

Chapter 3

Health Insurance Beyond Medicare

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SYNOPSIS

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Exhibit 3A. Benefits of the Twelve Standardized Medicare Supplemental (Medigap) Insurance Plans

3-1. Know Medicare Gaps

Though most retired Americans over age 65 are covered by Medicare, they need to know the benefits and shortcomings of Medicare.

Here are some of the major gaps left by Parts A and B of Medicare coverage. You must pay for:

- ▶ The inpatient hospital deductible for each benefit period;
- ▶ Daily coinsurance for long inpatient hospital stays per benefit period;
- ▶ Inpatient psychiatric care beyond 190 lifetime days;
- ▶ Daily coinsurance for Medicare-certified skilled nursing beyond 20 days per benefit period;
- ▶ All nursing home care other than Medicare's maximum of 100 skilled days;
- ▶ Home health care that is not skilled;
- ▶ The annual deductible for outpatient services;
- ▶ Coinsurance of 20 percent on outpatient hospital, doctors', and suppliers' services;
- ▶ Amounts in excess of Medicare-approved charges (up to 115 percent);
- ▶ Medical expenses while traveling abroad;
- ▶ Nonprescription drugs;
- ▶ Routine care, such as annual physicals (some preventive care is now covered);
- ▶ Dental exams;
- ▶ Eyeglasses;
- ▶ Hearing aids;
- ▶ Equipment that is considered non-medical or custodial; and
- ▶ Physical, occupational, or speech therapy after a maintenance level is attained and skilled therapy services are no longer indicated.

3-2. Options to Supplemental Medicare

To fill these gaps, many retirees obtain additional insurance coverage. Options include:

- ▶ Purchasing Medicare supplemental (Medigap) insurance;
- ▶ Enrolling in a Medicare Advantage plan, such as a Health Maintenance Organization (HMO);
- ▶ Continuing coverage to complement Medicare under an employer's group retirement plan;

- ▶ Applying for federal or state assistance programs, if eligible. This includes Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Qualified Individual 1 (QI-1), as well as standard Medicaid programs;
- ▶ Using military or veterans' hospitals, TRICARE for Life, if eligible;
- ▶ Purchasing long-term care insurance to cover nursing home and home health care costs; or
- ▶ Paying expenses out-of-pocket.

Some of these options are considered in more detail in the material that follows. State assistance programs are covered in Chapter 2, "Medicare," and Chapter 4, "Medicaid."

3-3. Supplemental Insurance

Standardized Plans

Medigap, or Medicare supplemental insurance, is a specialized type of insurance that coordinates benefits with original Medicare. It specifically fills some of the gaps left by Medicare, such as deductible and coinsurance, and, in some cases, may add additional benefits.

In Colorado, approximately 35 companies market these plans. Federal law mandates that each state adopt standardized Medigap benefit packages. Colorado permits the sale of 12 standardized plans that must be labeled Plan A, Plan B, Plan C, and so on, through Plan L. Any company selling Medigap is required to offer Plan A. Other plans are marketed at the company's option. Policies purchased before the standardization (May 1993 in Colorado) are subject to standards in effect when purchased. (See Exhibit 3A of this chapter.)

After December 31, 2005, new Medigap policies may no longer provide prescription drug coverage.

3-4. Protecting Customers

Colorado has regulations that govern Medigap policies, including:

- ▶ Each applicant must receive an outline of coverage.
- ▶ A free-look period of 30 days is provided, during which time the applicant may cancel the policy and receive a full refund.
- ▶ The maximum pre-existing medical condition waiting period is six months from the date the policy is in force.
- ▶ If the applicant is replacing a Medicare supplement policy, no waiting period by the replacement insurer is allowed if it has already been met.

- ▶ Medicare supplement policies must be guaranteed renewable for life. This means that companies cannot cancel or fail to renew a policy for any reason other than failure to pay premiums or misrepresentation.
- ▶ Agents are prohibited from selling duplicative insurance, using high-pressure tactics, and pressuring consumers to switch policies.
- ▶ A six-month open enrollment period exists when an individual first signs up for Medicare Part B (including disabled individuals under age 65), during which time Medigap coverage cannot be denied because of pre-existing conditions. Disabled individuals have a second open enrollment period when they turn age 65.

