Medicare for 2010: Deductibles and Premiums Update

Medicare is a federal health insurance program created in 1965 for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Part A – 99% of patients don't pay a premium for Part A (hospital insurance) because they or a spouse already paid for it through their payroll taxes while working. The $1,100 deductible for 2010, paid by the beneficiary when admitted as a hospital inpatient, is an increase from 2009. Part A helps cover:

- inpatient care in hospitals (excluding the physician fees), including critical access hospitals
- skilled nursing facilities (not custodial or long-term care)
- some hospice care
- some home health care

Medicare Part B – Part B (outpatient/doctor insurance) base premium for 2010: $96.40/month (no change from 2009.) Premiums are higher for single people over 65 making more than $85K per year and for couples making over $170K. Part B

premiums cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. In 2010, the Part B deductible is $155. Part B helps cover:

- physician fees in the hospital
- physician fees in their offices and other outpatient locations
- other outpatient services (x-rays, lab services)
- some services of physical and occupational therapists
- some home health care

Medicare Part C – Medicare now offers beneficiaries the option to have care paid for through private insurance plans. These private insurance options are part of Medicare Part C, which was previously known as Medicare+Choice, and is now called Medicare Advantage. Medicare Advantage expands options for receiving Medicare coverage through a variety of private insurance plans, including private fee-for-service (PFFS) plans, local health maintenance organizations (HMOs) and regional preferred provider organizations (PPOs), and through new mechanisms such as medical savings accounts (MSAs), as well as adding payment for additional services not covered under Part A or B.

Medicare Part D – Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. The so-called "doughnut hole" is the amount the patient pays between the initial coverage limit of $2,830 and the out-of-pocket threshold of $4,550 – a total of $1720 that the patient is responsible for.

- **Initial Deductible:** $310
- **Initial Coverage Limit:** $2,830
- **Out-of-Pocket Threshold:** $4,550

COMPARISON OF MEDICARE PLANS

Original Medicare Plan

WHAT? The traditional pay-per-visit (also called fee-for-service) arrangement available nationwide.

HOW? Providers can choose to participate ("par") or not participate ("non-par".) Participating providers accept the Medicare allowable and collect co-insurance (20% of the allowable.) Reimbursement comes to the providers. Non-participating providers may charge 15% more (called the "limiting" charge) than the Medicare allowable schedule, but the patient will receive the check, which is why some non-par practices require payment at time of service for Medicare patients. To be able to charge patients for non-covered services, patients must sign an ABN before the service is provided.

Original Medicare Plan With Supplemental Medigap Policy

WHAT? The Original Medicare Plan plus one of up to ten standardized Medicare supplemental insurance policies (also called Medigap insurance) available through private companies.

HOW? Medigap plans may cover Medicare deductibles and co-insurance, but typically will not cover anything Medicare will not. Medicare primary claims will "cross-over" to many Medigap secondary claims so the practice does not have to file the secondary Medigap claim. Patients may still have a small balance that is cost-prohibitive to bill for.

Medicare Coordinated Care Plan

WHAT? A Medicare approved network of doctors, hospitals, and

other health care providers that agrees to give care in return for a set monthly payment from Medicare. A coordinated care plan may be any of the following: a Health Maintenance Organization (HMO), Provider Sponsored Organization (PSO), local or regional Preferred Provider Organization (PPO), or a Health Maintenance Organization (HMO) with a Point of Service Option (POS).

HOW? You have to have signed a contract or be grandfathered in (called an "all-products" clause) under an existing contract to see patients and get paid. Primary care providers may have to provide referrals and/or authorization for specialty services and providers. A PPO or a POS plan usually provides out of network benefits for patients for an extra out-of pocket cost.

Private Fee-For-Service Plan (PFFS)

WHAT? A Medicare-approved private insurance plan. Medicare pays the plan a premium for Medicare-covered services. A PFFS Plan provides all Medicare benefits. Note: This is not the same as Medigap.

HOW? Most PFFS plans allow patients to be seen by any provider who will see them. PFFS plans do not have to pay providers according to the prevailing Medicare fee schedule or pay in 15 days for clean claims. Providers may bill patients more than the plan pays, up to a limit. It would be a good thing to notify patients if your practice intends to bill above the plan payment.

