Chapter 3 Original Medicare

A misconception about Medicare is that it will pay all of a senior's health care costs. Medicare was designed only to assist with those expenses.

The three important topics are these:

-What it covers
-What it does not cover
-How seniors can find private insurance coverage to pay for the difference

The following health plan choices are currently available throughout the Medicare system:

-The Original Medicare plan (Parts A and B)
-The Original Medicare plan with a supplemental insurance policy
-Private managed care plans (Medicare Advantage, or Part C) that have contracts with Medicare. In 2006, Medicare Advantage plan choices were expanded to include regional preferred provider organization plans (PPOs). MMA 2003 created regional PPOs, or RPPOs, which helped ensure that beneficiaries in rural areas as well as urban areas would have multiple choices of Medicare health coverage.
-Medicare Prescription Drug Coverage (Part D)

Original Medicare

Most people have both Medicare Part A and Medicare Part B coverage. This is called Original Medicare. This combination provides all the hospital and medical coverage that is available under Medicare. The two parts of the Medicare program are intended to work together to give participants a broad range of coverage, although it is not total coverage. Medicare Part A and Part B are responsible for different types of expenses; they are also subject to different types of deductibles, co-payments, and other benefit limitations. In reality, it is as if the insured were covered by two different insurance companies, or a third, if you consider Medicare Advantage.

For Medicare to cover medical care, it must be medically necessary or considered appropriate for the treatment of an insured's medical condition based on the usual standards applied by the health care profession. This determination is usually made by the attending physician but is subject to approval by Medicare. Usually Medicare will not pay for any care that is not considered mainstream or medically proven to be beneficial. Most alternative types of health care, such as acupuncture, are not covered.

Experimental procedures generally are not covered either. If Medicare refuses to pay for something because they judge it not medically necessary or consider it experimental, then the insured has the right to appeal the decision.

Medicare Part A—Hospital Insurance

Medicare Part A benefits are also referred to as Medicare Hospital Insurance, which is the basic coverage that all Medicare recipients have. Part A is financed directly through Social Security taxes. The funds are withheld from a worker's paycheck and forwarded to Medicare. Since its inception, the "pay ahead" funds have been deposited in what is known as the hospital insurance or HI trust fund. The HI fund has been heavily utilized over the last decade, and several major government arms, including the Social Security and Medicare Board of Trustees, have repeatedly warned Congress of a total depletion of the fund sometime before 2030 unless significant changes are made to Medicare Part A.

Part A helps pay for four kinds of medically necessary hospitalization as defined by the CMS:

-Inpatient care in a general or psychiatric hospital
-Inpatient care in a skilled nursing facility
-Home health care
-Hospice care

Part A does not pay for the doctors who attend the patient under Medicare while in the hospital, or for specialists such as anesthesiologists, psychiatrists, or surgeons. Instead, Part B covers these costs. Nor does Part A pay for long-term care such as that provided in a nursing home or intermediate care facility.

If a patient is not admitted as an inpatient to a hospital, the claim becomes a Part B claim, indicating an "observation" or outpatient coding.

Hospital Admission
During an approved hospital admission, Medicare will help pay for the following inpatient hospital services:

-Semi-private room (two or more beds)
-Meals received in the hospital, including any special dietary requirement
-General medical and surgical nursing care
-Special unit nursing care (intensive care, cardiac care)
-Rehabilitation services, such as physical therapy
-Prescription drugs (provided and/or administered in the hospital)
-Medical supplies
-Lab tests
-X-rays and radiotherapy
-Blood transfusions, except for the first three pints
-Operating and recovery room charges
-Other medically necessary services and supplies

For an expense to be covered by Medicare Part A, the following must apply:

-A physician must prescribe the care, and the patient must be coded as "admitted."
-The treatment can only be provided in a hospital.
-The hospital must participate in the Medicare program.
-The treatment cannot have been denied by a quality improvement organization (QIO) or Medicare intermediary.

No Limit on Number of Benefit Periods
There is no lifetime limit on the number of benefit periods allowed for each Medicare recipient. Within each benefit period of 60 days, the insured is responsible for a Part A deductible, which is $1,408 in 2020. There is no coinsurance for days 1 to 60. For days 61 to 90, Medicare pays all but $352 per day (in 2020). From the 91st day and beyond, Medicare pays all but $704 per day (in 2020). During this latter period, the patient must use his or her 60 lifetime reserve days. Once the lifetime reserve days are used, the patient (or the patient's Medicare supplement policy, or Medicare Advantage policy) is responsible for any additional days. After a period of 365 days, the patient is responsible for all charges.

The Prospective Payment System (PPS) and Diagnostic Related Groups (DRGs)
As hospital charges grew at unprecedented rates during the 1970s and 1980s, Medicare agencies saw a need to change the way in which hospital bills were handled and redesigned the process of paying for Medicare-approved hospital stays.

