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Top 10 Things You Need to Know about Medicare

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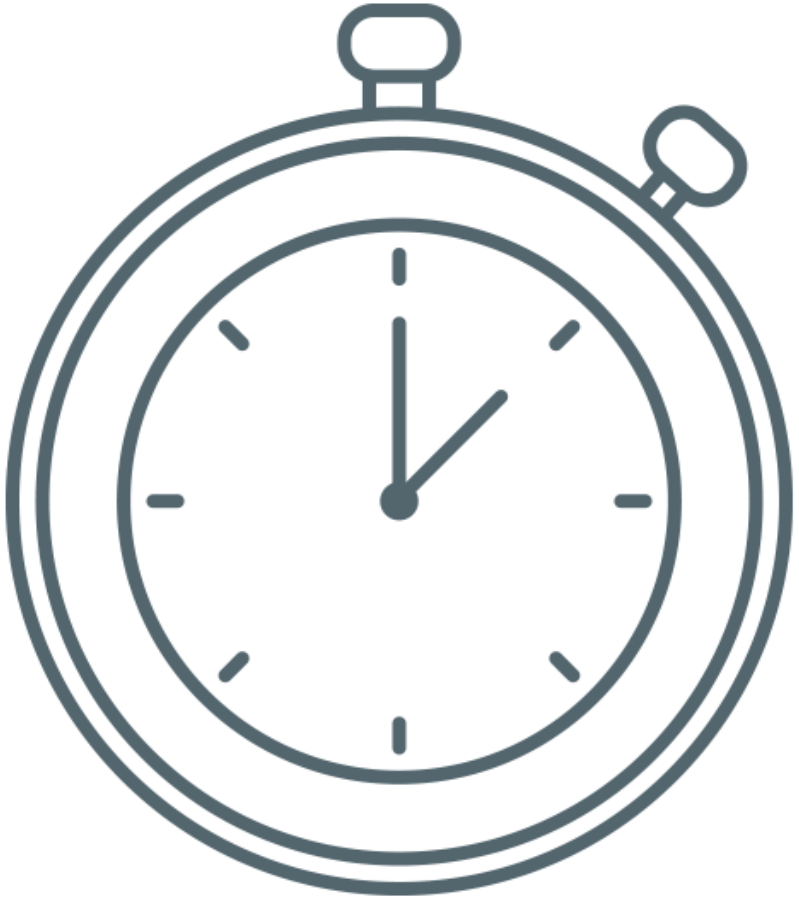
Ramsey County Library - Roseville

January 6, 2020

Medicare Facts and Figures



Medicare Overview

- Medicare was designed for acute care
  - All services must be medically reasonable or necessary to treat and illness or injury
  - Preventative services are relatively new to coverage
- Medicare was not designed for long-term care
  - However, there may be coverage under Traditional Medicare for some long-term care expenses

Entitlement to Medicare

- Individuals
  - Age 65 or older and eligible for Social Security or Railroad Retirement
  - SSDI Recipient for 24 months
  - With End Stage Renal Disease
  - With ALS (Lou Gehrig's Disease)

Enrollment

- Social Security Administration administers enrollment
  - Many individuals opt to enroll online
- *Eligible* beneficiaries receiving Social Security benefits, will get automatically enrolled in Part A and Part B

Enrollment

- 65+ but not yet receiving Social Security benefits?
  - These individuals will actively need to enroll
- 65+ and working?
  - These individuals will need to go through an analysis to determine whether enrollment is necessary

Enrollment

- Analysis for 65+ and working:
  - Act of retirement changes whether group health plan is primary or secondary
  - A change to current, active employment will impact need for enrollment
  - Retiree coverage is secondary to Medicare

Enrollment Period

- Initial Enrollment Period
  - 3 months prior to Eligibility (Month of 65th Birthday), with enrollment effective the first day of the month of eligibility
  - 3 months after Eligibility, with enrollment effect the first day of the month following application
- General Enrollment Period
  - First 3 months of a calendar year, with enrollment effective July 1st

Enrollment Period

- Special Enrollment Period
  - Designed for "working elderly"
  - Individuals over age 65 who are covered by an employer group health plan of their own, or from their spouse's employment have the option to enroll in Medicare past age 65
  - Can enroll while still covered by GHP or in the 8 months following GHP coverage end date

