

# MEDICARE & MEDIGAP INSURANCE

©Commonwealth Schools of Insurance, Inc.



P.O. Box 22414

Louisville, KY 40252-0414

Telephone: 502.425.5987

Fax: 502-429-0755

Web Site: [www.commonwealthschools.com](http://www.commonwealthschools.com) Email: [info@commonwealthschools.com](mailto:info@commonwealthschools.com)

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# MEDICARE & MEDIGAP INSURANCE

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## A. MEDICARE IN GENERAL

In brief, Medicare is “national health insurance” for the disabled and people aged 65 and older. It passed Congress in 1965 and was the subject of major amendments in 1983 and 1988.

Medicare is a federal program administered by the Health Care Financing Administration. Most people think of Medicare as part of the Social Security Administration. Social Security offices handle the program on the local level (e. g., enroll applicants, process claims, provide information), but the Social Security Administration does not establish Medicare policy.

Medicare is divided into 2 parts: Part (A), Hospital Insurance; Part (B), Medical Insurance.

Part (A) covers: inpatient hospital care; inpatient care in a “skilled nursing facility” (e. g., certain nursing homes, hospital rehabilitation facilities); home health care (e.g., a visiting nurse); hospice.

Part (B) covers: doctors’ services; home health care and other outpatient services not covered by Part A.

The federal government contracts out Medicare benefit payments to private insurers. Intermediaries are insurance companies that handle coverage and payment decisions for the Part (A). Carriers are insurance companies that handle claims for Part (B). Among the intermediaries’ and carriers’ responsibilities: decide reasonable charges for services; reimburse the patient or service provider; conduct research and statistical studies; handle appeals; follow nondisclosure rules.

Part (A) is financed through Social Security deductions. All of the dollar amount and percentages in the text are subject to change as directed by Congress. Many will change annually.

Social Security and Railroad Retirement recipients do not pay a premium for Part A, which is financed through part of the FICA (Social Security) tax, as discussed in the next paragraph. Some people are eligible to pay a premium for Part A benefits under limited conditions (e.g., someone under age 65 previously entitled to Medicare under the Social Security disability provisions, but no longer receiving disability benefits).

In 2011, Part A is a tax of 1.45% of all earnings paid by employees and employers.

Part (B) is financed (in part) by enrollees at a monthly premium of \$115.40 in (2011).

<b>If Your Yearly Income is:</b>		
<b>File Individual Tax Return</b>	<b>File Joint Tax Return</b>	<b>Part B Monthly Premium</b>
\$85,000 or less	\$170,000 or less	\$115.40
\$85,001-\$107,000	\$170,001-\$214,000	\$161.50
\$107,001-\$160,000	\$214,001-\$320,000	\$230.70
\$160,001-\$214,000	\$320,001-\$428,000	\$299.90
Above \$214,000	Above \$428,000	\$369.10

“In part” because the federal government (the taxpayer) pays about 75% of Part (B)’s costs. This premium is automatically deducted from the checks of Social Security and Railroad Retirement recipients.

People who apply for Social Security benefits are automatically enrolled in Medicare Part (A). Part (B) is voluntary and available for people age 65 and older who are not eligible for Part (A).

Medicare enrollees receive a card indicating which coverage's they maintain and the date the coverage started.

Medicare is available to: persons 65 years and older; certain disabled persons and persons with end-stage renal diseases (kidney failure) regardless of age. (Medicaid, another socialized medicine program, is designed for the indigent) Survivors and dependents of these people may also be eligible for Medicare.

Medicare is the "secondary payer" for most people age 65-69 who continue working. If their employer has 20 or more employees, these workers are entitled to the same group health benefits as younger employees. As a secondary payer, Medicare only pays costs not covered by the employer's plan. Workers aged 70 years or more may elect either Medicare or their employer's plan as their primary health coverage. (This also applies to disabled persons, although the employer must have 100 or more employees before Medicare becomes the secondary Payer)

Federal employees have been covered by Medicare since 1983, as are state and local government employees hired after 3-31-86. Some states extend coverage to employees hired before then.

Medicare Part A and B have a series of exclusions: Routine physical exams, regular dental care, eye exams, glasses, contact lenses, hearing exams and hearing aids, routine foot care, orthopedic shoes, etc. Cosmetic surgery, acupuncture, most treatment by chiropractors, optometrists, and psychologists, most prescriptions drugs, (although inpatient medicine furnished by a hospital is covered), most immunizations, services not medically necessary for diagnosis or treatment, service performed by a relative or member of the patients household, extra charges for a private room (unless medically necessary), "luxury" hospital items such as a TV or telephone, private duty nursing, skilled nursing facility for more than one hundred days, intermediary facility nursing home care, custodial care in a nursing facility home care, custodial care provided outside the U.S., medical charges in excess of those deemed "reasonable" (discussed later).

Moreover, Medicare does not pay just anybody. Local Social Security offices maintain lists of Medicare-certified providers. For certification, the provider must meet state and local licensing requirements and be certified by the Health Care Financing Administration.

Providers that must be Medicare-certified include: Hospitals, skilled nursing facilities, home health care agencies, hospices, ambulance companies, outpatient rehabilitative facilities, speech pathology centers, physical therapy centers, X-ray labs, diagnostic labs, rural health clinics, kidney dialysis and transplant facilities. Medicare beneficiaries can also seek services from a certified health maintenance organization, and competitive medical plan.