To contain hospital Medicare costs, and because of the geographic and demographic variation in

hospital charges, a new type of system was instituted by Medicare—the prospective payment system (PPS). PPS involves paying a hospital a preset amount for a certain number of days of care for each diagnosis rather than each hospital submitting bills for a patient's stay. This saves Medicare and hospitals a great deal of manpower and time, because there is not a system of passing bills and payments back and forth.

Hospital payments are based on a formula called diagnostic related groups, or DRGs. DRGs are a system of coding hospital procedures or services. During the first few years of employing the DRG classification system, there were approximately 700 defined DRG codes. By 2014, that number increased to over 100,000 codes because CMS determined that more specific codes related to each malady or injury were needed. By October 1, 2015, that number increased to 140,000 because of Medicare's requirement for another updated installation of a program known as ICD-10. (It is expected that the number of codes will decrease to 78,000 at some point in 2020, with ICD-11.)

Medicare allows a hospital a certain predetermined payment for diagnoses within certain diagnostic groups. For example, the DRG system allows eight days of hospitalization for a broken hip. Moreover, the payment is predetermined by CMS per zip code in the U.S. for that diagnosis and is paid to the hospital regardless of whether the patient is hospitalized for the duration of the fixed number of days allowed by the particular DRG. Some patients are discharged from the hospital before the full number of days the code allows has passed, and some stay longer. Regardless, the hospital is paid for the predetermined number of days the code allows.

Knowing that some patients would not be fully recovered to return home after certain hospital procedures—surgery, stroke, lingering sickness, etc.—but also knowing that the patient did not really need expensive hospital care, the trade-off was in transferring the patient to skilled nursing facilities to receive skilled nursing care. Thus, using the DRG system spurred an incredibly rapid growth in the nursing home industry, as terminology such as extended care, swing units, and skilled care facilities became commonplace. What was originally intended as a cost-saving measure to get people out of expensive hospital beds became costly itself, as people now were forwarded to expensive nursing home beds (although these were not as expensive as hospital beds).

In short, the implementation of the Prospective Payment System and the Diagnostic Related Group codes spawned a new growth industry—that of skilled care and skilled nursing facility care.

Skilled Nursing Facility (SNF) Care Covered by the Original Medicare Plan

Skilled care in a skilled nursing facility is not considered the same as custodial care in nursing homes, assisted care facilities, or intermediate care facilities, although one location may incorporate all three types of services. Skilled nursing facilities can be part of a hospital complex or entirely separate.

A skilled nursing facility offers nursing and/or rehabilitation services that are medically necessary to a patient's recovery. The services provided are not custodial in nature. Custodial services are those that assist a patient with personal needs, such as dressing, eating, bathing, and getting in and out of bed. Medicare does not pay for these and similar services. An exception is when these services are included as part of the necessary daily medical care being provided on an inpatient basis, where they are a routine and necessary adjunct to the medical care. By contrast, skilled nursing care includes services such as intravenous injections, tube feeding, administering oxygen, and changing sterile dressings on a wound. Any service that could be safely done by a nonmedical person (or the insured him- or herself) without the supervision of a registered nurse is not considered skilled care.

In a skilled nursing facility approved by Medicare, for skilled care only, Medicare covers the following:

-A semiprivate room (two or more beds to a room)
-Meals, including special dietary requirements
-Rehabilitation services, such as physical, speech-language, and occupational therapy
-Administration of prescription drugs and intravenous injections
-Other medically necessary services, equipment, and supplies used in the facility
-Skilled nursing care
-Medical social services—help with care needs, including activities of daily living
-Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that are not availed at the SNF

To be covered, the patient must:

-Require daily skilled care that can only be provided as an inpatient in this type of facility
-Be certified by a doctor or appropriate medical professional as requiring these services on a daily inpatient basis
-Have been a hospital inpatient (as opposed to being in the hospital for observation) for at least three consecutive days (not counting the day the patient is released) before being admitted to the skilled nursing facility
-Be treated for the same illness or condition for which he or she was a patient in the hospital
-Be admitted within 30 days of discharge from the hospital

Coverage in a skilled nursing facility is limited to a maximum of 100 days per benefit period. Under the Original Medicare program, the first 20 days are paid for, with no deductible or coinsurance. However, the patient is then responsible for daily co-payments after the twentieth day. The patient (or his or her insurance company) must be alerted that these daily co-payments are sizeable and should not be taken lightly. They really amount to deductibles. For 2020, the daily SNF co-payment was $176 for days 21 through 100.

Limited SNF Coverage
With respect to Medicare's coverage for SNF care, people must understand that Original Medicare pays only for skilled care and will pay the full amount for the first 20 days only.

From the twenty-first to the one-hundredth day of skilled care only, the daily co-payment has grown each year in the same way that the Part A deductible has grown. Medicare Advantage plans will differ in the benefit payments allowed, and some may not require hospitalization. Moreover, Medicare supplement policies that include an SNF care benefit only cover what Medicare covers—and that is skilled care only. Again, SNF care must be related to a hospital admission of at least three days, not counting the day of dismissal. Patients who are admitted to a hospital for observation may find that any follow-up care or treatment in a skilled nursing facility will not be covered by Medicare.

