

2011

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Strauss, Peter J., "Happy 65th Birthday: What Now?" (2011). *Articles & Chapters*. 1264.
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Happy 65th Birthday: What Now?

By Peter J. Strauss

Individuals age 65 or older are eligible to apply for and receive Medicare benefits.¹ To understand how Medicare will affect you, you need to understand the various components of the Medicare program.

Medicare Part A is hospital insurance; it helps cover inpatient care in hospitals and skilled nursing facilities, hospice and home health care.

Medicare Part B is medical insurance. It helps cover doctors' services, hospital outpatient care and home health care, as well as some preventive services to help maintain health and keep certain illnesses from getting worse.

Medicare Advantage Plans are health plans run by Medicare-approved private insurance companies. Also known as "Medicare Part C," these plans are similar to health maintenance and preferred provider organizations (HMOs and PPOs). They include Part A, Part B coverage, and usually other coverage like Medicare prescription drug coverage (Part D), sometimes for an extra cost.

Medicare Part D is the prescription drug option run by Medicare-approved private insurance companies. It helps cover the cost of prescription drugs and may help lower prescription drug costs and help protect against higher costs in the future.

So what does the working senior do when he or she turns 65? Should he or she maintain private health insurance or switch to Medicare? The decision is not an easy one, particularly for persons who are enrolled in PPO plans because their doctors are not "in network." The decision is further complicated by many factors, including analysis and comparison of the following costs:

Employer Plan:

- Employee premium cost
- Policy annual deductible
- Insurance company reasonable charge
- Co-insurance
(Reimbursement is typically 80% of reasonable charge but to keep costs down some employer plans now only allow 70% or 60%)

Medicare:

- Part B (physicians) and D (prescription drug) premium cost
- Medicare Part A, B & D annual deductibles and the "gap" for Part D
- Medicare reasonable charge
- Co-insurance (Medicare reimbursement is 80% of reasonable charge)
- Medigap policy premiums



Basic Health Care

At the time of this writing, Congress is debating the 2012 U.S. budget, including a Republican proposal to drop the current “fee for service” system of Medicare and give beneficiaries a voucher to pay for private insurance. Based on history, the value of the proposed voucher is not likely to cover the actual premium cost, thus placing beneficiaries and providers in an untenable position. These proposals are unlikely to be enacted; but Medicare will change.¹

The 2010 Affordable Care Act (ACA)² has several provisions that will affect Medicare and the benefits available to Medicare beneficiaries. Among these are the following, which emphasize preventive care, innovation and cost controls.

For example, certain preventive services will be available without the annual Part B deductible or 20% co-insurance. The free “Welcome to Medicare” examinations will continue, and Medicare will soon offer all beneficiaries free annual wellness exams and personalized prevention plans.

Medicare Advantage plans that implement new programs in areas such as care management, patient education and self-management, medication management, patient safety, and health information and technology will be eligible for bonuses. Among new projects being developed are the Medicare Independence at Home demonstration project – the idea is to pay physicians and nurse practitioners to provide primary care in patients’ homes. The Center for Medicare and Medicaid Innovations at CMS is working on better care delivery models; one such model is the patient centered medical home, where the primary care providers, along with interdisciplinary care teams, are charged with coordinating and overseeing a broad range of services for chronically ill persons.

New physicians and nurses, particularly in the area of primary care, will be needed to meet the needs of the growing senior population. As incentives, providers will receive a 10% bonus for *primary care services* to Medicare beneficiaries during 2011–2015; primary care physicians will receive the same pay for Medicaid patients as they do for Medicare patients; medical schools that train more primary care physicians will be allowed to request additional residency slots; and residency programs will be allowed to count training in non-hospital settings towards training completion. Medicare funding for graduate nursing education was increased; rural physician and nurse practitioner training grants were enacted; and National Health Care Service Corps scholarship and loan repayment programs were established for students who commit to service in community health centers for two to four years.

The ACA includes per capita spending targets. If, starting in 2014, the spending exceeds certain targets, an Independent Payment Advisory Board will recommend ways to reduce Medicare spending. The Secretary of Health and Human Services is required to adopt the board’s recommendations unless Congress adopts alternative means to achieve the same savings, with the caveat that the recommendations cannot “ration” or modify benefits, eligibility, premiums or taxes.

