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UNDERSTANDING MEDICARE: A GUIDE FOR CHILDREN OF AGING PARENTS

PREPARED BY THE REPUBLICAN STAFF

OF THE

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UNITED STATES SENATE
Senator JOHN HEINZ

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FOREWORD

Medicare is the single largest health insurance program in the United States. Although it provides direct health insurance coverage to over 30 million elderly beneficiaries, Medicare touches more than just the lives of older America. Medicare affects, in one way or another, nearly one-half of our population, many the adult children of aging parents.

This brochure is for those adult children who are increasingly called upon to provide financial, physical, and emotional care and support for their aging parents. With health care costs increasing, many elderly Americans are confused by what Medicare will and will not pay for. This brochure will help you, the children of aging parents, and your parents better understand how Medicare works and how to make the program work best for them.

This brochure was prepared by the Republican Staff of the U.S. Senate Special Committee on Aging. I want to thank Jeffrey Lewis, Staff Director, and Isabelle Claxton, Director of Communications and Public Policy, and, in particular, David Barnhart, a Congressional Fellow on detail from the Social Security Administration. This project would not have been possible without Mr. Barnhart's expertise, research, and writing.

I would also like to recognize and thank those people who assisted my Committee staff in preparing this brochure: Celinda Franco of the Congressional Research Service (CRS); Richard Getrost, John Thomas, Winona Hocutt, and Bill Ullman of the Health Care Financing Administration (HCFA); and Michael Diebert of the Pennsylvania Department of Aging. And, I would especially like to thank Louise Fradkin of Children of Aging Parents (CAPS) in Pennsylvania and Kristin Lund and Mary McKeown of the Dakota Area Resources and Transportation for Seniors (DARTS) in Minnesota.

JOHN HEINZ,
U.S. Senator.

MEDICARE—AN INTRODUCTION

If your parents are 65 or older and eligible for Social Security benefits, they are entitled to Medicare.

Medicare has two types of insurance:

Part A, Hospital Insurance

Part B, Supplemental Medical Insurance

When your parents are enrolled in Medicare, they are covered by Part A and Part B. While your parents have the option to drop Part B, most people don't because Part B currently pays a large portion of physician and outpatient medical services.

Medicare Part A pays a portion of the medical services provided a patient during a hospital stay, including a semi-private room, meals, and routine nursing care. Medicare Part A also pays a portion of the cost for skilled nursing facility care, home health care, and hospice care.

Part B pays a large portion of a doctor's bill wherever those services are provided, including surgical fees and hospital and office visits. Part B also pays a portion of the costs for outpatient medical services provided by a hospital or by medical providers outside the hospital and a portion of the costs for durable medical equipment.

MEDICARE—WHO TO CALL IN PENNSYLVANIA

If you have a question about Medicare benefits and coverage or other elderly health care issues, don't hesitate calling one of the following agencies and organizations in Pennsylvania:

- For questions about Medicare Part A, the hospital insurance covering inpatient hospital care, you can contact Pennsylvania's Keystone Peer Review Organization, Inc. (KEPRO), at 1-800-322-1914.
- For questions about Medicare Part B, the supplemental insurance which covers physician and other outpatient services, you can contact Pennsylvania Blue Shield at 1-800-382-1274.
- For questions about doctors, laboratories, and medical suppliers who accept Medicare assignment, you can contact also Pennsylvania Blue Shield at 1-800-382-1274.
- For questions about Medigap insurance, you can contact Pennsylvania's Department of Insurance, Accident and Health Rates Bureau in Harrisburg at 1-717-783-2101. The Department also has regional offices in:
  Philadelphia at 1-215-560-2630;
  Erie at 1-814-871-4466; and
  Pittsburgh at 1-412-565-5020.
- For complaints about Medigap insurance, you can contact the Department's Bureau of Consumer Affairs in Harrisburg at 1-717-787-2317 or one of the regional telephone numbers listed above.
- For information on your community's Area Agency on Aging or other local senior services, you can contact the Pennsylvania Department of Aging at 1-717-783-3126.
- For questions about home health care in your area, you can contact the Pennsylvania Department of Health at 1-800-692-7254.
- For questions about how your parents are being treated in a nursing facility or home, you can contact Pennsylvania's Nursing Home Ombudsman under the Department of Aging's Bureau of Advocacy at 1-717-783-7247.
- Contact Children of Aging Parents (CAPS) at 1-215-945-6900 for information on membership in their organization and services they provide on eldercare. If they do not answer, leave a message with your telephone number and area code, if long distance. CAPS will return your call, paying the cost of the call if it is long distance.
- To receive a Medicare application and find out information on Medicare, you can call the Social Security Administration's toll-free number, 1-800-2345-SSA. The best times to call are between 7:00 a.m.-9:00 a.m. and 4:00 p.m.-7:00 p.m.

DEFINITIONS

Let's define some words frequently used in any type of health insurance program, including Medicare...

PREMIUMS

Premiums are a fee you pay to maintain your health insurance. Premiums for Medicare's Part A, the hospital insurance, were paid through payroll taxes during a person's working years if that person also paid Social Security taxes. Therefore, under Part A, there are NO premiums to be paid by Medicare recipients.

