

CPA Continuing Education Society of PA
Russell Valante
President
Madison Bank Building
1767 Sentry Parkway West
Blue Bell, PA 19422
215-619-3920
rvalante@janney.com
www.cpasocietypa.org



Medicare

Medicare

What is Medicare?

Medicare is a federal health insurance program created in 1965 to help pay medical costs incurred by people over the age of 65, people with certain disabilities, and people with end-stage renal disease. Under the original Medicare plan (sometimes called fee-for-service), coverage consisted of two parts: Part A (hospital insurance) and Part B (medical insurance). The 1997 Balanced Budget Act created Part C (originally called Medicare + Choice). Part C allowed private companies to offer Medicare benefits as well as benefits not offered by Medicare. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act, the first major revision of the Medicare program since its creation was signed into law, preserving and strengthening the original plan, and offering important new prescription drug and preventative benefits, as well as extra help to people with low incomes.

Medicare Part A (hospital insurance)

Generally called hospital insurance, Part A covers services associated with inpatient hospital care (i.e., the costs associated with an overnight stay in a hospital, skilled nursing facility, or psychiatric hospital, such as charges for the meals, hospital room, and nursing services). Part A also covers hospice care and home health care.

Medicare Part B (medical insurance)

Generally called medical insurance, Part B covers other medical care. Physician care--whether it was received while you were an inpatient at a hospital, at a doctor's office, or as an outpatient at a hospital or other health-care facility--is covered under Part B. In addition, ambulance service, laboratory tests, and physical therapy or rehabilitation services are covered.

Example(s): Mom goes into the hospital for four days for treatment of her broken hip. Medicare Part B covers the cost of taking an ambulance to the hospital. Medicare Part A covers her room, meals, nursing care, emergency room charges, charges for the use of a wheelchair, physical therapy, and the cost of medications administered while she is in the hospital. Medicare Part B pays for her physician bills, including those incurred while in the hospital and those for her physical therapy after she leaves the hospital.

Medicare Part C

The 1997 Balanced Budget Act expanded the kinds of private health care plans that may offer Medicare benefits to include managed care plans, medical savings accounts, and private fee-for-service plans. These Medicare Part C programs are in addition to the fee-for-service options under Medicare Parts A and B.

Medicare Part D

Medicare Part D covers the costs of prescription drugs.

Who administers the Medicare program?

The Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services, has overall responsibility for administering the Medicare program. While the Social Security Administration processes Medicare applications and claims, the CMS sets standards and policies.

However, as a beneficiary, you deal mostly with the private insurance companies that actually handle the claims on the local level for individuals receiving Medicare coverage. Insurance companies handling Part A claims are called fiscal intermediaries, and insurance companies handling Part B claims are called Medicare carriers. Managed care plans handle Part C claims. Although the same private insurance company may handle both Part A and Part B claims, Part A and Part B are very different in administration, such as the requirement of separate deductibles and distinct co-payment requirements. There is virtually no overlap; it is as if you have two separate health insurance policies.

Tip: Because the majority of Medicare beneficiaries also receive Social Security benefits, local Social Security offices also provide information about and assistance with Medicare. You can also access information by visiting www.ssa.gov (Social Security Administration site) and at www.medicare.gov, or by calling (800) Medicare.

Who is eligible for coverage under Medicare?

Eligibility for Part A

You may be eligible for Medicare Part A if:

- You are age 65 or older and you are eligible for Social Security benefits
- You are a qualified Railroad Retirement beneficiary
- You are a dependent or a survivor of an individual age 65 or over who is entitled to Medicare Part A benefits or a dependent of an individual under age 65 who is entitled to Social Security retirement benefits

OR

- You are under age 65 and disabled, and
- You have permanent kidney failure, requiring dialysis or a transplant
- You have been receiving Social Security benefits for at least 24 months because you meet the Social Security Administration's definition of permanent and total disability (i.e., you are unable to hold gainful employment in any job), or
- Under special circumstances, you are entitled to Railroad Retirement benefits because of disability

Tip: Individuals who do not meet the eligibility requirements for premium-free hospital insurance can voluntarily enroll in Medicare Part A and pay a monthly premium. If you enroll in premium Medicare Part A, you must also enroll in Medicare Part B.

