



# *Paying for Health Care*

## Medicare

Medicare is a health insurance program for persons 65 years of age or older and the disabled. It is the health insurance companion to social security retirement and disability benefits. The program has no income or asset eligibility criteria. The act allows coverage **only when the services received are medically “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”**

### *Background and history –*

Medicare is our only national health insurance program. Initially passed by Congress in 1965, Medicare was intended to pay most of the cost of some health care services in order to ensure access to a basic level of health care for all older adults. Because Medicare is a national program, qualifying procedures and criteria should not vary state to state.

There are four basic parts to Medicare coverage – Part A, Part B, Part C, and Part D.

1. Medicare Part A covers:
  - Inpatient hospital care
  - Inpatient care in a skilled nursing facility for rehabilitation purposes
  - Home health care
  - Hospice care.

Medicare has a first day deductible for hospitalization. In 2012, this deductible is \$1156. The first 60 days of a hospital stay are otherwise covered without a deductible. Days 61 through 90 are covered with a co-payment. After day 90, coverage is dependent on circumstances. Part A coverage is available at no cost to those who have worked and paid into Social Security for at least 40 quarters. Those not meeting this requirement may buy into Part A coverage.

2. Medicare Part B is voluntary and covers:

- Medical care and services provided by physicians and other medical practitioners
- Durable medical equipment
- A variety of outpatient care services and therapies
- Home health services not otherwise covered under Part A.
- Blood transfusions

Medicare reimburses 80% of its allowed charges after a deductible. In 2012, this deductible is \$140. Beneficiaries must pay the other 20% and any difference in charges **between the provider's charges and the Medicare allowed charges. By law, excess charges** are limited to 115% of the Medicare rates nationwide. The New York State limit for excess charges is 105%. Part B has a monthly premium that is usually automatically deducted **from the beneficiary's monthly Social Security check. The 2012 base premium for Part B** is \$99.90/month. Higher rates apply for those with annual income above \$85,000 for a single and \$170,000 for a married couple.

#### *Enrollment –*

Enrollment is the process of applying for coverage. Applying for Social Security benefits will trigger automatic enrollment in both Medicare Part A and Part B for those age 65 or older. About three months before your 65<sup>th</sup> birthday you will be sent an Initial Enrollment Package with a Medicare Card and introductory booklet. Enrollment Period is seven months – **beginning three months before the beneficiary's 65<sup>th</sup> birthday** the month of the 65<sup>th</sup> birthday and 3 months after. There is also a general enrollment period from January – March each year.

If an individual is not collecting Social Security benefits at age 65, they need to apply for Medicare to avoid later penalties.

Participation in Part B is voluntary and requires the payment of a monthly premium. A beneficiary is offered the opportunity to decline enrollment in this part of the program; however doing so without other credible coverage could result in delays and late penalties when applying for Part B at a later date.

### *Failure to Enroll (in Part B)*

Failure to enroll can have serious implications. If you decline Part B at enrollment and later decide to take it, there is a surcharge of 10% per year assessed on the Part B premium for each year enrollment is deferred. What can be more serious is that failure to enroll at **the proper time will result in the individual's not being allowed to enroll in Medicare Part B** until the general enrollment. There may be several months when an individual may be vulnerable to costly out-of-pocket medical expenses.

It is permissible to waive enrollment in Part B when either the individual or their spouse is providing employer sponsored health insurance, and the covered employee is physically going to work. When active employment ends, the beneficiaries can enroll in Part B with no penalty.

### Does Medicare pay for Nursing Home Care?

Medicare pays for limited nursing home care only *if the nursing home placement is preceded by at least a three-day hospitalization and only if it has been determined that the person requires skilled nursing care for the purpose of rehabilitation.*

Coverage is limited to 100 days per 'spell of illness.' (A spell of illness begins with the first day of inpatient care and ends when the beneficiary has been in the hospital and/or nursing home for 60 consecutive days.)

For skilled care in a nursing home Medicare pays:

- The first 20 days in full
- The next 80 days there will be a co-pay - \$144.50/day in 2012

If the individual fails to make progress with regard to rehabilitation, Medicare will cease payment and the individual will have to self pay or apply for Medicaid unless Long Term Care Insurance is in place. See "Medicaid" for details

### Does Medicare Pay for Home Care?

There are home health care benefits under both Part A and B.