Enrollment Period

- Annual Coordinated Election Period (commonly referred to as Open Enrollment Period)
  - October 15 through December 7
  - Time period that Medicare beneficiaries can
    - Switch from Original Medicare to Medicare Advantage (MA) or MA to Original Medicare
    - Switch MA Plans (Part C)
    - Switch Prescription Drug (Part D) Plans

Enrollment Period

- Additional Open Enrollment Period for individuals with Medicare Advantage plans
  - Medicare Advantage Open Enrollment
  - January 1st through March 31st
  - Can change Medicare Advantage plan
  - Can switch from a MA plan to Original Medicare (and Part D)
  - Only one change during this period is permissible

Enrollment Period

- Failure to Enroll
  - Issue for Working Elderly
  - Can result in a 10% per year surcharge assessed on premiums
  - Could result in individual's being unable to enroll in until the next *general enrollment*
    - Remember, benefits would not begin until July 1 following general enrollment
    - Gap in coverage = $$$$$

Medicare Coverage

- Four Parts Make Up the Picture
  - Part A
  - Part B
  - Part C
  - Part D

Part A

- Part A: Hospital Insurance (Required)
  - Free for individuals age 65 or older with approximately 10 years of work history
  - Individuals with less work history may still be eligible, but will require a premium

Part A

- Coverage also includes:
  - Inpatient care in a hospital
  - Skilled nursing facility care
  - Inpatient care in a skilled nursing facility (not custodial or long-term care)
  - Hospice care
  - Home health care

Part A: Benefit Period

- Hospital and SNF Coverage
  - Limited by "Benefit period" (spell of illness)
    - A benefit period begins on the first day a beneficiary is admitted to the hospital and does not end until the beneficiary has not received a hospital or skilled nursing facility level of care for 60 days

Part A: Benefit Period

- Benefit Period Continued
  - Example: A Medicare recipient is hospitalized for 3 weeks (21 days). The recipient is discharged to TCU/SNF. He receives skilled care and therapy 7 days per week for 3 weeks (21 days). The recipient is discharged from the TCU/SNF. If the recipient is rehospitalized in less than 60 days, then the benefit period continues. This means that the recipient's cost sharing is determined on day 22 of coverage ($176/day).

Part B

- Part B: Health Insurance (Optional)
  - Premium of this is paid from SSA Check
    - 2019 Standard Premium is $144.60
- Part A and B combined are known as Traditional Medicare or Original Medicare

Part B

- Coverage includes:
  - Physician services
  - Outpatient care
  - Preventative services
    - Welcome to Medicare Exam
    - Wellness Visit
    - Advanced Care Planning

Part B

- Coverage also includes:
  - Lab tests
  - X-rays
  - Medical supplies
  - Durable medical equipment
  - Ambulance services

Part C

- Medicare Advantage Plans
  - Administered exclusively by private plans
  - It defines alternate delivery systems for Traditional Medicare services through Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs)
  - Private companies offering Medicare Advantage plans contract with and are approved by CMS to administer your Medicare benefits

Part C

- Part C is *not* supplemental insurance
  - Individuals may not receive Traditional Medicare and Medicare Advantage plans
  - You may change or switch coverage during Open Enrollment Period
- Cannot be sold a Medigap or Supplement policy
- Care is often subject to preapproval
- Network providers is a hallmark of the plans

Part D

- Part D provides outpatient prescription drug coverage
  - Part D is administered *exclusively* by private insurers
  - Voluntary Program: you must affirmatively enroll
    - Annual coordinated election period (10/15 – 12/7)
  - Late enrollment
    - If you do not enroll when you first become eligible for Medicare, you will face a penalty

Part D

- Cost Associated with Part D
  - Beneficiaries pay monthly premiums and cost sharing, which is based on annual income
  - Donut Hole: Gap in coverage when your total drug costs reaches a certain limit
    - ACA phases out donut hole
  - Part D low income subsidy, extra help that provides assistance with premiums and cost sharing amounts

Medigap

- Medigap Policies
  - Also known as Medicare Supplemental Insurance
  - Sold by private insurance companies
  - Helps you pay for some of the health care costs that Original Medicare does not cover
    - Coinsurance
    - Copays
    - Deductibles

Medicare "Advantage"?