Admitted vs. Observation Status
The "admitted" vs. "observation" status has surfaced as a serious issue for people who, upon leaving a hospital, learn that they were not "admitted" and thus do not qualify for the skilled care benefit. In 2009, this predicament happened to over a million people. By 2011, the number had grown to 1.4 million people, and by 2012, 1.8 million people were impacted. The problem may become worse as Medicare tightens its rules regarding admittance versus observation. CMS provides lesser payment to hospitals for an "observational" stay, making it a Part B function as opposed to an "admitted" stay, and it has been particularly mindful of "upcoding" by hospitals in order to receive higher payments. The patient is caught in a precarious state, not knowing if he or she will receive the skilled care benefit.

MOON Notice

In one of the most subtle, yet significant, measures that CMS has announced in years, the agency instituted what has become known as the "MOON" notice. Prior to October 1, 2016, hospitals did not have to inform patients that they were coded as being "observational" in the hospital, rather than being "admitted." Since millions of people over the years have complained about not knowing they were not admitted (and thereby losing the extended care benefits of skilled care in an SNF), Medicare adopted the "Medicare Outpatient Observation Notice" (MOON), and now requires that hospitals provide a notice to any patient staying longer than 24 hours in the facility if he or she were coded as "observational" and why.

The start date of delivering the MOON notice to patients was October 1, 2016. Patients or their representative must sign the notice, and the hospital must verify that it was given.

The "admitted" versus "observational" hospital stay problem still continues, despite implementation of the MOON notice. One troublesome issue remains the standards by which hospitals determine admitted or observational status for patients.

Home Health Care Covered Under Part A
Home health care services are provided through licensed public or private organizations that are Medicare-approved. The services are generally provided by a visiting nurse or a home health care aide and are medically necessary services, not personal care or housekeeping services. Medicare approval of the home health care agency means that the organization meets certain Medicare standards necessary for reimbursement. It does not signify any type of warranty of the individuals performing the services.

Many people confuse the term "home health care" with the term "home care." They are two different things, with two different meanings. Home care means services of a personal (nonskilled) care provider for assistance with activities of daily living (such as eating, bathing, dressing, continence, and transferring from a bed or chair) or incidental activities of daily living (such as housekeeping, laundry, bill-paying, grocery shopping, etc.). In contrast, home health care addresses the needs of an individual for professional care: that of a registered nurse, licensed practical nurse, physical therapist, speech therapist, occupational therapist, or doctor for medically necessary in-home visits.

An easy way to remember the distinction is as follows: home care means personal services; home health care means professional services. Medicare covers home health care; it does not cover home care.

Covered Home Health Care Services
The following types of home health care services are available:

-Part-time or intermittent skilled nursing services (registered and practical nurses)
-Physical therapy
-Speech language pathology therapy
-Occupational therapy
-Home health-aide services—A home health aide does not have a nursing license but serves to support any services that the skilled care nurse provides. Medicare covers home health-aide services only if the patient is also getting skilled care, such as nursing care or other therapy. The home health-aide services must be part of the plan of care to qualify for home care for the patient's illness or injury.
-Other medically necessary services for ongoing care
-Medical social services
-Durable medical equipment (such as hospital beds and wheelchairs) at 80 percent of their cost
-Certain medical supplies, such as wound dressings

Medicare does not pay for the following:

-24-hour-per-day care at home
-Meals delivered to the home
-Homemaker services like shopping, cleaning, and laundry
-Personal care given by home health aides (like bathing, using the toilet, or help in getting dressed) when this is the only care needed

The only home health care covered under Part A must be associated with inpatient hospitalization or a skilled nursing facility care. In addition, the duration of home health care coverage is limited to 100 days.

Qualifying for Home Health Care Payments
To qualify for Medicare home health care payments, the following requirements must be met:

-The patient must be confined to the home (homebound). Reasonable allowance is made for trips to a barber, beautician, visits to family members, or church services.
-A physician must certify the medical necessity and must prescribe the program of care (plan of care).
-The services must be provided by a participating Medicare-approved home health care organization.
-The patient must need at least one of the following:
    -intermittent skilled nursing care
    -physical therapy
    -speech language pathology or occupational therapy services

The maximum number of visits per week and the maximum number of hours per day that a patient can receive skilled nursing services and home health-aide service do have limitations. The patient pays no deductible or coinsurance for home health care services but has a co-payment of 20 percent of the Medicare-approved amount for durable medical equipment.

Hospitalization for Mental Health Care Under Part A
Payment for inpatient mental health care is limited, but during the course of covered treatment, the types of charges allowed are similar to those of a regular hospital inpatient stay.

