Medicaid Update 2015
NBI Continuing Legal Education Seminar
Columbia, South Carolina
June 9, 2015

Limitations on Medicare for Long Term Care Costs, the Medicare Appeals Process, and Long-Term Care Insurance

Bret H. Davis, JD, CPA
Davis & Boyd, LLC
1110 London Street, Suite 201
Myrtle Beach, SC 29577
(843) 839-9800
www.davisboydlaw.com
bdavis@davisboydlaw.com

I. Medicare Benefits for Long Term Care.

We continue to experience a national crisis regarding long term care for our aging population. Improvements in health care keep people alive longer than ever, causing people to often times outlive their assets, particularly if they have to go into an assisted living or skilled nursing facility. The costs of assisted living and skilled nursing care continue to rise. This leaves the all important question of how will these end of life costs be funded. There are a number of options when it comes to paying for these costs, such as self funding through personal income and assets, long term care insurance, Medicare, Medicaid, and/or VA benefits. The focus of this outline is on the use of Medicare for long term care expenses. It will also go through how the Medicare appeals process works. As will be explained in more detail, Medicare is not a solution to long term care costs, because it is designed to only handle short term, rehabilitation type services.

A. Brief History of Medicare.[1]

Medicare is contained within the previously enacted Social Security Act, and was signed into law by President Lyndon B. Johnson on July 30, 1965, with beneficiaries first able to sign up for benefits on July 1, 1966. It initially included only part A (for hospital care) and Part B (for general medical insurance). In 1972, President Richard M. Nixon increased Medicare to include individuals under age 65 with long term disabilities and individuals with end stage renal disease. The Omnibus Reconciliation Act of 1980 expanded Medicare further to include home health services. This Act also brought Medigap supplemental insurance under federal oversight. Hospice services were added in 1982, and the 1990's saw the additions of Part C (add on provisions to supplement coverage) and Part D (drug coverage). Also, the Medicaid laws were amended to provide payment of the Medicare premium for people between one hundred and one hundred twenty percent of the federal poverty level.

B. Long-Term Care Benefits Provided by Medicare[2].

Medicare Part A covers skilled nursing care if certain very specific criteria are met. First, the services must be medically necessary. Medicare will not pay for custodial care, such as bathing or dressing. The patient must need assistance with items such as changing sterile dressings, or similar type items. Second, the patient must have been admitted as an inpatient in a hospital for three (3) consecutive days preceding receiving the skilled nursing care. Medicare will not pay for

---

[1] Historical and current benefit information about Medicare was obtained from www.Medicare.gov and from research articles from the Henry J. Kaiser Family Foundation website. Information was also obtained from Franchelle C. Millender, et al., A Practical Guide to Elder and Special Needs Law in South Carolina (4th ed. 2014).

[2] Please see the attached 2014 Medicare Summary (Traditional Program) © Center for Medicare Advocacy. Used with permission.

skilled nursing care if the patient was not admitted on an inpatient basis. Particular attention must be given when the patient is admitted. If the patient was initially admitted on an outpatient basis and then changed to an inpatient basis, the patient must stay in the hospital for three consecutive days while on an inpatient basis before Medicare will pay for skilled nursing care. Lastly, the treating physician must determine that the patient needs skilled nursing care.

Specific items that Medicare will pay for include, but are not limited to: 1) Semi-private room, 2) meals, 3) skilled nursing care, 4) physical therapy, 5) speech pathology, 6) medications, 7) medical supplies, 8) ambulance transportation, 9) dietary counseling, and 10) swing-bed type services. It is also important to note that the facility in which the patient receives this care must be a Medicare approved facility. Additionally, in certain circumstances, and when specifically ordered by the treating physician, Medicare will pay for home health care. This is normally for more intermittent type services. Medicare will pay for all of this type care, except that the patient must pay twenty (20%) percent of the expenses for approved durable medical equipment.

