Healthcare/Medicare

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Background

MEDICARE is the federal health insurance program for the elderly and disabled. Congress established Medicare in 1965 as Title XVIII of the Social Security Act. It is now codified as 42 U.S.C.A sections 1395 et seq. Pub.L. No. 89-97, 79 Stat. 291. Medicare is an entitlement program for qualified beneficiaries and not a need-based program like MEDICAID, the federal-state health insurance program for low-income persons. Thus, the rich, the poor, and the middle class all may receive Medicare benefits, so long as they satisfy the eligibility criteria.

Medicare is administered by the Centers for Medicare & Medicaid Services (CMMS), formerly known as the Health Care Financing Administration (HCFA). It oversees issues concerning eligibility requirements, extent of coverage, and termination of benefits. CMMS is a division of the U. S. Department of Health and Human Services. Its main office is located in Baltimore, Maryland, and there are nine regional offices throughout the United States.

The Medicare program is divided into three parts: (1) Medicare Part A covers inpatient hospital services, skilled nursing facility services, home health services, and hospice services; (2) Medicare Part B covers other reasonable and necessary medical services, including outpatient hospital care and physician services; (3) Medicare Part C provides an array of private health insurance plans that are mandated to cover the same items and services offered by Medicare Parts A and B. Depending on the plan, Part C may also contain additional costs and offer additional benefits to those in Parts A and B.

Part A Medicare is largely funded by mandatory payroll taxes paid by employers and employees. Part B is an elective program financed in part through premiums paid by Medicare beneficiaries and in part through government contributions. Part C is essentially a medical savings plan that is also funded partly by BENEFICIARY premiums and partly by government contributions. Each part has its own trust fund. Part A payroll taxes are maintained in the Federal Hospital Insurance Trust Fund, while Part B premiums and contributions are maintained in the Supplementary Medical Insurance Trust Fund. Part C premiums and contributions are maintained by the Medicare+Choice MSA Trust Fund.

Individuals are generally entitled to coverage under any of the three parts if they are 65 years or older and (1) qualify for Social Security or Railroad Retirement benefits; (2) have received Social Security or Railroad Retirement DISABILITY benefits for at least 24 months; (3) or suffer from end-stage renal disease.

Individuals who elect retirement at age 62 are not eligible for Medicare until they turn 65, even if they qualify for Social Security or Railroad Retirement benefits earlier. Individuals who are eligible for Social Security retirement benefits and postpone retirement to continue working after age 65 can begin receiving Medicare benefits at age 65.

The largest group of Medicare recipients qualify for coverage based on their entitlement to Social Security benefits. Sometimes called Old Age, Survivors, and Disability Insurance (OSADI) benefits, these benefits are paid to workers eligible to retire, survivors of workers eligible to receive these benefits, and disabled workers. Workers are eligible to retire at age 62 if they are "fully insured," which means that they have worked and paid Social Security taxes for the requisite amount of time specified by STATUTE. Survivors are entitled to Social Security benefits according to their relationship with the deceased worker (i.e., widow, divorced spouse, child, or parent). Workers are "disabled" and entitled to Social Security benefits if they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months. 42 U.S.C.A. section 1382c.

Health care providers may participate in Medicare and receive Medicare payments if they satisfy state and federal licensing requirements and comply with the standards promulgated by CMMS. A health care provider must also enter into an agreement with the Secretary of Health and Human Services. The agreement designates the amounts the provider will charge Medicare patients and the manner in which it will provide medical services. Hospitals, skilled nursing facilities, home health agencies, clinics, rehabilitation agencies, public health agencies, comprehensive outpatient rehabilitation facilities, hospices, critical access hospital, and community mental health centers (CMHCs) may generally seek to participate in Medicare under a provider agreement. However, clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for services involving outpatient physical therapy and speech pathology. CMHCs may only enter into provider agreements to furnish certain hospitalization services.

Medicare: Part A

The hospital insurance program established under Part A of Medicare provides qualified individuals with basic protection against the costs of the following services: (1) inpatient hospital care; (2) extended care services furnished to skilled nursing facility inpatients; (3) home health care; and (4) hospice care for terminally ill persons. Inpatient hospital care may generally be provided by urban hospitals, most rural hospitals, certain psychiatric institutions, and Christian Science sanatoriums. 42 U.S.C.A. sections 1395c et seq. Specifically, the costs covered by Medicare include: bed and board at the hospital; most physician, nursing, and related services; most drugs, supplies, appliances, and equipment furnished by the hospital; diagnostic and rehabilitative services; occupational, respiratory, physical, and speech therapy; and social services for personal, emotional, and financial issues related to covered medical care. Anesthesia services provided by a certified registered nurse anesthetist, however, are expressly excluded from coverage.

Individuals who are ineligible for OASDI or railroad retirement benefits may establish entitlement to hospital insurance benefits under Medicare Part A if they have worked in Medicare qualified government employment or meet the requirements for "deemed entitlement" to OASDI benefits. Individuals who lack "fully insured" status are "deemed" entitled to OASDI benefits for the purpose of obtaining Part A coverage if they are 65 years old, are residents of the United States, are U. S. citizens or ALIENS lawfully admitted to the United States for permanent residence, and have filed an application for Medicare hospital insurance benefits. Individuals who cannot otherwise qualify for hospital insurance benefits may obtain Medicare Part A coverage by paying a premium.

