescription drug benefit. If you did not receive this information, contact your employer.

If your employer says your drug plan meets this test, you can either keep your employer health plan or enroll in a Medicare prescription drug plan. Compare the benefits offered under your employer plan with the benefits offered by Medicare drug plans in your area so you can be sure which plan is best for you.

If your employer plan does not meet the "creditable coverage" test, you may want to consider a Medicare plan for your drug coverage so you don't face a late enrollment penalty down the road.

If your "creditable" retiree coverage ends or you retire and are not offered retiree health benefits, you can then enroll in a Medicare prescription drug plan. You will not have to pay a late enrollment penalty as long as you join a Medicare plan within 63 days after your employer coverage ends.

Tip

You cannot receive the extra help available to people with low incomes for the Medicare drug benefit if you are in an employer plan, even if you qualify based on income and resources. People with low incomes should consider all of the options carefully before making a decision. Individualized help is available through your state SHIP program.

It is also important to point out a couple of things about employer coverage that are important to consider when making your choice about the Medicare drug benefit:

- Employer plans usually include other benefits besides drug coverage, so you should consider not only the drug coverage but all health care benefits offered by the employer plan.

- If you decide to drop your employer coverage, you will probably not be able to rejoin the plan in the future, so make sure you think through your decision.
- A final concern is whether you may qualify for additional help that is available to people with limited incomes and resources. This help can be quite valuable but is not available to you if you keep your employer coverage.

Do you currently have a Medigap supplemental policy and does it pay for prescription drugs?

If you are currently covered by a Medigap policy with no drug coverage (Plans A-G), you may want to keep your current Medigap policy and sign up for a Medicare drug plan. You would then have original fee-for-service Medicare for basic benefits, a Medicare prescription drug plan, and a Medigap policy to fill the gaps, all of which require a monthly premium. Another option would be to switch to a Medicare HMO or PPO, which would cover all Medicare benefits, including prescription drugs.

If you are currently covered by a Medigap policy with prescription drug coverage (Plans H, I or J), these policies are generally not considered "creditable," which means the drug coverage is typically not as generous as the standard Medicare drug benefit. You should have received a letter from your Medigap insurer describing your options for 2006. Assuming the letter indicates that your Medigap drug coverage is not as generous as the standard Medicare drug benefit, and you don't sign up for a Medicare drug plan in 2006, you will face a late enrollment penalty if you decide to sign up for Medicare drug coverage in the future.

Rather than keep what you have, you could switch to a Medigap policy without prescription drug coverage (Plans A-G, or H, I, and J without drug coverage) *and* enroll in a Medicare drug plan. If you make this switch, you would probably reduce your Medigap premium since policies without drug coverage are typically less expensive. Of course, you would also pay a premium for your new Medicare drug plan.

Another option would be to switch from traditional Medicare to a Medicare Advantage plan, like a Medicare HMO or PPO, which would cover all Medicare benefits, including prescription drugs. With this option, you could save money by dropping Medigap altogether but could face restrictions on the doctors, specialists, and hospitals you can use under the plan.

There are two new Medigap plans (K and L). These plans do not offer prescription drug coverage but are plans with high deductibles meant to cover catastrophic costs. Like Medigap plans A through G, you may still join one of these plans, keep original Medicare, and join a Medicare drug plan to receive traditional Medicare benefits, catastrophic coverage protection, and prescription drug coverage.

Are you currently enrolled in a Medicare Advantage (MA) plan (HMO, PPO, POS or PFFS plan)?

If so, you should have received information from your plan explaining what your options are for prescription drug coverage. If your plan covers prescription drugs, you can stay with your current Medicare Advantage plan and continue to receive all Medicare benefits through your plan, including drug coverage.

If your Medicare Advantage plan does *not* cover prescription drugs, you can keep your current coverage, but you will face a late enrollment penalty if you decide to switch to a Medicare stand-alone drug plan or Medicare Advantage plan that covers prescription drugs (called a Medicare Advantage prescription drug (MA-PD) plan) in the future. If you choose an MA-PD plan, you would continue to pay the monthly Part B Medicare premium and may pay another premium for additional benefits, such as the new prescription drug benefit.

If you are dissatisfied with your MA-PD plan and want to switch to another Medicare Advantage plan with prescription drug coverage, you can do so once through June 30, 2006. In 2007 and each year thereafter, you will be allowed to switch to another Medicare Advantage plan with drug coverage through March 30.

If you decide to disenroll from your Medicare Advantage plan and opt for health coverage through traditional Medicare, you will need to decide whether to sign up for a stand-alone plan that provides the Medicare prescription drug benefit. If you choose traditional Medicare with a prescription drug plan, you will pay a monthly premium for each.

Does Medicaid help pay for your medical care?

As of January 1, 2006, Medicaid no longer provides basic prescription drug coverage to people who are covered under both Medicare and Medicaid. Your drug coverage is now provided by a Medicare prescription drug plan, but Medicaid continues to pay for other benefits.

As someone with Medicare and Medicaid, you have been automatically enrolled into one of the new Medicare prescription drug plans to prevent any possible gaps in your drug coverage. You should have received a letter from Medicare with the name of the Medicare drug plan that you were assigned to for 2006. If you need to fill a prescription and are not sure which plan you are in, bring along your Medicare and Medicaid cards to the pharmacy and the pharmacist should be able to tell you which plan you've been assigned to and which of your drugs are covered by the plan.

If the Medicare drug plan to which you were assigned does not cover some of your medications, you can switch to another Medicare drug plan offered in your area that is better suited to your medication needs. However, before switching plans, check to see if the plan that you prefer would require you to pay an additional premium. In general, Medicare pays the full monthly premium for people with Medicare and Medicaid but only up to a certain amount. If you were to enroll in a higher premium plan, you would have to pay a share of the monthly premium for the more expensive plan.

For more information on extra help paying for a prescription drug plan, see Extra Help for Those with Low Incomes.

Do you still have a Medicare-approved drug discount card?

You can continue to use it but only until May 15, 2006. However, once you sign up for a Medicare prescription drug plan, you can no longer use your Medicare-approved discount drug card – even to help pay for prescriptions that are not covered by your new plan. However, the Medicare prescription drug benefit is expected to do a better job than discount cards in cutting drug costs for enrollees. Medicare drug plans offer insurance coverage and protection from catastrophic expenses, unlike discount cards which simply provide discounts off retail prices.

During 2004 and 2005, some people with modest incomes who signed up for a Medicare-approved drug discount card received up to a $600 credit to help pay for their prescriptions. If you received the credit but have not spent it, you can use the amount that is left over before May 15, 2006. However, if you enroll in a Medicare drug plan, the credit is not available to you once your coverage in a drug plan begins.

Medicare provides significant financial help to people with limited incomes and resources enrolled in Medicare drug plans. So, if you received the $600 credit with the discount card, you should apply for the extra help through the drug benefit, which will offer far more help than the discount card.

For more information on receiving extra help paying for a prescription drug plan, see Extra Help for Those with Low Incomes.

Understanding the Late Enrollment Penalty

After the initial enrollment period from November 15, 2005 to May 15, 2006, you are no longer able to sign up for Medicare drug coverage for 2006. You will have to wait until November 2006 to sign up for coverage for 2007. If you decide to wait to join a Medicare drug plan for a few years or you maintain drug coverage that is not "creditable," you will face a late enrollment penalty. The late enrollment penalty is based on the amount of time that you delay enrollment. Medicare will charge a one percent premium penalty for every month you wait to sign up. This premium penalty would increase the cost of your Medicare prescription drug coverage permanently.

Here is how it is expected to work:

- If you don't sign up for 2006, but enroll in 2007, you delayed enrollment for 7 months after the enrollment period ends on May 15, 2006. If the average premium for 2007 is $41/month, you would pay your plan's premium plus 7% (1% x 7 months) of $41, or an additional $2.87 per month. In all future years, you will pay a monthly premium that is increased by 7% of the average monthly premium for a given year.

- If you don't sign up until 2008, you would face a 19% premium penalty (a 7-month delay in 2006 and a 12-month delay in 2007). If the average premium in 2008 is $44/month, then the premium penalty would be 19% of $44 or another $8.36 per month added onto your premium, which is an additional $100 more that year.

As you can see, the premiums for Medicare prescription drug plans can rise pretty quickly if you delay enrollment, so it is important to make the decision of whether and when to sign up for the Medicare drug benefit with care.

Assessing What Type of Plan Is Best for You

There are two general types of Medicare drug plans being offered, and you may want to consider which type of plan is best for you before making a decision.

Medicare Prescription Drug Plan (PDP)

The first type of plan, called a Medicare prescription drug plan (PDP), covers prescription drugs and no other benefits. These plans, offered by Medicare-approved private companies, are generally best for people who need drug coverage but prefer to get their other benefits, such as doctor's visits, from the traditional fee-for-service Medicare program. There are at least 40 prescription drug plans offered in most states, so there are several choices for you to consider.

With a PDP, you receive prescription drug insurance directly from the Medicare-approved private plan, but you continue to use the doctors and hospitals that you have been using under traditional Medicare. While prescription drug plans generally have a similar structure to the standard Medicare drug benefit, the plans vary in their premiums, deductibles, formularies, and cost-sharing arrangements.

Medicare Advantage (MA) Plan

The second type of plan, called a Medicare Advantage plan, covers all Medicare benefits, as well as the Medicare drug benefit. These plans are also sponsored by private insurance companies and include HMOs, PPOs and private fee-for-service plans.

Medicare Advantage plans sometimes offer additional benefits to what traditional Medicare offers, but the plans typically impose restrictions on which doctors and hospitals enrollees may visit. In some areas, there are dozens of Medicare Advantage plans available. The drug coverage through Medicare Advantage plans also differs in the premiums, deductibles, formularies, and cost-sharing that is required.