Medicare coverage for inpatient mental health care covers the following:

-Semiprivate room (two or more beds)
-Meals received in the hospital, including any special dietary requirements
-Nursing care
-Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy
-Prescription drugs dispensed during the hospital stay
-Medical supplies
-Lab tests
-X-rays and radiotherapy
-Blood transfusions, except for the first three pints
-Other medically necessary services and supplies

To be covered:

-A physician must prescribe the care.
-The treatment can only be provided by a hospital, which may be a normal acute care hospital, an inpatient rehabilitation facility, a critical access care hospital, or a long-term care hospital.

-The hospital must participate in the Medicare program.
-The care cannot have been denied by a quality improvement organization (QIO) or Medicare intermediary.

Medicare benefits for treatment in a freestanding psychiatric hospital are limited to a lifetime maximum of 190 days. If an insured receives mental health care in addition to other medical treatment as part of a regular hospital stay, this limitation does not apply. Deductibles and co-payments are the same as for a regular inpatient hospital stay.

Mental Health Care Under Part B
For outpatient Part B mental health services, Medicare had traditionally paid 50 percent of the costs, leaving the patient responsible for the other 50 percent. MIPPA 2008 changed this: beginning in 2010, the coinsurance payment that a patient pays for outpatient mental health services was decreased gradually until it reached 20 percent in 2014. This brings the coinsurance rate for mental health services to the same level as those for other Medicare services. Again, the same requirements for Medicare-approved physicians and facilities apply. (Since 2014, the co-pay for outpatient mental health care is 20 percent for the patient; Medicare pays the remaining 80 percent.)

Medicare will pay for mental health services for conditions such as anxiety or depression on an outpatient basis, including visits with a psychiatrist, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker, and for substance or alcohol abuse and lab tests. The Part B deductible applies for diagnosis or treatment for visits to a doctor or other health care provider to diagnose the condition or change a prescription. It also applies for outpatient treatment, such as counseling or psychotherapy.

Under Medicare, mental health services include "substance abuse." Substance abuse and addiction, particularly to opioids and other prescription drugs, as well as illegal and illicit drugs, have become a major problem in America, and is prevalent even among Medicare beneficiaries. There has been a great demand on health care providers and insurance companies to combat the abuse. Much of the cost of treatment is relegated to mental health services, which means that Medicare is receiving and paying for a much higher number of drug-related mental health cases than it originally planned for.

Hospice Care
Hospice care is for terminally ill patients—those with fewer than six months to live. Hospice care is covered under Part A. In addition, special provisions of the Medicare Hospice Care program allow for the payment of some expenses not ordinarily covered by Medicare, such as homemaker services. A physician must certify that the patient is terminally ill and has six months to live, but the patient can be recertified for another six months and continue to receive coverage for hospice care.

Hospice care includes the following:

-Physician services
-Nursing care
-Prescription drugs, subject to a nominal co-pay, for symptom control and pain relief
-Medical social services and medical support services
-Home health aide and homemaker services
-Physical therapy
-Occupational therapy
-Speech therapy
-Dietary and other counseling
-Short-term respite care of up to five consecutive days (Inpatient respite care allows time off for the person who regularly provides care in the home. The patient pays 5 percent of

the Medicare-approved amount for inpatient respite care.)
-Medical supplies and certain durable medical equipment
-Spiritual and grief counseling
-Drugs and items and services needed for pain relief and symptom management

To qualify for Medicare to pay for hospice care:

-The terminal nature of the patient's illness must be certified by a physician (in a face-to-face interview) and the hospice medical director. The hospice medical team can prescribe care at home or in a Medicare-approved hospice facility and for short-term inpatient stays for pain and symptom management. The hospice certification will be reviewed every 90 days.
-The anticipated life expectancy must be six months or less.
-The patient must choose to use hospice care benefits rather than regular Medicare coverage for the treatment of the terminal illness (the usual Medicare coverage is still available for medical expenses not related to the terminal illness).
-The care must be provided by a hospice care agency that is approved by Medicare.
-A patient's physician must certify the terminal nature of the illness at the beginning of the first 180-day period and again at the beginning of the second 180-day period. If the patient chooses to do so, he or she may discontinue participation in the hospice care program and switch back to regular Medicare coverage.

The hospice care program has no deductibles but does require a co-payment for prescription drugs of $5 per prescription. Inpatient respite care has a co-payment of 5 percent of the Medicare-approved rate. Reimbursement under the hospice provisions applies only to treatment of the terminal illness. Medical treatment for other conditions are paid based on the usual Part A and Part B provisions.

As part of the MIPPA 2008 overhaul of the Medicare supplement array of products, a hospice benefit was added to all Medicare supplement policies as a part of the basic (core) benefits of all supplement policies sold after June 1, 2010.

Part B—Medical Insurance

Medicare Part B, Medical Insurance, is also called voluntary supplementary medical insurance (SMI) and is financed by payments from the federal government through Medicare and by monthly premiums paid by people enrolled in the plan. Part B helps pay for doctor's bills, outpatient services, and other medical services and supplies not covered by Part A. Part B also covers a multitude of preventive services.

It does not matter where medical services are received—at home, in a hospital, in a doctor's office, or in some other medical facility. All costs are subject to the same annual deductible ($198 in 2020) and the same coinsurance payments in any calendar year. The benefit period under Part B is a calendar year benefit period, in contrast to the Part A 60-day benefit period.