Eligibility for Part B

You may be eligible for Medicare Part B if:

- You are entitled to Part A hospital insurance (by entitlement to Social Security or Railroad Retirement Act retirement or disability benefits, Medicare-qualified government employment, or end-stage renal disease benefits) and you are a citizen of the United States, or
- You are 65 or older, a U.S. resident, and either a U.S. citizen or an alien legally admitted for permanent residence who has continuously resided in the United States for at least five years prior to your enrollment month

Special eligibility requirements for federal, state, and local government employees

Federal employees who were originally exempt from Medicare because they were not covered under Social Security may qualify for Medicare. To compensate for their not having been eligible to accrue Social Security credits throughout their career, they may qualify for benefits with less than 40 credits or may be able to get their work credited for purposes of becoming Medicare eligible. Almost all federal employees hired after 1983 are covered under Medicare. State and local government employees who were originally exempt from Medicare may qualify depending on their state's agreement with Medicare. State and local employees hired after March 31, 1986, are covered under Medicare provisions.

Caution: Unlike the state health insurance program, called Medicaid, eligibility for Medicare is not contingent on income. Medicaid is available to indigent individuals. You may be eligible for coverage

under both Medicare and Medicaid.

How do you sign up for Medicare?

Enrollment is usually automatic

Any individual who receives Social Security benefits before age 65 or who applies for Social Security benefits at age 65 will be automatically enrolled in Medicare. However, if you retire after age 65, remember to enroll in Medicare at age 65 anyway, because your enrollment won't be automatic. Individuals who will be automatically enrolled in Medicare will receive notification by mail from the Social Security Administration, usually three months before your 65th birthday.

If you need to enroll or want more information about it, call your local Social Security office. If you need assistance finding the local office number, you can call the Social Security Administration at (800) 772-1213. You may not even have to go into the local office; you may be able to enroll over the phone. The Social Security representative will fill out the application for you.

Tip: You can decline to enroll in Medicare Part B. If you have been automatically enrolled in Part B, you will be notified that you have a certain amount of time to decline coverage.

If you decline Part B coverage, will you have another chance to enroll later?

In your 65th year, you have seven months to enroll in Part B during the initial enrollment period, commencing at three months before your 65th birthday and lasting until 4 months after. If you decline Part B coverage that year, you can also enroll in later years during the annual general enrollment period from January 1 through March 31 each year. Coverage will begin in July of the year you enroll. However, the cost of the Part B monthly premium increases 10 percent for each 12-month period that you did not enroll although you were eligible, unless you did not enroll because you were still covered under an employer insurance plan. In that case, you need to enroll within eight months after termination of your coverage under your employer's plan (the special enrollment period).

How much does it cost to enroll in Medicare?

You do not pay a premium for enrolling in Medicare Part A. However, you will pay a premium for Part B. If you do not want to pay the Part B premium, you may decline to receive Part B coverage. You must be enrolled in Parts A and B to get Medicare through a managed care plan, and if you choose a managed care plan under Part C, you may also have a monthly charge from the plan.

Medicare coverage costs the same for any eligible individual, regardless of his or her medical condition. The various costs associated with Medicare, including the deductibles and Part B monthly premium, are usually adjusted annually, using factors such as the Consumer Price Index.

Cost of Medicare Part A coverage

There is no premium for eligible individuals. If you are 65, but not eligible for Medicare coverage, you may still be able to purchase it. In 2010, the monthly premium is \$461 (up from \$443 in 2009) for an individual with 29 or fewer Social Security credits, or for a disabled individual under age 65. The premium is \$254 (up from \$244 in 2009) for individuals with 30 through 39 credits. You must buy Parts A and B together, so you will also have to pay the Part B monthly premium, which for most beneficiaries is \$96.40 in 2010 (certain beneficiaries will pay more). You cannot buy Part A coverage alone.

If you are admitted to a hospital as an inpatient, you will be required to pay a deductible, plus coinsurance costs after 60 days as an inpatient. In 2010, the deductible is \$1,100 (up from \$1,068 in 2009). Coinsurance costs are \$275 (up from \$267 in 2009) a day for days 61 through 90, per benefit period, and \$550 (up from \$534 in 2009) a day for each lifetime reserve day used.

Example(s): Uncle Pat is admitted to the hospital in January of 2010. He is required to pay a deductible of \$1,100. Medicare will pay the balance of his costs for 60 days. Should he still be in the hospital after 60 days, he will then be required to pay \$275/day. Medicare will pay the balance. After 90 days, his coinsurance obligation is \$550/day, because he will need to use his lifetime reserve days.