Need more? Click on **CMS** (provider-oriented) or **Medicare** (patient-oriented.)

How to Develop a New Financial Policy For Your Practice: A Short Course

I've had lots of questions about financial policies since I did a webinar on patient collections last year. Here's a short course on developing a new financial policy for your practice. The topic is addressed more comprehensively in my book.

I dislike financial policies that are long and wordy. I prefer a simple format that everyone can understand and use.

The format I recommend is one with three columns titled:

1. Your Plan
2. What You Do
3. What We Do

Here's an example of how the three columns would read:

Your Plan

Medicare

What You Do

Pay your deductible ($155 for 2010) and co-insurance (20% of the allowable.)

What We Do

We will file Medicare for you.

I use the front of the financial policy to list all the variations of plans that the practice accepts. For instance, the Medicares might include:

- Medicare
- Medicare/Medicaid
- Medicare/supplemental policy
- Medicare Advantage Plan (HMO/PPO)
- Medicare Advantage Plan (PFFS)
- Medicare secondary (MSP)
- Railroad Medicare

Lump together any like plans that you will treat the same. Then decide what you will expect from the patient at time of service or after, and what the practice commits to doing. Don't forget to address patients being seen out-of-network and self-pay patients.

I use the back of the policy to cover everything that you would like the patient to sign off on. This could include:

- Receipt of Notice of Privacy Policies
- Receipt of Advance Directives/Living Will info
- Agreement to Financial Policy
- Assignment of Benefits to Practice
- Guarantee of Payment

When you put a new policy in place, you have a number of options to educate patients. Here are some:

- Put the policy on your website.
- Send a copy of the policy to all new patients.
- Discuss the policy when you call patients to remind them of their appointment.
- Discuss the new policy at check-in and/or check-out and let patients know it will be in effect at their next visit.
- Circle the patient's plan on the front, have the patient sign the financial policy on the back, and give them a copy to take with them.

How you decide to educate the patients will depend on how much time you have between making the appointment and seeing the

patient and the type of practice you have – primary care versus sub-specialty.

Also, don't forget to educate your staff. If they have not had to discuss money before, they will need some coaching and some practice.

If you'd like a free copy of my sample financial policy, shoot me an email at marypatwhaley@gmail.com.

Basics for Healthcare Managers: Medicare Parts A, B, C & D with 2009 Premiums & Deductibles

With the Centers for Medicare and Medicaid Services (CMS) revealing yesterday what the Medicare premiums and deductibles will be for 2009, it seems like a good time to brush up on Medicare and what choices providers have in enrolling and participating in Medicare.

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- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

TRADITIONAL/ORIGINAL FEE-FOR-SERVICE MEDICARE

Medicare Part A – 99% of patients don't pay a premium for Part A (hospital insurance) because they or a spouse already paid for it through their payroll taxes while working. The $1,068 deductible for 2009, paid by the beneficiary when admitted as a hospital inpatient, is an increase of $44 from $1024 in 2008. Part A helps cover:

- inpatient care in hospitals
- including critical access hospitals
- skilled nursing facilities (not custodial or long-term care)
- some hospice care
- some home health care

Medicare Part B – Part B (outpatient/doctor insurance) base premium for 2009: $96.40/month (no change from 2008.) Premiums are higher for single people over 65 making more than $85K per year and for couples making over $170K. Part B premiums cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. In 2009, the Part B deductible will be $135, the same as it was in 2008. Part B helps cover:

- doctors' services and outpatient care
- some services of physical and occupational therapists
- some home health care

Medicare Part D – Starting January 1, 2006, Medicare

prescription drug coverage became available to everyone with Medicare. In 2008, the deductible is $275, in 2009 it will be $295.

MEDICARE HEALTH PLANS (MEDICARE ADVANTAGE)

Medicare Part C – Medicare now offers beneficiaries the option to have care paid for through private insurance plans. These private insurance options are part of Medicare Part C, which was previously known as Medicare+Choice, and is now called Medicare Advantage. Medicare Advantage expands options for receiving Medicare coverage through a variety of private insurance plans, including private fee-for-service (PFFS) plans, health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and through new mechanisms such as medical savings accounts (MSAs), as well as adding payment for additional services not covered under Part A or B.

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Need more? Try **CMS** or **Medicare**.