Home health care benefits under Part A are benefits instituted after a hospital stay of at least 3 days. (Home care must be initiated within 14 days of discharge.) This benefit is limited to 100 visits per spell of illness.

Part B coverage can be indefinite if the person meets the following criteria:

- The beneficiary must require and receive intermittent skilled nursing, or physical, occupational or speech therapy;
- The beneficiary must be homebound
- The services **must be ordered under a physician's plan of care**

- The services must be provided through an agency approved by Medicare.

### *Hospice*

Once a beneficiary is determined to be terminally ill by the individual's attending physician, he/she can opt into receiving hospice services. The physician must certify in writing that the individual's medical prognosis is such that his/her life expectancy is six months or less.

Once an individual has opted to receive the hospice benefit, he/she waives all rights to Medicare services that relate to treatment. Hospice services include:

- Nursing care
- Social work services
- Physician services
- Counseling
- Short-term inpatient care for symptom control
- Medical supplies
- Home health aide services
- Homemaker services
- Services to help patient maintain activities of daily living

### *Medicare Appeals Process*

The Medicare program includes an appeals system for any coverage that is denied. Lifespan can provide guidance on the appeals process.

### *Medigap – Supplemental Insurance*

“Medigap” or Medicare Supplemental Insurance policies are designed to complement (work in combination with) original Medicare. “Medigap” insurance policies cover some or all of the *gaps* between the actual cost of medical care and the amount Medicare will pay. These policies offer a great deal of flexibility as the individual policy holder can choose which doctor or hospital, where, when and how often he or she wishes to be seen by that doctor or hospital. This flexibility comes at a price as premiums for Supplemental policies are significantly higher than the premiums for Medicare Advantage policies (see Medicare Part C).

It should be noted that Medicare Supplemental Policies *do not* include prescription drug coverage (Part D). If prescription coverage is desired in addition to the Medigap policy, a separate stand alone Prescription Drug Plan will have to be purchased.

*What kinds of policies are available?*

There are various standard Medigap policies each identified by a letter “A, B, C, D, F, G, K, L, M & N”. Each policy offers a different level of service (See chart of Medicare Supplemental Policies and Benefits). Not all policies are available in Monroe County. All Supplemental policies identified by the same letter are required by Medicare law to offer the same benefits regardless of the company that is offering the policy. The only variation allowed is price. These policies are community rated (based on local statistics) and prices set according to geographic area. Therefore, a person must purchase a policy offered in the area of primary residence. Many of these policies have “pre-existing condition” clauses that exclude coverage for a specific period of time (usually 6 months) for illnesses that existed prior to initiating coverage. Pre-existing conditions may be avoided if continuous coverage has been maintained prior to initiating a Medigap policy.

*Can I stay with my current doctor when I have a Medigap policy?*

Yes. Medigap policies pay the same supplemental benefit regardless of the medical provider.

*Do I need more than one policy to cover all my costs?*

No. As a matter of fact, State law prohibits an insurance company from selling you a second Medigap that duplicates coverage.

*What rights do I have regarding Medigap?*

Medigap Medicare Supplemental Insurance is regulated by the NYS Department of Insurance 1-800-342-3736. Consumers have the right to:

1. The free look provision – Insurance companies must give you at least 30 days to review a Medigap policy. If you decide that you do not want the policy, you can send it back to the agent within 30 of purchase. You should ask for a full refund of all the premiums you paid.
2. A Guaranteed renewable policy – The insurance company cannot refuse to renew your policy unless you do not pay the premiums or you made a material misrepresentation on the application.
3. Switch policies – You can change policies during the annual open enrollment period.

## MEDICARE PART C – Managed Care Medicare Advantage Plans

A Medicare Advantage Plan is another type of insurance to help cover what original Medicare does not. Advantage Plans replace standard fee-for-service Medicare Parts A and B. Unlike Medigap Supplemental Policies, with Medicare Advantage Plans there are co-pays associated with most services. The plan submits all necessary paperwork for payment. As with standard Medicare policies, long-term *custodial care* at home or in a nursing home *is not covered*.