Medicare Part B covers the following:

-Outpatient hospital services (Note that coding a hospital stay as "observational" versus "admitted" Will cause the stay to become a Part B claim.)
-Outpatient medical and surgical services and supplies
-Doctor's services (not routine physical exams)
-Outpatient drugs (those received in a doctor's office or hospital outpatient setting)
-X-rays, MRIs, CAT scans, EKGs, lab tests, diagnostic tests, and clinical laboratory services, HIV -Screenings, and pulmonary rehabilitation
-Ambulatory surgery center facility fees for approved procedures and outpatient chemotherapy

-Second surgical opinions and surgical dressing services
-Ambulance transportation for medically necessary services when other transportation would endanger the insured's health
-Breast prostheses after a mastectomy
-Physical therapy
-Occupational therapy
-Speech therapy
-Home health care (costs not covered by Part A) for medically necessary and skilled nursing care or medical social services
-Blood transfusions, except for the first three pints
-Mammograms and Pap tests
-Outpatient mental health services
-Artificial limbs and eyes, prosthetic devices, and their replacement parts
-Arm, leg, and neck braces
-Durable medical equipment (walkers, wheelchairs, oxygen equipment)
-Kidney dialysis, services, and supplies, kidney disease education services, and kidney transplants
-Heart, liver, lung, kidney, pancreas, intestine, bone marrow, and cornea transplants under certain conditions and when performed at Medicare-certified facilities and immunosuppressive drugs
-Medical supplies (surgical dressings and casts)
-One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens
-Travel outside of the United States with limitations, such as on board a ship within the territorial waters of the United States. Medicare may pay for inpatient care received in a foreign country in certain cases: (1) in case of an emergency, if a foreign hospital is closer than the nearest U.S. hospital; (2) while traveling through Canada en route to Alaska and a Canadian hospital is closer than a U.S. hospital; and (3) if a foreign hospital is closer than a U.S. hospital, regardless of whether an emergency exists
-Urgently needed care

Preventive Care:

-Screening for prostate cancer
-Colorectal cancer screenings and abdominal aortic aneurysm screening
-Mammography and breast exams
-Pap smears and pelvic exams, including cervical and vaginal cancer screening
-Bone-mass density loss
-Flu shots (one per season) and pneumonia inoculations
-Hepatitis B vaccinations
-Diabetes services and supplies and foot exams and treatment for diabetes-related nerve damage
-Certain chiropractic services (subluxation)
-Medical nutrition therapy services
-One-time initial preventive physical exam (the "Welcome to Medicare" benefit) within 12 months of when a person with Medicare first becomes enrolled in Medicare Part B (the Medicare deducible does not apply to this benefit)
-Yearly wellness exam, starting 12 months after the "Welcome to Medicare" exam (there is no deductible or co-pay for this service if it is intended to develop or update a personalized prevention plan based on current health and risk factors)
-Screening blood tests for early detection of cardiovascular diseases
-Diabetes screening tests for people at risk for diabetes and diabetes self-management training
-Alcohol misuse screenings and counseling
-Depression screenings
-HIV screenings

-Nutrition therapy services
-Obesity screenings and counseling
-Sexually transmitted infections screening and counseling
-Some oral anti-cancer drugs and certain drugs for hospice patients and certain durable medical Equipment such as nebulizers or external infusion pumps
-Bone mass measurements
-Glaucoma screening
-Hearing and balance exams
-Services of practitioners such as clinical social workers, physician assistants, and nurse practitioners
-Cardiovascular screenings every five years to test cholesterol, lipid, and triglyceride levels to prevent a heart attack or stroke and outpatient implantable automatic defibrillator surgery
-Cardiac rehabilitation programs
-Vaccinations—shots for flu, pneumococcal pneumonia, hepatitis B
-Tobacco use cessation counseling to stop smoking, if ordered by a doctor

Part B Deductible
As noted, Medicare Part B requires the insured to pay a deductible in each calendar year. This deductible is calculated against the Medicare-approved amount, which can be different from the amount billed by the insured's doctor or other medical provider. After the insured has met the deductible, Medicare pays for 80 percent of the approved charges. The patient is responsible for the remaining 20 percent as a co-payment. (This is where a Medicare supplement plan or a Medicare Advantage plan assists the beneficiary by covering some or all of the deductible and co-payment and coinsurance amounts.) Additionally, the insured is responsible for an additional 15 percent that some physicians may charge. Most of the preventive screening procedures are not subject to the Part B deductible and/or the 20 percent deductible.