Medicare Part B, the supplemental medical insurance, however, has a premium. In 1990, the monthly premium is $28.60 per person. If both your parents are living and insured under Medicare, their combined monthly premium for Part B is $57.20 (2 × $28.60). *If your parents are receiving Social Security, the premium for Part B is automatically taken out of their check.*

DEDUCTIBLE

A deductible is what you pay out-of-pocket for hospital, doctor, and other medical services before Medicare begins to pay. Once the deductible is paid or "met," Medicare will pay the Government's share of expenses. But keep in mind, Medicare has different deductibles for Part A and Part B. These are discussed in greater depth later in this pamphlet.

COPAYMENT

Also called coinsurance, a copayment (or copay) is what remains for you to pay after any health insurance has paid its share of your medical expenses. As with other health insurance programs, your parents share responsibility with Medicare for paying medical expenses. Your parent's share of the expenses is his copayment.

BENEFIT PERIOD

Medicare Part A pays benefits based on the number of days spent in a particular health care setting during a benefit period. Benefit periods apply to inpatient care at a hospital and skilled nursing facility, and outpatient and respite care from a hospice.

For *inpatient hospital care,* the benefit period begins when the patient enters the hospital and ends after the patient has been out of the hospital for at least 60 days in a row.

For *skilled nursing facility care,* the benefit period begins when the patient enters the hospital from which he then was transferred. The patient's benefit period ends 60 days after he stops receiving *daily skilled care* in the nursing facility.

For *hospice care* there is a one-time benefit period of 210 days.

There are no benefit periods for Home Health Care under Part A and physician health provider care under Part B.

Medicare Approved Charges

Medicare has established standard payment limits for all physician and medical service charges and for medical supplies and durable equipment costs. Medicare's approved charges are based primarily on the "usual and customary" charges for services or supplies in your community. Under Part B, Supplemental Medical Insurance, Medicare will pay 80 percent of the "approved charges" for medical services and supplies. The remainder of the charges are considered the Medicare patient's copayment.

Accepting Assignment

This means that a doctor, laboratory, or medical supplier has agreed to accept what Medicare pays for services they have provided and *WILL NOT* charge your parent more than 20 percent of Medicare's "approved charge" for that service.

Accepting assignment does not restrict the doctor from charging more than Medicare's approved charge. Rather, accepting assignment limits the doctor to only charging your parent *20 percent* of Medicare's approved charge. Regardless of the cost, if the doctor accepts assignment for a billed service, your parent only has to pay *20 percent* of Medicare's approved charge for that service, nothing else. Any charge above Medicare's limit must be absorbed by the doctor.

The following example will clarify this point:

> As Medicare's insurance carrier in the State, Pennsylvania Blue Shield is billed $125 by a doctor who *accepts Medicare assignment* for your parent's office visit. Medicare's approved charge for this visit, however, is $100. Pennsylvania Blue Shield will pay the doctor $80—80 percent of Medicare's approved charge. Although $45 remains, *the doctor can only bill your parent $20—the other 20 percent of Medicare's approved charge.* The remaining $25 *must* be absorbed by the doctor; it *cannot* be added to your parent's bill.

Your parents can obtain a list of doctors and other medical providers who accept assignment from Pennsylvania Blue Shield at 1-800-382-1274.

Medicare Beneficiary

Also known as "insured," a Medicare Beneficiary is a person who is enrolled in Medicare and receives benefits from the program.

MEDICARE PART A: HOSPITAL INSURANCE

Part A is the Hospital Insurance portion of Medicare. Part A pays for a portion of the health care provided in several kinds of institutional and outpatient settings: inpatient hospital and skilled nursing facility care, home health care, and hospice care.

INPATIENT HOSPITAL CARE

When your parent enters a hospital, Medicare's Part A pays for most of the cost of care received. Remember, however, that your parent must first pay a hospital deductible at the beginning of a benefit period before Medicare will start paying for anything. Although Medicare Part A pays a portion of inpatient hospital care, it only pays benefits up to the time your parent no longer needs to stay in the hospital.

Part A of Medicare doesn't pay for doctor services or visits in the hospital. These services are covered by Part B.

Medicare *will pay* the approved charges for the following hospital medical services:

- A semiprivate room.
- All meals, including special diets.
- Regular nursing services.
- Drugs furnished by the hospital during the hospital stay.
- Cost of special care units such as intensive care.
- Lab tests.
- X-rays and radiation therapy supplied in the hospital.
- Medical supplies provided during the hospital stay.
- Operation and recovery room costs.
- Rehabilitation services such as physical, occupational, or speech therapy.
- Certain medical equipment used by the patient in the hospital such as wheelchairs and walkers.

Medicare will *not pay* for the following hospital services:

- The first three pints of blood (although your parent will not be charged if he belongs to a blood transfusion program or he makes arrangements to replace the three pints of blood).
- Private nurses and the extra charges for a private room unless medically necessary.
- Personal comfort items such a television and telephone.
- Drugs not deemed "safe and effective" by the U.S. Food and Drug Administration. Your parent should ask his doctor if the drugs he has prescribed meet this requirement.

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BENEFIT PERIODS

Most adult children and their aging parents are introduced to Medicare Part A's complicated coverage during or after hospital visits. Much of the confusion centers around the benefit period, deductible, and copayment. Let's look at benefit periods first.

Benefit Period Begins

A benefit period begins when a person has not been in a hospital or received skilled care services in a skilled nursing facility for at least 60 days in a row.

Your father is admitted to the hospital. He hasn't been in a hospital for over 10 years and has never been in a skilled nursing facility. With this admission, *your father is beginning a benefit period.*

Benefit Period Continues

If a person is admitted to the hospital within 60 days of a prior hospitalization, he is in the same benefit period as the previous hospital stay. Although a benefit period can last indefinitely, Medicare will only pay for 90 days of hospital care during the same benefit period. And, these don't have to be 90 consecutive days. Medicare will not pay any benefits in the same benefit period after 90 days. And, a new benefit period will not begin until your parent has been out of the hospital for at least 60 days in a row.

