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Basic Estate Planning Fact Sheet Series

Medicare and Medigap

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The best reference for this fact sheet is provided by The Ohio Department of Insurance. A copy can be obtained by calling 1-800-686-1578 or 1-800-686-1526. You may also obtain numerous additional consumer guides such as explanations of auto or home insurance. A more detailed reference is also available on the topic of this fact sheet from the above number, or from your insurance agent, titled “Ohio Shopper’s Guide to Medicare Supplement Insurance and Medicare Options.” Go to <http://ohioinsurance.gov/> then click on “Consumer Publications” and a list of all the “Shopper’s Guides” will come up on your screen. Also, if you click on “Medicare Services” a more complete list of publications, links, and services are listed. Another 120-page bulletin is available by typing in <http://medicare.gov/> then clicking on “Medicare & You 2009” then clicking on it again on the new page. Then click on “View Adobe PDF.” You can also obtain this by calling Medicare at 1-800-633-4227 and going through a phone menu.

Medicare—Apply Early

Medicare is a government program that pays a large **part**, but not all, of medical expenses after one turns 65 (before 65 if disabled). The government will not pay your expenses unless you have applied. If you have already been on social security when you turn 65, you get a card notifying you that you will be enrolled in Medicare and the premium for Part B will be deducted from your Social Security check. If you are eligible for Social Security but not enrolled, apply for Medicare two or three months before the month of your 65th birthday, at the Social Security Office.

If you are not eligible for Social Security, you are not eligible for Medicare without paying a very high fee for Part A. Many spouses who were never employed are eligible for Social Security and Medicare because their spouse was employed. Most not eligible for Social Security have a medical plan that replaces Medicare. However, even

if you have other health benefits, most should apply for at least “Part A” of Medicare, if eligible, when you turn 65, as “Part A” is free for most. In fact, you should apply two to three months before the month of your 65th birthday.

The monthly premium for Part B is \$96.40 per month, so check with your health benefit provider to see if you need to enroll in Part B. If you chose not apply for Part B because your employer’s benefit package has Part B benefits, but you then retire, check immediately after retirement to see if you then need Part B. Most likely you should pick up Part B upon retirement. If you need insurance to supplement Medicare it should also be purchased at that time because there are advantages to enrolling during the open enrollment period. This is further discussed later. Remember, if eligible for Social Security, don’t forget to apply for Part A *before* the month of your 65th birthday, no matter if employed or not or if you have another medical plan or not.

Medicare—Explanation

In order for you to decide how to pay for medical expenses that Medicare does not cover, you need to have a basic understanding of Medicare and to have some idea of what expenses Medicare does not cover. Medicare consists of two parts, called “Part A” and “Part B.” Part A covers *part* of your hospital bills. Part A of Medicare covers the type of expenses that medical health plans refer to as “hospitalization.” Part B covers *part* of your doctor bills and other medical bills. Part B of Medicare covers the type of expenses that medical health plans refer to as “major medical.”

How much is not covered by Medicare and may need to be paid by you or some alternative arrangement? Medical expenses go up, and the figures quoted below may be different now.

Part A

First, let’s talk about part A, or the hospitalization part of Medicare. You pay the first \$1,024 every time you are admitted to the hospital in each “benefit period.” A benefit period begins when you are admitted and ends when you have been out of the hospital, skilled nursing or rehabilitation facility for 60 days. It also ends even if you remain in a skilled nursing facility but don’t receive any skilled care there for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins, you pay \$1,024 again, but you got a new “set” of benefits for the new benefit period. There is no limit to the number of benefit periods for hospital or skilled nursing facility care. For most people on Medicare, the \$1,024 “deductible” is all they pay for hospitalization. This is the case because most hospital stays are less than 60 days.

During each benefit period, the hospital room cost is covered for the first 60 days. After that, you pay \$256 of daily hospital room cost for the 61st through 90th day and Medicare pays the rest of hospitalization expenses. Hospital room cost is not covered beyond 90 days in any benefit period, except for an additional once in a lifetime allocation of 60 days (called lifetime reserve days). After you are in the hospital for more than 90 days, you may choose to begin using your allocation of 60 lifetime reserve days. Once used, those 60 days are gone and never renewed. You pay \$512 for each lifetime reserve day used and Medicare pays the rest of hospitalization expenses. You also pay \$128 per day between 21 and 100 days per benefit period for skilled nursing facility care. Hospital expenses deemed to be unnecessary by Medicare, such as private room if requested by patient, private duty nurse, telephone, and television are not covered by Medicare. Also, care outside the United States is generally not covered by Medicare.

