The Difference Between MEDICARE and MEDICAID

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Confusing the Two Programs

- Many people, including members of the media, confuse Medicare with Medicaid, and vice versa.
- Reasons for this include:
  - Both are large health coverage programs.
  - The names of the programs are very similar.
  - Confusions and errors by the media.
  - Involvement of *managed Care organizations* in both programs.
    - Some of the same companies have them in both programs.
  - Mass of mailings and advertisements from both programs.

Introduction

- **Medicare** and **Medicaid** are both programs providing important health care coverage for seniors and others.
- **Medicare** is a *national* program. **Medicaid** is established by federal and state laws, but each state runs its own program.
- **Eligibility for Medicare** is commonly linked to eligibility for Social Security benefits, and is not "means tested."
- **Eligibility for Medicaid** involves having income – and for some eligibility groups, resources -- under specified levels.
- **Services coverage rules** under the programs are substantially different.
- Many individuals have *both* Medicare *and* Medicaid

Eligibility Groups

- **Medicare covers**:
  - Individuals age 65 and older, or "disabled."*
  - Individuals of any age who have "End Stage Renal Disease."
- **Medicaid** covers about 40 eligibility groups, including:
  - Children up to age 19.
  - SSI recipients.
  - Pregnant Women.
  - Individuals between age 19 and 64, not otherwise eligible for Medicaid, and not eligible for Medicare (the "Medicaid Expansion" group).
  - Low income Medicare beneficiaries (coverage is limited)
- Individuals can be eligible for *both Medicare* and *Medicaid*.

* "disabled" as determined under strict Social Security guidelines

Financial Eligibility

- **Under Medicare**, individuals must have had a specified amount of lifetime *earnings* in Social Security-covered work.
  - That amount is calculated in terms of numbers of "credits" (formerly, "quarters") from work in Social Security-covered employment.
  - There are no income or resources eligibility tests.
  - Dependents and survivors (spouses, widow(ers),children, parents) are eligible based on the "**worker**" meeting the credits requirements.
- **Under Medicaid**, each individual must show that their *current* "**countable**" income – and in some case, resources -- are under an eligibility category's low financial eligibility levels.
  - "Countable" means that certain types and/or amounts of income and resources are not counted in determining

Covered Services -- 1

- **Under Medicare**, one set of services,grouped under three "**Parts**":
  - **Part A**: hospitalization and skilled nursing home stays; Home Health services, and Hospice.
  - **Part B**: physician, lab and X-ray, ambulance, medical equipment, therapies, and many other "outpatient" services.
  - **Part D**: Medicare's comprehensive prescription drug coverage.
- **Under Medicaid**, there are three main coverage packages:
  - Full-benefit Medicaid – comprehensive medical services coverage.
  - The "Alternative Benefit Plan" --for the age 19-64 group, which is reasonably comprehensive but not as comprehensive as full-benefit coverage.
  - Limited-benefit Medicaid; most notably for the "Medicare Savings Program" categories, which covers only Medicare Part A and B premiums, and, under the QMB category, Medicare cost-sharing.

Covered Services --2

- **Some noteworthy features of Medicare coverage**:
  - Coverage of long-term care is limited.
    - Nursing home coverage is limited to 100 days per "benefit period" and covers only skilled level care.
    - Scope of Home Health coverage is medically-oriented and limited
  - Little or no coverage for dental/dentures, and vision care
  - Substantial cost sharing obligations (*premiums*, deductibles, coinsurance, co-pays).
- **Some noteworthy features of Medicaid coverage:**
  - Substantial long-term care coverage
  - Little cost sharing (*e.g.,* no premiums, limited co-pays).
  - Care coordination, especially for higher-need beneficiaries

Cost Sharing and Enrollment Penalties

- As noted on the previous slide, cost sharing obligations under **Medicare** are extensive, *e.g.,*:
  - Monthly premiums for Part B; sometimes for Parts A and D.
  - Deductibles, coinsurance, and co-pays under Parts A, B, and D.
- Also as noted on the previous slide, cost sharing obligations under **Medicaid** are limited:
  - Generally no premiums, limited co-pays.
- **Enrollment Penalties:**
  - Under **Medicare**, higher premiums and delayed enrollment for "late" enrollments (*i.e.,* not enrolling when first eligible) – exceptions apply.
  - Under **Medicaid**, none.

Use of Managed Care Organizations

- Under **Medicaid,** all beneficiaries other than Native Americans are *required* to enroll with one of four managed care organizations (MCOs), and get all their services through them.
- Under **Medicare**, beneficiaries can *chose* to enroll with managed care organizations (and get all their Medicare-covered services – and often more -- through them).
  - The rules for these organizations and enrollees are in "**Part C**."
  - Beneficiaries can also choose to enroll with *Prescription drug* Plans; though most Medicare managed care plans include drug coverage).

Coverage Cards

- Under **Medicare**, all beneficiaries receive a white card with red and blue stripes.
  - However, if they have enrolled with managed care or drug plans, they will have those as well (and are more likely to retain plan cards).
  - *NOTE*: **All Medicare cards will be changing,** *e.g.,* to help fight *Identity Theft*; new cards will be issued to all beneficiaries between 4/18 and 4/19.
- Under **Medicaid**, most beneficiaries are issued a two-tone blue card.
  - The cards are *not* reissued each month, so beneficiaries and others may think their coverage is in effect even though the beneficiary has lost their eligibility.
  - **QMB** beneficiaries – who have limited coverage – are also issued the same two-tone blue card as beneficiaries with full-benefit eligibility.
- Having multiple, sometimes outdated, cards can cause confusion for beneficiaries and others.

Administration

- **Medicare**
  - Applications, eligibility, and premium matters handled by Social Security Administration offices.
  - Services coverage matters handled by Claims contractors or beneficiary's "Part C" managed care plan.
- **Medicaid**
  - Applications and eligibility determinations handled by the state Human Services Department's **Income Support Division** offices.
  - Services coverage determinations for most beneficiaries made by their managed care organization (MCO).
    - For Native Americans not in managed care, by the Human Services Department's **Medical Assistance Division**.

Appeal Rights

- **Medicare** -- Beneficiaries have appeal rights for most types of determinations, including:
  - For eligibility and premium issues – to Social Security Administration.
  - For services determinations, to Medicare contractors and ALJs.
    - Can involve multiple steps and contractors.
  - Special appeals from hospital, nursing home, and Home Health discharges.
- **Medicaid** – For all issues, mostly "**Fair Hearing**" appeals conducted by Human Services Department.
  - For services coverage issues, must first appeal to MCO.
- Most Medicare and Medicaid ***determination notices*** provide information on how to appeal.