Chapter 1

The ABCs (And D) of Medicare

In This Chapter

- Getting a grip on Medicare and how to qualify
- Checking out Medicare's benefits and costs
- Figuring out when and how to enroll in Medicare
- Discovering how to decrease your costs and increase your benefits

Medicare helps pay for your prescription drugs *only* if you're in the wider Medicare health program. You don't necessarily have to be using its medical services at this time to be eligible for drug coverage; you just need to have your very own numbered file in the vast Medicare system.

So with this info in mind, why not begin at the beginning with a quick tour through the essentials of Medicare as a whole? If you're already well acquainted with Medicare, you can skip to other chapters for the scoop on Medicare prescription drug coverage. But stick around if you're facing the mysteries of Medicare for the first time and need to know whether you qualify, how to sign up, and how the different parts of the program — each with its own benefits and costs — fit together.

This chapter outlines only the basics of Medicare, just enough to get you on your way. To find out where to go for more detailed information, turn to Appendix B.

Knowing Your Place in the Wide World of Medicare

Medicare is a federal government insurance system, begun in 1966, that helps tens of millions of seniors and people with disabilities nationwide pay for healthcare. It's the only national healthcare program — available regardless of income or where you live — in the United States, and it's enduringly popular among people who use it.

Medicare doesn't pay all of your medical bills by any means. Nonetheless, it still gives a lot of protection against today's high healthcare costs if you don't have other health insurance. And unlike other forms of health insurance you may have met in the past, you can't be excluded from Medicare, or pay more for it, because of advancing age or the state of your health. How's that for your tax dollars at work?

To qualify for Medicare, you must meet certain rules, depending on the following circumstances:

- **If you're age 65 or older:** You qualify for Medicare as soon as you reach age 65 if you *or* your spouse has worked long enough to entitle you to Social Security or Railroad Retirement benefits, even if you're not yet receiving them. You usually need at least 40 credits (amounting to about ten years of work) to become eligible for these retirement benefits, which are paid through monthly checks. Anyone with enough work credits can claim these benefits from the age of 62 onward, though doing so means accepting lower payments than when starting at or after full retirement age. (For people born between 1943 and 1954, full retirement age is now 66.) But remember — even if you claim these benefits early, you still have to wait until age 65 to qualify for Medicare.

  The annual statement you receive from Social Security says whether you qualify for Medicare or, if you're not eligible yet, when you will be. If you lose your statement, call Social Security at 800-772-1213 to ask for a replacement.

- **If you're younger than 65 and have disabilities:** You're entitled to Medicare at any age if you have a severe illness, injury, or disability that prevents you from earning more than a certain amount of money each month *and* you've received Social Security disability benefits for at least 24 months. These months need not be consecutive. Anyone diagnosed with Lou Gehrig's disease (Amyotrophic Lateral Sclerosis, or ALS) doesn't have to wait 24 months to join Medicare. If you think you may qualify and want to find out the earnings limits that apply to your circumstances, call Social Security at 800-772-1213 or go to `www.ssa.gov`.

- **If you have permanent kidney failure:** You're entitled to Medicare at any age if you have end-stage renal disease (ESRD) — usually defined as needing a kidney transplant or regular dialysis — *and* if you or your spouse has paid into Social Security through work for a certain length of time. This period depends on how old you are. For specific eligibility information, visit `www.ssa.gov` or call Social Security at 800-772-1213.

- **If you don't qualify for Medicare:** If you're 65 or older but don't have enough work credits, you may be able to buy into the system by paying premiums. You can buy in *only* if you're an American citizen or a legal resident (green card holder) who has lived in this country continuously for at least five years. The premiums for Medicare Part A (hospital insurance) are pretty hefty for people who don't qualify for Medicare — the amount varies depending on how many work credits you have — but they're probably less expensive than insurance you can buy yourself.

