MEDICARE PATIENTS

Some of you may not understand that having Medicare does not necessarily mean that you have no financial responsibility for your health care services. Indeed, it is a complicated program, and I am learning right along with you! I would like to share a few basic facts with you, and explain some aspects that are a little more complex, as I have come to understand them.

1. If your sole health insurance coverage is Medicare, then you are responsible for 20% of the Medicare Allowable amount for each visit. This is your co-pay. In addition to the contractual provider write-off, Medicare demands an additional reduction of 21% in its allowable rates for mental health services, which they call a "psychiatric reduction," and which defaults to patient responsibility. (I agree, this seems like an arbitrary and discriminatory fee for being a mental health patient, and I would encourage you to voice your concerns about this to your elected officials, as well as to Medicare. However, for now, that's the way it is).

2. Beginning in January 2013, Medicare is imposing a deductible of $147. Each Medicare recipient must meet this deductible, out-of-pocket, before Medicare pays your claims.

3. If you have secondary or supplemental coverage (which I highly encourage and have recommended to many of you), it may cover all or part of the patient responsibility of the Medicare Allowable rates. Medicare kindly bills your secondary insurance automatically after they process a claim, and the secondary insurers are generally obligated to cover any service that Medicare covers. In most cases, this process operates smoothly.

4. Some of you have secondary or supplemental coverage with Medicaid. This could be in the form of secondary OHP (Oregon Health Plan, which should function as a secondary insurance) or QMB (Qualified Medicare Beneficiary, which also covers Medicare premiums for those who meet income requirements). As with other secondary providers, Medicare bills DHS/OHP automatically when they process the claim. Thus far, for me, this process is *not* operating so smoothly! DHS has not yet approved my application for recognition as an approved provider, even though Medicare has. Therefore, the State is not yet reimbursing me for secondary payment of services provided to you. This may be the reason you see outstanding balances on your statement. As one of 26 states who have entered into cooperative Demonstration Projects with Medicare as part of the implementation of the Affordable Care Act, I do expect the State of Oregon to help make the integration of care to dual-eligible clients a smoother process in the future.

5. **Medicare** is responsive to its recipients, and I encourage you to familiarize yourself with your rights and responsibilities by reading the mail you receive from CMS (Centers for Medicare/Medicaid Services) such as EOB's (Explanation of Benefits) and other letters, navigating the CMS website, speaking with providers, and calling or writing Medicare with any concerns or questions you may have.

6. Again, if you do not qualify for secondary Medicaid or QMB (which could be determined by visiting our local DHS office or the office of Seniors and People with Disabilities), I encourage you to consider the option of supplemental insurance through a private carrier. I can recommend to you the services of Ida Lewis, at Great Basin Insurance, for assistance in making the best choice for your individual needs.