There are three major types of Medicare Advantage Plans:

HMO – Health Maintenance Organization

PPO – Preferred Provider Organization

PFFS- Private Fee For Service

With an HMO, a **beneficiary must choose a primary care physician from the plan's list of participating doctors**, referrals are often required to see a specialist and all care must be **sought from the plan's network of providers**.

A PPO will offer greater flexibility to seek care outside the network, usually with substantially higher co-pay.

Medicare PFFS plans provide maximum flexibility by allowing beneficiaries to use any Medicare provider with the caveat that the provider must be willing to accept the plan. Providers may choose to participate or not participate at any time.

When choosing a Medicare Advantage Plan one should always verify that your primary care physician participates with the plan and will accept it for payment!

Because of the limits on choice of doctors and the requirement for a primary care physician to monitor your care, premiums for Medicare Managed Care policies are substantially lower than Medigap policies.

Examples of Medicare Advantage Plans in our area include Medicare Blue Choice offered by Excellus, MVP Gold, United Health Care and Wellcare. Medicare Advantage policies may restrict access to certain doctors or hospitals

Medicare Advantage policies are available with and without prescription drug coverage (see Medicare Part D).

The only pre-existing condition that would exclude a person from a Medicare Advantage (MA) Plan is ESRD (End Stage Renal Disease) or kidney failure. However, if a person were to develop ESRD while covered by a MA plan, the person would be able to remain under the MA plan.

## Medicare and Working Past Age 65

### Primary vs. Secondary Coverage

If you are retired at age 65 and have a health care benefit from a past employer, Medicare becomes your *primary* coverage on your 65<sup>th</sup> birthday.

For beneficiaries or their spouses who continue to work after age 65 and have coverage **through an employer's health plan**, Medicare may be the *secondary* payer if and only if there are 20 or more employees at your place of employment and there are no active employees with disabilities. If there are active employees with disabilities, Medicare will be *secondary* only if there are 100 or more employees. Otherwise, Medicare will remain *primary*! If Medicare is *primary*, the individual will need to be enrolled in Medicare Part B and all premiums will need to be paid. It may be important to know whether Medicare is primary or secondary if there are dollar caps to certain types of coverage under your **employer's plan**.

If you or a spouse are 65 and still working:

- Enroll in Medicare Part A when you turn 65.
- Inform your employer and your other health insurance plan that you are eligible for Medicare, as this may require a coordination of benefits.
- You can delay enrollment in Medicare Part B without penalty provided the company you work for employs 20 or more employees. When you, or your spouse retires, or your active employment health insurance ends, you have an eight month special enrollment period to enroll in Medicare Part B without any penalty. In that case, you should contact the Social Security Administration to file an application.

Note: Health plans offered as a retiree benefit are not considered active employment group health plans.)

## Medicare Part D

Medicare Part D took effect Jan. 1, 2006 and covers prescription drugs. You can enroll in this plan at the time your Medicare becomes effective and change plans each year during the annual open enrollment period which beginning in 2011 will be from October 15<sup>th</sup> to December 7<sup>th</sup>, with coverage taking effect the following January.

Anyone with Medicare Part A and/or Part B is eligible for Medicare Part D prescription drug coverage. There are no income limits for this benefit. However, those with higher incomes (\$85k singles and \$170k couples) will pay higher premiums. In 2012 there are 29 approved Medicare Prescription Drug Plans available in NY.

If you are new to Medicare, you can enroll in a drug plan three months before your 65<sup>th</sup> birthday, the month of your birthday, and three months after your birthday. The plan is effective the first of the month after you enroll. If you are over 65 and losing your employer insurance, you have 2 months to enroll in a Part D-drug plan. Each year you can change drug plans during the annual coordinated open enrollment period (October 15<sup>th</sup> through December 7<sup>th</sup>). Your current plan will automatically continue into the following year if you do not take any action. To change plans, simply enroll in a new plan. Do not de-enroll from the old plan first. That will happen automatically.