Medicare establishes in each state a peer review organization (PRO) composed of doctors and health professionals to review hospital care received by Medicare patients. (This is also known as a "quality review organization") A PRO determines such matters as: when medical care is necessary, if the care meets medical standards, if the care is delivered in the most appropriate setting. Patient complaints are also examined by a PRO, which also has the power to deny payment. This is not to be confused with a "utilization review committee," which is an internal team appointed by a hospital to make similar determinations about the facility's procedures and personnel.

### Payment of Claims

Instead of the patient sending his medical bills straight to Medicare, the hospital sends them to a private insurer (selected by Medicare) for processing. This insurer, the intermediary, will pay the institution for the applicable bill and be reimbursed by Medicare. The patient receives a Medicare Benefit Notice on the claim. Bills not paid by Medicare are paid out of pocket by the injured or through a private Medicare Supplement Policy. (discussed at end of text)

Physicians and other medical care providers may submit charges directly to the intermediary or accept an assignment of benefits from Medicare. In the latter, the provider agrees not to charge more for a given service than Medicare will pay.

If the provider chooses to submit the charge directly to the intermediary, then Medicare will only pay what is deemed to be "reasonable" and (hopefully) to be paid by the patient or his carrier.

On the other hand, a doctor or supplier who accepts an assignment of benefits will receive that amount as full payment and cannot legally bill the patient for anything extra.

Doctors and suppliers who accept an assignment of benefits on all claims are listed on the Medicare Participating Physician/Supplier Directory, which is available for local Social Security and seniors organizations.

Medicare patients are issued a Medicare card, which lists the participant's permanent "claim number" (usually his Social Security number followed by a letter). It also describes the appropriate coverage's.

Physicians who do not accept Medicare claim assignments face restrictions on their charges, usually a ceiling of 115% of the fee schedule amount for nonparticipating physicians. The fee schedule sets a dollar amount on a physician service, based on work, practice costs, and malpractice insurance costs. Again, for physicians accepting claims, Medicare pays only 80% of the fee; the insured faces a 20% co-payment.

**Quiz A:**

Mrs. Yeager, a Medicare enrollee, is hospitalized. She undergoes surgery for spurs in her knees. Her private room has a TV and telephone. She also has an eye exam, hearing exam, and face lift. She receives medication for the face lift and decides to get a pair of orthopedic shoes. What will Medicare cover?

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**B. PART (A) BENEFITS**

Medicare Part (A) covers four types of care: inpatient hospital, inpatient in a “skilled nursing facility”, home health care, hospice care. Remember that Medicare only covers a “reasonable amount” of charges that are “medically necessary.”

Hospital bills will be paid by Medicare under the following circumstances: a doctor prescribes inpatient care; the patient needs the sort of care that can only be provided in a hospital; the hospital is certified by Medicare; a PRO (or hospitals utilization review committee) does not disallow the treatment or hospitalization.

Hospitalization Benefits

Medicare is not a limitless source of income for hospitals. The following table illustrates Medicare’s hospital payment schedules for 2011.

Days in Hospital	Medicare Pays	Patient Pays
1-60	All but \$1,132.00	\$1,132.00 deductible
61-90	All but \$283.00 per day	\$283.00 per day \$8,490.00 maximum
91-150*	All but \$566.00 per day	\$566.00 per day \$33,960.00 maximum
151 and over	Nothing	100%

(\*These are reserve days; they can be used only once and are not renewable)

Medicare divides benefit periods into spells of illness that last from the day the patient is admitted until the date of discharge. If the patient is readmitted within 60 days of the discharge, those days are added on the days of the initial spell of illness.

Thus the two 50 day stays within 2 months will push the patient into the reduced benefit period of the 61-90 day and the 91-150 day stays rather than have 2 stays with the maximum deductibles of \$1,132.00 each

On the other hand, if the next hospitalization begins more than 60 days after the last one, the next hospitalization is considered new spell of illness. Again, spells of illness are not considered by calendar year, but by days between hospitalizations.

Three limitations exist on hospital benefits:

- 1) Medicare will pay for inpatient care at non-certified hospitals only in cases of emergency treatment
- 2) Under the “blood deductible”, the patient pays for the first 3 pints of blood, Medicare all others
- 3) Medicare will pay for a lifetime total of only 190 days of inpatient psychiatric care.

Services covered include: Semi-private room, meals(including special diets), regular physician and nursing services, special care units, (e.g., intensive care), pharmaceuticals, blood transfusions (except first 3 pints), lab tests as well as other diagnostic and therapeutic services, oral and dental surgery (if hospitalization is required), x-rays and other radiology items, casts, surgical dressings, etc. Wheelchairs, operating and recovery rooms costs, rehabilitation services, medical social services.

Services excluded include: Physicians or surgeons services (covered by Part (B)), hospital stays exceeding 150 days, inpatient psychiatric care exceeding 190 days, luxury hospital room items (e.g. telephone, TV), private duty nurses, additional charges for a private room (unless medically necessary), outpatient diagnostic test (covered by Part (B)).

Most Medicare hospital payments are determined by the patients diagnosis when admitted. Costs incurred after admission are not figured into the payment plan. This is under the Prospective Payment System (PPS), which went into effect in 1983.

The admitted patient is assigned to a disease related group (DRG), a system of possible diagnoses organized by the Internal Classification of Diseases. Twenty-Three major diagnostic categories are divided into 470 distinct groups. The Medicare payment is the flat amount assigned to the DRG.