Your father is admitted to the hospital. He just left the hospital 20 days ago. In this case, *no new benefit period begins.* He is still under a previous benefit period because he hasn't been out of the hospital for at least 60 days in a row before this current admission.

Benefit Period Ends

A benefit period ends when your parent has not been in a hospital or received skilled care services in a skilled nursing facility for at least 60 days in a row.

Your father is admitted to the hospital. He was previously discharged from the hospital 3 months ago. In this case, *your father is beginning a new benefit period* because he's been out of the hospital for over 60 consecutive days.

DEDUCTIBLE AND COPAYMENTS

When your parent enters a hospital at the beginning of a new benefit period, she must pay a Medicare Part A deductible. This means that in 1990 your parent must pay for the first $592 of her hospital bill, the Part A deductible, before Medicare pays hospital benefits. *There is only one deductible per benefit period*—there is no deductible for other hospital stays in the same benefit period.

After your parent pays the deductible, Medicare will pay for approved inpatient medical services through the *60th day* of hospital care. These do not have to be 60 consecutive days.

Your mother hasn't been in a hospital for at least 60 days when she's admitted for surgery. Your mother's stay is short, she's discharged from the hospital after 10 days. Because this is the beginning of a benefit period, your mother will have to pay a deductible before Medicare begins to pay the remaining approved inpatient charges. In most cases, after your mother "meets" her deductible, she will pay nothing else for this hospital stay except for comfort items such as a television. If your mother doesn't re-enter the hospital for any medical reason for at least 60 days after her discharge, the benefit period will end. Any future hospital stay will result in a new benefit period *and* another deductible.

With the *61st day* of hospital care in a benefit period, your parent *will have to pay* a copayment, a portion of the cost for his hospital care. In 1990, your parent's copayment is $148 per day; Medicare Part A pays the remainder of the daily hospital costs.

Your father hasn't been in a hospital for at least 60 days when he's admitted for surgery. He is in the hospital for 10 days. Your father is responsible for the $592 deductible before Part A begins to pay. As in the first example, your parent will probably pay nothing else during this 10-day stay except for personal comfort items.

Your father is discharged from the hospital but returns in 4 weeks for more surgery. This second visit lasts 20 days. Because your father's second hospital visit is within 60 days of his first visit, your father is not required to pay another deductible—he is still under his original benefit period.

After being discharged from his second hospital stay, your father returns for a third hospital visit 10 days after the second visit ended. The third visit lasts 40 days. There is no deductible for the third visit because it is still within the original benefit period. *But an important change occurs.*

Your father will begin paying a copayment of $148 per day after his 60th cumulative day of hospital care within this benefit period. In this example, your father will exceed the 60-day limit three-quarters of the way through his third hospital stay. Your father will have to pay a copayment charge for the 10 remaining days. At $148 per day, your parent's copayment is $1,480 (10 × $148). Medicare will pay any of the remaining approved hospital charges for these 10 days after the copayment is deducted.

After 90 days of inpatient hospital care, Medicare generally stops paying its portion of hospital care until a new benefit period begins. However, if needed, a Medicare beneficiary has 60 days of lifetime reserve available

60 Days—Lifetime Reserve

Each Medicare beneficiary has 60 days of lifetime reserve for inpatient hospital care; these reserve days do not apply to skilled nursing facility or hospice care. These reserve days are available if your parent's inpatient hospital care extends beyond 90 days in a benefit period. Lifetime reserve days are used on a *one-time only* basis. Once a reserve day is used, it is never available for use again, *ever.* Therefore, your parent's lifetime reserve should be used only when absolutely necessary: When extended hospital care is your parent's only health care option; when such a stay is not covered by any other health insurance; and when your parent does not have the private resources to pay for his extended stay.

Your parent also has an out-of-pocket copayment charge for each lifetime reserve day used. This copayment is equal to one-half of the Medicare Part A deductible for a particular year. In 1990, your parent's copayment would be $296 a day if he used any of his lifetime reserve days ($592 × ½).

Your mother needed to stay, off and on, in the hospital for 110 days in one benefit period. Medicare would normally stop paying any hospital benefits after 90 days. Your mother, however, decides to use 20 of her lifetime reserve days. She has been told that once these 20 reserve days are used, her supply of lifetime reserve days will drop to 40 days (60 less 20). She will never have these 20 reserve days available again for inpatient hospital care. Your mother also knows that she will have an out-of-pocket copayment of $5,920 for these 20 reserve days ($296×20).

SKILLED NURSING FACILITY CARE

Medicare does not pay for what we traditionally think of as long-term, custodial care in a nursing home. Rather, Medicare limits reimbursement to skilled care services provided by a skilled nursing facility. These services include both skilled nursing care and skilled physical and speech therapy.

Skilled services:

Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical or occupational therapists, and speech pathologists; and

Must be provided directly by or under the supervision of the facility's skilled nursing or skilled rehabilitation staff.

To qualify for Medicare benefits, your parent's skilled nursing and/or skilled therapy must be provided either separately or in combination on a *daily basis.*

Your father has broken his hip. After a stay in the hospital, your father is ready to be released. Your father's doctor determines that your father needs skilled nursing care on a *daily basis* and physical therapy for 3 days a week to recover from the hip injury. Your father is admitted to a Medicare-certified skilled nursing facility. If he qualifies, he will receive Medicare Part A benefits for his stay as long as he receives skilled care 7 days a week. Medicare will stop paying benefits when your father no longer receives either skilled nursing care or physical therapy every day.

