A BRIEF EXPLANATION OF "MEDICARE"

HEALTH INSURANCE FOR THE AGED

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HEALTH INSURANCE FOR THE AGED

The 1965 social security amendments, which were signed into law by President Johnson on July 30, establish a broad program of health insurance, known popularly as "medicare," for people 65 or older. This program is important for persons now working, for they will have this protection in later years. But if you are already 65, or will reach that age soon, you especially will want to have the information this leaflet provides on how these health insurance programs will protect you when they start in July 1966.

TWO KINDS OF HEALTH INSURANCE

- **Hospital Insurance**—to help pay the bills when you are hospitalized. The program also provides payments for skilled nursing care and other services in an extended care facility after hospitalization, outpatient hospital diagnostic services, and home health services.

  This insurance is financed out of special contributions paid by people while they work, with matching contributions from employers, so that people will not have to pay for this protection when they are old and not working.

- **Medical Insurance**—to help you pay the bills for doctors' services and for a number of other medical items and services not covered under the hospital insurance program.

  The medical insurance program is voluntary. You decide whether to enroll for protection under the medical insurance program. You can have this important added protection at a low cost ($3 monthly) because the Federal Government will pay an equal amount toward the cost.

HOW PEOPLE 65 AND OVER QUALIFY

Most people will **not** have to go to the social security office to qualify for protection under the hospital and medical insurance programs.

You will **not** need to go to your social security office **if**—

- **you are getting social security or railroad retirement benefits.** You qualify automatically **for hospital insurance**, and an application card for **medical insurance** benefits will be mailed to you by December 1965 with a leaflet explaining both of these programs.
- **you are receiving a Federal civil service retirement annuity.** You will get further information by mail. You will be told if it is necessary to go to the social security office later.
- **you are receiving public assistance payments.** In most cases, the public assistance agency will assist you in applying for **hospital insurance** and will advise you about enrolling for **medical insurance.**

You **should** go to your social security office if you are not receiving any of the above payments **and**

- **you have worked under social security but have never applied for benefits.** The people in your social security office will help you apply for **hospital insurance.** They will also advise you on how you can enroll in the **medical insurance** program.
- **you have never worked under social security.** Get in touch with your social security office between September 1, 1965, and March 31, 1966.

HOSPITAL INSURANCE

Nearly every [1] American 65 or over will be protected under the hospital insurance program when it starts in July 1966. If you qualify, these are the benefits for which you will be eligible:

Hospitalization for up to 90 days in a "spell of illness"[2]—the program pays for covered services during 60 days of care in a participating hospital, except for the first $40, during a spell of illness. If you are hospitalized for more than 60 days during your spell of illness, the program will pay all but $10 daily for covered services during an additional 30 days of care.

There is a lifetime limitation of 190 days on payments for treatment in mental hospitals.

Outpatient Hospital Diagnostic Services—the program will pay 80 percent of the cost for diagnostic services you receive as an outpatient of a participating hospital during a 20-day period, except for the first $20 for each 20-day period.

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[1] Some Federal employees and former Federal employees who are not eligible for social security benefits are not eligible for hospital insurance. They may, however, enroll in the medical insurance program.

Aliens who are not eligible for social security cash benefits will be eligible for the hospital and medical insurance programs only if they were admitted to the United States for permanent residence and have resided continuously in the United States for 5 years.

[2] A "spell of illness" begins on the first day you receive covered services as a patient in a hospital or extended care facility. It ends after you have been out of a hospital or extended care facility for 60 consecutive days. You may be discharged and readmitted several times during a spell of illness, but a new spell of illness cannot begin until you have been out of a hospital or extended care facility for 60 consecutive days.

Posthospital Extended Care in the kind of skilled nursing home or part of a hospital which qualifies as an extended care facility—after a hospital stay of at least 3 days, the program pays for 20 days of extended care during a spell of illness. If you need this care for more than 20 days during a spell of illness, the program will pay all but $5 daily for an additional 80 days.

Posthospital Home Health Care Services—the program will pay the cost of up to 100 visits in the 365 days after your discharge from a hospital after a stay of 3 days or more or from an extended care facility, if these services are furnished under an approved plan. Services of visiting nurses, physical therapists, and other health workers (but not doctors) who come to your home to furnish health care services are covered. Doctor's visits are covered only under the voluntary medical insurance plan.