Part A coverage is based on "benefit periods." An episode of illness is termed a benefit period and starts when the patient enters the hospital or nursing home facility and ends sixty days after the patient has been discharged. A new benefit period starts with the next hospital stay, and there is no limit to the number of benefit periods a person can have. Medicare will pay the cost of hospitalization for up to 90 days. The patient must pay a one-time DEDUCTIBLE for the first sixty days of a benefit period and an additional daily fee called a co-payment for hospital care provided during the following thirty days. Apart from these payments, Medicare covers the full cost of hospital care.

So long as the premiums and deductibles are fully paid in a timely manner, beneficiaries remain entitled to Medicare coverage through the later of (1) the month of the individual's death, if the individual would have been entitled to OASDI or Railroad Retirement benefits if he or she had not died, or (2) the month in which the individual no longer meets Part A entitlement requirements. Individuals who die during the month in which they would have turned 65 are entitled to hospital insurance benefits for that month, even if death occurs before the individual's birthday, provided the individual would have met conditions for Medicare Part A entitlement had he or she not died.

Medicare: Part B

Medicare Part B provides benefits that supplement the coverage provided by Part A. It makes voluntary supplementary medical insurance (SMI) available to most individuals age 65 or over and to disabled individuals under age 65 who are entitled to hospital insurance under Medicare Part A. The SMI program is financed in part by beneficiaries who pay a monthly premium and a yearly deductible. The program also receives federal funding.

SMI is administered by insurance companies, referred to as carriers, which have entered into contracts with CMMS to perform designated functions as agents of CMMS. Those functions include receiving, disbursing, and accounting for funds in making payments for covered services; providing an opportunity for a FAIR HEARING if CMMS denies an enrollee's request for payment; and assisting enrollees in locating physicians participating in the Medicare Part B program.

Not every physician provides services covered by Medicare. Physicians must agree to participate in the Medicare program, promise to accept the Medicare approved charge as payment in full, and then submit only charges that are reasonable and necessary for treating the patient. 42 U.S.C.A section 1395u. Federal law prohibits physicians from charging more than 115% of Medicare's approved charge. Medicare will reimburse the beneficiary 80% of Medicare's approved charge, and the beneficiary is responsible for the remainder. 42 U.S.C.A. section 1395w-4(g)(2)(C). Fines and penalties apply to physicians who charge above the 115% cap, including exclusion from the Medicare program and monetary penalties of up to $2,000 per violation.

Persons entitled to Part A benefits are enrolled automatically in Part B, unless they indicate that they do not want to participate in Part B. Persons who do not apply for Social Security benefits and are therefore not automatically enrolled in Medicare can apply at the local Social Security Administration office or by mail. Generally, individuals can enroll in Medicare Part B during an initial seven-month enrollment period that begins 3 months before their 65th birthday and ends 3 months after it. Individuals who miss their initial enrollment period may only enroll during a general enrollment period, which lasts from January through March of each year. Coverage then becomes effective on July 1st of that year.

Individuals who enroll during the first three months of the initial enrollment period are eligible for Part B entitlement beginning in the first month of their eligibility to enroll. If an individual enrolls during the fourth month of the initial enrollment period, entitlement begins the following month. Individuals who enroll during

the fifth month of the initial enrollment period are eligible for Part B entitlement beginning with the second month after the month of enrollment. For individuals who enroll in either of the last two months of the initial enrollment period, entitlement begins with the third month after the month of enrollment.

Part B beneficiaries may terminate their enrollment at any time by giving CMMS written notice that they no longer wish to participate in the SMI program. Entitlement to benefits under the program terminates at the end of the month after the month in which the individual files the disenrollment request. Entitlement also terminates upon death, termination of entitlement to Medicare Part A benefits, or nonpayment of premiums. Termination upon death ends SMI entitlement on the last day of the month in which the individual dies.

Part B covers the services of physicians and other health practitioners; supplies furnished incidental to physicians' services; outpatient hospital services; rural health clinic services; comprehensive outpatient rehabilitation facility services; physical and occupational therapy services; speech pathology services; prosthetic devices and durable medical equipment; ambulance services; X-ray treatment; and diagnostic and other laboratory tests. 42 U.S.C.A. section 1395k(a); 42 U.S.C.A. sections 1395x et seq.

The Part B program is not comprehensive. Excluded items include dentures and other dental care; most outpatient drugs, except where the drugs are physician-administered during covered treatment; routine physical examinations; hearing aids; orthopedic shoes; and eyeglasses and eye examinations. 42 U.S.C.A. section 1395y(a). Medicare covers limited preventive care services, such as pap smears, pelvic exams, mammograms, colorectal cancer screening, prostate cancer screening, bone mass measurement tests, and flu, pneumococcal, and hepatitis B shots. It also covers diabetes glucose monitoring and diabetes education.