Medicare Part A will pay for up to 100 days of skilled nursing facility care in addition to the 90 days of hospital care in the same benefit period. (However, in most cases, Medicare coverage ends well before the 100 days. Medicare paid for only an average of *26 days per person* of skilled nursing facility care in 1988.) There is no deductible for skilled nursing facility care during a benefit period.

For Medicare to pay for services in a skilled nursing facility, the following requirements must be met:

- Your parent must be in the hospital for at least 3 consecutive days prior to entering a skilled nursing facility. These 3 days do not include the day your parent is released from the hospital.
- Although your parent does not have to enter the skilled nursing facility immediately upon release from the hospital, he must be admitted within 30 days of his release from the hospital.
- Your parent must enter the skilled nursing facility to treat the condition for which he was originally admitted to the hospital.
- Your parent's doctor and the skilled nursing facility must certify that your parent's medical condition can be improved by the nursing facility's rehabilitation services and that the rehabilitation is "reasonable and necessary".

○ The skilled nursing facility must be Medicare certified. That is, the skilled nursing facility must comply with certain standards of care set by the Federal Government.

Skilled nursing facility services covered by Medicare include:

○ Semiprivate room and meals, including special diets.

○ Skilled nursing care, medical social services, and rehabilitation services by licensed nurses, therapists, and nursing facility staff.

○ Prescription drugs, medical supplies, and durable medical equipment ordinarily used for patient care and treatment in a skilled nursing facility.

○ Other services that are routinely provided by the skilled nursing facility for the health and well-being of the patients, including but not limited to:

Intravenous, intramuscular, or subcutaneous injections; application of dressings involving prescription medications; and insertion, sterile irrigation, and replacement of catheters.

Skilled nursing facility services not covered by Medicare include:

○ Intermediate or custodial care *when your parent IS NOT receiving daily skilled nursing facility or skilled therapy.* Custodial care typically includes help in walking, getting in and out of bed, eating, dressing, bathing, using the toilet, and taking medicine. Custodial care essentially is personal care that *does not* require the continuing attention of trained medical or paramedical personnel.

○ Private room charges (unless medically necessary) and personal comfort items such as televisions.

○ Doctor services (which are covered under Medicare Part B).

A stay in a skilled nursing facility is covered by the same benefit period that covers your parent's stay in the hospital from which he was transferred. A benefit period ends when your parent is either:

Out of a *hospital* for at least 60 days in a row; or

Not receiving *daily* skilled nursing or rehabilitative therapy in a *skilled nursing facility* for at least 60 days in a row.

In March 1989, your mother was admitted to a skilled nursing facility directly from the hospital. She had entered the hospital in late February for a broken hip. This was her first and only, hospital and skilled nursing facility stays in 1989.

After 1 week in the skilled nursing facility, she no longer required skilled care on a daily basis—her condition had improved to where she only needed physical therapy *3 days a week.* Your mother stayed another 5 weeks, receiving this part-time physical therapy. Your mother was in the skilled nursing facility for a total of 6 weeks. She did not return to a hospital or a skilled nursing facility for the rest of 1989.

In our example, your mother's benefit period for Medicare's Part A began when she entered the hospital in February. This benefit period included her stay in the skilled nursing facility. *Your mother's benefit period ended 60 days after the daily skilled care ended in the skilled nursing facility, not 60 days after she left the skilled nursing facility.* This means the benefit period ended 60 days after the first week rather than after the sixth week of skilled nursing facility care.

Your mother's Medicare benefits also ended after her first week in the skilled nursing facility because she no longer required *daily* skilled nursing care or skilled rehabilitative therapy. She only needed part-time skilled therapy for the remaining 5 weeks.

You must remember that once her need for *daily* skilled care ends, Medicare will no longer pay for your parent's stay in a skilled nursing facility.

Of the various levels of nursing home care, skilled nursing care is the most expensive and medically intensive. Although your parent's rehabilitation and recovery is the main goal of any care, you may want to investigate other options, including home health care, which may be less expensive and allow your parent to recover at home. Medicare pays for various approved home health care services, including part-time and intermittent skilled nursing care and physical, speech, and occupational therapy. These benefits will be discussed in detail in the next section.

If your parent's physician or discharging hospital believe that a skilled nursing facility is the best recovery site, your parent can be referred to a skilled nursing facility. Your parent's physician or the hospital discharge plan must certify that your parent's condition will be improved by a level of care available only from a skilled nursing facility. Although finding bedspace may be difficult, *your parent must insist upon being admitted to a Medicare-certified skilled nursing facility ONLY.* If a parent is unable to act on his own behalf, adult children should act as their parent's health advocate, making sure the parent is admitted to a Medicare-certified skilled nursing facility.

Medicare will never pay for daily skilled care from a skilled nursing facility that is not approved by Medicare. Medicare certification, however, does not guarantee that Medicare will pay for your parent's stay at a skilled nursing facility. Your parent must also require daily skilled care to qualify for Medicare benefits.

If Medicare approves the claim for your parent's stay, Medicare will reimburse 100 percent of approved services during the first *20 days* of the skilled nursing facility care.

Beginning with the *21st day,* the patient pays out-of-pocket a copayment of $74 per day. Medicare pays the remaining approved daily medical expenses.