Medicare will pay nothing after 150 days.

Cost of Medicare Part B coverage

For 2010, the standard monthly premium is \$96.40 (certain beneficiaries will pay more). There is an annual deductible of \$155 (\$135 in 2009), and you are also required to pay a portion of your costs, usually 20 percent of the bill.

Example(s): In 2010, Dr. Brown treated Uncle Pat while he was in the hospital. Dr. Brown's bill is covered under Part B, even though he treated Uncle Pat while in the hospital. Unless Uncle Pat already paid his deductible (because he already incurred \$155 worth of Part B claims), he will also have to pay the deductible for his Part B coverage. This deductible is in addition to the \$1,100 deductible under Part A. Uncle Pat will also have to pay 20 percent of Dr. Brown's bill.

Cost of Medicare Part C coverage

The managed care plan may charge a monthly fee, along with associated costs.

How are Medicare payments determined?

The general rule is that Medicare pays for those costs it determines are reasonable and necessary for diagnosing or treating your illness or injury.

What are reasonable and necessary costs?

As a cost-control measure, Congress enacted complicated procedures for predetermining the dollar amounts Medicare will pay for the specific health care provided.

Part A costs are determined by calculating the average cost to diagnose and/or treat the principal diagnosis. Diagnoses are categorized into diagnosis-related groups, called DRGs. Part B costs are determined by calculating the cost of each variable in treating your illness or injury, such as the degree of expertise needed by the physician and the specific procedures used. Medicare will pay managed care plans directly under Part C. Costs may be adjusted for factors such as regional variations and the type of health-care facility providing the treatment.

Example(s): To illustrate how Medicare works, let us say that Medicare has predetermined that the cost of treating a kidney stone in a hospital under Part A is \$4,000. The hospital may choose various combinations of services to treat the kidney stone, including various lengths of stay in the hospital, but it will be limited to Medicare reimbursement of \$4,000. Part B coverage will depend on factors such as the specialty of the physician, the procedures used, and the average cost of treating a kidney stone in an area.

Example(s): So, when Dad (who is vacationing out of state) develops a kidney stone, he is admitted to the local hospital and is treated by an internist. However, had Dad been at home, he may have had access to a lithotripter, an expensive machine that breaks up kidney stones. In this case, he would have been treated by an internist and a radiologist but on an outpatient basis. So, what Medicare paid for treating Dad for a kidney stone in one state might be different than what it would have paid for treating Dad for a kidney stone in a different state, because his course of treatment would be different.

Limits on charges under Medicare

If the health-care provider (whether it is a hospital, a physician, or other kind of provider) accepts Medicare assignments, the provider has agreed to accept the amount Medicare will pay as payment in full. Your Medicare carrier can give you the list of providers that accept Medicare assignments. It is illegal for a provider accepting Medicare assignment to charge you more than these amounts. Providers annually have the opportunity to sign a contract with Medicare that they will accept assignments or can also choose to accept Medicare assignment on an ad hoc basis.

In addition, even without assignment, a provider generally cannot charge more than 15 percent above the Medicare approved amount, except in three situations:

- You have agreed that neither you nor the provider will submit a claim to Medicare and you plan to pay out-of-pocket
- You are participating in Medicare's medical savings account plan and are using funds from your assets to pay for the services in question
- Medicare approves a higher amount because of extenuating circumstances in your case, as documented by your provider

The 15 percent limit only applies to certain services, not supplies or equipment.

If you are concerned that you are being billed in violation of Medicare regulations (e.g., that Medicare is being billed for services you did not receive or that a provider is performing unnecessary procedures), you can report it by calling the U.S. Department of Health and Human Services's toll-free fraud and abuse hotline at (800) HHS TIPS ((800) 447-8477).

How do you cover medical expenses over and above what Medicare pays?

Many individuals purchase supplemental insurance known as Medigap to augment Medicare coverage. You should also understand the claims process and your rights if you disagree with the claims determination.

How Medicare claims are paid

The claims process

The health-care provider submits your claim to Medicare. If the provider accepts Medicare assignment, you will pay nothing. If the provider does not, not only may you have to pay more than what Medicare will cover, you may have to pay the provider up front and wait for Medicare reimbursement.

