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Second Quarter 2010 Newsletter

Welcome to the second quarter issue of **Social Security and Medicare News** for 2010. The featured article answers the question: *“How does the health care reform legislation impact Medicare?”* Included is a second article on whether a day makes a difference for Social Security and Medicare benefits.

Please email us at social.security@mercer.com with your suggestions and feedback on the newsletter.

Featured article

Health Care Reform: Selected Impacts on Medicare



The health care reform law enacted in March 2010 has broad, long-term implications for nearly all entities delivering and individuals receiving health care in the US. A vast array of changes are coming – notably, insurance companies will be subject to new federal standards for the medical policies they sell – including required benefits and premium limits; and health care “exchanges” will be created so individuals and some employers can readily compare health plans they could purchase – in terms of price, benefits, and the quality of care delivered. The Medicare program will also see many changes in the coming months and years. Read more on each of the selected changes below at the end of this newsletter.

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Does a day make a difference?

Does a day make a difference for Social Security and Medicare benefits?

Yes, there are many instances when one day can affect the date of entitlement to Social Security benefits or the calculation of the benefit amount.

For Social Security (and Medicare) purposes, you “reach an age” on the day before your birthday. The rule is:

- Birthday is the first of the month; age 62 is attained on the last day of the preceding month. The month of the birthday is the first full month you are 62.
- Birthday is the second of the month; age 62 is attained on the first, and you are 62 for the full month.



- Birthday is after the second; the following month is the first full month you are 62.

This rule also affects when a person reaches full retirement age (FRA) and is important when someone wants to claim retirement benefits with no early retirement reduction.

The effect of this rule is even more dramatic for a person born on January 1. They reach their age on the last day of the preceding year. For example, a person born on January 1, 1948, attained age 62 on December 31, 2009. This means that the 2009 wage indexing and Primary Insurance Amount formulas apply rather than the 2010 formulas.

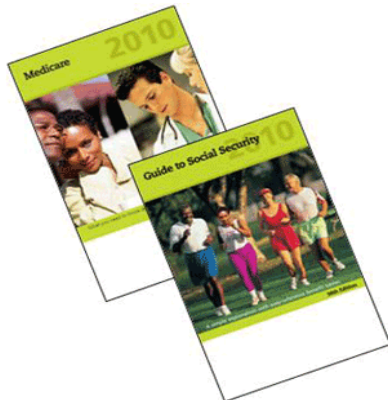
The day of the month of your birthday can also affect the day of the month benefits are paid. Benefits are paid the month after the month for which the benefit is due. For example, you receive the benefit for January in February. Most new beneficiaries are paid on either the second, third, or fourth Wednesday of each month based on the birthday of the insured worker – see the chart below.

If the insured worker's birthday is:	Then payment will be on the:
On the 1st through the 10th of the month	Second Wednesday of the month
On the 11th through the 20th of the month	Third Wednesday of the month
After the 20th of the month	Fourth Wednesday of the month

At the other end of the benefit range, the situation is similar. Medicare coverage extends until the moment of death. However, monthly Social Security benefits for any month are paid only if the person lives for the entire month. Partially offsetting this, however, is that any survivor benefits are payable in full for the month of death of the insured person, even if death occurs on the last day of the month.

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Did you know?

Beginning with people born in 1938, the full retirement age (FRA) gradually increases from age 65, eventually reaching age 67 for people born in 1960 and later. Even though the FRA is rising for Social Security, the Medicare eligibility age of 65 is not scheduled to increase.



Featured article *(continued)*

Health Care Reform: Selected Impacts on Medicare (Details of selected changes)

Elimination of the Medicare prescription drug coverage gap

The Medicare Part D prescription drug coverage gap (also called the “donut hole”) will gradually phase out and be eliminated by 2020. For 2010 only, a \$250 rebate payment will begin in mid-year to Part D enrollees reaching the coverage gap during the preceding calendar quarter.

Then in 2011, pharmaceutical manufacturers whose drugs are covered by Part D must give progressively larger discounts on brand-name drugs for beneficiaries in the coverage gap. By 2020, beneficiaries in the coverage gap will pay only 25 percent of prescription drug costs – the same percentage they pay now before hitting the gap. A similar provision will reduce the cost of generic drugs purchased during the coverage gap starting in 2011; by 2020, beneficiaries will pay 25 percent of the cost of these generic drugs.

Higher Part D premiums for high-income individuals

Starting January 2011, high-income Medicare beneficiaries will pay a premium surcharge for Part D prescription drug coverage (modeled on the high-income Part B premium surcharge). Individuals with annual incomes exceeding \$85,000 (\$170,000 if married, filing jointly) will pay higher premiums. The high-income amounts will stay the same until 2020; after that it will be indexed for inflation.

Like the Part B surcharge, the higher Part D premium will be based on the beneficiary’s income level for the tax year two years before the premium year. That means a beneficiary’s 2009 tax year income amount will be used to calculate the Part D premium for 2011. The 2011 premium-related income brackets will be announced in the fall of 2010. The Part D premiums will be withheld from the Medicare beneficiary’s Social Security or Railroad Retirement income payments.

Improved preventive benefits

Currently, Medicare beneficiaries are entitled to one initial preventive exam when they first become covered by Part B, but no other routine physicals are covered. Starting in 2011, Part B will cover an annual “personalized prevention plan” which includes a comprehensive health risk assessment. The plan will recommend preventive services and screenings based on the information gathered. In addition, most preventive services will be provided without any beneficiary cost-sharing.