For example, if Medicare determines that the relevant DRG requires a hospital stay of 5 days and the patient stays 7, the hospital will be paid for only 5 days. If the patient is released in 4 days, however, Medicare will still pay for the 5 days. Hospitals occasionally receive payments beyond the DRG, but only after proving that the patient required extraordinary care.

The PPS system was established to curtail extraordinary charges that some unscrupulous hospitals passed on to Medicare. To ensure quality medical care, the Health Care Finance Administration (which administers Medicare) contracts peer review organizations PROs to review hospital admissions and inpatient practices, concentration on quality of care, length of admission, and necessity of charges.

### SNF Benefits

“Skilled nursing facility” (SNF) is neither intermediary nor custodial nursing home care. SNF refers to a special facility that may be part of a hospital (or separate from a hospital) that offers skilled nursing and rehabilitate services. For Medicare to pay, the patient must enter a SNF within 30 days of discharge for the hospital for continuing treatment of the condition that caused hospitalization. Also, the hospital stay must have been for at least 3 days.

Medicare Part (A) is not a limitless stream of income for SNF’s. The following table illustrates Medicare’s SNF payment schedules:

Days in SNF	Medicare Pays	Patient Pays
1-20	100%	Nothing
21-100	All except \$141.50 day	\$141.50 day (\$11,320 max)
101 and over	Nothing	100%

Among the SNF services covered by Medicare, Semi-private rooms (private room if medically necessary), meals (special diets included), skilled nursing care (given or supervised by a registered nurse), pharmaceuticals, supplies, and equipment, blood transfusions (except for first 3 pints), medical social services, physical, occupational, and speech therapy.

Services excluded by Medicare Part (A): Doctors services while patient is in an SNF (covered by Part (B)), extra charges for private room (unless medically necessary), luxury room items such as TV or telephone, SNF stays longer than 100 days, custodial care (explained below)

“Custodial care” refers to SNF services on a long term, chronic basis, this is the typical nursing home patient. Medicare pays only for “acute care” which is only 3% of America’s total annual nursing home bill.

More over custodial care is defined as assistance in dressing, eating, toiletry, bathing, and walking. None of this is covered by Medicare. Medicare only covers skilled care provided on a 24 hour basis. Medicare does not cover bills of the patients needing care only once or twice weekly. Finally, the Medicare intermediary or the SNF’s utilization review committee must approve the patient’s stay.

Only one in four nursing homes qualifies as a SNF. About one-third of those qualifies as Medicare-approved. Only about 15% of all U.S. nursing homes meet both qualifications. Moreover, some facilities have a 6-9 month waiting list. For Medicare to pay, the patient must enter the SNF within 30 days of hospital discharge.

As you may have guessed, Medicare’s PPS system, which more quickly discharges inpatients, has increased Medicare payments to SNF’s. Since PPS was implemented in 1983, nursing home admissions have increased 40%.

### **Home Health Care Benefits**

Part (A) will pay for home health care services that meet the following conditions:

- 1) The care is intermittent, part-time, skilled nursing care, physical therapy, or speech therapy.
- 2) The patient is confined at home
- 3) A physician decides that home health care is necessary and designs an appropriate plan
- 4) The home health care provider is Medicare-certified.
- 5) Unlike SNF’s, previous hospitalization is not necessary

“Confined at home” denotes the patient’s leaving home to be: Medically unsafe, impossible without human assistance or without the support of a wheelchair, cane, etc. Confinement to a bed is not required.

Medicare Part (A) will pay the full cost of an unlimited number of home visits, so long as they are deemed medically necessary. There is neither a deductible nor a co-payment amount, except for durable medical equipment. (explained in next paragraph)

Medicare covers: intermittent or part-time home nursing care (and care by home health aides), physical, occupational, and speech therapy, medical social services, medical supplies (excluding pharmaceuticals and biological), (e.g. wheelchair, oxygen tent) services outside the outpatients home if the necessary equipment cannot be provided in the patients home.

Medicare Part (A) for home health care excludes housekeeping services, meals, full-time nursing care, pharmaceuticals and biologicals, blood transfusions, custodial care (e.g. bathing, dressing), transportation costs if services are provided outside of the patients home.

Medicare pays only 15% of the total annual home health care bill in the U.S. (For the record, Medicaid pays approximately 10% and the individual pays 57% out of pocket).

## Hospice Benefits

Medicare Part (A) covers some inpatient and outpatient hospice charges for terminal patients with a 6- month life expectancy. A Hospice provides services to the terminally ill, including pain reduction, symptom management and counseling. A Hospice does not provide curative treatment.

Medicare will help cover Hospice charges if:

- 1) The physician certifies the patient to be terminal
- 2) The patient chooses Hospice rather than standard Medicare benefits
- 3) Care is provided by a Medicare-certified Hospice

Medicare Part (A) usually covers 210 days (7 months) of hospice care. There is no deductible. Co-payments apply in only two instances:

- 1) Prescription drugs, where in the patient pays \$5.00 or 5% per prescription, which ever is less
- 2) Respite care ( up to 5 days temporary care in a hospice facility—only for the patient who is normally home ), where in the patient pays 5% of the Medicare approved rate ( not to exceed \$628.00 )

Since hospice is an alternative to traditional medical care, Medicare no longer pays for other medical services, ( except in cases that are unrelated to the terminal illness ). A patient who experiences a turnaround in the terminal condition may select traditional medical services with the attendant Medicare payments.