Once it is established that Medicare will pay for skilled nursing care, the next question regards how much will Medicare pay for the services. Medicare will pay one hundred percent (100%) of skilled nursing care for the first twenty (20) days. From day twenty one (21) until day one hundred (100), Medicare will pay a portion of the costs, with the patient being required to pay a coinsurance amount of One Hundred Fifty Seven and 50/100 ($157.50) Dollars[3] per day.

[3] This is the amount for the year 2015. The coinsurance amount is evaluated on an annual basis.

C. Who is entitled to Medicare Part A and what is the cost?

Part A coverage is provided without a premium to people that 1) are over age sixty five (65) and entitled to social security or railroad retirement benefits; or 2) disabled persons under age sixty five (65) who receive social security or railroad retirement benefits for twenty four (24) months, or who have ALS or end stage renal disease, or 3) people who have enough work credits to qualify. Otherwise, to receive Medicare, persons over age sixty five (65) must pay a monthly premium for the Part A coverage. For people that do not have to pay a premium, Part B is optional. For people that do have to pay a premium, Part B is required.

II. Medicare Part C - Advantage Plans (HMO, PPO, PFFS, SNP, and MSA).

Medicare Part C is designed to offer private health care plans in place of Medicare Parts A and B. This is different than Medigap coverage, which is a supplement to Parts A and B. Part C is also referred to as Advantage Plans and include several different types of plans, such as Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plans, Private Fee-For-Service (PFFS) plans, Special Needs Plans (SNP), and Medical Savings Plans (MSP). If you have a Medicare Advantage Plan, you would not also have Medicare Part A and/or Part B.

Most HMO plans require that you only go to doctors, hospitals, and other health care providers that are in the plan's network. However, there are some provisions for emergency care included. You normally must get a referral from your primary care physician for other services, such as any specialty medical care. Some HMOs include drug coverage. The advantages to HMOs is the coverage provided. The disadvantage is that you are limited by the network of doctors and other health care services.

PPOs are very similar to HMOs in that each has a network of health care providers. The main difference is that you are not required to have a primary care physician like you are with an HMO, which means that you do not have to get a referral from your primary care physician to go to a specialist if the specialist is in your network. As with HMO's, drug coverage is provided in some of the PPOs offered.

PFFS plans include a number of different types of plans that can be obtained in place of Medicare Parts A and B. The plans are similar to HMOs and PPOs in that you normally have a network of providers. The benefit of the Private Fee-For-Service plans is that it gives the person the opportunity to get the coverage that best fits their specific needs. As with Medicare Part B, there is a portion of the premium costs that the person must pay each month. Also, there may be additional costs in addition to the reduced premium if you want more comprehensive coverage. The important thing to understand is that with Medicare Advantage Plans, you are still on Medicare and you still receive the benefits of Medicare negotiated rates and having a large part of your monthly premiums for coverage paid by Medicare.

Medicare SNPs are a type of Medicare Plans that provides coverage for very specific diseases or characteristics (such as End-Stage Renal Disease, diabetes, HIV/AIDS, chronic heart failure, and dementia), and tailor benefits to best meet the needs of the participant. Membership in SNPs is limited to the people with the special needs covered. As with HMOs and PPOs, care is provided from doctors and hospitals in a network. However, emergency care may be provided from out of network providers in certain circumstances. Most often, a primary care physician is required, along with a referral from your primary care physician for any specialty services. One difference with SNPs is that oftentimes the person on the SNP will also be on Medicaid. In those cases, it is

important that the SNP plan providers utilized also accept Medicaid. Also, all SNPs must provide Medicare prescription drug coverage.

MSAs are very similar to Health Savings Account (HSA) plans in that each has basic high deductible coverage with a separate savings account. The main differences between the two are that the rates for providers are negotiated by Medicare and Medicare helps fund the savings account where with HSAs the participant is the only source of funds. The MSA plans starts paying for services once the annual deductible is met. Money in the savings account can be used (to the extent there is enough money in the account) to pay for services until the deductible is met. MSAs do not include drug coverage, so the participant must also obtain a Medicare drug plan if he or she needs drug coverage.