Choosing a Medicare Drug Plan: Consider the Following Questions

If you choose to enroll in a Medicare prescription drug plan you will want to compare the various features of plans available in your area. Plans set their own premium and benefits within certain guidelines established by Medicare. There are important differences between plans including premiums, deductibles, which drugs are covered, and how much you will pay to fill specific prescription drugs. There may also be differences in the availability of pharmacies across participating plans so it is important to do your homework before signing up for a plan. Consider the following questions when selecting a Medicare drug plan.

Tip

Before choosing a plan, find out:

- Which of your drugs are covered by the plan;
- What you will pay for your prescriptions, particularly your most expensive medications;
- Does the plan impose any restrictions on the specific drugs you take, like the number of prescriptions you fill or how many pills you can get at a time.

Are my prescription medications on the plan's list of covered drugs?

Each plan has a formulary – a list of drugs covered by the plan. Although all plans must meet Medicare's requirements to cover at least two drugs in each therapeutic class or category, formularies vary across plans and some may not cover all of the drugs that you take.

Formularies might also include some restrictions on what you have to do to get the drugs you take, including getting your doctor and the plan to approve the medication you take (prior authorization), getting you to take other, similar drugs before taking one that has been prescribed to you (step therapy), and how many pills you can get at a time (quantity limits).

Plans are expected to provide access to a "broad range of medically appropriate drugs," including a majority of drugs within the following classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and antineoplastics. Use the Formulary Finder for Prescription Drug Plans to identify plans in your area that cover your drugs (http://plancompare.medicare.gov/formularyfinder/selectstate.asp).

Tip

Before starting your research, make a list of drugs and dosages you are currently taking so you can use this to help pick a plan. If you select a plan that does not cover all of your drugs, your doctor or pharmacist may be able to suggest a generic version or a different medication covered by your plan.

Drug plans can change the drugs they cover or the prices that you pay for them during the year. The plan must let you know at least 60 days before your drug is removed from the list or if the cost of the drug is changing. If this happens to you, consult your doctor.

If your doctor thinks you need a drug that isn't on the list, or if one of your drugs is being taken off the list, you or your doctor can apply for an exception or appeal the decision. Plans are required to provide information to enrollees on how to do this. Check with the plan for more information.

How much will I have to pay for each of my prescriptions?

After checking to see whether your drugs are included on the formulary, you will want to know how much the plan charges for each medication. You may be required to pay different amounts for different drugs on the formulary because plans may have rules about which drugs are covered in different drug price categories. Often plans will have two or three levels (known as tiers) of copayments. Typically, they charge less for generics than brand-name drugs.

If you sign up for a Medicare drug plan that does not cover all of your prescriptions, the money that you spend out of pocket for drugs not covered by your plan will not count toward the $3,600 out-of-pocket spending limit needed to get catastrophic coverage.

If you think you could end up with expenses high enough to reach the doughnut hole, you might want to consider ways you can control costs in the benefit gap. Here are a few suggestions:

1. While the majority of Medicare drug plans have a gap in coverage, there are some plans with some coverage in the doughnut hole. Typically, these plans have higher monthly premiums and cover only generics in the gap.

2. If you enroll in a Medicare drug plan that has a doughnut hole, try to find out how much you will pay for each of your prescriptions when you reach the benefit gap. This information varies from plan to plan, but it is available on www.Medicare.gov & and by calling your Medicare drug plan.

3. If you enroll in a Medicare drug plan with a doughnut hole, plan ahead so you can anticipate and prepare to pay for your prescriptions later in the year, when you will be charged for the entire cost of your drugs. You should receive monthly statements from your Medicare prescription drug plan with information about your drug expenses. If you do not receive these statements, contact your plan so you are not caught off-guard at the pharmacy counter.

Is my regular pharmacy in the plan's network?

Drug plans must contract with pharmacies in your area, but they do not have to contract with all pharmacies. Before signing up with a plan, check to make sure the pharmacies in the plan are convenient to you, especially if you have a particular pharmacy where you fill your prescriptions. Some plans also allow you to get your prescriptions through the mail at a lower cost than purchasing them at a retail pharmacy.

Tip for Snowbirds

Many of the companies that offer Medicare prescription drug plans operate throughout the country. Before you choose a drug plan, be sure to ask if the plan is offered in the locations where you spend time and if the pharmacies that are convenient to you in both locations are part of the plan's network.

If you're not sure which plans include your local pharmacy in their network, ask your pharmacist for a list of plans they are accepting. If you fill a prescription at a pharmacy that is not in your plan's network, you may be charged more for your drugs, so be sure your plan has a pharmacy close by. If you go to a pharmacy that is not in your plan's network, be sure to keep track of your prescription drug expenses because a portion of these costs *do* count toward the $3,600 out-of-pocket limit. Save your receipts and submit the claims to your drug plan.

Getting Started on Choosing a Medicare Drug Plan

Here are a few questions and answers to get you started:

1. **How do I choose a Medicare drug plan?** Check to see if drugs that you take – especially your most expensive drugs – are covered by the plans offered in your area. Compare the price for each of your prescriptions. Check to see if your local pharmacy is in the plan's network. And, of course, compare monthly premiums.

2. **When can I enroll in a plan**? You have until May 15, 2006 to enroll in a plan for 2006. After May 15, you will generally have to wait until November 2006 to sign up for drug coverage for 2007.

3. **How do I enroll? Do I enroll directly with Medicare?** You can enroll directly with the plan over the phone, on the plan's website, or by filling out and mailing in an application. You can also enroll in most plans through Medicare's online enrollment center at www.Medicare.gov or by calling 1-800-MEDICARE.

4. **When does coverage begin?** Coverage began January 1, 2006, for those who signed up for a Medicare drug plan on or before December 31, 2005. If you sign up between January 1 and May 15, 2006, your coverage begins on the first of the month following your sign-up date. If you don't sign up by May 15, you will have to wait until 2007.

Using Information Sources to Select a Plan

There are a number of useful information sources that can help you learn more about the plans serving your area and help you compare plans so that you can select one that works best for you.

The *Medicare & You 2006* Handbook (http://www.medicare.gov/spotlights.asp#medicare2006)
The handbook, which is mailed to all people on Medicare, is a great place to start researching plans. The handbook lists plans in your area and includes basic information on the plans, like premiums, deductibles, and cost-sharing information.

Medicare.gov, the Official Medicare Website
In order to compare plans or find out more information about a particular plan, you can visit Medicare's Prescription Drug Plan Finder website at www.Medicare.gov. The website offers detailed information on monthly premium amounts and the deductible. It also lists what drugs are covered under the plan and at what level (or tier), meaning how much you pay for each individual drug, depending on how the plan structures its benefit and formulary (list of covered drugs).

The Prescription Drug Plan Finder can be used in various ways:

- You can enter your zip code and what type of plan you are interested in, and the tool shows you a list of all of the plans in your area. From there, you can research the individual plan's features.

- Or you can narrow your search by entering your list of drugs and/or your preferences for the amount you would pay for the premium and deductible, whether the plan offers mail order, and what pharmacy you prefer.

Either way you navigate the site, you are able to get contact information for the plans and even sign up for most plans through www.Medicare.gov.

1-800-MEDICARE, the Official Medicare Hotline

The Medicare program operates a toll-free hotline (1-800-MEDICARE) to answer your questions about the drug benefit and the plans that serve your area. If you do not have internet access to use the Prescription Drug Plan Finder on the Medicare website, you may call 1-800-MEDICARE for similar information. If you provide the Medicare operator with your zip code and a list of your drugs and dosages, the Medicare program will mail you comparison plan information from the Medicare.gov website.

Medicare Drug Plan Sponsors

You will likely receive information from some of the private plans that are offering the Medicare drug benefit in your area. You may also want to contact the plan sponsors directly so you can get answers to specific questions you may have about the drug coverage they provide. The *Medicare & You* handbook contains contact information for the plans. You can call them and, upon request, they will give you information on their formularies and cost-sharing information. In addition, some of the plans have their formularies posted on their websites. The organizations can also enroll you into one of their plans on the phone, online, or through a paper application.

Important Dates for the Medicare Prescription Drug Benefit

January 1, 2006
Coverage begins for those who join a Medicare prescription drug plan by December 31, 2005

May 15, 2006
Last day to sign up for a Medicare drug plan for 2006

October 2006
Medicare beneficiaries receive *Medicare & You 2007* handbook and Medicare.gov is updated with 2007 plan information

November 15, 2006
First day to sign up for a Medicare drug plan for 2007 or switch plans for those enrolled in 2006

December 31, 2006
Last day to sign up for Medicare prescription drug plan for 2007

January 1, 2007
Drug coverage begins for those who signed up for 2007 and those continuing coverage from 2006

State Health Insurance Assistance Programs and Community Organizations

You can also get help in finding the best plan for you by calling your State Health Insurance Assistance Program. See Additional Resources for phone numbers and websites in your state.

Other community-based groups may hold information sessions or health fairs at local senior centers, libraries, government centers or other community areas that may also be helpful. Some events may be sponsored by companies offering plans in your area or brokers that sell policies for plans. Make sure to find out who is sponsoring the events, so you can know who is presenting the information and whether it is educational or marketing information.

Making an informed decision will take some work on your part, but hopefully it will pay off with good drug coverage at a reasonable price.

Enrolling in a Plan

There are a number of ways that you can sign up for a Medicare drug plan:

- **Mail in or fax a paper application.** Contact the company offering the drug plan you select and request that they send you an application. Once you fill out the application, mail or fax it back to the company.
- **Visit the plan's website.** Log on to the drug plan's website. You may be able to sign up directly online.
- **Visit Medicare's website.** You are also able to enroll in most drug plans at www.Medicare.gov through Medicare's online enrollment center. Drug plan participation in Medicare's enrollment center is voluntary, so not all plans offer this option. To enroll in a plan online you have to provide your Social Security number and the number on your Medicare card.