> Purchasing Medicare Part A makes you eligible for other Medicare benefits, like prescription drug coverage. If you work long enough to earn enough credits to qualify for Medicare in the future, you no longer have to pay Part A premiums.

Now you know the general guidelines. Of course, the fine print of Medicare rules and regulations deals with many specific situations, but I avoid this nitty-gritty here because you'll find out where you stand when you go to sign up for Medicare. (I explain how to enroll later in this chapter.) If you want more detailed information, contact the sources listed at the end of this chapter.

Examining Costs and Coverage in Medicare's Four Parts

Medicare has never been a single unified program in which you pay just one premium to belong and a certain amount for each medical service you use. Instead, Medicare evolved over time and now has four parts, each covering different types of medical care and requiring different payments. The following sections are a brief overview that outlines what you pay and what you get in return. Here's where you dive into the Medicare alphabet soup and learn your ABCs all over again!

Part A

Part A is insurance that pays most of your costs when you're a patient in a hospital and also, in some circumstances, if you're in a skilled nursing facility or hospice, or are receiving treatment from a home healthcare agency. When you turn 65 and have enough work credits, as described in the previous section, you instantly qualify for Part A.

But wait! There's more good news: If you're eligible for Medicare, you pay no monthly premium charges for Part A. (That's because you, or your spouse, already paid payroll taxes for Medicare in a job.) Services received through Part A, however, aren't free; you pay a share of the costs when using them. For example, when you go into the hospital, you pay the first chunk of expenses until you meet the deductible, an amount set by law that usually goes up every year ($1,024 in 2008).

This amount isn't an annual deductible. Instead, it applies to every *benefit period* — the time you're treated in the hospital for a particular spell of illness or injury. After you've met the deductible, Medicare pays 100 percent of covered costs for a stay of up to 60 days (which need not be consecutive). After that, you pay a share of the costs ($256 a day in 2008) from Day 61 to Day 90. (If you need extra days, you can use up to 60 *lifetime reserve* days that Medicare allows for additional coverage over the rest of your life.

The co-pay for these days, in 2008, is $512.) If you go into the hospital for a *different* illness or injury, you start a new benefit period and again pay the deductible before coverage kicks in and the payment cycle starts over. There's no limit to the number of benefit periods you can use.

Part A covers the following inpatient services:

- A semiprivate room.
- Regular nursing care.
- All meals provided directly by the hospital or nursing facility.
- Other services provided directly by the hospital or nursing facility, including lab tests, prescription drugs, medical appliances, and rehabilitation therapies.
- A temporary stay (up to 100 days) in a nursing home or hospital under the skilled nursing facility benefit. This benefit is available *only* when nursing or rehabilitation care is necessary following at least three days in the hospital with a related illness or injury.

Part A doesn't cover the cost of a private room (unless one is medically necessary), private nurses, or nice-to-have conveniences such as a telephone or television. Except for the skilled nursing facility benefit, Part A doesn't cover the costs of living in a nursing home. (I explain this benefit, and nursing home care, in more detail in Chapter 18.)

Part B

Part B is insurance that helps you pay to see a doctor and use services outside of a hospital or nursing facility. Part B is voluntary, meaning you can choose whether you want it and, depending on your circumstances, when to sign up.

If you're 65 or older, you can purchase Part B coverage even if you don't qualify for Part A. To do so, you must be an American citizen or a legal resident who has lived in the U.S. continuously for five years.

Part B requires you to pay a monthly premium, even if you or your spouse paid taxes for Medicare while working. The Part B premium amount is set annually ($96.40 a month in 2008) and generally goes up from year to year. Most people pay the same premium. However, those with high incomes (more than $82,000 a year in 2008) pay more, and those with very low incomes may receive state help for paying these premiums, if they qualify. Part B also requires you to pay an annual deductible, determined by law ($135 in 2008), which is the out-of-pocket amount you pay for medical care at the beginning of the year before coverage kicks in. You also have to pay a share of the cost of services that Medicare covers — usually 20 percent of the bill, though some services (such as outpatient mental health care) cost more, and some (such as approved home healthcare) cost less.