Medicare: Part C

Congress significantly restructured the Medicare program with the establishment of Medicare Part C, the Medicare+Choice program. As of January 1, 1999, Medicare offers beneficiaries the following private health care delivery options: Medicare health maintenance organizations (HMOs), medical savings accounts (MSAs), preferred provider organizations (PPOs), private fee-for-services (PFFS), and provider sponsored organizations (PSOs). However, individuals are only eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization (MCO) if the plan serves the geographic area in which the individual resides.

Beneficiaries who reside in an area served by a Medicare Part C plan may opt out of either Part A or Part B and elect to enroll in Medicare Part C, except those with end-stage renal disease. Beneficiaries may only enroll during November of each year, and plan elections become effective in January of the following year. Beneficiaries who do not elect any option will automatically be enrolled in traditional fee-for-service Medicare. If a beneficiary does not make an election for a particular year and is already enrolled in Part C from the previous year, he or she will automatically be re-enrolled in that plan. Beneficiaries can also change plans if their plan contract terminates or if they move from their plan's service area. 42 U.S.C.A. section 1395w-21(e)(3).

The Secretary of Health and Human Services has established a process through which elections under Medicare Part C are made and changed. Individuals seeking to elect a Medicare+Choice plan must complete and sign an election form, provide the information required for enrollment, and agree to abide by the rules of the Medicare+Choice program. Within 30 days from receipt of the election form, MCOs transmit the information necessary for CMMS to add the beneficiary to its records as an enrollee of the MCO. A beneficiary's enrollment may not be terminated unless the beneficiary engages in disruptive behavior, provides FRAUDULENT information on the election form, permits abuse of the enrollment card, or fails to pay premiums in a timely fashion. Part C monthly premiums are calculated based on the rules set forth in 42

U.S.C.A. section 1395w-24(b)(1)(A).

A Medicare+Choice plan offered by an MCO satisfies the basic requirements for benefits and services if the plan provides payment in an amount that is equal to at least the total dollar amount of payment for such items and services as would otherwise be authorized under Medicare Parts A and B. The plan must also comply with (1) CMMS's national coverage decisions and (2) written coverage decisions of local carriers and intermediaries for jurisdictions handling claims in the geographic area for which services are covered under the plan.

Payment, Notice, and Appeals

Medicare payments provided under Parts A, B, or C can be sent directly to the health care provider or to the patient. Regardless of the method of payment, the patient must receive notice that the provider has filed a medical insurance claim. The notice should detail the medical services provided, identify the expenses that are covered and approved by Medicare, and ITEMIZE any expenses that have been credited toward the annual deductible and any expenses Medicare has already paid in full. Patients or providers who are dissatisfied with a decision made regarding a Medicare claim may ask CMMS or the insurance carrier to reconsider the decision, depending on the nature of the claim. Following reconsideration, either party may request a formal hearing before an administrative law judge, though no formal hearing will be granted for claims made under Part B unless the claim is for at least $100. Once the administrative law review process has been completed, aggrieved parties may appeal to federal district court. Part B claims must total at least $1,000, however, before a federal district court will hear the appeal.

The Future of Medicare

Approximately 76 million Americans born between 1946 and 1964 are expected to retire in the next 28 years. In 2001 about 39 million Americans were enrolled in Medicare, and that number is expected to swell to 77 million in 2030. Meanwhile, the ratio of workers to beneficiaries is expected to decline by over 40 percent between 2001 and 2030, and thus the number of persons who help finance Medicare through payroll taxes will decrease as the number of persons receiving Medicare benefits increases.

These figures have alarmed both politicians and voters, who have demanded that something be done to save Medicare from possible future of BANKRUPTCY and chaos. Proposals to "fix" the system have varied from conservative efforts aimed at "privatizing" Social Security and Medicare by allowing workers to invest their payroll deductions in the SECURITIES market to more liberal efforts aimed at placing Social Security and Medicare funds in a "lock box" to keep them safe from tampering and theft.

Following the inauguration of George W. Bush as the 43rd president of the United States, Congress began debating the future of Social Security and Medicare. However, much of the nation's domestic social agenda was temporarily placed on hold after the terrorist attacks in New York City and Washington, D. C., on September 11, 2001. Nonetheless, in December of 2001 the U. S. House of Representatives unanimously passed the Medicare Regulatory and Contracting Reform Act. H.R. 3391. The bipartisan bill is intended to streamline the complex and cumbersome rules governing Medicare so that doctors spend more time with patients and less time on paperwork. However, the bill did not address any issues concerning Medicare's long-term financial SOLVENCY.

Additional Resources

American Jurisprudence. West Group, 1998

http://guide.biz.findlaw.com/01topics/17govbenefit/gov_laws... . FindLaw: Government Benefits Law

Medicare: Nuts and Bolts. Baker, Joe, 101 PLI/NY 203, Practicing Law Institute, 2001.

West's Encyclopedia of American Law. West Group, 1998

Organizations

American Association of Retired Persons

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