Once your enrollment is processed, the company offering the drug plan will send you an acknowledgement letter confirming your enrollment. This letter serves as your proof of insurance until your membership card arrives 3 to 5 weeks later. Along with the card, you will receive a member handbook, a list of covered drugs, a pharmacy provider directory, complaint and appeal procedures, and other important information about being a plan member.

Changing Plans During the Year

For drug coverage in 2006, the annual coordinated election period runs from November 15, 2005 through May 15, 2006. In 2007 and beyond, the annual coordinated election period runs from November 15 through December 31 of the prior year and the drug coverage is effective January 1. During these periods you may sign up for a plan or, if already enrolled in a plan, switch to another one. In most cases, you will not be allowed to make a change outside of these designated time periods.

Tip

If you change your permanent residence and no longer live within the plan's service area, you have up to four months to select a new plan as long as you notify your former plan prior to your move date. The special enrollment period begins the month prior to your move and continues through the month of your move and up to two months following your relocation.

There are exceptions, however, for those who have Medicaid benefits, including help from Medicaid paying the Medicare Part B premium and those who reside in nursing homes. Individuals in these circumstances are able to switch plans on a monthly basis during the year. In addition, people who move to another state where their plan is not available and those whose "creditable" drug coverage is terminated also are able to switch plans during the year.

Extra Help for Those With Limited Incomes

Medicare provides extra help paying for prescription drug costs for people with limited income and resources. If your income is below $15,000 ($20,000 if married) and your resources are less than $11,500 ($23,000 if married) you may be eligible for additional assistance. Those who qualify get help paying for their drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance. The amount of extra help is based on income and resources (including savings and stocks, but not counting a home or car). The following descriptions are intended to help you get an idea of whether you are eligible for extra help.

Important Information for People on Medicare Who Get Help from Medicaid for Medical Care
As of January 1, 2006, you get your drug benefits from a Medicare prescription drug plan, instead of from Medicaid. You are not required to pay monthly premiums or a deductible, but depending on your income and whether you live in a nursing home, you could pay copayments of up to $5 for each of your prescription medications.

If your yearly income is *below* the poverty level ($9,800 for an individual; $13,200 for a couple in 2006), you pay $1 for generic drugs and $3 for brand-name drugs. After total drug spending reaches $5,100, you do not have to pay anything for your prescription drugs.

If your yearly income is *equal to or above* the poverty level ($9,800 for an individual; $13,200 for a couple in 2006), you pay $2 for generic drugs and $5 for brand-name drugs. After total drug spending reaches $5,100, you do not have to pay anything for your prescription drugs.

Which Resources are Counted?

Resources that are counted:

- Stocks, bonds, certificates of deposit, mutual fund shares
- Mortgages, promissory notes
- Checking and savings accounts
- Retirement accounts, 401k and IRAs
- Property in addition to your primary home
- Whole life insurance policy with value greater than $1,500

Resources that are not counted:

- Primary home
- Automobile
- Whole life insurance policy with value up to $1,500
- Personal belongings such as jewelry or household goods
- Machinery and livestock
- Non-cash business property
- Certain housing assistance
- Victims' compensation payments

Note: Resource levels allow up to $1,500 for funeral and burial expenses.

Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2006

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Individuals with Medicare and Medicaid	$0	$0	$1–$2/generic $3–$5/brand-name; no copays after total drug spending reaches $5,100
Individuals with Medicare and Medicaid in nursing homes	$0	$0	No copays
Individuals with income <135% of poverty and resources <$7,500/individual; $12,000/couple	$0	$0	$2/generic $5 brand-name; no copays after total drug spending reaches $5,100
Individuals with income 135%–150% of poverty and resources <$11,500/ individual; $23,000/couple	sliding scale up to $32.20*	$50	15% of total costs up to $5,100; $2/generic $5/brand-name thereafter

Note: Resources include $1,500/individual and $3,000/couple for funeral or burial expenses.
*$32.20 in the national monthly Part D base beneficiary premium for 2006.
SOURCE: Kaiser Family Foundation summary of Medicare prescription drug benefit low-income subsidies in 2006.

Regardless of your yearly income, **if you are on Medicaid and in a nursing home** (such as a skilled nursing facility or intermediate care facility), you do not pay anything for your prescription drugs.

Others with Limited Incomes and Resources
If you do not have prescription drug coverage from Medicaid but have limited income and resources, you may still be eligible for additional help paying for your Medicare prescription drug coverage.

If your yearly income is below 135% of the poverty level ($13,230 for an individual; $17,820 for a couple in 2006) and your resources are less than $7,500 for an individual or $12,000 for a couple, you pay no monthly premiums and no deductible. You pay $2 for generic drugs and $5 for brand-name drugs and have no other costs during the benefit gap. After total drug spending reaches $5,100, you do not have to pay anything for your prescription drugs.

If your yearly income is between 135% and 150% of the poverty level ($13,230 and $14,700 for an individual; $17,820 and $19,800 for a couple in 2006) and your resources are below $11,500 for an individual and $23,000 for a couple, you pay reduced monthly premiums and a $50 deductible. You pay 15% of the costs of your prescription drugs until total drug spending reaches $5,100, at which point, you pay $2 for generic drugs and $5 for brand-name drugs.

In general, resources are defined as any assets you may have that can be converted to cash within 20 days. This includes stocks, bonds, checking and savings accounts, retirement accounts, property (other than your primary home), and whole life insurance policies with values greater than $1,500.

The resource test *does not* count your primary home, car, life insurance policies with values up to $1,500, or personal items like jewelry and household goods. The resource limit allows for savings of up to $1,500 for funeral and burial expenses.

Who Should Apply for Extra Help?

People who received prescription drug benefits from Medicaid prior to January 1, 2006 are automatically eligible for extra help with their drug costs and do not need to apply separately for the extra help.

People who receive any help from Medicaid paying their Medicare premiums or receive Supplemental Security Income automatically get the extra help paying for the prescription drug benefit and do not need to apply separately. However, it is necessary to enroll in a Medicare prescription drug plan.

People who do not receive any assistance from Medicaid but have limited income and resources are encouraged to apply for extra help and enroll in a Medicare drug plan.

Receiving Extra Help

Receiving assistance with the Medicare drug benefit is generally a two-step process for most people with limited incomes (although these steps can be completed in any order):

1. You need to apply for extra help based on your income and resources; and

2. You must sign up for a prescription drug plan to begin using the benefit.

Applying for Extra Help

Applications for extra help are available from your local Social Security Administration (SSA) or Medicaid office (see Additional Resources for contact information). You can also submit an application online through SSA's website at www.ssa.gov.

There is no charge for applying, even if you don't qualify. You need to provide information about your income and resources but do not need to provide any documentation confirming that information. If you do not have all of the information available, fill out what you know and mail the application back. Someone from SSA will call you and help you complete the rest of the application over the phone or follow up with any further questions.

Signing Up for a Drug Plan

The second step is to join a prescription drug plan. In general, Medicare pays the full monthly premium for people receiving extra help but only up to a certain amount. You should check to make sure the plan you want does not charge a premium above the amount that Medicare will pay. If you enroll in a higher premium plan, you would have to pay a share of the monthly premium for the more expensive plan. Contact the individual plan or call 1-800-MEDICARE to find out which plans provide coverage to those qualifying for extra help.

Anyone who has been determined eligible for extra help but is not enrolled in a prescription drug plan by May 15, 2006, will be automatically enrolled in a plan which will begin coverage on June 1, 2006. If the plan Medicare chooses for them doesn't meet their needs, they can switch plans once before December 31, 2006. Those who qualify for extra help may want to choose a plan which meets their specific drug needs and enroll as soon as possible rather than wait to be auto-assigned.

Medicare Advantage Plans

- **Consider Your Medicare Options**
- **Know What You Want from a Medicare Plan**
- **Compare Medicare Plans Offered Where You Live**

Consider Your Medicare Options

More than 43 million people are covered by the Medicare program. People with Medicare can get their coverage through original Medicare (the traditional fee-for-service program) or from Medicare private plans (the Medicare Advantage program). Today, more than five million people with Medicare are enrolled in a Medicare private plan (HMO, PPO or PFFS). Most people with Medicare who have joined a Medicare private plan are in health maintenance organizations (HMOs), which have been available under Medicare since the mid-1980s.

To make an informed decision, you need to first understand how these health plans work and how they differ, then decide which option is best for you. Here is a brief description of each of the Medicare options.

Original Medicare

If you choose coverage under the traditional fee-for-service Medicare program, you can generally get care from any doctor or hospital you want and receive coverage for your care anywhere in the country. However, traditional Medicare has high cost-sharing requirements and does not currently cover the costs of certain services. To help pay for uncovered benefits and to help with Medicare's cost-sharing requirements, many people in the traditional Medicare program have supplemental insurance (see Health Insurance to Supplement Medicare).

Tip

Medicare Advantage plans may offer more benefits than traditional Medicare, but may limit your ability to get care from the doctor or hospital of your choice, depending on the plan you select.

Medicare Private Plans

Medicare HMOs

Medicare HMOs cover the same doctor and hospital services as the original Medicare program, but out-of-pocket costs for these services are usually different. HMOs appeal to some people with Medicare because they may provide additional benefits, such as eyeglasses, which are not covered by the traditional Medicare program. Medicare HMOs may charge a premium that you would need to pay in addition to the Part B monthly premium.

You should be aware that Medicare HMO enrollees generally can only use doctors, hospitals, and other providers in the HMO's network. For an additional fee, some HMOs offer point-of-service (POS) benefits that partially cover care received outside the network.

If you join a Medicare HMO, you will usually have to select a primary care doctor who is responsible for deciding when you should see a specialist and which specialist you should see.