Wondering what you get for this voluntary coverage? Part B covers

- Approved medical and surgical services from any doctor who accepts Medicare patients, whether provided in a doctor's office, hospital, long-term care facility, or at home, anywhere in the nation
- Diagnostic and lab tests done outside hospitals and nursing facilities
- A certain number of preventive services and screenings, such as flu shots and mammograms
- Some medical equipment (for example, wheelchairs and walkers)
- Some outpatient hospital treatment received in an emergency room, clinic, or ambulatory surgical unit
- Inpatient prescription drugs given in a hospital or doctor's office, usually by injection (such as chemotherapy drugs for cancer)
- Some coverage for physical, occupational, and speech therapies
- Outpatient mental health care (copay of 50 percent in 2008 reducing to 20 pecent by 2014)
- Approved home health services not covered by Part A

A wide range of medical services, such as dental, vision, and hearing care (including hearing aids); routine checkups; and outpatient prescription drugs, falls outside Part B's coverage zone. Fortunately, outpatient prescription drug coverage is exactly what Part D is for!

Part C

In the previous two sections, I outline costs and coverage under *traditional* or *original Medicare,* which earned the name because it follows the basic design of the program originally laid out in 1965. It's also called *fee-for-service Medicare* because each provider — whether a doctor, hospital, laboratory, medical equipment supplier, or whatever — is paid a fee for each service.

But Medicare also offers an alternative to the traditional program in the form of a range of health plans that mainly provide managed care. These plans are run by private companies, which decide each year whether to stay in the program. Medicare pays plans a fixed fee for everyone who joins the plans, regardless of how much or little healthcare a person actually uses. This health plan program is called *Medicare Advantage,* or Medicare Part C.

In most cases, you pay a monthly premium for a Medicare Advantage (MA) plan — with the amount varying from plan to plan — on top of the regular Medicare Part B premium. Some plans, however, don't charge an extra

premium, and a few also pay all or some of the Part B premium for their members. You pay a share of the costs of hospital and outpatient services. These co-pays vary from plan to plan and are usually different than those required in traditional Medicare.

MA plans must cover all services covered by Part A and Part B in the traditional Medicare program. They may also offer extra services that Medicare doesn't cover — for example, dental and eye care. Most plans include prescription drug coverage as part of their package.

Unlike traditional Medicare, your choice of doctors and hospitals under most MA plans is likely to be limited to those in the plan's provider network and to the plan's local service area. You also pay more if you go out of network. In a medical emergency, however, the plan must cover the treatment you receive from *any* doctor or hospital.

Part D

Part D is insurance for outpatient prescription drugs — meaning medications you take yourself, instead of having them administered in a hospital or doctor's office — that Medicare began offering in 2006. Like Part C, this program is run entirely through many private plans approved by Medicare, each of which has different costs and benefits. You can get Part D through *stand-alone plans* (which cover only prescription drugs and are used mainly by people in traditional Medicare) or through Medicare Advantage health plans that include drug coverage. But I don't dwell on Part D here, because the rest of this book explores the program in detail.

Comparing different types of Medicare insurance

All the different kinds of insurance under Medicare are enough to blow anybody's mind. (Would you believe there's another? Medicare supplementary insurance isn't a government program, but it can be bought to fill in some of the gaps in Medicare, as I explain in the later section "Lowering Costs and Adding Benefits.") Consequently, it isn't surprising people get confused about what each means and what the difference is between them.

Table 1-1 helps cut through the confusion by briefly describing coverage, provider details, and pros and cons for each kind of Medicare insurance, including the types of Medicare Advantage plans you're most likely to encounter. ***Note:*** Two types of Medicare Advantage plans aren't included here: Special Needs Plans (SNP) and Medicare Medical Savings Account Plans (MSAs), both of which restrict enrollment to certain groups of people.