Hospice services covered by Medicare Part (A) : Doctors services, nursing services, pharmaceuticals for pain or symptom relief, medical supplies and equipment, medical social services, physical, occupational and speech therapy, counseling services, respite care, short term inpatient care, home health care services.

### Quiz B:

Mr. Fox falls off a tricycle and is hospitalized for 122 days at \$248.00 per day. Two weeks after release, he is sent to a SNF for continuing treatment. He is there for 37 days at \$124.00 per day. What will Medicare Part (A) pay? (amounts and stays)

Do not use reserve days.

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## C. Part B benefits

Medicare Part (B) is an optional medical insurance program that supplements Part (A) (hospitalization). Even people failing to qualify for Part (A) can avail themselves for Part (B) for a monthly premium (\$115.40 in 2011). The federal government (i.e. taxpayers) subsidizes about 75% of the cost of Part (B) coverage.

Deductibles and co-payments apply to all Part (B) services. A patient is always responsible for: \$100.00 deductible, 20% of all covered charges and the first three pints of blood. The patient pays for all expenses that are considered "medically unnecessary" and for those above a "reasonable charge". (as in Part (A), a Medicare panel reaches those conclusions)

Part (B) covers most doctors' surgeons' and osteopaths' services (and accompanying supplies) regardless of where they are provided (e.g. hospital, SNF, doctors office).

Part (B) covers doctors' services including: medical and surgical services (and anesthesia), office visits, house calls, radiology and pathology, medical supplies (as a part of doctors' services), second opinions, diagnostic tests, X-rays, doctors' nurses services, physical, occupational and speech therapy, blood transfusions (after the first three pints), pharmaceuticals and biologicals that are not self-administrable.

Vision services, dental care, chiropractor treatments, and routine foot care are generally not covered although there are exceptions to each category. Psychiatrist (physicians) charges are covered to the lesser of:

- 1) 50% of all such charges
- 2) \$1100.00 annually. Psychologist (non-physicians) charges are not covered.

Medicare Part (B) does not cover: routine physicals, eye exams, foot care, hearing exams, most immunizations, cosmetic surgery.

Medicare Part (B) covers home health care services. There is no deductible or co-payment, except on durable medical equipment (\$100.00 deductible and 20% co-payment)

Medicare Part (B) will pay for certain services provided on an out patient basis for diagnosis or treatment. There is a \$100.00 deductible and the patient is responsible for 20% of all covered bills.

Among the outpatient medical service covered by Part (B): surgery (including anesthesiologist and surgeon), clinic services, emergency room, X-rays, lab tests, ambulance, purchased or rented durable medical equipment, artificial limbs and eyes, artificial replacement for internal organs, braces (neck, back and limbs), casts, splints, blood, (after the first three pints), physical, occupational, and speech therapy (limited to \$750.00 annually), pharmaceuticals and biologicals that are not self-adminstrable.

Medicare Part (B) will usually pay 50% for the outpatient cost of treatment for mental illness. Part (B) will pay 80% if hospitalization would have been required without outpatient treatment

Outpatient treatments not covered by Medicare Part (B) includes: routine physical exams, eye exams, hearing exams, most immunizations, routine foot care.

**Quiz C:** Mrs. Kimberlin is covered under Medicare Part (B). As an outpatient, she receives medical treatment for injuries sustained in roller derby accident. Surgery charges are \$10,400.00. She receives 4 pints of blood at \$125.00 pint. She also receives a prescription for self-administrable medicine. Her follow-up medical services run \$3,000.00. What will Medicare cover?

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Show Calculations:

**B. MEDIGAP INSURANCE**

Some private insurance companies sell Medicare supplement, or Medigap, insurance to fill the gaps in Medicare coverage. Effective July 30, 1, by Federal law, Medigap policies sold in the United States, U.S. territories, and the District of Columbia, are limited to 10 standard benefit plans.

The Kentucky Department of Insurance has approved all 10 plans (A-J) for sale in the state. The chart below is followed by a description of each plan:

CORE BENEFITS	PLANS									
	A	B	C	D	E	F	G	H	I	J
Part (A) Hospital (61-90 days)	X	X	X	X	X	X	X	X	X	X
Lifetime Reserve Days (91-150 days)	X	X	X	X	X	X	X	X	X	X
365 Life Hospital Days 100%	X	X	X	X	X	X	X	X	X	X
Parts (A) and (B) Blood	X	X	X	X	X	X	X	X	X	X
Part (B) Coinsurance 20%	X	X	X	X	X	X	X	X	X	X

ADDITIONAL BENEFITS	PLANS									
	A	B	C	D	E	F	G	H	I	J
Skilled Nursing Facility										
Coinsurance (days 21-100)			X	X	X	X	X	X	X	X
Part (A) deductible		X	X	X	X	X	X	X	X	X
Part (B) deductible			X			X				X
Part (B) Excess Charges	See Below									
Foreign Travel Emergency			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Prescription Drugs								1	1	2
Preventive Medical Care					X					X

For Part (B) Excess Charges, Plan G pays 80%, Plans F, I, and J pay 100%

Two Prescriptions Drug benefits are offered:

- Plans H and I offer a "basic" benefit with \$280.00 annual deductible, 50% coinsurance, and a \$1250.00 maximum annual benefit.
- Plan J offers an "extended" benefit containing a \$250.00 annual deductible, 50% coinsurance, and a \$3000.00 maximum annual benefit.