Your father is hospitalized for a serious accident. After 2 weeks in the hospital, he's discharged. To help your father recover from his accident, his physician prescribes physical rehabilitation at a local skilled nursing facility that is Medicare certified. The facility's director agrees with the physician that the institution's rehabilitation services can improve your father's condition.

Your father enters the skilled nursing facility the day after he leaves the hospital. He stays in the facility for 30 days. Medicare approves the claim for your father's stay in the skilled nursing facility and pays for 100 percent of his approved expenses for the first 20 days of this skilled care. Beginning with the 21st day of skilled care, your father starts to pay a copayment.

In 1990, your father's copayment for skilled nursing facility care would be $74 a day. In our example, his out-of pocket expenses for these 10 days would be $740 (10 × $74).

After *100 days* of skilled nursing facility care in a benefit period, Medicare coverage ends. These do not have to be 100 consecutive days.

Medicare will also stop paying benefits for skilled nursing facility care if your parent's rehabilitation program is determined to be no longer improving his condition; he has reached a plateau where no more improvement can be expected.

HOME HEALTH CARE

Medicare Part A pays for some of the cost of home health care for homebound Medicare patients. Home health care coverage, however, is limited to short-term, intermittent or part-time care for a parent whose condition is expected to improve or change. Medicare home health care benefits pay for patient recovery from an *acute* illness or injury. Medicare generally *does not* pay home health benefits for *chronic* conditions. In most cases, when a person's condition stabilizes, the treating doctor will no longer recommend home health care. At this point, Medicare's coverage, and most Medigap insurance's coverage, will cease paying home health care benefits. Under Medicare, home health care must not be viewed as long-term, in-home care for a chronic condition. On average, homebound patients only receive 23 home health visits under Medicare's coverage.

"Homebound" Does Not Mean "Bedbound"

To be considered homebound, your parent must have a physical or mental condition that severely restricts his ability to leave the house. Your parent's condition must be such that leaving the home requires considerable and taxing effort, or his condition requires special equipment to leave the home: wheelchairs, crutches, or walkers; special transportation; or the aid of another person when in a wheelchair or using a walker.

Homebound does not mean your parent cannot leave his home. He can leave, but only for short periods of time on an infrequent basis. If your parent, however, can leave his house on a daily basis, he will not qualify for Medicare's home health care benefits. *This requirement does not apply to leaving the home for prescribed medical treatment.*

To see if your parent can receive Medicare's home health care coverage, ask his physician to refer your parent to a Medicare-certified Home Health Agency. The Home Health Agency will schedule a free home visit to assess your parent's health care needs and determine if he qualifies for Medicare's home health care benefits. *Home Health Agencies must provide this home assessment for free to maintain their Medicare certification.*

Home health care benefits are almost always provided under Medicare Part A. However, home health care benefits can be provided under Medicare Part B if your parent does not have Medicare's Part A coverage.

To qualify for Medicare's home health care benefits:

- O Your parent must be homebound.
- O Your parent must be under a plan of care prepared by a doctor who must then periodically review your parent's plan of care to see if the home health care is still necessary.

Medicare's home health care benefits only cover skilled nursing care or physical or speech therapy when these services are expected to improve your parent's condition over a limited or predictable period of time. Medicare does not generally reimburse for home health care over an open-ended period of time when there is literally "no end in sight" for the need of such care.

- The Home Health provider must be Medicare-certified and provide these services at a reasonable cost. To find a Medicare-certified Home Health Agency, contact the Pennsylvania Department of Health at 1-800-692-7254.
- Your parent needs intermittent skilled nursing care *or* physical or speech therapy.

Intermittent is defined as needing skilled nursing care for 4 days, or less, per week. And, this intermittent nursing care cannot exceed 35 hours per week. (If your parent needs skilled nursing care for more than 4 days per week *and* does not require physical or speech therapy, he *will not* qualify for Medicare's home health care benefits.)

There are no restrictions on the number of days or hours per week of physical or speech therapy. The physical or speech therapy must be provided, however, on a "necessary and reasonable" basis.

There is *no deductible* for Medicare's home health care benefits. Your parent is not required to have a hospital stay before home health services are covered by Medicare. There are no benefit periods or limits on the number of days within a calendar year for Medicare's home health care benefits.

If your parent qualifies for Medicare coverage of home health care benefits, Medicare Part A *will pay* for:

- The intermittent or part-time services of a skilled nurse and home health care aide. There are limitations on the visits by skilled nurses and home health care aides:

Intermittent or Part-time limits the visits by a skilled nurse to 4 days, or less, per week; and

Intermittent or Part-time limits the visits by a skilled nurse *and* home health care aide (combined) to 35 hours per week with no visits exceeding 8 hours a day.

- Medical social services.
- Medical supplies and a portion of the cost of durable medical equipment.
- A physical and speech therapist when prescribed by your doctor and provided by a Medicare-certified home health care agency.

Medicare will only pay for occupational therapy when it is part of a physical or speech therapy program. If approved, however, Medicare will continue paying occupational therapy benefits even after physical or speech therapy ends.

Medicare Part A home health care benefits will NOT pay for:

- Full-time nursing care.
- Self-administered prescription drugs.
- Meals delivered to your parent's home.
- Transportation.
- Homemaker services that primarily assist your parent in personal care or housekeeping.
- Doctor bills, these are covered under Medicare Part B.

