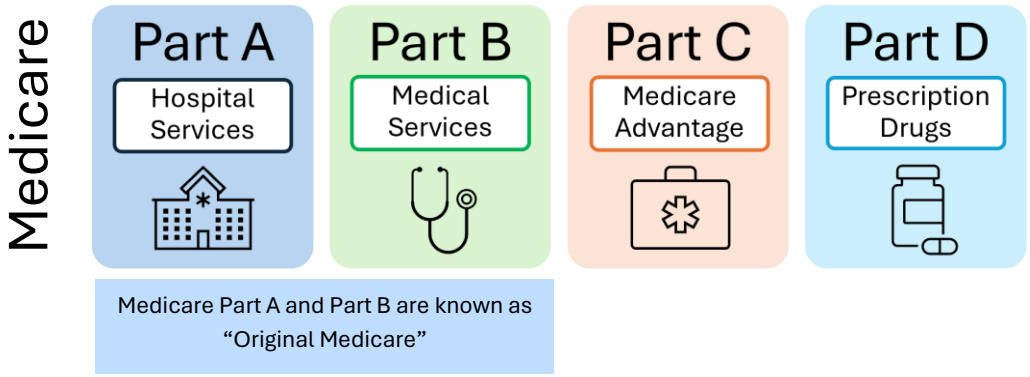
NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

The Basics: Medicare 101

2024

The Centers for Medicare and Medicaid Services (CMS) offer public government Health Care coverage in the United States. Medicare is a government-sponsored health insurance plan for people age 65 or older as well as some younger persons with disabilities and individuals diagnosed with End-Stage Renal Disease (ESRD) and ALS (Lou Gehrig's disease). Medicare has various parts that offer access to different services. And while Medicare helps cover the cost of health care, it does not cover all medical expenses.

The sections below briefly outline the distinct parts of Medicare, what services they cover, and the associated member cost sharing *Note: Health insurance cost sharing terminology and definitions are at the end of the document.*



	COVERED SERVICES	MEMBER COST SHARING
Part A – Hospital Services	• Hospital inpatient care • Skilled nursing facility care • Hospice care • Home health care (for up to 100 days as follow-up to institutional care)	Medicare Part A includes an annual deductible and coinsurance. In limited situations, there may also be a premium for Part A coverage.

*The **Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program** project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$3.2 million for grant year 4** with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.*

	COVERED SERVICES	MEMBER COST SHARING
	• Services from doctors and other health care providers • Outpatient care • Home health care (prior institutional stay not required) • Durable medical equipment (wheelchairs, walkers, hospital beds, other equipment) • Preventive services (screenings, vaccines, and yearly "Wellness" visits)	Medicare Part B includes an annual deductible, a monthly premium, as well as coinsurance.
	Medicare Advantage (MA) is an alternative to Original Medicare. These Medicare-approved managed care plans (operated by private health insurance companies) provide all services included in both Medicare Part A and Part B and usually include Part D prescription drug coverage. MA plans must ensure all Medicare-covered services are available in the policy. MA plans also have more flexibility in administering benefits than Original Medicare and may offer extra benefits that Original Medicare does not (e.g., vision, hearing, and dental services).	Most MA plans have restricted provider networks known as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Beneficiaries enrolled in these plans must use doctors who are in the plan's network in most cases. Out-of-network providers may also be available in some MA plans but may have higher out-of-pocket costs. MA plans often include monthly premiums and copays but may have lower out-of-pocket costs than Original Medicare.
	Part D helps cover the cost of prescription drugs. Beneficiaries can join a Medicare Part D drug plan to supplement Original Medicare or receive their prescription drugs through a MA Plan that includes drug coverage. Private health insurance companies administer standalone Medicare Part D prescription drug plans and must follow rules set by Medicare.	Medicare Part D includes premiums and other cost sharing requirements.

MEDICARE SUPPLEMENTAL INSURANCE PLANS

Private health insurance companies provide Medicare supplemental insurance plans (also known as "Medigap") to help cover any out-of-pocket costs associated with Original Medicare. Some Medigap policies may also cover additional benefits not provided through Medicare. Part C beneficiaries cannot enroll in a MA plan and a Medigap plan at the same time.

Because Medigap benefits are set by the federal government, the basic benefit structure is the same for each plan. However, different plan design options are available based on the coverage level provided in the plan. For example, some plans will cover 100% of the Part A deductible, and others may only cover 50%. Premiums for supplemental Medigap plans vary based on the level of coverage purchased, any additional benefits covered, and the company providing the benefit.

DUAL ELIGIBLE

Dual eligible beneficiaries are lower income individuals who qualify for both Medicare and Medicaid (the joint federal and state program that provides coverage for some people with limited income and resources). In this situation, Medicaid serves as the supplemental insurer, paying for Medicare premiums and other out-of-pocket costs. Medicaid may also provide coverage for some services not covered under Medicare (e.g., long-term services and supports). Dual eligible beneficiaries can enroll in Original Medicare or a Part C MA plan.