A description of each plan follows:

Plan A, the basic policy, consists of these core benefits:

Coverage for Part (A) coinsurance amount (\$283.00 per day in 2011) for the 61<sup>st</sup> through the 90<sup>th</sup> day of hospitalization in each Medicare benefit period.

Coverage for Part (A) coinsurance amount (\$566.00 per day in 2011) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.

After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part (A) eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient care during the policyholder's life. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System or another appropriate standard of payment.

Coverage under Medicare Parts (A) and (B) for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.

Coverage for the coinsurance amount for Part (B) services (generally 20% of approved amount) after \$100.00 annual deductible in met.

Plan B includes the core benefits and:

Coverage for the Medicare Part (A) inpatient deductible (\$1,132.00 per benefit period in 2011)

Plan C includes core benefits and:

Coverage for the Medicare Part (A) deductible.

Coverages for skilled nursing facility care coinsurance amount (\$141.50 per day for days 21 through 100 per benefits period in 2011).

Coverage for the Medicare Part (B) deductible (\$162.00 per calendar year in 2011).

Coverage for the medically necessary emergency care in a foreign country.

Plan D includes core benefits and:

Coverage for the Medicare Part (A) deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

Coverage for medically necessary emergency room care in a foreign country.

Coverage for at-home recovery. The at-home recovery benefit pays up to \$1600.00 per year for short-term, at home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery. Various benefit requirements and limitations exist.

Plan E includes core benefits and:

Coverage for the Medicare Part (B) deductible.

Coverage for the skilled nursing facility care daily coinsurance amount

Coverage for medically necessary emergency care in a foreign country.

Coverage for preventive medical care. The preventive medical care benefit pays up to \$120.00 per year for such things as a physical examination, flu shot, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

Plan F includes core benefits and:

Coverage for the Medicare Part (A) deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

Coverage for Medicare Part (B) deductible.

Coverage for medically necessary emergency care in a foreign country

Coverage for 100% of Medicare Part (B) excess charges (covers a percent of the difference between Medicare's approved amount for Part (B) services and the providers actual charges [limited by Medicare and \ or state law]).

Plan G includes core benefits and:

- Coverage for the Medicare Part (A) deductible.
- Coverage for skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 80% of Medicare Part (B) excess charges (as per plan F).
- Coverage for at-home recovery (as per plan D)

Plan H includes core benefits and:

- Coverage for Medicare Part (A) deductible.
- Coverage for skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 50% of the cost of prescription drugs to a maximum annual benefit of \$1250.00 after the policyholder satisfies a \$250.00 annual deductible (the basic prescription drug benefit)

Plan I includes core benefits and:

- Coverage for Medicare Part (A) deductible.
- Coverage for skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 100% of Medicare Part (B) excess charges (as per plan F)
- Coverage for at-home recovery (as per plan D)

Plan J includes core benefits and:

- Coverage for Medicare Part (A) deductible.
- Coverage for skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for Medicare Part (B) deductible
- Coverage for 100% of Medicare Part (B) excess charges (as per plan F)
- Coverage for at-home recovery (as per plan D)
- Coverage for preventative medical care (as per plan E)
- Coverage for 50% maximum annual benefit of \$3000.00 after the policyholder meets a \$250.00 deductible (the extended drug benefit)

For consumer ease in comparing plans and premiums, the standard benefits of the 10 plans must be described in the same format, language, and definitions. A uniform chart and outline of coverage must be included in the presentation. The idea behind such standardization is to allow consumers to fairly compare competing plans without confusion over definitions and benefits. If a consumer can make a rational choice, the theory goes, insurers will have to compete on the grounds of service, reliability, and price.

The federal government waived the 10 plan standardization program in states that already incorporated Medigap standardization plans (Minnesota, Massachusetts, Wisconsin). Delaware does not permit the sales of plans C, F, G, and H. Pennsylvania and Vermont do not permit the sales of plans F, G, and I. Since Montana and Oregon State legislatures did not meet in 1, both assemblies will review the federal plan this year.

The remainder of this course incorporates highlights of the Medicare Supplement Insurance Policy Regulation (806 KAR 17:066), effective September 10, 1, that are of importance in Kentucky.

#### **Section 4: Policy Provisions.**

1. Except for permitted pre-existing condition clauses as described in Sections 5(1) (A) and 6 (1) (A), no Medigap policy may be advertised, solicited, or issued if it contains limitations or exclusions on coverage that are more restrictive than those of Medicare.
2. A Medigap policy shall not contain a probationary or elimination period.
3. A Medigap policy shall not use waivers to exclude, limit, or reduce coverage or benefits to specifically named or described preexisting diseases or physical conditions.
4. No Medigap policy shall contain benefits duplicating those provided by Medicare.

#### **Section 6: Benefit standards for policies delivered after January 1, 1**

1. (A) A Medigap policy cannot exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy cannot define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.  
  
(B) A Medigap policy cannot indemnify against losses resulting from sickness on a different basis than losses resulting from accidents and cannot contain a probationary or elimination period.  
  
(C) A Medigap policy must provide that benefits designed to cover cost-sharing amount under the Medicare shall change automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.  
  
(D) A Medigap policy may not terminate coverage of a spouse solely because of the occurrence of an event specified for termination of coverage in the insured, other than non-payment of premiums.  
  