Covered Services in a Hospital or Extended Care Facility—benefit payments will cover (except for the deductible amounts) the cost of your room and board in semiprivate accommodations, ordinary nursing services, and the costs of drugs, supplies, and most other items of service you receive which are customarily furnished for the care of patients by the hospital or extended care facility.

Effective Dates—the benefits described above will become payable beginning July 1, 1966, except for posthospital extended care benefits which start on January 1, 1967.

SUPPLEMENTARY MEDICAL INSURANCE

The hospital insurance program will help you pay your hospital bills, but it does not pay doctor bills. You can provide in advance toward paying your doctor bills by signing up for medical insurance.

After you enroll for medical insurance, you pay a small premium ($3 monthly) with the Federal Government matching this amount.

The medical insurance program pays 80 percent of the reasonable charges for covered services, except for the first $50 in a calendar year.

Since the program does not begin until July 1, 1966, no expenses you have before that time can count toward the $50 for 1966.

The services covered under medical insurance include:

- **Physicians' and Surgeons' Services:** no matter where you receive the services—at home, in the doctor's office, in a clinic, or in a hospital.
- **Home Health Visits:** up to 100 home health visits under an approved plan each year with no need for prior hospitalization. This is in addition to the 100 visits you get under hospital insurance.
- **Other Medical and Health Services** regardless of where rendered: including such things as diagnostic tests (X-rays, etc.; laboratory services); X-ray or radium treatments; surgical dressings, splints, casts; certain ambulance services; braces, artificial legs, arms, and eyes; rental of medical equipment such as iron lungs; and many other medical items and services.

The voluntary medical insurance plan becomes effective starting July 1, 1966. If you enroll in time, your medical insurance

coverage will start on that day. The medical insurance program will not, of course, pay for any goods or services you receive before July 1966.

When You Can Enroll For Medical Insurance

The law provides specific periods of time, called enrollment periods, during which you can sign up for medical insurance benefits. The first enrollment period begins on September 1, 1965, and ends on March 31, 1966. As noted previously, people who are entitled to social security, railroad retirement, or civil service benefits will get their application cards by mail.

If you are 65 or older on January 1, 1966, you must sign up during the first enrollment period in order to be covered under the medical insurance program when it starts in July 1966. Remember, the first enrollment period ends on March 31, 1966.

If your 65th birthday occurs after January 1, 1966, your first enrollment period runs for 7 months beginning with the third month immediately before the month you reach 65, and ending 3 months after the month you are 65. For example, if you reach 65 in February, you may sign up any time between the preceding November 1 and the following May 31.

You will have protection as soon as you reach 65 only if you apply during the 3-month period just before the month in which you reach 65. Your medical insurance will not take effect before July 1, 1966.

What You Will Lose If You Enroll Late

There are several good reasons for signing up for the medical insurance program during your first enrollment period.

If you pass up your first opportunity, you will not have another chance to sign up until the next general enrollment period (October 1, 1967 to December 31, 1967). Also, if you wait to enroll, you may have to pay a higher premium for the same protection, **and** your coverage will not begin until 6 to 9 months after you enroll.

These provisions take into account the higher cost of insuring a person who does not enroll and begin paying premiums at his first opportunity.

Paying The Monthly Premium

If you join the voluntary plan and you are receiving monthly social security benefits or a railroad or civil service retirement annuity, $3 a month for medical insurance benefits will be deducted from your check each month. No deductions will be made before July 1966.

If you are not eligible for social security checks for one or more months, arrangements will be made for you to make the $3 payments in a convenient manner.

If you are not receiving any of these benefits, you will get information when you enroll about how to pay the monthly premiums when you enroll or soon afterward.

YOUR HEALTH INSURANCE CARD

After you qualify for the hospital insurance program you will receive a health insurance card by mail. If you enroll in the medical insurance program, your card will show that you have both medical and hospital insurance.

After June 1966, whenever you use any of the services which are covered,

show your health insurance card to the hospital, extended care facility, home health agency, doctor, or other person providing the services. The part of the bills for which payment can be made will then be taken care of by the program.