THE MEDICARE DIABETES PREVENTION PROGRAM

The Medicare Diabetes Prevention Program (MDPP) is a lifestyle change program based on the National Diabetes Prevention Program (National DPP) lifestyle change program. These programs are structured, one-year program designed to reduce the risk of developing type 2 diabetes. It consists of a set of curriculum-based sessions that focus on lifestyle change, healthy eating, physical activity, and modest weight loss. These sessions are taught by trained Lifestyle Coaches that can be health professionals or non-licensed personnel. MDPP is covered by CMS under Medicare Part B and Part C preventive service. There is no coinsurance for the MDPP as a preventive service—either through Original Medicare or if provided within an MA plan's network. However, there may be cost sharing requirements for out-of-network providers.

The MDPP differs from most other Medicare covered services. Most Medicare covered services are episode-based medical care (e.g., visits to primary care physicians, specialty care, and inpatient and outpatient hospital care) that identifies or treats specific medical conditions. The MDPP helps prevent the onset of type 2 diabetes and the need for ongoing treatment. It consists of a set of curriculum-based sessions that focus on lifestyle change (versus identifying or addressing specific medical needs) and utilizes trained lifestyle coaches, who are non-licensed, non-certified personnel.

As a Part B service, MA plans must cover the MDPP. MA plans either contract with MDPP suppliers to provide MDPP services to their enrollees as an in-network service, provide coverage of the MDPP as an out-of-network service, or the MA plan may enroll as an MDPP supplier and offer services through the plan.

MA plans do not have to contract with all MDPP suppliers in their area. Likewise, MDPP suppliers do not have to contract with all MA plans in their service area. Original Medicare and each MA plan may have different rules related to out-of-network plan cost sharing and billing requirements. Given these differences, it is important for suppliers to have a clear understanding of Original Medicare's and each MA plan's contracting and billing requirements when providing services to Medicare beneficiaries.

FOR MORE INFORMATION

MDPP-Shared-Learning-Resource-MDPP-and-Medicare-Advantage.pdf (coveragetoolkit.org)
MDPP Guide for Medicare Advantage (MA) Plans (coveragetoolkit.org)
Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet (cms.gov)
Medicare Diabetes Prevention Program (MDPP) Implementation Resources

REFERENCES

Parts of Medicare | Medicare
What is Medicare Supplement Insurance? | AARP® Medicare Supplement (aarpmedicaresupplement.com)
How Do Dual-Eligible Individuals Get Their Medicare Coverage? | KFF
Billing and Claims Webinar (cms.gov)
Medigap (Medicare Supplement Health Insurance) | CMS
Medicare eligibility for home health (Part A or Part B) (medicareinteractive.org)

*The **Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program** project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$4.2 million for grant year 6** with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.*

HEALTH INSURANCE COST SHARING TERMINOLOGY AND DEFINITIONS

Cost Sharing

Health insurance generally does not pay the full cost of health care services. The beneficiary and the health plan split the cost. Cost sharing is a broad term and includes a variety of ways the beneficiary pays for the cost of health insurance and health care services. Different types of cost sharing are defined below.

Premiums

A premium is what a beneficiary pays to maintain their health insurance policy. Premiums are assessed annually and typically paid monthly. Factors that influence the premium amount include a person's age and geographic location, the services covered under the policy, the breadth of the policy's provider network, and the level of the policy's other cost sharing amounts (deductibles, coinsurance, copayments, etc.).

Deductibles

A deductible is what a beneficiary will pay for covered health care services over a year before the health plan starts paying its share of the services. The deductible applies across all covered services. For example, if a health plan has a $5,000 deductible, the beneficiary must first pay $5,000 in charged services before the plan will start to pay its share of the covered health care costs.

Coinsurance

Coinsurance is the *percentage* of a health care bill that a health insurance plan requires the beneficiary to pay. Because the beneficiary pays the full cost of their health care services until their deductible is met, coinsurance payments do not set in until after the beneficiary has paid their full deductible for the year. For example, if a health plan's coinsurance is 20%, the beneficiary will pay 20% of their medical bills and the health plan will pay 80% after the plan's deductible is met. Medicare Part B services are generally subject to a 20% coinsurance.

Copay or copayment

A copay is like coinsurance, but instead of a percentage of a health care bill, it is the *set price* the beneficiary pays as part of the cost of receiving health care services. The copay is paid to the medical provider when the service is delivered. The copayment amount varies depending on the type of health care services received.

Out-of-pocket maximums

The out-of-pocket maximum is the most a beneficiary will pay for health care services over a year (not including premiums). Once a beneficiary reaches their out-of-pocket maximum, the health insurance company covers 100% of the cost of services covered under the health plan. Out-of-network and non-covered services may not factor into the out-of-pocket maximum.

Approved Amount

The approved amount is how much a health plan has agreed to pay the provider for a covered service.

References

What are the Medicare premiums and coinsurance rates? | HHS.gov
What is Medicare Coinsurance? How Is It Different From a Copay? (medicareadvantage.com)