(E) Each Medigap policy is guaranteed renewable and:
  1. The issuer cannot cancel or non-renew the policy solely on the ground of health status of the insured, and
  2. The issuer cannot cancel or non-renew the policy for any reason other than non-payment of premium or material mis-representation.
  3. If the Medigap policy is terminated by the group policyholder and is not replaced as provided under subparagraph 5 of this paragraph, the issuer shall offer an insured an individual Medigap policy that (at the option of the issuer):
    - A. Provides for continuation of benefits contained in the group policy, or
    - B. Provides for benefits that otherwise meet the requirements of the subsection.
  4. If an individual insured under a group policy terminates membership in the group, the issuer shall offer continuation and conversion coverage's in accordance with subparagraph 3 of this paragraph.
  5. If a group policy is replaced by another group policy, the succeeding issuer shall offer coverage to all person covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

- (F) Termination of a Medigap policy shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.
- (G) 1. A Medigap policy must provide that benefits and premiums under the policy shall be suspended at the policyholder's request for the period (up to 24 months) that the policyholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder notifies the issuer within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder that portion of the premium attributed to the period of Medicaid eligibility, subject to adjustment for paid claims.
2. If the policyholder loses entitlement to such medical assistance, the policy shall be automatically reinstated (effective of date of termination of medical assistance) if the policyholder proves notice of loss of entitlement within 90 days and pays the premium attributable to that period, effective as of the date of termination of the entitlement.
3. Reinstitution of coverage's:
- (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions,
  - (ii) Shall provide for coverage that is substantially equivalent to coverage in effect before the date of suspension.
  - (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder as would have applied had coverage not been suspended.
- (2.) Concerns "core benefits" illustrated on page 10 of this text.
- (3.) Concerns "additional benefits" of plans B through J, also illustrated on page 10 of this text.
- (3.)(K), however goes beyond plan J. Entitled "new or innovative benefits", it stipulates that an issuer may, with the commissioner's prior approval, offer policies with "new or innovative benefits that otherwise comply with applicable standards. These may include benefits that are appropriate to Medicare, new or innovative, not otherwise available, cost effective, and offered in a manner that is consistent with the goal of simplification of Medigap policies.

## **Section 8: Medicare Select Policies**

Kentucky is one of the 13 states to offer the "Medicare Select" pilot program (also offered in IN). Basically, the only difference between the standard Medigap program (plans A-J) and Medicare Select is that the latter pays the full benefits only if covered services are obtained through specified health care professionals, called "preferred providers".

In essence, Medicare Select operates similarly to a health maintenance organization. Kentucky's Medicare Select programs, fashioned after plans A-J, are available through Humana and Southeastern United Medicare.

Section 8 describes the Medicare Select in detail. For purposes of this course, it is sufficient to note that Medicare Select benefits are still covered when provided by other than "preferred providers" in cases of "emergency health care services, health care services that are not obtainable through a "preferred provider"

## **Section 9: Open Enrollment:**

As of November 5, 1991, for the six months immediately following enrollment in Part (B), a person aged 65 years or older cannot be denied Medigap insurance because of health problems. This is for the "six month open enrolment period" for buying Medigap insurance.

During this period, a consumer has a choice of different Medigap policies sold by any insurer doing business in Kentucky. The insurer cannot deny a policy, condition its effectiveness, or discriminate in pricing because of an applicants medical history, health status, or claims experience. However, preexisting condition restrictions can be applied to Medigap policies sold after the open enrollment period.

While some people are automatically enrolled in Part (B) upon reaching age 65 (or enroll during the initial seven-month enrollment period that starts within three months before they reach age 65), other people do not enroll because they continue to work past age 65. In such cases, they are covered by an employer's or spouse's insurance plan.

A special seven-month Part (B) enrollment period begins when their work (or their spouses work) ends or when they are no longer covered under the employer health insurance plan, which ever comes first. The "six-month open enrollment period" then begins after the person enrolls on Part (B). Again, an insurer is restricted as per the conditions noted in the preceding paragraphs.

## **Section 11: Loss Ratios**

All Medigap policies must have a loss ratio of at least 65% for individual policies and 75% for group policies.

## **Section 13: Permitted Compensation Arrangements**

- 1.) An issuer may provide an agent (or other representative) for the sale of a Medigap policy a commission (or other compensation) of no more than 200% of the commission (or other compensation) paid for selling or servicing the policy or certificate in the second year.
- 2.) The commission or other compensation provided in the subsequent renewal years must be the same as that provided in the second year, and shall be provided for not less than five years.
- 3.) No insurer shall compensate its agents or other producers for more than the renewal compensation payable by the replacing insurer on renewal policies if an existing policy or certificate is replaced, unless benefits of the new policy are clearly and substantially greater than the benefits under the replaced policy.
- 4.) For purposes of this section, "compensation" includes pecuniary remuneration of any kind relating to the sale or renewal of a policy, including, but not limited to, bonuses, gifts, prizes, awards, and finders' fees.

## **Section 14: Required disclosure provisions**

### **1. General Rules**

- (A) Medigap policies must contain a renewal or continuation provision. The language must be consistent with the type of policy issued. The provision shall be appropriately captioned and appear on the first

page of the policy, and shall include any reservation by the automatic renewal premium increases on the insured age.

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- (B) All riders or endorsements after the date of issue or at the reinstatement that reduce or eliminate benefits require a signed acceptance by the insured except, when the issuer effectuates a written request by the insured, when the issuer exercises a specifically reserved right under a Medigap policy, when the issuer is required to eliminate or reduce benefits to avoid duplication of Medicare benefits.

