The Difference Between MEDICARE and MEDICAID

Workshop Led By:
Michael C. Parks, Senior Citizens Law Office

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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.
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 choose 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).
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.
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.