# Chapter 3

# Health Insurance Beyond Medicare

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## SYNOPSIS



## 3-1. Know Medicare Gaps

Though most retired Americans over age 65 are covered by Medicare, many do not know its benefits and shortcomings.

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 co-insurance for long inpatient hospital stays (over 60 days) per benefit period;
- Inpatient psychiatric care beyond 190 lifetime days;
- 20 percent of the Medicare-approved amounts for mental health services from doctors and providers during inpatient psychiatric hospitalization;
- Daily co-insurance 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;
- Co-insurance of 20 percent for outpatient hospital, doctors', and suppliers' services;
- Up to 115 percent of amounts in excess of Medicare-approved charges;
- Medical expenses while traveling abroad;
- Nonprescription drugs;
- 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. However, the *Jimmo v. Sebelius* settlement agreement clarifies "maintenance" and that "improvement" is not required to obtain Medicare coverage for skilled therapy services.

## 3-2. Options for 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 (Medicare C), such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan;
- Continuing coverage to complement Medicare under an employer's group retirement plan;

- Appling for federal or state assistance programs, if eligible. Colorado has four different "Medicare Savings Programs" (MSP). These include Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Qualified Individual 1 (QI-1), and Qualified Disabled and Working Individuals (QDWI), as well as standard Medicaid programs;
- Using military or veterans' hospitals and 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 4, "Medicaid," and federal programs are covered in Chapter 2, "Medicare."

## 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 co-insurance, and, in some cases, may add additional benefits.

In Colorado, approximately 40 companies market these plans. There are 25 Medicare Advantage (health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plans) or other Medicare health plans that provide prescription drug coverage with health coverage. Federal law mandates that each state adopt standardized Medigap benefit packages. Colorado permits the sale of 10 standardized plans that must be labeled Plan A through Plan N (*see* Exhibit 3A of this chapter). 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.

Effective January 1, 2006, new Medigap policies may no longer provide prescription drug coverage, and seniors need to obtain drug benefit coverage. (See Chapter 2, "Medicare," for information on Medicare Part D.)

## 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 pre-existing medical condition 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 contact rating companies such as Weiss Research Inc. (www.weissratings.com, (877) 934-7778), Standard & Poor's (www.standardandpoors.com, (877) 772-5436), Moody's (www.moodys.com, (212) 553-1653), or A.M. Best Company (www.ambest.com, (908) 439-2200) 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 by asking 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).

## 3-6. Medicare Advantage Plans

The annual open enrollment period is from October 15 through December 7 for Medicare beneficiaries to supplement Medicare through one of the Medicare Advantage plans. Unlike "original" Medicare, these plans require the beneficiary to assign his or her Medicare Parts A and B benefits to an insurance company, for example, a health maintenance organization (HMO), and agree to receive all Medicare benefits, gap-filling benefits, and any extras such as prescription drugs from a network of providers set by the insurer. Medicare Advantage plans generally 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 Medicare Advantage plans available can be HMO plans, preferred provider organization (PPO) plans, or private fee-for-service (PFFS) plans. However, only HMO plans will be discussed in this chapter.

### Health Maintenance Organizations

HMOs provide or arrange for health services for a set monthly fee. Most Medicare Advantage 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,
- ▶ Live in an area served by the plan you want to join, and
- ▶ Not have end-stage kidney disease (ESRD).

To disenroll from an HMO and return to standard Medicare, the beneficiary must do so during the annual enrollment period of October 15 to December 7 or the Medicare Advantage Disenrollment Period (MADP) of January 1 to February 14.

## 3-7. Employer Group Health Plans

Many retired individuals who have Medicare also 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. Unlike Medigap policies, EGHPs are not strictly regulated by the states. 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 for prescription drugs and dental care. However, some EGHPs pay few benefits because the complex coordination of benefit formulas are difficult to understand, and benefits change 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 60 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 $90,000. 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, almost half of nursing home residents eventually are covered by Medicaid when their assets have been spent down to the qualifying level (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 to more than $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. Most pay when the policyholder loses the ability to perform two or more 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.

For more information, see Chapter 7, "Long-Term Care Insurance."

## 3-9. Resources

**Colorado Division of Insurance**
1560 Broadway, Ste. 850
Denver, CO 80202
(303) 894-7499 and (303) 894-7490
(800) 930-3745
www.colorado.gov/dora/division-insurance
dora_ins_website@state.co.us

**Colorado State Health Insurance Assistance Program (SHIP)**
1560 Broadway, Ste. 850
Denver, CO 80202
(888) 696-7213
www.colorado.gov/dora; click on "Senior Healthcare/Medicare" under "Help Center"

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

| MEDIGAP BENEFITS BY TYPE OF PLAN | A | B | C | D | F[1] | G | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|
| Part A Inpatient Hospital Deductible | | X | X | X | X | X | 50%[2] | 75%[2] | 50% | X |
| Part A Coinsurance days 61-90 | 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 |
| 100% of Medicare covered expenses for additional 365 lifetime days | X | X | X | X | X | X | X | X | X | X |
| Part B Coinsurance | X | X | X | X | X | X | 50%[2] | 75%[2] | X | X[3] |
| Reasonable cost of 3 pints of blood | X | X | X | X | X | X | 50%[2] | 75%[2] | X | X |
| Part A Skilled Nursing Facility Coinsurance | | | X | X | X | X | 50%[2] | 75%[2] | X | X |
| Part B Deductible | | | X | | X | | | | | |
| Foreign Travel Emergency (up to plan limits) | | | X | X | X | X | | | X | X |
| Part B Excess Charges | | | | | X | X | | | | |
| Prescription Drugs[4] | | | | | | | | | | |
| Part A Hospice & Respite Care | X | X | X | X | X | X | 50%[2] | 75%[2] | X | X |

**NOTE:** Minnesota, Wisconsin, and Massachusetts have different standardized Medigap plans.

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1. Medigap F policies are also available with a high deductible plan. If you choose this option, you must pay for Medicare-covered costs up to the deductible amount ($2,200 in 2017) before your Medigap plan pays anything.
2. For Plans K and L, after you meet your 2017 yearly out-of-pocket limit of $5,120 for Plan K and $2,560 for Plan L and your Part B deductible of $183, the Medigap plan pays 100 percent of all covered services for the rest of the calendar year (Part A & Part B Coinsurance).
3. Plan N pays 100 percent of the Part B coinsurance except for a copayment of up to $20 for some office visits and up to $50 for emergency room visits not resulting in a hospital inpatient admission.
4. The prescription drug benefits are no longer offered.