What Part B Does Not Cover
Part B does not cover the following:

-Outpatient prescription drugs (For this benefit, Part D Prescription Drug coverage must be purchased)
-Routine physical examinations beyond the annual wellness visits
-Eye glasses (except for one pair of standard frames after cataract surgery)
-Custodial care
-Dental care
-Dentures
-Routine foot care
-Hearing aids
-Orthopedic shoes
-Acupuncture
-Long-term care

Limiting Charges
In Medicare parlance, physicians and other providers are either "participating" or "nonparticipating." A participating physician or provider is one who has agreed to accept Medicare's assigned allowance as payment in full for all services delivered to a Medicare beneficiary. (This is referred to as "accepting assignment," meaning that a physician will accept the 80 percent paid by Medicare and the 20 percent paid by the beneficiary.) A nonparticipating physician or provider is one who can choose, on a claim-by-claim basis, whether or not to accept assignment. Nonparticipating physicians can charge a patient more than the Medicare-approved amount, but only up to a limit: 115 percent—that is, 15 percent more—of the Medicare allowable amount that nonparticipating providers are paid.

Rates

Each January 1, Medicare premium rates, deductibles, and coinsurance amounts change. Effective for 2020, the rates were:

-Part A deductible—$1,408 per benefit period
-Hospital coinsurance—$352 a day for days 61 to 90 in each benefit period
-Hospital coinsurance—$704 a day for days 91 to 150 for each lifetime reserve day
-Total of 60 lifetime reserve days—nonrenewable; stays the same
-Skilled nursing facility deductible—$176 per day for days 21 through 100 (for each benefit period)

In 2020, the Part A Hospital Insurance premium was $458 per month for people who have fewer than 30 quarters of Medicare-covered employment.

This Part A premium is paid only by individuals not otherwise eligible for premium-free hospital insurance. In addition, individuals with 30 to 39 quarters of coverage have a Part A premium of $252 (2020).

Part B Premiums and the Hold Harmless Rule

The "standard" monthly premium for Part B coverage for 2019 is $144.60, which most people will pay. The Part B premium has varied in the past few years due to the "hold harmless" rule. This rule ensures that Social Security benefits—from which Part B premiums are taken for most people—will not be reduced from one year to the next due to increases in Part B premiums. Conceivably, this could occur if an annual cost-of-living (COLA) increase in Social Security benefits was very low (or, as has been the case in some past years, 0 percent). This could result in Medicare beneficiaries having their Social Security benefits reduced to pay for increased Medicare premiums.

For any year, if the Social Security COLA is not large enough to cover the full amount of any increase in the Medicare premium, an individual will be "held harmless" and his or her premium increase would be the same as the increase in his or her Social Security benefits.

The hold harmless rule does not apply to:

-Those who are receiving Medicare for the first year
-Those whose incomes exceed certain amounts
-Those whose Medicare premiums are paid by their state's Medicaid program

Part B Premium Increases for High-Income Earners

Medicare Part B premium increases for higher income beneficiaries were included in MMA 2003. This process is known as means testing (income-related) and went into effect in 2007. About 5 percent of current Part B enrollees are subject to higher premium amounts based on their income. The regulations for high-income earners are known as Income Related Monthly Adjustment Amounts (IRMAA). The following are the amounts for 2020:

Part B Premiums for Higher Income Earners (2020)

Single Filers	Joint Filers	Monthly Premium
$87,000 – $109,000	$174,000 – $218,000	$202.40
$109,000 – $136,000	$218,000 – $272,000	$289.20
$136,000 – $163,000	$272,000 – $326,000	$376.00

$163,000 – $500,000	$326,00 - $750,000	$462.70
$500,000 +	$750,000 +	$491.60

Rates are different for beneficiaries who are married but file a separate tax return from their spouses. For these separate filers who have earnings of more than $85,000, the monthly Part B premium in 2020 is as follows:

Part B Premiums for Higher Income Earners
(Married, Filing Separately)

Income	Monthly Premium
$87,000 – $413,000	$462.70
$413,000 +	$491.60

Medicare Part B premiums are deducted from the insured's Social Security, Railroad Retirement, or civil service retirement benefits. If an insured does not receive any of these—for example, if the insured is not yet eligible for or not yet claiming Social Security retirement benefits—Medicare will bill him or her every three months for the Part B premium.

Emergency Services
Emergency services are covered inpatient or outpatient services furnished by a provider who is qualified to furnish emergency services and who is needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

-Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
-Serious impairment to bodily functions
-Serious dysfunction of any bodily organ or part

It is important that the insured notify his or her primary care physician or contracting medical group of an emergency medical condition so that they can be involved in managing the insured's health care, and transfer can be arranged when the insured's medical condition stabilizes. The arrangements will depend on the distance involved to the service area to receive follow-up care through the insured's primary care physician. However, follow-up care will be covered out of the service area as long as the care required continues to meet the definition for either "emergency services" or "urgently needed services."

Producers should understand that admission to an emergency room is not the same as admission to a hospital. While it is quite possible that a patient in an emergency room will be sent to the hospital, this does not mean that a person is "admitted" to the hospital. Admittance must be done by a hospital doctor, and then the question of whether the individual is admitted or "under observation" may arise.