III. Medicare Appeals Process.

A Medicare participant has an opportunity to contest or appeal a decision made by Medicare about coverage or payment of a claim. More specifically, the items that are appealable are the denial of 1) a request for health care service, supply, or prescription drug, 2) a request for payment for health care service, supply, or prescription drug, or 3) a request to change the amount the participant is required to pay for a health care, service, supply, or prescription drug. An appeal of a Medicare Savings Account decision can also be made if the participant does not agree that their deductible has been met because a service or item has not been counted. The appeals process has five (5) levels and is handled slightly different for each type of Medicare.

A. Medicare Part A and Part B (Original Medicare) Appeals.

Level 1: Redetermination by the Company that handles claims for Medicare. Review the Medicare Summary Notice (MSN) to determine which part(s) of the denial with which the

participant does not agree. The appeal must be filed within one hundred twenty (120) days of receiving the MSN, and can be filed by 1) filling out a Redetermination Request Form and sending it to Medicare at the address provided in the MSN; 2) sending in the MSN with the items appealed circled and an explanation of why the items should not have been denied, or 3) sending a written letter or request to Medicare outlining the appeal with all the pertinent information. If the participant is not satisfied with the results from Level 1, they can appeal again. The next appeal must be done within one hundred eighty (180) days after receipt of the decision.

Level 2: Reconsideration by a Qualified Independent Contractor. The determination letter from the Level 1 review will include the steps to take for this appeal. The independent contractor is a party that was not involved in the Level 1 review. If the participant disagrees with the Level 2 decision, they have sixty (60) days after receiving the Medicare Reconsideration Notice to file the Level 3 appeal.

Level 3: Hearing Before an Administrative Law Judge (ALJ). To request a hearing, the participant would need to follow the instructions included in the Medicare Reconsideration Notice. The participant can appeal the Level 3 decision within sixty (60) days of receiving the ALJ's decision.

Level 4: Review by the Medicare Appeals Council. The decision from the ALJ decision will provide instructions on how to request that the Medicare Appeals Council review the ALJ's decision. The participant has sixty (60) days from the Medicare Appeals Council's decision to make a Level 5 appeal.

Level 5: Judicial Review by a Federal District Court. The case must meet the minimum dollar amount ($1,460 for 2015) before the case can be appealed to a federal district court.

However, claims may be combined to meet the minimum amount. The decision from the Medicare Appeals Council will provide instructions on how to file a formal complaint in a federal district court.

B. Medicare Part C (Advantage Plans) Appeals.

Appeals for Medicare Part C are handled in a very similar way as appeals for Parts A and B. The main exception is that the Level 2 review with Part C plans is reviewed by an Independent Review Entity (IRE) instead of a Qualified Independent Contractor. There may also be specific provisions related to the insurance company that provides the Medicare Part C coverage.

C. Medicare Part D (Drug Coverage) Appeals.

As with appeals for Medicare Part C, appeals for Part D are handled in a very similar way as appeals for Parts A and B. However, one difference is that with a Part D appeal the first appeal would come from the Evidence of Coverage (EOC) received by the participant. Also, as with Part C appeal, the Level 2 appeal is heard by an Independent Review Entity instead of a Qualified Independent Contractor.

D. Medicare Special Needs Plan (SNP) Appeals.

The Medicare SNP must provide in writing the instructions on how to appeal. If the initial appeal is not satisfactory to the participant, the matter can be reviewed by an independent organization that works for Medicare and not the plan.

IV. Long-Term Care Insurance.

Privately funding long term care continues to be a major issue for our aging population. As would be assumed, having enough resources to simply write a check for any needed long term care would be the easiest option. However with the ever-increasing cost of care likely being out of reach

for the vast majority of families[4], other options must be explored. If a family can afford coverage, long term care insurance is the most sensible way to approach funding long term care costs. The various long term care insurance products can be grouped into three basic categories, which are 1) traditional long term care insurance, 2) life insurance with some sort of long term care insurance feature or rider, and 3) annuity type products with long term care insurance provisions.

