



For Publication

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Medicare for Railroad Families

The Federal Medicare program provides hospital and medical insurance protection for railroad retirement annuitants and their families, just as it does for social security beneficiaries. Medicare has the following parts:

- **Medicare Part A** (hospital insurance) helps cover inpatient care in hospitals and skilled nursing facilities (following a hospital stay), some home health care, and hospice care. Part A is financed through payroll taxes paid by employees and employers.
- **Medicare Part B** (medical insurance) helps cover medically-necessary services like doctors' services and outpatient care. Part B also helps cover some preventive services. Part B is financed by premiums paid by participants and by Federal general revenue funds.
- **Medicare Part C** (Medicare Advantage Plans) is another way to get Medicare benefits. It combines Part A, Part B, and sometimes, Part D (prescription drug) coverage. Medicare Advantage Plans are managed by private insurance companies approved by Medicare.
- **Medicare Part D** (Medicare prescription drug coverage) helps cover prescription drugs.

The following questions and answers provide basic information on Medicare eligibility and coverage, as well as other information on the Medicare program.

1. Who is eligible for Medicare?

All railroad retirement beneficiaries age 65 or over and other persons who are directly or potentially eligible for railroad retirement benefits are covered by the program. Although the age requirements for some unreduced railroad retirement benefits have risen just like the social security requirements, beneficiaries are still eligible for Medicare at age 65.

Coverage before age 65 is available for disabled employee annuitants who have been entitled to monthly benefits based on total disability for at least 24 months and have a disability insured status under social security law. There is no 24-month waiting period for those who have ALS (Amyotrophic Lateral Sclerosis) also known as Lou Gehrig's disease.

If entitled to monthly benefits based on an occupational disability, **and** the individual has been granted a disability freeze, he or she is eligible for Medicare starting with the 30th month after the freeze date or, if later, the 25th month after he or she became entitled to monthly benefits. If receiving benefits due to occupational disability and the person has **not** been granted a disability freeze, he or

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she is generally eligible for Medicare at age 65. (The standards for a disability freeze determination follow social security law and are comparable to the medical criteria for granting total disability.)

Under certain conditions, spouses, divorced spouses, surviving divorced spouses, widow(er)s, or a dependent parent may be eligible for Medicare hospital insurance based on an employee's work record when the spouse, etc., turns age 65. Also, disabled widow(er)s under age 65, disabled surviving divorced spouses under age 65, and disabled children may be eligible for Medicare, usually after a 24-month waiting period.

Medicare coverage at any age on the basis of permanent kidney failure is also available to employee annuitants, employees who have not retired but meet certain minimum service requirements, spouses, and dependent children who suffer from permanent kidney failure requiring hemodialysis or a kidney transplant. The Social Security Administration has jurisdiction of Medicare for those eligible on the basis of permanent kidney failure. Therefore a social security office should be contacted for information on coverage for kidney disease.

2. How do persons enroll in Medicare?

If a retired employee or a family member is receiving a railroad retirement annuity, enrollment for both Medicare Part A and Part B is generally automatic and coverage begins when the person reaches age 65. For beneficiaries who are totally and permanently disabled, both Medicare Part A and Part B start automatically with the 30th month after the beneficiary became disabled or, if later, the 25th month after the beneficiary became entitled to monthly benefits. Even though enrollment is automatic, an individual may decline Part B, if so desired; this does not preclude him or her from applying for Part B at a later date. Premiums may be higher if enrollment is delayed. (See question #7 for more information on delayed enrollment.)

If an individual is eligible for but not receiving an annuity, he or she should contact the nearest Railroad Retirement Board (RRB) office before attaining age 65 and apply for both Part A and Part B. (This does not mean that the individual must retire if presently working.) The best time to apply is during the 3 months before the month in which the individual reaches age 65. He or she will then have both Part A and Part B protection beginning with the month age 65 is reached. If the individual does not enroll for Part B in the 3 months before attaining age 65, he or she can enroll in the month age 65 is reached or during the next 3 months, but there will be a delay of 1 to 3 months before Part B is effective. Individuals who do not enroll during this Initial Enrollment Period may sign up in any General Enrollment Period (January 1 – March 31 each year). Coverage for such individuals begins July 1 of the year of enrollment.

