Chapter
6

Obtaining Medical Insurance

In This Chapter, Learn:

- What Medicare Covers
- What Medicare Does Not Cover
- How to Apply for Medicare
- How to Appeal Medicare Decisions
- About Additional Supplemental Insurance
- About Medicaid
- Whether You Should Buy Long Term Care Insurance
- Where to Go for Health Insurance Advice
- About Much More

Medicare

What Is Medicare?

Medicare is a health insurance program for those 65 years or older, and people with certain disabilities, Lou Gehrig's disease, or permanent kidney failure.

For the purposes of this book we will be discussing three major types of Medicare. Each type (Part A, Part B, and Part D) has different eligibility requirements and provides different services. (See charts below).

How can I receive Medicare?

Participants can choose to receive their benefits straight from Medicare, or they can choose a Medicare Advantage plan (otherwise known as Medicare Part C).

Under Medicare Advantage you can choose to receive Medicare benefits from a private health insurance company such as a Preferred Provider Organization (PPO), a Medicare Medical Savings Account (MSA), Medicare Managed Care (ie, HMO), Medicare Special Needs Plan, or a private fee-for-service plan (PFFS).

Each Medicare Advantage plan must offer you the minimum Medicare benefits. Medicare Advantage plans may also offer various additional benefits. If you choose Medicare Advantage, please research which provider and plan is best for you.

Medicare Benefits

What are the Medicare benefits?

The charts below summarize the minimum benefits of Medicare Parts A, B, and D — eligibility requirements, premiums, and services covered and not covered. To get the most current information, contact Medicare (see the "More Information" section on page 88).

MEDICARE PART A
WHAT IS MEDICARE PART A?
• Hospital insurance
WHO IS ELIGIBLE?
You are eligible if at least one of the following describes you: • You are at least 65 years old and eligible for Social Security or Railroad Retirement benefits. • You have a disability and have been on Social Security disability or Railroad Retirement disability for the last two years. • You are on dialysis because you have permanent kidney disease. • You have Lou Gehrig's disease.
WHAT IS THE PREMIUM?
• Nothing, if you meet the eligibility requirements stated above. • Around $248-$450 if you don't meet the eligibility requirements above.

MEDICARE PART A WHAT DOES IT COVER AND WHAT ARE THE DEDUCTIBLES?		
	Deductible	**Co-Payment (what you pay)**
Hospitalization (semi-private room and board, general nursing, and other hospital services and supplies)	$1,132 in 2011	Days 1-60: no co-payment, just pay the deductible. Days 61-90: your co-payment is $283 a day. Days 91-150: (60 reserve days only used once) you pay $566 a day. Days 151+: you pay all costs.
Skilled Nursing Facility (semi-private room and board, skilled nursing services, inpatient drugs, physical, speech and occupational therapy)	None, but you must meet Medicare eligibility requirements for skilled nursing and therapies.	Days 1-20: no co-payment. Days 21-100: you pay up to $141.50 a day. Days 100+: you pay all costs.
Home Health Care (skilled care, home health aides, speech and physical therapy, durable medical equipment)	None, but you must meet Medicare eligibility requirements for home health care.	For services: no co-payment. For durable medical equipment: you pay 20% of costs.
Hospice Care	None, as long as doctor certifies the need.	Small co-payment for outpatient drugs and inpatient respite care.

MEDICARE PART B
WHAT IS MEDICARE PART B?
• Medical insurance that covers medically necessary doctor services, outpatient care, medical services, and some preventive services.
WHO IS ELIGIBLE?
• Same as Part A eligibility, and you must be a U.S. citizen or must have been a legal resident for at least five years.
WHAT IS THE PREMIUM?
• Your monthly premium is around $100 a month. Premiums increase yearly.

MEDICARE PART B WHAT DOES IT COVER AND WHAT ARE THE DEDUCTIBLES?		
	Deductible	**Co-Payment (what you pay)**
	$162, general deductible before any Medicare Part B benefits begin	
Medical Expenses (doctor visits, medical services and supplies, physical therapy, diagnostic tests, durable medical equipment)	None, if medically necessary.	General medical expenses: you pay 20% of the approved amount and limited charges above the approved amount. Outpatient mental health services: you pay 50%. Therapies have $1,870 per year limit for each type (speech, physical, and occupational).
Laboratory Tests	None, if medically necessary.	No co-payment.
Home Health Care (skilled care, home health aides, durable medical equipment)	None, but you must meet Medicare eligibility requirements for home health care.	For services: no co-payment. For durable medical equipment: you pay 20% of costs.
Outpatient Hospital Treatment (diagnosis or treatment services)	None, if medically necessary.	Billed Amount: generally you pay 20% (after the deductible).

MEDICARE PART D
WHAT IS MEDICARE PART D?
• Insurance for outpatient prescription medication.
WHO IS ELIGIBLE?
• Anyone who is eligible for Medicare Part A or is enrolled for Medicare Part B. • You may also qualify for "extra help" (from Medicare to pay for medication) if your assets and resources are below a certain amount. Contact Medicare for more information.
WHAT IS THE PREMIUM?
• It depends on the plan you choose.

MEDICARE PART D		
WHAT DOES IT COVER AND WHAT ARE THE DEDUCTIBLES?		
***(Please note due to the Health Care Act being passed changes are being made to Medicare Part D benefits)		
	Deductible	**Co-Payment (what you pay)**
The Basic Prescription Drug Plan	up to $310	After paying your deductible, you pay 25% and Medicare pays for 75% of your prescription drugs. When your total drug costs (including your deductible and co-payments) reach $2,840 or more, you pay 100% of your prescription drugs until your coverage begins again or until your total drug costs reach $4,550. When your total drug costs (including your deductible and co-payments) reach $4,550, you pay only 5% of your drug costs or a small co-payment ($2.50 for generics and $6.30 for brand-name drugs).

MEDICARE DOES NOT COVER

Read over the list below for specifics on what Medicare does not cover.

MEDICARE PART A DOES NOT COVER

Medicare Part A does not cover:

- Most nursing home care.
- Full-time home health care.
- Long-term care, including assisted living care, adult day care, and nursing home care (this is different than skilled nursing care).
- Personal care such as help dressing, bathing, and eating.
- Cosmetic surgery.
- Anything that is not reasonably and medically necessary.
- Care while traveling abroad.

MEDICARE PART B DOES NOT COVER

Medicare Part B does not cover:

- Acupuncture and homeopathy.
- Dental care and services.
- Routine physical examinations, unless it is an initial wellness exam or if it is an exam as part of a diagnosis for a medical condition or complaint.
- Vaccinations and immunization, unless you have been exposed or are planning to travel abroad.
- Eye and hearing exams; eyeglasses, contacts, and hearing aids.
- Routine foot care.
- Experimental procedures.
- Anything that is not reasonably and medically necessary.

MEDICARE DOES NOT COVER

MEDICARE PART D DOES NOT COVER

Medicare Part D does not cover:

- Barbiturates (sedatives, drugs used to treat anxiety and certain seizures).
- Benzodiazepines (tranquilizers, drugs used to treat panic attacks or seizure disorders).
- Over-the-counter medications.
- Weight loss or gain medications.
- Drugs for erectile dysfunction.
- Prescription vitamins.

What are some of the major changes made to Medicare Part D from the Health Care Act?

- In 2011 you will get a 50% discount from brand name drugs when you are in the coverage gap.
- Additional drug discounts by 2020.
- Eventually the coverage gap will shrink so you will only pay for 25% of costs.

Applying For Medicare

Do I need to apply for Medicare Part A or am I automatically enrolled?

It depends. If you are currently receiving Social Security retirement, you will be automatically enrolled in Medicare Part A. However, you need to apply for Medicare if you are not receiving Social Security.

When can I apply for Medicare Part A?

If you are not taking Social Security (see above), the soonest you can apply is three months before your 65th birthday. However, there is a seven-month enrollment period during which you can apply. It consists of the three months before the month of your 65th birthday, the month of your birthday, and three months following your birthday month.

When should I apply for Medicare Part B?

For Medicare Part B, the initial enrollment period is the same as Medicare Part A (see above). If you miss this enrollment period, you can sign up for Part B during the general enrollment period, which is between January 1 and March 31 of each year, with your coverage starting July 1.

What if I don't sign up for Part B when I am 65?

A 10% penalty is added to your premium for each full 12-month period that you could have had Part B but did not sign up for it. There is an exception. No penalty will be added if you had comparable group medical insurance. You will have to sign up for Medicare Part B while you have the comparable insurance, during the eight-month period that begins the month employment ends, or the comparable insurance ends, whichever is first.

Appealing Medicare

What can I do if Medicare denies coverage?

Medicare is a very complex program. You might be denied a benefit when it should have been granted.

There may be times when Medicare decides that your stay in the hospital should end or they won't pay the amount you believe they should. Oftentimes this is because of an error.

You have the right to appeal (a request to change) Medicare decisions. How you appeal depends on whether you are appealing a decision under Medicare Part A, Part B, Medicare Advantage (Part C), or Part D.

For the purposes of this section we will only discuss the initial levels of appeals. Contact an attorney for more information.

How do I appeal traditional Medicare (Part A or Part B)?

When Medicare denies coverage under Part A or B, you will first find out from the health care provider and from a Medicare Summary Notice (MSN). Mistakes are often made due to insufficient information or simple mistakes. The first thing you should do is call the Customer Services Information number on the MSN.

How do I appeal a Medicare Part A or Part B decision?

You have 60 days from the date of the MSN to request an appeal, called reconsideration. You must request this in writing. The form will be provided with your MSN or you can print the form from www.medicare.gov/basics/forms.

If you don't appeal within 60 days, the decision becomes final and you cannot appeal later.

With the form, attach a letter to explain the situation. Be brief, but include the following key points: (1) what you believe Medicare should cover, (2) why

it is medically necessary, and (3) why Medicare's decision was incorrect.

It is extremely helpful to have your doctor's support throughout the Medicare appeals process. This might be as simple as providing a copy of your medical bill and a letter from your doctor. Include these relevant documents with your appeal form and letter.

If you disagree with the reconsideration decision, you should seek the help of an attorney to discuss whether you should appeal further.

How do I appeal a Medicare Advantage (Part C) decision?

If you receive Medicare A or B from a private insurance company, there is a different appeals process. The provider is required to provide you with information regarding their appeals process. In addition, every Medicare Advantage plan has internal grievance procedures for resolving issues.

First, you should ask the provider for a determination decision, in which the provider will decide whether they should have granted the benefit under Medicare. The provider must provide that decision in writing. Again, your doctor's support is essential to your appeal.

If you disagree with the decision, you should ask for a redetermination, then seek the help of an attorney to discuss whether you should appeal further.

What should I do if my drug is not covered at the pharmacy?

First, check to see if the drug is excluded from Medicare Part D's coverage. (See Part D chart above.)

Next, ask your doctor if another drug on the plan's list would suffice. Provide him or her with the plan's formulary (the list of drugs that the plan covers).

Talk to your doctor about appealing to the plan so it will cover the necessary drug.

Pharmacists can also provide valuable information to patients and providers about why a certain drug in a class is better than another.

If necessary, appeal the provider's decision. Your doctor's and pharmacist's support is critical when appealing Medicare Part D.

How do I appeal Medicare Part D?

If you are denied coverage under Part D, you can appeal. This is called a "determination" appeal. If you disagree with the outcome you can appeal again. This section discusses the first three levels of appeals.

Determination

You should ask for a written coverage determination from your Medicare Part D provider. As part of your request, you will need your doctor to submit a statement that (1) the drug you need is medically necessary and (2) the alternative drugs on the drugs formulary would either not help or would harm you.

Submit as much information as you can that point to this fact. You may also want to include a letter from your pharmacist that explains why the drug you want is better for your treatment than another drug on the formulary.

After you request the coverage determination, your provider must respond within 72 hours. Your doctor can ask for an expedited review if your health requires. If you are granted an expedited review, your provider must make a determination within 24 hours.

Redetermination

Your doctor and pharmacist should submit statements with as much evidence as possible that your drug is medically necessary and that no other drugs will help you or that they would be harmful to you. This evidence can include medical records showing the other drugs you took were ineffective or had side effects which were harmful, and medical journal articles stating that the drug you want is effective in treating your condition. The more evidence you have, the better. Contact your provider to ask where you should send the request. You must ask for a redetermination within 60 days of the determination. The provider must respond to the redetermination request within 7 days, or 72 hours on an expedited review.

Reconsideration

If your redetermination is denied, you will receive a reconsideration appeal form. You must appeal within 60 days of receiving the form. Your doctor will

have another opportunity to add any other medical evidence to support your case. Your reconsideration is looked at by a qualified independent contractor, who will consult doctors to help them make a decision. You should consider getting an attorney to help you at this stage of appeal. You will receive an answer within 7 days, or 72 hours on an expedited review.

If you disagree with the decision you should seek the help of an attorney to discuss whether you should appeal further.

Other Medical Insurance

Will Medicare cover all my costs?

Medicare was never intended to cover all medical costs. As you can see from the charts above, there are deductibles, co-payments, and areas that Medicare does not cover. After assessing your current and future health needs, determine whether or not to get additional health insurance. Research your options — Medicaid, Medigap, and long-term care insurance.

Medicaid

What is Medicaid?

Medicaid is a health insurance program for individuals and families of low income and assets. Medicaid coverage is more extensive than Medicare. It includes hospital and medical services, prescription drugs, and long-term care such as nursing home stays.

To be eligible for Medicaid, you must fit one of the categories and your monthly income must be under 55% or 133% of the Federal Poverty Level, depending on the category.

Can I spend down so Medicaid will pay for my nursing home care?

Spending down is when you deplete your finances so that you become eligible for Medicaid. Spending down is confusing and a complex part of the law. The law on asset "transfers" and "gifts" has recently changed and is very technical. Making mistakes could prevent you from being eligible for Medicaid. If you are considering spending down, please talk to an attorney who specializes in Medicaid planning.

Medigap

What is Medigap?

Medigap specifically helps pay for the expenses that Medicare doesn't, such as deductibles and coinsurance, and in some cases, may add additional benefits. (Medigap is good for people who have Original Medicare and not Medicare Advantage.)

There are a variety of Medigap plans. Some plans cover the gaps in Medicare for hospital insurance. Other plans may cover the gaps by providing coverage for skilled nursing care. The plan you choose depends on what coverage gap is most critical for you to have covered.

Long-Term Care

Does Medicare pay for long-term care (LTC)?

While Medicare pays for skilled nursing care, this coverage is very limited, and in general, Medicare does not pay for nursing home stays. Yet over 25 percent of those people who live to age 65 will eventually need some kind of long-term care.

Although your family might be able to provide part of the care for you, it is a huge financial strain. For

example, the average care in a nursing home in Utah is $40,000 a year.

Should I buy long-term care (LTC) insurance?

The answers depends on your health and financial situation.

Generally, if you have more than $1.5 million dollars, you may be able to pay for LTC without a policy. If you have fewer assets, you may be able to spend down to qualify for LTC under Medicaid. Contact Senior Health Insurance Information Program (SHIP) counselors to help you determine whether you need LTC insurance (see the "More Information" section).

You should consider a LTC policy if you have no one in your family who could take care of your long-term care needs, you have a family history of disease that may require long-term care, and your assets are between $250,000 and $1.5 million.

What should I know about buying long-term care insurance?

Age

Unless you currently have a disability, the best time to get LTC insurance is between age 60 and 65. Policies get more expensive the older you get.

Premiums

Although premiums usually stay the same, companies can raise them under certain circumstances (e.g., inflation, losses, or changes in the law).

Care

When selecting a policy, buy one that covers in-home care (e.g., adult day care, home health care) as well as out-of-home care (e.g., assisted living, nursing home).

Benefits

Insist on a simple outline of the policy, which describes the benefits offered. Under law, this outline must be given to a person when you apply, pay for, or receive the policy.

Financial Strength

Before selecting a policy, find out the financial strength of the insurance company by going to www.standardandpoors.com.

Coverage

In Utah, the policy must cover custodial care (i.e., help with activities of daily living), Alzheimer's disease, and mental or nervous disorder of organic origin.

Benefit Period

Less than half of the people who are in a nursing home stay longer than 90 days, and if they do, almost all of them stay for less than 2.5 years. So think about averages like these when looking at the policy benefit period.

Counseling

Where can I get health insurance advice?

You can receive free Medicare counseling through your local Senior Health Insurance Information Program (SHIP). This program gives free local health insurance counseling to people who are eligible, or will soon be eligible for Medicare with their health insurance questions including the Medicare Prescription Drug Program. SHIPs are independent and not connected to any insurance company or health plan. SHIP volunteers work hard to help you with the following Medicare questions or concerns:

- Your Medicare rights
- Complaints about your medical care or treatment
- Billing problems
- Plan Choices

There is no charge for the service, and there is no product for sale. You can find a local SHIP counselor by calling 877-424-4640. If you're interested in becoming a volunteer SHIP volunteer, contact the SHIP in your state to learn more.

More Information

MEDICARE AND MEDIGAP

Free counseling on Medicare, Medigap, and long-term care insurance

Senior Health Insurance Information Program (SHIP)
800-541-7735
www.daas.utah.gov

Utah Insurance Department, Health Insurance Division
801-538-3077
www.insurance.utah.gov

Information on Medicare

Medicare
800-MEDICARE (633-4227)
www.medicare.gov

MEDICAID PROGRAM

Information on Utah Medicaid

Utah Medicaid Program
800-662-9651
www.health.utah.gov/medicaid

LONG-TERM CARE INSURANCE

Information about long-term care

National Center for Assisted Living
800-628-8140
www.ncal.org

AARP
www.aarp.org