Table 1-1 Types of Medicare Insurance and What Each Means

Type of Plan	*What It Covers*	*Provider Access*	*Pros*	*Cons*
Traditional Medicare (Parts A and B)	Hospital care, doctor services, some other types of outpatient care, some medical supplies and screenings	Any doctor, hospital, lab or supplier that accepts patients with Medicare	Available anywhere within U.S.; charges standard co-pays for each service	Doesn't coordinate care or cover eye, dental, or hearing care; routine checkups; or outpatient prescription drugs
Medigap Supplementary Insurance	Some out-of-pocket expenses of traditional Medicare; some policies cover extra services	Not applicable — except for one type of policy called a "Select Plan" that limits coverage to network providers except in emergencies	Reduces costs of deductibles and co-pays; may help pay for some extra services	Can be expensive; doesn't cover out-of-pocket costs of prescription drug coverage; can't be used with Medicare Advantage plans
Medicare Stand-Alone Prescription Drug Plans (PDP)	*Only* prescription drugs; intended mainly for people in traditional Medicare who have no other drug coverage	Drugs available from pharmacies and mail-order services within plan's network; going out of network costs more	Cuts costs of medications; more generous help available for people with low incomes and/or high drug costs	Gap in coverage in most plans; comparing plans can be confusing because each has different costs and benefits

(continued)

Table 1-1 (*continued*)

Type of Plan	*What It Covers*	*Provider Access*	*Pros*	*Cons*
Medicare Advantage Plans	Everything that traditional Medicare covers and maybe some extras	Depends on type of MA plan — see the "HMO," "PPO," and "PFFS" entries in this table	Depends on type of MA plan — see the "HMO," "PPO," and "PFFS" entries in this table	Depends on type of MA plan — see the "HMO," "PPO," and "PFFS" entries in this table
HMO	Managed care; may or may not cover outpatient prescription drugs	Providers limited to those in plan's network, except in medical emergencies	Coordinates care; may have lower or higher costs and offer more services than traditional Medicare	Not portable — limited to service area; limited choice of providers; costs, benefits can change each year; costs not covered by Medigap insurance
PPO	Managed care; may or may not cover outpatient prescription drugs	Seeing providers outside network is allowed but costs more; no referral needed to see specialists	Coordinates care; may have lower or higher costs and offer more services than traditional Medicare	Not portable — limited to service area; costs, benefits can change each year; costs not covered by Medigap insurance
PFFS	Private fee-for-service; may or may not cover outpatient prescription drugs	Any provider that accepts the plan's conditions and payments	Available anywhere in U.S. from providers that accept plan	Not all providers accept plans; not easy to find out in advance which ones do; providers may accept plan on a visit-by-visit basis; doesn't coordinate care

Getting with the Program: When and How to Sign Up for Parts A and B

Don't panic if your 65th birthday is looming and you haven't a clue about how to sign up for Medicare — or even whether you should. You're not alone. Remember how you dived into a state of denial when you turned 50? Now you're 15 years further on, but you still haven't given much thought to Medicare, an even bigger psychological milestone — until now. In the following sections, I explain when to sign up at the time that's right for you and walk you through the process of enrolling.

It's all in the timing: When to sign up

You can (and should) sign up for at least Medicare Part A — hospital insurance — around the time you turn 65, whatever your circumstances (even if you're still working, have health insurance from your employer, or haven't yet begun to draw Social Security retirement payments). It costs nothing to enroll, and you have no premiums to pay. But even if you don't need any Medicare coverage right now, simply getting your name in the system as soon as possible may ensure a smoother ride later on if and when you decide you want (or need) to sample more of Medicare's offerings.

When to enroll in Medicare and what services you decide to sign up for depend on your circumstances. This section covers the possibilities.