Neither Medicare nor the HMO will pay for unauthorized visits to specialists in the plan, providers outside the HMO's network, or for non-emergency care outside the HMO's service area.

Medicare PPOs
Medicare PPOs, or "Preferred Provider Organizations," are private health plans, much like Medicare HMOs. HMOs and PPOs differ in two key ways:

1. Medicare PPOs cover some of the costs of your care if you use doctors and hospitals outside the network.

2. Medicare PPOs generally do not require that you see a primary care physician before going to a specialist.

Regional PPOs became available under Medicare in 2006. These plans are similar to local Medicare PPOs, but serve a larger geographic area (either a single state or multi-state area) and must offer the same premiums, benefits, and cost-sharing requirements to all beneficiaries in the region. Regional Medicare PPOs offer all Medicare benefits, including the prescription drug benefit, but unlike traditional Medicare, these plans have a single deductible for hospital and physician services and an annual out-of-pocket limit on cost sharing for benefits covered under Parts A and B of Medicare. Keep in mind that the out-of-pocket limit will vary depending on the plan you select. As with local PPOs, individuals who sign up for a regional PPO will typically pay more if they go to providers outside of the network.

Private Fee-for-Service (PFFS) Plans
Private fee-for-service plans cover Medicare benefits like doctor and hospital services, much like Medicare HMOs and PPOs. Unlike Medicare HMOs and PPOs, private fee-for-service plans do not have a formal network of doctors and hospitals. Still, not all doctors and hospitals are willing to treat members of a private fee-for-service plan. If considering enrolling in a private fee-for-service plan, make sure your doctor and hospital are willing to accept the private fee-for-service plan's payments for services before you enroll. Also, be sure you understand a plan's benefits and cost sharing requirements before you enroll because private fee-for-service plans decide how much enrollees pay for Medicare-covered services and may charge higher cost sharing for certain health care services than the original Medicare program. While private fee-for-service plans are not required to offer the Medicare drug benefit, most do. If you enroll in a private fee-for-service plans without drug coverage, you can also enroll in a Medicare stand-alone prescription drug plan for your drug coverage.

Special Needs Plans (SNPs)
Special needs plans are private plans that provide Medicare benefits, including drug coverage for beneficiaries with special needs. These include people who are eligible for both Medicare and Medicaid, those living in certain long-term care facilities (like a nursing home), and those with severe chronic or disabling conditions.

For additional information about Medicare Advantage plans, call 1-800-MEDICARE, or get information about Medicare options in your area on the Medicare Personal Plan Finder website, http://www.medicare.gov/MPPF/home.asp.

Medicare Advantage and Prescription Drugs

All companies offering Medicare Advantage plans must offer prescription drug coverage in at least one of their plans. Medicare Advantage plans with drug coverage may vary in their premiums, deductibles, formularies and cost-sharing, depending on the type of Medicare Advantage plan you select. See the Medicare and Prescription Drug section for more information.

Know What You Want from a Medicare Plan

Whether original Medicare, a Medicare HMO, or another private Medicare plan is right for you will depend on your unique needs and circumstances. Think about what is most important to you when you are healthy and when you are sick. Here are some topics to consider:

Receiving care from the doctor and hospital of your choice
Under original Medicare, you can use whichever specialists and hospitals you choose, whenever you need, and without a referral from another doctor. Medicare private plan options could limit your ability to get care from the doctor or hospital of your choice, or there may be extra charges for out-of-network care. If provider choice is a priority, you should consider original Medicare with added protection from a Medicare supplemental insurance policy, sometimes known as Medigap, or from an employer-sponsored or union retiree health plan, if you are eligible (see Health Insurance to Supplement Medicare).

Getting coverage of additional benefits to reduce your medical costs
If you are on a tight budget and are willing to limit your choice of doctors and hospitals, you may be able to reduce your health care expenses and get coverage of additional benefits through a Medicare Advantage plan. It is important to review the scope and limits of additional benefits when choosing among available plans. It is also important to look at how much your out-of-pocket costs will be if you get sick. For example, some Medicare private plans charge a copay for each day of an inpatient hospital stay, while original Medicare charges only a deductible but no daily copays for the first 60 days of a hospital stay.

Maintaining health care coverage while away from home
Under original Medicare, you will be covered for care anywhere in the United States. While private plans must cover emergency care for members outside the plan area, most do not cover other health care services while away from home. For example, Medicare HMOs have more restrictive networks of doctors and hospitals that limit coverage away from home.

Keeping supplemental coverage from a former employer or union
If you are considering joining a Medicare private plan (either a Medicare Advantage plan or a stand-alone prescription drug plan), you should talk to your employer or former employer to be sure you won't lose valuable retiree health benefits if you sign up for a private plan. Many employers offer retiree health coverage as a supplement to traditional Medicare; some also offer coverage through Medicare HMOs and other private plan options.

Coordinating with Medicaid benefits
If your income and assets are quite modest, you may qualify for Medicaid benefits or other special programs that will help pay some of your health care costs. For those who qualify, Medicaid often pays for valuable benefits, such as nursing home care, and also pays Medicare's premiums. If you are already covered by Medicare and Medicaid, you should find out what you must pay to join a Medicare private plan and whether Medicaid will cover the plan's copayments. Contact information for your state Medicaid office can be found in the Additional Resources section of this guide.

Changing your mind
In 2006, you have until June 30 to sign up for a Medicare Advantage plan, but you only have until May 15 to sign up for a plan with drug coverage. If you are in a Medicare Advantage plan with drug coverage, between May 15 and June 30, you can only switch to another plan with drug coverage. In 2007 and future years, this "open enrollment" period will be limited to just the first three months of the year.

If you enroll in a Medicare private plan that later stops serving people with Medicare, you can always return to original Medicare, the traditional fee-for-service program, or you can enroll in another Medicare Advantage plan.

Compare Medicare Advantage Plans Offered Where You Live

If you are happy with your original Medicare coverage you can stick with it. You can keep your coverage through your Medicare private plan if the plan continues operating in your area from year to year. If you think you may want to change, the next step is to find out which plans are offered where you live. While original Medicare is available in all parts of the U.S., certain types of private plans may not be. In some areas of the U.S., people with Medicare have a limited choice of private plans available, while in other areas, there are multiple Medicare private plans from which to choose.

For a list of plans in your area and a copy of the Medicare handbook, *Medicare & You*, call Medicare at 1-800-MEDICARE or visit Medicare's website at www.medicare.gov. For free help in understanding differences among Medicare plans, you can call your State Health Insurance Assistance Program (SHIP). Contact information for your state's SHIP is found in the Medicare handbook and in this guide under Additional Resources.

You should consider four important factors before signing up for a plan:

1. **Accessibility of doctors and hospitals**
   Can you continue to see the doctors you know and trust if you join a certain plan? Your doctor or specialist might be in one plan's network, but not in another's. Even if your doctor is in a plan's network, he or she can leave that network at any time. What about your choice of hospital?

2. **Extra benefits**
   The supplemental benefits offered by Medicare private plans vary widely and may change every year. If you want to join a plan because of the prescription drug benefit, make sure that the plan covers the drugs you need and you understand any limits that may apply.

3. **Cost**
   How much are the monthly premiums and copayments associated with different health care services? Is there a deductible? Keep in mind that costs generally change each calendar year.

4. **Quality and reputation**
   Not all Medicare private plans are not the same. Review each plan's written information and try to talk to plan members about their experiences. For information on quality and performance, visit Medicare's website at http://www.medicare.gov/MPPF/home.asp.

Know your rights
No matter which plan you choose – original Medicare, a Medicare HMO, or another Medicare private plan – understand your rights as a patient and a consumer. If you believe you have been unfairly denied any Medicare-covered benefits, you have the right to appeal. You should send a copy of the denial notice and, if possible, a letter from your doctor explaining your need for the denied service and a letter requesting a review to the company that issued the denial.

Insurance to Supplement Medicare

- **Understand Supplemental Health Insurance**
- **Learn About Programs for People with Low Incomes**

Understand Supplemental Health Insurance

If you want to stay in original Medicare, you may want to look into your options for supplemental coverage. Without such coverage, your out-of-pocket costs could be high if you require medical care. Supplemental insurance helps pay the deductibles and coinsurance costs that original Medicare does not cover.

You may be able to get supplemental insurance from a former employer or union (retiree coverage). If not, you can buy Medicare supplemental insurance (Medigap) directly from an insurance company. Depending on your income and savings, you may also qualify for Medicaid.

Retiree Health Coverage

As a rule of thumb, if you can get supplemental retiree coverage from a former employer or union, you should. Retiree policies are often more generous than Medigap. They also may be cheaper than Medigap policies, since employers tend to pay at least part of the cost. If you are not yet on Medicare, find out what benefits you may be eligible for from your employer when you go on Medicare and ask how these benefits coordinate with Medicare.

Tip

If you have supplemental coverage, Medicare will typically pay your health care bills first and your supplemental coverage will pay second. There are a few exceptions to this rule so let your doctor and hospital know if you have other insurance so they can handle your bills correctly.

Medigap

If you want to buy a Medicare supplemental insurance policy, known as Medigap, you must decide which benefit package to buy and which insurer to use. Before making a decision, you should clearly understand what benefits are covered and how to compare plans.

There are 12 different standardized Medigap plans, labeled A-L (except in Massachusetts, Minnesota and Wisconsin). Not all plans are available in all areas. Each Medigap plan pays for a particular set of benefits.

Plan A offers the fewest benefits and is usually the least expensive. The most popular Medigap plans are C and F, because they cover major benefits and are less expensive than other plans. Some Medigap plans offer limited coverage of prescription drugs, long-term custodial care at home or in a nursing facility, vision and dental care, hearing aids, or private duty nursing.