3. What is covered by Part A (hospital insurance) of the Original Medicare Plan, the traditional fee-for-service plan available nationwide?

Medicare Part A is designed to help pay the bills when an insured person is hospitalized. The program also provides payments for required professional services in a skilled nursing facility (but not for custodial care) following a hospital stay, some home health care, and hospice care.

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There is a limit on how many days of hospital or skilled nursing care Medicare helps pay for in each “benefit period.” A benefit period begins the day a patient goes to a hospital or skilled nursing facility. It ends after a person has not received any hospital or skilled nursing care for 60 days in a row. There is no limit to the number of benefit periods a person can have.

When a patient receives Part A benefits, he or she is billed by the hospital only for the deductible amount, any coinsurance amount and any noncovered services. The remainder of the bill from the hospital, as well as bills for services in skilled nursing facilities or home health visits, is sent to Medicare to pay its share.

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

4. What are the Medicare Part A deductible and coinsurance charges in 2011?

For the first 60 days in a benefit period, a Medicare patient is responsible for paying a deductible which, for 2011, is the first \$1,132 of all covered inpatient hospital services. The daily coinsurance charge that a Medicare beneficiary is responsible for paying for hospital care for the 61st through the 90th day is \$283 in 2011. If a beneficiary uses “lifetime reserve” days, he or she is responsible for paying \$566 a day for each reserve day used in 2011. Lifetime reserve days are an extra 60 hospital days a beneficiary can use if illness keeps him or her in the hospital for more than 90 days; a beneficiary has only 60 reserve days during his or her lifetime and the beneficiary decides when to use them.

In addition, the daily coinsurance charge a beneficiary is responsible for paying for care in a skilled nursing facility for the 21st through the 100th day is \$141.50 in 2011.

5. What are some of the services covered by Part B (medical insurance) of the Original Medicare Plan?

Part B covers physicians’ services, outpatient medical and surgical services, and many other medical and health services in and out of medical institutions. More information on specific services is available by calling 1-800-MEDICARE (1-800-633-4227) or by visiting www.medicare.gov.

There is an annual deductible for Part B services (\$162 in 2011). After the deductible is paid, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year; the beneficiary is responsible for paying the remaining 20 percent of the cost.

Claims for Part B benefits filed on behalf of railroad retirement beneficiaries in the Original Medicare Plan are generally handled by Palmetto GBA on a nationwide basis. Palmetto GBA is a private company that contracts with the RRB and Medicare to pay Part B claims for railroad retirement beneficiaries.

**Palmetto GBA
Railroad Medicare Part B Office
P.O. Box 10066
Augusta, GA 30999-0001
1-800-833-4455
www.palmettogba.com/medicare**

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Part B generally does not pay for services outside the United States. There are rare emergency cases where Part B can pay for care in Canada or Mexico.

6. What is the Medicare Part B premium in 2011?

The standard premium is \$115.40 in 2011. However, most Medicare beneficiaries did not see an increase in their monthly Part B premiums because of a “hold-harmless” provision in current law. Monthly premiums for beneficiaries protected by this provision continue to be \$96.40 or \$110.50, the same monthly amount that they paid in 2010.

Monthly premiums for some beneficiaries are greater, depending on a beneficiary’s or married couple’s modified adjusted gross income. The income-related Part B premiums for 2011 (\$115.40 plus a monthly adjustment amount) are \$161.50, \$230.70, \$299.90, or \$369.10, depending on the extent to which an individual beneficiary’s income exceeds \$85,000 (or a married couple’s income exceeds \$170,000), with the highest premium rates only paid by beneficiaries whose incomes are over \$214,000 (or \$428,000 for a married couple). Some individuals also pay premium surcharges because they enrolled late for Part B.

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

Premiums for Part B are increased 10 percent for each 12-month period the individual could have been, but was not, enrolled. However, individuals age 65 or older who wait to enroll in Part B because they have group health plan coverage based on their own or their spouse’s current employment may not have to pay higher premiums because they may be eligible for special enrollment periods. The same special enrollment period rules apply to disabled individuals, except that the group health insurance may be based on the current employment of the individual, his or her spouse, or a family member.