Medicare pays for ambulance services when an insured must be taken to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger his or her health. Medicare pays for the ambulance mileage to the nearest hospital or skilled nursing facility that provides the services needed. Medicare does not pay for ambulance transportation to a doctor's office. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if the patient needs immediate and rapid ambulance transportation that ground

transportation can't provide.

Appeals and Grievances

The Medicare insured has the right to appeal any decision about Medicare services. This is true whether he or she is in Original Medicare, a Medicare Advantage plan, or a Part D plan. If Medicare does not pay for an item or service an insured has been given, or if the insured is not given an item or service that he or she thinks should have been received, then the insured can appeal.

Appeal Rights under the Original Medicare Plan

If insureds are enrolled in the Original Medicare plan, they can file an appeal if they think Medicare should have paid for, or did not pay enough for, an item or service they have received. If they file an appeal, they must ask the doctor or provider for any information related to the bill that might help their case. The appeal rights are printed on the back of the Medicare Summary Notice, which is mailed to the insured from the company that administers claims for Medicare. The notice will also tell insureds why the bill was not paid and what appeal steps they can take.

There are five steps to filing an appeal:

1. Copy the original Medicare Summary Notice (MSN) that shows the item to be appealed.
2. Circle the items in dispute on the notice and write an explanation of the disagreement.
3. Sign and include the phone number and the Medicare number of the patient.
4. Send the copy to the Medicare contractor's address listed on the notice.
5. The appeal must be filed within 60 days of the date the notice is received and must be in writing.

If the patient needs help filing the appeal, they can call 1-800-Medicare, can ask the state Health Insurance Program, or can call the provider to help get a representative appointed to assist during the appeal process.

Appeal Rights under Medicare Advantage Plans

If the insured is in a Medicare Advantage managed care plan, he or she can file an appeal if the plan will not pay for, does not allow, or stops a service that the insured thinks should be covered or provided. If an insured thinks that his or her health could be seriously harmed by waiting for a decision about the service, he or she may ask the plan for what is called a fast decision. The plan must answer the patient within 72 hours.

Further, the Medicare managed care plan must tell the insured in writing how to appeal. After the appeal has been filed, the plan will review its decision. Then, if the plan does not decide in the insured's favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. Insureds should see the plan's membership materials or contact the plan for details about Medicare appeal rights. The insured may also contact Medicare to order a copy of "Medicare Appeals."

If insureds have concerns or problems with their plan that are not about payment or service requests, they have a right to file a complaint. In addition, if a person has received a denial regarding a Part D matter, he or she can call the toll-free Medicare number (or visit Medicare's website) and institute a single appeals process.

There are actually five levels to a complete appeal process. The first level is as described above; the second level (in case of a denial) is to appeal to an outside Independent Review Organization; the third level is to appeal to an Administrative Law Judge; the fourth level is an appeal to a Medicare Review Council; the fifth level is to initiate civil action, to be heard in a federal district court.

The Insured Is Protected While in the Hospital
Whether the insured is in the Original Medicare plan or in a Medicare Advantage plan, he or she is protected while in the hospital. If the insured is admitted to a Medicare participating hospital, he or she should be given a copy of "An Important Message from Medicare." It explains the rights of the hospital patient. If insureds have not been given this document, they should ask for it. However, hospitals must now present the document to the patient within 48 hours of admission.

The message contains the following information:

-"You have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital."
-"What to do if you think the hospital is making you leave too soon."
-"If you have questions about this, call the Quality Improvement Organization (QIO). [Their number is on the message.] You may be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before the QIO makes a decision."

Other Medicare Insured Rights
In addition to the appeals and rights just listed, insureds can appeal their Medicare Prescription Drug plan's decisions. Written explanations, exceptions, and coverage determination instructions are available in the "Medicare and You" booklet distributed each year to recipients by CMS.

Other Medicare rights are to:

-Get information and have questions about Medicare answered
-Get emergency room or urgently needed care services
-See doctors, specialists (including women's health specialists)
-Participate in treatment decisions
-Know treatment choices
-Get information in a culturally acceptable manner in certain circumstances, and get information in an understandable way from Medicare and health care providers
file complaints (grievances), such as quality of care complaints
-Not be discriminated against
-Have the right to privacy in personal and health information

Medicare as Secondary Payor—Coordination with Group Health Insurance
Medicare as a secondary payor and/or in coordination with retiree group health plans was addressed in MMA 2003, not only with respect to Medicare Advantage plans, but particularly as to how the Part D benefits of Medicare coordinate with existing employee (retiree) group health plans. The objective of MMA 2003 was to allow retirees with existing prescription drug benefits of the group plans (which may have been as good as or better than Part D) to stay in these plans and not switch to a stand-alone Part D plan or a Medicare Advantage plan. Employers, on the other hand, were seeking ways to cut the expenses of Medicare-age retirees in group health plans; each year since 2006, they have been removing age 65+ retirees from their group health plans. Many large employers have moved these retirees to group Medicare Advantage plans or group Medicare supplement plans.