Plans H, I, and J are typically the most expensive and include some prescription drug coverage. These plans are no longer being sold because the Medicare drug benefit has begun, but those enrolled can remain in them, either with or without drug coverage. However, it is important to note that the drug coverage offered by plans H, I, and J is not considered to be as generous as the Medicare drug benefit, which could result in a late enrollment penalty if you decide to sign up for a Medicare drug plan in the future (see the Medicare and Prescription Drug section for more information).

There are two new Medigap plans (K and L). These plans have high deductibles meant to cover catastrophic costs. Compared to current Medigap options, these new plans are designed to provide more protection when you are very sick and include less coverage of your initial expenses. For example, neither plan covers the Part B deductible and both cover all hospital inpatient costs. The first plan covers 50% of anything else you owe under Medicare Part A or Part B, and it pays for everything after you reach an annual out-of-pocket limit of $4,000. The second is similar, but covers 75% of your cost-sharing and everything after you spend $2,000 in one year. In exchange for paying a high deductible, your monthly premium should be lower.

The cost of your Medigap policy depends on the type of Medigap plan you choose and the company from which you buy it. When you have chosen the type of plan you want (A - L), it pays to shop around. Plans with the same letter name offer the same benefits, but the premiums vary from company to company. If you buy your Medigap policy during your open enrollment period or other federally mandated times, your premium cannot vary based on your health status.

No insurance policy fills gaps in coverage for Medicare HMOs or any of the Medicare private plan. Should you select an HMO, PPO, or other type of plan, you should budget for any costs that the plan doesn't cover.

For free assistance with understanding your options, contact your local SHIP (see Additional Resources). More information about Medigap plans can be found at: www.medicare.gov/mgcompare/home.asp.

Medigap Plans at a Glance 2006												
Medigap Benefits	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Basic benefits: Coinsurance for hospital days 61-150 and payment in full for 365 additional days; 20% coinsurance for physician and other Part B services after Part B deductible has been met; first three pints of blood	★	★	★	★	★	★	★	★	★	★	★	★
Hospital deductible: $952 in 2006		★	★	★	★	★	★	★	★	★	★	★
Skilled nursing facility: Coinsurance of $119 for days 21-100 in 2006			★	★	★	★	★	★	★	★	★	★
Part B deductible: $124 in 2006			★			★				★		
Part B excess charges: Part B excess charges up to 115% of Medicare's approved amount						★ 100%	★ 80%		★ 100%	★ 100%		
Emergency care outside the United States: 80% during the first two months of the trip, with $250 deductible and lifetime up to $50,000			★	★	★	★	★	★	★	★		
Annual at-home recovery benefit: Up to $40 a visit for 40 visits — $1,600 per year			★				★		★	★		
Part A hospice coinsurance: 50% of covered benefits											★	
Part A hospice coinsurance: 75% of covered benefits												★
Preventive services: Up to $120 a year if ordered by doctor				★						★		
Preventive services: 100% of Part B covered benefits											★	★
Prescription drug costs: Up to 50% of $2,500, after a yearly $250 deductible (up to $1,250)								★	★			
Prescription drug costs: Up to 50% of $6,000, after a yearly $250 deductible (up to $3,000)										★		
Out-of-pocket maximum: 100% of covered benefits after beneficiary pays $4,000 out of pocket											★	
Out-of-pocket maximum: 100% of covered benefits after the beneficiary pays $2,000 out of pocket												★

Do Your Medigap Homework

After you have chosen a Medigap plan, you must select an insurance company that sells it. The following four steps will help you decide wisely.

1. Call the insurance department in the state where you live for a list of companies that offer Medigap. Compare the premiums; they may vary a lot and may rise at different rates each year.
2. Understand how premiums are calculated and how they will change as you get older. Policies that base their annual premium on age (attained age policies) may seem like a good deal when you are 65 but may be far costlier than other policies by the time you turn 75.
3. Determine whether the Medigap insurer has arranged for Medicare to file Medigap claims automatically. Automatic claims filing can save time and headaches.
4. Check the insurer's reputation with your state insurance department. Generally, companies rated "A" or better are reputable.

Plan for Medigap Enrollment

Once you turn 65, you can sign up for any of the nine Medigap plans (A-G; K and L) during a six-month open enrollment period. Once you are enrolled, the Medigap insurer must renew your policy for life, as long as you pay your premiums. If you miss a premium payment, you may risk losing your coverage.

Under federal law, once your open enrollment period ends, Medigap insurers can refuse to offer you a Medigap plan because of your age or health status. However, you may have special protections if you want to buy Medigap because you or your employer drops coverage. State laws on Medigap consumer protections differ. For example, some states give you the right to buy a Medigap policy at any time, regardless of your health or age. You should check with your state's insurance department about your Medigap rights and protections.

Learn About Programs for People with Low Incomes

Like millions of seniors, you may be living on a limited income and unable to afford supplemental insurance. If so, you may be able to get assistance from Medicaid or a Medicare Savings Program. If you qualify, you could save hundreds of dollars on your monthly Medicare Part B premiums. You might be able to save even more if you qualify for additional Medicaid benefits, such as long-term care.

Tip

Find out about programs for low-income people on Medicare. Many low-income people on Medicare are eligible for financial assistance under Medicaid, but they do not apply.

Below are some of the basic rules for programs that exist for people on Medicare with low incomes. To get additional information about whether you may qualify for full Medicaid benefits or one of the Medicare Savings Programs in your state, contact your state Medicaid program (see Additional Resources). Another option is to use the online tool provided by the National Council on Aging (www.benefitscheckup.org).

Medicaid Benefits to Supplement Medicare

Medicaid is a federal and state program that covers medical care for people with low incomes. The Medicaid program varies a great deal from state to state. Each state has its own way of determining eligibility depending on your age, family size, medical condition and financial situation.

If you receive cash assistance under the Supplemental Security Income (SSI) program, you are eligible for full Medicaid benefits. To receive SSI, your income cannot exceed $603 a month in 2006 ($904 per couple) and your assets must be less than $2,000 ($3,000 per couple). Some states allow people with Medicare to have higher monthly incomes to be eligible for Medicaid (up to $817/individual and $1,100/couple in 2006).

If you have a higher income, but fairly high medical or long-term care expenses, you may qualify for Medicaid if your state has a "spend-down" program. For more information, contact your state Medicaid program (see Additional Resources).

Medicare Savings Programs: Qualified Medicare Beneficiary Program

Called QMB for short, this program is for people whose income is at or below 100% of poverty (up to $817 a month for singles, and $1,100 a month for couples in 2006) and whose savings are limited (up to $4,000 for singles, $6,000 for couples). For those who qualify, the state will pay Medicare premiums and may pay some or all of the deductibles and coinsurance.

Medicare Savings Programs: Specified Low-Income Medicare Beneficiary Program

The Specified Low-Income Medicare Beneficiary (SLMB) program pays Medicare's Part B premiums for people whose income is between 100% and 120% of poverty (up to $980 a month for singles, $1,320 a month for couples in 2006) and whose savings are limited.

Qualifying Individual Program (QI-1)

The QI-1 program pays Medicare's Part B premiums for people whose income is between 120% and 135% of poverty (up to $1,103 a month for singles and $1,485 a month for couples in 2006) and whose assets are limited (some states do not have an asset test for QI-1).

To learn more about these programs or to apply, contact your local Medicaid office (see Additional Resources).

Long-Term Care

Assess Long-Term Care Needs and Options

The idea of shouldering the cost of nursing home care and seeing your savings consumed by long-term care costs is daunting. The very possibility may already have prompted you to consider how you would like to receive and pay for long-term care should you need it in the future.

Long-term care may include care in a nursing home and medical and personal care at home. Medicare covers only a fraction of long-term care costs and, even then, only in certain situations. As a result, you must understand Medicare's benefits and limits and plan ahead for whatever expenses you may incur. You also need to consider who will care for you when you need help, what kind of care you want, and where you will live as you age.

Determine the Level of Care Needed. When you are no longer able to live independently and appear to need some help taking care of yourself, the first step is to determine the type of care you need. Evaluating care options is easier once you know the range and extent of services required. Often, you and your family members are best equipped to make this assessment, since you know your situation and how much day-to-day help you really need. If you prefer, you can hire a geriatric care manager, nurse, or social worker for a professional evaluation. If you are eligible for Medicaid, a state social worker sometimes will do this assessment without charge.

Explore Long-Term Care Options. There are a number of different ways to meet your long-term care needs, ranging from a few hours of personal assistance in the home to skilled, round-the-clock care in a nursing home. Depending on your needs and preferences, there are several home-, community-, and institutionally-based services available. You may especially want to discuss with family members whether you want to stay in your own home or whether you would feel comfortable in an outside facility.

Tips for Choosing a Living Facility

If you think that you may need to move into a facility of some type, consider the following tips for choosing among facilities:

- Visit the facility unannounced at various times, including at mealtime and on the weekends to see how the residents are treated. Is the staff respectful of the residents' wishes and privacy? Are the residents properly dressed and assisted with activities? Is the environment pleasant for residents? Is it somewhere you could picture yourself living?
- Talk to residents and their family members. Most facilities have both a residents' council and a family council that may be helpful.
- Ask to see the most recent survey of the facility made by the state licensing and regulatory agency. The survey spells out the facility's deficiencies. Contact a long-term care ombudsman to discuss any concerns he or she may have about the long-term care facility. Every facility must post the ombudsman program's phone number in a visible place. Required by law, an ombudsman acts as an advocate for residents and helps resolve complaints. See Additional Resources for contact information.

Home-based care. Many older people prefer to remain in their own homes rather than move into a supervised facility when they need long-term care. If you elect to stay at home, you may need to consider how much care you will require. For example, will you need help in the middle of the night, or a few hours of personal assistance several days each week? You may be best suited by a "patchwork" of formal and informal caregivers and services. Formal services may include visiting nursing services, home health aides, and such social service programs as "Meals on Wheels." Services in your community may be found by calling the local Area Agency on Aging or the Eldercare Locator at 1-800-677-1116.

