Chapter 8: Just in Case – Additional Material

Here I go into detail about Medicare, Medicare Advantage (MA) plans, and Medigap plans.

What about Medicare?

Medicare is a federal health insurance program for people age 65 or older, who are eligible for Social Security retirement benefits or railroad retirement benefits. Medicare pays for a significant portion of our medical bills after age 65, so it's an important part of our financial security. If we can somehow make it to age 65 with respect to our health and medical insurance, we can breathe a financial sigh of relief. However, Medicare doesn't pay all medical bills – in fact, by some estimates, it pays only a little more than half of seniors' medical costs. So, there's no excuse to stop taking care of ourselves, both for financial and for quality-of-life reasons.

As a result of the recently passed Medicare reforms, there are now four parts to Medicare:

- Part A covers services provided by hospitals, nursing homes, home health agencies, and hospices.
- Part B covers services provided by physicians and other outpatient services.
- Part C is called Medicare+Choice, and allows beneficiaries to join managed health care plans in return for increased services and reduced cost-sharing amounts. The Medicare Reform Act changed the name to Medicare Advantage (MA).
- The newly enacted Part D covers prescription drugs, effective January 1, 2006.

Now let's take a look at each Part.

Part A. We're automatically eligible for Part A benefits if we are eligible for Social Security retirement benefits. This requires paying Social Security taxes (F.I.C.A. taxes) for at least 40 calendar quarters (10 years) over our lifetime. In this case, there is no premium for Part A coverage.

If we do not have 40 quarters of coverage, we can buy Part A benefits (monthly premiums in 2004 are $189 if we had at least 30 quarters of paying F.I.C.A. taxes, and $343 if we had less than 30 quarters). Most workers are covered by Social Security and Medicare, except for some employees of state and local governments. If we don't have any other medical coverage, we should consider buying Part A coverage. At $189 per month, it's a good deal. At $343 per month, we might want to shop around for less expensive solutions.

Part A covers most inpatient services that are provided by health care institutions and are approved by Medicare. The word 'inpatient' usually refers to a situation where the patient stays overnight at the facility, such as a hospital, skilled nursing facility, or hospice. There are many rules and conditions regarding the insurance coverage. I won't go into detail here, but below I show a few important limits:

- There is a deductible ($876 in 2004) for each spell of illness. We can have more than one spell of illness per year.

- Inpatient hospital coverage expires after 90 days per spell of illness, although there is an additional lifetime reserve of 60 days.

- There is no copayment, other than the deductible, for the first 60 days in a hospital. There is a copayment of $219 per day in 2004 for the 61st through 90th days in a hospital. If lifetime reserve days are used, the copayment is $438 per day.

- There is no copayment, other than the deductible, for the first 20 days in a skilled nursing facilitiy. There is a copayment of $109.50 per day in 2004 after 20 days in a skilled nursing facility.

All of the above deductibles and copayments increase each year for inflation.

The reason I mention the above limits is to demonstrate the case for buying a Medicare supplement policy (see later in this document). In *Live Long & Prosper!* I advocate buying catastrophic medical policies before age 65. However, in my mind Medicare by itself has too many limits to be a satisfactory catastrophic policy. Just look at the copayments mentioned

above – a lengthy stay in a hospital or skilled nursing facility can result in thousands of dollars, and we haven't even talked about the copayments for Medicare's other Parts.

Part B. While Medicare defines Part A coverage in terms of the provider of service (i.e. hospital, nursing home), Part B coverage is defined by the kind of service provided. Only services specifically listed by Medicare are covered by Part B. These include services performed by physicians, surgeons, or nurses, certain drugs that must be administered by a health-care professional, outpatient hospital services, X-ray and laboratory services, certain physical therapy services, diagnostic services, certain medical equipment and supplies, prevention services, home health services, and a whole host of other services. This isn't intended to be a complete list.

We must pay a monthly premium for Part B benefits of $66.60 per month in 2004 (it increases each year). Currently, Part B premiums are about 25% of the cost of the coverage, with a 75% subsidy from the government. In 2007, the Medicare Reform Act will begin means-testing the premiums, and will phase in increases in the Part B premiums for higher-income individuals through 2011. The following table summarizes the higher premiums that will ultimately apply in 2011 and beyond.

Table 8.2. Means-testing for Medicare Part B premiums, effective 2011.

Income for Singles	Income for Married Couples	Increase Over Basic Premium
Under $80,000	Under $160,000	No increase
$80,000 to $100,000	$160,000 to $200,000	1.4 times basic premium
$100,000 to $150,000	$200,000 to $300,000	2 times basic premium
$150,000 to $200,000	$300,000 to $400,000	2.6 times basic premium
Over $200,000	Over $400,000	3.2 times basic premium

Furthermore, Part B has a deductible of $100 per year, plus a copayment of 20%. Finally, Medicare prescribes the amounts it will pay for various services; we are on the hook if our provider charges more. Again, I won't go into detail here, other than to make a few more points:

- I'll buy Medicare Part B – it's a good deal.