Some people who have Medicare have other insurance (not including Medicare supplement policies), such as employer-sponsored group health insurance for the beneficiary or a spouse. The employee may still be working and want to continue to work, or the employee may be retired.

Order of Payment
When a person is covered by both Medicare and an employer-sponsored group plan, questions may arise regarding which plan provides primary and/or secondary coverage. The order of payment depends on the size of the employer group—whether it is over or under 20 employees. If

an employer has less than 20 covered employees, Medicare becomes the primary payor and the group's health insurance becomes the secondary payor. If the group has 20 or more employees, the group health insurance becomes the primary payor and Medicare becomes the secondary payor. Agents are sometimes asked questions about the best advice to give to an employee with respect to enrolling in Part A and Part B. Here are some helpful scenarios:

-Even if still working, an employee is eligible for Medicare Part A and Part B if the employee is 65 or older and has earned the qualifying 40 quarters of coverage. (Do not confuse this with an application for Social Security—the employee may wish to continue working and not apply for Social Security retirement benefits yet.) Because they are two different programs, enrolling in Part A of Medicare has nothing to do with receiving or not receiving Social Security or Railroad Retirement benefits. The employee would be eligible for Part A regardless of whether he or she chooses to begin receiving Social Security or Railroad Retirement benefits. Also, the employee may be covered by his or her own or spouse's group health insurance plan.

-Acceptance or rejection of Part B is a different matter. As noted earlier, if the employee is covered by a group plan, the size of the group dictates which payor—the group plan or Medicare—is the primary payor. For employers with 20 or more employees, the group plan is the primary payor for those who are entitled to Medicare. For employers with fewer than 20 employees, Medicare is the primary payor for enrollees who are entitled to Medicare.

Thus, for those who are part of an employer plan with fewer than 20 employees, rejecting Part B might make sense because Medicare would be the primary payor, and the employee would be paying for the Part B premium as well as perhaps part of the group insurance premium. Because a year's premiums for Part B will be substantial compared to the Part B deductible and coinsurance, this might not constitute prudent use of dollars, considering that the group health plan will be paying a substantial part of the bill. In any event, the employee may sign up for Part B at any time during employment or within eight months after leaving employment (or the group health plan) without penalty.

-If an employee is in a group of 20 or more employees, signing up for Part B may make sense given the group plan's coinsurance requirement and deductibles, which may be quite high. Because the group health plan would be primary, the remaining amount of a Part B claim could well be covered by the secondary payor—Medicare—and may make the premiums spent for the purchase of Part B very worthwhile.

-If the employee is covered by a spouse's group health plan, the employee should consult his or her employee benefits or human resources director (or that of the spouse) for advice on whether to utilize Medicare in combination with the employer's (or spouse's employer's) health plan. In some cases, the employer may require the employee to enroll in Part B before the group health insurance will pay.

-The secondary payor pays only if there are costs the primary payor didn't pay. Keep in mind that even if a person has both Medicare and employer-sponsored group coverage, not all of his or her health care costs may be covered.

-Delaying enrollment in Medicare due to coverage under an employer's plan could affect enrollment in Part D. Those who want prescription drug coverage under Part D must enroll in a Part D plan within a certain time after becoming eligible for Medicare; delaying Part D enrollment could result in a permanent surcharge penalty on Part D premiums. However, the penalty can be avoided if an individual has creditable coverage, such as through an employer-provided plan. For employer-provided or union-provided drug coverage to be considered "creditable," its actuarial value must at least equal the actuarial value of basic Part D coverage. Medicare will make the determination as to whether a person's previous group coverage was "creditable" or not.

Employees can also be covered by Medicare if they are under age 65 and they:

-Have Medicare because of permanent kidney failure
-Have an illness or injury covered under workers' compensation, the federal black lung program, no-fault insurance, or any liability insurance
-Have been certified by Social Security as disabled prior to age 65

If the insured matches any of these descriptions and he or she has other insurance along with Medicare, then the other insurance will often be the first payor on his or her health claims, and Medicare will be secondary. Insureds should tell their doctors, hospitals, and all other service providers about their other insurance. Their claims can then be sent to the right insurer first. In such cases, he or she will only receive benefits that the employer group plan does not cover but that Medicare will cover. A special rule applies if the insured has or develops end-stage renal disease (ESRD).

If a person has any no-fault or liability insurance (or payment from a liable third party) available to him or her, then benefits under that plan (or from that liable third party) must be applied to the costs of health care covered by that plan. Where Medicare has provided benefits, and a judgment or a settlement is made with a no-fault or liability insurer (or liable third party), the person must reimburse Medicare. However, his or her reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers' compensation for treatment of a work-related illness or injury should also be applied to covered health care costs by this plan.

If the person has or develops ESRD and is covered under an employer group plan, he or she must use the benefits of that plan for the first 30 months after becoming eligible for Medicare. ESRD Medicare is the primary payor after this coordination period. However, if the person's employer group plan coverage was secondary to Medicare when he or she developed ESRD because it was not based on current employment as described previously, then Medicare continues to be the primary payor.