Quite often informal caregivers -- family members and friends -- end up providing a large share of assistance. To supplement caregiving in the home, some families use community-based services such as adult daycare and senior centers. Call your local Area Agency on Aging to find out about available services in your neighborhood.

If home-based care is the most appropriate solution to your long-term care needs, you may need help making simple adaptations to your home to make it a safe and comfortable environment. Improvements may include appropriate lighting, railings, well-secured carpeting, and quick access to emergency response, if needed.

If it becomes too difficult or too expensive to receive long-term care at home, a supervised living facility, such as an assisted living facility or nursing home, may be an option.

Continuing care retirement communities
These facilities offer long-term contracts that usually provide lifelong shelter and access to specified health care services. To be admitted, large advance payments often are required. Eligibility for new residents is generally based on age, financial assets, income level, and physical health and mobility. Residents usually are expected to move into a continuing care community while they are still independent and able to care for themselves. Find out what happens when people become sick or frail and can no longer live independently. Does the retirement community have a nursing facility on the premises? What if the nursing facility is full when they require that level of care? What happens if a person runs out of money?

Assisted living facilities
These facilities (also called "board and care" or "adult care") are usually in a residential or home-like setting. Most provide meals, housekeeping, and some assistance with activities of daily living such as dressing and bathing. Some of these facilities care for people who require skilled nursing and 24-hour attentive supervision. Find out where you would get your health care, whether you will continue to see your own doctors, and how you will get to medical appointments. Health care services may be delivered at the facility itself or elsewhere, through an arrangement with another provider such as a hospital. Ask what happens (both in terms of services and price) if your condition declines after you enter an assisted living facility. Ask if the facility takes responsibility for making sure residents take their medicines properly. Some facilities may discharge you if your health care needs increase considerably.

Nursing homes
These facilities provide custodial and skilled care prescribed by doctors and delivered by registered nurses, licensed practical nurses, and certified nurse assistants. Find out whether you can get physical, occupational, and other therapy, and whether Medicare or Medicaid will pick up the cost. Costs and quality of care can vary considerably. Be sure to ask if the nursing home meets Medicare and Medicaid quality standards. Information on every Medicare- and Medicaid-certified nursing home in the U.S. is available on the Centers for Medicare and Medicaid Services' Nursing Home Database website (www.medicare.gov/nhcompare/home.asp).

Consider Ways to Pay for Long-Term Care

The price tag for long-term care can be astronomical, beyond the resources of most families. At best, Medicare pays only a fraction of these costs. Extended nursing home stays for an individual requiring skilled care can easily cost in excess of $5,000 a month, although fees vary widely. Although home care is generally far cheaper (in part because it does not include housing and food costs, which are factored into nursing homes' rates), it too can be very expensive to patients and their families. Costs may depend on the level of care needed, the number of hours of care per week, and where you live.

Before the need for long-term care becomes a reality, you should consider very carefully how to pay for it: through Medicaid, if you qualify, with private long-term care insurance, or out-of-pocket. Often, the decision is about money. Here are some fundamentals to help guide this tough decision.

Be Aware of Medicare's Limits. While Medicare covers some home health, skilled nursing, and hospice care, it is not a long-term care program. For example, although Medicare covers relatively short-term, medically necessary home health care, it does not pay for custodial care services such as cleaning or cooking at home. Nor does the program pay for prolonged care in a nursing home.

Home Health Care

Home health care is covered for homebound people who need the services of a skilled nurse or a skilled physical, speech, or occupational therapist. In these cases, Medicare will also cover home health aide services to help with bathing, toileting, feeding, other personal care, and medical social services. Home health benefits are only covered if you meet certain requirements: the visits must be prescribed by a doctor, and you must need intermittent or part-time skilled nursing care or therapy services and generally must be homebound. There is no copayment for home health services under Medicare, and no limit to the number of covered visits, as long as you continue to meet these criteria.

Skilled Nursing Facility Care

Medicare covers up to 100 days of nursing home care, but only in limited situations. To qualify for this benefit, you must need daily skilled care (seven days a week of nursing care or five days a week of rehabilitative care). Moreover, for Medicare to cover your SNF stay, you must have been hospitalized for at least three days within the 30 days preceding admission to a Medicare-certified skilled nursing facility. In addition, you will have to pay a daily copayment ($109.50 in 2004) for the 21st through the 100th day of their care.

Medical Equipment

Medicare also helps cover some durable medical equipment for use at home, whether it is rented or purchased. These items include walkers, canes, wheelchairs, and commodes that could assist with long-term care needs.

Hospice Care

Hospice care is available under Medicare for people with advanced illness and who are expected to live six months or less. It concentrates on improving quality of life, not on curing the condition. Medicare's hospice benefit covers a range of services, including care from doctors, nurses, therapists, and home health aides. It also covers services that Medicare usually does not, including respite care and continuous nursing services for medical emergencies.

Hospice care is designed to help with pain management and other symptoms, so that patients can make the most of the time that remains. In addition, it can provide emotional and spiritual support to you and your family members.

Medicaid Coverage of Long-Term Care. Medicaid is the country's largest public payer for long-term care. If you qualify for Medicaid, it will pay for nursing home care and other costs that Medicare does not cover. Medicaid may also pay for some long-term care services provided at home.

There is more than one way you can qualify for Medicaid. If you receive Supplemental Security Income (SSI), you are likely to qualify for Medicaid automatically. If you don't have SSI, but have extremely limited income and assets, you may be able to qualify for Medicaid anyway. The exact income eligibility levels for Medicaid vary by state, so check Medicaid rules where you live. Medicaid also looks at assets such as savings accounts when determining eligibility, although assets generally don't include homes, cars, household furnishings, or burial plots.

If your income is higher than the state's Medicaid eligibility level, you may still be eligible for Medicaid coverage. In several states, people can qualify for Medicaid after spending their income and assets on nursing home and other health care expenses. This is called Medicaid "spend down."

Some people enter a nursing home as private-pay patients but become eligible for Medicaid over time because of the high cost of such care. Generally, states let nursing home residents covered by Medicaid keep $2,000 in assets and an income of about $30 per month.

Medicaid rules vary by state. If you or family members have questions about Medicaid, contact the state Medicaid office or long-term care ombudsman in your area (see Additional Resources).

Long-Term Care Insurance. Long-term care insurance covers some of the costs of long-term care and may help you preserve a portion of your assets. Today, more than 100 insurance companies sell private long-term care insurance that covers nursing home and home care, but only a small share of people on Medicare have a long-term care policy.

While long-term care insurance can limit costs for some people, it is not a good option for everyone. Such insurance is expensive, and the older you are when you buy it, the higher the cost of the monthly premiums. Policies purchased at age 65 average $1,800 a year for four years of comprehensive coverage; at 79, they average $5,900 a year. And people with Alzheimer's or other serious health problems may not even be able to buy a policy at any price.

To Buy or Not to Buy?
A major reason for purchasing long-term care insurance is to avoid depleting life savings with a prolonged nursing home stay and to preserve savings and other assets for children and grandchildren. Another is to help offset the cost of long-term care for couples whose assets are limited, but whose income is fairly high (over $35,000 a year). But, if you already qualify for Medicaid or would quickly spend down your assets to qualify, long-term care insurance might not be sensible. Nor is it a prudent investment if you can't afford to pay the premium for the rest of your life. Even if you can, long-term care insurance may not be a wise choice if you can pay for your care out-of-pocket.

Do Your Long-Term Care Insurance Homework

No two long-term care insurance policies are alike. Before you decide to buy a policy, consider these issues:

Find out what the policy covers
Does it provide for care in a nursing home, in your home, or in a community setting? Some policies will pay cash once you meet eligibility requirements and will allow you to spend the money for care in the location of your choice. Others will pay for care only in a specifically defined location. Be sure the policy covers the type of care you want.

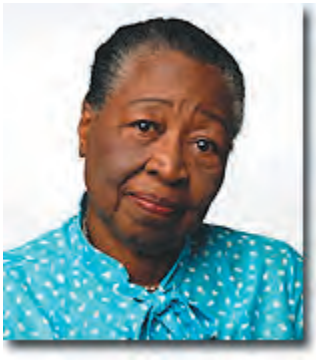
Be sure you can afford the premiums
Check to see if, and by how much, the premiums will rise over time, and consider whether you can afford premium hikes in the future. Premiums are also affected by the number of years covered under the policy. Four years of coverage is a good compromise between lifetime coverage (which can be quite expensive) and the risk of less coverage. Consider this: people between age 65 and 94 who enter a nursing home stay, on average, two and a half years, while 90% stay less than four years.

Examine the costs of elimination periods
Many long-term care insurance policies have elimination periods, which are waiting periods that act as deductibles. Individuals must pay for their own care during that time. The longer the elimination period, the lower the premium. Whatever you decide, be sure you can afford the out-of-pocket costs you will incur before your policy begins paying.

Consider the level of coverage you are buying
Choose a policy with a benefit that will cover a good portion of the daily cost of services you may need. Bear in mind that the cost of care will rise with inflation.

Individuals need coverage that keeps up with the rising cost of long-term care. Otherwise, a policy they buy today to cover 80% of these costs may cover only 40% later on, when they need such care. Inflation protection is often sold as a "rider" to long-term care products.

Compare how companies determine eligibility for benefits
Long-term care policies have different ways of determining if and when someone is eligible for benefits. For example, under some plans, policyholders qualify for coverage when they cannot perform activities of daily living on their own. These may include eating, walking, moving from a bed to a chair, dressing, bathing, and using the toilet. Make sure bathing is mentioned specifically, since people with long-term care needs are likelier to require help with this task than with any other activity. Read the fine print before purchasing a long-term care plan.