- I'll buy it as soon as I'm eligible, which is age 65. If I delay my enrollment, the premium increases by 10% for each 12-month period that I was eligible but declined coverage. The one exception is if I am covered by a medical plan at work, or my spouse's medical plan at his or her work.

- When I do buy medical services, I'll ask to make sure that my provider accepts the Medicare reimbursement and doesn't charge more.

The Medicare Reform Act of 2003 added payment for certain preventative services effective January 1, 2005, including an initial physical upon enrollment in Part B, and screening for cardiovascular disease and diabetes.

Part C – now known as Medicare Advantage (MA). This part was called 'Medicare Plus Choice,' and the Medicare Reform Act of 2003 renamed these plans Medicare Advantage (MA). With this arrangement, private companies, often HMOs, contract with Medicare to provide all the services normally paid by Medicare Parts A and B, plus some additional services and expenses that aren't covered by Medicare. Medicare reimburses the Medicare Plus Choice programs for providing these services.

Here are examples of additional services and expenses that a Medicare Plus Choice plan might cover:

- Prescription drugs (but note that starting in 2006 these will be covered by Part D).

- Medicare's deductibles and copayments.

- Stays in hospitals or skilled nursing facilities beyond Medicare's maximums.

- Costs of routine physical exams, hearing aids, and eye exams.

The premiums for Medicare Plus Choice plans vary, depending on the generosity of the benefits. Some may charge just the Part B premium that we would otherwise pay. However, for more generous policies, there can be an additional premium for services that go well beyond

services covered by Medicare. It remains to be seen how premiums will increase for Medicare Advantage plans in 2006, when prescription drugs are covered by Part D.

The downside of Medicare Plus Choice programs is, ironically, choice, or lack thereof. Participants are usually limited to using doctors and facilities that belong to the Medicare Plus Choice or Medicare Advantage program, just like other HMOs. We might expect introduction of Medicare Advantage plans more like PPOs, which could be a good option.

When Medicare Plus Choice was first introduced, there was a lot of optimism that these plans could provide more services at lower cost. Initially, many people signed up. However, experience over the years has been mixed. Some Medicare Plus Choice plans haven't realized the expected cost savings, and have found that the government reimbursements were inadequate. Many participants have been disappointed with these plans as well. Enrollment has declined, and some HMOs and other companies have abandoned their programs.

The Medicare Reform Act has provisions that are intended to beef up the newly named Medicare Advantage (MA) plans. We will see the MA landscape change in the next few years, and I'll share experience as it unfolds on my web site, www.restoflife.com.

Part D. The Medicare Reform Act of 2003 added coverage for prescription drugs; this represents a significant change, since previously Medicare did not pay for prescription drugs. This coverage begins January 1, 2006.

Part D provides for voluntary coverage; it is estimated that the initial monthly premium will be about $35. The premium will increase significantly if we do not elect it when we are first eligible. We don't yet know all the details on how this increase will be calculated, but it will be at least 1% for each month that we have declined coverage. For example, if I delay enrolling in Part D for 30 months, my premium will increase by at least 30%, maybe more.

There will be three ways to elect this coverage.

1. Through a plan sponsored by an employer, if we are still working.

2. Through stand-alone prescription drugs plans (PDPs), offered by private organizations such as insurance companies.

3. As part of a Medicare Advantage (MA) program, which we just discussed.

The Part D coverage has significant gaps, a situation that has even coined the term 'Part D doughnut.' Let's take a look at how the annual limits work.

- We have a deductible of $250, which means we must pay for the first $250 of prescription drug costs each year.

- After we pay the $250 deductible, we pay for 25% ($500) and Medicare pays for 75% ($1,500) of the next $2,000 in prescription drug costs.

- Once we've incurred costs of $2,250 (the $250 plus $2,000), we pay for the entire cost of prescription drugs, until total spending for prescription drugs reaches $5,100.

- If we have incurred $5,100 in total costs for prescription drugs, we've paid $3,600 of this amount, and Part D has paid $1,500.

- Part D will pay for 95% of prescription drug costs above $5,100.

All of the above amounts will be indexed for inflation.

Here's a table which summarizes these costs.

Table 8.3. Out-of-pocket costs for prescription drugs under Medicare Part D.

For drugs costs between…	I pay…	Up to…	My total costs are…
$0 and $250	100%	$250	$250
$251 and $2,250	25%	$500	$750
$2,251 and $5,100	100%	$2,850	$3,600
Over $5,100	5%	No limit	$3,600 plus 5% of drug costs above $5,100

Add the estimated annual premium of $420 to the above amounts.

The Part D 'doughnut hole' is the amount of drugs between $2,251 and $5,100 that we must pay entirely.

Should we buy Part D coverage? There isn't an easy answer. The benefits aren't generous for most people. It pays well if I have relatively small costs, under $2,250. If I have moderate costs, between $2,251 and $5,100, it doesn't pay any more, and it really kicks in only if I have very high drug costs. Note that the annual Part D premium will start at $420. For this premium, we get reimbursed for only $1,500 of total drug costs up to $5,100. I consider Part D to be catastrophic coverage – it protects us against prescription drug costs that greatly exceed $5,100.