Services Not Covered By Health Insurance

The hospital insurance plan gives you basic protection against the high cost of illness in old age, but it will not pay all of your health care bills. For example, physicians' and surgeons' services, including the services of pathologists, radiologists, and anesthesiologists in the hospital, are **not** covered by the hospital insurance plan. (If you enroll under the voluntary medical insurance plan, that plan will help toward paying your doctor bills.)

Some items and services are not covered under either plan: routine physical checkups, eyeglasses, hearing aids, private duty nurses, custodial care, and personal services such as a telephone or television in your hospital room.

Under the hospital insurance program, drugs are covered only when they are furnished to a patient in a hospital or extended care facility. Under the medical insurance program, drugs are covered only when they are administered by a physician and cannot be self-administered.

Payments will ordinarily be made under the program only in the 50 States, Puerto Rico, the Virgin Islands, Guam, and American Samoa. Hospital services under the basic hospital insurance plan may be provided in border areas immediately outside the United States if comparable services are not accessible in the United States for a beneficiary who becomes ill or is injured in this country.

HOW THE HOSPITAL AND MEDICAL INSURANCE PLANS WILL BE FINANCED

The financing provisions for hospital and medical insurance are separated completely from the financing provisions of the regular social security program.

The hospital insurance program will be financed by special contributions from employees and self-employed people. Employers will pay a like amount. For each, the hospital insurance contribution rate will be 0.35 percent in 1966 on the first $6,600 of earnings. Thus, a worker who earns $4,000 yearly will pay $14 in 1966. In 1967, the rate will be 0.5 percent. Thus the worker with $4,000 earnings will pay $20 in 1967. The contribution rate is scheduled to increase periodically until 1987, so that in 1987 a worker will pay $32 yearly on $4,000 earnings. On the maximum earnings of $6,600 yearly, a worker will pay $23.10 in 1966, $33.00 in 1967, and $52.80 in 1987 and thereafter.

The hospital insurance contributions will be in addition to, and collected at the same time and in the same manner as the regular social security contributions. Income from the hospital insurance contributions will be put into the Hospital Insurance Trust Fund from which the program's benefits and administrative costs will be paid. (A special provision was included in the law to reimburse the Hospital Insurance Trust Fund from general tax revenues for the costs of providing hospital insurance coverage for the 2 million people who are not entitled to monthly social security or railroad retirement benefits.)

The medical insurance program will be financed through monthly premiums

paid by people over 65 who enroll in the program and by matching payments from the Federal Government from general revenues. Income from the medical insurance premiums and the matching Federal payments will be put into the Supplementary Medical Insurance Trust Fund, and the benefits and administrative expenses of medical insurance will be paid from this fund.

At least until 1968, the monthly premium (and the matching Federal payment) will be $3 for each person who chooses coverage. The law requires that the premium rates be examined every 2 years starting in 1967. If the premium rate, including the government's share, is not enough to cover the cost of the program for the next two years, the rate may be changed. The government will continue to pay half the cost.

When you enroll for medical insurance, you are not under any obligation to continue it beyond the end of the next odd-numbered year. Thus, if there is at any time an increase in the premium rate, you will at the same time have an opportunity to drop out of the program if you wish.

Late Enrollment And Re-Enrollment

If you do not enroll at your first opportunity, you may enroll later, but only during certain periods. These periods are the last three months of odd-numbered years beginning with 1967.

If your premiums are being deducted from your social security benefits and you decide to drop out of the medical insurance program, you may drop out during an enrollment period. If you are paying your premiums in cash, your enrollment

may be ended if you fail to pay the premiums.

If your enrollment is ended, you may re-enroll once, but only during one of the enrollment periods and only if you re-enroll within three years.

IF YOU CANNOT MEET YOUR MEDICAL EXPENSES

The health insurance programs will pay a large part of the cost of health care for most older people, but they do not pay the entire bill. If you have medical expenses you are not able to pay, you may qualify for aid from your public welfare agency. Most States have medical care programs for aged people who cannot pay their medical bills, and the 1965 Amendments make it possible for the States to strengthen and improve these services. Your public welfare agency may be able to help you.

FOR FURTHER INFORMATION

For more detailed information about the new health insurance plans, call, write, or visit your nearest social security district office.

Do not because of this new law cancel any hospital or medical insurance you may now have. The health insurance provisions of the new law give no protection whatsoever until July 1966.

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