Paying for Long-Term Care Yourself. Because Medicare's coverage is limited, and many don't qualify for Medicaid or are unable to afford a long-term care policy, often elderly people and their families must tap into savings to pay for care. You need to think about how much care may cost over an extended period of time and as you become increasingly frail.

The cost of institutional care depends heavily on the amount of time it is used. Find out about nursing home care costs in your area. Then, calculate how much money you would need for a four-year stay. If you can set aside enough to cover four years of residential care, you should consider simply paying for it yourself. But realize that actual costs can't be predicted. Individuals who suffer from Alzheimer's or other forms of dementia may need care for many more years.

Home care often costs much less than residential care. Since people with long-term care needs often wish to continue living in their own homes, you may want to research the costs of home and community-based services in your area. Such services, along with home adaptations, can help you stay in your own home.

Don't wait until you need long-term care to begin discussing it with your family members. Talking about your preferences and needs now can help you plan how to pay for care. Depending on the decisions you make together with your family, purchasing a long-term care insurance policy, relying on savings, or using Medicaid may be right for you.

Planning For Your Care

It's important to think about your wishes concerning medical care and to put them in writing in the event that you become too ill to communicate. Having such instructions, called advance directives, will comfort you and save your family members from having to make difficult decisions without knowing what you want. It is important to put your wishes in writing and make sure family members know where you keep important documents, such as wills and advance directives.

Keep in mind that, since advance directives are legal documents, you must write them while you are still mentally competent, so it is important to plan ahead.

Although laws vary from state to state, there are basically two types of advance directives:

Health Care Proxies

A health care proxy is a legal document that allows you to appoint an agent to make medical decisions for you when you are unable to do so. You can select anyone you trust, such as a friend or family member. Generally, your agent may make health care decisions whenever you cannot speak for yourself.

Tip

Let a family member or close friend know where you keep important papers, such as financial statements, advanced directives, and your will.

Living Wills

A living will is a legal document that allows you to state your wishes about which medical treatments you do and don't want in the event that you are unable to communicate for yourself at the end of life. Typically, living wills direct health care personnel whether or not to prolong life if the patient is suffering from an incurable or irreversible condition. For example, your living will can have a "Do Not Resuscitate" order, which means that you will not be revived if your heartbeat and breathing stop. It can also state whether you want your organs donated.

Be sure your advance directives comply with laws of the state in which you live and that your doctors, lawyers, and other trusted persons have copies. Health personnel can follow the directions of the living will only if they have a copy of it. To obtain forms that are valid in your state, contact the state ombudsman program or a hospital or medical society in the area (see Additional Resources).

Additional Resources

There are a number of places to turn for information about Medicare and health care coverage. Since different agencies supply different types of information, you might have to contact several before finding one that can help.

Places to Start

Get basic Medicare information, including information about the Medicare drug benefit, by calling the National Medicare Hotline at 1-800-MEDICARE; TTY/TTD 1-877-486-2048 or visiting www.medicare.gov on the Internet.

You can also order *Medicare & You*, an overview of Medicare, by calling the hotline or by writing to Medicare Publications, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244-1850.

Get information on Medicare enrollment and eligibility by calling the National Social Security Hotline at 1-800-772-1213. Also call this number to report lost Medicare cards and a change of address.

Find out about Medicaid eligibility requirements and enrollment procedures at your state or local welfare office, social service, or Medicaid agency.

Get referrals for local agencies that can help you obtain information and services in your community on issues including home health care, nursing home care, and long-term care insurance by calling the Eldercare Locator at 1-800-677-1116.

Request detailed information in English or Spanish about the Medicare Advantage (MA) plans available in your area by calling the automated Medicare Special Information number at 1-800-MEDICARE (1-800-633-4227) or by visiting www.medicare.gov.

Additional Resources by State

A variety of state and local agencies can provide more specific information about Medicare, Medigap, and long-term care. The following state-by-state lists include some of these sources.

State Health Insurance Assistance Programs (SHIPs)
For information and free counseling related to Medicare, Medigap, MA plans, and long-term care, call your State Health Insurance Assistance Program. These are federally funded programs established to help beneficiaries with their health insurance choices.

State Medicaid Agencies
To answer questions about eligibility and enrollment in Medicaid, call your state Medicaid agency. It administers Medicaid benefits, including QMB, SLMB, and QI-1 programs.

Long-Term Care Ombudsmen
For questions about nursing homes and other long-term care facilities in your area, call this number. Your state long-term care ombudsman protects the rights of nursing home residents and responds to questions about facilities.

Social Security Offices
To find your local Social Security office, call 1-800-772-1213 or enter your zip code at this website: http://s00dace.ssa.gov/pro/fol/fol-home.html. State Social Security office websites are listed in the state-by-state table below.

State Pharmacy Assistance Programs
Many states have programs that are helping low-income Medicare beneficiaries with their Medicare prescription drug benefit coverage. To find out if there is a program in your state, see www.medicare.gov and follow the link for prescription drug assistance programs. See the table below for state websites and phone numbers.

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Alabama	800-243-5463 or 334-242-5743 http://www.adss. state . al.us/Ship.htm	800-362-1504 or 334-242-5000	877-425-2243 or 334-242-5743	http://www.ssa.gov/ atlanta/ southeast/al/ alabama .htm	
Alaska	800-478-6065 or 907-269-3680 http://hss.state.ak.us/dsds/medicare.htm	800-211-7470 or 907-465-3030	800-730-6393 or 907-334-4480	http://www.ssa.gov/ seattle/ index.htm	907-269-3680 or 800-478-6065 http://health.hss.state.ak.us/dsds/seniorcaresio.htm
Arizona	800-432-4040 or 602-542-4446 http://www.de.state.az.us/ aaa/programs/ship/default.asp	800-528-0142 or 602-417-5010	602-542-6454	http://www.ssa.gov/sf/ offices/ sf-arizona-offices.htm	

Arkansas	800-224-6330 or 501-371-2785 http://www.accessarkansas.org/insurance/ srinsnetwork/ seniorshlth_p1.html	800-482-8988 or 501-682-8292	501-682-8952	http://www.ssa.gov/dallas/state_ar.html	
California	800-434-0222 http://www.aging.ca.gov/html/programs/hicap.html	916-552-3492	800-231-4024 or 916-323-6681	http://www.ssa.gov/sf/ offices/sf-california-offices.htm	
Colorado	888-696-7213 or 303-894-7552 http://www.dora.state.co.us/insurance/senior/ senior.htm	800-221-3943 or 303-866-2993	800-288-1376 or 303-722-0720	http://www.ssa.gov/denver/colorado.htm	
Connecticut	800-994-9422 http://www.ctelderlyservices.state.ct.us/ choices.htm	800-842-1508 or 860-424-4908	866-388-1888 or 860-424-5200	http://www.ssa.gov/boston /CT.htm	800-423-5026 or 860-832-9265 http://www.connpace.com/
Delaware	800-336-9500 or 302-739-6266 http://www.state.de.us/inscom/eldindex.htm	302-255-9040	800-223-9074 or 302-453-3837	http://www.ssa.gov/phila/states/delaware.htm	800-996-9969 x17 http://www.state.de.us/dhss/ dss/dpap.html
District of Columbia	202-739-0668 http://www.dcoa.dc.gov/dcoa/cwp/view,a,3,q,523610.asp	202-442-5988	202-434-2140	http://www.ssa.gov/phila/states/distofcolumbia.htm	

Florida	800-963-5337 or 850-414-2060 http://elderaffairs.state.fl.us/doea/english/shine.html	888-419-3456	888-831-0404 or 850-414-2377	http://www.ssa.gov/atlanta/southeast/fl/florida.htm	888-419-3456 or 850-487-4441 http://www.floridahealthstat.com/silversaver.shtml
Georgia	800-669-8387 or 404-657-5347 http://www2.state.ga.us/departments/dhr/agingcares.html	866-322-4260 or 770-570-3300	888-454-5826 or 404-463-8384	http://www.ssa.gov/atlanta/southeast/ga/georgia.htm	
Hawaii	888-875-9229 or 808-586-7299 http://www2.state.hi.us/eoa/programs/sage_plus/	800-316-8005 or 808-524-3370	808-586-0100	http://www.ssa.gov/sf/offices/sf-pacific-offices.htm	
Idaho	800-247-4422 or 208-334-4350 http://www.doi.state.id.us/shiba/shiba_health.aspx	208-334-5500	877-471-2777 or 208-334-3833	http://www.ssa.gov/seattle/index.htm	
Illinois	800-548-9034 or 217-785-9021 http://www.ins.state.il.us/Ship/ship_help.htm	800-226-0768 or 217-782-2570	800-252-8966 or 217-785-3143	http://www.ssa.gov/chicago/illinois.htm	866-226-0768 or 800-624-2459 http://www.seniorcareillinois.com/
Indiana	800-452-4800 or 317-233-3475 http://www.state.in.us/idoi/shiip/index.html	800-234-0225 or 317-233-4455	800-288-1376 or 800-622-4484 or 317-232-7000	http://www.ssa.gov/chicago/indiana.htm	866-267-4679 or 317-234-1381 http://www.in.gov/fssa/hoosierrx/

