CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 82	**Date: November 15, 2013**
	Change Request 8527

SUBJECT: Update to Medicare Deductible, Coinsurance and Premium Rates for 2014

I. SUMMARY OF CHANGES: This recurring CR provides instruction for Medicare Contractors to update the claims processing system with the new CY 2014 Medicare rates.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/10/10.3/Basis for Determining the Part A Coinsurance Amounts
R	3/20/20.2/Part B Annual Deductible
R	3/20/20.6/Part B Premium

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Recurring Update Notification

Pub. 100-01	Transmittal: 82	Date: November 15, 2013	Change Request: 8527

SUBJECT: Update to Medicare Deductible, Coinsurance and Premium Rates for 2014

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. 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.

B. Policy:

2014 PART A - HOSPITAL INSURANCE (HI)

Deductible

- $1,216.00

Coinsurance

- $304.00 a day for 61st-90th day
- $608.00 a day for 91st-150th day (lifetime reserve days)
- $152.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)

Base Premium (BP)

- $426.00 a month

BP with 10% surcharge

- $468.60 a month

BP with 45% reduction

- $234.00 a month (for those who have 30-39 quarters of coverage)

BP with 45% reduction and 10% surcharge

- $257.40 a month

2014 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

Standard Premium

- $104.90 a month

Deductible

- $147.00 a year

Pro Rata Data Amount

- $114.99 1st month
- $32.01 2nd month

Coinsurance

- 20 percent

See Attachment A: "Income Parameters for Determining Part B Premium"

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8527.1	Contractors shall update the 2014 Medicare Part A inpatient deductible rate to $1,216 per benefit period.	X							X			X	
8527.1.1	The CMS shall update the hospital inpatient limit to $1,216 in the Outpatient Prospective Payment System (OPPS) Pricer. (This is used as a threshold	X							X				OPPS Pricer

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	amount for which the national coinsurance may not exceed).												
8527.2	Contractors shall update the 2014 Medicare Part A coinsurance rate to $304.00 a day for days 61-90 in each period.	X							X			X	
8527.3	Contractors shall update the 2014 Medicare Part A coinsurance rate to $608.00 a day for days 91-150 for each “Lifetime Reserve” day used.	X							X			X	
8527.4	Contractors shall update the 2014 Medicare Part A coinsurance to $152.00 per day in a Skilled Nursing Facility for days 21-100 in each benefit period.	X							X			X	
8527.5	Contractors shall update the 2014 Medicare Part B deductible to $147.00 per year.	X	X		X				X	X		X	
8527.6	The CWF shall make changes to incorporate the new 2014 Pro-Rata Data amounts of $114.99 for the 1st month and $32.01 for the 2nd month.											X	
8527.7	Contractors shall update their Interactive Voice Response scripts with information provided in the above requirements (as applicable).	X	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8527.8	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.	X	X		X				

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.								

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Shauntari Cheely, Shauntari.Cheely@cms.hhs.gov , Sarah Shirey-Losso, Sarah.Shirey-Losso@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
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be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

Medicare General Information, Eligibility, and Entitlement

Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations

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10.3 - Basis for Determining the Part A Coinsurance Amounts

(Rev.82, Issued: 11-15-13, Effective: 01-01-14, Implementation 01-06-14)

The applicable inpatient deductible is the one in effect during the calendar year in which the patient's benefit period begins (i.e., in most cases, the year in which the first inpatient hospital services are furnished in the benefit period). Except for 1989, the coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur.

When Deductible and/or Coinsurance Are Applicable for Part A

Inpatient Hospital- First 60 Days	Deductible applicable equal to national average cost per day
Inpatient Hospital- 61st thru 90th Day	Coinsurance per day always equal to 1/4 of inpatient hospital deductible
Inpatient Hospital- 60 Lifetime Reserve Days (nonrenewable) - 91st thru 150th day	Coinsurance always equal to 1/2 of inpatient hospital deductible
Skilled Nursing Facility 21st thru 100th Day	Coinsurance always equal to 1/8 of inpatient hospital deductible
Home Health Agency	No Deductible No Coinsurance (except for 20 percent coinsurance for DME and prosthetics/ orthotics)
Blood	1st 3 pints (or equivalent units of packed red blood cells) in a calendar year - combined Part A and B
Hospice * a. Drugs and Biologicals b. Respite Care	a. 5 percent of the cost determined by the drug copayment schedule (may not exceed $5 per prescription) b. 5 percent of the payment for a respite care day

*Hospices may charge coinsurance for two services only, drugs and biologicals, and respite care. The amount of coinsurance for each prescription may not exceed $5.00. The amount for respite care may not exceed the inpatient deductible for the year in which the hospital coinsurance period began.

