

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



The ICD-10-related implementation date is now October 1, 2015. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice. Keep Up to Date on ICD-10. Please visit the [ICD-10](#) website for the latest news and resources to help you prepare.

MLN Matters® Number: MM8052

Related Change Request (CR) #: CR 8052

Related CR Release Date: December 7, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R81GI

Implementation Date: January 7, 2013

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and A/B Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8052 which informs Medicare contractors about the changes needed to update the claims processing system with the new Calendar Year (CY) 2013 Medicare rates. Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

The following deductible and coinsurance rates apply for 2013.

- **2013 PART A - HOSPITAL INSURANCE (HI)**
 - Deductible - \$1,184.00
 - Coinsurance:
 - \$296.00 a day for 61st-90th day
 - \$592.00 a day for 91st-150th day (lifetime reserve days)
 - \$148.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)

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- Base Premium (BP) - \$441.00 per month
- BP with 10% surcharge - \$485.10 a month
- BP with 45% reduction - \$243.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45% reduction and 10% surcharge - \$267.30 a month
- **2013 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)**
 - Standard Premium - \$104.90 a month
 - Deductible - \$147.00 a year
 - Coinsurance - 20 percent

Additional Information

The official instruction, CR8052 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R81GI.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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