Iowa	800-351-4664 or 515-281-6867 http://www.shiip. state.ia.us/	800-338-8366 or 515-327-5121	800-532-3213 or 515-242-3327	http://www.ssa.gov/kc/fos-ia.htm	
Kansas	800-860-5260 http://www.agingkansas.org/shick/	800-792-4884 or 785-274-4200	877-662-8362 or 785-296-3017	http://www.ssa.gov/kc/fos-ks.htm	800-432-3535 or 785-296-6319 http://www.agingkansas.org/kdoa/programs/pharmassistprog.htm
Kentucky	877-293-7447 http://chs.ky.gov/Aging/programs/State%20Health %20Insurance%20Assistance.htm	800-635-2570 or 502-564-2687	800-635-2570 or 502-564-2687	http://www.ssa.gov/atlanta/southeast/ky/kentucky.htm	
Louisiana	800-259-5301 or 225-342-5301 http://www.ldi.state.la.us/office_index/Office_of_health.htm	255-342-9500	800-259-4990 or 225-342-6872	http://www.ssa.gov/ dallas/state_la.html	
Maine	800-750-5353 or 207-623-1797 http://www.maine.gov/dhhs/beas/hiap/welcome.htm	800-321-5557 or 207-287-3094	800-499-0229 or 207-621-1079	http://www.ssa.gov /boston/ME.htm	866-796-2463 or 800-423-4331 or 800-262-2232 http://www.maine.gov/dhhs/beas/medbook.htm

Maryland	800-243-3425 or 410-767-1100 http://www.mdoa.state.md.us/Services/ship.html	800-492-5231 or 410-767-5800	800-243-3425 or 410-767-1100	http://www.ssa.gov/phila/states/maryland.htm	800-226-2142 or 800-972-4612 or 410-821-9262 http://www.dhmh.state.md.us/mma/mpap/
Massachusetts	800-243-4636 or 617-727-7750 http://www.800ageinfo.com/programs/shine.cfm	800-325-5231 or 617-628-4141	800-243-4636 or 617-727-7750	http://www.ssa.gov/ boston/MA.htm	800-243-4636 or 617-727-7750 http://www.mass.gov/portal /index.jsp?pageID=elderstopic&L=3&sid=Eelders&L0=Home&L1=Health+Care&L2=Prescription+Advantage
Michigan	800-803-7174 or 517-886-0899 http://www.mymmap.org/	800-642-3195 or 517-335-5001	866-485-9393 or 517-335-1560	http://www.ssa.gov/ chicago/michigan.htm	866-747-5844 or 517-241-3424
Minnesota	800-333-2433 or 651-296-2770 http://www.mnaging.org/seniors/healthinsurance/SHIP.html	800-366-8930 or 651-297-3933	800-333-2433 or 651-296-0382	http://www.ssa.gov/chicago/minnesota.htm	651-296-8517 or 800-333-2433 http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/DHS_id_006258. hcsp
Mississippi	800-948-3090 or 601-359-4929 http://www.mdhs. state.ms.us/aas_info.html	800-421-2408 or 601-359-6050	800-948-3090 or 601-359-4929	http://www.ssa.gov/ atlanta/southeast/ms/mississippi.htm	

Missouri	800-390-3330 or 573-893-7900 http://mpcrf.org/404.asp?404;http://mpcrf.org/beneficiaries/medicare_help.asp	800-392-2161 or 573-751-4815	800-309-3282	http://www.ssa.gov/ kc/fos-mo.htm	866-556-9316 http://www.dhss.mo.gov/MoSeniorRx/
Montana	800-332-2272 or 406-444-4077 http://www.dphhs.state.mt.us/sltc/protective_legal/07.02.SHIP.CMS.htm	800-362-8312 or 406-444-5900	800-332-2272 or 406-444-4077	http://www.ssa.gov/ denver/montana.htm	
Nebraska	800-234-7119 or 402-471-2201 http://www.state.ne.us/home/NDOI/nica/nica.htm	402-471-3121	800-942-7830 or 402-471-2307	http://www.ssa.gov/kc/fos-ne.htm	
Nevada	800-307-4444 or 702-486-3478 http://www.nvaging.net/ship/ship_main.htm	702-486-5000	775-688-2964	http://www.ssa.gov/sf/offices/sf-nevada-offices.htm	800-262-7726 http://www.nevadaseniorrx.com/
New Hampshire	800-852-3388 http://www.nhhelpline.org/hiceas/hiceas/index.cfm	603-271-4238	800-442-5640 or 603-271-4375	http://www.ssa.gov/ boston/NH.htm	888-580-8902 or 877-852-4060
New Jersey	800-792-8820 or 609-943-3437 http://www.state.nj.us/health/senior/ship.shtml	800-356-1561 or 609-588-2600	877-582-6995 or 609-943-4026	http://www.ssa.gov/ny/services-fo.htm	800-792-9745 or 609-588-7048 http://www.state.nj.us/health/seniorbenefits/paadapp.htm

New Mexico	800-432-2080 or 505-476-4799 http://www.nmaging.state.nm.us/benes.html	888-997-2583 or 505-827-3100	866-842-9230 or 505-255-0971	http://www.ssa.gov/dallas/state_nm.html	
New York	800-333-4114 http://www.hiicap.state.ny.us	800-541-2831 or 518-747-8887	800-342-9871 or 518-474-7329	http://www.ssa.gov/ ny/ services -fo.htm	800-332-3742 http://www.health.state.ny.us/nysdoh/epic/faq.htm
North Carolina	800-443-9354 or 919-733-0111 http://www.ncshiip.com/consumer/shiip/shiip.asp	800-662-7030 or 919-857-4011	919-733-8395	http://www.ssa.gov/atlanta/southeast/nc/north_carolina.htm	866-226-1388 http://www.ncseniorcare.com/index.htm
North Dakota	800-247-0560 or 701-328-2440 http://www.state.nd.us/ndins/consumer/details.asp?ID=58	800-755-2604 or 701-328-2332	800-451-8693 or 701-328-2310	http://www.ssa.gov/denver/ndakota.htm	
Ohio	800-686-1578 or 614-644-3999 http://www.ohioinsurance.gov/ConsumServ/Oshiip/WhatisOSHIIP.htm	800-324-8680 or 614-728-3288	800-282-1206 or 614-466-6190	http://www.ssa.gov/ chicago/ ohio.htm	
Oklahoma	800-763-2828 or 405-521-6628 http://www.oid.state.ok.us/consumer/shicp.html	800-522-0114 or 405-522-7300	800-211-2116 or 405-521-2327	http://www.ssa.gov/dallas/state_ok.html	

Oregon	503-947-7984 or 800-722-4134 http://oregonshiba.org	800-527-5772 or 503-945-5772	503-378-6533	http://www.ssa.gov/ seattle/ index.htm	
Pennsylvania	800-783-7067 http://www.aging.state.pa.us/aging/CWP/view.asp?A=282&QUESTION_ID=173806	800-692-7462	717-783-7247	http://www.ssa.gov/phila/%20states/pennsylvania.htm	800-225-7223 or 717-651-3600 http://www.aging.state.pa.us/aging/cwp/view.asp?A=293&Q=173876
Rhode Island	401-464-4000 or 401-462-0508	401-462-5300	401-785-3340	http://www.ssa.gov/ boston%20/RI.htm	800-322-2880 or 401-222-2858 http://www.dea.state.ri.%20us/socialservices.htm
South Carolina	800-868-9095 or 803-898-2850 http://www.caresouth-carolina.com/vantage.htm#icare	803-898-8206	800-868-9095 or 803-898-2850	http://www.ssa.gov/atlanta/southeast/sc/south_carolina.htm	877-239-5277 http://southcarolina.fhsc.com/Beneficiaries/silverxcarddocuments.asp
South Dakota	800-536-8197 or 605-773-3656 http://www.state.sd.us/social/ASA/SHIINE/	605-773-3495 or 800-452-7691	866-854-5465 or 605-773-3656	http://www.ssa.gov/denver/sdakota.htm	
Tennessee	877-801-0044 or 615-741-2056 http://www.state.tn.uscomaging/ship.html	800-669-1851 or 615-741-0192	877-236-0013 or 615-741-2056	http://www.ssa.gov/atlanta/southeast/tn/tennessee.htm	

Texas	800-252-9240 http://www.tdoa.state.tx.us/benefitsbasics/benefitsbasichicap.htm	888-834-7406 or 512-424-6500	512-438-4356	http://www.ssa.gov/dallas/state_tx.html	
Utah	800-541-7735 or 801-538-3910 http://www.hsdaas.utah.gov/health_ins_info.htm	800-662-9651 or 801-538-6155	801-538-3910	http://www.ssa.gov/ denver/utah.htm	
Vermont	800-642-5119 http://www.medicarehelpvt.net	800-250-8427 or 802-241-2800	800-917-7787 or 802-863-2316	http://www.ssa.gov/ boston/VT.htm	800-250-8427 or 802-241-2992 http://www.dsw.state.vt.us/districts/ovha/ovha8.htm
Virginia	800-552-3402 or 804-662-9333 http://www.aging.state.va.us/vicap.htm	804-726-4231	804-565-1600	http://www.ssa.gov/phila/states/virginia.htm	
Washington	800-397-4422 http://www.insurance.wa.gov/consumers/shiba/default.asp	800-562-3022	800-562-6028	http://www.ssa.gov/seattleindex.htm	
West Virginia	877-987-4463 or 304-558-2241 http://www.state.wv.us/seniorservices/shine/	304-558-1700	304-558-3317 or 800-834-0598	http://www.ssa.gov/phila/states/westvirginia.htm	

Wisconsin	800-242-1060 or 608-267-3201 http://www.dhfs.state.wi.us/aging/Genage/BENSPECS.HTM	800-362-3002 or 608-221-5720	800-815-0015 or 608-246-7014	http://www.ssa.gov/chicagowisconsin.htm	800-657-2038 http://dhfs.wisconsin.gov/seniorCare/
Wyoming	800-856-4398 or 307-856-6880 http://www.wyomingseniors.com/WSHIIP.htm	888-996-8678 or 307-772-7531	307-322-5553	http://www.ssa.gov/denver/wyoming.htm	

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

Washington Office:
1330 G Street NW, Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

www.kff.org

Additional copies of this publication (#7067) are available on the Kaiser Family Foundation's website at www.kff.org.