A. Coverage.

Not all long term care insurance is the same. Just because someone says that they have coverage, that does not mean that they are fully covered. Policies have many different options and features and coverage amounts that need to be explored and understood. Some provide primarily for custodial care while others also include skilled nursing care, and each policy will have maximum daily and lifetime coverage amounts[5].

Traditional plans and life insurance products most often include periodic payments for coverage, while annuity type products and some life insurance products include up front lump sum premium payments. The recent trend in long term care insurance is a hybrid type annuity product. Annuity type products have long term care insurance benefits, death benefit provisions, and a feature that the other products do not have, which is the return of the premium either immediately or after a short surrender period. With these type products, if the insured changes his or her mind, or has a significant change in their financial condition, they can simply request the return of their

[4] For a comparison of care costs, see the Genworth Cost of Care Survey for 2015, which can be found at www.genworth.com/corporate/about-genworth/industry-expertise/state-maps.

[5] Attached to this outline are a few generic quotes for long term care insurance from some of the industry leaders in long term care insurance. The quotes do not represent all of or necessarily the best companies that provide long term care coverage. The quotes are provided for illustration purposes only.

entire premium. These plans also have death benefits if the long term care insurance is not used. These features address the long time complaints of insureds that the costs are high and if the coverage is not used then the premium payments are lost. Attached are some generic quotes of

B. Coordination with Medicaid Benefits - State Partnership Program.

After the Deficit Reduction Act of 2005, South Carolina implemented a partnership program to encourage people to obtain long term care insurance[6]. For qualifying long term care insurance, the State with allow a person to exclude for Medicaid eligibility purposes assets equal to the amount of long term care insurance used for the applicant. The excluded assets would also not be subject to estate recovery.

C. Health Care Reform and Long-Term Care.

To say that there has been much ado about the Affordable Care Act (ACA)[7] would be an enormous understatement. Among the countless complaints about the Act, a glaring issue with the Act is that it does very little in the area of providing benefits for long term care coverage[8]. We are still faced with the need to find funds for the care needed by our aging population. A companion issue to the lack of funds is that skilled nursing facilities are reluctant to take patients in as Medicaid

---

[6] See Bulletin Number 2009-04 from the South Carolina Department of Insurance dated April 30, 2009, which outlines the background and purpose of this program. The Bulletin can be found at http://doi.sc.gov/documentcenter/home/view/2434.

[7] The official name for the Act is the Patient Protection and Affordable Care Act (PPACA). It is also referred to as Obamacare.

[8] There are some very small long term care related benefits that the Affordable Care Act addressed, such as closing the "donut hole" which created a large deductible for certain people on Medicare that had large drug costs, along with adding certain preventative care benefits. See generally Congresswoman Jan Schakowsky, "A Healthy Future for America's Seniors, The Benefits of Obamacare" (U.S. House of Representatives 2012).

patients. This means that the patient needs to meet the Medicare requirements to come in on Medicare initially or come in as a private pay patient with the goal of moving to Medicaid later. Also, a large number of facilities do not accept Medicaid, which adds the burden of the patient or their family having to first find a facility that accepts Medicaid and then figure out how and when the patient can become a patient of the facility as a Medicaid paying patient.

V. Conclusion.

Medicare provides limited benefits for long term care costs. There are multiple ways to appeal an adverse decision for Medicare coverage. Our country continues to need to address additional Medicare or Medicaid coverage to help families pay for the ever-increasing costs of long term care. Short of having enough money to self fund the costs of long term care, some type of a long term care insurance or annuity product is a very good option to pursue. Annuity type products with up front lump sum premiums appear to be the latest trend in coverage.