HOSPICE CARE

A hospice is an organization that provides a program of inpatient, outpatient, and home care for terminally ill patients. Hospice care includes medical and social services for patient and family counseling, symptom control, and pain reduction. These services include physician and nursing care, medical appliances and supplies, outpatient drugs for managing symptoms and pain, short-term inpatient respite care, counseling, therapy, and home health care aide and homemaker services.

Medicare will pay for hospice care from a Medicare-approved hospice. Medicare beneficiaries certified as terminally ill may elect hospice care benefits under Part A in place of regular Medicare. When your parent chooses hospice care, his other Medicare benefits which cover the terminal illness stop except for doctor services. If your parent does need medical care for reasons unrelated to the terminal illness, regular Medicare benefits are available to pay for these services.

Part A can pay for two 90-day benefit periods and one 30-day benefit period for a total of 210 days of hospice care. Hospice care benefits are not available beyond the 210-day limit.

To receive Medicare's hospice care benefits, the following conditions must be met:

- Your parent's doctor and the hospice medical director must certify that your parent is terminally ill.
- Your parent must state, *in writing,* that he wants Medicare hospice benefits in the place of regular Medicare benefits.
- A plan of care must be prescribed before your parent begins hospice care.
- The hospice must be Medicare-approved.

Part A has no deductible for approved hospice care, only a small copayment for prescription drugs and respite care. A beneficiary pays 5 percent of the cost for outpatient, prescription drugs to manage symptoms and pain with a copayment limit of $5 for each prescription. A beneficiary also pays 5 percent of the cost of inpatient respite care with a copayment limit of $592 for each benefit period. Medicare covers up to 5 days at a time of respite care in an approved facility. Respite care allows the patient's caregivers time to rest while the patient receives care elsewhere.

MEDICARE PART B: SUPPLEMENTAL MEDICAL INSURANCE

Medicare Part B has an annual deductible of $75 per person. Once this deductible is met, Part B pays 80 percent of Medicare's approved "reasonable" charge, a payment limit, for approved physician and medical services. The Medicare patient pays the remaining 20 percent copayment and any medical costs above Medicare's approved charge.

Physicians, laboratories, and medical suppliers who accept Medicare assignment agree to accept Medicare's payment limit as payment for their services. "Participating Physicians" have agreed to accept assignment for all their services. Other physicians may accept assignment on a case-by-case basis.

A doctor, who accepts assignment, charges your mother $100 for an approved office visit, the Medicare payment limit. Medicare will pay $80 (80 percent) of the doctor's charge. Your mother will pay the other $20 (20 percent). If your mother has other health insurance, such as a Medigap policy, which pays Part B copayment charges, the health insurer will pay the $20.

A physician who accepts assignment can charge more than Medicare's limit, but can only *collect* Medicare's payment limit.

A doctor, who accepts assignment, charges your mother $125 for an office visit. However, Medicare's approved limit for this visit is $100. Medicare will pay $80 of the doctor's charge, 80 percent of the Medicare approved limit. Although that leaves $45, your mother *will only have to pay $20,* the other 20 percent of Medicare's payment limit. *Your mother will not have to pay for any charge which exceeds Medicare's payment limit when the medical service is provided by a doctor who accepts Medicare assignment for that service.*

Physicians who do not accept assignment may charge more than Medicare's payment limit. Congress, however, limits the amount a physician *can collect* to 15 percent above Medicare's approved limit.

Your mother's doctor doesn't accept assignment. Your mother is billed $135 for her recent office visit. Medicare's payment limit for this visit is $100. The doctor's charge is 35 percent above Medicare's approved limit for this service. The physician, however, is limited *to collecting only 15 percent* above Medicare's payment limit. Although the doctor has charged $135, the doctor can only collect $115 from Medicare and your parent. In this case, the additional $15 is 15 percent of the Medicare's payment limit.

Medicare will pay $80 (80 percent) of their limit. Your mother will have to pay the $35 copayment: the remaining 20 percent of Medicare's limit plus the doctor's additional $15 charge. If your mother has health insurance which supplements Medicare coverage, the insurer may pay part or all of the copayment charges. Medicare, however, will only pay 80 percent of their payment limit regardless of whether or not your mother's physician accepts assignment.

Medicare Part B covers part of the costs of physician services, laboratory services, outpatient care, and durable medical equipment. (Medicare will not pay for medical services, diagnostic tests, or durable medical equipment from laboratories or suppliers who are not Medicare-approved.)

After your parents have "met" their $75 deductible for the year, Medicare Part B will pay part of the charges for:

- Doctor services in the hospital, doctor's office, or at home. Medicare Part B covers medical supplies furnished as a part of the doctor's service, including surgical dressings, splints, casts, and similar medical supplies ordered by a doctor.
- Physical or occupational therapy and speech pathology services in a doctor's office, as an outpatient, or in the home.
- A portion of the rental, lease, or purchase cost of durable medical equipment used in the home from Medicare-approved suppliers, including oxygen tanks, hospital beds, and wheelchairs.

  Currently, Medicare pays 80 percent of these charges for new durable medical equipment. On the other hand, Medicare will pay 100 percent of the cost of approved equipment which is used rather than new.
- Eye care, other than eye examinations and eyeglasses fittings, from licensed Doctors of Optometry. Medicare only covers the eye care for which the optometrist is licensed by the state to perform.
- Diagnostic, X-ray, laboratory and other tests. Medicare will pay for laboratory tests conducted by independent, Medicare-approved laboratories which accept assignment. Tests conducted by a doctor, rather than a laboratory, are covered by Medicare *only when the doctor accepts assignment for these tests.*
- Artificial replacements for all or part of an internal body organ, including heart pacemakers, colostomy bags and supplies, and artificial limbs and eyes; and, braces for limbs, backs, or neck.
- Drugs that cannot be self-administered, blood-clotting factors for hemophilia, and immunosuppressive drugs used during the first year after an organ transplant.
- X-ray, radium, and radioactive-isotope therapy (including technician services).
- Ambulance services (excluding service between a patient's home and his doctor's office).