Part B

Part B of Medicare covers doctor bills and medical expenses other than the hospital room cost. You pay the first \$135 of Medicare approved charges and Medicare pays 80% of the remaining Medicare approved expenses. That leaves 20% of the “major medical” expenses that you need to pay, or make other arrangements to be paid assuming Medicare approves all your expenses. If Medicare does not recognize all the care as covered by Medicare, they will not cover those expenses. Therefore, you could easily have to pay more than the first \$135 plus 20% of “major medical” expenses. However, generally the bulk of your expenses are the 20% of the “major medical” expenses not covered. This short description by no means gives all details and specifics of Medicare.

So, what are the options to pay what Medicare will not pay? First, if your income and assets are low enough, most if not all medical expenses will be covered. (Medicaid requirements are discussed in another fact sheet in this series.) There are several other programs that may pay medical expenses and are also administered by the County Human Services Office, as is Medicaid. For example, you may be a “Qualified Medicare Beneficiary” (QMB). If you are a QMB all your medical expenses not paid by Medicare are paid. The QMB Program is like a free Medicare Supplement or Medigap policy.

General guidelines to qualify as a Qualified Medicare Beneficiary (QMB) in 2008 were: monthly income less than \$867 if single or \$1,167 if married; and assets less than \$4,000 if single or \$6,000 if married, (not including your home, home furnishings, one car, \$1,500 in burial fund, personal jewelry and life insurance).

If you are not a “QMB,” you may be a “SLMB.” SLMB stands for Specified Low Income Medicare Beneficiary Program. SLMB pays only for the Part B premium charged for Medicare

(\$96.40 per month). It also pays the premium for the three months prior to qualifying. To qualify for SLMB, one must have monthly income of \$1,040 or less (\$1,400 for a couple) and countable assets less than \$4,000 (\$6,000 for a couple). Unlike the above two programs, a “Qualified Individual” (QI) only is approved if they apply before the designated funds run out. Like SLMB, QI only pays the \$96.40 per month for part B. To qualify as a QI one must have monthly income less than \$1,190 if single or \$1,595 if married and must also have countable assets less than \$4,000 (\$6,000 for a couple). All these limits will change annually and are for 2008.

If you have more income than that necessary to qualify for Medicaid, QMB, or SLMB, you may have other medical insurance or may be in a medical plan that will cover most and possibly all those expenses that Medicare will not. You may have medical coverage through your employment or your retirement fund may include a health insurance plan as part of your retirement benefit. Remember, many health insurance plans assume that if you are eligible for Medicare, that you have it. Therefore, they will then pay only what Medicare will not pay.

As of January 1, 2006, new prescription drug coverage is available for everyone with Medicare.

Managed Care Plan

Managed Care Plans, sold by health maintenance organizations (HMO) are becoming increasingly popular. Managed health care plans have played an increased role in medical care in recent years. You may wish to join a plan sold by HMO's, if an HMO services your location. HMO's have contracts with Medicare to provide services to the HMO members. If you have a plan with an HMO you *must* use the HMO's doctors and facilities for all medical services (unless an emergency makes it impossible). For plans that contract

with HMO's, if you use out of HMO network medical care, not only will the HMO not pay for those services, but Medicare will also not pay. With an HMO, in addition to monthly premiums, a small co-payment for each visit may be charged. However, an HMO cannot reject your application because of poor health (except for permanent kidney failure). Also, depending on the plan, an HMO may give you "comprehensive care," including physical exams and "preventative" tests.

As mentioned above, with an HMO, if you go outside the network (except for emergencies), you pay the full bill. Medicare will pay nothing and the HMO will pay nothing. Therefore, if you travel extensively or spend your winters in Florida and are considering an HMO, make sure your HMO will cover your expenses if you become ill away from your primary residence. Some HMO plans do not even pay for emergencies when the member is outside the plan's territory for longer than 90 days. The bulletin does an excellent job of comparing HMO's and indicating what plans are available to you. If you are seriously considering an HMO, get the bulletin by calling 1-800-686-1578. Remember, if you are eligible for Medicare and have joined an HMO, you will receive all services through the HMO, will pay no Medicare deductible, co-insurance, or Part B premium, but you must use the HMO's facilities.