Changes to Medicare Advantage plan payments

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries enrolled in their plan. This is an alternative to the more traditional fee-for-service payments made under Original Medicare. Payments to MA plans are determined by comparing plan bids to a benchmark. Under the health reform law, government payments to MA plans for 2011 will be frozen at 2010 levels, and a different benchmark calculation will be phased-in starting in 2012. Beginning in 2014, Medicare will take steps to ensure that at least 85% of the MA plan’s premiums are

spent on health care costs and no more than 15% on administrative and other expenses. Beneficiaries enrolled in MA plans may see changes in costs, covered benefits, and the number of vendors due to these changes.

New standards for certain Medigap plans

Medicare beneficiaries can purchase insurance policies that help pay for some or all Medicare cost-sharing obligations. The Department of Health and Human Services will work with the National Association of Insurance Commissioners to develop new standards for Plans C and F. The key changes will provide nominal cost-sharing for Part B expenses to encourage appropriate use of physicians' services. The new plan designs should be available in 2015.

Changes to Medicare annual enrollment period

Currently, Medicare beneficiaries may enroll or change their enrollment during the annual election period from Nov. 15 through Dec. 31. Coverage is effective on Jan. 1 of the following year. During the first three months of the calendar year, beneficiaries in a Medicare Advantage (MA) plan may drop that plan and go back into Original Medicare. Starting in 2011, the annual coordinated election period moves to Oct. 15 through Dec. 7 with coverage effective on Jan. 1 of the following year. The current three month disenrollment period is shortened to 45 days (from Jan. 1 through Feb. 15) and beneficiaries dropping an MA plan during that time can return to Original Medicare and elect a Part D plan.

Special enrollment period for disabled TRICARE beneficiaries

A new provision creates a 12-month Part B special enrollment period (SEP) for military retirees, their spouses (including widows/widowers) and dependent children. If eligible, they will be notified by the Secretary of Defense. These individuals are eligible for TRICARE and entitled to Medicare Part A based on disability or end-stage renal disease, but have previously declined Part B. This 12-month SEP will be available to individuals once in their lifetime and begins the day after the last day of the initial enrollment period (IEP), or if later, the month after they are notified of the SEP. Individuals will also have the option of choosing Part B coverage retroactive to the first month after their IEP. The Part B late enrollment penalty will not apply to individuals who enroll during the SEP. The SEP is available for any Medicare IEP that ends after March 23, 2010.

Changes for low-income beneficiaries

Certain low-income beneficiaries (including those eligible for Medicaid) receive premium assistance and reduced cost sharing for Part D. Individuals without cost sharing for drugs is expanded to include beneficiaries receiving care under a home and community based waiver who would otherwise require institutional care.

Federal agencies determine beneficiaries' low-income status and revisit that determination each year. However, health reform provides a special rule for surviving spouses who were part of a low-income household. To prevent a change in low-income status during the calendar year of the spouse's death, starting in 2011, the surviving spouse will not have to undergo a re-determination until one year after the normal re-determination date following the spouse's death.

Health reform also provides additional funding of state-based agency outreach efforts for Medicare's low-income assistance programs.

Payment changes to fee-for-service providers and suppliers

Medicare generally re-evaluates and re-sets its payment rates at the start of each year. The rates are often linked to inflation or market indexes. The rate setting can affect hospitals, skilled nursing facilities, home health agencies, physicians, and other providers. The health reform law changes some payment calculations for fee-for-service providers and suppliers, providing incentives and penalties to encourage quality and best practices. The changes include:

- Limiting payment increases to acute care hospitals, restructuring payments to address treatment inefficiencies, and reshaping subsidies to certain hospitals with a high share of low-income patients.
- Subjecting skilled nursing and dialysis facilities to a productivity adjustment starting in 2012.
- Reducing the home health index for annual pricing updates by one percentage point in 2011 through 2014; and subjecting them to a productivity adjustment starting in 2015.
- Extending and expanding the Physician Quality and Reporting program and similar initiatives for professionals, encouraging accountable care and value-based payments in the physician fee schedule.

Revised payment methods for power-driven wheelchairs

Medicare currently pays for new or replacement power-driven wheelchairs either through monthly rental payments during the beneficiary's period of medical need (not to exceed 13 continuous months), or on a lump-sum basis. Starting January 1, 2011, the health reform law will restrict the lump-sum payment option for new or replacement chairs to only the complex, rehabilitative power wheelchairs – all other wheelchairs will be eliminated (except in certain supplier-bid cases). The rental payment will become 15% (instead of 10%) of the purchase price of the chair for each of the first 3 months, and 6% (instead of 7.5%) of the purchase price for each of the remaining 10 months.

Medicare eligibility based on exposure to environmental hazards

A new provision allows for Medicare coverage and medical screening services to certain individuals exposed to environmental health hazards. A person with one or more specified lung diseases or types of cancer who was present for 6 months in an area subject to a public health emergency (declared by the Environmental Protection Agency) as of June 17, 2009, is entitled to benefits under Part A and eligible to enroll in Part B. The 6 months need not be consecutive, but must have occurred during a certain period before the individual is diagnosed with a covered disease or illness. The Secretary of Health and Human Services can specify additional diseases that will qualify under this provision.

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