Medicare Part B will NOT pay for the following medical services:

- Health care and services Medicare doesn't consider medically "reasonable or necessary."
- Physician charges above Medicare's approved amount.
- Regularly scheduled physical examinations.
- Teeth cleaning and dentures.
- Foot care, unless prescribed by a doctor because of a medical condition, such as diabetes, which affects the legs and feet.
- Eye and hearing examinations, and examinations to prescribe or fit eyeglasses and hearing aids.
- Most outpatient, self-administered prescription drugs and immunizations, unless needed to prevent infection.
- Cosmetic surgery, unless needed because of an injury or to improve the function of a malformed body part.
- The first three pints of blood (though your parent will not be charged if he belongs to a blood transfusion program or makes arrangements to replace the three pints of blood).
- Acupuncture.
- Medical care outside of the United States except under limited circumstances in Canada and Mexico.

Medicare Part B is optional. Your parents can decide to drop Part B at anytime. If your parents do drop Part B and want to re-enroll later, they have to wait until the annual enrollment period, January 1 through March 31. If your parents re-enroll, they will be subject to higher premiums. In addition to their monthly premium, your parents will pay an extra 10 percent of their monthly premium for each 12-month period they're not covered by Part B. And, *this re-enrollment charge is permanent.*

Your parents have not been enrolled in Medicare Part B for 2 years. If your parents enroll in Part B during the enrollment period in 1990, they will pay the monthly premium plus an additional 10 percent of that premium for each 12-month period they weren't enrolled. Because your parents weren't covered by Part B for two 12-month periods, they will pay the monthly premium plus a 20 percent re-enrollment charge.

For 1990, the monthly premium is $28.60 for each Medicare beneficiary, $57.20 for a couple. When you add a 20 percent re-enrollment charge of $5.72 per person, a parent's 1990 monthly premium will increase to $34.32. For both parents, the monthly premium for 1990 will increase to $68.64. Although monthly premiums may increase in the future, the re-enrollment charge will always remain the same amount. That is, regardless of premium increases, the $5.72 per person re-enrollment charge will *never* increase.

FILING MEDICARE BENEFIT CLAIMS

To receive reimbursement from Medicare, a claim must be filed for the health care provided. Claims are filed by a hospital or skilled nursing facility, a physician, other health care providers, or by the Medicare beneficiaries themselves.

Part A claims are processed by a Medicare *intermediary*; Part B claims are processed by a Medicare *carrier*. After a claim has been processed, the Medicare beneficiary will receive a letter or form which explains what health care was covered by Medicare and the amount Medicare paid for the approved care.

Your parents should keep a record of all health insurance claims in case they need to inquire about their claim or to appeal a claim decision.

MEDICARE PART A

Under Part A, Medicare makes payments to hospitals based on the average cost for treating a particular illness or injury. A patient's condition is categorized under a group of related illnesses or injuries called a "diagnosis related group," or DRG. Based on a patient's DRG, the hospital receives a predetermined payment from Medicare for the beneficiary's illness or injury.

Participating hospitals, skilled nursing facilities, home health care agencies, and hospices submit Part A claims directly to one of three Medicare intermediaries in Pennsylvania.

MEDICARE PART B

Doctors, laboratories, and medical suppliers who accept assignment submit their claims directly to Pennsylvania Blue Shield, the State's Medicare carrier for Part B payments.

If the doctor or medical supplier doesn't accept assignment, the Medicare beneficiary must submit his own Part B claims to the Pennsylvania Blue Shield until September 1990.

Beginning September 1, 1990, Federal law will require *all* doctors to file Part B claims with their State's Medicare carrier, whether the doctor accepts assignment or not. After September 1, your parents will no longer have to file their own Medicare Part B claim with Pennsylvania Blue Shield for any doctor's services.

However, until September 1, if your parents must submit their own Part B claims, they should use a *Patient's Request for Medicare Payment* form. Most doctors' offices, all Social Security offices, and Pennsylvania Blue Shield have copies of this form. When submitting any insurance claim, your parents must include the itemized bills for all medical services for which they are claiming payment.

DISPUTING MEDICARE BENEFIT CLAIMS

Your parents have the right to dispute the denial of any Medicare benefit. Part A disputes generally concern the denial of admission to a hospital or skilled nursing facility, or denial of continued stays at a hospital or skilled nursing facility. Part B disputes generally concern medically "necessary and reasonable" physician, home health care, laboratory, and other health care provider services and durable medical equipment costs.

If your parent is denied Medicare benefits, he will receive a letter or form which tells him why the benefits are denied. If your parent disagrees with the denial, he can request a reconsideration of the decision. This request can be filed on a HFCA Form 2649 which is available from any Social Security office, the State's Medicare intermediary or carrier, or the State's Peer Review Organization. Your parent has 60 days to request a reconsideration. Your parent's request should focus on the nature of the denial and the *"medical necessity"* for the institutional, physican, or outpatient care.