Seniors will be – and have already been – affected by financial provisions. Medicare Part B premiums increased for many beneficiaries over the past several years and will probably continue to do so. Medicare Part B premiums are already significant for beneficiaries with higher incomes.

- In 2013, the Medicare payroll tax for workers will increase for individuals earning more than \$200,000 or married couples earning more than \$250,000 from 1.45% to 2.35% (a 62% increase).
- In 2013, “high income” taxpayers will pay a tax on unearned income, such as interest income, dividends, annuities, royalties, rent and capital gains.³
- In addition, the current medical expense deduction “floor,” now 7.5%, will increase to 10% starting in 2013, but this increase is postponed for taxpayers 65 or older until 2017.

Medicare beneficiaries also should be aware that premiums for Medicare Supplemental Insurance policies are increasing. Since Medicare has deductibles and co-insurance, a “Medigap” policy is necessary. A meaningful plan (one that covers more than the basic Medicare deductibles) can cost \$250 a month or more. Seniors should consider a policy that will pay more than the Medicare reasonable charge when the beneficiary’s physician does not “accept assignment.”⁴ Keep in mind that under federal Medicare law a physician may not bill more than 115% of the Medicare reasonable charge and New York law limits the allowable “excess” charge to 105% of the reasonable charge.⁵

While changes in Medicare are inevitable – the Medicare Trust Fund is reported to be in danger of running out of funds by 2024 – the basic Medicare structure is not likely to change. According to an August 2010 assessment by the trustees of the Medicare Trust Fund, the ACA will result in cost savings which, together with the new funding mechanisms contained in the act, will stabilize the system.⁶

1. *The New York Times* reported on May 6, 2011 that “House Republicans signaled Thursday that they were backing away from the centerpiece of their budget plan – a proposal to overhaul Medicare – in a decision that underscored both the difficulties and political perils of addressing the nation’s long-term fiscal problems.”

2. Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (2010 Health Reform), 42 U.S.C. §§ 300gg et seq. Public Laws 111-148 and 111-152, 111th Congress.

3. For a discussion of the new tax, see CRS Report R41413, *The 3.8% Medicare Contribution Tax on Unearned Income, Including Real Estate Transactions*, by Mark Keightley, 111th Cong., Oct. 7, 2010.

4. By accepting assignment the physician agrees to accept the reasonable determined by Medicare charge for his or her services.

5. N.Y. Public Health Law § 19(1)(a); *Med. Soc’y of the State of N.Y. v. Dep’t of Health*, 83 N.Y.2d 447 (1994).

6. CMS fact sheet on the Medicare Trustees Report can be found at <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3823>. Also see HHS and CMS report found at <http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf>. These reports indicated that the Medicare Trust Fund would be exhausted in 2029, but in a report issued on May 13, 2011, the trustees reported that because of the weak economy and lower payroll tax revenues the Trust Fund would run out in 2024.

Another important factor in the “Medicare or not” decision is whether the senior’s physicians participate in the Medicare program. If they choose not to participate – which is their right – no payments to the physician by the patient may be submitted to Medicare for reimbursement, and the fees will not be covered by a Medicare Supplement policy. The patient must absorb the entire cost. And seniors also need to look at the “reasonable charge” problem. Medicare and health insurance plans reimburse a participant for a percentage of the reasonable charge for a physician’s services as determined by Medicare or the insurance company, as the case may be.

More and more physicians are electing to drop out of the Medicare program. The primary reason is because physicians feel the Medicare reasonable charges are prohibitively low and then they are subject to the “limiting charge” rules. Under federal Medicare law, a physician may not bill more than 115% of the Medicare reasonable charge; New York law limits the allowable “excess” charge to 105% of the reasonable charge.² The same problem exists with respect to the reasonable charges used by insurance companies in paying employee claims for reimbursement when the employee goes “out of network” under a PPO plan.