Any rider or endorsement that increases benefits or coverage with a concomitant increase in premium must also be signed by the insured, unless the benefits are required by the minimum standards for Medigap insurance or other law.

- (C) Medigap policies shall not provide for payment of benefits based on standards described as "usual and customary", "reasonable and customary" or similar phrases
- (D) If a Medigap policy contains any limitations for preexisting conditions, these limitations shall appear as a separate paragraph and be labeled as "preexisting condition limitations."
- (E) Medigap policies shall have a notice prominently printed on the first page of the policy, or attached thereto, stating that the policyholder has the right to return the policy within 30 days of delivery and to have the premium refunded if, after examination of the policy, the insured is not satisfied for any reason.
- (F) Issuers of Medigap policies shall also deliver to the applicant a "Medicare Supplement Buyers Guide" in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 points.

Delivery of the buyers guide shall be made whether or not the policies are advertised, solicited, or issued as Medigap policies.

Delivery of the buyer's guide shall be made to the applicant at the time of application and acknowledgement of receipt of the buyers guide shall be obtained by the issuer. Direct response writers shall deliver the buyers guide to the applicant upon request, but not later than the time the policy is delivered.

## 2. Notice Requirements

- (A) As soon as possible, but not later than 30 days prior to the annual effective date of any Medigap benefit changes, and issuer shall notify its insureds of modifications it has made to its Medigap policies. As well as being in a form acceptable to the commissioner, the notice shall:
1. Include a description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medigap policy, and
  2. Inform each policyholder as to when any premium adjustment is to be made due to changes in Medicare.
- (B) The notice of benefits modifications and any premium adjustments shall be made in outline form and in clear and simple terms so as to facilitate understanding
- (C) The notices shall not contain or be accompanied by and solicitations

**Section 15: Requirements of application forms and replacement coverage**

1. Comparison Statement. When a Medigap policy is to replace another, the applicant shall be presented (at least at the time of taking the application) with a comparison statement substantially identical to the Kentucky Medicare Comparison Statement (available from the Department of Insurance). Direct response issuers shall present the comparison statement no later than the time of delivery of the policy.

Agent shall obtain the signature of the applicant on the comparison statement and shall send the comparison statement to the issuer. A copy of the comparison statement shall be attached to the replacement policy.

2. Applications forms shall include the following statements and questions to determine whether the applicant has another Medigap policy:

**(A) Statements:**

1. You do not need more than one Medicare Supplement Policy.
2. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement Policy
3. The benefits and premiums under your Medicare Supplement Policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning Medicaid.

**(B) Questions: To the best of your knowledge:**

1. Do you have another Medicare Supplement policy in force? If so with which company?
  2. Do you have any other health insurance policies that provide benefits that this Medicare Supplement policy would duplicate? If so, with which company? What kind of policy?
  3. If the answer to either of the above questions is yes, do you intend to replace these health policies with this policy?
  4. Are you covered by Medicaid?
3. Agents shall list any other health insurance policies they have sold to the applicant
    - (A) List policies sold that are still in force
    - (B) List policies sold in the past five years that are no longer in force

4. In the case of direct response: the issuer must supply a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy

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5. Upon determining that a sale will involve replacement of an existing policy: the issuer (or its agent) shall furnish the applicant (prior to issuance of the replacing policy) a notice regarding replacement. One copy of the notice signed by the applicant and agent shall be provided to the applicant, an additional signed copy shall be retained by the issuer
6. The notice required by subsection 5 of this section shall be provided in substantially the following form in no less than 10 point type:

**NOTICE TO THE APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE**

**(INSURER NAME AND ADDRESS)**

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE**

According to (your application or information you have furnished), you intend to terminate existing accident and sickness insurance and replace it with a policy to be issued by: (insurer name). Your new policy provides (insert amount of time here not less than 30 days) within which you may decide without cost whether or not you desire to keep this policy.

You should review this new coverage carefully. Compare it with all health insurance you have now. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

**STATEMENT TO APPLICANT BY ISSUER OR AGENT (OR OTHER REPRESENTATIVE)**

I have reviewed your current health insurance coverage. The replacement of insurance involved on this transaction does not duplicate coverage, to the best of my knowledge. This replacement policy is being purchased for the following reason(s) check one:

- Additional Benefits
- No Benefits change, but lower premiums
- Fewer Benefits and lower premiums
- Other (please specify)

- 
- (A) Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas

a similar claim might have been payable under your present policy (this paragraph may be modified if preexisting conditions are, in fact, covered under the new policy)

- (B) State law provided that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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- (C) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been recovered properly. (If the policy or certificate is guaranteed issue, this paragraph need not appear)

- (D) Do not cancel your present policy until you have your new policy and are sure that you want to keep it.

Signature of Agent or Representative \_\_\_\_\_

Typed name and address of Agent

The above "notice to applicant" was delivered to me on: \_\_\_\_\_ (date)

\_\_\_\_\_ (applicant's signature)

(7) Subsection (5) (A) and (B) of this section may be omitted from the replacement notice if the replacement policy or certificate does not involve application of a new preexisting condition limitation.