- Statistics from Kaiser Family Foundation
  - 2018 | 34% of Medicare recipients opted for MA
  - Enrollment has doubled in the last decade
- Chronically ill enrollees could face loss of coverage or increase pricing structures
  - Hard to return to Traditional Medicare
  - Hard to obtain Medigap coverage

Guaranteed Issue Rights

- Guaranteed Issues Rights = Medigap Protections
  - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy even if you have health problems ("pre-existing conditions")
  - Examples of when it may be used:
    - When your plan is leaving Medicare
    - Within 12 months of trial of Medicare Advantage

Omissions from Coverage

- Coverage does not include:
  - An annual physical exam
  - Vision care
  - Prescription drugs
  - Routine dental care
  - Hearing aids
  - Foot care
  - Travel limitations

Qualifying Stays

- Part A Covers Skilled Nursing Facility care under specific circumstances
  - Skilled Nursing Facility Coverage
  - Requires 3-day, inpatient hospital stay (3 midnights)
  - Care must be reasonable and necessary
- Cost Considerations:
  - Days 1 – 20 | $0.00
  - Days 21 – 100 | $176

Observation Status

- Care in hospital is generally indistinguishable for inpatients and outpatients
- Observation status or outpatient has become status quo
  - CMA reports that the financial motive of observation status is more linked to the fear of losing money than making money
  - KFF reports that between 2006 – 2014, outpatient status has increased 103%

Observation Status

- If an individual is not inpatient then:
  - Denied Part A coverage for Part A hospital stay (if no Part B)
  - Denied Part A coverage for SNF stay
  - Denied Part A coverage prescription drug coverage while hospitalized
- **No current way to appeal Observation Status**
  - *Alexander v. Azur*

Observation Status

- What are patient's current rights?
  - Individuals are entitled to a MOON Notice (Medicare Outpatient Observation Notice) within 36 hours
  - Patient may argue with hospital about designation/status, but any changes may not occur retroactively
    - A community physician could also advocate and serve as an ally if enlisted

"Improvement Standard"

Medicare does NOT require a patient to improve in order to receive ongoing coverage for rehab, skilled nursing, outpatient therapies, or home health care.

"Improvement Standard"

"Skilled services would be covered where such skilled services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided."

"Improvement Standard"

- *Jimmo v. Sebelius* (Settlement reached in 2013)
  - Medicare coverage is improperly denied for skilled nursing or rehabilitation when the denial is based on an individual's stable or chronic condition
  - There is no expectation of improvement in a reasonable period of time
  - Applies to SNF, HH, Outpatient Therapy, Inpatient Rehabilitation Facilities
  - Corrective Action Plan, includes webpage and *change of practice*

Home Care Benefits

- Home Health Coverage
  - Common misperception that Medicare does not cover home care or if it does it must be limited in duration
  - This is FALSE and could greatly impact your clients
    - *Area of advocacy and education!*

Home Care Benefits

- Qualifications

1. Beneficiary must be *homebound* (not bedbound)

    - Examples: Beneficiary needs a cane, walker, or assistance of another person to leave home or cannot leave home without a considerable taxing effort.

    - Examples of absences that are not counted against beneficiary: Adult day, medical appointments, religious services

Home Care Benefits

2. Services must be ordered by a physician under Plan of Care
3. Dr. must have face-to-face meeting with Patient
4. Dr. must sign document re: face-to-face
5. Patient must require skilled care on an intermittent basis
6. Care is provided by a Medicare-certified home health agency

Home Care Benefits

- Does not generally provide daily care, but may cover up to 28-35 hours/week of skilled nursing and home health aid services
- Some dependent coverage included
- Not limited in duration!
- No co-pays or deductibles
- Does not require hospitalization first!

Medicare Appeals

- What happens when your clients have been denied Medicare coverage? APPEAL
  - Expedited Appeals
    - Address whether the provider's termination of Medicare-covered services was proper
  - Standard Appeals
    - Address whether any subsequent services the beneficiary chose to receive are coverable

Medicare Appeals

- Five Level Review Framework
  - 1st Level: Redetermination (Rubber stamp denials?)
  - 2nd Level: Reconsideration (Rubber stamp denials?)
  - 3rd Level: ALJ Hearing
  - 4th Level: Medicare Appeals Council
  - 5th Level: Federal Court

Resources

- Center for Medicare Advocacy
  - *Upcoming Webinar re: Medicare Appeals post Jimmo*
- Senior Linkage Line
- Medicare.gov

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Thank You!

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