Most health insurance companies determined their reasonable charges by purchasing data from Ingenix, a subsidiary of United Health Group. In 2009, then Attorney General Andrew Cuomo took action against United Health Group, alleging that the data used to reimburse insureds who went “out of network” was flawed and increased insurance company profits at the expense of patients and physicians. United Health Group agreed to settle the charges and paid \$50 million to fund creation of a not-for-profit organization which would develop new “reasonable charge” data for insurance companies operating in New York. Many other carriers signed on to the new approach and agreed to make contributions, which have reached a total of \$100 million. This entity, FAIR Health, has developed new data which is intended to be free of conflicts of interest – that is, neutral and fair.³

Here’s another option for retirees. Employees over the age of 65 who decide to retire may choose to remain on the law firm’s health insurance plan under COBRA. If the lawyer’s firm has more than 20 employees, federal law allows the retiree to elect COBRA coverage for 18 months.⁴ The COBRA election is lost if the employee is “entitled” to Medicare. “Entitlement” means enrollment in Medicare, not just that the employee is “eligible” for Medicare by being over 65. Further, if the Medicare enrollment was prior to a COBRA election, COBRA benefits may not be discontinued.⁵

There are also New York State COBRA protections for employees of firms that employ fewer than 20 persons.⁶ The New York “Mini COBRA” law extends the federal rights to employees of these firms; in 2009 the New York

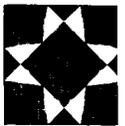
law extended the COBRA period to 36 months, not just for employees of firms employing fewer than 20 persons but also for employees of larger firms who have used up their 18 months under federal law.

The budget debates in Washington and the focus on what to do about Social Security and Medicare will affect all current seniors and the baby boomers who will soon be “seniors.” How issues about benefits (including benefits at the end of life), payments to physicians and hospitals, the future of the prescription drug program (Part D) and beneficiary costs are resolved will affect all of us. Whether these decisions will be for better or worse only time will tell. ■

1. Persons under 65 who suffer from end stage renal disease or who have received Social Security disability benefits for 24 months are also eligible for Medicare benefits. It should be further noted that persons are automatically enrolled in Medicare Part A when they apply for Social Security benefits.
2. N.Y. Public Health Law § 19(1)(a); *Med. Soc’y of the State of N.Y. v. Dep’t of Health*, 83 N.Y.2d 447 (1994).
3. FAIR Health promises that consumers will be able to check the new reasonable charges for medical procedures by August, 2011, on its website, FH Consumer Cost Lookup www.fairhealthconsumer.org.
4. In some limited cases the period can be longer.
5. FAQs For Employees, U.S. Department of Labor, http://www.dol.gov/ebsa/pdf/faq_consumer_cobra.pdf. See also Treas. Reg. § 54.49808-7, Q/A-3(b). This protects a person’s eligibility when the person is automatically enrolled in Medicare Part A at the time he or she applies for Social Security benefits at age 65.
6. N.Y. Insurance Law § 3221(m).



"I've told you before, Warner. You're not allowed to spend the entire day complaining until you make partner."



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8. When traveling, use the Florida address as the residence when registering at hotels, motels, etc.
9. Change the homeowner's insurance policy to show the Florida residence as the client's principal address.
10. Most or all of the client's bank accounts and safe deposit box(es) should be relocated to Florida.
11. All bills should be sent to the Florida address.
12. To the extent possible, resign from local clubs and organizations or obtain non-resident membership, and join Florida clubs and organizations.
13. To the extent possible, transact business from Florida.
14. Execute a last will and testament declaring Florida as the client's residence.
15. Spend as much time as possible in Florida.

There are many considerations when advising the Florida snowbird client regarding estate and long-term care planning. The items discussed here are only a handful of the issues that can arise in this situation. The best course of action for New York practitioners with Florida snowbird clients would be to consult with or co-counsel with a Florida elder law attorney to address these issues on their clients' behalf. □

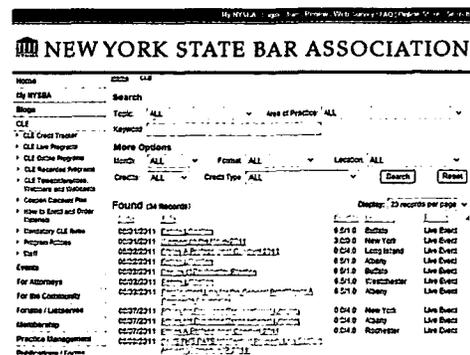
1. Fla. Stat. § 733.302.
2. Fla. Stat. § 733.304.
3. Fla. Stat. § 733.305.
4. Fla. Stat. § 732.2065.
5. Exempt property includes, among other things, household furniture, furnishings, and appliances in the decedent's usual place of abode up to a net value of \$10,000 as of the date of death and all automobiles held in the decedent's name and regularly used by the decedent or members of the decedent's immediate family as their personal automobiles. Fla. Stat. § 732.402.
6. Fla. Stat. § 732.2025(8)(a).

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