If your parent's reconsideration is denied, he has the right to request a hearing before an Administrative Law Judge. Although your parent can appeal any denial claim, for an appeal to go beyond the reconsideration stage to the Administrative Law Judge level, the disputed amount must be:

At least $200 in the case of Peer Review Organization (PRO) denials of hospital services;

At least $200 in the case of denials made by a hospital's Utilization Review Committee;

At least $100 in the case of skilled nursing facilities and home health care agencies; or

At least $500 for physician services under Part B. Beneficiaries may lump together several disputed claims to reach the $500 minimum.

MEDICARE SUPPLEMENT INSURANCE

(Better Known as Medigap)

Although we cannot recommend one Medigap policy over another, there are some things your parents should look for when reviewing an insurance policy to supplement their Medicare health insurance.

Your parents should look for a Medigap policy that:

Covers their Medicare Part A and Part B deductibles and copayment charges.

Covers prescription drugs since, in most cases, Medicare doesn't.

Automatically covers increases in their Medicare copayment and deductibles.

Requires that they pay by a check made out to the insurance company, not the insurance agent.

Your parents should avoid a Medigap policy that:

Duplicates any supplemental health insurance they may already have.

Is nonrenewable or has very restrictive renewal clauses.

Limits their total annual payment and sets a lifetime limit under $500,000.

Doesn't cover services for a condition that has preexisted for over 6 months (a pre-existing condition).

Your parents should ask the insurance agent:

What the average policyholder pays in out-of-pocket medical expenses annually including deductibles, premiums, copayments, and noncovered service charges.

To clearly identify what benefits they are getting and what medical expenses they will be responsible for.

Finally, your parents need to be sure:

The insurance benefits meet their needs;

They can afford the premiums; and

They understand and accept the policy's limitations and exclusions.

Your parents should read any sales brochures carefully before buying Medigap insurance. And, if they purchase any Medigap insurance, they should read their policy carefully after they receive it. The provisions written in the Medigap policy determine the supplemental coverage, nothing else.

If your parents have any questions concerning duplicate coverage, they can contact their local Area Agency on Aging or the Pennsylvania Department of Insurance to find out about organizations which can compare their current health insurance coverage with Medigap policies they are considering.

(**Remember,** Medicare Supplement Insurance (Medigap) does not cover long-term, custodial care in a nursing home. If your parent's are interested in long-term care insurance, there are insurance programs specifically designed to cover long-term care.)

THINGS TO REMEMBER

Your parents should participate in *all* decisions regarding their medical services and treatment. To learn more about their health situation, your parents should ask questions. When their doctor recommends a medical or surgical procedure, your parents should ask:

Is the procedure necessary? Can I live a relatively healthy life without it?

Is there another procedure that's equally effective yet less expensive?

What health benefits can I expect from this procedure, and what are the potential side effects?

If your parents are not comfortable asking these questions or they are unable to due to a physical or mental condition, you should make an effort to ask these questions of your parent's doctor.

If your parents have any doubt about the need for a proposed procedure, they should seek a second opinion. Although Medicare pays a large share of most medical bills, your parents will have to pay a part of almost any medical care and service they receive. So your parents need to be sure they are paying for something that is really needed.

Though your parents may already have a doctor, they should ask if the doctor accepts Medicare assignment. If the doctor doesn't, your parents may want to either negotiate or shop around. Medicare/Pennsylvania Blue Shield has a list of doctors who accept assignment.

If your parents want to remain with a doctor who doesn't accept Medicare assignment, they should first ask the doctor if he would begin accepting assignment. If the doctor won't, your parents should then ask that the doctor's charges be kept within Medicare's assigned limits. (If your parents and Medicare pay more than $1,000 a year to the same doctor, your parents are an important customer for that doctor.)

If they decide to look for a doctor who accepts assignment, your parents should look for one who promotes good nutrition, physical exercise, and other types of wellness activities. The doctor should be a good listener; discuss medical problems openly; and spend enough time with your parents to develop a comfortable one-on-one relationship with them. Your parents should be partners with the doctor in their medical care, not merely observers.

Before your parents have an illness or an accident, locate Medicare approved home health care, outpatient hospital services, and other medical and social services available to senior citizens in the community. These services include senior centers, Meals on Wheels, group homes, church volunteer groups, companion services, and congregate meal services.

- You can get information on the availability of these services by calling the local Area Agency on Aging or contacting the Pennsylvania Department of Aging at 1-717-783-3126.
- You can get a list of Medicare approved skilled nursing facilities and hospices from Pennsylvania Blue Shield at 1-800-382-1274 or Pennsylvania Department of Aging at 1-717-783-3126.
- You can get a list of approved medical and social services, laboratories, and medical suppliers from Pennsylvania Blue Shield at 1-800-322-1914.

Becoming familiar with these services in advance will prevent unnecessary aggravation during a time when your parents may be ill and you have more important things to concentrate on.

- Remember, Medicare generally provides for short-term, acute care hospitalization only. Your parents and you must realize that approved hospital care will only be for a limited time. Your parents long-term medical care will be provided outside the hospital by doctors, skilled nursing facilities, home health care specialists, or through other medical or social service organizations.

Finally, your parents should be their own health care advocate, with some help from you.

- In most instances, your parents can manage their own health care situation easily. However, there may be times when your parents are unable to cope with, understand, or control their health care circumstances. They may then need your assistance during hospital and outpatient care.

You can also help your parents understand the Medicare program better: What medical services and costs Medicare does cover and what medical services and costs Medicare doesn't cover; what copayments your parents will be responsible for; and what your parent's rights are under the Medicare program.

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