**Section 16: Filing Requirements for Advertising of Medigap policies.**

- (A) An issuer shall provide a copy of any Medigap advertisement intended for use in Kentucky whether through written, radio, or television, to the commissioner prior to use. Ads disapproved by the commissioner shall not be used.
- (2) Issues and agents shall not use the name and addresses of persons purchased as "leads" unless the solicitation material used to obtain such "leads" are filed as advertisements as required by this section. Solicitation materials disapproved by the commissioner shall not be used.

**Section 17: Policy Delivery.**

If a Medigap policy is not delivered by mail, the agent or issuer shall obtain a signed and dated delivery receipt from the insured. If the delivery receipt is obtained by an agent, it shall be forwarded to the issuer.

## Section 18: Standards of Marketing

(1) An issuer, directly or through its agents or other representatives shall:

- (A) Establish marketing procedures to assure that any comparison of policies by its agents or other representatives will be fair and accurate.
- (B) Establish marketing procedures to assure excessive insurance is not sold or issued.

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- (C) Display promptly by type, stamp, or other appropriate means, on the first page of the policy, the following disclosure: **NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES**
  - (D) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant to enroll for Medigap insurance already has accident and sickness insurance.
  - (E) Establish audible procedures for verifying compliance with this subsection
- (2) In addition to the practices prohibited in KRS Chapter 304.12 and 806 KAR Chapter 12, the following acts and practices are prohibited:
- (A) "Twisting" Making an unfair or deceptive representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
  - (B) "High Pressure Tactics" Employing any method of marketing having the effect or of tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or under pressure to purchase or recommend the purchase of insurance.
  - (C) "Cold Lead Advertising" Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or carrier.
- (3) The terms "Medicare Supplement", "Medigap", Medicare wrap-around" and words of similar import shall not be used unless the policy is issued in compliance with this administrative regulation

## Section 19: Appropriateness of recommended purchase and excessive insurance:

- (1) In recommending the purchase or replacement of any medigap policy, an agent shall make reasonable efforts to determine the appropriateness of recommended purchase or replacement
- (2) Any sale of more than one Medigap policy to an individual is prohibited.

## Section 20: Reporting of multiple policies:

- (1) On or before March 1 of every year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medigap policy:
  - (A) Policy and certificate number
  - (B) Date of issuance
- (2) The items set forth above shall be grouped by individual policyholders.

**Section 21: Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies.**

- (1) If a Medigap policy replaces another, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new policy for similar benefits to the extent that such time was spent under the original policy.
- (2) If a Medigap policy replaces another that has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.

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**A FINAL FEW WORDS**

*(NOT FROM THE KENTUCKY INSURANCE CODE)*

Federal criminal and civil charges can be brought against agents (and carriers) that commit infractions in presenting Medigap Insurance. Agents misrepresenting themselves as employees or agents of the Medicare program also face federal charges. False statements made by an agent concerning a policy's certification also violate federal law.

Remember that Medigap policies may fill the gaps of Medicare and perhaps raise limits, but are not designed to cover custodial nursing home care. To that end, consumers should purchase Long Term care insurance.

**Quiz D:** Miss Goodson, insurance agent, represents herself to Medigap prospects as the Surgeon General of the United States. The policy she recommends duplicates Medicare coverage's, she does not discuss such policy features as deductibles and exclusions. She does not give her prospects copies of the Medicare Buyers Guide, and she freeloards drinks at their home. How many felonies does Miss Goodson commit on the average sales call?

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## Glossary

**ASSIGNMENT OF BENEFITS**—An arrangement through which a provider agrees not to charge a patient more for a given service than Medicare will pay.

**CARRIER**—In relation to Medicare, an insurer that handles claims for Part (B)

**DISEASE-RELATED GROUP**—System of possible diagnoses, 23 major categories and 470 distinct groups.

**GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE**—Book that agents are required to give Medicare Supplement Insurance prospects residing in Kentucky

**HOSPICE**—Provides services to the terminally ill, but not curative treatment.

**INTERMEDIARY**—In relation to Medicare, an insurer that handles coverage and payment for decisions for Part (A).

**KENTUCKY ADMINISTRATIVE REGULATIONS**—Rules promulgated by the Kentucky Department of Insurance

**KENTUCKY REVISED STATUTES**—Laws passed by the Kentucky General Assembly

**MEDICAID**—Socialized Medicine program designed for the indigent

**MEDICARE**—National health insurance for the disabled and people aged 65 and older, enacted into law 1965

**MEDICARE-CERTIFIED**—A hospital, hospice, skilled nursing facility, or other provider that has been certified by Medicare as meeting its standards.

**MEDICARE PART (A)**—Hospital Insurance component of Medicare

**MEDICARE PART (B)**—Medical Insurance component of Medicare

**MEDICARE SUPPLEMENT INSURANCE**—Private insurance designed to provide medical coverage where Medicare does not (e.g. deductibles, co-payments, exclusions)

**PEER REVIEW ORGANIZATION**—A panel of doctors and health professionals that review hospital care received by Medicare patients. Also reviews patient complaints and can deny a Medicare payment.

**PROSPECTIVE PAYMENT SYSTEM**—Method through which Medicare determines hospital payments, incorporates patients diagnosis upon admission

**SKILLED NURSING FACILITY**—Facility that offers skilled and rehabilitative services, above a custodial or intermediate facility

**SOCIAL SECURITY**—Although technically not part of the Medicare system, the program is funded through it. Part A is financed through Social Security deductions, Part (B) in financed through the checks of Social Security recipients.

**SPELL OF ILLNESS**—How Medicare divides benefit periods.