Medicare Select

Medicare Select (MedSelect) policies are a cross between an insurance policy and the managed care plans just discussed. Since MedSelect policies can be sold by either insurance companies or HMO's, they have some of the characteristics of the traditional Medicare supplement insurance (Medigap) policy and the managed health care plans discussed in the earlier section. MedSelect companies, like HMO's, require you

to use specific hospitals and most require you to use specific doctors. Like the HMO's, those restrictions generally do not apply in the case of emergency. Also like HMO's, if you do not follow the plan's rules, the Med-Select company may pay less or nothing. Like HMO's, because of the restriction of using the plan's facilities, the cost for medical care may be lower. However, like the regular Medicare supplement insurance (Medigap, to be discussed in the next section) there are 10 standardized plans from which you can pick, with each of the 10 plans offering the same general benefits regardless of the company chosen. MedSelect policies, and accompanying premiums are listed at the end of the charts for Medicare supplement (Medigap) insurance in the bulletin. Again, if you are seriously considering a MedSelect policy, call 1-800-686-1578 for the bulletin.

Medigap

The rest of this fact sheet concerns those insurance policies written specifically to pay what Medicare will not pay. These policies are called Medigap or Medicare Supplement Insurance, hereafter referred to as "Medigap." They are sold by private insurance companies, not the government, but are highly regulated. You pay a premium to the insurance company so it will pay those medical expenses Medicare will not pay.

Plan A is the Basic Plan C Through J Add Coverage and Cost

In 1992 the government required all Medigap companies to offer no more than 10 plans, designated by letter A through J, and made it illegal to sell you duplicate policies. Every plan A offers the same benefits, as does every plan with the same letter. Plan A has the fewest benefits and the lowest prices. Plan A includes the most important benefits, but other plans add to the basic plan A. After you paid the initial \$1,024 Medicare deductible, your plan A combines

with Medicare to cover all Medicare-approved hospital charges for at least 150 continuous days in a hospital. If you are in and out of the hospital, plan A with Medicare will likely cover even more than 150 days. There is also 365 days of lifetime coverage that once used is gone. Plan A along with Medicare will also cover all your Medicare-approved medical expenses (including blood expenses) that are in addition to the hospital room expenses. But you will have to pay \$100 per year in any year that you have medical expenses.

So, why plans B through J? The additional plans give you different combinations of additional coverage. Every plan except Plan A covers the \$1,024 Part A Medicare deductible. Every plan except A and B covers Skilled Nursing Co-Insurance and Foreign Travel Emergencies. Refer to the back of the bulletin for a summary of the additional coverages for plans B through J.

Medigap Open Enrollment

There is an open enrollment period for Medigap insurance, during which every company must accept you for any policy it sells, at its lowest price for customers in your age group. In other words, during the open enrollment period a company cannot reject you or charge you a higher rate because of poor health. Your open enrollment period starts the month you enroll in Part B of Medicare and ends 6 months later. If you have Medicare because you are disabled and you are not yet 65, your open enrollment period begins the month of your 65th birthday and ends 6 months later. If you are going to purchase Medigap insurance, and you have had a past history of health problems, it is especially important to do so during the open enrollment period. However, if there is a pre-existing condition, you may have to wait up to 6 months for coverage, even if you purchase the Medi-gap insurance during the open enrollment period.

Balance Billing

Your doctor cannot charge you more than what Medicare approves. Ohio law prohibits the medical industry from “excess charging” any Medicare patient. Medigap policies offer coverage for excess charges; however, only those who will be spending a significant amount of time in a state or country that does not prohibit balance billing (such as winters in Florida), should supplement their Medigap policy with “excess charge” coverage. Plans F & G add excess coverage to plans C & D, respectively, thus should not be considered unless one will be spending a considerable amount of time in a state that allows balance billing.

Standardized Post-1992 vs. Pre-1992

Medigap policies were sold before 1992 but were not required to be standardized. Some of the pre-1992 policies were better and some were worse than the standard post-1992 policies. Some coverages were available before 1992 but not available now. You never need two Medigap policies: in fact, it is considered unethical to knowingly sell you a second Medigap policy unless you drop your present plan. But if you are considering switching from an old to a new policy, use the worksheet on the inside of the back cover of the reference bulletin to compare the two policies. Also, managed care plans through an HMO are a substitute for Medigap insurance. You do not need two or more Medigap policies and do not need both a Medigap policy and a HMO. If you join a HMO, cancel the Medigap policy as soon as you have confirmed your membership in the HMO. Likewise, if you move from an HMO’s territory, you will likely “dis-enroll” from the HMO and consider a Medigap policy, or other arrangement to cover expenses that Medicare will not.