You already receive Social Security benefits

When I say "Social Security benefits" here, I'm referring to Social Security benefits for retirement, dependents, and survivors — or similar benefits for Railroad Retirement. If you're already receiving any of these benefits and *haven't* yet turned 65, you don't need to sign up for Medicare. In this case, Social Security automatically enrolls you in Medicare Part A and Part B, and you receive your Medicare card in the mail. Coverage starts on your 65th birthday. The same automatic enrollment takes place if you've been getting Social Security disability benefits for two years, regardless of your age.

In both situations, you have the right to cancel Part B coverage if you don't want it (for example, if you already receive medical coverage from an employer or union health plan). But if you're considering canceling because the Part B premium is more than you can afford, you may want to apply for your state's Medicare Savings Program. If you qualify, the state pays your Part B premium, and you automatically become eligible for low-cost prescription drug coverage under Part D's Extra Help program, as explained in depth in Chapter 5.

You don't receive Social Security benefits yet

If you don't receive Social Security benefits by the time you're 65, you need to apply to enroll in Medicare. Timing is very important here because you have a seven-month window, or *initial enrollment period,* to sign up. It begins three months before the month in which you turn 65 and ends three months after your birthday month. So if you're going to celebrate 65 years on June 22, you can sign up any time between March 1 and September 30.

Sooner is better than later. If you enroll early, your coverage starts the month you turn 65. If you wait until after your birthday, it begins on the first day of the month after you enroll.

If you don't sign up for Medicare Part B when you first become eligible, you have to pay a late penalty when you do eventually sign up. (The exception is if you're still working and have group health insurance from an employer or union that's *primary* to Medicare, meaning that your group plan pays your medical bills first.) A late penalty means paying more for Part B in the form of permanently higher premiums — 10 percent higher for every year you could've had Part B but didn't. After your personal deadline for joining Part B has passed, you can sign up *only* during a general enrollment period from January 1 to March 31 each year. Your coverage then begins July 1.

You have no other health insurance

If you don't currently have health insurance, you'll need Medicare for all of your medical coverage. So you'll probably want to sign up for both Part A (hospital insurance) and Part B (insurance for doctor visits and outpatient services). You should sign up for these programs during your seven-month initial enrollment period around the time of your 65th birthday (see the preceding section). If you don't sign up for Part B during this time but decide to do so later, you'll pay a late penalty.

You work and have group health insurance

If you're still working after the age of 65 and have group health insurance from your employer or union, check with your benefits administrator to find out whether this coverage is primary or secondary to Medicare. *Primary* means your own insurance pays your medical bills first; *secondary* means Medicare pays first and your insurance pays for certain services that Medicare doesn't cover. So how does this explanation relate to your specific situation? Here are your options:

- **If your insurance is secondary:** You should sign up for Medicare Part B within your seven-month initial enrollment period (see the earlier section "You don't receive Social Security benefits yet"). In fact, your employer or union health plan will probably insist on it as a condition for continuing your current coverage. (If your employer has fewer than 20 employees and you are 65 or older, your health plan is automatically secondary to Medicare.)

- **If your insurance is primary:** You don't need to sign up for Part B at this time. However, when you sign up for Part A, make sure that Medicare documents that you have primary coverage from elsewhere. In the future, if you lose your employer or union coverage, you'll need Medicare to know that you once had it so you can enroll in Part B at that time without incurring a late penalty. If you do lose your current coverage, you'll have eight months to sign up for Part B, starting from the end of the month in which you lose coverage. As long as you sign up within this period (or earlier), you won't pay a late penalty, and you'll still have guaranteed access to Medigap insurance. (I explain guaranteed access to Medigap later in this chapter.)

