MEDICARE: WHAT YOU NEED TO KNOW

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Introduction

Understanding Medicare is necessary when advising elderly clients. All elderly clients have health concerns and the associated cost of these health concerns necessitates the understanding of Medicare benefits. The Medicare program has changed dramatically since its inception, and will probably will continue to evolve as our nation ages and health care costs rise.

Medi**care**, as opposed to Medi**caid**, is a health insurance program for people age 65 and older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease. Medicare is not a needs-based health insurance program. The very poor, as well as the very wealthy, all have the same Medicare benefits. In the future, wealthier Medicare beneficiaries will pay higher premiums than less-affluent Medicare beneficiaries.

Medicare has an excellent website, www.medicare.gov, that has an overview of the entire Medicare program, including rating nursing homes and lists all co-pays and deductibles.

Medicare has four areas that will be reviewed during this presentation: Part A, Part B, Part D and Medigap policies.

A. Medicare Part A Coverage

Medicare Part A helps pay inpatient care in hospitals, including critical access hospitals, a limited benefit for skilled nursing care, hospice and some home health care. Most beneficiaries pay no monthly premium for Part A; regular wage earners have effectively paid for Part A through payroll withholding taxes, currently 2.9% of gross wages, subject to annual limits. For those individuals that did not participate in the payroll withholding taxes for Medicare, or who were disabled (and thus received Part A), but have now returned to work, Part A can be purchased for $393 per month.

1. **Hospital Stays.** Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care provided in critical care access hospitals and mental health care. This doesn't include private duty nursing, or a television or a telephone in the room. It also does not include a private room, unless the private room is medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

2. **Skilled Nursing Care Facility.** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies. This benefit is only related to a three-day inpatient hospitalization, and does not include custodial nursing home care.

3. Home Health Care. Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language pathology that are ordered by a doctor and provided by a Medicare-certified home health agency. This benefit also includes medical social services, durable medical equipment, such as wheelchairs, hospital beds, oxygen, walkers, medical supplies, and other services.

4. Hospice Care. For individuals with a terminal illness, including drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare, such as grief counseling. Hospice care is usually provided in the home, which may include a nursing facility if the nursing facility is the home.

B. Medicare Part B Coverage

Medicare Part B covers doctors' services and outpatient care, as well as other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some health care. Part B pays for part of these covered services and supplies when they are medically necessary. The Part B premium for 2006 is $88.20 per month for most beneficiaries, but in some cases the premium is higher if the individual did not make a timely election for Part B.

1. Medically Necessary Medical and Other Services. These include doctors' services, but excluding routine exams other than a one-time "Welcome to Medicare"

physical available within six months of enrollment, outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment, such as wheelchairs, hospital beds, oxygen, and walkers. It also covers a second, and sometimes a third, surgical opinion for surgery that isn't an emergency, outpatient mental health care, and outpatient occupational and physical therapy, including speech-language pathology.

2. Clinical Laboratory Services. This includes blood tests, urinalysis, some screening tests and other similar lab services.

3. Home Health Care. Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language pathology that are ordered by your doctor and provided by a Medicare-certified home health agency. Also includes medical social services, durable medical equipment.

4. Outpatient Hospital Services. Hospital services and supplies received as an outpatient as part of a doctor's care.

5. Blood. Pints of blood provided as an outpatient or as part of a Part B-covered service.

6. Preventative Services. Bone mass measurements, cardiovascular screenings, colorectal cancer screening, diabetes screening, flu shots, glaucoma tests, hepatitis B shots,

pap tests and pelvic exam, including clinical breast exam, pneumococcal shot, prostate cancer screening and screening mammograms.

Exclusions for Medicare Parts A and B

Medicare does not cover all medical services and specifically excludes the following: acupuncture, dental care and dentures, cosmetic surgery, custodial nursing home care, eye refractions, health care while traveling outside the United States, hearing aids and hearing exams for the purpose of fitting a hearing aid, hearing tests not ordered by a doctor, orthopedic shoes, prescription drugs, routine foot care, routine eye care and most eyeglasses, routine or yearly physical exams, screening tests and screening laboratory tests, vaccinations and some diabetic supplies.

Co-Payments and Deductibles (2006)

- $124.00 Medicare Part B deductible
- $952.00 for a hospital stay of 1-60 days for each benefit period
- $238 per day for days 61-90 of a hospital stay for each benefit period
- $476 per day for days 91-150 of a hospital stay for each benefit period
- All costs for each day of a hospital stay over 150 days
- $0 for the first 20 days of a skilled nursing facility stay for each benefit period
- $119 per day for days 21-100 of a skill skilled nursing facility stay for each benefit period

- All costs for each day of a skilled nursing facility stay after day 100 in the benefit period
- 20% of the Medicare-approved amount for most doctor services, outpatient therapy, preventative services and durable medical equipment
- $0 for Medicare-approved home health services
- $0 for Medicare-approved clinical laboratory services
- 50% for most outpatient mental health services
- All costs for the first three pints of blood as part of an inpatient hospital stay

C. Medicare Part D

As part of massive changes to the Medicare program under a 2003 law, Medicare now offers prescription drug coverage under a new Part D. The new plan became available on January 1, 2006, with an enrollment deadline for current Medicare beneficiaries of May 15, 2006. Unlike other Medicare Parts A and B, Part D is more optional and has more flexible coverage options. Part D participants choose the drug plan and pay a monthly premium. Like other Medicare Parts, if participants choose not to enroll when first eligible, a penalty may be incurred.

