FINANCIAL PLANNING

Whether you are receiving benefits now or are paying into the system and expect to receive benefits later, it is helpful to understand what Medicare does and does not cover.

A Practical Look at What You Need to Know About Medicare

By Michael E. Leonetti

Social Security and Medicare will pay out $550 billion dollars in 1996, most of it tax free. If you aren't one of the 43 million persons getting benefits each month, you probably are one of the 143 million working under Social Security who expect to receive benefits later.

The purpose of this article is to provide you with information you need to know about Medicare in simple, practical terms.

Medicare

The Medicare programs has two parts—A and B. Part A is hospital insurance while Part B is supplementary medical insurance.

Part A of Medicare pays some of the cost of hospitalization, certain related inpatient care, and some home healthcare services. Part B primarily covers doctor's fees, most outpatient hospital services, and certain related services.

Medicare covers only services that are medically necessary and charges that are considered "reasonable."

Part A is financed primarily by payroll taxes based on covered work, both before and after becoming eligible for benefits. Approximately one-fourth of Part B is financed by monthly premiums from enrollees in the program and about three-fourths by the general revenues of the federal government.

When you enroll in Part A of Medicare you also automatically enroll in Part B unless you tell the Social Security Administration that you don't want it. Since many private Medicare supplements require you to have Part B prior to insuring you under the supplement, it's normally a good idea not to opt out of Part B unless there is some other specific reason to do so. If you enroll in Part B at the earliest opportunity, you are scheduled to pay premiums of $42.50 per month during 1996, but Congress may increase this (and also may require high income persons to pay even more of the cost). These premiums are ordinarily deducted from your Social Security benefits, if you get them. If you enroll late, or if you drop out and enroll again, you may have to pay higher premiums. You will pay 10% more for each full 12 months that you did not participate when you were eligible. You don't include any months when you were not enrolled in Part B while an active employee, or spouse of an active employee, covered by an employee-sponsored group insurance plan. Monthly premiums are adjusted every January.

When It's Available

Medicare becomes available at the beginning of the month when you turn 65, whether you are retired or still working. Medicare also becomes available after you have been entitled to Social Security disability benefits for two years, and generally if you have chronic kidney disease. Certain members of your family with kidney disease may also qualify.

You automatically apply for Medicare when you apply for Social Security benefits. When you become entitled to Medicare, Social Security will ask you if you wish to enroll in Part B or decline it. If you plan to work past age 65, you should apply for Medicare separately when you turn 65. Your spouse can qualify for Medicare Part A at age 65 based on your work record if you are eligible for monthly Social Security benefits, even if you are not yet 65. Almost everyone in the United States can enroll in Part B at age 65, but they must pay the monthly premiums.

Hospital Insurance Benefits

In addition to the basic benefits for inpatient hospital care, Part A provides benefits for skilled nursing facility care, home healthcare services, and hospice care. You must, in most cases, pay part of the cost of covered services. Some people carry additional private insurance—Medicare Supplement Policies—to carry some or all of the costs Medicare doesn't cover.

The amounts you pay change each year, depending on increases in hospi-

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tal costs. The following description is based on 1996 amounts.

Hospital Benefits. When you are admitted to a hospital, you will have to pay an initial deductible of $736, but no more than the actual charges. After the first 60 days, you will have to pay $184 per day. After 90 days, you can choose to pay $368 per day for up to 60 "lifetime reserve" days (or else pay the full charges yourself). Your benefit period ends 60 days after discharge from the hospital or skilled nursing facility. If another hospital admission occurs after that, you'll have to pay another deductible, as well as the other cost-sharing amounts.

Skilled Nursing Facility Benefits. You may qualify for limited benefits at a skilled nursing facility if both the facility and your diagnosis and treatment plan meet Medicare's strict standards. Daily skilled nursing or rehabilitation services must be available to you. You are not provided custodial care. Skilled nursing facility benefits are available to you only following a hospital stay of at least three days and beginning within 30 days of leaving the hospital.

If you qualify, you pay nothing for the first 20 days, except for any charges that Medicare does not allow. For the next 80 days, you pay charges up to $92.00 per day, and Medicare pays all remaining allowable charges. No benefits are available after 100 days of care in a benefit period.

Home Health Services Benefits. Home health services such as part-time or intermittent skilled nursing care, physical therapy, medical social services, medical supplies, and some rehabilitation equipment, may be paid for in full by Medicare when you are confined at home, as long as the services are prescribed by a doctor. You are not required to have a hospital stay before home health services are covered. Services must be provided by a home health agency that participates in Medicare.

Hospice Benefits. A hospice is an organization that furnishes a coordinated program of inpatient, outpatient, and home care for terminally ill patients. Emphasis is on counseling, controlling symptoms and pain reduction, but not curative treatment. When you are an inpatient in a facility (not to exceed five consecutive days), in order to provide respite for your usual caretaker, you pay 5% of this cost. Also you pay 5% of the cost for prescription drugs, but not more than $5.00 for each prescription, for symptom management and pain relief. Hospice benefits are limited to 210 days unless you are recertified as terminally ill. When you choose hospice benefits, all other Medicare benefits stop except for physician services and treatment of conditions not related to the terminal illness.

Care in Christian Sanitoriums. Part A of Medicare can help pay for inpatient hospital skilled nursing facility services that you receive in a Christian Science Sanitorium operated or listed and certified by First Church of Christ Scientist in Boston.

Care in Psychiatric Hospitals. Part A will pay up to 190 days of inpatient psychiatric care in a lifetime. Restrictions apply to people who are hospitalized for psychiatric care when they are first covered by Medicare.

