HAAS Financial Services Inc.
Investments - Planning - Education

IPE Insights

JUNE 2013

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Medicare Primer

JIM'S JOURNAL

This month's IPE Insights article will take a break from our ongoing discussions on investments and Social Security. Instead, I will focus on another all-encompassing social welfare program that we will be a part of at age 65 – Medicare.

Medicare is a federal health insurance program that covers individuals age 65 or older, individuals of any age with permanent renal (kidney) failure, and certain disabled individuals. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), a federal agency in the Department of Health and Human Services. Social Security Administration (SSA) offices throughout the country process Medicare applications and claims, and provide information about the program. However, the SSA does not set Medicare policy.

The Center for Medicare & Medicaid Services forms partnerships with thousands of health care providers across the country ranging from hospitals to doctors to medical service and equipment providers. Private insurance companies are employed to process and pay claims; and, health care professional are contracted to monitor the quality of care given to Medicare beneficiaries.

The Medicare umbrella consists of four elements: Part A – Hospital Insurance, Part B – Medical Insurance, Part C - Medicare Advantage (formerly known as Medicare +Choice) and Part D – Prescription Drug Insurance.

Hospital Insurance (Part A) provides institutional care, including inpatient hospital care, skilled nursing home care, post-hospital home health care, and, under certain circumstances, hospice care. An individual entitled to Social Security monthly benefits or a qualified railroad retirement benefit is automatically entitled to Part A benefits beginning with the first day of the month that you turn 65. Medicare is the secondary payer if a person is covered by an employer group health insurance plan, veteran's benefits, workers compensation or black lung benefits. Medicare is also a secondary payer if no-fault insurance or liability insurance is available as the primary payer. Medicare beneficiaries help fund part of the program by paying deductibles, coinsurance, and premiums.

Medical Insurance (Part B) is a voluntary program of health insurance which covers physician's services, outpatient hospital care, physical therapy, ambulance trips, medical equipment, prosthesis, and several other services not covered under Part A. It is funded by enrollee monthly premiums which cover about 25% of program costs. The remaining 75% is paid through contributions from general revenues of the U.S. government. Standard monthly premiums for Part B vary according to income. In 2013, the basic premium is $104.90 per month but may be up to $335.70 per month for those with higher incomes.

Medicare Advantage (Part C) allows contracts between the Centers for Medicare & Medicaid Services and a variety of managed care and fee-for-service organizations. These contracts may be negotiated with and include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) Provider Sponsored Organizations (PSOs), fraternal benefit society plans and private fee-for-service plans. Individuals may optionally choose one of these programs and payments will be sent directly to that provider through the Medicare Advantage arrangement. It should be noted, however, that most Medicare beneficiaries still receive benefits through the original Medicare reimbursement program.

Medicare Prescription Drug Insurance (Part D) was added to Medicare by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Prescription Drug Insurance is a voluntary program that covers part of prescription drug costs not generally covered by other Medicare programs and is offered through private health plans. Participants may stay with traditional Medicare and enroll in a drug-only plan or may choose a Medicare Advantage plan with comprehensive benefits. Monthly premiums are averaging about $30 per month in 2013. Beneficiaries who choose not to enroll in a Prescription Drug Insurance plan during their initial enrollment period may face a late enrollment penalty if they choose to enter the program at a later date.

As you saw from the title, this article is a Medicare primer and provides an overview of the basics. It still amazes me how complicated the subjects of Social Security and Medicare can be. These are two programs that almost every citizen in the United States will come under as they grow older. Social Security retirement benefits are available as early as age 62 and Medicare coverage starts at age 65. Few people really understand the options associated with these programs. It is my goal to provide information in these two essential areas to compliment the active management of your assets in the Haas Financial Money Management Program.

As I write this article, the stock market appears to be at a decisive point right now – bonds have been weakening and stock gains will depend on further stimulus from the Federal Reserve. This will be discussed in next month's newsletter. Take good care!!!

Table of Hospital Insurance (Part A)

Effective January 1, 2013

Service	Benefit	Medicare Pays	A Person Pays
HOSPITALIZATION Semiprivate room and board, general nursing, and other hospital services and supplies.[1]	First 60 days 61st to 90th day 91st to 150th day[1] Beyond 150 days	All but $1,184 All but $296 a day All but $578 a day Nothing	$1,184 $296 a day $578 a day All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other other services and supplies.[2]	First 20 days Additional 80 days Beyond 100 days	100% of approved amount. All but $148 a day Nothing	Nothing $148 a day All costs
POST-HOSPITAL HOME HEALTH CARE Part-time or intermittent skilled care, home health aid services, durable medical equipment and supplies and other services.	First 100 days in spell of illness	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% for approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	For as long as the doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited costs for outpatient drugs and inpatient respite care
BLOOD When furnished by a hospital or skilled nursing facility during covered stay.	Unlimited if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.[3]

1. 60 Reserve days benefit may be used only once in a lifetime. 2. Neither Medicare nor private Medigap insurance will pay for most home care.
3. Blood paid for or replaced under Part B of Medicare during the calendar year does not have to be paid for or replaced under Part A.

Table of Medical Insurance (Part B) Benefits

Effective January 1, 2013

Service	Benefit	Medicare Pays	A Person Pays
MEDICAL EXPENSE Doctors' services, inpatient and outpatient medical and surgical services and Supplies, physical and speech therapy, diagnostic test, durable medical equipment and other services.	Unlimited if medically necessary.	80% of approved amount (after $147 deductible). Reduced to 50% for most outpatient mental health services.	$147 deductible,[1] plus 20% of approved amount and limited charges above approved amount. above approved amount.[2]
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE Part-time or intermittent skilled care home health aide services, durable medical equipment and supplies, and other services.	Unlimited but covers only home health care not covered by Hospital Insurance (Part A).	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% for approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury	Unlimited if medically necessary.	Medicare payment to hospital based on hospital cost.	20% of whatever the hospital charges (after $147 deductible).[1]
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $147 deductible and starting with 4th pint).	For first 3 pints plus 20% of approved amount for additional pints (after $147 deductible.[3]
AMBULATORY SURGICAL SERVICES	Unlimited if medically necessary.	80% of predetermined amount (after $147 deductible).	$147 deductible, plus 20% of predetermined amount.

1. Once a person has $147 of expense for covered services in 2013, the part B deductible does not apply to any further covered services for the rest of the year. 2. A person pays for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. 3. Blood paid for or replaced under Part A of Medicare during the calendar year does not have to be paid for or replaced under Part B.

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