



Kiplinger Financial Services' COMMON CENTS MATTERS

AUGUST, 2004

HEALTH CARE (Part 1 of 2)

Reviewing health care coverage in preparation for retirement or during a period of unemployment can be confusing. According to the Employee Benefits Research Institute (EBRI), actual expenses are five times greater than those projected by people approaching retirement. Medicare doesn't cover as much as people think. Further, most people have not had to pay health care costs because they have received employer-subsidized health care coverage during their employment years.

According to a study released in early 2004 by the Kaiser Family Foundation and Hewitt Associates, 10% of employers said they dropped plans for future retirees within the previous year, and 20% said they are likely to drop coverage in the next three years. Only 38% of employers with 200 or more workers offer retiree health plans, compared with 66% in 1988.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, was signed into law by President Bush on December 8, 2003. Health care programs, such as Medicare, have been changed and new health plans, the Health Savings Accounts (HSA) have been established. Let's review the highlights of these programs to gain a better understanding of health care coverage available. In *Health Care, Part 1 of 2*, we will review the benefits that Medicare provides and in Part 2 of 2, we will look at the HSAs.

MEDICARE – CURRENT LAW

ELIGIBLE PARTICIPANTS Medicare is a health insurance program primarily for people age 65 or older. It is also available to people under age 65 that have certain disabilities and those with end-stage renal disease.

MEDICARE STRUCTURE Medicare is divided into two parts: Part A, hospital insurance and Part B, medical insurance.

➤ **Part A – Hospital Insurance**

Premium Cost – Free as long as the participant or spouse paid Medicare taxes while working.

Coverage – Hospital stays, skilled nursing facility care, home health care and hospice care. The participant pays a portion of the costs for each benefit period, which begins the day the participant is admitted into the hospital or skilled nursing facility and ends 60 days after discharge. If the participant reenters the hospital within 60 days of discharge, it is considered to be the same benefit period. If the participant reenters more than 60 days after discharge, a new benefit period begins. There is generally no limit to the number of benefit periods per participant, unless the care is for hospice.

Participant Co-Insurance Payments in Effect for 2004:

- **Hospital Stays – Participant Pay**
 - A total of \$876 for a hospital stay of 1-60 days
 - \$219 per day for days 61-90
 - \$438 per day for days 91-150
 - All costs for each day beyond 150 days
- **Skilled Nursing – Participant Pay**
 - Nothing for the first 20 days
 - Up to \$109.50 per day for days 21-100
 - All costs beyond the 100th day in the benefit period (skilled nursing does not include custodial or long-term care)
- **Home Health Care – Participant Pay**
 - Nothing
 - 20% of the Medicare-approved amount for durable medical equipment
- **Hospice Care – Participant Pay**
 - A co-payment of up to \$5 for outpatient prescription drugs
 - Around 5% of the Medicare-approved amount for inpatient respite care (short-term care given to hospice patients so the usual care giver can rest) depending on location

➤ **Part B – Medical Insurance**

Premium Cost – The monthly premium for 2004 is \$66.60 and is usually deducted from the participant's Social Security check.

Coverage – Doctor visits and other outpatient medical services and supplies including diagnostic tests and durable medical equipment, i.e., wheelchairs, hospital beds, etc.

Participant Co-Insurance Payments – Each year the participant pays:

- \$100 deductible
- 20% of the Medicare-approved amount. If the provider charges more than the Medicare-approved amount (it cannot be more than 15% higher), the participant pays the difference, in addition to the 20%.
- 20% for all outpatient physical, occupational and speech-language therapy services
- 50% for outpatient mental health care

TYPES OF HEALTH CARE SERVICES PLANS

- **The Original Medicare Plan** – is a fee-for-service plan and is available nationwide. Participants often buy a supplemental Medigap policy from a private insurer to cover gaps in coverage.
- **Medicare + Choice Plans** – are offered by private providers and vary. They include both Parts A and B and may include additional benefits similar to Medigap policies.

Medigap policies are divided into 10 packages “A” through “J” with increasing benefits and increasing premiums. Plans range from basic coverage of some of the Medicare coinsurance amounts to some prescription drug coverage.

ENROLLMENT You are automatically enrolled in Medicare if you are entitled to receive Social Security at age 65. You receive your Medicare card about three months before you attain age 65.

- **Part A:** If you are not receiving Social Security benefits at age 65, application can be made three months before your 65th birthday at no charge.
- **Part B:** There are several enrollment periods to choose from for Part B:
 - **Initial enrollment** – This is the seven-month period that begins three months before age 65. If you are enrolling for Parts A and B at the same time, this is the enrollment period to take advantage of.
 - **General enrollment** – This period runs from January 1st through March 31st of each year with coverage beginning the following July 1st. The penalty for waiting beyond age 65 is a premium cost that is 10% higher for each 12-month period that you could have had Part B, but did not take it unless the reason for waiting is that you or your spouse were working and

you were covered by an employer-sponsored health plan (see special enrollment).

- **Special enrollment** – If you have delayed Part B coverage due to being covered by an employer-sponsored health plan, there is no premium-cost penalty. This enrollment period ends eight months after the employer-sponsored coverage ends or when the employment ends (whichever is first). If you do not enroll during this special enrollment period, then the general enrollment provisions apply.
- **Medigap open enrollment** – This period begins when you enroll in part B and extends for six months. You may not be denied coverage or be charged higher premiums regardless of your medical condition during this time. Once the Medigap open enrollment period ends, insurers are free to deny coverage, charge higher premiums or place restrictions on the policy.

MEDICARE & THE NEW LAW

The timeline of significant changes is as follows:

- **2004 – 2005:** Enrollees receive a 10% to 15% discount on some drugs, and low-income enrollees can get a \$600 annual credit on drug purchases.
- **January 2005:** The Medicare, Part B deductible increases from \$100 to \$110 and is indexed for inflation thereafter.
- **November 15, 2005 to May 15, 2005:** This is the initial enrollment period to sign up for the new Medicare Advantage plan, a new managed care plan that includes prescription drug benefits. If you delay enrolling, you will pay more, unless you have drug coverage at work. Once coverage ceases at work, you will have 63 days to sign up.
- **January 2006:** New drug benefit and Medicare Advantage program goes into effect.
- **January 2007:** Higher premiums for Medicare Part B will be paid by individuals with incomes over \$80,000 and couples with incomes over \$160,000, regardless of whether or not they sign up for the drug benefit. The extra payments will be calculated on a sliding scale and will be phased in over five years. By 2011, the highest income group will pay three times the regular premium.

Hopefully, this overview gives you an indication of the coverage Medicare provides. Look for *Health Care, Part 2 of 2* which will discuss Health Savings Accounts (HSAs).