3-5. How to Compare Policies

Since all Medigap policies are standardized, comparing policies is fairly easy. When comparing policies, consider:

- ▶ **Cost.** Premiums differ among companies for the same benefits, so it is important to compare premiums. Most companies increase premiums at some defined anniversary as the policyholder ages. In addition, most companies raise premiums annually as their costs go up.
- ▶ **Financial stability of the company.** You can call rating companies such as Weiss Research Inc., Standard & Poor's, Moody's, Duff & Phelps, or A.M. Best Company to check the financial rating of a company, or check the resources at your public library or on the Internet.
- ▶ **Waiting period.** By law the maximum waiting period for pre-existing conditions is six months. Some companies have shorter waits; others have no wait. In some situations, when an individual has prior creditable coverage, a company may have to waive some or all of the waiting period.
- ▶ **Customer service.** Learn how efficiently claims are processed by asking friends who have filed claims with that company or ask your doctor's bookkeeper.
- ▶ **Health underwriting standards.** A company may refuse to issue a policy because of a pre-existing health condition, except during the open enrollment period (and in some other limited situations). Underwriting for plans H, I, and J are the most difficult to buy because they contain the prescription drug benefit.

3-6. Medicare Advantage Plans

Each year during the annual election period from November 15 through December 31, Medicare beneficiaries are notified of the options they have in their area to supplement Medicare through one of the Medicare Advantage plans. In brief, unlike "original" Medicare, these plans require the beneficiary to assign his or her Medicare over to an

insurance company (such as an HMO) and agree to receive all Medicare benefits, gap-filling benefits, and any extras, such as prescription drugs, from a network of providers described by the insurer. Medicare Advantage plans do not provide the same level of skilled therapy rehabilitation services (physical, occupational, and speech therapy) as original Medicare fee-for-service plans.

Currently in Colorado, the only type of Medicare Advantage plan that is available is the HMO option. Therefore, we will only discuss the HMO plans.

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) provide or arrange for health services for a set monthly fee. Most Medicare HMOs have contractual arrangements with the federal government under which the HMO agrees to provide Medicare and supplemental benefits in return for a fixed payment from the government for each enrollee. The enrollee continues to pay the Medicare Part B monthly premium, as well as a monthly premium to the HMO, if any.

Currently, most Medicare HMOs have a lock-in feature. That means if the patient goes to a non-HMO doctor or hospital, neither the HMO nor Medicare will pay the bills. A few HMOs omit this lock-in feature, which means if the patient receives services outside the HMO network, Medicare, not the HMO, will pay the balance left by Medicare.

To be eligible to enroll in an HMO, a Medicare beneficiary must meet the following requirements:

- ▶ Have Medicare Parts A and B, and live in an area served by the HMO.
- ▶ Not have end-stage kidney disease (ESRD).

To disenroll from an HMO and return to standard Medicare, the beneficiary must notify the HMO in writing at least one month in advance.

3-7. Employer Group Health Plans

Many retired individuals who have Medicare have additional health insurance coverage resulting from their own or their spouse's employment. These employer group health plans (EGHPs) are secondary to Medicare. That means that Medicare pays benefits first, and the EGHP pays what is not covered by Medicare. EGHPs are not strictly regulated by the states, as are Medigap policies. This means that EGHP benefits can differ from plan to plan and are not subject to minimum benefit requirements.

Since some plans are excellent, it may be prudent to keep the EGHP as a back-up to Medicare if the premium is low and the benefits are good, especially prescription drugs and dental care. However, some EGHPs rarely pay any benefits because the complex coordination of benefit formulas are difficult to understand, and they change benefits annually.

3-8. Long-Term Care Insurance

Long-term care is the most common catastrophic health expense. It can range from simple help with activities of daily living at home, such as bathing and dressing, to highly skilled nursing care. Though families continue to provide the majority of services to elderly relatives in the home, long-term care also is provided by nursing homes, senior centers, home health agencies, adult day care centers, and assisted living facilities. It is estimated that more than 25 percent of those people who live to age 65 eventually will need some kind of long-term care. Half will stay in a nursing home less than 90 days and the other half will stay at least several months.

Depending on location and quality, annual costs in a nursing home easily can exceed \$60,000. Medicare pays only a small percentage of nursing home costs since it only covers short-term skilled care, usually following hospitalization. Medigap insurance and employer health insurance plans seldom pay anything toward nursing home care. Nationally, when their assets have been spent down to the qualifying level, almost half of nursing home residents eventually are covered by Medicaid (see Chapter 4, "Medicaid").

It is possible to buy insurance specifically for nursing home care. New federal tax laws give favorable treatment to those who purchase this type of insurance. Long-term care insurance pays the policyholder a specified amount for each day that he or she qualifies for benefits. Depending on the policy, it may make payments when the individual needs home care, lives in an assisted living facility, attends adult day care, or resides in a nursing facility.