Shopping for Medigap Insurance

Some key points to keep in mind when shopping for Medigap coverage are:

- 1) More than one Medigap policy is a waste of money.
- 2) If you are going to buy a policy and have had health problems, make sure you buy it during the open enrollment period. The open enrollment period is the time period between enrollment in Part B of Medicare (or your 65th birthday if disabled) and 6 months from that date.
- 3) Don't pay with cash. When paying by check, make it out to the insurance company, not the insurance agent.
- 4) Remember, you may not need a Medigap policy, especially if covered by a retirement or other health plan, or if your income and assets are low enough so that you are eligible for Medicaid or are a Qualified Medicare Beneficiary.
- 5) There is a 30-day no-obligation period during which you can cancel a policy and get your money back.

Medigap Policy and Premium Comparison Chart

If you are shopping for Medigap insurance, the charts in the bulletin will help. Also, the *Consumer Reports* magazine, available at your local library, has excellent articles on Medigap insurance. Finally, if you are serious about purchasing a policy, call 1-800-686-1578 or 1-800-686-1526 (the same

numbers where you can get the bulletin) to talk to a counselor of the Ohio Department of Insurance, as explained below.

Ohio Senior Health Insurance Information Program

As mentioned in the last fact sheet in this series, the Ohio Department of Insurance coordinates a program to personally assist seniors. The Ohio Senior Health Insurance Information Program (OSHIIP), accessed by the same toll free numbers mentioned above, has volunteer counselors throughout Ohio to help you:

- 1) understand Medicare and Medicaid;
- 2) deal with and make sense of the medical bills and statements you receive;
- 3) make sure you get the benefits to which you are entitled;
- 4) better understand insurance and Medicare/Medicaid;
- 5) decide if your insurance coverage is adequate;
- 6) select the appropriate insurance program.

Throughout this fact sheet we have referred you to toll free numbers. If you find that you are unable to get the assistance you need on your long term care, nursing home, or medical insurance questions, you may also call the OSHIIP Counseling Center nearest you. The phone numbers of offices throughout Ohio are also listed in the bulletin.

These fact sheets should in no manner be considered as a replacement for consulting with estate planning professionals, nor should the general principles in these fact sheets be applied to specific situations without consulting with an attorney.

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TDD No. 800-589-8292 (Ohio only) or 614-292-1868

Answers

Fact Sheet 11

1. You should apply for Medicare? (pick one of the following)

- X Before you are 65 _____ The day you turn 65
 _____ During the month of your 65th birthday

Apply before you are 65. To start Medicare benefits as soon as possible, you should apply between three months before the month of your 65th birthday, and the month before your 65th birthday. Even if medical insurance is available to you free of charge, you should apply for at least Part A, as there is no cost to you for such coverage. The bulletin describes the delays in coverage if you apply the month of your 65th birthday or after.

2. Medicare has two parts, Part A and Part B.

Which part is “free”? A

For which part is a monthly premium charged? B

Medicare does not charge participants a “premium” for coverage for Part A. However, the “premium” charged for Part B is \$96.40 per month.

3. Medicare is like medical insurance, you pay the government for a premium for Part B and it covers part of the medical expenses. Medicare, like insurance, has “deductibles,” or fees you pay before Medicare pays anything.

What was the “deductible” for Part A, the part that pays hospital bills? \$1,024

What was the “deductible” for Part B, the part that pays doctor bills and nonhospital expenses? \$135

You pay the \$1,024 deductible before Part A pays anything. Then Part A generally covers hospitalization costs through the 60th day of your hospital stay. You pay the \$135 deductible before Part B pays anything.

4. Part B of Medicare pays a portion of medial expenses other than hospital bills. After you pay the \$135 deductible, the government pays 80 % of Part B expenses and you pay 20 %.

Part B generally pays only 80% of the nonhospital medical expenses. You or your insurance are responsible for the remaining Part B expenses. With sizable medical expenses, your 20% can be very expensive.

5. Managed Care Plans, sold by HMO's are becoming increasingly popular. These plans generally cover all medical expenses for a monthly fee. Name at least one disadvantage and at least one advantage of the plans offered by HMO's.

Disadvantage: If you travel away from the service area, only emergency care is available elsewhere.

Disadvantage: If you move from the service area, you must make other arrangements for medical care.

Advantage: Generally lower cost.

Advantage: Many offer preventative health care that traditional plans do not.

6. Do you plan to investigate buying Medigap insurance?

Yes _____ No _____

Again, this answer varies for each person. If you decide to buy Medigap insurance and can afford the premium for a Medigap policy with the benefits you desire, you are lucky! Remember, you do not need to duplicate coverage, such as two Medigap policies; a managed health plan (HMO) and a medigap policy; or a Medigap policy if you are covered by other medical insurance.

If you determine that Medigap insurance is for you, definitely call 1-800-686-1578 to get the reference bulletin. Also consider talking to a counselor at the Ohio Department of Insurance at the above number.