Individuals deciding when to enroll in Medicare Part B must consider how this will affect eligibility for health insurance policies which supplement Medicare coverage. These include “Medigap” insurance and prescription drug coverage and are explained in the answers to questions 8 through 11.

8. What is Medigap insurance?

Many private insurance companies sell insurance to help pay for services not covered by the Original Medicare Plan. This kind of insurance is called “Medigap” for short. Policies may cover deductibles, coinsurance, copayments, health care outside the United States and more. Generally, individuals need Medicare Part A and Part B to enroll. A monthly premium is charged.

When someone first enrolls in Medicare Part B at age 65 or older, he or she has a 6-month “Medigap open enrollment period.” During that time, the individual has a right to buy the Medigap policy of his or her choice regardless of any health problems. The company cannot refuse a policy or charge the individual more than all other open enrollment applicants. If an individual does not buy a policy when first eligible, the cost may go up or the desired policy may not be available.

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More detailed information about Medigap policies can be found in the publication *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, available by calling the Medicare toll-free number 1-800-633-4227 or at www.medicare.gov.

9. Do Medicare beneficiaries have choices available for receiving health care services?

Yes. Under the Original Medicare Plan, a beneficiary can see any doctor or provider who accepts Medicare and is accepting new Medicare patients, or a beneficiary can choose a Medicare Advantage Plan (Part C). In limited instances, other Medicare Health Plans may be available. To find out which plans are available in an area, beneficiaries should go to www.medicare.gov or they can call 1-800-633-4227.

10. What is Medicare Advantage?

Medicare Advantage Plans combine Medicare Part A and Part B coverage, and are available in most areas of the country. A beneficiary must have both Medicare Part A and Part B to join a Medicare Advantage Plan, and the individual must live in the plan's service area. Medicare Advantage Plan choices include regional preferred provider organizations (PPOs), health maintenance organizations (HMOs), private fee-for-service plans and others. A PPO is a plan under which a beneficiary uses doctors, hospitals, and providers belonging to a network; beneficiaries can use doctors, hospitals, and providers outside the network for an additional cost. Under a Medicare Advantage Plan, a beneficiary may pay lower copayments and receive extra benefits. Most plans also include Medicare prescription drug coverage (Part D).

For those in a Medicare Advantage Plan, information on out-of-pocket cost is available by calling 1-800-633-4227 or by going to www.medicare.gov.

11. How do Medicare prescription drug plans work?

Medicare offers voluntary insurance coverage for prescription drugs (Part D) through Medicare prescription drug plans and other health plan options.

Medicare contracts with private companies to offer beneficiaries prescription drug coverage through a variety of options, with different covered prescriptions and different costs. Beneficiaries pay a monthly premium (averaging about \$32 in 2011), a yearly deductible (up to \$310 in 2011) and part of the cost of prescriptions. Those with limited income and resources may qualify for help in paying some prescription drug costs.

Beginning in 2011, the Affordable Care Act requires some Part D beneficiaries to also pay a monthly adjustment amount, depending on a beneficiary's or married couple's modified adjusted gross income. The Part D income-related monthly adjustment amounts are \$12.00, \$31.10, \$50.10, or \$69.10, depending on the extent to which an individual beneficiary's modified adjusted gross income exceeds \$85,000 (or a married couple's income exceeds \$170,000), with the highest amounts only paid by beneficiaries whose incomes are over \$214,000 (or \$428,000 for a married couple).

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To enroll, individuals must have Medicare Part A or Part B. (They are also required to live in the prescription drug benefit plan's service area.) Beneficiaries can join during the period that starts 3 months before Medicare coverage starts and ends 3 months after the first month of Medicare coverage. There may be a higher premium if an individual doesn't join a Medicare drug plan when first eligible, and he or she does not have other prescription drug coverage that, on average, covers at least as much as standard Medicare prescription drug coverage. In most cases, there is no automatic enrollment to get a Medicare prescription drug plan. Individuals enrolled in Medicare Advantage Plans will generally get their prescription drug coverage through their plan.

More information about Medicare prescription drug plans, as well as free personalized information, is available online at www.medicare.gov, or by calling the Medicare toll-free number, 1-800-633-4227. In addition, free personalized counseling is available from the local State Health Insurance Assistance Program (SHIP) and other local and community-based organizations.

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