You no longer work but have retiree health insurance

After you retire, consider signing up for Part B, even if you still have health insurance from your former employer or union under a retiree plan. Yes, this precaution probably means paying two premiums — and of course you have the right not to join Part B if you don't want to (unless your employer or union insists on it as a condition of your retiree coverage). But if at some future date you lose or drop your retiree benefits and need to sign up for Part B at that time, you'll have to pay a late penalty. You won't incur a late penalty if you join Part B within eight months of retiring from your job.

You don't qualify for Part A

If you don't qualify for Part A's hospital insurance, you may be able to buy into the system by paying a premium for this coverage (see the earlier section "Knowing Your Place in the Wide World of Medicare"). Regardless of what you choose to do with Part A, you can still get outpatient medical coverage under Part B as long as you're 65 or older and an American citizen or have lived in the U.S. as a legal resident for at least five years. To receive this benefit, you simply pay the same premium, deductibles, and co-pays as anyone else. To join the Part B party, and avoid a late penalty, enroll at one of the following times:

- During the seven-month initial enrollment period around the time of your 65th birthday if you have no other health coverage, or if your current coverage is secondary to Medicare
- Within eight months of losing your current health coverage, if it's primary to Medicare
- Within eight months of retiring from a current job that provides retiree health benefits

You live outside the United States

If you have enough Social Security credits to qualify for Medicare, you should file for Medicare Part A (hospital insurance) around your 65th birthday if you live outside the U.S. You can't use this insurance abroad, but, after all, it doesn't cost you anything to sign up. To do so, contact the U.S. embassy or consulate in the country you're living in — or the Department of Veterans Affairs's regional office if you live in the Philippines.

Deciding whether to buy Part B (doctor and outpatient services) may be trickier. If you're still working and have primary group health insurance from your employer, you don't need to join Part B yet. But if you don't have such insurance (or are perhaps relying on the public health service of the nation where you live) or are retired, you have two options:

- Sign up for Part B when you turn 65 and pay the required premiums — even though you won't be able to get Part B medical services while living abroad.
- Delay signing up after you turn 65 and incur a late penalty if you join Part B after moving back to the U.S.

Taking the plunge: How to sign up

When you don't automatically qualify for Medicare — that is, if you're not *already* receiving Social Security or Railroad Retirement payments — you must apply for the program. All you have to do is make one toll-free phone call to the Social Security Administration (*not* Medicare) at 800-772-1213. A customer representative will ask for your Social Security number and will give you the choice of signing up for Medicare directly on the phone or making an appointment for you to visit your local Social Security office. Signing up on the phone is simpler, but you need to send important documents (such as your birth certificate or passport and, if you're not an American citizen, proof of legal residence) to Social Security through the mail. If this process unnerves you, you can take the documents with you to an office appointment. The representative you initially speak with schedules the appointment and gives you the address of the nearest Social Security office.

During this interview, whether on the phone or in person, you can discuss your Medicare needs — such as whether you want to sign up for Part B right now — and whether you want to start receiving Social Security payments as soon as you're eligible. The customer representative then answers your questions and enters your information into the computer system. A week or two later, you'll receive your Medicare card in the mail. The card indicates which benefits (Part A alone, or Part A and Part B) you've signed up for. With your card, you'll also receive a copy of your information that's been entered into the Medicare system. If any details are wrong, call the phone number listed in your mailing to have them changed.

Lowering Costs and Adding Benefits

Medicare has a whole slew of out-of-pocket expenses and doesn't cover all medical services. What, if anything, can you do to lower costs and get more benefits? These sections break down your possible options, depending on various circumstances.

Medicare supplementary insurance (also known as Medigap)

Medicare supplementary insurance is *not* a government program offered by Medicare. It's a separate private insurance you can purchase for an additional monthly premium to fill in some of the gaps in traditional Medicare, which is why it's often called *Medigap.* Depending on the kind of policy you buy, Medigap covers out-of-pocket expenses in Medicare, such as deductibles and co-pays, and may cover extra services (for example, at-home recovery after hospitalization and emergency treatment abroad). Medigap features 12 standard policies, designated A through L, each offering a different range of coverage options — the more options, the more expensive the policy. These policies are sold by many insurance companies at varying premiums. You can compare benefits and costs online at `www.medicare.gov` or by calling Medicare at 800-633-4227.