Here's one example that illustrates my ambiguity on prescription drug coverage. For the medical plan of one large client, we analyzed the top 50 prescription drugs that cost the most money. Of these, 85% of the cost was for conditions that could have been prevented by a healthy lifestyle. These included drugs to reduce cholesterol, reduce blood pressure, reduce stress, treat ulcers, and relieve arthritis. It keeps coming back to this – the best way to protect against catastrophic costs for prescription drugs is to take care of ourselves. This starts with the four factors mentioned in Chapter 7 of *Live Long & Prosper!* – diet, exercise, don't smoke, and don't abuse alcohol.

To summarize Medicare, it's an important part of our financial security once we reach age 65. However, it's not complete, so we'll also need to supplement this coverage with private insurance, unless we participate in a Medicare Advantage plan. I cover Medicare supplement plans next.

This book isn't intended to be a complete guide to Medicare, or on obtaining Medicare benefits when we have an illness.. When I need more information, I'll look at the wealth of information about Medicare on the official Medicare web site: www.medicare.gov.

Medicare Supplement Policies

We can buy private health insurance policies that fill in the gaps in the Medicare Parts A and B coverage. Hence the common name 'Medigap' plan. And as we've seen, the gap in Medicare is

indeed large. According to a study conducted by the Kaiser Family Foundation, Medicare covers only 56% of total health care expenditures for people age 65 and older, and as a result, 87%of these Americans buy some sort of supplemental policy.

If we participate in a Medicare Plus Choice plan (now known as Medicare Advantage), then we don't need a Medigap plan. In fact, it is illegal for anyone to sell us a Medigap plan if they know we are enrolled in a Medicare Advantage plan.

In *Live Long & Prosper!* I identified resources for individually purchased health care plans - we can use the same resources for Medigap policies.

There are 10 standardized Medigap plans, called 'A' through 'J'. Each plan has a different set of benefits. Plan A covers only basic benefits, which are included in all the plans. Plan J provides the most generous benefits, with the highest premiums. Not all insurance companies offer all the Medigap plans, and all types of plans may not be available in certain states or geographic areas.

Basic benefits, covered by all the plans, include the following.

- Copayments under Part A for hospital stays.
- Coverage for hospital stays beyond the Part A maximums.
- Copayments under Part B for most covered services.

As we go from Plans B through F, the following benefits and services are added.

- The Part A hospital deductible.
- Coinsurance for skilled nursing facilities.
- The Part B deductible.
- Costs of emergencies in foreign countries.

- Coverage for some home health services.
- Coverage for specified preventive medical care.
- Payments for physician charges in excess of Medicare-approved charges.

An important milestone is Plan H, which usually adds limited coverage for prescription drugs. The drug benefit gets more generous as we go to the highest plan - Plan J.

One nice feature of Medigap policies is that they must be guaranteed renewable. This means that if we keep paying our premiums, the insurance company cannot cancel our policy, regardless of how sick we get.

The Medicare Reform Act prohibits Medigap policies from covering prescription drug expenses in 2006. As a result of this and other features of this new law, we can expect significant changes in Medigap policies in the future. I'll summarize experience as it unfolds on my web site, *www.restoflife.com.*

Here are examples of budgets for annual premium amounts in 2004 for Medicare and private insurance, once we turn age 65. This is just an example for budgeting our total *rest-of-life* expenses, which we will do in later chapters. I had to mix apples and oranges, because Medicare Part D won't be available until 2006. For Medigap insurance, I used a Plan F policy offered in 2004 – a generous plan that doesn't cover prescription drugs, since Part D will cover drugs beginning in 2006. During 2004, monthly premiums for these plans ranged from $100 to $200 – I used the higher number for the budget below.

Medicare Part B	$800
Medicare Part D	$420
Medigap	$2,400
Out of pocket costs	$3,600
Total	$7,220

Table 8.4. Sample annual budget for medical costs.

The out-of-pocket costs are for medical expenses that aren't covered by any of these plans. For example, if we are heavy users of prescription drugs, we might need to include estimates of out-of-pocket maximums under Medicare Part D. I just used an estimate of $300 per month, which one study identifies as average out-of-pocket expenses. If we take care of ourselves, we might be able to reduce this significantly, perhaps close to zero.

These costs aren't cheap! It's one important reason to consider Medicare Plus Choice – now Medicare Advantage. It's also a good reason to take care of ourselves, and to build a financial cushion in an HSA, as I advocate in *Live Long & Prosper!*

This document is intended to complement and reinforce the themes in *Live Long & Prosper!* I don't intend for it to make complete sense without reading the book.

The main point of *Live Long & Prosper!* is that I won't let the fear of high costs for medical insurance prevent me from living the life I want! I have the tools and knowledge to manage my fear of high medical bills.