#### 2012 Medicare Part D Drug Plans:

- Plan premiums- range from \$15.10 to \$109.70 a month
- Deductible- up to a maximum of \$320- some plans may have a lower or no deductible.
- Co-pays – you will have to pay co-pays for your prescriptions after you reach the deductible which will continue until you reach gap (donut hole).
- Donut Hole - Once your total cost of drugs reaches \$2,930 (what you have paid and what the plan has paid) there is a gap in coverage from \$2,930 to \$6,658. As a result of the Health Care Reform Act passed in 2010, when you reach the coverage gap or donut hole you will be responsible for 50% of the cost of brand name drugs and 86% of the cost of generics. The pharmaceutical manufacturers will contribute the balance.
- Several plans cover generic drugs in gap but there are no plans in New York State that offer coverage for brand name drugs in the gap in 2012.
- Catastrophic Coverage - After the total cost of your drugs exceeds \$6,658 in the year 2012, you pay a maximum of 5% of drug costs for the remainder of the calendar year.

### Tips for Choosing Part D Plans:

Compare the drugs you are currently taking to plan formularies before you select a plan. Not all plans cover all drugs. Be sure your pharmacy will accept the plan you choose. Go to [www.medicare.gov](http://www.medicare.gov) to compare plans or contact the HIICAP office at Lifespan. Generally, if you have creditable prescription coverage as a retiree benefit, VA, TRICARE, or Federal Retiree prescription coverage (see below), you do not need a Part D-drug plan.

### The Low Income Subsidy: Help to pay for Part D

Those who are not eligible for Medicaid, but meet the income and asset requirements may **qualify for “extra help” for their prescription drugs. The extra help consists of lower premiums, lower or zero deductibles and much lower co-pays for their prescription drugs.** The income ranges to qualify for this assistance is 100 – 135 % of the FPL (Federal Poverty Level) and 135-150 % of the FPL. Different asset tests must also be met for each of the levels. (In 2011, assets must be under \$12,510 if single and under \$25,010 for couples. Income: Under must be under \$1354/month for singles and under \$1821/month for couples. (Assets that do not count are your home and vehicle). Apply at Social Security Administration, apply on line or in person or call Monroe county HIICAP (244-8400 ext. 113) for an application.

### Creditable Coverage

Many people in the Rochester area already have prescription drug coverage and should not enroll in Medicare Part D. If you have prescription drug coverage provided by a **former employer or union or a spouse’s former employer or union, you will have received a notice from that company indicating whether or not that coverage is “Creditable,”** meaning the plan provides benefits equal to or better than the standard benefit described by Medicare Part D. If you received this notice of Creditable Coverage it means you have adequate coverage and you do not have to do anything else. Furthermore, if you enroll in a Medicare Part D plan you will be disenrolled from the company plan and lose not only the drug benefit but all the medical benefits that company offers. Once you are de-enrolled from a company benefit plan you will never be able to get those benefits back.

A letter of Creditable Coverage is a very important document. You should save it in a safe place for future reference if needed. In the event that the coverage is no longer offered at some time in the future, you will need to prove that you have had Creditable Coverage in effect up until then in order to switch into a new plan without delay or penalty.

Another form of Creditable Coverage is the prescription drug coverage offered by the Veterans Administration and Tri-Care for Life. These plans are Creditable and can be **used as an individual’s Medicare Part D plan separately or in conjunction with another**

Part D plan. If you have one of these three plans you do not need to do anything more. These plans are Creditable and provide all the benefits of a Medicare Part D plan on their own.

Starting Jan 1, 2012, the New York State Pharmaceutical Insurance Plan (EPIC) underwent significant changes and is no longer be **considered “Creditable Coverage.”** Anyone using EPIC must have a Part D plan as primary insurance for prescriptions.

If you do not have Creditable Coverage for prescription drugs and want a Medicare Part D plan, you may purchase the coverage as a stand-alone policy or as part of a Medicare Advantage Plan (Part C). Remember, you cannot have both. The only time double coverage is allowed is if one of the plans is either EPIC or VA as noted earlier in this section. If you normally purchase your medical insurance from a HMO (Health Maintenance Organization) or a PPO (Preferred Provider Organization) such as Excellus-Blue Cross/Blue Shield or MVP (the main choices in this area), you will be given the opportunity to purchase a plan with or without Part D prescription coverage. You do not have to have Part D coverage. It is optional. However, if you choose to opt out of Part D and then decide you want back in at a later date, you will be assessed a penalty. The penalty will be 1% per month for every month you opted out times the current average cost of Part D plans nationwide. This penalty will be added to the cost of whatever plan you select and continue for life.

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