Deductible and Coinsurance Amounts

Year	Inpatient Hospital Deductible, 1st 60 Days	Inpatient Hospital Coinsurance, 61st-90th Days	60 Lifetime Reserve Days Coinsurance	SNF Coinsurance
1986	$492	123	246	61.50
1987	520	130	260	65.00
1988	540	135	270	67.50
1989	560	0 (1)	0 (1)	0(2)

1990	592	148	296	74.00
1991	628	157	314	78.50
1992	652	163	326	81.50
1993	676	169	338	84.50
1994	696	174	348	87.00
1995	716	179	358	89.50
1996	736	184	368	92.00
1997	760	190	380	92.00
1998	764	191	382	95.50
1999	768	192	384	96.00
2000	776	194	388	97.00
2001	792	198	396	99.00
2002	812	203	406	101.50
2003	840	210	420	105.00
2004	876	219	438	109.50
2005	912	228	456	114.00
2006	952	238	476	119.00
2007	992	248	496	124.00
2008	1,024	256	512	128.00
2009	1,068	267	534	133.50
2010	1,100	275	550	137.50
2011	1,132	283	566	141.50
2012	1,156	289	578	144.50
2013	1,184	296	592	148.00
2014	*1,216*	*304*	*608*	*152.00*

1. Coinsurance was not charged for inpatient hospital care in CY 1989 due to Catastrophic Coverage. The deductible was applied.

2. Under Catastrophic Coverage, a coinsurance payment of $25.50 was due for days 1-8 of SNF care. No SNF coinsurance was due after day 8 in 1989.

20.2 - Part B Annual Deductible

(Rev.82, Issued: 11-15-13, Effective: 01-01-14, Implementation 01-06-14)

In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

Calendar Year	Deductible
1966 – 1972	$50
1973 – 1981	$60
1982 – 1990	$75
1991 – 2004	$100
2005	$110
2006	$124
2007	$131
2008	$135
2009	$135
2010	$155
2011	$162
2012	$140
2013	$147

2014	*$147*

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. Non-covered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services not subject to the deductible cannot be used to satisfy the deductible.

Pro Rata Amounts

Pro Rata Amounts		
	First Month	Second Month
2012	$100.20	$39.80
2013	$103.95	$43.05
2014	*$114.99*	*$32.01*

The Part B deductible is split into pro rata amounts. The purpose of the pro rata amount is to provide beneficiaries who are enrolled in managed care plans the benefit of assuming they have paid their deductible as if they were not enrolled in a managed care plan. The pro rata amount does not apply only to just the first two months of the year but rather for the number of months after first enrollment in a managed care plan that is necessary to cover the Part B deductible. Each year starts the deduction for the pro rata amount over again.

20.6 – Part B Premium

(Rev.82, Issued: 11-15-13, Effective: 01-01-14, Implementation 01-06-14)

The Centers for Medicare and Medicaid Services (CMS) updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium
1996	$42.50
1997	$43.80
1998	$43.80
1999	$45.50
2000	$45.50
2001	$50.00
2002	$54.00
2003	$58.70
2004	$66.60
2005	$78.20
2006	$88.50

Beginning on January 1, 2007, the Part B premium is based on the income of the beneficiary. See the following Change Requests (CRs) for more information.

For 2008, see CR 5345 at http://www.cms.hhs.gov/transmittals/downloads/R41GI.pdf
For 2008, see CR 5830 at http://www.cms.hhs.gov/transmittals/downloads/R49GI.pdf
For 2009, see CR 6258 at http://www.cms.hhs.gov/transmittals/downloads/R56GI.pdf
For 2010, see CR 6690 found on the "2009 Transmittals" page at
http://www.cms.hhs.gov/Transmittals/2009Trans/list.asp
For 2011, see CR 7224 found on the "2010 Transmittals" page at
http://www.cms.gov/Transmittals/2010Trans/list.asp
For 2012, see CR 7567 found on the "2011 Transmittals" page at
http://www.cms.gov/Transmittals/2011Trans/list.asp
For 2013, see CR 8052 found on the "2012 Transmittals" page at
http://www.cms.gov/Transmittals/2012Trans/list.asp
For 2014, see CR 8527 found on the "2013 Transmittals" page at
http://www.cms.gov/Transmittals/2013Trans/list.asp

Attachment A: Income Parameters for Determining Part B Premium

	Income Parameters for Determining Part B Premium		
Premium/ month	**Individual Income**	**Joint Income (Married)**	**Married filing Separate**
$104.90	$85,000 or less	$170,000.00 or less	$85,000.00 or less
$146.90	$85,000.01 - $107,000.00	$170,000.01 - $214,000.00	
$209.80	$107,000.01 - $160,000.00	$214,000.01 - $320,000.00	
$272.70	$160,000.01 - $214,000.00	$320,000.01 - $428,000.00	$85,000.01 - $129,000.00
$335.70	$214,000.01 or more	$428,000.01 or more	$129,000.01 or more

Individual Income = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)
Joint Income (Married) = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also file a joint tax return.
Married filing Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse