

**\*\*THE FOLLOWING ARTICLE WAS PRESENTED BY MR. HUFFMAN AT A SEMINAR HELD IN FORT WAYNE, INDIANA, TO A GROUP OF 29 ATTORNEYS AND 1 FINANCIAL PLANNER\*\***

### **MEDICARE--WHAT YOU NEED TO KNOW**

**Where Medicare Stops and Medicaid Begins.** Medicare and Medicaid are both federal programs. The similarity in the names of these programs creates a great deal of confusion. This is drastically complicated because Medicaid is administered differently in every state, while Medicare has uniform rules (for the most part) across the country.

Medicare eligibility and the cost of coverage have been the same for all eligible individuals in the past without regard to their assets or income. This has made the program easier to administer because there has not been the need to develop complicated rules on what assets and income count towards eligibility thresholds. Also, there has not been a need to monitor eligibility and to punish recipients who obtain benefits for which they are not eligible.

This is changing as the lines between Medicare and Medicaid converge. The Medicare Part D Program now provides extra help for those that meet certain asset and income guidelines. The increase in the Part B premiums for people earning more than \$85,000 per year is another example of this convergence.

When a Medicare recipient enters a hospital for a stay of 72 hours or more and is discharged to the skilled care unit of a nursing home for therapy or treatment, Medicare often pays for the first 20 days and co-pays with a supplemental health insurance company for up to the next 80 days (unless an advantage plan puts them at a disadvantage). A person must participate in therapy or treatment during this 100-day period and show stabilization or improvement to remain eligible for Medicare benefits. The person receives a two-day notice of loss of Medicare benefits once the stay becomes custodial. The person can immediately appeal a discontinuance notice, but this is rarely done.

The Medicare coverage period is a very valuable period to address how the person's assets will be used or preserved for his/her future care and that of his/her spouse and children. This is the time to consult an elder law attorney to learn what the family is faced with in the future if the person does not have nursing home insurance to pay for the person's care.

The first date of "institutionalization" of either spouse for more than 30 consecutive days after September 30, 1989, is a critical date for the establishment of Medicaid eligibility for nursing home care in the future. The first date of 30 or more days of institutional care will be used in the future to establish eligibility for Medicaid. Every estate planning attorney in Indiana should have a question on his or her estate planning form asking if either spouse has ever been in a hospital and/or nursing home for 30 or more consecutive days. It is easier to get verification of the assets on the snapshot date now than it will be some years in the future.

**Qualified Medicare Beneficiaries.** Medicare is a health insurance program for persons age 65 and over and for some disabled workers. Income and assets are not eligibility factors. Part A covers up to 100 days of extended care services in a skilled nursing facility (SNF).

In order to qualify for the 100-day SNF benefit, one must be hospitalized for a medically necessary condition for at least three consecutive days and admitted to a nursing home within 30 days of discharge. Part A pays in full for the first 20 days and co-pays with the patient for up to the next 80 days. The 2007 co-payment amount is \$124.00 per day. This co-payment amount is usually paid by a supplemental insurance policy, if your client carries supplemental insurance.

Part B coverage is available to people who enroll and pay a premium. Most people automatically enroll in Part B when they start receiving Social Security payments. In fact, most people do not realize they pay for Part B coverage.

One must pay a monthly premium for Part B coverage, which is \$93.50 a month in 2006, unless you enrolled late for Part B. One must pay a deductible of \$131 for the first medical expenses incurred in a calendar year. There are also various deductible

payments that must be paid during the year, depending on the treatment your client receives.

When advising low-income seniors, you should be aware of the following Medicare “Buy-In” programs. If your client can answer yes to each of the following questions, he or she could save hundreds of dollars a year—a very significant amount for low-income seniors. Applications for each of the following programs are made with the local office of the Division of Family Resources.

- a. Does your client have Medicare Part A coverage?
- b. Is your client’s monthly income at or below \$1,123 (single person) or \$1,505 (married couple)?
- c. Are your client’s countable financial assets below \$4,000 (single person) or \$6,000 (married couple)?

Qualified Medicare Beneficiary—QMB. The State of Indiana pays your client’s Medicare premiums, coinsurance, and deductible. The average Medicare beneficiary pays over \$2,000 out-of-pocket each year, so this can be a significant savings for your client.

Specified Low-Income Medicare Beneficiary—SLMB. The State of Indiana pays your client’s Part B premium, a \$1,122 annual savings!

Qualified Individual—QI-1 and QI-2. The State of Indiana reimburses your client for a portion of their Part B premium at the end of the year.

**Monthly Income Limits as of March 1, 2006**

	<u>Individuals</u>	<u>Couples</u>
QMB	\$858	\$1,133
SLMB	\$1,025	\$1,355
QI-1	\$1,094	\$1,444
QI-2	\$1,151	\$1,522

- If your client has Medicare Part B, the premium of \$93.50 is taken out of his or her Social Security check each month. Add this amount to your client’s Social Security check to see if his or her current income is within these limits.
- If your client has employment income, half of it—before taxes—does not count toward the limit.

**Asset Limits**

	<u>Individuals</u>	<u>Couples</u>
All Levels	\$4,000	\$6,000

Assets are things your client owns, such as checking and savings accounts, certificates of deposit (CDs), cash value of life insurance, stocks, and bonds.

Some things your client owns do not count toward his or her asset limit, such as his or her home and furnishings, car, pre-paid funeral trusts, and income-producing real estate.

There is also help with Part D payment for individuals with low income and low assets. Please visit [www.Medicare.gov](http://www.Medicare.gov) for up-to-date information about Part D. Extra help is available for single people with an income of less than \$14,700 per year and assets of less than \$11,500. The income limit is \$19,800 for married couples and the asset test is \$23,000.

**Medicare Basics--Part A**

Medicare is our nationalized health insurance program for those 65 years of age or older and for disabled persons. Medicare is not means-based tested. Eligibility is automatic at age 65 or upon establishment of a disability (after a waiting period).

Enrollment and questions about participation in Medicare are handled by the local Social Security office for Part A. Medicare is operated by the Centers for Medicare and Medicaid Services. You can visit [www.Medicare.gov](http://www.Medicare.gov) for information about all aspects of Medicare. You will want to print off a copy of Medicare and You 2007 to use as a desk reference for your clients.

Medicare Part A is hospital insurance. You must enroll in Part A. You should enroll three months before you turn 65. You generally become eligible for Part A when:

- (A) You turn 65;
- (B) You have been on Social Security or Railroad Disability for 24 months;
- (C) You have end-stage renal disease;
- (D) Ineligible persons who do not have a proper earnings record but are otherwise eligible and elect to participate in the program and pay the appropriate premiums.

You can receive Medicare at age 65 even though you are still working if you could retire and receive Social Security retirement benefits. The dependents and survivors of an insured worker are also eligible to receive benefits at age 65, provided the insured worker is entitled to Social Security retirement benefits. Please note that Railroad Retirement beneficiaries are considered Social Security retired workers for purposes of this paper.

Please note, while you can elect to receive Social Security retirement benefits at age 62, you do not receive Medicare until you are age 65. This is also true for your spouse and dependents.

You become eligible for Part A benefits on the first day of the month you turn 65. If you are born on January 31, your eligibility begins on January 1.

You have six months after you turn 65 to apply for Medicare, and you will be enrolled retroactive to the first day of the month you turn 65. Should you enroll later, your eligibility will generally go back six months from the date you enroll.

You do not have to enroll in Medicare if you start receiving retirement benefits before your turn 65. You will be automatically enrolled in Part A and B on the first day of the month you are born in. You receive your Medicare card in the mail approximately three months before your birthday. With the ever-increasing costs of health care insurance, this will likely be the best birthday card you ever receive!

You also do not have to enroll if you have been on Social Security Disability for 24 months. You should receive a Medicare card three months before the end of the 24<sup>th</sup> month of disability with benefits beginning on the 1<sup>st</sup> day of the 25<sup>th</sup> month.

Part A is generally free if you have worked for 10 years or more. You must pay a monthly premium of \$226 if you or your spouse worked between 7.5 and 10 years. The monthly premium is \$410 if you or your spouse worked less than 7.5 years.

What if I am still employed? I recommend everyone sign up for Medicare at age 65. If you are still employed in a company that employs 20 or more full-time employees (100 if you are disabled), your employer's insurance will pay first and Medicare will pay second. You can delay your Medicare enrollment and then enroll without penalty if you enroll within eight months of terminating your employment or losing health care coverage from your employment.

Persons employed in companies with less than 20 full-time employees should always enroll in Medicare at age 65. In these situations, your employer's insurance only pays after Medicare pays. The same is generally true for retiree coverage.

#### Part A Benefits and Costs

##### Inpatient Hospital Services:

- The annual deductible is \$992
- The co-insurance cost is \$248 per day for days 61-90
- The co-insurance cost for lifetime reserve days is \$496 for a maximum of 60 days

Medicare generally only pays for hospital stays of 90 days or less. You begin a new hospital stay once you are out of a hospital for 60 consecutive days. You can use your lifetime reserve days if a stay is longer than 90 days.

##### Skilled Nursing Facility:

- No deductible
- No co-insurance for days 1-20
- \$124 co-insurance for days 21-100

##### Home Health Care:

- No deductible or co-insurance

##### Hospice:

- No deductible or co-insurance
- Small co-payment for outpatient drugs and inpatient respite care

## **Medicare Basics--Part B**

Part B is a program that provides physician's services and other benefits for eligible people who enroll in the program and pay a premium. A person over age 65 is eligible to enroll in Part B (also called Supplemental Medical Insurance) when the person is entitled to hospital insurance under Part A and is a resident of the United States, or is a permanent resident alien. This allows Federal and State employees not covered by Part A to participate in Part B. A person can participate in Part A and opt out of Part B.

You are automatically enrolled in Part B if you are receiving retirement benefits when you turn 65. You need to voluntarily enroll in Part B if you will start receiving benefits as of the date you turn 65. The enrollment process is the same as for Part A.

Coverage under Part B begins when a person is enrolled in Part B and a premium is due. Enrollment begins in the first month of eligibility when you enroll in the three month period before you turn 65. When you enroll the month after you turn 65, coverage begins the month following enrollment. When you enroll in the second month after turning 65, coverage begins in the second month after enrollment. When you enroll in the third or fourth month after turning 65, coverage begins with the third month following enrollment.

An individual who does not enroll in the initial enrollment period may enroll during the next general enrollment period, which is January 1<sup>st</sup> through March 31<sup>st</sup> of the next year. A late enrollee will pay a higher premium. The penalty for late enrollment is 10% per year for each year you were not enrolled, except in special circumstances.

Example: Mr. Smith turns 65 on July 3<sup>rd</sup> and is not receiving Social Security benefits. He may enroll in Part B any time from March 1 until October 31, to enroll.

The premium for Part B for 2007 is \$93.50 per month if your annual income is below \$80,000 for individuals or \$160,000 for couples. For the first time ever, enrollees with higher incomes will pay more for Part B coverage.

Part B pays for:

- Doctors and other Medical Services

- Outpatient Hospital Services
- Home Health Care
- Clinical Diagnostic Lab Services
- Diabetes Self-Management
- Durable Medical Equipment
- Physical Therapy Services
- Ambulance Services—Emergency
- Chiropractic Services—Limited
- Blood

### **Medicare Basics--Part C**

#### **Medicare Advantage?**

The Medicare Prescription Drug Improvement and Modernization Act of 2003 changed the name of Part C from Medicare +Choice to Medicare Advantage. Persons who live in a plan's service area, who are entitled to benefits under Part A and enrolled under Part B, may sign a written election to enroll in an Advantage plan. If you meet these qualifications, you are generally eligible to enroll in any Advantage plan, without regard to insurability unless you have end stage renal disease.

Be aware that with Plan C you are leaving the original Medicare plan managed by the federal government. Under the original Medicare plan, you can go to any doctor that is enrolled and accepts Medicare. You can also go to any hospital or facility. The rules for coverage are uniform throughout the United States. You pay a deductible and then Medicare pays  subject to coinsurance or co-payment. You generally have a Medigap policy that pays when Medicare does not pay.

The Medicare Advantage plans are health plans operated by private companies that have been approved by the federal government. When you join an Advantage plan you are still in Medicare. Medicare pays a certain amount each month to the plan for your health care costs. You may be limited in the physicians, specialists, and hospitals you can receive service from. You are entitled to emergency service if you are out of the service area covered by the plan.

### Types of Medicare Advantage Plans:

- Preferred Provider Organization Plans
  - Health Maintenance Organization Plans
  - Private Fee-for-Service Plans
  - Special Needs Plans
  - Medicare Medical Savings Account Plans
1. Preferred Provider Organization Plans. These plans usually combine prescription drug coverage with payments toward the Part A and B co-payments and deductibles. A person generally does not need to choose a primary care physician. You generally are required to use physicians and hospitals that are in the network, but may pay a higher cost to use out of network providers. You need to carefully review the plan's rules and coverage.
  2. Health Maintenance Organization Plans. Most plans include prescription drug coverage. You generally must have a primary care physician who must refer you to other health care providers, as needed. You generally are limited to health care providers in the network. If you go out of network, you usually have to pay the entire cost.
  3. Private Fee For Service Plans. The plans usually do not include prescription coverage, so you would also choose a Part D plan. You do not have a primary care physician. The company decides how much it will pay for services and how much you will pay.
  4. Special Needs Plans. These plans are designed for people with certain chronic diseases and other ailments. These plans provide all Part A and B services and must provide Part D coverage. These plans are designated for people in institutions, dual eligible, or who have one or more chronic or disabling conditions. The Plan may limit membership to those individuals needing extra services.
  5. Medicare Medical Savings Account Plans. These are new in 2007. These plans are similar to Health Savings Account plans. These plans have two parts. The

first part is a high deductible Advantage Health Plan. The plan does not pay until you have paid this deductible. The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health costs.

Advantage Plans with Prescription Drug Coverage:

Warning. You must participate in the prescription drug program offered in your Advantage Plan. Enrollment in a Part D Plan will automatically terminate your enrollment in the selected Advantage Plan and return you to the original Medicare Plan. This means you will probably be without supplemental insurance for some period of time.

In general, each plan must accept eligible people without regard to their medical conditions during each annual enrollment period. These are special election periods when individuals may change plans. The election period to choose regular Medicare or an Advantage Plan is generally the first three months of the year. Enrollment is effective on the first day of the month following enrollment. Institutionalized individuals may change at any time without penalties. New enrollees, who are eligible for the first time, have a variety of enrollment options.

The decision to change from one Advantage Plan to another is generally allowed from November 15 to December 31. The change is then effective on January 1st.

The Medicare Advantage plan provider must give each enrollee each year a written summary showing:

- The service area
- The benefits offered and the coverage exclusions
- Coverage out of the area
- Coverage during emergencies
- Supplemental benefits
- Grievance and appeal procedures
- Quality information
- Prior authorization requirements
- A comparison of benefits under the original benefits plan and the Advantage Plan

## **Medicare Basics--Part D**

The Medicare prescription drug program is known as Part D. Part D is optional. You will pay a premium for Part D. Part D was created by the Medicare Prescription Drug Improvement and Modernization Act of 2003.

You are eligible for Part D if you are entitled to benefits under Part A or enrolled under Part B and are 65 years of age. You receive help with prescription drug coverage under a Prescription Drug Plan or under a Medicare Advantage Plan.

The enrollment time period for initial enrollment generally matches the enrollment period for Part B. There are exceptions for individuals who have other drug coverage that is “credible”. Those individuals can generally enroll later, without penalty, within 63 days of termination of their other credible coverage.

### **Beneficiaries Costs:**

The actual cost to each beneficiary is determined by the plan the person is in. The general support payments are determined by the base coverage which is in 2007:

1. Participant pays the annual deduction of \$265.
2. The participant pays 25% or \$533.75 and Medicare pays \$1,601.25 of the next \$2,135.
3. The participant is in the doughnut hole and pays the next \$3,051.25.
4. The participant then pays 5% of the remaining costs.
5. The participant pays a monthly premium to the Part D provider.

### **Late Enrollment Penalty**

A person without other credible coverage or who is eligible to enroll in Part D who elects to enroll later must pay a penalty. The penalty is 1/2% per month for each month from when the person could have enrolled to when they do enroll.

### **Change in Plans**

The open enrollment period is each November 15 to December 31 for most enrollees. A participant can change to any plan available in the area without medical underwriting or other penalty.

### Comparing Plans

You should advise your clients to visit [www.medicare.gov](http://www.medicare.gov) to compare plans in your area. You can enter your zip code, drugs you are currently taking and the dosage, and other information. You can then see the projected costs for each plan for the entire year. You can enroll online and change plans online.

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