The best time to buy Medigap insurance is within six months of signing up for Medicare Part B, because this timing gives you significant consumer protections. During the six-month window, you have a *guaranteed* right to buy any Medigap policy sold in the state where you live. In other words, you can't be turned down because of poor health or any pre-existing medical conditions. Nor can you be charged higher premiums based on your age. You get this window, with all of its guarantees, regardless of when you enroll in Part B, even if you sign up late for Part B.

Other factors may affect your decision to purchase Medigap insurance:

- You can't use Medigap if you're in a Medicare Advantage health plan. So if you enroll in one of these plans immediately after joining Part B, you lose your right to buy Medigap with guaranteed protections. (However, you may be able to get this right back if you leave the MA plan within your first year in Medicare or if you gave up a Medigap policy to join an MA plan for the first time. I explain the details of these exceptions in Chapter 17.)
- No Medigap policies sold after 2005 include drug coverage, and you can't use them to cover out-of-pocket expenses in Part D.

Medicare Advantage plans (Part C)

Medicare Advantage (MA) plans may have lower costs and offer more benefits than traditional Medicare. Depending on the plan, lower costs may include zero premiums, a reduced hospital deductible, a flat co-pay (for example, $10 or $20) rather than 20 percent coinsurance for each doctor visit, and a cap on out-of-pocket expenses in a calendar year. Extra benefits may include coverage for vision or hearing services, emergency treatment

abroad, or exercise programs. However, some plans charge higher costs than traditional Medicare for some services and offer only minimal extra benefits. Also, you need to recognize that most MA plans limit the choice of doctors and hospitals and may not cover treatment outside of their service area, except in emergencies. (I compare MA plans with traditional Medicare in Chapter 9.)

Veterans benefits

If you qualify for federal health benefits from the Department of Veterans Affairs (VA), you can use them in addition to, or instead of, Medicare. You can also decide which benefits to use for each medical service you need. If you choose the VA for treatment, you must obtain your treatment at a VA facility. Medicare doesn't pay for care at VA facilities but does pay for Medicare-covered medical services that you obtain elsewhere. If you're a veteran with a low income or a high enough service-related disability rating, you may qualify for free VA care. Whether you're eligible for free care or not, you should consider signing up for Medicare in case you need future services that the VA can't provide or you have to travel too far to get to a VA facility. For more info, call 877-222-8387 or visit `www.va.gov/healtheligibility`.

Medicaid

Medicaid is a healthcare program for low-income people and is administered by each state, which shares the costs with the federal government. (In some states it has a different name — for example, MediCal in California, MassHealth in Massachusetts, and TennCare in Tennessee.) Eligibility depends on the level of your income and savings and varies among the states. If you qualify for both Medicaid and Medicare, you should pay little or nothing for medical treatment — because Medicaid covers Medicare's out-of-pocket expenses — and you have coverage for broader benefits, such as nursing home care. In addition, you automatically qualify for low-cost prescription drug coverage under Medicare Part D's Extra Help program. (Extra Help is covered in detail in Chapter 5.) To find out whether you qualify for Medicaid and how to apply, call your State Health Insurance Assistance Program (SHIP). See Appendix B for the local number to call.

State Medicare savings programs

If you don't qualify for Medicaid, but the Medicare Part B premiums and other costs are still more than you can afford, you may be eligible for help from your state to pay for them. Getting this assistance depends on your income level and any savings you may have. If you qualify, you also automatically receive the full Extra Help benefit under Part D, which provides prescription drug coverage at low cost. Call your State Health Insurance Assistance Program (SHIP) to find out whether you qualify for a Medicare savings program and how to apply. (SHIP contact information is in Appendix B.)