Some of the variables to consider when shopping for long-term care insurance are:

- ▶ **Age.** The risk of being admitted to a nursing home increases rapidly after age 75. Some insurance companies will not offer long-term coverage to persons older than 80 or 82.
- ▶ **How benefits are paid.** Most long-term care insurance pays a fixed daily amount rather than a percentage of the costs. Daily benefits can range from \$50 per day to \$250 per day. Many policies pay actual costs up to the daily benefit selected by the policyholder, while other plans pay the full daily benefit selected.
- ▶ **Covered settings.** Companies generally offer coverage for home care, assisted living, and nursing home care. The best coverage covers all these living settings.
- ▶ **Benefit triggers.** Under some contracts, benefits are paid when care is medically necessary. Others pay when the policyholder loses the ability to perform certain activities of daily living: dressing (should include braces and artificial limbs), bathing, toileting, eating (should include taking medications), transferring (moving in and out of a chair), remaining continent, or when the person suffers cognitive impairment.
- ▶ **Length of coverage.** Purchasers select coverage for a specific period of time; perhaps only for two years or indefinitely. The insurance company pays the daily benefit for the number of years selected when the policyholder meets the requirements for services.

- ▶ **Elimination of “waiting” period.** (Also called a deductible period.) This refers to the number of days the individual must qualify for benefits before the insurance will begin to pay benefits. Most plans offer choices ranging from no wait to a one-year wait. The longer the wait, the lower the premium.
- ▶ **Health underwriting.** Most companies ask very detailed health questions before deciding to insure the applicant. They are especially sensitive to such risks as heart problems, leukemia, rheumatoid arthritis, Alzheimer’s disease, Parkinson’s disease, people already bedridden, and people with known mental or physical disorders. Companies would rather refuse business than assume a bad risk. Policies can be later canceled if patient information is found to be inaccurate or fraudulent.
- ▶ **Renewability of policies and premiums.** Long-term care policies issued in Colorado beginning July 1, 1990, must be guaranteed renewable. This means the company will not cancel or fail to renew the policy as long as the insured pays the premiums on time. Policies issued in Colorado prior to 1990 might not be guaranteed renewable. The premium is determined by the applicant’s age at the time the policy is issued, and usually does not increase because the policyholder ages, although it may eventually be raised for everyone.
- ▶ **Inflation protection.** Consumers can purchase benefit increase options to protect against the rising costs of long-term care. This kind of protection increases premiums but is a very important benefit.

3-9. Glossary

Coinsurance. The portion of the bill that the beneficiary is required to pay, even after the deductible is met. For example, Medicare pays 80 percent of the Medicare-approved rate for a doctor’s visit and the beneficiary is responsible for the other 20 percent coinsurance.

Employer Group Health Plan (EGHP). Health insurance coverage provided through an employer group to workers and/or retirees.

Health Maintenance Organization (HMO). An insurance that limits enrollees to a network of physicians and other health professionals who in turn provide a full range of medical care and treatment for a set monthly fee.

Skilled Nursing. The need for daily inpatient skilled care or rehabilitation. It does not include “custodial care,” which is care that could be given by someone without medical training, such as help with dressing or eating.

Medigap Insurance. Private insurance that supplements Medicare, providing coverage for benefits that Medicare does not provide.

Secondary Insurance. Insurance coverage that is accessed only after the primary insurance benefits are exhausted. Usually refers to employer group health plans.

3-10. Resources

Colorado Division of Insurance

1560 Broadway, Ste. 850
Denver, CO 80202
(303) 894-7499
(800) 930-3745
www.dora.state.co.us/insurance

Colorado Senior Health Insurance Assistance Program

(888) 696-7213
www.dora.state.co.us/insurance/senior/senior.htm

Exhibit 3A.
Benefits of the Twelve Standardized Medicare
Supplemental (Medigap) Insurance Plans

MEDIGAP BENEFITS BY TYPE OF PLAN	A	B	C	D	E	F**	G	H	I	J**	K	L
Part A Coinsurance days 61-90	X	X	X	X	X	X	X	X	X	X	X	X
Part A Coinsurance 60 lifetime reserve days	X	X	X	X	X	X	X	X	X	X	X	X
100% of Medicare covered expenses for additional 365 lifetime days	X	X	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance	X	X	X	X	X	X	X	X	X	X	50%***	75%***
Reasonable cost of 3 pints of blood	X	X	X	X	X	X	X	X	X	X	50%***	75%***
Part A Inpatient Hospital Deductible		X	X	X	X	X	X	X	X	X	50%***	75%***
Part A Skilled Nursing Facility Coinsurance			X	X	X	X	X	X	X	X	50%***	75%***
Part B Deductible			X			X						
Foreign Travel Emergency			X	X	X	X	X	X	X	X		
At-Home Recovery				X			X		X	X		
Part B Excess Charges						100%	80%		100%	100%		
Preventive Care					X						X	X
Prescription Drugs								Basic*	Basic*	Basic*		
Part A Hospice & Respite Care											50%***	75%***

* The prescription drug benefits may no longer be offered after December 31, 2005.

** Medigap F and J policies are also available with high deductible options.

*** 100% of all Part A & Part B Coinsurance after annual out of pocket (\$4,000 for K; \$2,000 for L).