After receiving your claim, Medicare will send you a notice that may include an amount for actual charges, approved charges, and excess charges. The actual charge is the amount the provider is seeking. The approved charge is the amount Medicare will pay, based on complicated formulas such as determining the cost of each component of a service and factoring in variables such as regional variations and physician specialties. You may be responsible for the amount that the actual charge exceeds the approved charge, called the excess charge. However, except as described above, that amount cannot be more than 15 percent greater than the Medicare approved amount.

The provider can appeal to Medicare for additional reimbursement if the cost in diagnosing or treating your condition entails exceptional costs or an exceptionally long hospital stay. The approved amounts for Medicare coverage are typically based on average costs and therefore do not factor in any of the several variables that could affect the cost of your care.

Caution: Medicare regulations specifying what services it will cover almost always begin with a general rule, followed by a myriad of exceptions. If you are denied coverage, it is always wise to look into whether or not you can meet one of the exceptions.

Tip: As a Medicare beneficiary, you have a right to receive the care that is necessary for the diagnosis and treatment of your illness or injury. A hospital may not discharge you merely because Medicare payment has run out.

Claims review and hearing procedures

If you disagree with a determination from Medicare that it will not pay a charge and the amount in dispute is \$100 or more for a Part A claim or \$500 or more for a Part B claim, you can request a hearing before an administrative law judge. There are similar, but separate, procedures for resolving claims under Part C, described in the section on Part C.

If the hospital believes that Medicare will not pay for the care, however, it may attempt to discharge you, in which case you should seek a formal determination as to whether or not Medicare will pay for the coverage by contacting your local Peer Review Organization.

Peer Review Organizations (PROs) are local groups of physicians paid by the federal government to review the medical necessity, appropriateness, and quality of care provided for Medicare patients in a hospital. You have the right to request a review by a PRO of any written notice from Medicare that it will not pay for some or all of your hospital bill. Similarly, you can appeal denials of coverage under Part B to the Medicare carrier.

If you disagree with the decision of the PRO or the Medicare carrier, you can ask the PRO or carrier to reconsider its decision. The request for a reconsideration must be made within 60 days of the adverse decision. If you are seeking admission to a hospital or to stay in a hospital, you may request expedited reconsideration, and the PRO is required to deliberate the reconsideration within three days. Otherwise, the PRO has 30 days.

You can appeal a PRO reconsideration if the amount in dispute is \$100 or more by requesting a hearing before an administrative law judge. Again, you must make your request within 60 days of the adverse decision.

If you are still faced with an adverse decision, you may appeal to the Social Security Appeals Council.

Finally, if the disputed amount is \$1,000 or more, for Part A or B, you can appeal in federal court.

You must appeal the decision following these levels of appeals. The principle is called exhaustion of your administrative remedies.

Example(s): Medicare provides you a written notice that it will not pay for the fifth day of inpatient care for your operation. You appeal the decision to the PRO, which decides that the fifth day was not reasonable and necessary. You may appeal this decision or decide to submit your claim to your Medicare supplemental insurance company.

Example(s): Your local PRO determined that the physical therapy you received could have been provided in an outpatient facility and your inpatient stay was not medically necessary. Medicare will not pay for the inpatient stay. You may request that the PRO reconsider its decision. If, on reconsideration, the PRO upholds its decision, you may request a hearing before an administrative law judge. Your last resort would be in federal court.

Janney Montgomery Scott LLC Financial Advisors are available to discuss the suitability and risks involved with various products and strategies presented. We will be happy to provide a prospectus, when available, and other information upon request. Please note that the information provided includes reference to concepts that have legal, accounting and tax implications. It is not to be construed as legal, accounting or tax advice, and is provided as general information to you to assist in understanding the issues discussed. Neither Janney Montgomery Scott LLC nor its Financial Advisors (in their capacity as Financial Advisors) give tax, legal, or accounting advice. We would urge you to consult with your own attorney and/or accountant regarding the application of the information contained in this letter to the facts and circumstances of your particular situation.

Janney Montgomery Scott LLC, is a full-service investment firm that is a member of the NYSE, the FINRA and SIPC.

CPA Continuing Education
Society of PA
Russell Valante
President
Madison Bank Building
1767 Sentry Parkway West
Blue Bell, PA 19422
215-619-3920
rvalante@janney.com
www.cpasocietypa.org