

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.

Medicare is a 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)



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.



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 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 Organ. (PPO), or a Health Maintenance Organization 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 Medicare fee schedules 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? Try **CMS** or **Medicare**.