Two types of Medicare plans provide prescription drug coverage. Prescription drug coverage is offered through Medicare Advantage Plans and other Medicare Health Plans. All Medicare health care is offered through these plans. The other prescription drug coverage is added to the Original Medicare Plan, and some Medicare Cost Plans and

Medicare Fee-For-Service Plans. These plans are offered through insurance companies and other private companies approved by Medicare. Both of these types of plans are referred to as "drug plans."

A basic optional drug plan has an additional monthly premium, co-payments and deductibles. The minimum coverage plans must provide requires a monthly premium that averages $32 and has a $250 deductible. After the $250 deductible is paid, the participant pays 25% of the yearly drug costs from $250 to $2,250, and the plan pays the remaining 75% of the costs. Annual costs from $2,250 to $5,100 are paid 100% by the participant. The participant pays 5% of the drug costs for the rest of the calendar year afer the participant has paid $3,600 out of pocket. Drug plans can offer more coverage and charge additional premiums. In Virginia, the monthly premiums can vary from as little as $19 for higher deductible plans to as much as $92 with no deductibles. Many plans have formularies. Formularies are approved brand drugs for certain ailments. For example, one plan may cover Lipitor for cholesterol, while another plan may only allow Mevacor, a generic cholesterol drug with lower efficacy.

1. Assistance for Low Income Participants. Some participants qualify for a combination of reduced monthly premiums, deductibles and co-pays based on income and resources.

a. For participants with less than $12,920 annual income ($17,321 for married couples living together) and less than $7,500 in resources ($12,000 for a

married couple living together), the monthly premium may be $0, the yearly deductible is $0 and prescription drugs will be between $2 and $5 each.

b. For participants with less than $12,920 annual income ($17,321 for married couples living together) and more than $7,500 but less than $11,500 in resources (more than $12,000 but less than $23,000 for a married couple living together), the monthly premium may be $0, the yearly deductible is $50 and prescription drugs will cost 15% of the posted rate.

c. For participants at or above $12,920 but less than $14,355 annual income (at or above $17,321 but below $19,245 for married couples living together) and resources are not more than $11,500 ($23,000 for a married couple living together), the monthly is discounted, the yearly deductible is $50 and prescription drugs will cost 15% of the posted rate.

d. For institutionalized Medicaid beneficiaries, no premiums, no deductibles and no co-pays apply.

e. For other Medicaid beneficiaries, no premiums and no deductibles apply, but each prescription has as co-pay of between $1 and $5.

2. Penalties for Late Enrollment. While enrollment is Medicare Part D is optional, if Medicare participants do not enroll when first eligible, they may be penalized upon later enrollment. The penalty is 1% per month. For example, if a Medicare participant waits a full year after initially eligible to purchase Medicare Part D, the

participant my incur a 12% premium increase. The late enrollment penalty can be avoided if the participant is currently enrolled in a drug plan that is at least as good as the Medicare Part D plan. All providers of prescription drug plans for retirees are required to notify plan participants if their drug plan is at least as good as Medicare Part D. Moreover, the government has provided financial incentives for employers to maintain prescription drug coverage for retirees in an effort to avoid private industry shifting retiree health benefits to Medicare.

D. Medigap

Original Medicare plans do not cover all medical expenses. They have coinsurance, copayments and deductibles. These out-of-pocket costs are call "gaps" in Medicare coverage. A Medigap policy covers these gaps in Medicare coverage. Some Medigap policies also cover medical expenses excluded by Medicare, such as emergency health care while traveling outside the U.S. In addition to the original Medicare plans, some areas have Medicare Advantage Plans are often referred to as Medicare Part C. These Medicare Advantage Plans often have lower copays and deductibles and have networks and prescription drug coverage. Individuals enrolled in Medicare Advantage do not need a Medigap policy. Like Medicare Part D, the Medigap policies are issued by private insurers that charge variable premiums.

1. Types of Medigap Policies. Since 1992, there have been 10 standardized Medigap policies called Medigap plans A through J. In 2005, two new standardized

plans became available and are called Medigap Plans "K" and "L." The front of each Medigap policy must identify it is "Medicare Supplemental Insurance." The benefits for each Medigap plan are the same, regardless of the issuing insurance company.

2. Types of Coverage Not Medigap. Medigap policies are different from Medicare Health Plans, an employer or union plan, TRICARE and Veterans' benefits. These plans are purely private and have no relationship whatsoever to Medicare.

3. Who Can Buy a Medigap Policy? To buy a Medigap policy, generally an applicant must have Medicare Part A and Part B. Guaranteed issuance exists for those persons in an open enrollment period and covered under Medigap protection. Medigap protection exists for the following persons:

a. Medicare Health Plan enrollees and the plan is leaving the Medicare program.

b. Applicants that have group employer health insurance or union coverage that is ending.

c. Applicant's coverage ends because the applicant has moved out of the plan's service area.

d. The applicant joined a Medicare Advantage Plan or PACE when first eligible for Medicare at age 65 and within the first year of joining, the applicant decided to switch to the Original Medicare Plan.

e. The applicant dropped a Medigap policy to join a Medicare Advantage Plan or other Medicare Health Plan for the first time, the applicant has been in the plan for less than one year, and the applicant wants to switch back.

f. The Medigap insurance company goes bankrupt and the applicant loses coverage, or the Medigap policy coverage otherwise ends through no fault of the applicant.

g. The applicant leaves the Medicare Advantage Plan or discontinues a Medigap policy because the company hasn't followed the rules or misled the applicant.

h. The applicant has a Medigap policy that covers prescription drugs, but the applicant wants to enroll in Medicare Part D and switch to another Medigap policy that doesn't have prescription drug coverage.