Care in Non-Participating Hospitals. A few qualified hospitals do not participate in the Medicare program. Medicare will pay part or, in some cases, all of your expenses in a non-participating hospital if you have an emergency and it is the closest hospital.

Supplementary Benefits

You pay the first $100 of charges allowable by Medicare for covered medical services provided to you in a calendar year. This is the annual deductible. After that, you will pay 20% of covered expenses (which may not exceed the charges allowed by Medicare) plus any additional amount that the physician is allowed to charge. In a few instances (such as clinical diagnostic lab tests), Part B pays all costs.

Covered items are:

- Physician services, regardless of where provided, and supplies furnished as part of such services;
- Physical therapy, speech pathology, and occupational therapy by physicians or institutional providers;
- Services or independent physical therapists and occupational therapists with limits on the dollar amounts of services covered in a year when performed by a physician;
- Diagnostic X-ray, laboratory, and other tests;
- X-ray, radium, and radioactive-isotope therapy (including technician services);
- Periodic mammography screenings;
- Flu shots and pneumococcal vaccine;
- Certain drugs that cannot be self-administered;
- Blood for transfusions, after the first three pints per year (including any considered under Part A);
- Surgical dressings, splints, casts and similar medical supplies ordered by a doctor;
- Necessary ambulance services;
- Rental of durable medical equipment used in the home, including oxygen tanks, hospital beds, and wheelchairs (under some circumstances, purchase of such equipment);
- Home health services (same as provided by Part A) for persons enrolled in Part B only;
- Artificial replacements for parts of the body (covered by Part A under some circumstances);
- Colostomy bags and supplies; and
- Braces for limbs, back, or neck.

Outpatient treatment for mental illness is covered under special payment rules. You'll ordinarily pay 50% of allowable charges. However, you'll pay only 20% of allowable outpatient hospital charges if you would have required admission to the hospital without the treatment. Also, you will pay any additional that the physician is allowed to charge.

What Medicare Does Not Cover

Medicare does not cover all healthcare expenses. A telephone call to the carrier that handles your Medicare claim is the best way to get answers about specific cases. Some of the items not covered are:

- Services not reasonable or medically necessary;

- Items of services for which you are not legally obligated to pay;
- Services Paid for by the government or workers' compensation;
- Services performed by a relative or household member;
- Services outside the U.S. (exceptions are Canadian and Mexican facilities if they are nearest to your home or while you are traveling to or from Alaska through Canada);
- Routine physical exams, eye exams, glasses, hearing aids, and dental care;
- Routine foot care and orthopedic shoes, except for diabetics;
- Custodial care;
- Cosmetic surgery (except after an accident);
- Most prescription drugs and medicines taken at home;
- Most immunizations;
- Private nurses; and
- Extra charges for a private room (unless medically necessary), telephone, television, and other personal comfort items.

Administrative Issues

• **Claim Number:** When you become eligible for Medicare benefits, you will receive a Medicare card containing your claim number. This number is very important to keep because no claim will be paid without it. The card is the only evidence that your are covered.

• **How Claims Are Paid:** Claims are processed by an "intermediary" (Part A) or a "carrier" (Part B). These are insurance companies or other organizations, such as Blue Cross/Blue Shield under contract to the government. Hospital charges to be paid by Medicare are billed by the hospital to intermediaries. Doctors and other suppliers of covered medical services may submit charges directly to carriers by "taking an assignment." Doctors and suppliers who take assignment may not charge more than the amount allowable by Medicare.

Even if the doctor does not take assignment, he or she must send the claim to the Medicare carrier for you. Some charges may be higher than those allowed by Medicare, but the doctor cannot charge more than 15% above the allowable charge. Because your benefit payment will be based on the allowable charge, you will have to pay the excess over the allowable charge.

If you are eligible for Medicare at age 65 or older and are working for an employer with 20 or more employees, then you are entitled to the same employer-sponsored healthcare benefits offered to younger employees. If you have such benefits and are working, then Medicare is the "secondary payer," paying only with respect to charges not covered by your employer-provided plan. These rules apply to your spouse at age 65 or older if you are working for such an employer regardless of your age. These rules also apply to any disabled Medicare enrollee who is also covered by an employer-provided healthcare plan as a currently working employee or as a family member of an employee. However, this applies only if the plan covers the employer with 100 or more employees.

Medicare is also the secondary payer when medical care can be paid for under any liability policy, such as automobile insurance.

Is Medicare Going to Change?

Congress is considering important changes to the Medicare program. The system operates today much as it did when it began 30 years ago, in spite of changes in the marketplace that gives the public choices in how they receive healthcare benefits. Many of these options have resulted in savings for both employees and employers.

Current legislative proposals aim to solve two concerns with Medicare. The first is the desire to provide Medicare participants with healthcare options that are available to persons not under Medicare. This includes health maintenance organizations (HMOs), preferred provider organizations (PPOs), and medical savings accounts (MSAs). HMOs are already available, but only 9% of eligible Medicare participants are enrolled in them. Legislation being debated in Congress would encourage more persons to participate in HMOs.

The second reason that changes are being considered in Medicare is that the hospital insurance trust fund (Part A) is projected to run out of money by 2002. Supplementary medical insurance (Part B) is financed by general revenues and participant premiums. For several years, Part B participants paid about 25% of the cost, but with the rate of healthcare inflation decreasing in recent years, the established premium became 31.5% of the cost in 1995. What figure to use for 1996 (and the basis for later years) is part of the current debate. Also, all Part B participants pay the same premium regardless of income level. This may change also.

At the time this article was researched, no legislation had been enacted that would change Medicare for 1996 other than what has been outlined above. However, it seems likely that amendments will be enacted that will provide greater choice and a higher cost to participants. Any changes will probably be widely reported in the press, so keep on the lookout for these announcements.